REPORT OF THE DOMESTIC VIOLENCE HOMICIDE ADVISORY PANEL

2009

Contents

1. Executive Summary

The Domestic Violence Homicide Advisory Panel (the Advisory Panel) was established by the Premier to review domestic violence related homicides in NSW. The Advisory Panel's Terms of Reference were to:

- Define the meaning of 'domestic and family violence related' homicide;
- Consider the NSW Bureau of Crime Statistics and Research (BOCSAR)'s analysis of trends and patterns in domestic and family violence related homicides in NSW for the period 1 January 2003 to 30 June 2008;
- Consider the elements of an ongoing review mechanism, including –
  - The need for a legislative basis,
  - The need for any amendments to privacy legislation,
  - Data collection methodology;
- Recommend any changes to practices and procedures that would contribute to a reduction in preventable domestic and family violence related homicides, including a model for an ongoing review mechanism.

What is a Homicide Death Review Process?

A domestic violence homicide review is a collaborative process, involving government and non government agencies, that seeks to reduce the incidence of domestic violence related homicides and improve service delivery to domestic violence victims and perpetrators. Underpinned by a philosophy of nonjudgmental evaluation of the events leading up to the homicide, its purpose is to identify and recommend improvements in the responses by the many agencies that make up the collaborative response to domestic violence. It also monitors progress in the implementation of its recommendations and draws on emerging research to develop best practice guidelines.

Methodology

The methodology adopted by the Advisory Panel included: a review of research literature on domestic violence related homicides, risk assessment, and homicide review mechanisms; consideration of the analysis of domestic violence related homicides between January 2003 and June 2008 conducted by BOCSAR (Appendix A); an analysis of international models for domestic violence homicide reviews including a briefing on United Kingdom developments from Dr Laura Richards, an expert in the field; documentation of existing death review mechanisms in NSW; consultations with officers from the Office of the NSW Ombudsman and

the NSW Coroner; and attempted an analysis of five case studies of domestic violence related homicides in NSW.

International Experience

a) Domestic violence homicide review mechanisms

Domestic violence homicide review mechanisms have been established in several countries including Canada (Ontario), New Zealand, the United Kingdom and the United States. Since 1991, at least 82 domestic violence homicide review teams have been developed across the United States. The models vary, but share common features including: a legislative basis; membership comprising government and non-government representatives; members are bound by strict confidentiality provisions; the view that domestic violence related homicides are preventable; and focus on prevention and intervention.

Positive outcomes that have been attributed to domestic violence homicide review mechanisms include:

- Greater knowledge about domestic violence;
- Improvements to services and systems;
- Enhanced public and professional education and training; and
- Generating inter-professional information sharing and discussions for change.

b) Identifying risk factors

Extensive international research has resulted in a general consensus that certain factors, including the following, may indicate a higher potential for a domestic homicide to occur:

- Prior domestic violence;
- Threats of, or use of weapon against a woman partner;
- Threats to kill a woman partner;
- Attempts to choke (strangle) a woman partner;
- Estrangement;
- The presence of a gun in the house.[1]

[1] Other factors may include: victim threatened or tried to commit suicide, partner threatened or tried to commit suicide, partner violent outside the home, partner reported for child abuse, woman believed he was capable of killing her, woman ever beaten while pregnant, partner drunk every day or almost every day; partner uses illicit drugs, physical violence increased in frequency, partner controls most or all of woman's daily activities, physical violence increased in severity, woman forced to have sex when not wanted, partner violently and constantly jealous.

The Ontario committee has consistently found seven or more risks factors were present in more than two thirds of the cases that they have reviewed; they consider that the presence of seven or more risk factors indicates that the homicide was preventable.[2]

National Developments

The National Plan to Reduce Violence against Women has identified the establishment of domestic homicide review processes as a priority area for action. Victoria is the only Australian jurisdiction with a review mechanism, which considers family violence deaths investigated by Victorian Coroners, supported by a prevention unit. As that mechanism has only recently been established, it is too early to measure the effectiveness of its outcomes.

Other Death Review Mechanisms in NSW

The Advisory Panel considered the following NSW death review mechanisms with a view to identifying potential models, and avoiding potential overlap should a Domestic Violence Homicide Review mechanism be established:

- Child Death Review Team;
- The Department of Community Services' (DoCS) Child Deaths and Critical Reports Unit;
- NSW Ombudsman;
- NSW Coroner;
- Mental Health Sentinel Events Review Committee; and
- NSW Ministerial Maternal and Perinatal Committee.

BOCSAR Analysis of Domestic Violence Homicides in NSW

The BOCSAR study analysed information held on the NSW Police Force's Computerised Operational Policing System (COPS) database for homicide between January 2003 and June 2008, supplemented by Supreme Court judgments (where available) and media sources. A key finding, in the view of the Advisory Panel, was that 43 percent of relevant cases were *not* flagged as domestic violence related on the COPS system and that 36 percent of those homicides were found to be intimate partners/intimate partner related.[3]

The majority of victims and offenders involved in domestic homicide had not come to the attention of police in the preceding 12 months. This is consistent with research evidence that

[2] This finding is contrasted with the findings of the BOCSAR report which suggests that it is not possible using data collected by police to determine which cases of domestic assault are mostly likely to result in a domestic homicide.
[3] This information is not contained in the BOCSAR report but was information obtained by the Panel after the Report was completed.

victims of domestic violence commonly seek assistance from informal sources and a range of services, and that many incidents of domestic violence are not reported to the police.

The study also compared intimate partner femicides (a subset of domestic homicides), to a random selection of non-lethal domestic assaults by males on their current or former intimate female partners. Based on the prior history data recorded by the NSW Police Force, the femicide offenders did not differ from offenders who came to the attention of police for a non-lethal assault on most dimensions, apart from the fact that, compared with the offenders in the non-lethal assault group, a higher proportion of femicide offenders were ex-spouses or ex-partners of the victim. The majority of offenders in both groups were likely to have had contact with the police for a violence related offence over the past five years but this was higher for the non- lethal assault group (70%) than of the femicide group (53%). Over the past 12 months, ten percent of offenders within each of these groups were involved as the person of interest in at least one assault against the victim. Almost one in five of the homicide offenders and one in ten assault offenders were the defendants in an AVO, with the victim as the protected person.

Information Exchange and Privacy Considerations

To assist in its deliberations, the Advisory Panel intended to consider five cases of domestic violence homicides in depth. However, following advice from the Privacy Commissioner and the Crown Solicitor's Office, the Advisory Panel was limited to reviewing only that information that was publicly available, which proved to be inadequate for the intended purpose. This demonstrates that it is an absolute requirement that any review mechanism be supported by a legislative framework that facilitates the sharing of information between agencies.

The Need for a Domestic Violence Homicide Review Mechanism in NSW

The Advisory Panel believes that the findings reviewed above underscore the need to establish a specialised domestic violence homicide review mechanism in NSW, as a means of identifying whether victims and offenders have access to appropriate agencies and services, and to ensure that laws, policies, and services are effective. Such a mechanism needs to be supported by improved data collection, including enhancements to COPS to ensure the identification of relevant cases, but also should draw on data held by other departments and agencies.

Recommendation 1

The NSW Government should establish a domestic violence homicide review mechanism.

Proposed NSW Definition of a Domestic Violence Homicide

The definition recommended by the Advisory Panel is consistent with s5 of the *Crimes (Domestic and Personal Violence) Act 2007* to the extent that the section deals with an intimate relationship. The proposed definition takes into account the specific requirements of a review mechanism and the kinds of cases which may fall within its purview. For example, there are cases where an intimate partner will kill children but not the other partner; this is not solely a child protection issue, but also a brutal form of domestic violence.

Recommendation 2

A death should be considered to be a domestic violence homicide, and therefore capable of being reviewed, if the death appears to be directly or indirectly caused by a person who was in a domestic relationship with the deceased or, in the case of an Aboriginal person or a Torres Strait Islander, is or has been part of the extended family or kin of the other person according to the Indigenous kinship system of the person's culture.

A person has a domestic relationship with another person if the person:

a) was married to the deceased person; or

b) had a de facto relationship, within the meaning of the Property (Relationships) Act 1984, with the deceased person; or

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

d) was a parent of the deceased person, or had been exercising parental responsibilities for the deceased person; and there was a history of violence between the person and any other parent or person exercising parental responsibilities for the deceased person;

e) has any other such relationship as the Domestic Violence Homicide Review Team deems to be appropriate for review.

Functions of Domestic Violence Homicide Review Mechanism for NSW

The Advisory Panel identified seven functions that an adequate domestic violence homicide review mechanism should entail; these were based on the international literature, and the NSW context.

Recommendation 3

Any domestic violence homicide review mechanism in NSW should have these functions:

1. *Review individual deaths and identify where intervention may have prevented the death;*
2. *Identify trends and patterns in domestic violence homicides that have occurred during a particular time frame;*

3. *Establish and maintain a comprehensive database about the victims and perpetrators of domestic violence homicides and their circumstances ;*
4. *Conduct research where appropriate;*
5. *Identify best practice guidelines for agencies with reference to emerging research;*
6. *Educate the community and professionals about domestic violence; and*
7. *Provide a comprehensive report with findings and recommendations which highlight and address:*
    a. *systemic failures;*
    b. *procedural failures;*
    c. *risk management;*
    d. *suggestions for reform to legislation, policy, training and implementation of reforms.*

Essential Features for any Option

The Advisory Panel identified essential features necessary to ensuring the effectiveness of any review mechanism.

Recommendation 4

A domestic violence homicide review mechanism for NSW should include a strong legislative framework incorporating the following:

- *protection from disclosure in legal proceedings;*
- *immunity to those who disclose information to the review mechanism that would ordinarily be confidential or privileged;*
- *exemptions from freedom of information legislation;*
- *the ability for the review mechanism to compel information from relevant agencies;*
- *a statement of objectives that centre upon a 'no blame' philosophy, ensuring culpability of the perpetrator for the death is emphasised;*
- *a requirement that members are bound by confidentiality provisions as laid out in the legislation;*
- *a clear process for the notification of cases, including a provision enabling any person or agency to refer a case to the review team for potential inclusion in the review process;*
- *the power to make publicly available recommendations that can be directed at both government and non-government agencies;*
- *a mechanism to ensure the implementation of recommendations;*
- *membership that includes all relevant government and nongovernment service providers, noting the particular expertise that each sector and agency can bring to the process; and capacity for the review mechanism to seek expert advice where required;*

- *a minimum requirement for number of meetings per year;*
- *oversight mechanisms such as providing an annual report to an overseeing body; and*
- *statutory review on a periodic basis against clear measures and indicators.*

Terms of Reference

The Advisory Panel identified terms of reference, which should be used as a starting point for a review mechanism in NSW.

Recommendation 5

The following terms of reference should be established for any future review mechanism:

- *to examine the events leading up to the deaths of people who died within the context of domestic violence in order to gain a better understanding of domestic violence and improved criminal justice and human services responses;*
- *to examine the contacts made with services for support and assistance by the victim and offenders, and the appropriateness and quality of services and other relevant interventions provided to the victim and offender;*
- *to examine issues of access to such services for the victim and offender;*
- *to identify barriers to access and other impediments to help-seeking;*
- *to identify gaps in systems and service delivery;*
- *to identify systems failures;*
- *to recommend improvements to service delivery, training, systems and law reform, as appropriate;*
- *to monitor progress in the implementation of recommendations;*
- *to report to Parliament annually on findings of death reviews, recommendations made and progress of implementation of previous recommendations made;*
- *to create and maintain a comprehensive database about the victims and perpetrators of domestic violence homicides and their circumstances; and*
- *to stimulate educational activities and disseminate educational information where appropriate.*

The Model Preferred by the Majority for a NSW Domestic Violence Homicide Review Mechanism

The Advisory Panel reached consensus on a number of critical elements regarding a recommended model for a domestic violence homicide review mechanism for NSW including:

the scope of its functions, terms of reference, membership and what the model should look like, that is, a team of government and non government representatives with an appointed convenor. The one point of divergence between Panel members was who the appropriate convenor of a review team would be.

The majority preferred a model where the expert review team is convened by the Ombudsman. This model builds on existing powers and expertise in death review, and wider systemic reviews, held by the Ombudsman and his staff. This model was considered to be the best fit with the full range of the Terms of Reference proposed for the review mechanism, including the capacity to establish a database on domestic violence related homicides, draw from emerging research, and undertake public and professional education. It was also considered to avoid duplication and facilitate information sharing with respect to the review of related child deaths. It would ensure that government and non-government agencies were represented, and that work would be informed by wide ranging expertise. Consultations with the Deputy Ombudsman and staff indicated their support for the preferred philosophical approach to domestic violence death reviews, that is, of moving away from a shame and blame framework to one focussed on prevention and the improvement of systems.

The NSW Police Force preference is for a model that is based with the NSW State Coroner, as it considers that this is the body best placed to conduct these types of reviews. However, in the spirit of cooperation and to progress the discussion to determine an outcome, the NSW Police Force representatives supported the general consensus of an Ombudsman review model, while reiterating their preference for the Coronial review model.

The Attorney General's Department noted that whilst it agreed with the proposed form of review team, its preference was also for the team to be convened by the Coroner. In its view, the proposal is a focussed expansion of the existing functions of the Coroner which is to investigate deaths and make recommendations in relation to them. Given that the coronial model has already been adopted in other jurisdictions, the Coroner is also in the advantageous position of being able to utilise current and developing coronial networks across Australia and potentially internationally.

The Office for Women's Policy considered that the options of the NSW Ombudsman and NSW Coroner as convenor both had merit and that the policy arguments for and against each were finely balanced. On this basis, a preferred option was not identified.

Recommendation 6

The model preferred by the majority for a domestic violence homicide review mechanism in NSW is one that is established by appointing the Ombudsman as the convenor of an expert team with specific powers to investigate and review homicides relating to domestic violence (similar to the existing Child Death Review Team model).

Data Collection Issues

Accurate and thorough data collection is essential when attempting to understand domestic violence homicides so that policies and procedures can be put in place to prevent its occurrence. BOCSAR clearly identified a number of limitations concerning the collection of data including difficulties in identifying a domestic homicide population due to misclassifications and a lack of standardised reporting and recording mechanisms. Limitations were also identified in other systems including the national coronial database (NCIS) and at present no reliable system exists for the identification of domestic violence related suicides.

Recommendation 7

Improved data collection practices should be put in place as soon as possible, whether or not a domestic violence homicide review mechanism is adopted. These practices should include but not be limited to: enhancements to the Police COPS system and the National Coroners Information System (NCIS) to ensure more accurate flagging of domestic violence related homicides; the establishment and maintenance of a database to monitor domestic violence related homicides; and the development of mechanisms for the identification and reporting of domestic violence related suicides.

Avoiding Duplication, Ensuring Consistency

The Advisory Panel recognised that it is crucial that the domestic violence homicide review mechanism works in a manner that is consistent with, and does not duplicate, the work of other death review mechanisms, such as the Child Death Review Team. Other review mechanisms would also need to be cognizant of any recommendations flowing from a domestic homicide review team.

Recommendation 8

The Government should consider ways of ensuring that the various death review bodies in NSW are informed of relevant recommendations made by one another, to improve efficiencies and limit the risk of duplication.

Review

Recommendation 9

Consideration should be given to reviewing the scope of the definition of domestic homicide after 24 months, with a view to including suicides, should the Advisory Panel's recommended definition be adopted.

PREFERRED MODEL OF THE MAJORITY

The Advisory Panel considered at length the research concerning domestic violence homicide reviews. After initially determining what review mechanisms merited further examination, the Advisory Panel concluded that a mechanism should be adopted in NSW, and the majority of the Panel concluded that preferred model for a review team is one convened by the Ombudsman. This model builds on existing powers and expertise in death review, and wider systemic reviews, is a good fit with the full range of the Terms of Reference proposed for the review and should avoid duplication with the review of related child deaths, as well as enabling sharing of information on relevant child deaths. Given the extent of the Ombudsman's existing powers, it is envisaged that minimal legislative amendment would be needed.

The Ombudsman is now the convenor of the Child Death Review Team and can draw upon the experiences of that Team, as well as the experience and expertise of his staff to develop a successful review mechanism in minimal time. The Ombudsman's Office has a dedicated community services division which is responsible for reviewing and promoting improvements in the standards of delivery of community services as well as another dedicated team which works exclusively with NSW Police. Teams consist of legal officers, researchers, intelligence and information analysts and Aboriginal support officers. These officers already have access to the COPS and DoCS databases, as well as the considerable research the Ombudsman has already conducted on domestic violence. The Domestic Violence Homicide Review Team would be supported by this wealth of experience and knowledge, which would assist with the development of research and education, and a comprehensive database.

2. Recommendations

A Domestic Violence Homicide Review Mechanism

Recommendation 1

The NSW Government should establish a domestic violence homicide review mechanism.

Definition

Recommendation 2

A death should be considered to be a domestic violence homicide, and therefore capable of being reviewed, if the death appears to be directly or indirectly caused by a person who was in a domestic relationship with the deceased or, in the case of an Aboriginal person or a Torres Strait Islander, is or has been part of the extended family or kin of the other person according to the Indigenous kinship system of the person's culture.

A person has a domestic relationship with another person if the person:

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c) *had an intimate personal relationship with the deceased person, whether or not the intimate relationship involves or has involved a relationship of a sexual nature; or*
d) *was a parent of the deceased person, or had been exercising parental responsibilities for the deceased person; and there was a history of violence between the person and any other parent or person exercising parental responsibilities for the deceased person; or*
e) *has any other such relationship as the Domestic Violence Homicide Review Team deems to be appropriate for review.*

Functions of Domestic Violence Homicide Review Mechanism for NSW

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Any domestic violence homicide review mechanism in NSW should have these functions:

1. *Review individual deaths and identify where intervention may have prevented the death;*
2. *Identify trends and patterns in domestic violence homicides that have occurred during a particular time frame;*
3. *Establish and maintain a comprehensive database about the victims and perpetrators of domestic violence homicides and their circumstances ;*
4. *Conduct research where appropriate;*

5. *Identify best practice guidelines for agencies with reference to emerging research,*
6. *Educate the community and professionals about domestic violence; and*
7. *Provide a comprehensive report with findings and recommendations which highlight and address:*
    a. *systemic failures;*
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Essential Features for any Option

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A domestic violence homicide review mechanism for NSW should include a strong legislative framework incorporating the following:

- *protection from disclosure in legal proceedings;*
- *immunity to those who disclose information to the review mechanism that would ordinarily be confidential or privileged;*
- *exemptions from freedom of information legislation;*
- *the ability for the review mechanism to compel information from relevant agencies;*
- *a statement of objectives that centre upon a 'no blame' philosophy, ensuring culpability of the perpetrator for the death is emphasised;*
- *a requirement that members are bound by confidentiality provisions as laid out in the legislation;*
- *a clear process for the notification of cases, including a provision enabling any person or agency to refer a case to the review team for potential inclusion in the review process;*
- *the power to make publically available recommendations that can be directed at both government and non-government agencies;*
- *a mechanism to ensure the implementation of recommendations;*
- *membership that includes all relevant government and nongovernment service providers, noting the particular expertise that each sector and agency can bring to the process; and capacity for the review mechanism to seek expert advice where required;*
- *a minimum requirement for number of meetings per year;*
- *oversight mechanisms such as providing an annual report to an overseeing body; and*
- *statutory review on a periodic basis against clear measures and indicators.*

Terms of Reference

Recommendation 5

The following terms of reference should be established for any future review mechanism:

- *to examine the events leading up to the deaths of people who died within the context of domestic violence in order to gain a better understanding of domestic violence and improved criminal justice and human services responses;*
- *to examine the contacts made with services for support and assistance by the victim and offenders, and the appropriateness and quality of services and other relevant interventions provided to the victim and offender;*
- *to examine issues of access to such services for the victim and offender;*
- *to identify barriers to access and other impediments to help-seeking;*
- *to identify gaps in systems and service delivery;*
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- *to recommend improvements to service delivery, training, systems and law reform, as appropriate;*
- *to monitor progress in the implementation of recommendations;*
- *to report to Parliament annually on findings of death reviews, recommendations made and progress of implementation of previous recommendations made;*
- *to create and maintain a comprehensive database about the victims and perpetrators of domestic violence homicides and their circumstances; and*
- *to stimulate educational activities and disseminate educational information where appropriate.*

Preferred Model

Recommendation 6

The model preferred by the majority for a domestic violence homicide review mechanism in NSW is one that is established by appointing the Ombudsman as the convenor of an expert team with specific powers to investigate and review homicides relating to domestic violence (similar to the existing Child Death Review Team model).

Data Collection Issues

Recommendation 7

Improved data collection practices should be put in place as soon as possible, whether or not a domestic violence homicide review mechanism is adopted. These practices should include but not be limited to: enhancements to the Police COPS system and the National Coroners Information System (NCIS) to ensure more accurate flagging of domestic violence related homicides; the establishment

and maintenance of a database to monitor domestic violence related homicides; and the development of mechanisms for the identification and reporting of domestic violence related suicides.

Avoiding Duplication, Ensuring Consistency

Recommendation 8

The Government should consider ways of ensuring that the various death review bodies in NSW are informed of relevant recommendations made by one another, to improve efficiencies and limit the risk of duplication.

Review

Recommendation 9

Consideration should given to reviewing the scope of the definition of domestic homicide after 12 months, with a view to including suicides, should the Advisory Panel's recommended definition be adopted.

3. Background

Domestic Violence Homicide Advisory Panel

Despite there being review mechanisms in place for other kinds of deaths, such as the deaths of children, people with disabilities, people in care and maternal and perinatal deaths, there is no mechanism for the systematic review of domestic violence related homicides in New South Wales.

Against this background, there has been increasing community support for the establishment of a domestic violence homicide review process. Advocates argue that a domestic homicide review process provides governments with the information required to identify practices, protocols, behaviours and attitudes associated with service and criminal justice response systems that may result in homicides. A review process is also argued to have a valuable community educative role and the potential to help identify best practice guidelines for agencies.

On 19 December 2008, following the death of Melissa Cook, who was shot fatally by her estranged husband, the Minister for Women, the Hon Verity Firth MP, announced that the Government would bring forward the examination of domestic violence related homicide as a matter of urgency and that an ongoing review process would be considered as part of the response to the Report of the Special Commission of Inquiry into Child Protection Services in NSW (the Wood Report).

It was determined that an expert advisory panel would be convened to review domestic violence related homicides in NSW over the past 5 years and report to the Premier with recommendations on any changes to practices and procedures that would contribute to a reduction in preventable homicides.

The Advisory Panel has met since early 2009 and comprises government and non-government representatives. Dr Lesley Laing, the Deputy Chair of the Premier's Council on Preventing Violence Against Women and Senior Lecturer at the Faculty of Education and Social Work, University of Sydney, chairs the Panel. Professor Julie Stubbs, Deputy Director Institute of Criminology, University of Sydney, and Ms Betty Green, the Convenor of the Domestic Violence Coalition Committee, comprise the other non-government representatives.

Senior officers from the Office for Women's Policy, the NSW Police Force, Attorney General's Department, Department of Community Services and Department of Health represented their respective agencies.

The Bureau of Crime Statistics and Research (BOCSAR) provided the Advisory Panel with a comprehensive analysis of domestic violence related homicides in NSW for the period 1 January 2003 to 30 June 2008.

Domestic Violence Homicide Advisory Panel's Terms of Reference

The Advisory Panel's Terms of Reference were to:

- Define the meaning of 'domestic and family violence related' homicide;
- Consider BOCSAR's analysis of trends and patterns in domestic and family violence related homicides in NSW for the period 1 January 2003 to 30 June 2008;
- Consider the elements of an ongoing review mechanism, including –
    - The need for a legislative basis,
    - The need for any amendments to privacy legislation,
    - Data collection methodology;
- Recommend any changes to practices and procedures that would contribute to a reduction in preventable domestic and family violence related homicides, including a model for an ongoing review mechanism.

Existing Death Review Mechanisms in NSW

The Advisory Panel considered the following NSW death review mechanisms with a view to identifying potential models, as well as potential overlap should a Domestic Violence Homicide Review mechanism be established:

- Child Death Review Team;
- The Department of Community Services' (DoCS) Child Deaths and Critical Reports Unit ;
- NSW Ombudsman;
- NSW Coroner;
- Mental Health Sentinel Events Review Committee; and
- NSW Ministerial Maternal and Perinatal Committee.

A detailed overview of these models is attached at Appendix B. Further consideration is also given to relevant models when the options for a NSW domestic homicide review mechanism are discussed below.

Domestic Homicides in NSW

BOCSAR analysed domestic violence related homicides in NSW over the period 1 January 2003 to 30 June 2008. For the purposes of its analysis, BOCSAR defined homicide as murder or manslaughter, excluding driving related fatalities. Homicides were identified as 'domestic violence related' if the victim and offender were in a 'domestic relationship' as defined in the *Crimes (Domestic and Personal Violence) Act 2007.* In reading the BOCSAR report, which is attached at Appendix A, it is important to note that this legislation captures a wide range of 'domestic' relationships and that it is critical, for the purposes of a domestic violence homicide review team, to identify those aspects of the report that are of relevance to intimate partner related homicides.

BOCSAR's analysis found the following over the period January 2003 to June 2008:

Referring to domestic homicides as broadly defined in the legislation

- Approximately 42 percent of all homicides in NSW were domestic, defined with reference to the *Crimes (Domestic and Personal Violence) Act* 2007, (a total of 215 victims);
- The rate of domestic homicide per year remained stable, ranging from a low of 0.46 per 100,000 population in 2004 to a high of 0.63 per 100,000 population in 2006;
- For every one domestic homicide there were over 620 domestic violence related assaults;
- Stabbing was the most common act causing death, with knives used in over one-third of domestic homicides;
- Ten percent of victims had a recorded police contact in relation to violence involving the alleged homicide offender in the 12 months prior to the homicide;
- Twenty-six percent of offenders were persons of interest in a violence related incident in the 12 months prior to the homicide and this was the case for 53 percent in the 5 years prior to the homicide; and
- The types of matters for which offenders were most commonly involved with the police prior to the homicide event were assault, "domestic violence – no offence recorded", and apprehended violence orders.

Referring specifically to intimate partner homicides

- Approximately 18 percent of all homicides were intimate partner homicides;
- 43 percent of domestic homicide victims (70 females and 22 males) were killed by intimate partners. The cases involving 70 female victims are referred to as "femicides";
- Approximately 30 percent of those who killed intimate partners (including intimate partners of intimate partners) or their children (including step-children and grandchildren) were persons of interest in a violence related incident in the 12 months prior to the homicide; this was the case for 54 percent of those who killed intimate partners and 61 percent of those who killed their children (including step-children and grandchildren) in the 5 years prior to the homicide;
- Of the 10 percent of victims who had a recorded police contact in relation to violence involving the alleged homicide offender in the 12 months prior to the homicide, the majority were victims of intimate partner homicide.

Comparing a sample of (non fatal) intimate partner assaults with the 70 femicides

Overall, there were characteristics of intimate partner assault which were very similar to the femicide sample, and there was little to distinguish the two groups other than the following:

- Compared with the offenders in the non-lethal assault group, a higher proportion of femicide offenders were ex-spouses or ex-partners of the victim (27 percent vs. 16 percent);
- In the five years prior to the event, a majority of offenders in each group had had contact with the police for a violence related incident but the percentage was higher in the non-lethal assault group than in the femicide group (70 percent vs. 53 percent); and
- In the 12 months prior to the homicide or non-lethal assault, similar proportions of offenders in these groups (around 1 in 4) had had contact with the police in relation to a violence related incident against the victim.

BOCSAR's analysis is discussed in further detail at Page 48.

4. Domestic Violence Homicide Reviews

A Domestic Violence Homicide Review – what is it?

As noted by Dr Neil Websdale, a prominent academic in the area of domestic violence homicide reviews:

> *The principal purpose of a domestic violence fatality review is to reduce domestic violence related deaths and injuries through the identification and subsequent rectification of problems in the civil and criminal justice systems including the delivery of multiple services to families.*[4]

Dr Websdale also suggested that:

> *A domestic violence fatality review is a 'deliberative process' to prevent future domestic violence and homicide, provide strategies to ensure safety, and hold perpetrators and systems accountable.*[5]

The purpose of a homicide review team is to review domestic violence homicides and collate data about them. It is typically a multi-agency taskforce seeking improvement in service delivery and a reduction in domestic violence homicides. Its purpose is holistic and positive, focusing on systemic issues as opposed to individual performance and negligence. The function of a homicide review team is different from a complaints and integrity commission, and separate in focus from the traditional role of an ombudsman.

A common characteristic of homicide review teams is that they examine the events prior to the death, the circumstances surrounding the death, and action that may be taken to prevent domestic violence related deaths occurring in similar circumstances in the future. Domestic homicide review teams focus on systematic and procedural weakness, not the actions or negligence of individuals; it is the operating procedures, laws and systems in place at the time of the domestic violence related death that come under scrutiny of the investigation.

There is limited evidence concerning the extent to which domestic violence homicide review mechanisms directly prevent such deaths. In part, this reflects the fact that few of the existing mechanisms have been formally evaluated. In addition, many review mechanisms have no

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[4] Websdale, N, Town, M, and Johnson, B. (1999) 'Domestic Violence Fatality Reviews: From a culture of blame to a culture of safety', *Juvenile and Family Court Journal*, Vol 50, No 2, pp. 61-74.

[5] Websdale, N. and Wilson, J. (2006). *Domestic Violence Fatality Review Teams: An Inter-Professional Model to Reduce Deaths*, Journal of Interprofessional Care, Vol 20, No 5 pp. 535-544.

appropriate authority to ensure that their recommendations are implemented, and thus have a limited capacity to bring about change.

However, the contribution made by domestic violence homicide review mechanisms cannot, and should not, be measured by simple reference to whether or not there is a decline in domestic violence and/or family violence related deaths. While this is clearly one important objective of such mechanisms, the factors that shape homicide rates are numerous. It is unlikely that the effects of a homicide review mechanism can be disentangled from other factors such as changes in law, policy, practices and service provision related to domestic violence, or from the broader demographic, social, cultural and economic factors that shape homicide rates more generally.

Benefits of Domestic Violence Homicide Reviews

Homicide review teams can identify barriers to accessing services or agencies, and gaps and flaws in their response. They can then apply that information to all domestic homicides within a specific time, to establish whether the problem with the response is systemic, and make recommendations to improve interventions and service effectiveness. Domestic violence homicide reviews are consistent with a broader preventive framework because they offer the opportunity to reflect on past and current practice for the purpose of improving future responses and may provide information relevant to primary, secondary and tertiary prevention.

The research identifies a number of beneficial outcomes in those jurisdictions where domestic violence homicide reviews are established.[6] Outcomes include:

- Reviewing domestic violence related homicides to provide a broader perspective and knowledge about the culture and context of intimate partner violence;
- Recommendations made to improve systems gaps and services;
- Educating /informing the public, professional and agencies; and
- Generating inter-professional information sharing and discussions for change.

For instance, the Ontario Domestic Violence Death Review Committee report for 2006 notes that '*the majority of domestic homicides may have been prevented if professionals and/or the public were more aware of the dynamics of domestic violence and the risk for lethality*'.[7]

[6] Wilson, J S & Websdale N (2006) 'Domestic violence fatality review teams: An interprofessional model to reduce deaths', *Journal on Interprofessional Care*, Vol 20, No 5, pp. 535-544.

In a number of international jurisdictions, there have been positive outcomes reported following the establishment of domestic violence homicide review teams. Some overseas experiences have resulted in:

- The establishment of a centralised, county wide reporting system for domestic violence in **Contra Costa County California** to improve the accuracy of domestic violence data;
- A Protocol for law enforcement to report all child witnesses of domestic violence homicides in **Maine** due to the discovery of high numbers of child witnesses to family murders;
- Improved compliance regulations with Department of Corrections for private mental health practitioners conducting perpetrator programs in **Georgia** after it was found such practitioners were using dangerous and out of date intervention strategies such as 'anger management' for perpetrators;
- **Hennepin County, Minnesota** established a Task Force of mental health professionals to develop guidelines for screening men for partner abuse after finding all perpetrators of murder/suicide cases either told someone they were suicidal or had seen a mental health professional prior to the homicide, but the mental health issues went unrecognised and undiagnosed;
- **New Hampshire** identified the need to expand domestic violence training to all continuing professional education requirements for a number of relevant disciplines including but not limited to Police, all courts handling domestic violence, faith communities, education, employee assistance programs, all mental health providers and all alcohol and substance abuse treatment providers;
- **San Diego** and **New Hampshire** identified increasingly brutal attacks using multiple methods to murder, particularly strangulation and stabbing – both recommended further research needs to be conducted;
- **Ontario** identified outcomes including public education initiatives, the development of guides for teachers and other educators, programs for youth, professional training for physicians, the further development of risk assessment tools, enhancements to child protection and legislative changes.

[7] Office of the Chief Coroner (2006) Fourth Annual Report of the Domestic Violence Death Review Committee, p. 21, http://www.mcscs.jus.gov.on.ca/english/publications/comm_safety/DVDRC_2006.pdf.

Concerns regarding Domestic Violence Homicide Reviews

Concerns around the establishment of domestic violence homicide review teams have related to:

- Potential for duplication[8] – homicides in NSW are subject to several different systems of investigation including those conducted by the NSW Police Force, NSW Coroner and the NSW Ombudsman. Care would be required to ensure that any domestic violence homicide review mechanism is not perceived as duplicating existing work within NSW. In addition, it would be important to ensure that any NSW-based mechanism did not duplicate aspects of the work of national groups currently looking at domestic violence homicides such as the Australian Institute of Criminology's National Homicide Monitoring Program (NHMP);
- Retrospective focus – international homicide review committees predominately focus on closed cases, after the criminal proceedings are completed[9]. These reviews generally occur several years after the homicide as criminal proceedings can take a number of years to finalise. A key problem with this approach is that agencies may have already implemented changes to practices and systems following their own internal review. A homicide review team's work could therefore be duplicating the internal reviews of agencies and their recommendations may be superfluous.

These concerns may be mediated to varying degrees based on the model adopted for a review of domestic violence homicides and through effective risk management. For example, the risk of duplication can be limited by ensuring that knowledge gained from one review is shared with other related reviews.[10]

Review Mechanisms in Other Jurisdictions

Review mechanisms are already in place in a number of international jurisdictions, including in the United Kingdom, Ontario, New Zealand and the United States. While models vary significantly in relation to scope, mode of operating and resourcing, mechanisms for review commonly:

- have a legislative basis;

[8] See David, N (2007) 'Exploring the Use of Domestic Violence Fatality Review Teams', *Australian Domestic & Family Violence Clearinghouse Issues Paper 15*, p. 14.
[9] Note: in NSW, the Ombudsman would not be restricted in this way, as discussed later in the report
[10] See further discussion below at p. 45.

- comprise government and non-government representatives;
- require members to be bound by strict confidentiality provisions; and
- adopt the view that domestic violence related homicides are preventable and have, as a primary focus, prevention and intervention.

At present, Victoria is the only Australian jurisdiction with a review mechanism, which considers family violence deaths investigated by Victorian Coroners, supported by a prevention unit. As that mechanism has only recently been established, it is too early to measure the effectiveness of its outcomes.

Domestic or family violence homicide review committees in overseas jurisdictions typically are not designed to lay blame at the door of any particular agency or individual but rather to identify systemic failures and make recommendations for the improvement of policies and the response of agencies.

The constitution of such teams or committees varies widely. For instance, in New Zealand, there are eight non-government members on the Committee, each selected for their expertise in one of the following areas: mortality review systems, social science research, family violence law, child abuse and protection issues, and service provision in the social sector. The Committee is chaired by a representative of the Ministry of Health and assisted by six Government advisors. By way of contrast, in Ontario, the Committee sits within the Chief Coroner's Office and consists of representatives from law enforcement agencies, healthcare, social services and other public safety agencies and non-government organisations and is chaired by the Regional Supervising Coroner.

Currently, international family violence death review committees primarily examine closed cases. A case is considered 'closed' after the criminal and coronial hearings or proceedings are complete. This prevents reviews of family violence deaths being seen as potentially prejudicial to criminal or coronial investigations.

It should be noted that, internationally, there is a move to conduct open case reviews in the future. Both New Zealand[11] and the United Kingdom[12] are seeking to permit open case reviews

[11] In New Zealand preference has been expressed to initiate a review of open cases within 3 months of a death. They are currently taking legal advice on operational arrangements to permit open case reviews. It is likely that a local review will be initiated by police and inform the national committee (two tier review system).
[12] In the United Kingdom the draft guidance leaves the decision of looking at open/closed cases up to the local review body, to decide in consultation with the law enforcement agencies on a case by case basis. If a review of an

and are finalising guidelines for the operation of their respective family violence death review committees.

All of the models discussed below operate within a legislative framework, although the extent of the powers bestowed upon each Committee differs.

Victoria

In 2008, the Victorian Law Reform Commission considered the role of a family violence death review committee, noted the benefits and concerns in relation to the operation of such committees internationally and made the following recommendation in its *Review of Family Violence Laws Report*:

> *In consultation with the State Coroner, the State-wide Steering Committee to Reduce Family Violence should investigate and make recommendations to the government regarding the creation of a family violence death review committee in Victoria.* (Recommendation 153)

The Victorian Government accepted this single recommendation of the Law Reform Commission and has funded the establishment of a specialist support service ('a prevention unit') to assist the Coroner in relation to the formulation of prevention recommendations as well as to help monitor and evaluate the effectiveness of the recommendations. Judge Jennifer Coate, appointed as State Coroner of Victoria in 2007, is the first Judge to be appointed to this position.

The prevention unit reviews family violence deaths that have been investigated by Coroners in Australia (by using the National Coroners Information System) and relevant academic literature and provides information that will assist Coroners to make better informed recommendations. The unit also assesses whether coronial recommendations relating to family violence deaths are being implemented.

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open case were conducted the final report would not be published until criminal proceedings were concluded (agencies could still act on recommendations in the meantime).

The United States

Following the 1991 public investigation into a domestic violence homicide-suicide in San Francisco, at least 82 domestic violence homicide review teams have been developed in 35 states, across the United States.[13] While not identical in makeup or process there are several common characteristics:

- Established by legislation;
- Review teams have diverse membership, including representatives from government and non-government agencies;
- Mostly annual reporting requirements;
- Review of violence homicides, for indications of system improvements and better agency and interagency response; and
- Analysis of statistics, trends, and broader facts surrounding domestic violence.

The teams focus on moving away from the 'blame and shame' of agencies, towards greater collaboration of various agencies to identify how to better identify and prevent domestic violence related homicides.

States vary in terms of which cases are reviewed, and the depth of review of particular cases. For example, the Philadelphia Death Review Team reviews hundreds of women's deaths per year, taking perhaps 30 minutes per review. The aim is to ascertain whether the victim died as a direct or indirect result of domestic violence. By contrast, the Los Angeles County in California conducts an extremely detailed analysis (including public testimony) of just one case each year, in order to identify system failures.[14]

In Washington State there are two models for death reviews: the Investigative Fatality Review and the Systems Analysis Fatality Review. The investigative model prioritises the need to identify domestic violence homicides that have not been previously identified as such, by police, prosecutors and Coroners. It aims to improve recognition of domestic violence-related homicides, provide "*a more accurate count of domestic violence related deaths, [and] also increase public awareness of domestic violence as a threat to life and well-being*."[15] The systems approach

[13] Wilson, J S & Websdale, N (2006) 'Domestic violence fatality review teams: An interprofessional model to reduce deaths', *Journal of Interprofessional Care*, Vol 20, No 5, pp. 535-544, p. 539.
[14] Websdale, N & Sheeran, M (unpublished) *Reviewing Domestic Violence Fatalities: Summarizing National Developments*, p. 6, 22 and 25.
[15] Ibid p. 28.

seeks to identify how interventions were ineffective and aims to change policies and procedures of agencies to prevent domestic violence related homicides.[16]

In 1999, Virginia State established a Family and Intimate Partner Fatality Review. The review is an intentional, interdisciplinary, non judgmental evaluation of events leading up to a homicide. It aims to analyse system responses to violence and identify prevention strategies to reduce the incidence of deaths associated with family and intimate partner violence. In Virginia, the review teams are usually formed at the local and regional levels through individual efforts and the voluntary cooperation of agencies involved with such deaths.

Review Teams in the United States have varying powers regarding acquisition of information. An example is the Delaware review team, which has the power to administer oaths, compel attendance of witnesses and the production of records related to the death under review.[17] Other teams analyse cases on the basis of written documents only.

There are conflicting views about the appropriate extent of family participation in homicide reviews. Some teams advocate that there should be limited participation from families as the process cannot be used as grief counselling; other teams involve families either directly or via a family advocate, on a case by case basis. Some teams such as the Pinellas County Domestic Violence Task Force, Florida, do not interview families at all.

Most review teams report on an annual basis outlining their activities, findings and recommendations for change. Recommendations have broadly included: better interagency cooperation and communication (including greater systematic collection of data and analysis of 'warning signs');[18] greater dissemination of information to victims of domestic violence; education of the general public; and producing guidelines and screening mechanisms for service providers, courts, law enforcement, health personnel and child protection workers.

A number of teams have produced interagency agreements that facilitate the sharing of information and assist in the collation, coordination and synthesis of data from each agency.

[16] Ibid p. 28.
[17] Ibid p. 31.
[18] The Florida Mortality Review Report defined these 'warning signs' as including reports of history of prior violence, police involvement, injunctions, prior criminal history, mental illness, separation pending in the relationship and history of obsessively possessive behaviour, and recommended a screening mechanism or instrument to identify high risk cases before homicides occur. Ibid p. 32.

Outcomes in the United States

As noted above, the effects of domestic violence death review mechanisms are difficult to isolate from other factors that shape homicide rates, including other enhancements to law, policy and service provision, and broader social factors. Thus, the literature does not attribute any reduction in homicide rates solely to the introduction of domestic violence homicide teams.[19] Commentators have looked instead at whether the teams' recommendations had influenced or changed system response to services and safety of victims. Some changes included: developing better reporting protocols for homicides related risk factors, including perpetrator and victim contact with mental health services prior to the homicide, and the screening of all homicides to see if domestic violence was present.

Ontario, Canada

Thus far, Ontario is the only Canadian province to have established a review mechanism. The Domestic Violence Death Review Committee sits within the Chief Coroner's office and assists it with reviewing homicides that have involved a person and/or his/her child(ren) committed by the person's intimate partner or ex-partner. The Committee consists of representatives from law enforcement agencies, healthcare, social services and other public safety agencies and non-government organisations and is chaired by the Regional Supervising Coroner.

It examines the facts of individual cases to develop understandings of why domestic violence related homicides occurred, any primary risk factors, and how such homicides might be prevented. The Committee has reviewed 100 cases since its inception in 2003.

The Committee's objectives are set out in its terms of reference, including:

- Offering expert opinion to the Chief Coroner regarding the circumstances of the events leading to the death in the individual cases reviewed;
- Creating and maintaining a comprehensive database about the victims and perpetrators of domestic violence homicides and their circumstances;
- Identifying the presence or absence of systemic issues, problems, gaps or shortcomings of each case to facilitate appropriate recommendations for prevention;
- Conducting and promoting research where appropriate;
- Stimulating educational activities through the recognition of systematic issues or problems and referring to appropriate agencies for action;

[19] See for example supra 2 (Wilson) at p. 540.

- Developing protocols with a view to prevention; and
- Disseminating educational information where appropriate.

The Committee reports annually to the Chief Coroner regarding the trends, risk factors and patterns identified through the reviews, and makes appropriate recommendations to prevent deaths in similar circumstances.

Despite the Committee's power to make recommendations (as is the case with other teams reviewed), it has no power to implement or ensure implementation of them. In its 2007 report the Committee noted that it is:

> *finding that due to recurring issues and themes, recommendations made by the Committee are now repeating themselves. It is the hope of the Committee that all agencies give the same careful contemplation to the implementation of recommendations as was given to their creation. As such, the Committee is recommending that an audit be conducted of all recommendations made by this Committee since its inception…and that the Ministry of the Attorney General take a leadership role in creating an inter-ministerial committee that will methodically review all community agency and government responses to recommendations that have been made by the Committee since its inception.*[20]

New Zealand

The Family Violence Death Review Committee was established in June 2008 and first met in October 2008. It has eight members, each of whom has expertise in one of the following areas: mortality review systems, social science research, family violence law, child abuse and protection issues, and service provision in the social sector. The Committee is assisted by six Government advisors. This enables those departments' information, expertise and advice to be available to the Committee, so that the Committee's discussions and debates are fully informed. The advisors are accountable to their department, and are not members of the Committee. The advisors are from the following agencies:

- the Chief Coroner's Office;
- the Ministry of Health;
- the Ministry of Social Development;
- the Ministry of Justice;

[20] Office of the Chief Coroner Province of Ontario (2007) *Fifth Annual Report of the Domestic Violence Death Review Committee*, p. 4.

- the New Zealand Police; and
- the Office of the Children's Commissioner.

The Committee's terms of reference state the overarching goal of the Committee is to contribute to the prevention of family violence and family violence deaths, by conducting a multi-agency systematic analysis of the lives of victims, perpetrators and their families, and events leading up to and factors surrounding the death(s).

The Committee's terms of reference set out its functions as including:

- Reviewing and reporting to the Minister for Health on family deaths, with a view to reducing the numbers of family violence deaths, and to promote continuous improvement of the quality of systems, services and policies that may contribute to such a reduction;
- Developing strategic plans and methodologies designed to reduce family violence morbidity and mortality and advising the Minister on any related matters;
- Monitoring, analysing and reporting on number, category and demographics of family violence deaths and identify patterns and trends;
- Liaising and assisting other mortality review committees with reviews of deaths that are within the scope of those other committees; and
- Providing an annual report, unless otherwise required by the Minister.

The terms of reference require that the Committee and the terms of reference be reviewed and evaluated three years from the date of establishment. In particular, the definition of 'family violence death' will be reassessed, with a view to broadening the definition to include those deaths currently excluded.[21]

[21] The terms of reference set out mandated tasks for the Committee in its first year of operation. These include:
- Developing mechanisms and protocols for family violence death reviews;
- Determining the availability, reliability and validity of existing data collection processes and determining where additional data might be collected from;
- Deciding on definitions to be used for each piece of data during collection, analysing and reporting;
- Establishing functional relationships with other death review committees and other key stakeholders in the family violence sector including: The Child and Youth Mortality Review Committee, other agencies who conduct family violence mortality reviews and key domestic violence non-government services;
- Establishing protocols for ensuring security of particular information gathered in relation to reviewing cases, and to ensure that the Committee acts in a culturally appropriate, sensitive and responsive manner.

United Kingdom

In 2006 the United Kingdom Home Office released a consultation paper, proposing that local bodies be authorised to carry out domestic homicide reviews under the *Domestic Violence, Crimes and Victims Act 2004* (2004 Act). It was proposed that the Secretary of State would also be able to direct a person or body to carry out such a review.

The consultation paper set out the purpose of a review as being to identify the lessons to be learnt (and acted upon) from the death, and to improve inter-agency working and the protection for domestic violence victims. The review process was based upon the existing serious case reviews of the death or serious injury of a child where abuse or neglect is, or is suspected to be a factor. As most agencies were familiar with this process it was regarded as beneficial to use a similar process for domestic homicide review process.[22] Local agencies were also required to consider whether there was any overlap with other death review processes (including an existing mental health investigation).

The Home Office's *National Domestic Violence Delivery Plan: Annual progress report 2007/08* reported delays in setting up the domestic homicide review process following responses received from the consultation paper. It reported that by late 2008 the Domestic Homicide Reviews will be established on a statutory basis by implementing section 9 of the 2004 Act. As of April 2009, this has not yet occurred.

Risk Identification Research in Domestic Violence Homicides

Risk factors

Considerable international research, particularly in the United States, has been undertaken into the factors that may be considered as indicative of risk when considering domestic homicides.[23] There is general consensus that certain factors, including the following, may indicate a higher potential for a domestic homicide to occur:[24]

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[22] Home Office (2006) *Guidance for Domestic Homicide Reviews under the Domestic Violence, Crimes and Victims Act 2004*, p. 7.

[23] *Reducing Intimate Partner Homicide Rates: What are the Risk Factors for Death when a Woman is being Abused*? Presented by Carolyn Rebecca Block, Illinois Criminal Justice Information Authority, International Conference on Homicide: Domestic-Related Homicide, Australian Institute of Criminology, December 3, 2008.

[24] Campbell, J, Webster, D, Koziol-McLain, J, Block, C, Campbell, D, Curry, M, Gary, F, McFarlane, J, Sachs, C, Sharps, P, Ulrich, Y and Wilt, S (2003) 'Assessing Risk Factors for Intimate Partner Homicide', *National Institute of*

1. Prior domestic violence;
2. Partner used or threatened woman with a weapon;
3. Partner threatened to kill woman;
4. Partner tried to choke (strangle) woman;
5. Estrangement; and
6. Gun in the house.

One of the best known studies in this area, *Intimate Partner Homicide: Review and Implications of Research and Policy*, provides compelling evidence of the strong correlation between these factors and domestic violence homicides.[25] In that study, the authors noted that:

> *The number one risk factor for IPH (intimate partner homicide)…is prior domestic violence. Important risk factors for IPHs after prior domestic violence are gun access, estrangement, threats to kill and threats with a weapon, nonfatal strangulation and stepchild in the home…*

By considering risk factors in depth, both government and non-government agencies are better placed to detect risk and intervene before the risk escalates. Tools, such as the Danger Assessment Tool used in the United States, have been developed which help identify volatile risk factors that reviews and other research have shown significantly increase a domestic violence homicide. The Ontario committee has consistently found seven or more risks factors were present in more than two thirds of the cases that they have reviewed; they consider that the presence of seven or more risk factors indicates that the homicide was preventable. Actual or pending separation and a history of domestic violence were present in approximately three-quarters of all cases.[26]

Guns

Many studies have looked at the relationship of gun ownership or possession and intimate partner homicides. One Canadian study found that women who were threatened or assaulted with a gun or other weapon were 20 times more likely than other women to be murdered. Women whose partners threatened them with murder were 15 times more likely than other women to be killed. When a gun was in the house, an abused woman was 6 times more likely

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Justice Journal, Vol 250, pp. 14-19; Hart, B (1990), *Assessing Whether Batters Will Kill*, Pennsylvania Coalition Against Domestic Violence.

[25] Campbell, J C, Glass, N, Laughon, K and Bloom, T (2007) 'Intimate Partner Homicide: Review and Implications of Research and Policy', *Trauma, Violence Abuse*, Vol 8, No 3, pp. 246-269.

[26] Office of the Chief Coroner (2006) Fourth Annual Report of the Domestic Violence Death Review Committee, p. 21, http://www.mcscs.jus.gov.on.ca/english/publications/comm_safety/DVDRC_2006.pdf., pp10-11.

than other abused women to be killed.[27] Another found that with respect to intimate partner homicide, female victims are twice as likely to die from a gunshot wound as from stabbing, strangling, or other methods; and firearm ownership is shown to increase the likelihood of intimate partner homicide by a factor of 5.[28] Care must be taken in applying such data to the Australian context. In 1997, the Australian Institute of Criminology, in its review of Firearms Homicides in Australia, found that 35 percent of firearm homicide incidents occurred within the context of an intimate relationship or were associated with the termination of an intimate relationship.[29] More recent data suggests a reduction in the use of guns in Australian homicides although they still account for approximately one in five intimate partner homicides.[30]

Previous threats and harm

The Australian Institute of Criminology found that one-third of intimate partner homicides resulted from conflicts associated with jealousy or the termination of a relationship. The remaining incidents arose from domestic arguments.[31] Studies have also shown that most female homicide victims (88 percent) and offenders (81 percent) have experienced violence at the hands of their partner in the past year.[32]

Violence against a former intimate partner has been found to be an important risk factor for intimate partner homicide and any future development of databases should strive to identify and include this item.

Non-fatal strangulation (choking)

The Chicago Women's Health Risk Study examined the characteristics of lethal and non-lethal cases of woman abuse. They found that choking was a notable feature in the lethal violence group. While 12 percent of all of the women in their study who had experienced choking were in the lethal violence group, only 6 per cent of women who had not experienced choking were in the lethal group. Several other recent studies in the United States and the United Kingdom have suggested that non fatal strangulation is a common form of violence against women and

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[27] Ibid.

[28] Roberts, D (2009) Intimate Partner Homicide: Relationships to Alcohol and Firearms, *Journal of Contemporary Criminal Justice*, Vol 25, No 1, pp. 67-88.

[29] Carcach, C & Grabosky, P N (1997) *Firearms Homicide in Australia*, Australian Institute of Criminology.

[30] Carcach, C & Grabosky, P N (1997) *Firearms Homicide in Australia*, Australian Institute of Criminology; Mouzos J and Rushforth C (2003) Family homicide in Australia, *Trends & Issues in Crime and Criminal Justice* No. 255, Australian Institute of Criminology .

[31] Carcach, C & James, M (1998) *Homicide between Intimate Partners in Australia*, Australian Institute of Criminology.

[32] *Reducing Intimate Partner Homicide Rates: What are the Risk Factors for Death when a Woman is being Abused*? Presented by Carolyn Rebecca Block, Illinois Criminal Justice Information Authority, International Conference on Homicide: Domestic-Related Homicide, Australian Institute of Criminology, December 3, 2008.

is associated with more severe abuse and the risk of violence resulting in death.[33] These results underscore the need to screen for nonfatal strangulation when assessing women for domestic violence.

Estrangement

Estrangement or separation has been widely acknowledged as a significant risk factor in the context of domestic violence homicides. As noted by Wilson and Daly in their paper *Spousal Homicide Risk and Estrangement*:[34]

> *Women who attempt to terminate relationships with men are frequent homicide victims. The explanations offered by the killers and the circumstances surrounding these violent events suggest that the killer was typically impassioned by sexual jealousy and/or by his concern about losing his wife. Declarations like "If I can't have her, nobody can" are recurring features of such cases, and the killer frequently intends to kill himself, too.*

Typically in such cases, there is a history of non lethal violence as well as threats to kills. The most thorough published analysis of this issue suggests that actual or imminent separation is highly relevant to risk. Wallace reported that 98 of 217 women killed by their intimate partners (45 percent) in New South Wales, from 1968-81, had left their partner or were in the process of leaving.[35] Wallace also noted that it made no discernable difference as to whether the victim and offender were legally married, de-facto or divorced, men were just as likely to kill de-facto wives from whom they were separated as they were estranged legal wives.[36] It is often at the point of deciding to separate that women seek assistance from services and are most at risk of harm. A domestic violence homicide review would explore whether the victim had sought assistance, whether she had access to any available services and the quality of any assistance that was offered.

Conversely, this high incidence of estrangement among wife-killings is apparently not mirrored in husband-killings. Whereas 98 of the 217 wives killed were separated from the offender, the same was true for just 3 of 79 husbands who were killed.[37] Wallace and other researchers have consistently found that women who kill their partners typically do so in response to violence perpetrated by their partners on them and/or other family members. Men

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[33] Glass N, Laughon K, Campbell J, Block CR, Hanson G, Sharps PW, and Taliaferro, E (2008) 'Non-fatal strangulation is an important risk factor for homicide of women', *Journal of Emergency Medicine*, Vol 35 No. 3, pp. 329-335.
[34] Wilson, M and Daly, M (1993) 'Spousal Homicide Risk and Estrangement', *Violence and Victims*, Vol. 8, No. 1.
[35] Wallace, A (1986). *Homicide: The social reality*, New South Wales Bureau of Crime Statistics and Research.
[36] Ibid.
[37] Ibid.

however tend to kill their partners for entirely different reasons often associated with separation, the threat of separation and sexual jealousy. [38]

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Assessment of risk

In 2007 the NSW Government publicly endorsed the development of a risk assessment model stating that it had "*commenced the development of a cross-agency risk assessment service to ensure domestic violence victims receive consistent and effective advice when dealing with different government agencies*." It was intended that the model would be trialled across the State and would be used by service providers at appropriate points where domestic violence was already identified, in order to:

- assess the risk of further violence;
- assess the needs of the victims, including children;
- identify existing interventions and service options designed to reduce the risk of violence and address the needs of victims;
- provide appropriate referrals and/or reports; and
- liaise with other agencies to develop a clearer picture of the risks (including documentation of decision-making processes, sharing information between agencies and a standard format for data).

The model currently represents a common assessment framework to guide the assessment and management of risk of domestic and family violence, based on the analysis of the evidence. Site selection for the trial and training development is due to commence shortly, and it is expected that the trial will commence in September 2009.

[38] See also Morgan, Jenny (2002) *Who Kills Whom and Why? Looking Beyond Legal Categories*Victorian Law Reform Commission.
[39] Ibid.

Importantly, an evaluation will be conducted of the model and it is expected that this evaluation report will be provided to Government by December 2009. It will be critical for any evaluation of the trial to consider linking the model with any domestic violence homicide review mechanism in order to ensure that findings regarding relevant emerging practice are combined into a common resource.

In looking at the research about risk factors and at risk assessment tools, it is important to recognise that the process of risk assessment is not about prediction per se; rather it is undertaken so that appropriate risk *management* interventions can be put in place. A domestic violence homicide review process is more concerned with exploring issues such as: did service providers recognise high/escalating risk (implications for training); was this communicated clearly between agencies (implications for interagency work); and were all possible interventions put in place to manage the risk and increase the safety of women and children (service delivery, legislation implications).[40]

[40] Dutton, D. G. and Kropp, R. P. 2000, 'A review of domestic violence risk instruments', *Trauma, Violence and Abuse,* 1(2), 171-181.

5. Definition of 'Domestic Violence Homicide'

The review mechanisms in international jurisdictions vary considerably regarding the deaths that come within the scope of review. For instance, some jurisdictions only consider intimate partner deaths with a history of domestic violence, while others consider all family and household relationships. Types of homicides included for review are:

- intimate partners or ex-partners (usually including married couples, de facto partners, dating relationships) – this is the most common approach;[41]
- children of intimate partners or ex-partners;[42]
- family members (including parents, children, siblings, etc);[43]
- members of the same household;[44]
- caregivers;[45]
- bystanders/third party interveners where family violence involved;[46] and
- sexual assault homicide (not necessarily an intimate relationship).[47]

Less commonly, mechanisms review deaths that have a direct causal link to domestic violence but that are not a homicide. For example:

- suicides primarily attributable to domestic violence;[48] or
- fatal accidents that are related to domestic violence.[49]

[41] For example: Delaware Fatal Incident Review Team; Iowa Domestic Abuse Death Review Team; Kansas Domestic Violence Fatality Review Board; New Mexico Intimate Partner Violence Death Review Team; New Zealand Family Violence Death Review Committee; Oklahoma Domestic Violence Fatality Review Board; Ontario Domestic Violence Death Review Committee; Santa Clara Domestic Violence Death Review Committee; United Kingdom Domestic Violence, Crime and Victims Act (2004); West Virginia Domestic Violence Fatality Review Team.

[42] For example: Ontario Domestic Violence Death Review Committee; Delaware Fatal Incident Review Team (reviews deaths of children where the parents had an abusive relationship and child death was related to this. Delaware also has a separate child death review process for other child deaths).

[43] For example: Delaware Fatal Incident Review Team; New Zealand Family Violence Death Review Committee (uses definition of 'family' from the New Zealand Family Violence Act); Delaware Fatal Incident Review Team (only where the death is related to intimate partner abuse); Oklahoma Domestic Violence Fatality Review Board; United Kingdom Domestic Violence, Crime and Victims Act (2004); Santa Clara Domestic Violence Death Review Committee (only reviews deaths of other family members if the death is related to intimate partner violence); West Virginia Domestic Violence Fatality Review Team.

[44] For example: New Zealand Family Violence Death Review Committee; Oklahoma Domestic Violence Fatality Review Board; United Kingdom Domestic Violence, Crime and Victims Act (2004); West Virginia Domestic Violence Fatality Review Team.

[45] For example: New Zealand Family Violence Death Review Committee

[46] For example: Delaware Fatal Incident Review Team (Includes bystanders where the bystander has a relationship with the victim); New Mexico Intimate Partner Violence Death Review Team (if in the context of intimate partner violence).

[47] For example: New Mexico Intimate Partner Violence Death Review Team.

[48] Delaware Fatal Incident Review Team (around 10% of reviewed cases are suicides); Iowa Domestic Abuse Death Review Team; Santa Clara Domestic Violence Death Review Committee.

[49] Santa Clara Domestic Violence Death Review Committee.

Proposed NSW definition of a domestic violence homicide

The Advisory Panel agreed that any definition in NSW should include people currently or previously married, in a de facto relationship or otherwise 'intimate'.

The *Crimes (Domestic and Personal Violence) Act 2007* contains a definition of what is a 'domestic relationship'. It is important that there is consistency between this definition and the proposed definition of a domestic violence homicide. To that end, the definition proposed by the Advisory Panel is consistent with s5 of the *Crimes (Domestic and Personal Violence) Act 2007* to the extent that the section deals with what is commonly termed an intimate relationship. The proposed definition takes into account the specific requirements of a review mechanism and the kinds of cases which may fall within its purview. For example, there are cases where an intimate partner has killed a child(ren) but not the other partner. There can be no doubt that in certain cases, this is not solely a child protection issue, but rather a particularly brutal form of domestic violence.

The Advisory Panel recognised that some deaths of children may arise in the context of domestic violence and that, whilst there is a Child Death Review Team in existence, a domestic homicide review mechanism would need to be capable of operating in conjunction with the Child Death Review Team where necessary. The case study below, in which children were murdered in the context of domestic violence, demonstrates how a child protection focussed review would not adequately address the issue of the use of children as a tactic of domestic violence where the mother was clearly a target of the actions, though not herself killed.

CASE STUDY

June 2008

Pericoe (Southern NSW)

Victims: Jack Damen BELL (8), Maddie Rose BELL (7), Bon Victor BELL (15mths)

Offender: Gary BELL (deceased)

Gary Bell murdered his three children and suicided. A letter written by Bell claimed that he took the lives of his children and himself due to the breakdown of his marriage and because he thought he was going to gaol in connection with an assault matter. Earlier in the week he had been arrested and charged by Police for assaulting his partner, an AVO had been taken out for the protection of Karen Bell, and he was released. The family was known to Police and the Department of Community Services.

In order to ensure the review mechanism has sufficient flexibility to consider appropriate cases and maintain consistency with existing legislative definitions, the following definition is proposed:

> *A death is considered to be a domestic violence homicide, and therefore capable of being reviewed, if the death appears to be directly or indirectly caused by a person who was in a domestic relationship with the deceased or, in the case of an Aboriginal person or a Torres Strait Islander, is or has been part of the extended family or kin of the other person according to the Indigenous kinship system of the person's culture. A person has a domestic relationship with another person if the person:*
>
> *a) was married to the deceased person; or*
> *b) had a de facto relationship, within the meaning of the Property (Relationships) Act 1984, with the deceased person; or*
> *c) had an intimate personal relationship with the deceased person, whether or not the intimate relationship involves or has involved a relationship of a sexual nature; or*
> *d) was a parent of the deceased person, or had been exercising parental responsibilities for the deceased person; and there was a history of violence between the person and any other parent or person exercising parental responsibilities for the deceased person;*
> *e) has any other such relationship as the Committee deems to be appropriate for review.*

The terms of reference could require that the review mechanism re-assess the definition of 'domestic violence homicide' with a view to broadening the definition to include any deaths which may be excluded.

In defining the scope of the cases to be included in a domestic violence homicide review process, there was discussion by the Advisory Panel about including domestic violence related suicides. It was noted that a proportion of domestic violence related homicides involve the suicide of the perpetrator in what are commonly termed murder-suicides. The context of these deaths would no doubt be considered as part of the homicide review pertaining to their murder victim and their occurrence is marked by considerable media coverage.

Some members of the Panel argued that the suicides of people who have been victims of domestic violence should also be included in the scope of the review because of the well-documented association between women's experiences of domestic violence and severe mental health impacts, such as increased rates of depression, anxiety, Post-traumatic Stress Disorder and suicidality.[50] Although identifying women's suicides that occur in the context of domestic violence would present some challenges, it was argued that omitting the possibility of reviewing these cases would fail to inform practice with these otherwise 'invisible' homicides associated with domestic violence. International research indicates that 42 percent of domestic violence homicide victims had been seen by health services in the year before the incident.[51] This suggests that including suicides of women in the scope of the review could yield important information that could lead to improvements in the identification and assistance offered to women suffering severe impacts on their mental health.

Identifying cases where domestic violence was associated with the suicide, and establishing causation, is likely to be difficult. How to accurately identify such cases warrants further investigation and it may be that if the recommendations of the Advisory Panel are adopted, consideration could be given to including suicides caused by domestic violence in the definition once it has been determined whether such cases can be identified. It is therefore recommended that consideration be given to reviewing the scope of the definition after 12 months, with a view to including suicides, should the Advisory Panel's recommended definition be adopted.

[50] Golding, J M (1999) 'Intimate partner violence as a risk factor for mental disorders: a meta analysis', *Journal of Family Violence*, Vol 14, No 2, pp. 99-132; Stark, E (1996) 'Killing the beast Within: Woman Battering and Female Suicidality', in E Stark and A Flitcraft, *Women at Risk: Domestic Violence and Women's Health*; Ellsberg, M, Jansen, H A F M, Heise, L, Watts, C H and García-Moreno, C (2008) 'Intimate partner violence and women's physical and mental health in the WHO Multi-country study on women's health and domestic violence: An observational study' *The Lancet,* Vol 371, pp. 1165-72; Victoria Health (2004) *The Health Costs of Violence : Measuring the burden of disease by intimate partner violence*.

[51] Campbell, J C, Glass, N, Laughon, K and Bloom, T (2007) 'Intimate Partner Homicide: Review and Implications of Research and Policy', *Trauma, Violence and Abuse*, Vol 8, No 3, pp. 246-269.

6. Data Collection and Privacy Issues

Data

As made evident in the report by BOCSAR, there are significant limitations concerning data collection in this area. The Advisory Panel was advised that up to 43 percent of matters had not been properly flagged as a domestic violence homicide in the Police COPS data system and were subsequently identified and correctly re-classified by BOCSAR prior to data analysis for the Advisory Panel. It was noted by the Advisory Panel that of that 43 percent, 36 percent were intimate partners or intimate partner related.[52]

BOCSAR reported to the Advisory Panel that a number of limitations were identified relating to the data:

1. The identification of the domestic homicide sample was not straightforward. Some incidents that should have been classified in NSW Police Force's Computerised Operational Policing System (COPS) as a domestic related event, or as having a relevant relationship type, did not in fact have those characteristics coded accurately. This is likely to be due to the fact that when the deceased is found, the perpetrator is sometimes not known and these fields are left at their default settings until the offender is known. However, because there is no operational need to update these fields in COPS they are sometimes never updated with accurate information.

   Overall, of the domestic homicides identified for this study, 43 percent did not have the associated domestic violence flag.

   It is also possible that police do not always identify victim-offender relationships as domestic (as defined in the legislation), particularly where the parties are not intimate partners or family members.

2. The information in the COPS narratives is not standardised, so the degree of detail varies, particularly regarding the history leading up to the event and associated issues such as the offender's mental health at the time of the offence. Supreme Court judgments were found to be a good supplementary source of information. However, judgments are not a reliable source of information as some cases may take years to

[52] This information is not contained in the BOCSAR report but was information obtained by the Panel after the report was completed.

finalise, and for other cases, judgments are not publicly available. In addition, in the absence of Supreme Court judgments, much less is generally known about homicides in which the offender commits suicide. This will be even more of an issue if an ongoing review process was put in place to collect information on homicides as they occur. Preliminary inquiries suggest that the National Coroners Information System (NCIS), which documents reports to coroners, does not provide a comprehensive list of relevant cases. It was reported that in cases where there is no inquest, Coroners typically are provided with limited information; police provide brief details compiled at or around the time that the death was discovered and this information is less than subsequently appears on COPS. The quality or accessibility of other possible sources such as the National Homicide Monitoring Program (which supplements police reports with information from investigative officers and toxicology reports from coroners)[53] and alternative police systems (e.g. E@glei) is not known but should be explored further.

3. The COPS data fields of employment, country of birth and Indigenous status may not be available or reliable. These are all potentially important factors associated with domestic homicide.

4. Only a small proportion of perpetrators had contact with police for any offence in the year preceding the homicide, and particularly when looking at past incidents also involving the victim. BOCSAR found that even fewer victims of domestic violence had reported the incident to police (10 percent). These findings are consistent with the research into women's help seeking patterns. Research evidence based on victim surveys demonstrates that the majority of incidents of domestic violence are not reported to police[54]. Many victims will first disclose to non-police sources, for example health services or informal support such as family or friends. These results highlight the importance of looking beyond NSW Police Force data and seeking out other sources of information.

[53] See Australian Institute of Criminology (2009), National homicide monitoring program, http://www.aic.gov.au/research/projects/0001.html.
[54] ABS (2005) Personal Safety Survey

Best Practice and Data Collection

Government and other agencies often possess a wide range of critical information concerning victims and perpetrators. For instance, government agencies possess the following information, which may be relevant to a domestic homicide:

- NSW Police Force
  - Apprehended Violence Order - Applications for orders
  - "COPS" profiles of victims and offenders and recorded incidents
  - C.A.D. (000 calls - phone calls)
  - Case Files (includes police notebooks and duty books)
  - P79a (reports to the Coroner)
  - Domestic Violence Liaison Officer (DVLO) Intelligence

- Department of Health
  - Client files
  - Ambulance records
  - Accident and Emergency records and hospital records

- Department of Community Services
  - Child protection reports

- Attorney General's Department
  - Court files
  - Victim Services files relating to counselling and compensation

- Housing NSW
  - Client files.

The sharing of relevant information between agencies is essential and the report conducted by BOCSAR, and the attempts of the Advisory Panel to obtain information on five individual cases, has highlighted the obstacles that prevent effective collaborative approaches to identifying issues. Clearly, difficulties associated with the sharing of information are not unique to domestic violence homicides. However, the Advisory Panel has formed the view that it is an issue that will only become more pronounced over time and systems should be put in place to ensure a best practice model for the collection of data and sharing of relevant

information is implemented so that information concerning victims of domestic violence is not lost.

After considering the inadequacies of data collection in this area, the Advisory Panel considered what a best practice model of data would look like. It was agreed that a best practice model would do the following:

- comprehensively capture the suicides of women who take their own lives (and possibly those of their children) as a direct result of domestic violence;
- ensure that the COPS database has the ability to properly 'flag' homicides as domestic violence homicides;
- capture data concerning violence against previous partners;
- allow a review mechanism to have access to all relevant data including, but not limited to the COPS database, the DoCS database, NCIS and Justicelink (the court database); and
- improve and strengthen the information currently captured by NCIS.

Privacy

The Advisory Panel found that if any one organisation were to attempt to seek to gain an understanding of what the main issues were facing domestic violence homicides, that organisation would be significantly hampered by the various statutes that relate to privacy and the sharing of information. There are, of course, extremely compelling reasons why such legislation is necessary and it is not the position of the Advisory Panel that the right to privacy be diminished. However, when it is in the public interest for such information to be shared, there should be flexibility to allow that to occur in a streamlined and efficient manner.

The Advisory Panel noted that whilst it is possible for members of a review mechanism to sign a deed of confidentiality, which is legally binding and requires a formal commitment by members to maintain confidentiality of any information obtained in relation to individual homicides, that this is not enough to ensure that there are no breaches of relevant legislation. The *Privacy and Personal Information Protection Act 1998* (PPIP Act) and the *Health Records and Information Privacy Act 2002* (HRIP Act) are the statutes which specifically govern privacy in NSW and permit exceptions to the prohibition on disclosure in limited circumstances by way of a direction from the Privacy Commissioner. There are however many statutes which impose obligations on agencies not to disclose information and a direction under either the PPIP Act or the HRIP Act will not override those laws.

An example of the limitations of current information sharing processes was highlighted when the Advisory Panel decided to consider five cases of domestic violence homicide in depth, in addition to the cases contained within the BOCSAR analysis. The purpose of considering these cases in depth was to address the term of reference which required the Advisory Panel to report back on any changes to practices and procedures that would contribute to a reduction in preventable homicides. The Advisory Panel intended to provide a comprehensive "snap shot" of what features are common to domestic violence homicides in NSW and where, based on these limited cases, there is need for further research or improvement. However, the Advisory Panel was unable to complete the in depth analysis due to privacy constraints and based on the advice of the Privacy Commissioner and the Crown Solicitor's Office.

The Advisory Panel agreed that it is crucial to recognise that (apart from internal investigations within individual agencies) without specific legislative authority, there is currently no one organisation that would be permitted to review and investigate a domestic homicide in order to establish systemic failures and that any review mechanism would need to be supported by legislation which permits or requires disclosure (where it would otherwise be prohibited) and imposes strict confidentiality requirements upon members.[55]

[55] As part of the NSW Government's response to the Special Commission of Inquiry into Child Protection Services in NSW, the Children and Young Persons (Care and Protection) Act 1998 has recently been amended to permit the exchange of information between human services and justice agencies, and between such agencies and the non-government sector, where that exchange is for the purpose of making a decision, assessment, plan or investigation relating to the safety, welfare and well-being of a child or young person.

7. BOCSAR Trends Analysis

In January 2009, the Minister for Women, the Hon Verity Firth MP, asked the NSW Bureau of Crime Statistics and Research to conduct an analysis of trends and patterns in domestic and family violence related homicides in NSW over a five-year period. To that end, the report (attached at Appendix A) aimed to:

- describe the trends and characteristics of domestic homicides in NSW over the period 1 January 2003 to 30 June 2008; and
- examine intimate partner femicides in greater detail to explore whether factors could be determined from police data that could be used to identify women at increased risk of domestic homicide.

The analysis includes all incidents of murder and manslaughter (not including driving), defined as domestic or family violence related based on the *Crimes (Domestic and Personal Violence) Act* 2007. Characteristics such as the age, sex and relationship of victims and offenders are described, as are the circumstances of the homicide event.

In exploring the ability for police data to identify women at increased risk of domestic homicide, the key finding to emerge from the study was the low percentage of victims who had contact with the police as a victim of domestic violence where the eventual homicide offender was the person of interest. In the case of the overall domestic homicide sample, only 10 percent of victims had been in contact with the police in the 12 months leading up to the homicide with involvements of this nature of these the majority were victims of intimate partner homicide. However, the majority of offenders in both groups were likely to have had contact with the police for a violence related offence over the past five years but this was higher for the non- lethal assault group (70%) than of the femicide group (53%). This highlights the difficulties that would be faced by the police in identifying offenders and victims who are likely to be at risk of being involved in a domestic homicide.

This is consistent with the research only a minority of victims report the violence to the police and that they are more likely to seek help from informal sources such as friends and family, and other services, such as health services.

Of those who came to the attention of police, there is little indication, based on the prior history data recorded by NSW Police, that the femicide offenders are any different to those offenders who came to the attention of police for a non-lethal assault. One exception to this is

the finding that a higher percentage of the non-lethal assault group than the femicide group had a recorded history of assault in the previous 5 years.

The data collected by BOCSAR suggests that it is not possible, using data collected by police, to determine which cases of domestic assault are mostly likely to result in a domestic homicide. Nor does the police data contain sufficient detail about the context and antecedents of the homicide. BOCSAR concluded that those charged with the responsibility for preventing domestic violence therefore have little choice but to either treat all victims of domestic violence as equally at risk of domestic homicide or use the risk markers identified in overseas studies as a guide to which victims of domestic violence may be most at risk. The former course of action imposes a bigger demand on resources but BOCSAR considered that it may be more prudent until the issue of risk markers for domestic homicide has been more fully investigated in Australia.

While one part of the BOCSAR report focussed on the issue of prediction of homicide, it is important to note that prediction is not, nor can it be, the core aim of a domestic violence homicide review.

8. Options for Mechanisms in NSW

Functions of a Review Mechanism

It is proposed that any domestic violence homicide review mechanism in NSW should have seven key functions:

1. Review individual deaths and identify where intervention may have prevented the death;
2. Identify trends and patterns in domestic violence homicides that have occurred during a particular time frame;
3. Establish and maintain a comprehensive database about the victims and perpetrators of domestic violence homicides and their circumstances;
4. Conduct research where appropriate;
5. Develop best practice guidelines for agencies with reference to emerging research;
6. Educate the community and professional groups about domestic violence; and
7. Provide a comprehensive report with findings and recommendations which highlight and address:
    a. systemic failures;
    b. procedural failures;
    c. risk management;
    d. suggestions for reform to legislation, policy, training and implementation of reforms.

Essential Features for Any Option

The Advisory Panel considers that there are a number of common features that are essential to incorporate into any review mechanism model in order to ensure its effectiveness. These common features are critical to overcoming problems and obstacles facing a review mechanism, and include:

- A strong legislative framework incorporating the following:
    - protection from disclosure in legal proceedings (e.g. review mechanism documents cannot be obtained by court subpoena and review mechanism members cannot be called to give evidence about what was discussed in any court proceeding);
    - immunity to those who disclose information to the review mechanism that would ordinarily be confidential or privileged;

- exemptions from freedom of information legislation;
- the ability for the review mechanism to compel information from agencies such as:
    - Police incident reports;
    - "000" call transcripts and Police briefs;
    - Court documents;
    - Coroner's files including autopsy reports;
    - Office of the Director of Public Prosecutions briefs;
    - criminal trial transcripts; and
    - client files from government and non-government agencies.
- a statement of objectives that centre upon a 'no blame' philosophy, ensuring culpability of the perpetrator for the death is emphasised;
- a requirement that committee members are bound by confidentiality provisions as laid out in the legislation;
- a clear notification of cases structure, which will rely upon the NSW Police Force to notify the review mechanism, as well as other agencies, such as the State Coroner and Department of Health. Consideration should also be given as to whether other parties (including family members or friends of the victim) can request a review;
- the power to make publically available recommendations that can be directed at both government and non-government agencies;
- a mechanism to ensure the implementation of recommendations (e.g. a reporting back system);
- membership that includes all relevant government and nongovernment service providers, noting the particular expertise that each sector and agency can bring to the process; capacity to seek expert advice where necessary;
- a requirement for the mechanism to meet a minimum number of times per year;
- oversight mechanisms such as providing an annual report to an overseeing body[56]; and
- a statutory review mechanism that considers the mechanisms work on a periodic basis against clear measures and indicators[57] and considers, after 24 months, whether the review mechanism is appropriately constituted.

[56] E.g. the Delaware Fatal Incident Review Team reports to the Domestic Violence Coordinating Council; the New Hampshire Domestic Violence Fatality Review Committee provides reports to the Governor and other relevant agencies; the Ontario Domestic Violence Death Review Committee reports to the Chief Coroner; New Zealand Family Violence Death Review Committee will report annually to the Minister of Health and this report will be tabled in Parliament; Santa Clara Domestic Violence Death Review Committee makes recommendations to the Board of Supervisors of the Domestic Violence Council.

The Advisory Panel recognised that it is crucial that, if an additional homicide review mechanism is established, the recommendations of that mechanism are consistent with, and do not duplicate, the recommendations of other death review mechanisms, such as the Child Death Review Team. By the same token, other review mechanisms would need to be cognizant of any recommendations flowing from a domestic homicide review team and ensure that their recommendations are not inconsistent with or duplicate domestic homicide review recommendations.

The Advisory Panel recommends that the Government consider ways of ensuring that the various death review bodies in NSW are informed of relevant recommendations made by one another, to improve efficiencies and limit the risk of duplication.

Terms of Reference for a Review Mechanism

It is recommended that the following terms of reference be used as a starting point for any future review mechanism:

- to examine the events leading up to the deaths of people who died within the context of domestic violence in order to gain a better understanding of domestic violence and improved criminal justice and human services responses;
- to examine the contacts made with services for support and assistance by the victim and offenders, and the appropriateness and quality of services and other relevant interventions provided to the victim and offender;
- to examine issues of access to such services for the victim and offender;
- to identify barriers to access and other impediments to help-seeking;
- to identify gaps in systems and service delivery;
- to identify systems failures;
- to recommend improvements to service delivery, training, systems and law reform, as appropriate;
- to monitor progress in the implementation of recommendations;
- to report to Parliament annually on findings of death reviews, recommendations made and progress of implementation of previous recommendations made;
- to create and maintain a comprehensive database about the victims and perpetrators of domestic violence homicides and their circumstances; and

[57] E.g. the New Zealand Ministry of Health will conduct an evaluation of the Death Review Committee once it has been operational for three years.

- to stimulate educational activities and disseminate educational information where appropriate.

Options for a Domestic Violence Homicide Review Mechanism

There are five possible options for a domestic homicide review mechanism:

1. Appointing the NSW Ombudsman as the convenor of a team with specific powers to investigate and review homicides relating to domestic violence (similar to the existing Child Death Review Team);
2. Expanding the NSW Ombudsman's present statutory review powers to allow him to investigate and review domestic violence homicides (similar to the existing reviewable deaths model);
3. Appointing the NSW State Coroner as the convenor of a team with specific powers to investigate and review homicides relating to domestic violence (similar to the existing Child Death Review Team model);
4. Empowering the NSW State Coroner to review homicides relating to domestic violence,[58] with the support of a specialist unit and an ad hoc advisory committee;
5. An independent, government and non-government Premier's Advisory Committee (similar to the NSW Ministerial Maternal and Perinatal Committee).[59]

NSW Ombudsman

Two possible approaches

A review of domestic violence deaths could be undertaken by the Ombudsman in his capacity as a Convenor, similar to his role as the Convenor of the Child Death Review Team, which reviews all child deaths. Alternatively, the Ombudsman already has significant review powers pursuant to the *Community Services (Complaints, Reviews and Monitoring) Act 1993* and those powers could be expanded to encompass domestic violence homicides.

[58] Examples: Ontario Domestic Violence Death Review Committee; West Virginia Domestic Violence Fatality Review Team; Victoria Family Fatality Review.
[59] International examples: Kansas Domestic Violence Fatality Review Board (appointed by and report to the Governor of Kansas); New Zealand Family Violence Death Review Committee (reports to the Minister of Health and administered by the Ministry of Health along with three other death review bodies).

The Ombudsman already has considerable expertise in the area of domestic violence. For instance, in December 2006, the Ombudsman released a comprehensive report to Parliament called "*Domestic violence: improving police practice*" which focused on three critical areas: enhanced support for victims of domestic violence; better cooperation between NSW Police and other agencies with key responsibilities, especially the Department of Community Services and local courts; and more effective frontline policing responses. The report highlighted significant improvements since the Ombudsman's earlier review of policing domestic violence in 1999, but also focussed on the need for further reforms.

In order to understand precisely how a domestic violence homicide model might work based on either of the above options, it is necessary to gain an understanding of how the Child Death Review Team and the Ombudsman's statutory powers operate.

1. The Child Death Review Team Model

How the current Child Death Review Team operates

Pursuant to Part 7A of the *Commission for Children and Young People Act 1998* the Child Death Review Team (CDRT) is convened by the Ombudsman. The CDRT considers all child deaths and is required by the legislation to:

a) maintain the register of child deaths occurring in New South Wales that has recorded such deaths since 1 January 1996;
b) classify those deaths according to cause, demographic criteria and other relevant factors;
c) analyse data to identify patterns and trends relating to those deaths;
d) with the approval of the Minister, to undertake, alone or with others, research that aims to help prevent or reduce the likelihood of child deaths;
e) make recommendations, arising from the Team's maintenance of the register of child deaths and from its research, as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths; and
f) identify areas requiring further research by the CDRT or other agencies or persons.[60]

Members of the CDRT must include:

- the Convenor of the CDRT, namely the Ombudsman and persons appointed by the Minister;

[60] Section 45N, *Commission for Children and Young People Act 1998*

- Representatives of each of the following:
    - the Department of Community Services,
    - the Department of Health,
    - the NSW Police Force,
    - the Department of Education and Training,
    - the Attorney General's Department,
    - the Office of the Coroner,
    - the Department of Ageing, Disability and Home Care;
- persons recommended by the Convenor and who, in the opinion of the Minister, are:
    - experts in health care, research methodology, child development or child protection, or
    - persons who, because of their qualifications or experience, or both, are likely to make a valuable contribution to the work of the CDRT; and
- two persons who are Aboriginal (within the meaning of the *Aboriginal Land Rights Act 1983*).[61]

The Convenor of the CDRT may appoint persons with relevant qualifications and experience to advise the CDRT in the exercise of its functions.[62] The CDRT must meet at least 4 times a year and a majority of persons holding office as members of the CDRT constitutes a quorum for any meeting of the CDRT. The CDRT is required to prepare, within the period of 4 months after 30 June in each year, a report of its operations during the year ended on that 30 June and table that report in Parliament.

A report by the CDRT must include the following:

- a description of its activities during that year in relation to each of its functions, and details of the extent to which its previous recommendations have been accepted;
- whether any information has been authorised to be disclosed by the Convenor; and
- if the CDRT has not presented a report to Parliament within the previous 3 years, the reasons why such a report has not been presented.

A report by the CDRT may include comment on the extent to which any previous recommendations have been implemented in practice.

[61] Section 45C, *Commission for Children and Young People Act 1998*
[62] Section 45O, *Commission for Children and Young People Act 1998*

The CDRT is also required to prepare, within the period of 4 months after 30 June in each year, a report consisting of data collected and analysed in relation to child deaths registered during the previous calendar year and table that report in Parliament.

Secretariat and research support for the CDRT is now provided by the staff of the Office of the Ombudsman.

2. *The Reviewable Deaths Model*

How the current statutory powers of the Ombudsman operate

The Ombudsman's statutory responsibilities under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* ('the Act') include reviewing the deaths of certain children, including:

- children whose deaths were a result of abuse or neglect, or occurred in suspicious circumstances;
- children in care; and
- children in detention.

The most relevant Ombudsman function, for the purpose of considering an appropriate model for reviewing domestic violence homicides, is his ability to review child deaths resulting from abuse or neglect, or occurring in suspicious circumstances.

The Ombudsman has the relevant following functions under the Act:

- to monitor and review reviewable deaths;
- to formulate recommendations as to policies and practices to be implemented by government and service providers for the prevention or reduction of deaths of children or children at risk of death due to abuse or neglect or in suspicious circumstances;
- to maintain a register of reviewable deaths occurring in New South Wales after a date prescribed by the regulations classifying the deaths according to cause, demographic criteria or other factors prescribed by the regulations; and
- to undertake research or other projects for the purpose of formulating strategies to reduce or remove risk factors associated with reviewable deaths that are preventable.[63]

For the purpose of exercising those functions the Ombudsman may:

- keep under scrutiny systems for reporting reviewable deaths;
- undertake detailed reviews of information relating to reviewable deaths;

[63] Section 36(1), *Community Services (Complaints, Reviews and Monitoring) Act 1993*

- analyse data with respect to the causes of reviewable deaths to identify patterns and trends relating to those deaths; and
- consult with and obtain advice from any person or body having appropriate expertise.[64]

This reviewable death function of the Ombudsman is described in the NSW Ombudsman's Annual Report 2007-2008 as:

> *identifying shortcomings in agency (not only DoCS) systems and practice that may have directly or indirectly contributed to the death of a child, or that may lead to children being exposed to risk in the future.*[65]

Under the Act the Ombudsman has the power to convene an Advisory Committee to assist him by giving expert advice. The Ombudsman may either accept or reject that advice. With respect to reviewing child deaths, the Reviewable Child Death Advisory Committee met twice during 2007-2008. The Department of Community Services, the NSW Police Force, the Attorney General's Department, the Department of Health and the Coroner are not represented on the Committee.

The Ombudsman's findings and recommendations are tabled in Parliament annually and are also contained with the Ombudsman's annual report.

An Ombudsman Review Model: Team or the Reviewable Deaths Model

A mechanism for reviewing domestic violence homicides could be adapted from either the CDRT or the Ombudsman's specific statutory review powers. The primary difference between the two models is that, regarding the CDRT, the Ombudsman is but one of a panel of people (both government and non-government) who make collaborative decisions about recommendations and findings whereas, under the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, the Ombudsman independently investigates and reports on reviewable deaths and only draws on the advice of the Advisory Committee when required.

[64] Section 36(2), *Community Services (Complaints, Reviews and Monitoring) Act 1993*
[65] NSW Ombudsman Annual Report 2007-2008, p. 72

(a) Legislative compulsion for information to be provided

The legislation relating to both the CDRT and the Ombudsman imposes a duty on the following persons to provide full and unrestricted access to records that are under the person's control, or whose production the person may, in an official capacity, reasonably require, being records to which the Team or the Ombudsman reasonably requires access for the purpose of exercising functions under either Act:

- a service provider (whether or not a government agency);
- the chief executive officer of a service provider;
- the relevant Minister for a service provider;
- the Department Head, chief executive officer or senior member of any department of the government, statutory body or local authority;
- the Commissioner of Police;
- the Commissioner for Children and Young People;
- the State Coroner; and
- the holder of any office prescribed by the regulations.

The CDRT has access to NCIS, an on-line computerised data storage facility that holds information on deaths reported to Coroners within Australia. The Ombudsman has access to the COPS database as well as to the DoCS database.

It is envisaged that similar legislation and access to databases would be required for either the Ombudsman acting alone or as convenor of a Domestic Violence Homicide Review Team.

(b) Closed / open cases?

Both the CDRT and the Ombudsman frequently investigate cases that are still subject to ongoing criminal proceedings. The issue of prejudicing criminal proceedings is circumvented by way of the legislation explicitly stating that a Team-related person, or the Ombudsman or an officer of the Ombudsman, is not required:

- to produce to any court any document or other thing that has come into the person's possession, custody or control; or
- to reveal to any court any information that has come to the person's notice, by reason of being a Team-related person.

Similar legislative protections would be required for either the Ombudsman acting alone or as Convenor of a Review Team.

(c) *Privilege/Confidentiality*

The Ombudsman is, in the exercise of functions under the Act, exempt from the operation of the *Freedom of Information Act 1989*.

With respect to the provision of information by agencies to the Ombudsman:

- the furnishing of the information is not, in any proceedings before a court, tribunal or committee, to be held to constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct;
- no liability for defamation is incurred because of the provision of the information; and
- the provision of the information does not constitute a ground for civil proceedings, for malicious prosecution or for conspiracy.

The CDRT legislation requires that no information obtained by the Team can be disclosed to any other person unless it is made under s.45U of the *Commission for Children and Young People Act 1998*. That section allows the Convenor of the Team to provide information in the following circumstances:

- in connection with research that is undertaken in order to reduce or prevent the likelihood of deaths of children in New South Wales;
- in connection with a possible criminal offence;
- reporting that a child or class of children may be at risk of harm;
- where it may relate to a death that is within the jurisdiction of the State Coroner, whether or not the death has been the subject of an inquest under the *Coroners Act 1980;* and
- where the information concerning the death of a child is relevant to the exercise of any of the Ombudsman's functions.

Similar powers and protections would need to be bestowed upon the Ombudsman acting alone or as Convenor of a Review Team.

(d) *Governance and Review Oversight*

Both the CDRT and the Ombudsman are currently required to report to Parliament annually and both the CDRT and the Ombudsman are overseen by a Parliamentary Joint Committee. A similar system of governance is proposed if either model were adopted to review domestic homicides.

The Ombudsman's annual report to Parliament includes the following:

- a report as to data collected and information relating to reviewable deaths that occurred in the State during the previous calendar year,
- any recommendations made for the purposes of section 36 (1) (b) in the period covered by the report,
- information with respect to the implementation or otherwise of previous recommendations (as appropriate).

The report to Parliament by the CDRT is required to contain similar information.

A similar system of oversight would be suggested if either model were adopted to review domestic homicides.

(e) Relationship to State Coroner

The State Coroner provides relevant information both the CDRT and to the Ombudsman and it is envisaged that this would continue under a model where there is a Review Team or the Ombudsman alone reviews domestic violence homicides.

(f) Responding to recommendations

Annual reports by the CDRT and the Ombudsman contain information with respect to the implementation or otherwise of previous recommendations. Monitoring of and reporting on implementation of recommendations would be essential for any domestic violence homicide review mechanism.

(g) Resources

The Ombudsman's Office has indicated that if it were to be tasked with reviewing domestic violence homicides in a manner similar to their current review function under the Act: i.e. as an independent statutory body, it would require somewhere in the vicinity of $500,000 per year recurrent funding. This amount is provisional at this stage, as it is not yet known what the precise scope of the review mechanism will be.

A model based on the Child Death Review Team may require slightly less funding but again, this would depend of the scope of matters required to be considered by the Team.

NSW State Coroner

Two possible approaches

International death review bodies have different models for involvement of the Coroner. For the purposes of a NSW review body it is proposed to concentrate on two models: one where the Coroner hosts and facilitates the death review mechanism[66] and the second, where, similar to the Child Death Review Team, the Coroner convenes a domestic violence homicide review team.

The current role of the Coroner as outlined in the NSW *Coroner's Act 1980* ('the Act') is to determine the identity of the deceased and the date, place, manner and medical cause of death of the deceased. In order to fulfil this role, the Coroner relies on information obtained from pathologists, police personnel, general practitioners and specialist physicians.

Every coronial investigation is different. It is up to the Coroner to decide what investigation is necessary. This may involve:

- a review of the person's medical history and the circumstances of the death;
- an autopsy and pathology tests;
- specialist reports from experts and external investigators such as police, doctors, engineers, the fire brigade, air safety officer etc; and
- statements from witnesses, such as family and friends.

Most investigations are finalised by the Coroner without the need for an inquest. Where a Coroner conducts an inquest pursuant to s.13 of the Act into an unnatural death, he or she must, if possible, make findings concerning the identity of the deceased person, the date and place of his or her death and, crucially, the cause and the manner of his or death. The findings must be recorded. A Coroner also has a discretion, in an appropriate case, to make such recommendations that appear necessary or desirable relating to the death in question (s.22A of the Act). Section 19 of the Act states that upon making a finding as to the identity of a person suspected of killing the deceased person, the inquest must be suspended and the matter referred to the Director of Public Prosecutions.

The role of NSW Coroner also includes reviewing the systematic failures which may contribute to a death. An example is the inquest into a triple murder–suicide at Wilberforce in

[66] E.g. Victoria, West Virginia.

2003. Phithak Kongsom fatally stabbed his children Marilyn, 4, and Sebastian, 23 months, in the driveway of their Wilberforce home in September 2003. He also fatally stabbed his father in law, who was caring for the children. Kongsom's estranged wife, Ingrid Poulson had taken out an apprehended domestic violence order which had already been breached on several occasions. The NSW Deputy Coroner, Mr Carl Milovanovich, examined the role of police and the Department of Community Services (DoCS) in the months leading up to and including the day of the stabbings.

Mr Milovanovich found there had been a number of shortcomings in the way police handled various domestic incidents involving Mr Kongsom and Ms Poulson. Mr Milovanovich found that police should have taken greater action to arrest Mr Kongsom on the morning of the murders and called for the NSW Police Commissioner to review the adequacy and frequency of officer training on domestic violence issues, and recommended the implementation of mandatory ongoing training.

Mr Milovanovich also recommended an examination of standard arrest procedures in domestic situations, and asked the NSW Attorney General to review specific laws pertaining to domestic violence offences and apprehended violence orders.[67]

1. Domestic Violence Homicide Review Team convened by the Coroner

Similar to the Ontario model, and the NSW Child Death Review Team, this model would entail the Coroner convening a committee or team which would consist of representatives from law enforcement agencies, health, social services and other relevant agencies and non-government organisations.

The team would examine the facts of individual cases to develop understandings of why domestic violence related homicides occurred, any primary risk factors, and how such homicides might be prevented. The team would be required to undertake research, identify trends and patterns, and identify areas requiring further research by the team or other agencies or persons. The team would also be required to compile an annual report, which would be tabled in Parliament.

[67] The NSW Police Force advises that all the recommendations made by the Coroner were supported and have been implemented through the Domestic and Family Violence Standard Operating Procedures released in November 2008, and the new Domestic and Family Violence training, presently being rolled out.

2. Coroner Hosts and Facilitates the Death Review Mechanism

A Coronial model where the Coroner is responsible for reviewing deaths, with the support of a dedicated unit, would be an extension of the current role of the Coroner, but would require some additional powers. The Coroner would, under this model, examine all domestic violence homicides committed in NSW and have discretion to consider domestic violence homicides from the past.

The Coroner would be provided with a support unit to assist with the collating of evidence from sources such as Police documents, "000" call transcripts; criminal trial transcripts; agency client files; and/or statements from witnesses. The unit would also review domestic violence homicides that have been investigated by coroners in Australia (by using NCIS) and relevant academic literature and provide information that would assist the Coroner to make better informed recommendations. The unit could also assess whether Coronial recommendations relating to domestic violence homicides were being implemented.

Having considered all the evidence prepared for each matter by the support unit, the Coroner would make findings in relation to the victim's or victims' background experience of violence and access to services and safety, including police intervention and the making and enforcement of protection orders.

It is envisaged that the aggregated findings of inquiries into a number of deaths may show patterns of systems failures. Recommendations to improve service delivery and developing relevant policies to address systemic gaps would be made. The implementation by agencies of recommendations and the evaluation of agencies' progress in implementing these recommendations would be the responsibility of the Coroner, who could report back to the Parliament through an Annual Report.

The Coroner would be empowered to convene an advisory committee consisting of senior officers of relevant Government Departments (for instance, Department of Premier and Cabinet, Attorney General's Department, NSW Police Force, NSW Health, Department of Community Services, Department of Corrective Services, Housing NSW) and representation from the non-government sector with expertise in responding to victims of domestic violence.

A State Coroner Review Model: Coroner convening a Team or Coroner hosting alone

A model whereby the State Coroner facilitates and hosts the domestic violence homicide review mechanism would be most similar to the model adopted by Victoria. The Coroner would have a dedicated support unit attached to the Coroner's office and would be able to draw on the expertise of an advisory Committee when required. On the other hand, a model where the Coroner convenes a team made up of government and non-government members would mean that the Coroner is but one of a panel of people who can make collaborative decisions and share information. This model is closer to the model in Ontario, Canada.

(a) Legislative compulsion for provision of information

The Coroner already has wide ranging powers to investigate a death. A Coroner who is investigating a death can subpoena documents and, during an inquest, subpoena people to give evidence including family members and friends, Police, court staff and professional staff who provided services or advice to the victim. The Coroner can also provide immunity from prosecution to people giving evidence.

These powers could be expanded so that the Coroner, when reviewing domestic homicides, could impose a duty on both government and non-government agencies to provide full and unrestricted access to records that are under the agency's control.

Likewise, a team convened by the Coroner could have similar legislative powers conferred upon them so that all relevant information is obtained. In either model, the Coroner and/or the team should have access to all necessary databases such as NCIS, COPS and the DoCS database.

(b) Closed / open cases?

Presently, the Coroner's inquest function is suspended when it becomes apparent that a person is a likely suspect and that charges will be laid. This is to prevent any prejudice to the defendant in the criminal proceedings. However, if a model involving the Coroner were adopted, as the issues being considered are systemic and not about individual culpability, with proper legislation protections in place, the Coroner or the team could continue to consider matters relating to systems issues even when criminal proceedings were on foot.

Alternatively, the Coroner or the team could consider only matters where either no charge has ever been laid (and is not going to be) or where the criminal proceedings have concluded (including all appeal avenues). As noted above, however, waiting for the appeals process may affect the timeliness of any recommendations.

(c) Privilege/Confidentiality

If either Coronial model were adopted the legislation would be required to provide specific safeguards, namely, protection from disclosure in legal proceedings (for example, files would not be subject to discovery, could not be obtained by court subpoena and neither the Coroner nor any team member could be called to give evidence about what was discussed in any court proceeding).

(d) Governance and review oversight

As a member of the judiciary, the State Coroner is not directly responsible to the Government or Parliament, except where specified by the relevant legislation. Rather, he or she can make recommendations where he or she sees fit to do so. However the Governor may, for any cause which to the Governor seems sufficient, remove any Coroner from office.

The Coroner or the team would be required to make their findings public by way of an annual report which would be tabled in Parliament. That report would be required to contain similar information as set out for the Child Death Review Team.

(e) Relationship to State Coroner and Ombudsman

The State Coroner would have direct control over the review process as an independent judicial body or be the Convenor of a team. A representative of the Ombudsman would be a member of the team.

(f) Recommendations

Presently, a Coroner may make recommendations to any government department, public statutory authority or non-government entity on any matter concerned with an investigation.

If either Coronial model were adopted, the legislation would need to provide for a reporting back mechanism. There is precedence for this in the Northern Territory's *Coroners Act*. Section 46A of that Act requires that the Attorney General receive a report or

recommendations from the Coroner and if those recommendations relate to another agency, the Attorney is responsible for giving a copy to that agency. Section 46B requires that whosoever receives a copy of that report or recommendation must, within 3 months, provide a written response to the Attorney General. The Attorney is then obliged to give the response to the Coroner and table a copy of the response in Parliament.

Similar legislative provisions could be put in place in NSW. Alternatively, the recommendations (and whether they were implemented) could be contained within an annual report which would then be tabled in Parliament.

Whilst the Coroner alone or the team as a whole would not have the power to 'order' agencies to implement the recommendations, it would, as noted above, be able to evaluate agency responses and report back to Parliament on those responses.

(g) Resources

Should either Coronial model be adopted, it would be expected that a specialist Coroner (magistrate) would oversee the review mechanism, possibly on a part time basis. Either the Coroner alone or the team would need to be supported by a unit which would comprise senior officers with relevant expertise. As noted above, the Coroner alone model would also be assisted by an expert Advisory Committee.

Functions such as maintaining a database of relevant deaths, and undertaking relevant research and education activities as contemplated in the recommended Terms of Reference would need to be developed within the unit, as has occurred in some international models. It is estimated that a model along either of these lines would require recurrent funding of approximately $500,000 per annum, given the need for improved infrastructure resources and the development of expertise in new areas such as research.

5. Premier's Advisory Committee

An independent Premier's committee, comprising both government and non-government representatives, could be established to review domestic violence related homicides. This committee could be modelled on the NSW Ministerial Maternal and Perinatal Committee (MMPC), but would report directly to the Premier (see Appendix B)**.** Following this model, the members of the Committee would be appointed directly by the Premier and would represent both the community and government. This committee would identify systemic failures, trends

in domestic violence deaths and make recommendations with a prevention focus. A Secretariat unit, similar to that which supports the MMPC, could be established in the Department of Premier and Cabinet, given the cross-portfolio nature of any review.

(a) *Legislative compulsion for information to be provided*

The *Health Administration Act* permits the Minister for Health to authorise the MMPC to conduct research or conduct investigations into morbidity or mortality occurring within New South Wales. An authorisation may be of general application or be limited by reference to specified factors or exceptions. Information disclosed to the Committee under these powers is protected and people required to disclose are exempted from the general privacy offences.[68]

(b) Open / closed cases?

The MMPC typically considers cases where no charges are ever going to be laid. However, where there is a coronial investigation or occasionally, where there is a police investigation, the MMPC suspends its consideration of the case until the proceedings have been resolved.

A domestic violence homicide mechanism which reports to the Premier could only consider open cases if legislative protections were in place. However, considering closed cases would limit any risk to prejudicing on going criminal or coronial investigations.

(c) Privilege / Confidentiality

The MMPC is governed by the *Health Administration Act 1982*. The privilege provided under that Act, applies to Committee members and internal documentation prepared by them. This means that Committee members cannot be compelled to produce or give evidence of any document created by, at the request, or solely for the purpose of the Committee or any matter or thing which came to their attention as part of the Committee.

Likewise reports of MMPC are not admissible as evidence in any proceedings claiming a procedure or practice was careless or inadequate. MMPC members acting in good faith for the purposes of the Committee are also protected from personal liability, including actions for defamation.

[68] Section 23, *Health Administration Act 1982*

The legislation establishes tight confidentiality protections, making it an offence for a MMPC member to disclose any information obtained during the MMPC. To ensure confidentiality, material concerning cases for consideration is de-identified and couriered to members - on occasion a member is asked to present a case where they will have the identifiable records but cases are discussed in a de-identified manner. All papers are retrieved and destroyed at the end of the meeting. If members are involved in a case, they are required to leave the meeting and not participate in deliberations.

Similar legislative provisions would be required for a domestic violence homicide review mechanism modelled on the MMPC.

(d) Review oversight

Under an Advisory Committee model, the review committee would report directly to the Premier after each review.

(e) Relationship to State Coroner and Ombudsman

A domestic violence homicide review committee membership could include the State Coroner or a Coroner and/or the Ombudsman, but this is not fundamental to the model.

(f) Recommendations

Reports regarding each death reviewed and any recommendations arising could be made directly to the Premier. In addition, the Committee could produce an Annual Report to be tabled in Parliament by the Premier. This report could also include government feedback on its progress in addressing recommendations made by the Committee. The MMPC is required to furnish reports concerning their activities to the Minister and to relevant health services organisations. That report may, in turn, be included in the Health's NSW Annual report which is tabled in Parliament.

(g) Resources

The approximate cost of the MMPC is $100,000 per year. This includes a secretariat support staff member, sitting fees for members and other costs such as travel reimbursement and venue fees. As this figure is based on 8-10 cases per year, it would be expected that a domestic violence homicide review committee would require at least twice that amount.

9. Assessment of the Options

MODEL	KEY FEATURES	COST (BASED ON 25-30 CASES p/a)	KEY ADVANTAGES	KEY DISADVANTAGES
Option 1 Ombudsman to Convene a Team	• Modelled on the CDRT • Team of government and non-government representatives convened by the Ombudsman to review domestic violence homicides • Undertakes review, research and education • Supported by the Office of the Ombudsman	Approximately $500,000 p/a	• Existing model in the CDRT • Expertise in review, research and education • Already has comprehensive legislative powers, including the ability to compel information / documentation • Semi - independent • Ensures government and non-government participation • Capacity to draw on material arising from systemic reviews of agencies, undertaken as part of wider powers • Capacity to share information on relevant child deaths and avoid duplication	• Only meet intermittently (could be resolved through the legislation) • Inconsistent with Ombudsman's traditional role as a complaints handling body • Impact of CDRT functions on the Ombudsman's Office is yet to be determined • Inconsistent with Victorian approach to domestic violence homicide review

			• Not restricted to closed cases	
Option 2 Ombudsman to perform review	• Expansion of Ombudsman's current powers to review certain deaths	Approximately $500,000 p/a	• Significant review/investigative expertise • Already has comprehensive legislative powers , including the ability to compel provision of information /documentation • Independent • Ability to examine open cases (provided the criminal trial has been completed or no charges laid) in addition to closed cases, a possibility resulting in timely system response to learnings • Capacity to draw on material arising from systemic reviews of agencies undertaken as part of wider powers • Capacity to share information on relevant child deaths and avoid duplication	• Inconsistent with Ombudsman's traditional role as a complaints handling body • Non-government and government representatives only involved in advisory capacity and potentially ad hoc • Impact of CDRT functions on the Ombudsman's Office is yet to be determined

			• Has existing research capacity within Office, undertakes education, and has potential to develop a database	
Option 3 State Coroner to convene a review Team	• Modelled on the CDRT • Team of government and non-government representatives convened by the Coroner to review domestic violence homicides • Undertakes review, research and education • Supported by the Office of the Coroner	Approximately $500,000 p/a	• Significant expertise in review, in particular homicide review • Existing ability to compel information/documentation • Independent of CDRT – able to consider domestic violence homicides through a strictly domestic violence lens • Semi - independent • Ensures government and non-government participation • Precedent exists for leading Coronial role in Victoria (although Coroner in Victoria is a Judge) and Ontario, Canada • A network already exists for	• Would require greater legislative change and provision of infrastructure resources than the option of Ombudsman as convenor, taking longer to implement • Lack of physical capacity for more staff, pending re-location to larger premises in 2011 • Coroner's Office does not currently engage in research and education, in as direct a way as the Ombudsman's Office

			sharing information between Coroners in Australia • Implementation of the Coroner's recommendations is currently under consideration by SCAG. It is anticipated that reforms will be in place to ensure that Coroner's recommendations are acted upon	
Option 4 State Coroner to perform review	• A systemic review of domestic violence homicides led by State Coroner's Office (SCO) • Support provided by an attached unit	Approximately $500,000 p/a	• Significant expertise in review, in particular homicide review • Existing ability to compel information/documentation • Independent • Ability to examine open cases (provided the criminal trial has been completed or no charges laid) in addition to closed cases a possibility resulting in timely	• Would require greater legislative change and provision of infrastructure resources than the option of Ombudsman as reviewer • Lack of physical capacity for more staff, pending re-location to larger premises in 2011. • Non-government and government representatives only

			system response to learnings • Judicial champion • Capacity for educative function to other courts regarding domestic violence • Adopting a similar approach to Victoria would set a strong foundation for collaboration and national learning	involved in advisory capacity and potentially ad hoc • Coroner's Office does not currently engage in research and education, in as direct a way as the Ombudsman's Office • NCIS data would need to be supplemented
Option 5 Premier's Council	• Premier's Advisory Committee comprising both government and non-government members • Supported by a DPC secretariat unit • Report directly to Premier	Up to $200,000 p/a based on the Ministerial Maternal and Perinatal Committee	• Status as Premier's Council would give prominence to the review • Collaborative, integrated approach • Government and non-government participation	• No statutory independence • Focus on closed cases means diminished timeliness of learnings to be applied • Power to compel information may be insufficient • No specific review expertise • Only meet intermittently • Unlikely to have capacity to maintain a database, and undertake education and research

NSW Ombudsman Model

The majority of the Advisory Panel concluded that, should a mechanism should be adopted in NSW, the preferred model for a review team is one convened by the Ombudsman. This model builds on the Ombudsman's existing powers and expertise in death review, as well as wider systemic reviews. In addition, it is a good fit with the full range of the Terms of Reference proposed for the review, given the breadth of the Ombudsman's existing activities. It should also avoid duplication with the review of related child deaths, as well as enabling sharing of information on relevant child deaths.

The Ombudsman's Office has a dedicated community services division which is responsible for reviewing and promoting improvements in the standards of delivery of community services as well as another dedicated team which works exclusively with NSW Police. Teams consist of legal officers, researchers, intelligence and information analysts and Aboriginal support officers. These officers already have access to the COPS and DoCS databases, as well as the considerable research the Ombudsman has already conducted on domestic violence. The Domestic Violence Fatal Review Team would be supported by this wealth of experience and knowledge, which would assist with the development of research and education, and a comprehensive database.

It was a concern for some panel members that the Ombudsman will always be reliant on information from other sources. However, the Coroner indicated that there is an excellent and well functioning system of information exchange currently operating between the two agencies.

The Ombudsman can draw upon the experiences of that CDRT, as well as the experience and expertise of his staff, to develop a successful review mechanism in minimal time. Also contributing to the ease of implementation is the extent of the Ombudsman's existing legislative powers, which should limit the need for legislative amendment.

NSW Coroner Model

The model preferred by the NSW Police Force and Attorney General's Department is the Coroner as convenor of a review team. Such a model would fit with the Coroner's homicide expertise, and would be a focussed expansion of the existing functions of the Coroner which is to investigate deaths and make recommendations in relation to them.

Conferring this additional function on the Coroner would complement changes made to the *Coroner's Act* in 2007, which expanded the Coroner's powers to confirm that the role of the Coroner has not concluded when an inquest or inquiry is terminated and that it is open to the Coroner to continue proceedings at a later stage to complete the proceedings. This is particularly significant, as it recognises that there may well be issues which the Coroner needs to further consider after the conclusion of criminal proceedings, for example, systemic issues.

The Commonwealth Government, through the Standing Committee of Attorneys-General, has committed to working with the States and Territories to conduct a thorough review of current procedures to monitor the consideration, implementation and reporting of coronial recommendations in order to identify best practice approaches with respect to domestic violence homicides. The NSW Coroner convening a homicide review team would complement this process.

The recently released Commonwealth Government report, *National Plan to Reduce Violence Against Women - Immediate Government Actions - April 2009* stated that it "*will work with the states and territories to assess the impact of strategies to encourage responsiveness to Coroner's recommendations including on domestic violence related deaths*".[69] A NSW Coroner's model would allow for this to occur through its existing mechanisms and consequently enhance the national agenda. However, the recently released National Plan to Reduce Violence against Women does not recommend a preferred model and each state is encouraged to develop a model that is most effective for its own jurisdiction.

While a Coronial model has some of the advantages of the Ombudsman model, some Panel members expressed concern about the time it will take to implement such a model. Concerns related to the more extensive legislative change required (compared to the Ombudsman model) and additional infrastructure resources to equip the Coroner's Office to have the capacity to respond to the full range of the Terms of Reference. For instance, undertaking and drawing on emerging research to inform practice and public education are not currently functions of the Coroner's Office. Although the Coroner already has access to the NCIS, access to COPS and the DoCS database would need to be negotiated.

[69] *National Plan to Reduce Violence Against Women - Immediate Government Actions - April 2009* p.12

Premier's Advisory Council Model

The Advisory Panel did not support this model, on the grounds that it would not have adequate investigative and review expertise.

10. Conclusion

The Advisory Panel considered at length the research concerning domestic violence homicide reviews. It was agreed that a domestic violence homicide review mechanism should be established in NSW. The Advisory Panel reached consensus on a number of critical elements regarding the review mechanism including the scope of its functions, terms of reference and membership. It was agreed that a team, comprising government and non-government representatives, should be established by legislation to undertake a range of review, research and educative functions. The one point of divergence was who would be the appropriate convenor of such a review team.

The majority of the Advisory Panel concluded that, should a mechanism should be adopted in NSW, the preferred model for a review team is one convened by the Ombudsman. This model builds on existing powers and expertise in death review and wider systemic reviews, is a good fit with the full range of the Terms of Reference proposed for the review and should avoid duplication with the review of related child deaths, as well as enabling sharing of information on relevant child deaths. Given the extent of the Ombudsman's existing powers, it is envisaged that minimal legislative amendment would be needed.

The NSW Police Force and the Attorney General's Department, whilst supportive of the recommendation of the majority, preferred a review team that is convened by the NSW Coroner, given the Coroner's significant expertise in homicide review. The Attorney General's Department considered that such a model would be a focussed expansion of the existing functions of the Coroner, which are to investigate deaths and make recommendations in relation to them. Given that the Coronial model has already been adopted in other jurisdictions, the Coroner was also considered to be in the advantageous position of being able to utilise current and developing Coronial networks across Australia and potentially internationally.

The Office for Women's Policy considered that the options of the NSW Ombudsman and NSW Coroner as convenor both had merit and that the policy arguments for and against each were finely balanced. On this basis, a preferred option was not identified.

11. Appendices

A. Domestic homicides in NSW, January 2003 – June 2008, NSW Bureau of Crime Statistics and Research

B. Existing NSW death review mechanisms