Australian Human Rights Commission

A National System for Domestic and Family Violence Death Review

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Part 1

Executive Summary

1.1 Report aims

This Report aims to:

- highlight the importance of domestic and family violence death review mechanisms in Australia,
- identify the steps needed to expand the function to jurisdictions where it does not exist; namely Tasmania, the Australian Capital Territory and the Northern Territory. identify how to better ensure national coherence of data, and
- identify mechanisms to ensure that recommendations made to Federal Government agencies in Death Review processes are actioned.

1.2 Report methodology

This Report was developed using the following methods:

- Literature review
- Questionnaire to Coroners, the Western Australian Ombudsman, and Domestic and Family Violence Death Review Teams
- Meetings with Coroners and the Western Australia Ombudsman
- Meetings with the Australian Domestic Violence Death Review Network members
- Meetings with National Coronial Information Service and Australia's National Research Organisation for Women's Safety.

1.3 Report terminology

The Report recognises that there is variance in the use of terms 'domestic violence', 'family and domestic violence' and 'domestic and family violence'. It also recognises that consistency of terminology in the context of statistical data and evidence based reform is critical. In this regard the work undertaken by the Australian Law Reform Commission[1] and the Australian Bureau of Statistics[2] in this area is key. For the purposes of this report the term 'domestic and family violence' is used in relevant contexts.

1.4 Report structure

This Report is divided into the following 5 sections with 2 appendices:

1. Executive summary
2. Human rights obligations

3. Models of domestic and family violence death review
4. Guiding principles for the death review process
5. National data collection, monitoring and reporting

Appendix A: Coroner and Death Review Function and remit by Jurisdiction

Appendix B: Compiled responses to the Commission questionnaire sent to Australian Coroners and the Western Australian Ombudsman in 2015.

1.5 The domestic and family violence death review function in Australian states

Domestic and family violence is a feature in a high proportion of homicides in Australia. Data from the Australian Institute of Criminology shows that **the most common relationship between a homicide victim and offender is a domestic relationship.**[3]

Of the 479 homicide incidents in Australia from 2010 to 2012, 196 occurred in a domestic context. This is over 40 percent of all homicides in Australia.[4] While the data can't tell us with certainty that domestic violence was the causal factor, it is reasonable to assume that a high proportion were domestic violence related. **Available Australian data can identify whether the homicide was of intimate partners; of children, of siblings, or of parents killed by children. Intimate partner homicides are the most common of all domestic homicides at 58 percent.**[5]

Australia has a human rights obligation to assess the risk factors in relation to domestic violence death and to shape policy and law based on empirical evidence. The obligations under human rights treaties require the collection and use of reliable data as an evidentiary basis for developing, funding and implementing death prevention and protection initiatives.[6]

The death review function fulfils Australia's obligations under the following treaties:

- The *Convention on the Rights of the Child*;
- The *Convention on the Elimination of Discrimination Against Women;*
- The *International Covenant on Civil and Political Rights*; and
- The *Convention on the rights of Persons with Disabilities*.

Much work has already been done to commence a national domestic and family violence death review database. In 2011 the Australian Domestic and Family Violence Death Review Network was established. The Network has adopted a consistent definition of domestic violence, taken from the definition of family violence in the *Family Law Act 1975* (Cth), for the purpose of national data collection. The Network has also developed a National Consensus Statement and Data Collection Protocol for use in establishing a National Minimum dataset.[7] This work is the foundation for the collection of authoritative and consistent national domestic and family violence death data and reporting.

(a) History of the domestic violence death review function

The domestic violence death review function originated in the United States of America in the early 1990s after a high profile murder suicide in San Francisco. A Domestic Violence Fatality Review Team was established after it emerged that the murdered woman had made numerous requests for protective orders and had approached a number of services in the 15 months prior to her death. Domestic Violence Fatality Review Teams are now widespread in the USA. They 'have proven invaluable in identifying common weaknesses in systems and protocols responding to domestic violence that have led to a fatality'.[8]

The first Australian Domestic and Family Violence Death Review Team was established in Victoria in 2009. They now exist in most Australian states with a mandate to review deaths where there has been a context of domestic and family violence. In most cases, they were set up as a result of a State Government review into domestic violence. Death Review Teams vary in size and structure and are generally conducted by a small secretariat; comprising one or more staff, and supported by the multi-disciplinary advisory groups. This report will use the term Death Review Team to describe the death review personnel.

Death review is a forensic investigation into the complex array of factors and circumstances that have bearing on domestic and family violence death. It examines the ways in which our systems and services performed when they were most challenged. It investigates the history of service engagement by the deceased and the perpetrator as well as scrutiny of the events leading up to the death. Death review is a form of evaluation of all the factors that could have assisted in preventing the death.

Death Review Teams are the only entities to collect data on all domestic violence deaths within a jurisdiction. Using a common definition of domestic and family violence death, they collect categories of data about a range of characteristics. The Teams review these deaths, regardless of whether there has been a coronial inquest or not.

While there are differences in the operation of Death Review Teams, they have a common function. They view domestic violence deaths 'as a connected group rather than isolated events. This enables some prediction of behaviour in future instances and, at the least, an ability to collate more cohesive and accurate statistical information'.[9] **They operate with the philosophy that recommendations for improvement in systems and services provide opportunities to prevent similar deaths occurring in future.**[10]

Death reviews identify patterns of deaths and can detect vulnerable groups or lethality factors. If, for example, there are clusters of deaths amongst a cultural group or located in a geographic area, the death review can distinguish trends and recommend action to target services and support to these areas.

For example, available data shows us that Aboriginal and Torres Strait Islander women are five times more likely to be homicide victims than non-Indigenous women.[11] Likewise, women from culturally and linguistically diverse backgrounds have particular vulnerabilities in relation to domestic violence. More research needs

to be done to map the trends and patterns of these vulnerabilities. Death reviews can map demographic patterns as well as lethality factors.

Recommendations made by Death Review Teams can be directed to all government and non-government agencies with a role in preventing or protecting against domestic violence death. Some recommendations are published in Coronial findings, public reports and in some jurisdictions, recommendations are tabled in Parliament.

(b) The national picture

While Coroners operate in Tasmania, the Australian Capital Territory and the Northern Territory, these jurisdictions do not have established entities to collect death review data on all domestic and family violence deaths. It is therefore not possible to compare deaths Australia wide.

There is good reason to collate data nationally. Domestic violence does not always fall within jurisdictional borders and families cross borders to escape violence.[12] Death review data that is national in scope may eventually be able to assess the coherence and communication of systems across jurisdictions.

The national picture is important because federal agencies have contact with victims and perpetrators. Without a federal body, there are limitations on monitoring coronial or death review recommendations made to agencies such as the Federal and Family Courts or Government Departments such as Centrelink. Death review data can identify vulnerable groups and assist in our understanding of patterns of service engagement. This information is valuable for decision-makers with influence on policy, law, procedures and funding allocations.

Death review is designed to prevent future avoidable deaths by identifying patterns and risk factors and by reviewing the effectiveness of policies, protocols and services designed to protect the vulnerable. In summary, a coherent national system of death review is needed to:

- Collect and collate reliable domestic and family violence death data across all jurisdictions;
- Investigate cross-jurisdictional system failures;
- To understand patterns of deaths and identify vulnerable groups;
- Monitor recommendations made to federal agencies; and
- Inform Commonwealth funding bodies and decision-makers about targeted strategies for community safety.

1.6 National responses to domestic violence and cooperative federalism

The requirement for States to work together is paramount when issues of community safety are at stake. For example, if Domestic Violence Orders are not recognised across states and territories the safety of vulnerable people is compromised. To this end, the Commonwealth Government has developed a National Plan and a CoAG Advisory Panel with a mandate to work towards a national approach to domestic violence. These high level strategies acknowledge that cooperative federalism is necessary for a coherent system of domestic violence protection and prevention. In

April 2016, the CoAG Advisory Panel on Reducing Violence against Women published a Final Report with 28 recommendations for CoAG consideration.[13]

The Panel recommended that all governments adopt a common approach to achieve generational and lasting change. Some of its key recommendations include:

- Responses must focus on empowering women and their children to make informed choices;
- Children and young people must be recognised as victims of violence against women;
- Aboriginal and Torres Strait Islander communities need trauma informed responses; and
- Integrated responses are required to keep women and their children safe.[14]

In order to ensure these recommendations are underpinned by empirical evidence, all Australian governments will need to commit to domestic and family violence death review.

(a) National Plan to Reduce Violence against Women and their Children 2010-2022

The Commonwealth Government has made commitments to share information across jurisdictions and act on information from domestic violence death review.

The current agenda of the *National Plan to Reduce Violence against Women and their Children 2010-2022* (National Plan) through the *Second Action Plan 2013-2016 Moving Ahead* (Second Action Plan), include 26 practical actions that 'are designed to drive national improvements'. Action 19 requires the sharing of information through domestic and family violence-death review.

> Domestic homicide reviews identify the sequence of events leading to domestic violence related deaths. The learnings from these reviews can be used to identify possible gaps in system responses to develop more effective interventions. Under the Second Action Plan, jurisdictions will share information and good practice from domestic homicide and child death reviews, and other review mechanisms. This will enhance review processes and drive improvements to the way Commonwealth, state and territory systems work together to identify and respond to women experiencing violence and, ultimately, prevent domestic violence homicides.[15]

The Second Action Plan sets out 5 National Priorities to respond to domestic and family violence.[16] Priority 3 requires the development of 'integrated' service systems and Priority 5 requires the building of an 'evidence base'. Action to expand the death review function to all Australian jurisdictions and to collecting and monitoring death review information nationally will assist in realising Priorities 3 and 5.

The *Third Action Plan 2016 – 2019* (Third Action Plan) builds on the work undertaken through the Second Action Plan. It recognises that:

> For the National Plan to be successful in achieving its long term target, a solid national evidence base is required.[17]

The Third Action Plan records that the:

> Work on the National Data Collection and Reporting Framework will be progressed further under the Third Action Plan, along with work begun under the Second Action Plan to improve systems that support reviews of domestic and family violence related deaths and child deaths. This work will be progressed by the Australian Human Rights Commission, which will consult states and territories to scope the development of data collection protocols and a proposed national data collection mechanism.[18]
>
> The continuing building of an evidence base will link with, and be informed by, work underway as part of the research agenda of the National Framework for Protecting Australia's Children.[19]

(b) The CoAG Advisory Panel on Reducing Violence against Women

Commonwealth, state and territory governments are engaged in high-level activity to address domestic violence through the Council of Australian Governments (CoAG).

At its 39th meeting in April 2015, CoAG agreed to a national Domestic Violence Order Scheme, where domestic violence orders will be automatically recognised and enforceable in any state or territory of Australia. As part of this agreement, CoAG agreed to consider strategies to tackle the increased use of technology to facilitate abuse against women.

Death review reports and data provide important inputs into the development of prevention strategies, including initiatives related to the use of technology or the functionality of the domestic violence order system.

1.7 Funding domestic violence death review

Death review in Australian states is funded by state governments. Jurisdictions without the death review function have indicated that they require resources to establish the function.

Newly established Death Review Teams would also require support in developing systems to collect appropriate data based on the Homicide Consensus Statement and the National Data Collection Protocol.[20]

Members of the Australian Domestic and Family Violence Death Review Network have agreed to provide training to new Death Review Teams. The Network would need to be resourced to do this work as it will take them away from their jurisdictional responsibilities.

The Commonwealth Government should also consider establishment of a federal mechanism to collect and collate national data, and to monitor recommendations made to federal agencies. It has the responsibility to support and resource this function and to make decisions about how it would be undertaken and by whom.

In the interests of commencing a national approach to domestic and family violence death review, it is recommended that all jurisdictions agree to collect data for a National Minimum Dataset[21] as soon as possible. It is also recommended that CoAG consider funding options to establish data collections in jurisdictions without the death review function.

1.8 Positive change as a result of death review

In its operation, death review has led to changes and improvements in practice.

For example, in South Australia there have been 35 recommendations specific to improving systemic responses to domestic and family violence. These have resulted in significant systemic reform including the state-wide expansion of regional multi-agency collaborations; the implementation of systems for intelligence sharing amongst Specialist Domestic Violence Services to enhance risk and safety assessments; improved policing responses and legal supports; and broader legislative changes.[22]

Likewise, in Western Australia, the Ombudsman has reported that in relation to all 54 recommendations made in its report *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*[23]

> …the relevant state government departments and authorities have either taken steps, or propose to take steps (or, in some cases, both) to give effect to the recommendations. In no instance has the office found that no steps have been taken, or are proposed to be taken, to give effect to the recommendations.[24]

Death Review Teams have been shown to assist in interagency relations and cooperation, leading to a more cohesive approach to domestic violence. In Victoria, for example, findings and recommendations of the Death Review Team have identified opportunities for collaboration and increased transparency amongst government and non-government organisations.[25]

Death review has been able to identify duplication of services and contradictory or conflicting service responses. It has also helped to promote mutual understanding and respect of organisations' roles, constraints and limits.[26]

1.9 Report Findings

	Findings
Part 1: The national picture	Domestic violence death review has proved valuable in informing governments and decision makers about patterns and trends of domestic and family violence deaths. Australia does not have Australia-wide data on domestic and family violence deaths because not all jurisdictions have Death Review Teams. Tasmania, the Australian Capital Territory and the Northern Territory do not yet have this function. Members of the Australian Domestic and Family Violence Death Review Network have agreed to provide training to new Teams collecting data for the National Minimum Dataset.

	Findings
	The Network will need to be resourced to do this work as it will take them away from their jurisdictional responsibilities.
Part 2: Australia's Human Rights Obligations	Australia has obligations under three human rights treaties to collect empirical data about domestic violence deaths and develop interventions based on this evidence. The International Covenant on Civil and Political Rights (ICCPR) describes the right to life as an inherent right that must be protected by law. 'No one shall be arbitrarily deprived of life and there is a positive duty to prevent death'. Domestic violence deaths are not isolated events. One study has noted that violence is a leading cause of ill-health and death among women aged between 15 and 44 years in Victoria. Aboriginal and Torres Strait Islander women are five times more likely to be homicide victims. Australian children are also victims in domestic violence related homicides.
Part 3: Models of death review in Australian states and territories	There is no one-size-fits-all model for domestic and family violence death review. Death Review Teams vary in their structure, mandate, resources and history. Some of these differences reflect the history of the development of the Team or the size of the population and different caseload requirements.
Part 4: Guiding Principles for Domestic and Family Violence Death Review	The Australian Domestic Violence Death Review Network has developed a set of principles that underpin the effective functioning of the death review process. In order to create a consistent national approach, newly established Death Review Teams or functions should be guided by the same principles.
Part 5: National data Collection, monitoring and reporting	The Australian Domestic and Family Violence Death Review Network has developed a Homicide Consensus Statement which defines the inclusion criteria adopted by the Network for domestic and family violence homicide.

	Findings
	The Network has also developed a preliminary data collection protocol for use by Network members. The goal of this data collection is to develop a staged standardised National dataset concerning domestic violence homicides.
Part 5: **National data Collection, monitoring and reporting**	Australia does not have a funded entity to collate and prepare reports about national trends in domestic and family violence deaths or report on recommendations made to Federal agencies and implementation action. Many Australian states have limited options for following up on Coronial recommendations to federal agencies. Most Coroners agree that there can be improvements to this system. There is no mechanism under statute at the federal level to require federal agencies to respond to coronial recommendations.

1.10 Recommendations

1. That CoAG and the Commonwealth Government support efforts in Tasmania, the Australian Capital Territory and the Northern Territory to develop the domestic and family violence death review function.

2. That commitment is given by the Commonwealth, State and Territory Governments and all Domestic and Family Violence Death Review teams to collecting data for a National Minimum Dataset on domestic and family violence death using the Australian Domestic and Family Violence Death Review Network National Data Collection Protocol and Homicide Consensus Statement.

3. That the Australian Domestic and Family Violence Death Review Network be provided with funding to train new Death Review Teams (once established) on data collection protocols for the National Minimum Dataset.

4. That the Commonwealth Government ensure that meaningful national level data is collated so death prevention measures are based on empirical evidence, including evidence from domestic violence death reviews.

5. That all governments design measures to protect vulnerable groups, including women and children and especially those from Aboriginal and Torres Strait Islander communities, using evidence collected from domestic and family violence death review.

6. That each jurisdiction ensure that it has a family violence death review process by developing or maintaining a model appropriate to jurisdictional requirements within the parameters of the death review principles and

definitions developed by the Australian Domestic Violence Death Review Network.

7. That the Homicide Consensus Statement and National Data Collection Protocol of the Australian Domestic and Family Violence Death Review Network be used as the template for the National Minimum Dataset on Domestic and Family Violence Deaths.

8. That in the short-term, the Commonwealth Government provide funding to an appropriate organisation to collect and collate national data on domestic and family violence deaths and report on available data.

9. That the Commonwealth Government introduce a mechanism to identify all recommendations made to Federal government agencies and monitoring processes to identify actions taken to respond or implement Coronial recommendations.

10. That in the longer term, the Commonwealth Government review potential legislative or other mechanisms to establish an entity with (or bestow on an existing entity) a mandate and function to monitor and report on national domestic violence deaths and the implementation of coronial recommendations made to federal agencies.

Part 2

2 Australia's human rights obligations

Australia has ratified a number of international treaties which, while not specifically dealing with domestic violence, necessarily impose obligations relevant to it. These cascading obligations include the obligation to protect and promote; the right to life[27] and the right to be free from gender-based violence.[28] Both of these rights are underpinned by obligations to prevent death and prevent violence against women and children. This in turn imposes an obligation to act with due diligence to prevent, investigate, punish and provide remedies for acts of violence regardless of whether these are committed by private or State actors.[29]

The obligation to act with due diligence includes various elements, such as the duty to; investigate incidents of violence against women,[30] collect data[31] and to provide appropriate training to relevant personnel.[32]

2.1 Duty to protect life and prevent death

Australia is bound by the *International Covenant on Civil and Political Rights* (ICCPR); a treaty that includes protection of the fundamental right to life.[33] The ICCPR describes the right to life as an inherent right that must be protected by law. No one shall be arbitrarily deprived of life and there is a positive duty to prevent death.[34]

International case law provides guidance as to what the positive obligation of protect life involves.[35] In *Opuz v Turkey* the European Court of Human Rights (ECHR) held that for a positive obligation to arise it must be established that the authorities knew or ought to have known of the existence of a real and immediate risk to the life of an identified individual from the criminal acts of a third party.

Where there is a known and real risk to a person's life, the right to life is paramount and it is reasonable to limit the rights of the alleged perpetrator in order to protect the life of a victim/survivor of domestic/family violence.[36]

The CEDAW Committee noted that women's human rights to life and to physical and mental integrity cannot be superseded by other rights [of the perpetrator], including the right to property and the right to privacy.[37]

2.2 The obligation to protect against gender based violence

Article 2 of *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) imposes an obligation on States to prohibit discrimination against women. The Committee on the Elimination of All Forms of Discrimination against

Women, the monitoring body of CEDAW, and the Human Rights Council[38]have noted that;

> The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender-based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence.[39]

In monitoring this provision, the CEDAW Committee asks countries to provide information in their regular reports about legislation and other measures it uses to protect women from violence, as well as the support services available to women.

The issue of domestic violence as a form of discrimination against women is specifically addressed in Recommendation 19 which states:

> Family violence is one of the most insidious forms of violence against women. It is prevalent in all societies. Within family relationships women of all ages are subjected to violence of all kinds, including battering, rape, other forms of sexual assault, mental and other forms of violence, which are perpetuated by traditional attitudes. Lack of economic independence forces many women to stay in violent relationships. The abrogation of their family responsibilities by men can be a form of violence, and coercion. These forms of violence put women's health at risk and impair their ability to participate in family life and public life on a basis of equality.[40]

It is also the subject of a specific resolution of the Human Rights Council in 2015 *Accelerating efforts to eliminate all forms of violence against women: eliminating domestic violence*.[41]

The UN *Declaration on the Elimination of Violence Against Women* requires States to pursue by all appropriate means, and without delay, a policy of eliminating violence against women.[42] Article 4 of that Declaration requires States to take action to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons.[43]

The United Nations Human Rights Council has reiterated the duty of States to accelerate efforts to eliminate all forms of violence by adopting and implementing policies and programmes that enable women to avoid and escape situations of violence and prevent its recurrence. This may include financial support and affordable access to safe housing or shelters, childcare and other social supports.[44]

The *Convention on the Rights of Persons with Disabilities* also imposes an obligation on States to:

> take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.[45]

2.3 The obligation to act with due diligence

States are obliged to show due diligence in their efforts to prevent and respond to acts of violence against women by family members and others.[46] This requires

prompt, thorough, impartial, and serious investigation of allegations of violence against women.[47]

The standard of due diligence is high. Having a system in place to address the problem of domestic violence is insufficient; the system must be put into effect by the States who understand and adhere to the obligation of due diligence.[48]

(a) Obligation to collect data

While the obligation to collect and collate data is not expressly provided for in the text of the relevant international human rights treaties, in a practical sense, Australia's commitments under international human rights law require the collection and collation of reliable statistics on domestic and family violence, including data on domestic violence deaths.

The obligations under the ICCPR and other human rights instruments, require the collection and use of reliable data as an evidentiary basis for developing, funding and implementing death prevention and protection initiatives.[49]

Part of the data collection obligation is the duty to ensure that interventions designed to prevent and respond to violence against women and children are based on accurate empirical data. This requires reliable statistics and indicators concerning violence against women and the evaluation of interventions designed to eliminate them.[50]

(b) Obligation to Investigate

It is well established under international law that there is an obligation to investigate gender-based violence against women, including domestic violence.[51]

In 2010, the CEDAW Committee explained that, 'under general international law and specific human rights covenants, States may … be responsible for private acts if they fail to act with due diligence … to *investigate* … acts of violence…'.[52] The responsibility lies in the failure of the State to take reasonable measures to investigate alleged violations of human rights by a non-state actor.[53]

The obligation to investigate aims to, amongst other things:

- ensure the effective implementation of laws and policies that protect human rights related to gender-based violence, including the right to life;
- avoid repetition of the violence, both against the individual victim/survivor and more broadly within society;
- ensure accountability of State actors for deaths occurring under their responsibility; and
- end impunity for gender-based violence against women.[54]

International jurisprudence provides some guidance on the measures necessary to ensure an investigation that is prompt, thorough, impartial and serious.[55]

Much of this jurisprudence approaches this question from the perspective of the 'particular vulnerability of victims of domestic violence'.[56] In *A.T. v Hungary*,[57] the CEDAW Committee recommended that the State Party take steps to 'investigate *promptly*, *thoroughly*, *impartially* and *seriously* all allegations of domestic violence and bring the offenders to justice in accordance with international standards'. (emphasis added) [58]

Other international decision-making bodies have also regularly called on States Parties to conduct investigations that are prompt, thorough, impartial and serious.[59]

To satisfy the obligation to investigate, a State must be able to demonstrate that it initiated, without unreasonable delay, an investigation into allegations of domestic violence.[60] This requires States to adopt measures to ensure the necessary framework and resources are in place so that authorities can provide an immediate and effective response to reports of violence.[61]

In order to be held accountable under the due diligence obligation to investigate, it must be established that the State failed to put in place the necessary framework and resources to mitigate that risk. A further failure of accountability is if the authorities knew or ought to have known of the existence of a real and immediate risk to life, but failed to 'take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk'.[62]

Whether or not the authorities did all that could be reasonably expected of them in their investigation to avoid a real and immediate risk to life is a question that can only be answered in the light of all the circumstances of any particular case.[63]

A number of factors are likely to be relevant to a determination concerning the seriousness of an investigation into domestic violence. These include whether or not the investigation was adequate in the context of known threats of violence, the severity and extent of those threats, past history of violence and the particular vulnerability of domestic violence victims. In *Opuz v Turkey*, for example, the ECHR suggested that, in light of the 'positive obligation to take preventive operational measures to protect an individual whose life is at risk, it might have been expected that the authorities, faced with a suspect known to have a criminal record of perpetrating violent attacks, would take special measures consonant with the gravity of the situation with a view to protecting'[64] the victim against violence.

It requires thorough investigations in instances where the system or the services failed to protect victims, and recommendations for improvements to systemic responses. Death review is an important part of this investigation process.

(a) Obligation to ensure adequate training

A further element of the duty to act with due diligence is to provide appropriate training to personnel, such as police and custodial officers including gender-sensitive training for law enforcement officials.[65]

States are under a positive obligation to adopt measures to ensure that their authorities have the capacity and sensitivity to understand the seriousness of the phenomenon of violence against women and the willingness to act immediately.[66] This includes providing the competent authorities with the necessary training,

material and human resources to act with due diligence to investigate gender-based violence and would extend both to the technical aspects of investigations and the human rights and gender issues associated with violence.[67]

In *V.K. v Bulgaria*[68] the Committee on the Elimination of Discrimination Against Women (CEDAW Committee) found the State failed to protect V.K. effectively against domestic violence and recommended that mandatory training be provided for law enforcement personnel on the definition of domestic violence and on gender stereotypes. The CEDAW Committee concluded that Bulgaria had failed to protect V.K. effectively against domestic violence, in violation of articles 2(c)-2(f) of CEDAW, read in conjunction with article 1, and article 5(a), read in conjunction with article 16(1) and General Recommendation No. 19.

2.4 Protection of these rights in Australia

Data from the Australian Institute of Criminology shows that women in Australia are more likely than men to be the victims of homicide in domestic contexts. As **Chart 1** below shows, of the 196 domestic homicides recorded from 2010 to 2012, 121 deaths or 62 percent, were of women or girls. Of the 109 intimate partner homicides, 83 individuals, or more than 76 percent, were of women.[69]

CHART 1: DOMESTIC HOMICIDE BY SEX OF VICTIMS, 2010–12[70]

Domestic Homicide Type	Male (n=75)		Female (n=121)	
	n	%	n	%
Intimate partner	26	24	83	76
Filicide	21	50	21	50
Parricide	11	48	12	52
Siblicide	5	83	1	17
Other family homicide	12	75	4	25
Total Domestic	**75**	**38**	**121**	**62**

SOURCE: AUSTRALIAN INSTITUTE OF CRIMINOLOGY

VicHealth has argued that violence is a leading cause of ill-health and death among women aged between 15 and 44 years.[71] Australian women are most likely to experience physical and sexual violence in their home at the hands of a male current or ex-partner.[72] Of the women who had experienced violence from an ex-partner:

- 73 percent had experienced more than one incident of violence;
- 61 percent had children in their care when the violence occurred, including 48 percent who stated the children had seen the violence;
- 58 percent had never contacted the police; and
- 24 percent had never sought advice or support.[73]

Aboriginal and Torres Strait Islander women and their children are more likely to experience violence than any other section of society. When compared to non-Indigenous women, Aboriginal and Torres Strait Islander women are five times more

likely to be homicide victims. Rates of domestic assault reported to police are also more than six times higher for Indigenous women.[74]

Given the high proportions of Aboriginal women who are subject to family and domestic violence, cultural competence training is also required and the threshold for this training requires more than cultural 'awareness' programs.[75]

In consecutive reports on Australia in 2006 and 2010, the UN CEDAW Committee raised concerns about the high levels of violence against women in Australia, particularly domestic violence in Indigenous, refugee and migrant communities.[76] In its Concluding Observations, the Committee raised concerns about the low rates of reporting, of prosecutions and of convictions in sexual assault cases. The Committee raised concerns that the laws designed to protect victims of domestic violence, particularly those that require perpetrators to be removed from the family home, were not regularly enforced.[77]

Australian data on domestic and family violence death is limited. While a number of Australian entities collect data on homicide, there is no nation-wide mechanism to identify whether these deaths occurred in the context of domestic violence.

> … a stronger evidence base is required as the full extent of domestic violence remains unknown… [nevertheless] it is known that the majority of those who experience domestic violence are women, and such violence affects members of all cultures, ages and socio-economic groups.[78]

The work of the Coroners and Domestic and Family Violence Death Review Teams fulfils part of this data collection obligation. Coronial data on domestic violence deaths and coronial findings and recommendations aimed at preventing future avoidable deaths are part of Australia's response to the duty to protect life.

Australian Coroners and Domestic and Family Violence Death Review Teams have an important role in meeting Australia's human rights obligations. Their role is twofold. In the first instance, Coroners and Death Review Teams are uniquely positioned to collect and collate reliable data about domestic and family violence homicide. This includes the collection of prevalence data.[79]

A second role for some teams is in evaluating domestic violence interventions as part of the inquest or death review process. In this role, the Coroner and the Death Review Team look at the circumstances leading up to the death, and the role of Government and non-Government parties in taking reasonable steps to protect life and prevent avoidable deaths in future. The scope of this examination varies among the Death Review Teams, with some simply conducting an examination and others undertaking an evaluation of those interventions and actions.

In recognition of the significant role of death review, various civil society organisations have made recommendations for the death review mechanism to be expanded across Australia. Recommendations have been made to CEDAW and other treaty bodies, including the Human Rights Committee and the UN Committee against Torture. The *Joint NGO Report to the UN Committee against Torture* specifically recommends:

> That all states and territories establish their own domestic/family violence death reviews that are statutorily based, securely funded, adhere to core best practice

> principles (which include independence, accountability, transparency and the active participation and central involvement of advocates for women and experts in violence against women), and collaborate with one another.
>
> That the Australian Government establish an accessible national public database of death review recommendations, responses and practical outcomes.[80]

2.5 Role of the Coroner and Australia's human rights obligations

Human rights are a legitimate guide for the exercise of the Coroner's statutory discretions and obligations. It is a well settled principle of statutory construction that, to the extent of any ambiguity, all domestic statutes should be applied as far as practicable, to conform to Australia's obligations under international law.[81] It is also an accepted principle that human rights law is a valid guide in the development and interpretation of the common law.[82]

Human rights provide relevant and applicable standards for monitoring and assessing the protection and prevention obligations of States in relation to domestic and family violence. They set out the States' positive obligations to vulnerable people and provide standards against which safety measures, response times and monitoring measures can be assessed.

In recent years, there have been 'considerable developments in coronial law' including the potential for Coroners to review systemic causes of death in the interests of preventing future avoidable deaths.[83] The Royal Commission into Aboriginal Deaths in Custody recommended that Coroners expand their focus beyond the circumstances and causes of individual deaths, to make findings of a more universal nature where there is systemic failure, or failure of policy.[84]

> The Royal Commission [into Aboriginal Deaths in Custody] recommended an expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. [85]

Domestic violence deaths are often fertile ground for Coroners to take a proactive role in investigating underlying contributors to deaths including systemic failures. In instances where they do not conduct inquests, the Domestic and Family Violence Death Review process fulfils this function.

With leave of the Court, the Australian Human Rights Commission has the power to intervene in court proceedings that involve issues of human rights including Coronial inquests. The power to seek leave to intervene is contained in the *Australian Human Rights Commission Act 1986* (Cth) ss 11(1)(o) and 31(j).

When a relevant human rights issue arises, the Commission can provide expert assistance that would otherwise not be available to the Court. The role of the Commission is to assist the Court by drawing attention to the human rights issues arising in the case and making submissions as to the law or relevant facts.

(a) Case Study: The Andrea Pickett inquest

The following case study is of the Inquest into the death of Andrea Pickett in Western Australia. The Australian Human Rights Commission was granted leave to intervene in 2012.[86]

The Commission's role in that case was:

- To identify the relevant human rights issues;
- To provide an understanding of the interplay between those rights and the circumstances surrounding the death; and
- To assist in interpreting the obligations on the State in the protection and implementation of those rights.

When the Commission is granted leave to intervene, there is an opportunity to add a human rights framework against which to assess the actions of the State. The Commission provides an additional layer of expertise in reviewing the policies and practices of the State in relation to international law obligations.

The Commission submitted that the evidence demonstrated a range of systemic failures that contributed to Andrea's death. In particular:

- The failure of the Violence Restraining Order to prevent Andrea's death. This failure arose as a result of failure to investigate breaches of the Orders promptly, thoroughly and seriously.
- The failure of the parole system to prevent re-offending, particularly by failing to detain Mr Pickett in circumstances where it knew, or ought to have known, of a real and immediate risk to Andrea's life and to adequately supervise him.
- The failure to provide adequate housing for Andrea and her children.

In its submission, the Commission submitted that there was a failure of the State to promptly, thoroughly and seriously investigate allegations of domestic violence. In particular, there was a lack of integration of police systems and practices with the Department of Corrective Services and the Department of Child Protection systems to ensure that there was adequate information to take appropriate actions to protect Andrea Pickett and her children. This included a failure to ensure that the best interests of the child were paramount, especially in relation to the youngest child.

Finally, the Commission submitted that the State had failed in the provision of domestic violence training to police, including a lack of training around appropriate domestic violence response strategies, and a lack of Aboriginal cultural competence training.

These submissions were reflected in the findings of the Coroner.

2.6 Child deaths: The obligation to take measures to protect children

The Australian Institute of Criminology reported 34 filicides; deaths of children under the age of 18, attributed to a parent or step-parent over the period 2010–12. The average age was 6.9 years.[87] Its data showed that children comprised the second most

frequent group of victims of family and domestic homicides (21%) after intimate partner homicides (56%).[88]

Of the 238 filicide cases (homicides where the victim is the child of the offender), 229 of these were children under 18 (96%). 51% of all filicide cases were attributed to children aged between 1 to 9 years, 32% for children under the age of one; 11% for children aged 10 to 14 years; and 2% for children aged 15 to 17 years.

Governments of Australia have a duty to children in relation to domestic violence., Children also have an inherent right to life that is protected by an international treaty and states are under an obligation to 'ensure to the maximum extent possible the survival and development of the child. [89]

The *Convention on the Rights of the Child* also requires that States "take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, … negligent treatment, maltreatment … while in the care of parent(s), legal guardian(s) or any other person who has the care of the child".[90]

Filicide is an extreme form of domestic violence and in some instances it is part of a history of intimate partner violence in the home. It is also well established that exposure to domestic violence can have detrimental psychological, behavioural, and health impacts upon children. Almost one in four children in Australia have witnessed violence against their mothers or step-mothers.[91] Forty two percent of Indigenous young people reported witnessing violence against their mother or stepmother, compared with 23 percent of all children.[92]

The UN Committee on the Rights of the Child has acknowledged that violence against women in the family detrimentally affects children.[93] In its most recent concluding observations on Australia it indicated grave concerns at the high levels of violence against women and children. The Committee noted particular concern for Aboriginal and Torres Strait Islander women and children.[94]

Emphasising the State party's obligations under articles 19 and 37(a) of the Convention and the Committee's General Comment 13 (2011) on the right of the child to freedom from all forms of violence, the Committee urges the State party to develop federal legislation as a general framework to reduce violence and promote the enactment of similar and complementary legislation at state and territory level. It also recommends that the State make efforts to understand the factors contributing to the high levels of violence among Aboriginal women and children. A death review process is one of the mechanisms that can provide empirical evidence about the risk factors for children in the most extreme of circumstances.

(a) National examination into the impact of family and domestic violence on children

During 2015 the National Children's Commissioner conducted a national examination into the impact of family and domestic violence on children. The report noted the definitional challenges in relation to children affected by family and domestic violence and how this impacts on the data that is collected about them.[95] It also noted that:

> the use of varied terms, different definitions and the disparate means of identifying family and domestic violence was raised as problematic in terms of establishing prevalence at the national level and challenging for those working in the field.

The report concluded that:

> Comprehensive data about children is required to improve our understanding about the prevalence and impact of family and domestic violence on children at the national level. As a first step, the ABS National Data Collection and Reporting Framework should be used by all jurisdictions.[96]

2.7 Findings

	Findings
2.1	Australia has obligations under three human rights treaties to collect empirical data about domestic violence deaths and develop interventions based on this evidence. The International Covenant on Civil and Political Rights (ICCPR) describes the right to life as an inherent right that must be protected by law. 'No one shall be arbitrarily deprived of life and there is a positive duty to prevent death'.
2.2	Domestic violence deaths are not isolated events. One study has noted that violence is a leading cause of ill-health and death among women aged between 15 and 44 years. Aboriginal and Torres Strait Islander women are five times more likely to be homicide victims. Australian children are also victims in domestic violence related homicides.

Part 3

3 Models of death review in Australian states and territories

The first Domestic Violence Death Review Team was established in the United States in the early 1990s. Almost 20 years later, a Death Review Team was set up in Australia.

Death Review Teams have been developed in many jurisdictions in recognition that a high proportion of homicides have domestic and family violence as a feature. There is also recognition that while some domestic and family violence deaths occur without warning, in many cases both the victim and perpetrator had contact with services and potential opportunities for intervention.

Death Review Teams have been created to analyse information relating to specific domestic and family violence deaths in order to identify common characteristics, service gaps or failures and opportunities for intervention. This information leads to the development of recommendations which aim to reduce the likelihood that similar deaths will occur in future.

The death review functions in Victoria, New South Wales, Queensland, South Australia and Western Australia have different enabling legislations. A pilot Review is currently in operation in the Australian Capital Territory.

To date, Tasmania, the Northern Territory and the Australian Capital Territory do not have the death review function.

The origins, mandate, functions and resourcing of Death Review Teams varies from jurisdiction to jurisdiction. This Chapter describes the different models of death review in the jurisdictions where they exist. While there is no necessity for Teams to be identical in their processes, there are commonalities in the adopted principles and approaches to their functions.

3.1 The death review process

Death review is a complex process. In its first stage, it requires a review of all unnatural or violent reportable deaths within a jurisdiction. The current death review process is a classification process to determine whether the death meets the domestic or family violence definition and case inclusion criteria. At this identification phase, Teams are able to collect prevalence level data for their database and identify cases for further specific review.

Death Review Teams have access to many sources of information. Sources can include police databases, police reports to the Coroner, briefs of evidence (prosecutorial or coronial), government files, post-mortem and toxicology reports, sentencing remarks in Court processes and media reports. Enabling legislation gives Death Review Teams access to this information.

Teams examine the demographics of the victim and perpetrator, the events prior to the death and the circumstances surrounding the death. They map the service interaction of victims and perpetrators and document any failures in systems or services.

Some Teams carry out a second phase death review process and develop an In-Depth Case Review or Report. This is a thorough investigation of the death. The Review investigates the services available to victims and perpetrators and maps any gaps in protection or prevention initiatives. This Review is conducted with a view to making recommendations to agencies.

In some jurisdictions, Death Review Teams produce annual or periodic reports on domestic and family violence deaths. Some, but not all of these reports are publicly available. The reports contain the findings from the domestic and family violence death dataset including numbers of deaths by categories of demographic and relationship characteristics.

Some death review reports provide a greater level of detail. For example, the New South Wales Death Review Team reports include case summaries that give a detailed understanding of the circumstances of domestic and family violence deaths. New South Wales also provides enhanced data reporting on the history of domestic violence in each case and tracks the patterns of service contact. The report concludes with findings and recommendations directed to public and private agencies.[97]

A further example is the Western Australian Ombudsman who provides detailed, de-identified case studies in their major own motion investigations.

Death Review Teams can investigate fatalities more broadly than a typical criminal justice approach allows. This is because Teams have the capacity to bring more scrutiny to individual cases through an understanding of context, risk factors and points of intervention. The specialised nature of this approach can result in risk assessment methods that are more focused and better informed.[98]

Death review procedures and functions differ across jurisdictions depending on the mandate, the resources available to the Team, and the rates of domestic violence death in the jurisdiction.

The following descriptors of death review processes may not apply to all Teams. The aim here is to set out the broad range of actions that can form part of the death review process.

(a) Identify deaths that occurred in a domestic and family violence context

Death Review Teams examine deaths reported to the Coroner to determine if they meet the criteria set out in the Homicide Consensus Statement developed by the Australian Domestic and Family Violence Death Review Network. Cases of homicide and homicide/suicide are included within these criteria. The South Australia Senior Research Officer also examines single fatality suicides.[99] The New South Wales Death Review Team has commenced reviews of single fatality suicides in 2016. Suspected domestic and family violence-related deaths are then

identified and monitored as they progress through the coronial and/or criminal processes.

(b) Assist the Coroner in investigations of reportable deaths

Review Teams located within the Office of the Coroner support the work of the Coroner in open domestic and family violence death investigations. The Queensland Domestic and Family Violence Death Review Unit provides assistance and advice to Coroners with respect to certain aspects of a case, as it relates to the history of domestic and family violence between the deceased and/or offender, as part of the broader coronial investigation, by gathering information about the broader context of the death and preparing reports that form part of the coronial brief of evidence.[100] The Victorian Systematic Review of Family Violence Deaths provides an evidence base for coronial recommendations and sources additional information or opinion at the Coroner's direction.[101] The South Australia Senior Research Officer also has specific input into coronial investigations and inquests related to domestic violence.[102]

(c) Conduct case reviews of individual deaths

The primary function of Death Review Teams is to conduct in-depth case reviews of domestic and family violence-related deaths. The range of factors considered include:

- The nature and history of the domestic relationship;
- The circumstances of the incident;
- Prior interaction with/ action taken by agencies, organisations or other services and the effectiveness of these actions;
- Potential points of intervention and policies and protocols to strengthen responses; and
- Law reform and other prevention strategies.

The focus of the review is on systemic and procedural weakness rather than the actions or negligence of individuals. The information relied upon in the review process primarily derives from official reports (e.g. toxicology or forensic) and police briefs of evidence. Through this review process, the Teams identify missed opportunities or gaps in services that may have occurred, as well as strategies for perpetrator intervention that may have been overlooked.[103]

While all Teams conduct case reviews, the scope of investigation differs. The New South Wales Domestic Violence Death Review Team conducts an in-depth review of every domestic violence homicide. In contrast, the New Zealand Family Violence Death Review Committee uses a two-tiered death review system, and selects only some deaths to be subject to additional intensive, multi-sectoral review.[104]

Within Australia, the Victoria, Queensland, South Australia and Western Australia Teams review both open and closed cases, while the New South Wales team reviews only closed cases. The Western Australian Ombudsman can also review cases progressing through the criminal justice system, with de-identified issues and improvements to public administration reported to Parliament and publically.

(d) Identify fatality risk factors

All Australian Death Review Teams strive to identify risk factors for domestic violence deaths through the review process and through the adoption of the National Minimum Dataset[105] have the ability to identify and summarise the main risk factors identified among deaths.[106]

(e) Source and gather additional information for case reviews

The main source of information for case reviews are official reports and briefs of evidence. While some Teams have the ability to call for additional information, others are not mandated to gather additional information, apart from when requested by the Coroner. However, in the United States, the majority of Death Review Teams allow suitably qualified members to undertake further examinations into any gaps in the initial investigation.[107] A similar trend in both the United States and United Kingdom has been the increase in review teams interviewing members of the deceased's or perpetrator's family to contribute information.[108]

(f) Establish and maintain a database, collect data, and identify trends and patterns across deaths

Death Review Teams are tasked with the creation and maintenance of a database on domestic and family violence-related deaths.[109] In this role, Teams capture data on the offender(s), deceased(s), and circumstances surrounding the homicide. This function is important not only to quantify the annual frequency of domestic violence homicides, but also to discern patterns or emerging trends among incidents, with particular reference to: risk factors, service contact, and the context surrounding the death.[110]

A number of Australian Teams have also retrospectively gathered data. The New South Wales and Victorian Teams have collected data from 2000, and the Queensland team from 2006.[111]

(g) Develop recommendations for systematic change

Having identified service gaps and limitations during the case review process, Teams formulate recommendations targeted towards stakeholders. These seek to remedy these gaps and limitations, with the aim of preventing deaths occurring in a similar situation in the future. In Victoria, Queensland and South Australia, recommendations are delivered via coronial findings. In New South Wales, recommendations are set out in the Team's Annual Report. In Western Australia, the Ombudsman makes the recommendations to public authorities.

(h) Monitor the progress and uptake of recommendations

Death Review Teams should monitor the progress and uptake of recommendations. The New South Wales Domestic Violence Death Review Team publishes a monitoring table of recommendations in its annual report.[112]

(i) Prepare and publish reports on key cases and findings

All Australian Death Review Teams prepare reports on their findings. The publication of these reports differs across jurisdictions. The New South Wales Domestic Violence Death Review Team presents its findings and recommendations in an Annual Report to parliament. Similarly, the Western Australian Family and Domestic Violence Fatality Review reports its findings in the Ombudsman's Annual Report and own motion investigation reports. Queensland has reported publicly on statistics on domestic and family violence deaths within the Office of the State Coroner Annual Report, since the establishment of the unit. Whilst reviews aren't published in their entirety, for matters that proceed to Inquest a section or review summary may be included in the published coronial findings, if a Coroner makes a determination to do so. Further, the Domestic and Family Violence Death Review and Advisory Board is required to report annually to the Minister in relation to the performance of the Board's functions, which is also required to be tabled in parliament. In Victoria and South Australia, the case reports or interim reports prepared by the Teams form part of the Coroner's brief of evidence and are not made directly public.[113]

(j) Liaise with other death review teams

All Australian Death Review Teams are members of the Australian Domestic and Family Violence Death Review Network, which was established in 2011. Within this Network, Teams share practices and trends, align their findings to programs at a national level through the application of the Homicide Consensus Statement and National Data Collection Protocol developed by the Network with the aim of establishing the National Minimum Dataset.[114]

(k) Conduct literature reviews and maintaining an electronic library

The Victorian Systemic Review of Family Violence Death team conducts regular literature searches of scientific research and grey literature, and holds the information collected in an electronic library. This ensures that the team can provide Coroners with current findings and developments within the domestic and family violence research sphere.[115]

(l) Undertake independent research and investigations

Death Review Teams undertake independent research or investigations on domestic and family violence issues even when they are not specifically mandated to do so. Members of the Victorian, New South Wales and South Australian Death Review Teams have published research on the Australian death review models.[116] Further, the Queensland Domestic and Family Violence Death Review and Advisory Board has a statutory function to analyse data and apply research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland. Through this process the Board may inform policy change either through research, or through a specific recommendation.

The Western Australian Ombudsman is also mandated to undertake major own motion investigations. After identifying a pattern of cases in which Violence

Restraining Orders were in place, the Ombudsman commenced a major investigation into issues associated with Violence Restraining Orders and their relationship with domestic violence related fatalities which was tabled in the Western Australian Parliament in November 2015.[117]

(m) Contribute to and collaborate with research projects and government enquiries

The Victorian Systematic Review of Family Violence Deaths has contributed to a small number of research projects with domestic and international universities.[118] Likewise, the New South Wales Death Review Team has contributed to and collaborated with research projects and government enquiries including the New South Wales Legislative Council Select Committee on the Partial Defence of Provocation.[119]

(n) Collaborate and engage with law and policy sectors

Death Review Teams have a valuable function in enhancing professional knowledge and awareness about domestic violence. The South Australian, Victorian and New South Wales Teams have given a number of presentations at international and domestic conferences and forums, and the Western Australian Ombudsman has spoken at seminars and events to explain the role of the Family and Domestic Violence Fatality Review.[120] The New South Wales Death Review Team has also conducted significant public and community education in relation to domestic violence, including within NSW Local Health Districts and Mental Health Services and the legal profession in NSW.[121]

(o) Engage with the wider community

In Australia, the Western Australian Ombudsman conducts outreach activities with Aboriginal and regional communities to build relationships relating to the domestic and family violence fatality review function.[122]

(p) Provide an advisory role to governments

A key mandate of the New Zealand Family Violence Death Review Committee is to advise on any matters relating to family violence deaths that the Minister for Health specifies.[123] In South Australia, the Senior Research Officer (Domestic Violence) position is embedded within the States 'A Right to Safety' Governance Structure and reports on recommendations and trends directly to the Minister for the Status of Women and the state Chief Executive Group.[124]

3.2 History and resourcing of death review in Australia

Over the last twenty years, significant advocacy and research have helped frame domestic and family violence as an issue that demands government response.

This response has often come in the form of government led reviews and inquires into domestic violence. In a number of states, the findings and recommendations of these reviews and inquiries have resulted in the establishment of Domestic Violence

Death Review processes. In the jurisdictions where they exist, most Death Review Teams have come about as a direct result of government inquires. This Chapter sets out the development process of each Death Review Team in Australia.

(a) Victoria

(i) History and mandate

In 2006, the Victorian Law Reform Commission released the *Review of Family Violence Laws* report. The report presented the results of a review into the justice system's response to domestic and family violence.[125]

The report noted that a high proportion of Australian homicides occur in a context of domestic and family violence and identified a death review function as a potentially effective systemic response to such deaths. The Commission recommended that:

> 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.[126]

This led to consultation between government and key stakeholders regarding the establishment of a death review function and resulted in the creation of the Victorian Systemic Review of Domestic Violence Deaths, which commenced operation in 2009.

The review has been established under the power of the Coroner as per the *Coroners Act 2008* (Vic).[127] It does not have a specific statutory mandate.

(ii) Functions and resourcing

The Victorian Systemic Review of Domestic Violence Deaths has five main aims, which are to:

- Examine the context in which family violence deaths occur;
- Identify risk and contributory factors associated with family violence;
- Identify trends or patterns in family violence-related deaths;
- Consider current systemic responses to family violence; and
- Provide an evidence base for Coroners to support the formation of prevention focussed recommendations aimed at reducing family violence.[128]

At the time of its establishment the Review was designated $250,000 funding. This included the equivalent of two and a half full-time staff to conduct research domestic and family violence death cases. In 2010 funding was cut and the costs associated with the Review's work were absorbed into the existing budget of the Coroner's court.[129] This funding cut led to the reduction of designated staff to one part-time position.[130]

The Victorian Government committed to refunding the Review in its 2015-2016 budget[131] and the team is currently staffed by a part-time Manager, a full-time Project Officer and assisted by a part-time Solicitor and two part-time Investigators.[132]

The Victorian Systemic Review of Domestic Violence Deaths has released one report since being established. The 2012 report included the analysis of deaths between 2000 and 2010 and 28 in-depth case reviews.[133]

(b) New South Wales

(i) History and mandate

In 2008 the New South Wales Government established the Domestic Violence Homicide Advisory Panel to conduct a review on domestic violence homicides in New South Wales and consider the need for a death review mechanism in New South Wales.

The Advisory Panel was established following increased advocacy and campaigning for the need for a death review mechanism in New South Wales. It also aligned with an increasing government focus on the issue of domestic and family violence.[134]

In 2009 the Advisory Panel released its report. It recommended that New South Wales establish a domestic violence homicide review mechanism and outlined the recommended functions and features.[135]

In November 2009 the New South Wales Government announced that it would establish an ongoing domestic violence death review process to be convened by the Coroner. The team was established by the *Coroners Amendment (Domestic Violence Death Review Team) Act 2010* (NSW) which came into force in July 2010.

The Domestic Violence Death Review Team released its first report in 2011, followed by annual reports in 2012 and 2013.

In late 2013, the State Coroner resigned her post, which included her role as Convenor of the Death Review Team. Following this resignation, there was a period of several months during which the death review team did not convene as new panel members had not been appointed.[136] This led to a delay in the release of a 2014 Annual Report, with the deaths falling within the 2013-14 reporting period instead incorporated in the 2013 – 2015 Annual Report, released in late 2015.

(ii) Functions and resourcing

The Domestic Violence Death Review Team has the following functions:

- To review closed cases of domestic violence deaths occurring in New South Wales;
- To analyse data to identify patterns and trends relating to such deaths;
- To make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths;
- To establish and maintain a database (in accordance with the regulations) about such deaths; and
- To undertake, alone or with others, research that aims to help prevent or reduce the likelihood of such deaths.[137]

The New South Wales Domestic Violence Death Review team consists of a full-time secretariat of two (a Manager and Research Analyst) and of a multidisciplinary group of 12 government and two non-government representatives, and two sector experts.

The team has recurrent annual funding.

(c) Queensland

(i) History and mandate

In 2009, the Queensland Government established the Domestic and Family Violence Death Review panel to conduct a review on existing coronial processes as they relate to domestic and family violence deaths and to provide advice on options to strengthen these processes.[138]

The Panel released its report in 2010. The report recommended the establishment of an ongoing death review process consisting of a Domestic and Family Violence Homicide Prevention Unit to support the State Coroner in their investigation of domestic and family violence related deaths.[139]

The Queensland Government established the Domestic and Family Violence Death Review Unit in 2011. The unit was originally established on a trial basis but became a permanent function within the Office of the State Coroner in 2012.

The Unit does not have an explicit statutory mandate, instead being established under the power of the Coroner as per the *Coroners Act 2003* (Qld).[140]

In September 2014, the Queensland Government established a Special Taskforce on Domestic and Family Violence. The role of the Taskforce was to define the domestic and family violence landscape in Queensland and make recommendations to prevent and reduce domestic violence.[141]

The Taskforce recommended that the government establish a Domestic and Family Violence Death Review Board to review domestic violence deaths in order to identify systemic failures and gaps and make recommendations to improve systems, practices and procedures.[142]

In October 2015 the Queensland Government passed the *Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Act 2015* which established the Domestic and Family Violence Death Review and Advisory Board.

The Board is designed to enhance the systemic review of these types of deaths, and consider patterns, trends and issues across cases. It recognises, and extends upon, the work undertaken by the Domestic and Family Violence Death Review Unit with respect to the coronial investigation of domestic and family violence related deaths.

(ii) Functions and resourcing

With these recent amendments, Queensland now has a two tiered domestic and family violence death review process.

Tier 1

The Domestic and Family Violence Death Review Unit assists Coroners in their investigations of domestic and family violence-related deaths and those child deaths where there has been prior contact with the child protection system.

The Domestic and Family Violence Death Review Unit is currently staffed by one manager, one principle researcher and coordinators, two senior advisors and two administrative staff. Prior to 2015, the unit staff consisted of one principle researcher and coordinator and one senior advisor.[143]

The unit is also responsible for the provision of Secretariat support to the Board, and collates data in relation to domestic and family violence related homicides and suicides.

Tier 2

The Domestic and Family Violence Death Review and Advisory Board has the following functions under the *Coroners Act 2003*:

- To review domestic and family violence deaths in Queensland;
- To analyse data and apply research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland;
- To carry out, or engage other persons to carry out, research to prevent or reduce the likelihood of domestic and family violence deaths;
- To use data, research findings and expert reports to compile systemic reports into domestic and family violence deaths, including identifying key themes and elements of good practice in the prevention and reduction in the likelihood of domestic and family violence deaths in Queensland;
- To make recommendations to the Minister about improvements to legislation, policies, practices, services, training, resources and communication for implementation by government entities and non-government entities to prevent or reduce the likelihood of domestic and family violence deaths in Queensland; and
- To monitor the implementation of recommendations.[144]

The Domestic and Family Violence Death Review and Advisory Board consists of up to 12 experts appointed by the Minister.

(d) South Australia

(i) History and mandate

In 2010, the South Australian Government announced that it would establish a Senior Research Officer (Domestic Violence) position to support the Coroner's office on domestic violence cases, to collect data relevant to domestic violence deaths and conduct research projects to identify trends, gaps and areas for improvement.[145] This was in response to increasing advocacy for the need to raise awareness of domestic violence and undertake programs to prevent domestic violence deaths.[146]

The Senior Research Officer (Domestic Violence) commenced in January 2011. The position is based within the Coroner's office and works in partnership with the Office for Women.

The position was originally limited to a four-year period but has since been designated as ongoing.[147]

The death review function does not have an explicit statutory mandate.

(ii) Functions and resourcing

The core functions of the Senior Research Officer (Domestic Violence) are to:

- Identify deaths with a domestic violence context;
- Assist in the investigation of the adequacy of system responses and/or interagency approaches that may underpin the prevention of domestic violence related deaths;
- Provide advice to the Coroner's office in relation to domestic violence dynamics, system responses and possible lines of coronial inquiry in relation to deaths that occur in a domestic violence context;
- Review files, provide interim reports and have specific input into Coronial inquests which relate to domestic violence;
- Develop data collection systems that can provide advice to Coronial processes and identify demographic or service trends, gaps or improvements more broadly; and
- Conduct specific retrospective research projects relevant to building a Domestic Violence Death Review evidence base.[148]

One full-time member of staff (the Senior Research Officer) is assigned to the review of domestic and family violence deaths in South Australia. The Office for Women and the Coroners Court provide support and advice to the Senior Research Officer.

(e) Western Australia

(i) History and mandate

The Western Australian Annual Action Plan 2009-2010, which supports the implementation of the Strategic Plan for Family and Domestic Violence 2009-2013, identified the establishment of a family and domestic violence fatality review committee as a key action for 2009-10.[149]

Following the release of the annual plan, the Western Australian Government established a working group to examine models for a family and domestic violence fatality review process.

The fatality review mechanism would review the circumstances in which family and domestic violence deaths occur, identify patterns and trends that arise in the context of family and domestic violence deaths and make preventative recommendations to public authorities.[150]

The Government requested that the Western Australian Ombudsman take responsibility for the reviews and on 1 July 2012 the Family and Domestic Violence Fatality Review function commenced within the Ombudsman's office.[151]

(ii) Functions and resourcing

The core functions of the Family and Domestic Violence Fatality Review process are:

- To review the circumstances in which family and domestic violence fatalities occur;
- To identify patterns and trends that arise from reviews of family and domestic violence fatalities; and
- To make recommendations to public authorities about ways to prevent or reduce family and domestic violence fatalities.[152]

The Ombudsman can also conduct thematic investigative reviews into specific issues relating to family and domestic violence deaths. In 2015, the Ombudsman released the first thematic report, which focused on the investigation of issues associated with violence restraining orders and their relationship with family and domestic violence fatalities.[153]

The Review Team, which is responsible for reviewing domestic and family violence deaths *and* child deaths, consists of the Ombudsman, an Assistant Ombudsman, a Director, a Principal Aboriginal Liaison Officer and a number of Investigating Officers.[154]

(f) Australian Capital Territory

In July 2014, the Australian Capital Territory Government asked the Domestic Violence Prevention Council to conduct a review of deaths that occurred in a domestic violence context between 1988 and 2012.[155]

In April 2015, the Domestic Violence Prevention Council provided the Australian Capital Territory Government with a report summarising the discussions from an Extraordinary Meeting about the safety and security of victims of domestic and family violence. The report included information gathered through consultations conducted as part of the Domestic Violence Death Review.[156]

The Domestic Violence Prevention Council reported on the outcomes of the death review process in May 2016.[157] In its response that report, the Australian Capital Territory Government accepted all 28 recommendations of the Findings and Recommendations from the Review of Domestic and Family Violence Deaths in the Australian Capital Territory which included:

> The ACT Government establish a family violence death review mechanism to review all family violence homicides.[158]

3.3 International examples of death review processes

(a) United States of America

The United States of America was the first country to establish a domestic violence death review mechanism, in the city of San Francisco.

The establishment of the review followed a high-profile murder-suicide which took place in the context of domestic and family violence.[159] In this case, the victim had reached out to numerous agencies in the months before her murder, having obtained restraining orders and custody orders and made official complaints to police.[160]

Following the murder-suicide a coalition of service providers assisting victims of domestic and family violence requested the Commission on the Status of Women conduct an investigation into the murder. The Commission agreed, and established a subcommittee to examine the systemic, policy and procedural issues that related to the case.[161]

The report made several recommendations to various government agencies in order to prevent or reduce the likelihood of similar deaths occurring in future. The final recommendation of this report was for:

> The creation of a review team to examine homicide cases related to domestic violence [which] will evaluate the system's response to individual cases, submit reports and make further recommendations…on improving the system.[162]

Since 1991, at least 82 death review mechanisms have been established across the United States.[163]

There are several examples of Teams in the USA which currently analyse and report on suicides and near fatalities that occur within a domestic violence context. The jurisdictions that review near fatalities generally have lower numbers of domestic and family violence homicides. Reviewing a wider range of cases can provide more opportunities to identify themes and common characteristics.[164]

(b) Canada

The first death review mechanism in Canada was established in Ontario in 2002. This followed the release of findings for two inquests into domestic violence homicides. The recommendations from these inquests identified several areas in which policies, procedures and other systemic responses could be improved. One of these recommendations was for the establishment of a Domestic Violence Death Review Committee.[165]

Since 2002, death review mechanisms have also been established in several Canadian provinces, including Alberta, Manitoba, New Brunswick and British Colombia.[166]

(c) New Zealand

New Zealand established the Family Violence Death Review Committee in 2008. The establishment of the Committee followed years of advocacy for the establishment of a domestic violence death review mechanism.[167] The Committee is a ministerial committee working under the *Public Health and Disability Act (2000)(NZ).*

The Committee first met in 2008 and released its first report in 2009. Four other annual reports have since followed.[168]

(d) United Kingdom

In 2011, the United Kingdom passed an amendment to the *Domestic Violence, Crime and Victims Act (2004)* (UK) to require domestic homicide reviews to be carried out after every death that takes place in the context of domestic violence in England and Wales.[169]

Local government areas that are responsible for individual reviews submit reports to the Home Office. Since 2011, dozens of domestic homicide review reports have been submitted.[170]

3.4 Positive outcomes of domestic violence death review

> *We are convinced that this work saves members of our community from early and tragic death.*[171]

Domestic and Family Violence Death Review Teams have assisted law enforcement agencies, judicial and social service agencies and other public agencies to improve practices in Australia and internationally. One of the most tangible benefits of death review is its ability to identify a systems approach to protecting victims of domestic violence. It can make connections between organisations and see the larger picture.

In Victoria, findings and recommendations of the Death Review Team have helped to encourage collaboration and transparency among government and non-government organisations working in the area of domestic violence.

> The Coroners Act requires agencies to respond to recommendations within three months of receiving them from the court, and responses are then published on the family violence investigations page of the court's website. To date, the findings of 17 cases have been posted and responses for seven cases have been published. This process is an opportunity to monitor themes and patterns in family violence deaths, point out systemic gaps and consider the Coroner's recommended solutions.[172]

The international literature on the benefits of death review is extensive.

In the United States, for example, Hennepin County have made over twenty-five improvements to their justice system based on recommendations by the Domestic Violence Fatality Review Team. These improvements include increased consequences for perpetrators and greater support for victims.[173]

Similarly, in 2006 the Macomb County Death Review Team in Michigan made a number of recommendations after looking at the operation of family and local criminal

courts with respect to restraining orders. The Team was able to identify procedural problems and issues with jurisdictional overlap.[174] A number of their recommendations were subsequently adopted, which has led to a more streamlined, inclusive and cohesive approach to the way courts monitor restraining orders in the region.

The San Diego Death Review Team, identified access to firearms as one of the greatest risk factors for death. Of the thirty-seven domestic violence homicides in that period, twenty-two were committed with a firearm.[175] The Team made a number of recommendations that were supported by Senator Christine Kehoe, who introduced a Bill requiring perpetrators of domestic violence to surrender their firearms to police. By 2006, only eight of the twenty-five domestic violence homicides were committed using a firearm; a reduction of approximately 50 percent.[176]

3.5 Challenges, strengths and limitations of Australian death review

The following analysis of death review is from the responses of Australian Coroners and the Western Australian Ombudsman to the Commission's 2015 Questionnaire. It sets out the strengths and challenges of the death review processes as experienced in each jurisdiction. The full responses to the Commission's questionnaire are available at Appendix B of this report.

(a) Statutory basis

Many Death Review Teams were established by statute.[177] In Australia, the Death Review Team in New South Wales was established by statutory amendments to the *Coroners Act 2009* (NSW) in 2009 and the Queensland Death Review Team, was established in 2011 by way of amendment to the *Coroners Act 2003* (QLD). These amendments enshrine provisions regarding relevant definitions, the functions of the Teams, their membership and their ability to access information.[178]

In South Australia and Victoria, Death Review Teams sit within the Coronial function and operate under existing Coronial legislation. In Western Australia the Team operates in accordance with the *Parliamentary Commissioner Act 1971*(WA).

The Western Australian Ombudsman, and the South Australian Senior Research Officer (Domestic Violence), have stated that an explicit statutory basis is not necessary as the existing arrangements are sufficient for their work.[179]

The New South Wales Coroner submits that a strong statutory basis is a critical element because it empowers and supports the Team to effectively undertake their various functions.[180]

The Victorian Coroner and Death Review Team similarly argue that an explicit statutory basis is desirable as it ensures the sustainability of the Review function.[181]

While a statutory basis may be desirable, it is not the only model for death review. It should not preclude the establishment of new Death Review Teams. In some instances, the process for developing the death review function may be staged.

(b) Resourcing

Levels of staffing and other resourcing for Death Review Teams vary across jurisdictions. Most Teams consist of a secretariat of one to two people and are supported by the work of a multidisciplinary team.

In terms of funding, the New South Wales Domestic Violence Death Review team has $500,000 annual funding. This supports the work of the secretariat and broader team. The New South Wales team reports that this is adequate.

The Western Australian Ombudsman undertakes death reviews, and similarly described existing resources as adequate and appropriate.

Other Review Teams reported that improved resourcing levels could improve their work. For example, while the Victorian Systemic Review into Domestic Violence Deaths has stated that current funding levels (which provide for a part-time manager, full-time project officer and the support three other part-time staff members) are sufficient for conducting case-by-case investigations, it indicated that additional resources for research and evaluation would be valuable.

Similarly, the Senior Research Officer (Domestic Violence) in South Australia reported that an additional staff member could enhance the work of the team.[182] The Senior Research Officer also noted that having a broader team that could review the data would also be beneficial.[183]

(c) Cases reviewed

(i) Open coronial and criminal cases

The majority of Death Review Teams in Australia review both open and closed coronial cases. Teams may also offer advice and support to Coroners in relation to specific open cases.[184]

The majority of Teams in Australia do not consider cases while they are subject to criminal proceedings. Many Teams felt that this was the correct approach, for two reasons.

First, some Teams felt that the consideration of open criminal cases could undermine the criminal justice process.[185]

Second, Teams noted that waiting until the criminal justice process had been concluded enables them to access a wider range of valuable information for their review, including prosecution materials and sentencing remarks.[186]

In contrast, the Western Australian Ombudsman and the Queensland Domestic and Family Violence Death Review and Advisory Board can review cases concurrently with criminal proceedings. The Western Australian Ombudsman has stated that this helps to ensure that death reviews are conducted, and recommendations formulated, in the ‘most timely way possible’.[187]

(ii) Non-homicide cases

The focus of most of the work of Domestic and Family Violence Death Review Teams is on cases of domestic violence homicide and homicide-suicide.

However, most Teams in Australia can analyse non-homicide cases. In particular, suicide deaths that occur in a context of domestic and family violence fall within the remit of reviewable deaths by most Death Review Teams.

Death Review Teams have indicated that the analysis of such deaths would be useful.[188] For example, the South Australian Coroner stated that 'the review of suicide…deaths is valuable in terms of understanding the dynamic that domestic violence may play in those deaths and subsequently informing prevention strategies'.[189] It may therefore be beneficial for Teams to be provided with the support or resources necessary to undertake these reviews.

In jurisdictions with higher numbers of homicide cases, it may be appropriate to prioritise the analysis of homicide cases. However, in smaller jurisdictions, enabling Domestic and Family Violence Death Review Teams to consider non-homicide cases that occur within a context of domestic and family violence may provide the opportunity for Teams to better identify trends and commonalities than would be possible if only homicide cases were considered.[190]

3.6 Findings

	Findings
3.1	There is no one-size-fits-all model for domestic and family violence death review. Death Review Teams vary in their structure, mandate, resources and history. Some of these differences reflect the history of the development of the Team or the size of the population and different caseload requirements.

Part 4

4 Guiding Principles for Domestic and Family Violence Death Review

The purpose of this section is to describe the principles that guide the death review process in Australia. **These principles can, and should, provide a template for the development of the death review function in jurisdictions where they do not currently exist.**

The principles described here are those developed by the Australian Domestic Violence Death Review Network.[191] Australian Coroners and the Western Australian Ombudsman have made statements supporting these principles in their responses to the Australian Human Rights Commission questionnaire in 2015.[192]

Domestic and Family Violence Death Review Teams vary in size, composition and mandate. In Australia, they have evolved over time to reflect the contexts of each jurisdiction and the historical resource allocation that led to their development. The differences in the Death Review Teams are relatively minor in terms of their basic function. Variations in the Teams are more likely to be in composition, structure, affiliation and mandate to report.

Death Review Teams are co-located with a range of entities across Australia. These include Coroner's Courts, a South Australian Government Department. In Western Australia death reviews are undertaken by the Office of the Ombudsman.

There is no requirement for domestic violence death review to be modelled on a one-size-fits-all approach. The diversity in each model fits the purposes of each jurisdiction. Nevertheless, some basic commonality in the function of death review is essential for national reporting and for comparison of service responses to domestic and family violence deaths.

The commonalities that bind the Death Review Teams are, in essence, the principles by which all Death Review Teams operate. Existing Death Review Teams are part of the Australian Domestic Violence Death Review Network. The Network has developed a set of principles that underpin effective death review functionality.[193]

The principles are replicated in the headings that follow.

4.1 Government endorsement, reliable funding and engagement with public and private sector agencies

The first principle for an effective death review process is that Teams establish standing, authority and endorsement from Government and non-Government agencies. The Australian Domestic Violence Death Review Network identifies the need for government support as a key of effective death review models.[194] This includes consistent funding, without which, the death review function can lapse.

There is a history of inconsistent funding of death review in some states, and this had led to gaps in reporting on domestic violence deaths.

(a) Funding

Government funding is required for the adequate staffing levels that are required to fulfil the function of collecting, analysing and reporting on death cases over time.[195]

The adequacy of funding will depend on jurisdiction size and the make-up and function of the particular Death Review Team. In Australia, the collection, collation and analysis of information is generally conducted by a Team of at least two staff.

In South Australia, however, there is only one dedicated officer to death review. As described by the Senior Research Officer, death review 'is resource intensive work and timeliness of review can be dependent on resource availability.'[196]

To maintain consistency, death review funding needs to be secure and recurrent, regardless of the size or location of the Team.

(b) Government endorsement

Government endorsement is essential for Teams to work effectively and collaboratively with Government agencies. Death Review Teams require access to information from various sources. This can include access to files from Government and non-Government Departments and agencies including police, health, education, child protection and housing.

Without Government support, Death Review Teams could face challenges to their credibility and barriers or delays in accessing information which could impede their ability to analyse and report in a timely manner.

(c) Statutory basis

While a statutory basis is not a mandatory requirement for the death review function, some Governments choose to establish the role through statute. In New South Wales and Queensland, the death review function has been established by statute. In other states, Teams operate under existing legislation outlining the functions of the Coroner. In Western Australia, the function is set out in the *Parliamentary Commissioner Act 1971* (WA). See Appendix A for information about the enabling legislation for each jurisdiction.

4.2 Appropriate powers to access information

Domestic and Family Violence Death Review Teams rely on information from various databases and sources to conduct quantitative and in-depth case reviews of domestic and family violence deaths. Death Review Teams rely on enabling legislation that provides access to information from all agencies where the deceased and the perpetrator had contact. They also require access to policies and procedure documents from agencies where these policies may have bearing on domestic and family violence.

Legislation which establishes the functions and responsibilities of Death Review Teams varies across the jurisdictions. For example, the *Coroners Act 2009* (NSW) provides that Government Department Heads, the Commissioner of Police, medical and health practitioners and heads of relevant welfare services must give the Domestic and Family Violence Death Review Team 'full and unrestricted access to records that are under [their] control.'[197]

Similarly, the *Coroners Act 2003* (Qld) states that the Advisory Board has a right to all relevant information under the control of Government Department Chief Executives, the Commissioner of Police, the Queensland Family and Child Commission and relevant service providers.[198]

Death Review Teams that fall within the remit of the Coroners or Ombudsman Office are generally able to access information through information sharing provisions and in the relevant enabling legislation. This can include access to police reports and databases, information from civil and criminal proceedings and information from relevant service providers.

4.3 Support from experts in domestic and family violence and policy

Death Review Team personnel require a degree of specialist knowledge of issues pertaining to domestic and family violence. This expertise can be enhanced through the advisory mechanisms that support the Death Review Teams. Advisory mechanisms are typically constituted by representatives of relevant government departments, including police, health, justice and family services. Teams often include representatives from non-governmental services and organisations.

Most Death Review Teams in Australia (those operating in Queensland, Western Australia and Victoria) are supported by multidisciplinary advisory Teams. In South Australia, there is no such formal arrangement, but the Senior Research Officer, through membership of relevant government committees, is able to access expert advice from relevant government agencies and through reporting arrangements to the Chief Executives Group of the South Australian Office for Women.[199]

Advisory group members can provide informed advice as to how to best frame preventative recommendations aimed at their Department or non-Government Agency.[200]

The advisory group also enables knowledge sharing with other representatives and facilitates linkages between different Government Departments and organisations. This can lead to a more cohesive response to the issue of domestic and family violence.[201]

4.4 Capacity to make and monitor recommendations

Making and monitoring recommendations is an important function of domestic and family violence death review. Recommendations aim to prevent the likelihood of similar deaths occurring in future.[202] Recommendations are made to improve or modify the following:

- Legislation and policy;
- System and service responses;
- Data collection and management; and
- Public awareness and education campaigns.[203]

In some jurisdictions (Victoria, Queensland and South Australia), Death Review Teams assist the Coroner to develop recommendations as part of the Coronial investigation process.[204] In others (New South Wales, Western Australia and Queensland), Death Review Teams develop their own recommendations and communicate these directly to Government.[205]

Recommendations can be made to Government Departments and Non-Government agencies in the state or territory of the Death Review Team.[206] In all states apart from Western Australia, Death Review Teams can make recommendations to Commonwealth agencies.[207]

4.5 Powers to conduct quantitative and qualitative reviews

Both quantitative and qualitative information is collected in the death review process.

Teams conduct in-depth qualitative case reviews in order to gain a detailed understanding of the circumstances surrounding domestic and family violence deaths. This can include the events leading up to a death, the relationship history of those involved, and the level and adequacy of service contact.[208]

Quantitative analysis includes the characteristics of victims and perpetrators, the history of violence and the history of service contact.

Teams categorise data and this enables quantification of the prevalence of domestic and family violence deaths by a range of factors. It also enables Teams to identify trends common to domestic and family violence death cases, such as gaps in service delivery, problems with policies and procedures and opportunities for intervention.

This holistic approach has the potential to inform the development of appropriate policy and service responses and identify opportunities for systemic change.

4.6 Contribution to a National Network

Collaboration across jurisdictions is essential for the development of a coherent monitoring system in domestic violence death review. The existence of a national body acknowledges that we are a series of federated states and that domestic and family violence is not limited by state boundaries. We need uniformity in data collection and death review across the states and territories as a matter of national safety and community safety.

In Australia, Death Review Teams are members of the Australian Domestic and Family Violence Death Review Network. As a Network they have worked collaboratively to achieve an agreed definition of domestic and family violence, consistent case identification and inclusion criteria, a *National Minimum Dataset* and *National Data Collection Protocols* to guide future collective reporting.

The Network ensures that the death review process can evolve while maintaining a level of consistency across the states. Data collection categories can change or expand as the circumstances of deaths are recorded and understood over time. Network members can discuss patterns and trends from their own jurisdiction and make comparisons. The collection and collation of new categories of data potentially helps policy makers understand the changing risk factors in domestic violence and new or emerging trends.

Team members from different jurisdictions add to the cumulative knowledge of the Network. The Teams meet at intervals determined by the Network to respond to emerging issues and to maintain a level of communication throughout the year.

4.7 Case identification procedures and mechanisms

Domestic and Family Violence Death Review Teams must have clear parameters to determine the cases that fall within their review function.

The Australian Domestic Violence Death Review Network has developed a 'Homicide Consensus Statement' which outlines basic criteria for classifying homicides that have occurred in a domestic violence context.[209] The Consensus Statement sets out protocols for determining which deaths fit into the category of a domestic and family violence related homicide for the purposes of review. The Network assess the interaction of four categories of information:

- The case type of the death;
- The role of human purpose in the event resulting in a death (intent);
- The relationship between the parties (i.e. The deceased-offender relationship); and
- The domestic and family violence context (i.e. Whether or not the homicide occurred in a context of domestic and family violence).[210]

(a) Case type

In Australia, all Teams consider domestic and family violence homicides and homicide-suicides as fitting the case type of a classifiable death. Most Teams are also able to consider suicides that occur in a context of domestic and family violence but, to date, the majority of Teams have not counted these deaths in their data. Many Teams in Australia noted that the ability to consider *all* deaths occurring in a context of domestic and family violence would be valuable to their work.

In certain international jurisdictions, Death Review Teams consider non-fatal events, such as severe assaults and attempted murders. This occurs most often in small jurisdictions where the homicide rate is low.[211] Considering a wider range of incidents in smaller jurisdictions may facilitate the identification of a more accurate picture of domestic violence than would be possible if only homicide cases were reviewed.[212]

(b) Human purpose (intent)

The Network's 'Homicide Consensus Statement' sets out the parameters under which the human purpose or intent fit the category of domestic violence:

> Injury from an act of violence where physical force by one or more persons is used with the intent of causing harm, injury, or death to another person; or an intentional poisoning by another person. This category includes intended and unintended victims of violent acts (e.g. bystanders).
>
> Death which occurred due to injuries that were inflicted by police or other law-enforcing agents (including military on duty), in the course of arresting or attempting to arrest lawbreakers, suppressing disturbances, maintaining order or other legal action. These actions much have occurred in the context of a domestic violence situation.[213]

(c) Relationship between the parties

Death Review Teams identify the relationship between the parties involved in the death event. A familial relationship is not necessarily a defining factor for a domestic violence death.

The Network recognises current or former intimate partners (heterosexual and homosexual), family members (adults and children), extended family members and kinship relationships relevant to Aboriginal and Torres Strait Islander communities.[214]

The Network definition also recognises people with no relationship to each other and people who are unknown to each other. Bystanders can be killed in a domestic violence context and individuals can be mistakenly killed in the context of domestic violence.

(d) Domestic and family violence context

An essential consideration in determining whether a death meets the criteria for domestic violence is to understand the context in which the death occurred. This is important since not all deaths occurring between family members will have occurred in a context of domestic and family violence. In addition, deaths may occur in a domestic and family violence context even if there is no familial relationship between the victim and offender. For example, a bystander killed when intervening to assist a victim of domestic and family violence can be said to have been killed in the context of domestic and family violence. A domestic violence perpetrator may be killed by police and yet there is no pre-existing relationship between the parties.

Death Review Teams assess whether there was an identifiable history of domestic and family violence in each particular case.[215] This may include unreported and anecdotal histories.[216]

In conducting this assessment, Teams are guided by the definition of domestic and family violence from their jurisdiction. Often these definitions are enshrined in statute. Given that the definitions of domestic and family violence vary between states and territories, the Network protocols, using the definition set out in s 4AB of the Family Law Act 1975 (Cth) assist in setting out the circumstances under which data is collected for the purposes of Domestic and Family Violence Death Review and ensure Network members are using the same definition.

4.8 Collaborative, consultative and independent

Working collaboratively with Government departments and non-Government organisations is an important element of the death review function. Collaboration occurs in many forms. It can be managed through the multidisciplinary advisory groups or through contact between Death Review Team members and staff from domestic and family violence agencies. Collaboration is essential so that Team members understand the operating contexts of agencies and are able to draw on the knowledge of experts in various specialty areas.

Death Review Team members require a detailed knowledge about the operation of a wide range of departments, services and agencies. Domestic and family violence occurs in the day to day lives of people. There can be numerous factors in play before a death.

The responses to the Commission's questionnaire of Coroners, the Western Australian Ombudsman and Death Review Teams, emphasised the importance of independence.

Independence is generally enshrined in statute. This is either in legislation establishing a death review function or in legislation determining the functions of Coroners or the Western Australian Ombudsman, under which the Death Review Teams operate.

4.9 National, state and territory domestic violence frameworks

Domestic and family violence services operate in a policy environment at the Federal, State and Territory levels. The various tiers of policy and the overarching frameworks set the direction of domestic violence services. They underpin funding arrangements and guide the development of protocols and practice.

Death Review Teams assess service responses to domestic violence in the context of these frameworks.

4.10 Confidentiality and privacy protections

Domestic and family violence Death Review Teams operate in accordance with confidentiality and privacy provisions. This ensures that Teams know the rules regarding access to and disclosure of confidential information which is important in light of the wide range of information that Death Review Teams need to be able to access as part of the death review process.

For Teams that were established by legislation, specific statutory provisions will determine the rules regarding confidentiality.[217] For other Teams, relevant rules and protections can be found in legislation pertaining to the work of the Coroner or Ombudsman's office.

4.11 Overarching philosophy of death review

Domestic and Family Violence Death Review Teams operate in accordance with the philosophy that conducting death reviews can lead to the identification of

opportunities to improve responses to domestic and family violence deaths and thus prevent the likelihood of similar deaths occurring in future.[218]

4.12 Findings

	Findings
4.1	The Australian Domestic Violence Death Review Network has developed a set of principles that underpin the effective functioning of the death review process. In order to create a consistent national approach, newly established Death Review Teams will need to be guided by the same principles.

Part 5

5 National data collection, monitoring and reporting

The death review process is extremely valuable to policy makers and decision-makers because when all domestic violence deaths are investigated across a jurisdiction, trends or patterns emerge.

Domestic violence deaths are not isolated incidents. Trends in these deaths and in service responses can be used to inform decision-makers about where to target resources. They also show where changes to policy, law or practices are required or have had an impact. Death review evaluates the responses of agencies such as police, child protection, crisis accommodation or domestic violence services.

Unfortunately, there is no system of domestic and family violence death review on a national basis. Efforts are underway to rectify this situation, most notably by the Australian Domestic and Family Violence Death Review Network.

However, until all jurisdictions develop Death Review Teams, the national picture will not be complete. The Northern Territory, Tasmania the Australian Capital Territory are yet to develop the death review function.

While there is some data collected in relation to domestic and family violence deaths on a national basis, there is no authoritative data source that shows the number and nature of domestic violence deaths in Australia.

The Australian Institute of Criminology (AIC) collects information on homicides through its National Homicide Monitoring Program (NHMP) which reports every two years on the nature and frequency of homicides in Australia. These reports provide some granular data about different types of homicide and even the precipitating events prior to a death. However, the NHMP does not report on the context of domestic violence and therefore cannot present trends or patterns on this important feature. It does not collect death data about blood relatives who are not members of the immediate family such as aunts or grandparents, or data about Aboriginal and Torres Strait Islander kin related deaths.

The National Coronial Information Service collects information about all reportable deaths across Australia but with some limits on data relating to domestic and family violence.

The Domestic and Family Violence Death Review Teams have the most comprehensive dataset on domestic and family violence deaths, and as a Network, they have been collecting data since 2012. However, not all jurisdictions have Death Review Teams. The Northern Territory, Tasmania and the Australian Capital Territory do not have this function and have not collected this data to date.

5.1 Why we need national reporting

Australia needs reporting on a national basis and an agreed definition of domestic and family violence death for the following reasons:

- To identify the prevalence of these deaths nation-wide;
- To understand the trends and patterns in deaths that may be addressed by a national approach;
- To assess any cross-jurisdictional gaps or system deficiencies;
- To recommend changes to federal systems or policies to prevent future avoidable deaths;
- To identify and support vulnerable groups including women and children from Cultural and Linguistically Diverse communities and Aboriginal and Torres Strait Islanders; and
- To appropriately direct federal resources based on empirical evidence.

In order to establish a comprehensive national information system on domestic and family violence death, the following is required:

- To extend the Domestic and Family Violence Death Review function into the Northern Territory, Tasmania the Australian Capital Territory;
- To develop a funded national body to collect, collate and report on Domestic and Family Violence Death Review and to monitor the recommendations that are made to federal agencies;
- To publish national Domestic and Family Violence Death Review reports on a regular basis;
- To develop a national website;
- To apply the definition of domestic and family violence death from the *Family Law Act 1975* (Cth), for domestic and family violence homicides (as relied on by the Australian Domestic and Family Violence Death Review Network) to all Australian jurisdictions;
- To develop a nationally consistent definition of domestic and family violence death for suicides.

(a) National Coronial Information System

The National Coronial Information Service is a data storage and retrieval system. It enables Coroners and their staff to access data about reportable deaths since July 2000.

Coronial data tells us about the prevalence of categories of reportable deaths. In cases where Coroners recommend and conduct an inquest, their findings can identify failures in systems or services and recommend improvements to procedures, programmes or policies. Since the recommendations of the Royal Commission into Aboriginal Deaths in Custody, Coroners have increasingly focussed their findings to prevent future avoidable deaths.

The coronial determination of the ‘cause of death’ is the starting point for the information stored by the National Coronial Information Service and the case detail is built from there. Some examples of the ‘cause of death’ categories include; blunt force, piercing or penetrating force, threat to breathing, head and neck injuries and

about 300 other categories. The 'cause of death' explains how a person died, but it does not explain why a person died. Without the circumstances of death, it is not possible to understand the context of the death.

Until all jurisdictions have adopted the agreed definition of domestic and family violence deaths, it will not be possible for the National Coronial Information Service to collect and code this data.

The Australian Domestic and Family Violence Death Review Network has developed its Consensus Statement and National Collection Protocol for these deaths. Once all jurisdictions agree to collect data according to this protocol, it may be possible to provide this data for the National Coronial Information System. Further consideration will need to be given as to how such data in the NCIS could be effectively utilised.

(b) Australian Institute of Criminology

The Australian Institute of Criminology (AIC) collects information about homicides through its National Homicide Monitoring Program. It has three categories that define the relationship between victim and offender: (1) domestic homicide, (2) acquaintance homicide and (3) stranger homicide.[219] While it is reasonable to assume that a high number of domestic homicides have a domestic violence context, the remaining two categories do not identify whether the death occurred in the context of domestic violence. Therefore, the AIC data does not capture the actual numbers of domestic violence deaths in Australia in any of its categories.

The Australian Institute of Criminology acknowledges the importance of consistent definitions. Factors 'can complicate the development of homicide typologies … with the exception of specific legal definitions, which may vary across jurisdictions … [because] there is no universally agreed method for classification.[220]

(c) Australian Domestic and Family Violence Death Review Network

The Australian Domestic and Family Violence Death Review Network brings together representatives from each operating Domestic and Family Violence Death Review Team to share information, data and improve knowledge about domestic and family violence deaths.[221] It was established in 2011. The overarching goals of the Network are to:

- improve knowledge of the context and circumstances in which domestic and family violence deaths occur, in order to identify practice and system changes that may assist in reducing these types of deaths;
- identify at a national level the context of, and risks associated with, domestic and family violence-related deaths; and
- identify, collect, analyse and report national data on domestic and family violence-related deaths, and
- align domestic and family violence death review findings to programs at a national level.[222]

The Network has now finalised its Homicide Consensus Statement which confirms the adoption of the definition of domestic and family violence set out in the *Family Law Act 1975* (Cth) for domestic and family violence homicides.[223] While the Network

provides an important forum for centralising information about domestic violence deaths, the lack of formal death review processes in the three remaining jurisdictions means it is not yet able to develop a full dataset about domestic and family violence deaths.

The Network has also developed a preliminary data collection protocol for use by Network members. The goal of this data collection is to develop a staged standardised National dataset concerning domestic violence homicides. The National Data Collection Protocol establishes what information will be collected by each jurisdiction, at a minimum, to inform national data collection and reporting. It contains detailed information regarding specific demographic and case characteristics of both the deceased and perpetrator with respect to intimate partner homicides only.

The definition of homicide is described in the following terms in the Consensus Statement:

> The definition of 'homicide' adopted by the Network is broader than the legal definition of the term. 'Homicide', as used by the Network, includes all circumstances in which an individual's intentional act, or failure to act, resulted in the death of another person, regardless of whether the circumstances were such as to contravene provisions of the criminal law.[224]

In the first phase of its reporting, the Network's National Minimum Dataset[225] will include:

a) Details of the homicide
b) Demographics
c) Case characteristics
d) History including types of violence
e) Relationship characteristics

The Network domestic and family violence definitions and categories of data are the most expansive of existing collections.

The Network *National Data Collection Protocol*, sets out the current and proposed future expansion of data collection by the Network. This expansion will be a phased approach as indicated in the Consensus Statement.[226]

5.2 How will national data be sourced?

The only organisations to collect the information that is relevant for a national database on domestic and family violence deaths are the members of the Australian Domestic Violence Death Review Network. Network members are uniquely positioned to investigate and record data about all deaths in their jurisdiction that fit into this category.

Each jurisdiction with a Death Review Team is in a position to provide data to a national, centralised source.

In order to establish a fully functioning national body, it will be necessary to fund at least one staff member to collate national data from all jurisdictions; to prepare reports; and to publish information.

An appropriate national entity must be part of the membership of the Network and work closely with all jurisdictions. In fact, the national body will need to follow the same protocols and data collection design of the Network. Once national data is collated it can be published and become available to stakeholders, policy makers and decision-makers.

5.3 Monitoring recommendations to federal agencies

At the current time, there is no national body tasked with monitoring recommendations that are made by state and territory Coroners to federal agencies. Federal agencies include federal Government departments, non-Government groups, Federal Courts and others who have influence or a role in domestic and family violence. Under current arrangements, many coronial recommendations to federal agencies are not implemented. In some jurisdictions, there is no formal process for the recommendation to be accepted and no response to the recommendation.

In 2015, the Commission asked Coroners to respond to questions about their recommendations to national bodies. With the exception of New South Wales, all jurisdictions with the death review function, indicated that there could be improvements in national reporting and monitoring.

Their responses to the questions about the process for making recommendations and the efficacy of the responses are at Charts 5A and 5B.

CHART 5A: Process For Making Findings And Recommendations To Commonwealth Agencies

QU.	**Do you make findings and recommendations to Commonwealth agencies? Do you monitor the responses to these findings and recommendations, and if so, what is the process?**
New South Wales	The Team can make recommendations in relation to Commonwealth agencies, and the Team will identify issues at a Commonwealth level through its death review process. Responses to recommendations targeting Commonwealth Agencies are included in the Annual Report as with other recommendations.
Queensland	The Domestic and Family Violence Death Review and Advisory Board will have the capacity to if considered relevant. Monitoring of Commonwealth agency responses is not currently undertaken in Queensland.
Western Australia	Yes, when appropriate to do so.
South Australia	Recommendations have been made to Commonwealth Agencies, however, there is no formal mandate for them to respond or comply. There is no formal process to date to track these recommendations.
Victoria	Yes and these are responded to in the same manner as any other public statutory authority or entity.

CHART 5B: The Effectiveness Of Current Systems Of Reporting And Response To Coronial Recommendations At The Commonwealth Level And Suggestions For Improvement

QU.	**How would you describe the efficacy of current systems to report, monitor and follow-up on coronial recommendations to national agencies? What steps, if any, could be taken to improve national reporting and follow-up of coronial recommendations?**
New South Wales	The Team makes recommendations through its Annual Reports which are tabled in New South Wales Parliament, including recommendations which target national government agencies (for instance, the Department of Immigration and Citizenship in the Team's 2011/12 report, and the Family Court and Federal Circuit Court of Australia in the Team's 2013/15 report.). The Team has a mandated monitoring function whereby the details of the extent to which its previous recommendations have been accepted and the progress thereof is to form part of the Annual Report. It is the Team's perspective that this is an efficient process to report, monitor and follow up on all recommendations made by the Team.
Queensland	N/A Resources to support the functioning of the existing Australian Domestic and Family Violence Death Review Network.
Western Australia	Recommendations to Commonwealth agencies are rare. State Coroner monitors all responses to recommendations. This would best be achieved through National Coronial Information Service .
South Australia	There is no formal process to date to track these recommendations
Victoria	This occurs very rarely and not recently in relation to family violence. That national agencies are required to respond to State recommendations directed to them.

5.4 Findings

	Findings
5.1	The Australian Domestic and Family Violence Death Review Network has developed a Homicide Consensus Statement which defines the inclusion criteria adopted by the Network for domestic and family violence homicide. The Network has also developed a preliminary data collection protocol for use by Network members. The goal of this data collection is to develop a staged standardised National dataset concerning domestic violence homicides.
5.2	Australia does not have a funded entity to collate and prepare reports about national trends in domestic and family violence deaths or report on recommendations made to Federal agencies and implementation action. Many Australian states have limited options for following up on Coronial recommendations to federal agencies. Most Coroners agree that there can be improvements to this system. There is no mechanism under statute at the federal level to require federal agencies to respond to coronial recommendations.

Part 6

6 Next steps

This report has identified a range of challenges to ensure that we have appropriate death review mechanisms in place nationally for family violence related deaths.

In addition to these challenges, one further area not addressed in this report that requires further consideration[227] is the collection of data specifically in relation to children who are victims of domestic violence, and the intersection of the Child Death Review Teams and the National Minimum Data Set. Further work in this area will also contribute to the implementation of the strategies in the *National Framework for Protecting Australia's Children*.[228]

The Australian Government has recognised the importance of advancing the issues raised in this paper. On 28 October 2016, it launched the Third National Action Plan to Reduce Violence against Women and their Children for 2016-2019. It includes funding for advancing data collection issues relating to family violence deaths as follows:

> Work on the National Data Collection and Reporting Framework will be progressed further under the Third Action Plan, along with work begun under the Second Action Plan to improve systems that support reviews of domestic and family violence related deaths and child deaths. This work will be progressed by the Australian Human Rights Commission, which will consult states and territories to scope the development of data collection protocols and a proposed national data collection mechanism.
>
> The continuing building of an evidence base will link with, and be informed by, work underway as part of the research agenda of the *National Framework for Protecting Australia's Children*.[229]

The Commission looks forward to engaging with governments and coroners nationally over the next 12 months to identify mechanisms to address the national data collection needs identified in this report, as well as to work with states to ensure death review processes exist in all states and territories.

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Appendix A

	Coronial reporting and response requirements	Coroner's findings and recs published	Database information of DV-related recs	Government./agency responses	DFVDRT remit	DFVDRT reports/ recs published	Separate DFVDRT reports/recs	Definitional aspects
NSW	Statute: **Coroner:** *may* make recs (as are considered necessary or desirable) in relation to any matter connected with a death; *must* provide copies to any person/body to which a rec is directed, the Minister and any other Minister responsible for the person/body to which a rec relates.[230] **DVDRT** *must* provide to Parliament within 4 months of end of financial year an annual report on DV deaths.[231] If rec included in report that report be made public, Presiding Officer of a House of Parliament may make it public whether or not the House is in session and whether or not it has been laid before the House; the report still attracts the same privileges as if it had been laid before the House.[232] Policy: **Government agencies** to provide written response to AG within 6 months, outlining action to be taken (or reasons for rejection).[233] **AG** must publish all responses in June and December each year.	Online	'Catchwords' indicate if DV-related and if recs have been made	Ministry of Justice website contains table of responses to coronial recs	Est by statute: *Coroners Act 2009* (NSW), Chapter 9A. Reports to NSW Parliament. Child Death Review Team	Annual Report to Parliament[234]	Annual Report 2010 - 2011 Annual Report 2011 - 2012 Annual Report 2012 - 2013 Annual Report 2013 - 2015	**Coroner**[235] DV cases could fall within Coroner's investigatory remit, falling under violent, unnatural or unknown cause death, Coroner cannot investigate circumstances of death if a person has been charged with an offence related to the death. **DVDRT**[236] Role defined in *Coroners Act 2009 (NSW)* Domestic violence death means death caused directly or indirectly by a person where, at the time of death: Deceased was or had been in domestic relationship with perpetrator, was mistakenly believed to be in a relationship with a current or former partner of the perpetrator; was a witness or attempted to intervene in domestic violence between perpetrator and a third party. Domestic relationship defined in 101C, includes marriage, de facto partner, intimate relationship, relative (including various – see 101C(2)), for Aboriginal and Torres Strait Islander part of extended family.
VIC	Statute: **Coroner** *may* report to the AG and *may* make recs to any Minister, public stat authority or entity on any matter connected with a death; *must* publish response of a public statutory authority or entity on the internet. **Stat authority or other entity** must respond within 3 months in writing. Response must include statement of action that has or will be taken.[237]	Online Specific page on DV investigations	'Catchwords' indicate if DV-related and if recs have been made	On Coroner's website. Found in webpage of each separate case, eg this DV case	Not by statute; but under leg mandate of *Coroners Act 2008* (Vic) Work to the Coroner.	Recs included within (i.e. they inform) the Coroner's recs	Separate report (2009 and 2012 Reports)	**Coroner**[238] DV cases could fall within Coroner's investigatory remit, falling under violent, unnatural or unknown cause death. Further, where a second or subsequent child has died the death is reviewable by the coroner. If a person has been charged with an indictable offence in respect to the death, the coroner is not required to hold an inquest. **VSRFVD** Team is governed by role and responsibilities of the coroner under *Coroners Act 2008 (VIC)*. Family violence and family members are defined in accordance with *Family Violence Protection Act 2008 (Vic)*[239], whereby violence includes physical, sexual, emotional, economic abuse, threats or coercion. Perpetrators include family members, domestic partners, and relatives.[240] Non statutory elements: Team also considers meaning of family violence as per the Victorian Indigenous Family Violence Taskforce Report (2003). Team can consider cases where the offender and deceased were or had been in an intimate or familial

								relationship and if the death occurred in the context of family violence (must be both).
SA	Statute: **Coroner** *must*, as soon as practicable after completion of an inquest, give findings in writing; *may* make recs in those findings that might prevent or reduce the likelihood of a recurrence; as soon as practicable forward a copy of findings and recs to the AG and (in case of death in custody) a relevant Minister. **Ministers** and **Government. agencies** *must* respond by tabling a response in parliament within 8 sittings days of the expiration of six months after receiving a copy of the findings and recs; response must include action to be taken; response also to be forwarded to the coroner.[241]	Online	Not searchable for DV cases or recs.	Government responses are included in Coroner's Annual Report, eg 2013-2014 p32	Not by statute; but under leg mandate of *Coroners Act 2003* (SA). Work to Coroner and *SA Government. 'A Right to Safety' Chief Executive Group*	Recs included within (i.e. they inform) the Coroner's rec Section on the DV death review function in the Coroner's Annual Report to the AG, eg 2013-2014 pp9-10.		**Coroner**[242] DV cases could fall within Coroner's investigatory remit, falling under violent, unnatural or unknown cause death. However, if a person has been charged in criminal proceedings with causing the event that would be subject to an inquest, the court may not commence or proceed with the inquest until the criminal proceedings have ended. **SA Senior Research Officer (DV)** works as part of Coronial investigation team (under *Coroners Act 2003 (*SA) and works out of the SA Office for Women. Includes homicide, suicide and homicide/suicide. Definition of domestic violence based on *Intervention Orders (Prevention of Abuse) Act 2009* (SA)[243]. Abuse includes physical injury, psychological or emotional harm, economic abuse. Relatives include domestic partners, spouses or others in intimate relationships, child, stepchild, grandchild or under guardianship, brothers or sisters, other relations either through blood, marriage, domestic partnership or adoption, for Aboriginal and Torres Strait Islander kinship rules are recognised as part of family group, carers.
QLD	Statute: **Coroner** *may* comment on anything connected with a death that relates to public health or safety, administration of justice or ways to prevent similar deaths in future; if a Government entity deals with matters to which comments relate, ***must*** give a copy of comments to the relevant Minister, the AG and CEO of the entity.[244] Policy: **Government** to publish its responses in an annual report (incl. responses by Government agencies, incl. Queensland police).[245]	Online	'Catchwords' indicate if DV-related or if recs have been made	Department. of Justice website contains links to Annual Reports which contain responses to coronial recommendations	Not by statute; but under leg mandate of *Coroner's Act 2003* (Qld).	Recs included (i.e. they inform) the Coroner's recs		**Coroner** DV cases could fall within Coroner's investigatory remit, falling under violent, unnatural or unknown cause death An inquest must not start or must be adjourned if a person is charged with an indictable offence relating to the death[246] **DFVDRU** Under functions of Coroner. Cases referred on basis that they meet definitions in *Domestic and Family Violence Protection Act 2012 (QLD)*[247] Domestic violence is defined as per *Domestic and Family Violence Protection Act* 2012 (QLD). DV is defined in s8 (physical, emotional, economic, psychological abuse, threats or coercion).[248] Relevant relationships include intimate personal relationship, family relationship, informal care relationship
WA	Statute**:** **Coroner** *may* comment on any matter connected with a death investigated; where death is of a person in care, ***must*** comment on quality of supervision, treatment and care of the person.[249]	Online Also, Department. of Health has Inquest findings	Not searchable for DV cases or recs.	Responses to all coronial recommendations are published on coroner's website, next to the finding. Responses to coronial recommendations regarding deaths of	Not by statute but under leg mandate of the *Parliamentary Commissioner Act 1971* (WA).	In WA Ombudsman's Annual Report and Ombudsman's Major	2012-2013 2013-2014 Ombudsman's Major Investigation Reports	**Coroner** DV cases could fall within Coroner's investigatory remit, falling under violent, unnatural or unknown cause death An inquest cannot proceed where a person has been charged with an offence in which the question of

	Must report annually to AG on deaths investigated in each year, including a specific report on the death of each person held in care.[250] **The State Coroner** *may* make recommendations to the AG on any matter connected with a death investigated;[251] However, in practice, relevant agencies are informed in writing in respect of all recommendations. **Government (AG)** *must* table Coroner's annual report in Parliament within 12 sitting days of receiving it.[252] Policy: Nothing on internet re central government policy on responses; Department. of Health publishes an annual report with recommendations and Department. responses, *From Death We Learn* (the most recent one was 2014). Department. of Health has a Unit and a Coronial Review Committee.	re relevant deaths online		persons held in care are also published as Annexures in Coroner's Annual Reports, found in 'Publications' on Coroner's website.		Investigation Reports	2015	whether the accused person caused the death is in issue until proceedings have been concluded. **Ombudsman** Investigates family violence deaths as part of Family and DV Fatality Review. Definitions as per *Restraining Orders Act 1997* (WA).[253] Violence includes assault, kidnap, property damage, intimidation or offensive or emotional abuse, pursuing with intent to intimidate. Relationships include people that are married, in de facto relationship, related to each other, children, or other intimate or personal relationships
TAS	Statute: **Coroner** *must* make recs with respect to ways of preventing further deaths and on any other matter the coroner considers appropriate; *may* comment on any matter connected with the death; *must* report on the care, supervision or treatment of a person who died while in custody or in care or escaping from prison, mental health unit, detention or police custody.[254] *May* report to AG on a death; *may* make recs to AG on any matter connected with a death; *must* report to AG if the coroner believes that an indictable offence has been committed.[255] **Chief Magistrate** *must* report to AG annually including details of deaths of persons held in custody and findings and recs made by coroners.[256] **AG** *must* table in Parliament the annual report from Chief Magistrate within 10 sitting days of receiving it.[257] Policy: nothing on internet re central government policy on responses.	Online	Not searchable for DV cases or recs.	Not obvious. Not on Coroners website, Magistrates Annual Reports or Justice Department's Annual Reports.	NA	NA	NA	**Coroner**[258] DV cases could fall within Coroner's investigatory remit, falling under violent, unnatural or unknown cause death Inquest should be adjourned if criminal proceedings are in progress re: death[259]
NT	Statute: Re deaths in custody, **Coroner** *must* investigate and report on care, supervision and treatment of person in custody; *may* investigate and report on matter connected with public health or safety or administration of justice relevant to the death; *must* make recs re the prevention of future similar deaths as considered relevant.[260] *Must* give a copy of reports and recs to AG 'without delay'.[261] *May* report to AG on a death or disaster; *may* make recs to AG on a matter connected with a death or disaster investigated by coroner; *must* report to	Online	Not searchable for DV cases or recs.	Not obvious. Responses tabled in parliament	NA	NA	NA Other: Most recent relevant case found here (April 2012)	**Coroner** DV cases could fall within Coroner's investigatory remit, falling under violent, unnatural or unknown cause death

	Commissioner of Police and Director of Public Prosecutions if coroner believes that a crime may have been committed.[262] **AG** *must* without delay give a copy of report or rec under s27 or s35 to CEO of an Agency or Commissioner of Police (where a comment in a report or rec relates to the agency or police); *must* without delay give copy of report or rec to Cth Minister responsible for a relevant department or agency.[263] **CEO of Government agency** and **Commissioner of Police** must report to the AG with action to be taken within 3 months.[264] **AG** must, after receiving the response from the CEO or Commissioner of Police, report on the Coroner's recommendations and the response without delay, and table that (AG's) report in Parliament within 3 sitting days after completing the report.[265]							
ACT	Statute: **Coroner** *must* say in findings whether a matter of public safety is found to arise and if it is, comment on the matter; *may* comment on any matter about the administration of justice connected with the inquest or inquiry.[266] **Coroner** *may* report to AG on an inquest or an inquiry into a fire; *must* report to the AG on an inquiry into a disaster; must give a copy of a report to the AG to the responsible minister as well.[267] **AG** *must* table report from Coroner and responsible Minister and AG's response in Legislative Assembly within 6 months.[268] **Coroner** *must* report to AG, the custodial agency, the Australian Institute of Criminology, the ALS (if relevant) on an inquest into a death in custody.[269] Re death in custody, **custodial agency** *must* **respond** to findings to the Minister responsible for the agency within 3 months, incl. statement of action. **Minister responsible** for the agency *must* give copy of response to Coroner; **Coroner** *must* give copy to each person/agency to whom the report was originally given under s75.[270] **Coroner** *must* give AG annual report within 6months of end of financial year detailing reports, notice, recommendations, and responses of agencies. The Coroners Annual Report is to be tabled in parliament.[271]	'Selected findings' online	Not searchable for DV cases or recs.	In Coroner's Annual Reports there is section 'Responses of agencies under s76'. Latest Annual Report online is 2010-11.	Not by statute; Family and Domestic Violence Prevention Council given the function to commence mid-2015.	NA	NA	**Coroner** DV cases could fall within Coroner's investigatory remit, falling under violent, unnatural or unknown cause death. Circumstances re: investigations while criminal proceedings are in place[272]

Appendix B

Chart A - responses from all jurisdictions where the death review function exists

QUESTION	NSW	QLD	WA OMBUDSMAN	WA CORONER	SA	VIC
1.2 Why was a domestic and family violence death review team or function established in your jurisdiction? In brief, can you describe the process of its establishment?	Following the establishment of domestic violence death review mechanisms in a number of overseas jurisdictions throughout the 1990s – and on the back of significant local advocacy – in late 2008 the NSW Government announced the establishment of the Domestic Homicide Advisory Panel to consider the issue of establishing a domestic violence fatality review process in NSW. In mid-2009 the Panel handed down its report, unanimously recommending that a permanent domestic violence death review mechanism be established in NSW and setting out the essential functions and features of such a review mechanism. In July 2010 the *Coroners Amendment (Domestic Violence Death Review Team) Act 2010* commenced, amending the *Coroners Act 2009* (NSW) with the insertion of Chapter 9A thereby establishing the NSW Domestic Violence Death Review Team (the Team). Additional information relating to the background of the Team is set out in the Team's 10/11 Annual Report (at http://www.coroners.justice.nsw.gov.au/Documents/dvdrt_annual_report_oct2011x.pdf)	The Queensland Domestic and Family Violence Death Review Unit (DFVDRU) was established as a trial in 2011 stemming from the report of the Domestic and Family Violence Death Review Panel (2010) http://www.communities.qld.gov.au/resources/communityservices/violenceprevention/deathreviewpanel.pdf . In 2012 it became a permanent function within the Office of the State Coroner, and in 2015 the function has been expanded as part of the implementation of recommendations from the Special Taskforce on Domestic and Family Violence Final Report 'Not Now, Not Ever: Ending Domestic and Family Violence in Queensland.'	The WA Strategic Plan for Family and Domestic Violence 200913 set out a number of principles to address family and domestic violence. The associated Annual Action Plan 200910 identified a range of strategies including 'a capacity to systematically review family and domestic violence deaths and improve the response system as a result'. The Annual Action Plan 200910 sets out 10 key actions to progress the development and implementation of the integrated response in 200910, including the need to 'research models of operation for family and domestic violence fatality review committees to determine an appropriate model for Western Australia'. Following a Government working group process examining models for a family and domestic violence fatality review process, the Government requested that the Ombudsman undertake responsibility for the establishment of a family and domestic violence fatality review function. At the time of this request, the Ombudsman had been undertaking a function to review certain child deaths since 30 June 2009. On 1 July 2012, the Ombudsman's Office commenced its family and domestic violence fatality review function.	The Office of the State Coroner does not have a DVDRT. This function is undertaken by the Western Australian Ombudsman.	Over the past 15 years, in South Australia (as with most other jurisdictions), there has been considerable advocacy from the nongovernment and women's sectors to raise awareness and recognition of the killing of women in domestic violence relationships. This advocacy also called for the establishment of a review mechanism to assist in preventing the killing of women in the context of domestic violence. In response to election commitments made by the South Australian Government, the Office for Women and the SA Coroner's Court established a partnership to both research and investigate open coronial cases of domestic violence related deaths. The position of Senior Research Officer [Domestic Violence] commenced in January 2011.	In March 2006, the Victoria Law Reform Commission(VLRC) released the Review of Family Violence Laws report. This was produced following a wide-reaching community consultation and comprehensive review of the justice system's response to family violence. The VLRC noted that both in Australia and internationally, a substantial proportion of homicides occur in a context of family violence. In response, it was reported that countries such as the United States of America and Canada had established death review processes within their respective jurisdictions. Giving consideration to the various models of operation that were in place internationally, the VLRC recommended that in consultation with the State Coroner, the State-wide Steering Committee to Reduce Family Violence investigate and make recommendations to the government regarding the establishment of a family violence death review process in Victoria. Following consultation with government and other key stakeholders, it was determined that a death review process would be established in the coronial jurisdiction. Key to this decision was the independence and experience of the coroner in conducting death investigations, coupled with their ability to formulate recommendations aimed at preventing similar deaths from occurring. The Victorian Systemic Review of Family Violence Deaths (VSRFVD) commenced operation in 2009. The VSRFVD is led by the State Coroner and situated within the

						Coroners Prevention Unit (CPU) of the Coroners Court of Victoria (CCOV). Accordingly, the *Coroners Act 2008* (Vic), which governs the role and responsibilities of the coroner and the operations of the court, serves to define the ambit and sphere of influence of the VSRFVD.
QUESTION	NSW	QLD	WA OMBUDSMAN	WA CORONER	SA	VIC
1.3 What are the core functions of your death review team? Are there additional functions that could optimise the work of the team?	Section 101F(1) of *the Coroners Act 2009* (NSW) sets out the functions of the Team, as follows: a) Review closed cases of domestic violence deaths occurring in NSW b) To analyse data to identify patterns and trends relating to such deaths c) To make recommendations as to legislation, policies, practices and services for implementation by government and nongovernment agencies and the community to prevent or reduce the likelihood of such deaths d) To establish and maintain a database (in accordance with the regulations) about such deaths e) To undertake, alone or with others, research that aims to help prevent, or reduce, the likelihood of such deaths. There are no additional functions that would optimise the work of the Team.	The existing function of the DFVDRU has been to assist coroners in their investigations of domestic and family violence related deaths. As a result of recent amendments it will also provide a secretariat function to an independent, multidisciplinary Domestic and Family Violence Death Review and Advisory Board (DFVDRAB), which will be responsible for making recommendations that aim to prevent or reduce domestic and family violence related deaths to the Minister, for implementation by government and nongovernment agencies.	The family and domestic violence fatality review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce family and domestic violence fatalities. The Ombudsman has a number of functions in relation to the review of child deaths and family and domestic violence fatalities: • Reviewing the circumstances in which and why family and domestic violence fatalities occur; • Identifying patterns and trends that arise from reviews of family and domestic violence fatalities; and Making recommendations to public authorities about ways to prevent or reduce family and domestic violence fatalities.	NA	The core functions of the SRO role are to: • Identify deaths with a domestic violence context • Assist in the investigation of the adequacy of system responses and/or interagency approaches that may underpin the prevention of domestic violence related deaths • Provide advice to the Coroner's in relation to domestic violence dynamics, system responses and possible lines of coronial inquiry in relation to deaths in a domestic violence death. • Review files, provide interim reports and have specific input into Coronial Inquests which relate to domestic violence. • Develop data collection systems that can provide advice to Coronial processes and identify demographic or service trends, gaps or improvements more broadly. • Conduct specific retrospective research projects relevant to building a Domestic Violence Death Review evidence base.	The VSRFVD has five main aims, which are to: • examine the context in which family violence deaths occur; • identify risk and contributory factors associated with family violence; • identify trends or patterns in family violence related deaths; • consider current systemic responses to family violence; and • provide an evidence base for coroners to support the formulation of prevention focussed recommendations aimed at reducing non-fatal and fatal forms of family violence.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.4 Does your team consider	The Team reviews all domestic and family violence related deaths in accordance with the legislative	Yes. The criteria includes suicides of both perpetrators and victims, where there is a known history of	The Ombudsman's Office considers all deaths that occur in the context of family and domestic	NA	The scope of this position includes the examination of single	The VSRFVD also considers family violence suicides an important to the measurement of

non-homicide domestic and family violence deaths, for example, deaths by suicide or self-harm? What is your view about including these cases?	framework provided by Chapter 9A of the *Coroners Act 2009* (NSW). This includes domestic violence deaths that are the result of homicide, homicide-suicide, suicide and accidents. It is the Team's perspective that all deaths that can be attributed or causally linked to domestic violence should be reviewable by domestic violence death review mechanisms. It is noted that, to date, the Team has focused on domestic violence related homicides but that the development of case identification and review protocols in relation to domestic violence related suicide will be progressed in 2016.	domestic and family violence, but also where there is a clear link between domestic and family violence and the suicide. This may include reference to the history of abuse in a suicide note, a recent precipitating event such as a domestic and family violence related assault or recent contact with services seeking support for domestic and family violence.	violence. Information is provided to the Office by the Western Australia Police (WAPOL) after the fatality occurs, and includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner. Family and domestic violence fatalities reviewed by the Ombudsman may include non-homicide deaths such as apparent suicide. The Office is of the view that it is appropriate to include these cases.		instance suicide or intentional self-harm deaths. There is no barrier to reviewing other deaths (e.g. accidents, mixed drug toxicity) where there is domestic violence background. These type of 'out of scope' reviews are exceptional due to resource constraints. The review of suicide / ISH deaths is valuable in terms of understanding the dynamic that domestic violence may play in those deaths and subsequently informing prevention strategies.	the burden of family violence. This includes suicides where a person' exposure to family violence (as a victim and / or perpetrator) was a relevant factor in the death. For a number of reasons, these deaths are no systematically reviewed as part of the VSRFVD. Instead these deaths have been the subject of a specialist review on a case-by-case basis at the discretion of the Coroner and examined as part of a separate program of work o suicide.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.5 Does your team collect information on family and domestic violence death cases while they are subject to criminal proceedings ? Is there benefit in considering these cases concurrent with criminal proceedings ?	The legislative framework provides that the Team is to review closed cases, that is, cases where the Coroner has dispensed with or completed an inquest concerning the death and any criminal proceedings have been finally determined. Death review teams of the kind established in NSW should not review open criminal proceedings. Reviewing cases subject to current criminal proceedings could prejudice the legal process, and undermine the criminal justice system.	Yes. It means that reviews can be conducted earlier however Coroners do not make their findings into a death until criminal proceedings (and any associated appeal periods/proceedings) are finalised and the *Coroners Act 2003* prevents an inquest being held into the death while criminal proceedings are underway. The DFVDRAB will also have the capacity to review open coronial cases, while they are subject to criminal proceedings. The Board will be able to make recommendations relating to these deaths before criminal proceedings are finalised or Coroners make their findings.	WAPOL notifies the Ombudsman's Office of family and domestic violence fatalities as they occur. Reviews of the fatalities can be, and are, conducted by the Office concurrently with criminal and coronial proceedings occurring. Reviews may be finalised prior to the completion of criminal and coronial proceedings. This has the benefit of ensuring that findings of reviews and, where appropriate, recommendations about ways to prevent or reduce family and domestic violence are made in the most timely way possible.	NA	This position reviews open cases for the Coroner to determine whether an Inquest is to be held. The investigation process is conducted after the criminal proceedings have been finalised to mitigate the possibility of prejudicing the criminal justice process. The prosecution materials and investigations can be made available for the Coronial review after the criminal process is completed. S 21 (2) of the *Coroner's Act 2003* (SA) prohibits concurrent criminal / coronial investigations However, if a person has been charged in criminal proceedings with causing the event that is, or is to be, the subject of an inquest, the Court may not commence or proceed further with the inquest until the criminal proceedings have been disposed of, withdrawn or permanently stayed. Where relevant, there can be communication between investigating officers and the Coroner's Court regarding the scope and progress of the criminal investigation. Active coronial investigations should not run concurrently with active criminal investigations or proceedings because of the	See response to question 1.5. In addition, much of the material generated for the criminal investigation is provided to the coroner, including, where relevant, sentencing remarks. Sentencing remarks are an invaluable source of information about the offender, which enable the CCOV to gain an understanding of both parties involved in the incident**.**

					possibility of prejudicing the criminal process and undermining the criminal justice system.	
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.6 Does your team collect information on family and domestic violence death cases while they are subject to coronial processes? Is there benefit in considering these cases concurrent with coronial processes?	Open coronial cases are not subject to review by the multidisciplinary Team – as discussed above, the legislative framework provides that the Team only reviews closed coronial and criminal cases. The Secretariat of the Team is, however, able to assist the Coroner in reviewing open coronial cases. The benefits of informing coronial processes include that the Secretariat can assist Coroners in understanding, and recognising the complex dynamics of domestic violence through identifying these features in relevant cases. It should be noted that this kind of review process does not necessarily result in more timely recommendations.	Yes. The DFVDRU is embedded within the coronial jurisdiction so it can collect information on both closed and open cases. It also means that the DFVDRU has the capacity to provide ongoing advice to coroners in relation to what information needs to be gathered to inform their investigation.	See 1.4.	Information is collected as part of the process for investigating "reportable deaths" as defined in Section 3 of the *Coroners Act 1996*.	The scope of reviews in South Australia includes 'open' coronial cases. The DV review process is an active component of the coronial investigation process and involves: • developing investigation plans and preparation of Coronial Directions for relevant information • actively investigating the circumstances proximate to the death, the domestic violence context and service system contact. • Providing this investigation to the Coroner for consideration • assisting the Coroner where there is an inquest There are several benefits to being directly involved in the Coronial investigation: • Timeliness, the criminal proceedings may (in some cases) take some considerable time to resolve however deaths can be reviewed during the coronial process. Rather than waiting for the Coronial process to also finalise. • The compulsion to provide all documents requested • The ability under the *Coroners Acts 2003* (SA) to conduct very broad investigations including obtaining telephone records, electronic transmissions (email) and phone recordings • Transparent and independent process thereby removing the possibility of conflict of interest by the reviewer/s • Building the capacity of the Coroner's Court to	The CPU maintains a surveillance system to prospectively capture data on all deaths reported to the CCOV on a daily basis. Case identification involves the detection and preliminary classification of homicide according to the VSRFVD's inclusion/exclusion criteria. Using information provided in the Victoria Police report of death to the coroner, details about the deceased and the circumstances in which the death occurred are recorded. Deaths that appear to be a result of homicide are flagged for further investigation. This preliminary classification is reviewed and revised as more information is made available during the course of the investigation. Deaths that meet the definition of homicide are recorded in the Victorian Homicide Register (VHR). The VHR is purpose built data-set of all homicides occurring is Victoria since 2000. The VHR is used to support coroners' investigations, specifically to: • generate frequency data on the number of homicides by the deceased-offender relationship that occur in Victoria each year; • identify specific demographic groups most affected by homicide; • identify risk and contributory factors among homicide; • record the types of services both the deceased(s) and offender(s) were in contact with prior to the fatal event; an identify trends and patterns among homicides.

					conduct specific domestic violence reviews and make specific prevention oriented recommendations for service improvement relating to the prevention of domestic violence deaths The weight of Coronial recommendations and the accountability agencies have to regard them	
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.7 How are domestic and family violence deaths defined in your jurisdiction for the purposes of review? What sources are used for the definition?	The Team's definition of a 'domestic violence death' is outlined at s101B(1) of the *Coroners Act 2009* (NSW). This definition reflects the findings from the Domestic Homicide Advisory Panel and recognises that domestic violence can have both direct and indirect fatal consequences.	The DFVDRU reviews homicides, murder suicides and suicides that are identified as domestic and family violence related. For homicides, the DFVDRU adopts the definition developed through the Australian Domestic and Family Violence Death Review Network (ADFVDRN). Specific criteria are contained within the State Coroner's guidelines. http://www.courts.qld.gov.au/__data/assets/pdf_file/0017/206126/oscstatecoronersguidelineschapter7.pdf Definitions for the DFVDRAB are found in the legislation here: *Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Act 2015* (Qld)	WAPOL informs the Office of all family and domestic violence fatalities and provides information about the circumstances of the death together with any relevant information of prior WAPOL contact with the person who died and the suspected perpetrator. A family and domestic violence fatality involves persons apparently in a 'family and domestic relationship' as defined by section 4 of the *Restraining Orders Act 1997* (WA). More specifically, the relationship between the person who died and the suspected perpetrator is a relationship between two people: a) Who are, or were, married to each other; or b) Who are, or were, in a de facto relationship with each other; or c) Who are, or were, related to each other; or d) One of whom is a child who (is) Ordinarily resides, or resided with the other person; or (ii) Regularly resides or stays, or resided or stayed, with the other person; e) One of whom is, or was, a child of whom the other person is a guardian; or f) Who have, or had, an intimate personal relationship, or other personal relationship, with each other.	We do not apply a definition to domestic and family violence deaths. They are investigated as "reportable deaths".	The range of relationships and behaviours which constitute domestic abuse in South Australia are contained within the *Intervention Orders (Prevention of Abuse) Act 2009* (SA). The Australian Domestic and Family Violence Death Review Network (ADFVDRN) Homicide Consensus Statement then provides further criteria for the standard classification of cases as 'Domestic Violence Deaths' and further defines the following criteria: i) the case type; ii) the role of human purpose in the event resulting in a death (intent); iii) the relationship between the parties (i.e. the deceased offender relationship); and iv) the domestic and family violence context (i.e. whether or not the homicide occurred in a context of domestic and family violence).	A family violence homicide is defined as a death that has occurred: • as a result of external causes where such external causes were attributed, directly to indirectly, to a person through the application of assaultive force or by criminal negligence; AN between parties in an intimate, familial o family-like relationship (as defined by the Family *Violence Protection Act, 2008* (Vic)); AN in a family violence context (e.g. following an identifiable history of family violence, during o as a result of pending or actual relationship breakdown, or as a result of child custody disputes). The definition of family violence adopted for the purpose of the VSRFVD is in accordance with the *Family Violence Protection Act 2008* (Vic). The Act recognises that this behaviour extends beyond physical and sexual violence, to include emotional, psychological, social or economic abuse. Conceptualising family violence in this way promotes consideration of the wide range of actions and behaviours that constitute the spectrum of violent behaviour. The VSRFVD also incorporates the definition of family violence

			'Other personal relationship' means a personal relationship of a domestic nature in which the lives of the persons are, or were, interrelated and the actions of one person affects, or affected the other person. 'Related', in relation to a person, means a person who – a) Is related to that person taking into consideration the cultural, social or religious backgrounds of the two people; or b) Is related to the person's – (is) Spouse or former spouse; or (ii) De facto partner or former de facto partner. If the relationship meets these criteria, a review is undertaken.			provided by the Victorian Indigenous Family Violence Taskforce, which recognises harm done to kinship networks and communities by family violence. The definition of a family member used for the purpose of the VSRFVD is also drawn from the *Family Violence Protection Act 2008* (Vic). The VSRFVD utilises this definition in order to classify the deceased-offender relationship and for the purpose of case identification an inclusion. In addition to intimate and biological connections, Indigenous notions of kinship and caregiver who are considered to be 'family like' fall within the ambit of the VSRFVD.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.8 Is there a statutory basis for your death review team? Is a statutory basis desirable? Why/why not?	As noted above, the Team is established under Chapter 9A of the *Coroners Act 2009* (NSW). A strong legislative basis was identified by the Homicide Advisory Panel as a critical element for an effective domestic violence death review mechanism. A statutory basis is desirable as this includes the ability to call for information, confidentiality provisions, outlines monitoring requirements in relation to recommendations, and otherwise empowers and supports the Team in a legislative way.	Legislation was recently enacted to establish the DFVDRAB under the *Coroners Act 2003.* *Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Act 2015* The DFVDRU itself does not have a statutory basis. Records used in the death review process are obtained under the *Coroners Act 2003*. Under this Act, Coroners have the power to make recommendations aimed at preventing these types of deaths for those matters that proceed to inquest.	The statutory basis for the family and domestic violence fatality review team is the *Parliamentary Commissioner Act 1971* (WA) and the *Royal Commissions Act 1968* (WA). These Acts give the Ombudsman a full range of powers, including all the powers of a Royal Commission to undertake reviews.	N/A	The DV death review process is based in the Coroner's Court and is enabled by the consent of the Coroner to allow researchers access to court records *Coroners Act 2003* (SA) S 38 There have been no impediments to the review process due to a lack of specific legislation enabling it. The *Coroners Act 2003* (SA) provides all of the powers and protections necessary for this type of review. Including: • Compulsion to provide/give evidence • Extensive powers of investigation • Inquests may review more than 1 case or event where there are similarities to explore • Protection of reviewers from civil liability • Ability to make Coronial recommendations and direct them to the highest levels The Coronial jurisdiction also captures all of the deaths required	No, however the *Coroners Act 2008* (Vic), which govern the role and responsibilities of the coroner and the operations of the court, serves to define the ambit and sphere of influence of the VSRFVD. It may be desirable to have a statutory basis for the VSRFVD if it was to remain within the Coroners Court o Victoria. This would ensure the sustainability of the VSRFVD.

					for review (e.g. all unnatural or violent deaths are reportable). Being part of the Coronial team allows access to the local and national Coronial Information Systems. The *Intervention Orders (Prevention of Abuse) Act 2009* (SA) provides the State definitions of relationship and behaviours and a separate legislative definition is not required. Not having specific legislation allows for the review process to be flexible and evolve it's processes without requiring legislative change to enable that. The inclusion of this position/review mechanism in the SA A Right To Safety agenda embeds it within the strategic policy landscape of the state. This provides a level of protection for the continuity of the process without enshrining it in legislation. The advisory elements of this position sit outside of the review process and so legislation is not required to constitute an advisory group or committee. There does not appear to be a need for specific legislation to be drafted regarding the SA review process.	
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.9 Under what body does your death review team sit? Describe the benefits or challenges to this arrangement	The Team is established pursuant to the *Coroners Act 2009* (NSW) and reports directly to NSW Parliament, that is, the Team does not report directly to a Minister. The Team is an agency within the NSW Department of Justice. There are no specific benefits and challenges to this arrangement.	The DFVDRU sits within the Office of the State Coroner embedded within the Department of Justice and Attorney General. The DFVDRAB is an independent body that is supported by the DFVDRU.	The family and domestic violence fatality review team are employees of the Office of the Ombudsman and operate under the delegated authority of the Ombudsman. This arrangement has a number of benefits, including: the capacity to undertake major own motion investigations into issues associated with family and domestic violence fatalities; operating with the powers of the Office of the Ombudsman (including the powers of a Royal Commission); peer and management expertise and support available to a team as part of a large office; and the scale and scope economies that	N/A	The position of Senior Research Officer (Domestic Violence) is embedded within the SA A Right To Safety (ARTS) agenda (see attachment 1). The position therefore is embedded within the ARTS Governance Structure (See attachment 2) and reports directly into the ARTS Chief Executive Group and is informed by the Service Provision and Protection working groups. The position is funded through the Office for Women and based in the Coroners Court. This is a formal partnership arrangement. Benefits:	Working under the auspices of the coroners' jurisdiction to investigate reportable and reviewable deaths, and by virtue of the coroners' legislated focus on prevention, the VSRFVD is enabled to examine family violence-relate deaths to effect change. The strengths of this approach are that: • family violence related deaths meet the definition of a reportable death under the *Coroners Act 2008* (Vic); • coroners have a range of powers to compel information; • the coroner's death investigation process

			would not be available to a very small stand-alone team. The Ombudsman is an independent and impartial statutory officer. The Ombudsman is responsible to the Parliament and does not report to the government of the day or a particular Minister.		• Access and reporting to the State Executive e.g. Minister and Chief executives • Being embedded within the state agenda give the review legitimacy and context • The Coronial process is independent and therefore conflict of interest does not arise as it may in a multiagency review team • Ability to build the capacity of the Coronial process to encompass DV • Ability to influence the Coronial process while it is alive and therefore provide submissions regarding prevention/service provision aspects. • Ability to access expertise across Government and nongovernment agencies through collaboration with the ARTS working groups. • Ability to provide feedback regarding emerging trends/practice issues to key Government and Nongovernment service providers through the working groups. • The review work contributes to the work of the Coroner's Office but is also embedded in the policy arm of the state and therefore has influence beyond recommendations. Challenges: Resources this is resource intensive work and timeliness of review can be dependent on resource availability The partnership in SA is very strong and effective, if that partnership was not strong there could be conflict of interest at times for the researcher.	provides an opportunity to obtain direct insight into the circumstances that precede a family violence related incident; • the CCOV is a specialist independent inquisitorial court which ensures an open and transparent review; • the legislative framework enables the coroner to make comments and recommendations on an matter connected with the death including public health or safety; and the legislation requires public statutory authorities and entities to respond to the coroners' recommendations, which must be published.

QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.10 What is the staffing and resource model for domestic and family violence death review functions in your jurisdiction? Is this model adequate? What changes, if any, would you recommend to improve your staffing and resource model?	The Team is constituted by a secretariat of two: a Manager and a Research Analyst. The Team is comprised of 12 government, two nongovernment representatives and two sector experts. Nongovernment representatives are entitled to minimal remuneration. The Team has protected and recurrent funding of $500,000 annually. The current resourcing and staffing model is adequate.	With the recent changes the current staffing model for the DFVDRU includes 1 x Manager, 1 x Principal Researcher and Coordinator, 2 x Senior Advisors and 2 x Administrative staff. This extends the previous staffing structure which was 1 x Principal Researcher and Coordinator and 1 x Senior Advisor.	The Review Team within the Ombudsman's Office conducts reviews of certain child deaths and family and domestic violence fatalities. The Review Team consists of an Assistant Ombudsman, a Director, a Principal Aboriginal Liaison Officer, and a number of Principal Investigating Officers/Investigating Officers reporting to the Ombudsman. This model is considered to be adequate and appropriate.	N/A	There is 1FTE dedicated Senior Research Officer assigned to review these deaths. The Office for Women and the Coroner's Court provide various in kind and support/advice functions to the SRO. The review process could be enhanced by the addition of another research office or analyst.	At present the VSRFVD is led by the State Coroner, who investigates the majority of family violence homicides. The State Coroner is principally support by the Manager of the Coroners Prevention Unit who is employed a 0.5FTE to manage the VSRFVD. The CPU Manager is responsible for the supervision of a 1.0 FTE Project Officer who co-ordinates case identification, initial review against the VSRFVD criteria, maintains the VHR and is secretariat for the Reference Group and Death Revie Panel. The case reviews are conducted by three other staff: a 0.6FTE Coroners Solicitor, a 0.8FTE Case Investigator and a 0.6FTE Case Investigator. The funding for this arrangement is in place until 30 Jun 2019. This model is adequate for case-by-case investigations, however it would be valuable to have additional resource for a research and evaluation. I would also be valuable to have ongoing funding for the VSRFVD.

QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.11 Does the death review model in your jurisdiction include a multidisciplinary reference group? Is there benefit to a reference group guiding the work of the team?	The Team is comprised of 16 government and nongovernment representatives. These include representatives from NSW Health, NSW Police Force, Department of Education and Communities, Ageing, Disability and Homecare, Family and Community Services, Corrective Services, Aboriginal Affairs, Women NSW, Juvenile Justice and Housing NSW. The benefits are that the Team encourages interagency collaboration.	Yes. As previously mentioned a DFVDRAB is being established. In the early stages of the original implementation of the DFVDRU in 2011 there was an Advisory Group, however this was dismantled in 2012 when the unit became permanent.	The Ombudsman's Advisory Panel is an advisory body established to provide independent advice to the Ombudsman on: • Issues and trends that fall within the scope of the family and domestic violence fatality review function; • Contemporary professional practice relating to the safety and wellbeing of people impacted by family and domestic violence; and • Issues that impact on the capacity of public authorities to ensure the safety and wellbeing of individuals and families.	N/A	In SA open coronial cases are reviewed. This means that the matter is still before the court and so it is not appropriate to have other agencies (potentially involved in the matter) to be involved in the review. This review process allows for the SRO to seek advice on current/past practice, policy contexts or models/frameworks from various government and nongovernment agencies and practitioners from various disciplines. This is through the membership of the ARTS working parties and connection with the Family Safety Framework Implementation Committee. The Court can also seek expert opinion or have a matter	Expert advice and consultative support is provided to the VSRFVD by a Reference Group. The Reference Group assists in the identification of system wide issues pertaining to family violence, as well as advising on policy and program developments occurring at a local, state and national level. The wealth of collective knowledge and experience held within the Reference Group is a significant resource to the VSRFVD. The Reference Group is comprised of members from both government and non-government organisations, including Koori family violence services; legal services, police, and the Magistrates' Court; culturally an linguistically diverse services;

			In 201415, among other things, the Panel provided advice to the Ombudsman regarding the first major own motion investigation in relation to family and domestic violence fatalities.		overviewed by an expert to provide advice. Once the full SA data set is captured, it could be beneficial to have a broader team review the data and extrapolate trends or broader recommendations.	disability, health and welfare organisations; academics and policy analysts.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.12 Is advocacy required to optimise domestic and family violence death review systems and resources in your State or Territory?	No.	Yes. Both the DFVDRU and the DFVDRAB were established as a result of strong community and sector support and advocacy.	Resources to undertake the Ombudsman's role are considered appropriate.	N/A	Unsure – it would depend what 'advocacy' looked like or what was being suggested.	This has been helpful at times when the VSRFVD was not supported by additional funding to the CCOV.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.13 What databases do you use to source information on domestic and family violence deaths in your jurisdiction ?	The Secretariat derives information from the Criminal or Coronial Brief of Evidence, and uses court databases (Caselaw, JusticeLink, JIRS) and police databases (COPS database) to identify cases for inclusion and collect case review information. The Team is also empowered to call for information from government and nongovernment agencies in relation to cases subject to review. The Team also has access to NCIS, but these databases do not provide reliable information in relation to domestic and family violence context.	The DFVDRU maintains a database on domestic and family violence related deaths that have occurred in Queensland since 2006. For individual deaths, information is sought from agencies where it is identified that the deceased and/or perpetrator has had contact in relation to domestic and family violence. This may include the police, health, social services or courts.	The Ombudsman is able to access all relevant databases using the powers contained in the *Parliamentary Commissioner Act 1971* (WA) and the *Royal Commissions Act 1968* (WA). These include the relevant information contained in databases of Western Australia Police, the Department for Child Protection and Family Support and the Department of Health. The Ombudsman may also request relevant data held by Courts.	We do not have a dedicated database. Western Australian data is maintained on the National Coronial Information System (NCIS).	• The National Coronial Information System • SA Coronial Information System • Coroners Domestic Violence Information System (purpose built data system to house specific DV death review information) • Homeless to Home data base (housing and domestic violence service information system) Police Information Management Systems information is provided upon request.	The Victorian Homicide Register and Austlii.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.14 How do you report findings and recommendations in your jurisdiction ? Describe both formal	The Team reports its findings and recommendations annually to NSW Parliament. The Team does not report informally.	For the DFVDRU for cases that go to inquest, findings are published on the courts website and distributed via existing networks. DFVDRU activities and statistics are reported annually in the OSC Annual Report. Coroners also have the discretion to publish non inquest findings if they	Findings and recommendations, where appropriate, in relation to family and domestic violence fatality reviews are reported to the relevant State Government department or authority. The relevant Minister is informed of any recommendations. The Ombudsman reports annually to Parliament on his responsibility	Inquest findings appear on the website of the Coroner's Court of Western Australia. Findings and recommendations are reported to the relevant Minister and incorporated by the State Coroner in the Annual Report to the Attorney General, which is tabled in the WA Parliament and appears on the website.	Findings and recommendations are released publically by the Coroner at the completion of an Inquest. Findings and recommendations are tabled at the ARTS Chief Executive Group and ARTS working groups	Coroners' findings without recommendations may be reported on the CCOV's website at the individual discretion of the coroner, taking into account the wishes of the family. There may be circumstances where families request that findings not be made public due to cultural belief systems and to protect living

and informal processes.		consider it is in the public interest to do so. The DFVDRAB is required to the Minister annually on their activities and preventative recommendations.	to review family and domestic violence fatalities including, among other things, information on demographics, risk factors and social and environmental characteristics of family and domestic violence fatalities, identified patterns and trends relating to those fatalities and improvements to public administration. Annual reports can be found on the Ombudsman's website, at: http://www.ombudsman.wa.gov.au/Publications/Annual_Reports.htm. The Ombudsman also reports findings and recommendations arising from family and domestic violence fatality reviews to Parliament (and the public) through reports on major investigations. The Ombudsman will table a major investigation into issues associated with family and domestic violence in 2015. The report of the investigation will be provided to the Australian Human Rights Commission upon tabling. Reports of the Ombudsman's major investigations can be found on the Ombudsman's website at: http://www.ombudsman.wa.gov.au/Publications/Reports.htm.		Findings and recommendations are tabled at the ARTS working group Findings and recommendations are presented in public forums including conferences, forums, seminars, symposiums and to relevant executive and staff groups within SA.	persons, particularly children of the parties involved. Where a finding is made with recommendations, the CCOV is required to publish the finding on their website. In some circumstances, the finding may be redacted to protect the identities of living persons, most often children. Annually, the activities of the VSRFVD are reported in the CCOV's annual report.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.15 What is the process for governments and agencies to respond to coronial findings and recommendations? Is it adequate?	Women NSW convenes a Whole of Government response to the Team's report after it is tabled in NSW Parliament. Governments and agencies work with Women NSW in responding to the Team's recommendations. The Team monitors recommendations in its Annual Report, including responses to recommendations and information regarding implementation.	Government agencies are required to report on coronial recommendations annually to the Department of Justice and Attorney General and a report is tabled in the Parliament by the Attorney-General – this is an administrative arrangement only. The recent amendments require that progress on the implementation of DFVDRAB recommendations to be reported annually to the Minister in an Annual Report.	The *Parliamentary Commissioner Act 1971* (WA) provides for the process to respond to recommendations of the Ombudsman that have not been agreed by State Government departments and authorities. Following, where appropriate, an opportunity to be heard in relation to a review/investigation report, recommendations are provided to State Government departments and authorities. During the term of the current Ombudsman, 100% of the Ombudsman's recommendations have been agreed. The Ombudsman also monitors the implementation of recommendations and periodically reports to Parliament on this	There are currently no provisions in the *Coroners Act 1996* to compel responses.	Where the death is a death in custody, a report from the Attorney General must be tabled in Parliament within 6 months of the release of the findings. Other recommendations made are directed to the highest level possible e.g. Premier, Ministers, Commissioner of Police. Each Government agency has some mechanism for receiving and processing the recommendations, however, there is no mandated/legislated requirement to report on responses to recommendations. Through the ARTS structure, recommendations are tabled and accounted for at the CE level. It would require changes to the *Coroners Act 2003* (SA) to	Any public statutory authority or entity directed a recommendation must respond in writing within three calendar months about what action has or will be taken. This response, as well as the coroners' finding, must be published on the CCOV's website. There are varying views about the adequacy of this process. On the one hand there is the view that this process is adequate because it affords the public statutory authority or entity the necessary discretion to make changes and given the exchange is on the public record, a level of accountability is implied. On the other hand, there is the view that the CCOV should be monitoring the implementation of recommendations. This is beyond the current mandate of the CCOV

			monitoring. These processes are considered adequate.		enforce agencies to formally respond to recommendations (as in Victoria and NSW). This mechanism could improve accountability and transparency for the public regarding the progress (or not) of any recommendations.	and the implementation of previous recommendations are often followed up when a subsequent similar death occurs. In this way, there is an ad hoc monitoring function.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.16 What is the process to monitor, track and review government and agency responses to findings and recommendations? Is it adequate?	The Team monitors recommendations, responses and implementation in its Annual report. This is adequate.	Government agencies are required to report on coronial recommendations annually to the Department of Justice and Attorney General and a report is tabled in the Parliament by the Attorney-General – this is an administrative arrangement only. Progress on the implementation of the DFVDRAB recommendations will be reported annually to the Minister in an Annual Report.	Recommendations arising from the Ombudsman's reviews and investigations are monitored by the Ombudsman to ensure their implementation and effectiveness. This monitoring includes requesting relevant State Government departments and authorities to provide detailed information regarding the implementation and effectiveness of findings, the response to recommendations and the provision of evidence to support this information, and the Ombudsman analysing and assessing this information. The results of this monitoring are periodically reported to Parliament.	The responses are voluntary. The system is monitored by the State Coroner and responses appear on the website, next to the relevant finding.	The Governance structure of the ARTS agenda enables recommendations to be discussed, actioned and tracked at an Executive level.	See response to 1.14.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.17 Is there evidence that your findings and recommendations are leading to improvements in systems and services aimed at preventing domestic and family violence deaths? How do you assess your progress?	The Team's recommendations are developed following in-depth multiagency review and additional consultation where necessary and in many cases implemented by the agencies targeted. More detail regarding this can be seen in the Team's 12/13 and 13/15 (forthcoming) reports. The Team continues to monitor the implementation of recommendations. Evaluating whether the implemented recommendations are 'leading to improvements' to systems and services is not within the ambit of the Team's work.	Yes. Coronial recommendations stemming from domestic and family violence related deaths have been adopted and implemented by agencies. This is particularly salient for the Inquest into the death of Noelene Beutel with relevant recommendations being supported in the Special Taskforce Report on Domestic and Family Violence. The Queensland Government has agreed to implement those recommendations, including those relating to the development of a common risk assessment framework and information sharing protocols.	Since the family and domestic violence fatality review jurisdiction commenced on 1 July 2012, the Ombudsman has identified and reported in the annual report on issues relating to the involvement of State Government departments and authorities in relation to family and domestic violence fatalities. In the Annual Report 201415, the Ombudsman also reported on improvements to public administration through the actions undertaken by public authorities to address the identified issues. In addition to reviews of individual family and domestic violence fatalities and own motion investigations, the Office uses a range of other mechanisms to improve public administration with a view to preventing or reducing family and domestic violence fatalities. These include:	There is no DVDRT at the Office of the State Coroner.	Recommendations are tracked by the SRO and the Office for Women. Over 35 DFV specific recommendations have been made across 6 Inquests. These recommendations are tabled for the Minister and the ARTS Chief Executive Group. There have been many internal agencies responses regarding training and education of staff and development of policy/procedure. Most notably (and directly linked to Coronial recommendations are: • The Implementation of the Family Safety Framework in the Murray Mallee region. • The state wide rollout of the Family Safety Framework and it being embedded as a formal state system and	This is difficult to evaluate as often systems and services are changed as a result of many factors, not just a death. Even if a system / service was changed as a direct result of the coroners' finding or recommendations, the CCOV is only provided with that information at one point in time, not on an ongoing basis. A sufficient passage of time must also elapse to measure the impact. In addition, given the relatively small number of deaths that occur, it would be problematic to determine a cause and effect relationship on a reduction in deaths. The only thing that could be measured is changes to systems / services and whether the impetus for such changes was the coronial investigation. This would require a research and evaluation component to the

			• Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties; • Through the Ombudsman's Advisory Panel, and other mechanisms, working with public authorities and communities where individuals may be at risk of family and domestic violence to consider safety issues and potential areas for improvement, and to highlight the critical importance of effective liaison and communication between and within public authorities and communities; • Exchanging information, where appropriate, with other accountability and oversight agencies including Ombudsmen and family and domestic violence fatality review bodies in other States to facilitate consistent approaches and shared learning; • Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and Taking up opportunities to inform service providers, other professionals and the community through presentations.		therefore subject to Coronial scrutiny. • The development of a serial offender Data base • The development of a corporate DFV policy framework in the Department of Correctional Services • The establishment of the Women's Safety Strategy Team in the SA Health Department • The Premiers response to the recommendations of Zarah Abrahimzadeh include his Taking a Stand policy agenda which announced: The establishment of the Women's Domestic Violence Court Support Service and a Domestic Violence Response Review process • From 10 Coronial recommendations to SA Police, through the Abrahimzadeh inquest, over 45 specific responses to practice, policy, training and multi – agency work have been developed and implemented (or being implemented). The ARTS governance structure tracks these recommendations and monitors their progress.	VSRFVD, which we currently do not have.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC

1.18 **Are there mechanisms to address reoccurring recommendations?**	Any mechanism to address recurring recommendations would be included in the Team's Annual Report to Parliament.	The DFVDRAB has the power to make recommendations to the Minister about any matter likely to prevent or reduce domestic and family violence deaths and can recommend that its reports be tabled in Parliament.	Mechanisms to address reoccurring recommendations include reporting to Parliament on reoccurring recommendations and undertaking own motion investigations on reoccurring issues underlying reviews.	Yes, staff members are instructed to make inquiry of NCIS regarding past recommendations.	No	The CPU has a recommendations database, which can be queries to determine whether a previous similar recommendation has been made.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.19 **Do you make findings and recommendations to Commonwealth agencies? Do you monitor the responses to these findings and recommendations, and if so, what is the process?**	The Team can make recommendations in relation to Commonwealth agencies, and the Team will identify issues at a Commonwealth level through its death review process. Responses to recommendations targeting Commonwealth Agencies are included in the Annual Report as with other recommendations.	The DFVDRAB will have the capacity to if considered relevant. Monitoring of Commonwealth agency responses is not currently undertaken in Queensland.	No and, therefore, not applicable.	Yes, when appropriate to do so.	Recommendations have been made to Commonwealth Agencies, however, there is no formal mandate for them to respond or comply. There is no formal process to date to track these recommendations.	Yes, and these a responded to in the same manner as any other public statutory authority or entity**.**
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.20 **How would you describe the efficacy of current systems to report, monitor and follow-up on coronial recommendations to national agencies?**	The Team makes recommendations through its Annual Reports which are tabled in NSW Parliament, including recommendations which target national government agencies (for instance, the Department of Immigration and Citizenship in the Team's 2011/12 report, and the Family Court and Federal Circuit Court of Australia in the Team's 2013/15 report.). The Team has a mandated monitoring function whereby the details of the extent to which its previous recommendations have been accepted and the progress thereof is to form part of the Annual Report. It is the Team's perspective that this is an efficient process to report, monitor and follow up on all recommendations made by the Team.	N/A	See 1.18.	Recommendations to Commonwealth agencies are rare. State Coroner monitors all responses to recommendations.	There is no formal process to date to track these recommendations.	This occurs very rarely and not recently in relation to family violence.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC

1.21 What steps, if any, could be taken to improve national reporting and follow-up of coronial recommendations?	The Team's establishing legislation mandates the production of annual reports which set out quantitative and qualitative analysis of domestic violence deaths; thematic commentary and recommendations derived from these analyses; and monitoring of uptake and implementation of previous recommendations. It is the Team's perspective that the production of such publically available reports is both adequate and appropriate in terms of reporting and following up the Team's recommendations	Resources to support the functioning of the existing ADFVDRN.	See 1.18.	This would best be achieved through NCIS.	Unsure	That national agencies are required to respond to State recommendations directed to them.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.22 Is there benefit in a uniform, national identification and classification framework for identifying and defining domestic and family violence deaths? Explain any benefits.	There is benefit in developing a common case identification and classification review process to analyse domestic and family violence deaths at a national level. In recognition of this benefit, the Australian Domestic and Family Violence Death Review Network was established in 2011 to: • Better understand the context and circumstances in which domestic and family violence related deaths occur; • Identify practice and systemic changes that may prevent domestic and family violence related deaths or the likelihood of such deaths occurring in the future; • Identify, at a National level, risk factors associated with, domestic and family violence related deaths; • Identify, collect, analyse and report national data concerning domestic and family violence related deaths; and • Analyse and compare domestic and family violence death review findings and	We already have this under the ADFVDRN.	The Office of the Ombudsman believes there would be benefits in a uniform, national identification and classification framework for identifying and defining domestic and family violence deaths, including national consistency, quality of reporting, policy development and benchmarking.		Yes, there is benefit in undertaking this work and uniformly classifying Domestic Violence deaths. The National Domestic and Family Violence Death Review Network (NDFVDRN) has already progressed this work in relation to the standard national classification of homicides through their Homicide Consensus Statement. The Network is progressing the classification of DV suicide deaths. The Network has also developed a standard definition of DFV homicide and Minimum Dataset Collection Protocol	Yes. These benefits have been recognised by the Australian Domestic and Family Violence Death Review Network (ADFVDR Network) and efforts have been expended to achieve this via the Homicide Consensus Statement and the national minimum dataset. The benefits of these tools are: • national and comparable statistics on the burden of family and family-violence homicide • identification and monitoring of spatio-temporal trends • identification of common risk factors • identification of factors unique to particular cohorts • development of evidence-based national family • violence prevention policy and programs • development of evidence-based local family violence prevention policy and programs

	recommendations at a National level (Network TOR attached). The Network has developed a standardised definition of domestic and family violence homicide and minimum case inclusion criteria. The definition and case inclusion criteria underpin the Network's Minimum Dataset Collection Protocol (Protocol attached).					
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.23 Is there value in establishing a purpose specific national secretariat that acts as a repository of information and data about domestic and family violence deaths? If so, do you have a view about where this secretariat should be located?	The Australian Domestic and Family Violence Death Review Network would benefit from the support of a secretariat to coordinate the collection and reporting of national data derived from the individual state and territory review processes. It is noted, however, that until those jurisdictions without a death review process have these mechanisms established, the collection and reporting of complete National data will not be possible. If secretarial support was available, it would be best located in a jurisdiction where it can work closely with members of the Australian Domestic and Family Violence Death Review Network.	Yes, potentially within one of the existing jurisdictional review mechanisms.	See 1.21 and 1.23.	This would best be achieved through NCIS.	The Network would benefit from the support of a secretariat in relations to the project work of the network and the coordinate the collection and reporting of national data. The Network Chair rotates annually and so there is no one place which would be more or less beneficial. Technologically, the secretariat could be housed anywhere there was a Network review mechanism.	If the purpose of the secretariat was to support and advance the work already undertaken by the ADFVDR Network, the Coroners Court of Victoria would support such an initiative. Ideally a secretariat function should be attached to the jurisdiction chairing the ADFVDR Network for the calendar year.
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.24 Is there value in publishing national reports on domestic and family violence deaths that consider recurring themes and actions towards making system	There is value in publishing national reports on domestic and family violence related deaths which give due consideration to common themes and issues. As noted above, this is one of the key functions of the Australian Domestic and Family Violence Death Review Network.	Yes. It is likely to bring together the collective wisdom of the different jurisdictions.	The Office notes that the National Plan to Reduce Violence against Women and their Children 20102022 suggests that 'outcomes for women and their children could be improved by governments working more collaboratively through building the evidence base, sharing information and tracking performance'. The Office considers that there would be value in publishing national reports on domestic and family violence deaths that consider recurring themes and actions	Yes the message needs to get out there to raise public awareness and the total unacceptability of domestic violence, highlight the fact that it can lead to tragic deaths and advocate in respect of recommendations aimed towards systemic improvements.	Yes, there is value in that, however, not all jurisdictions have a DFV death review mechanism and therefore a 'national' report would not be possible until then. One of the Networks key functions is to • Identify, collect, analyse and report national data concerning domestic and family violence deaths. State to State data is being prepared and will form the beginning of comparative reporting across jurisdictions.	Yes, this is crucial to advancing our understanding of family violence and informing the development and / refinement of policies and programs initiated to prevent family violence.

	improvements?		towards making system improvements.			
QUESTION	NSW	QLD	WA **OMBUDSMAN**	WA **CORONER**	SA	VIC
1.25 Other comments						Thank you for the opportunity to contribute our views to this project**.**

Chart B responses from the Northern Territory and Tasmania

QUESTIONS		TASMANIA	NORTHERN TERRITORY
The role and function of domestic and family violence death review			
1.1	Is your Government considering the establishment of a domestic and family violence death review function in your jurisdiction?	There has been no official statement that the Tasmanian Government is considering the establishment of a domestic and family violence death review function in the state, over and above the investigative and review functions performed by a coroner pursuant to the *Coroners Act* 1995. Nor has the Coroner been involved in any informal or preliminary discussions about the establishment of such a function	
1.2	What is your view about developing a domestic and family violence death review function in your jurisdiction?	Tasmanian coroners support the development of a tailored and appropriately scaled domestic and family violence death review function in Tasmania compatible with the coroner's function as the prime investigator of reportable deaths. It will improve the state's coronial practice, assist coroner's with more definitive research, enable better targeted recommendations and points of intervention in death prevention and is consistent with best practise in other states/territories.	This is a small jurisdiction and the various reportable deaths are readily apparent. There is no discernible utility in separating out the various discrete areas.
1.3	What are the views of other major stakeholders concerning the need for a death review function?	Tasmanian coroners have not had the opportunity to consult or seek the views of other major stakeholders concerning the need for a death review function. A domestic and family violence death review function was not part of the Tasmanian Government's $25.57m *Safe Homes, Safe Families: Tasmania's Family Violence Action Plan 20152020* launched in August http://www.dpac.tas.gov.au/safehomessafefamilies.	
1.4	Which stakeholders need to be approached to enhance domestic and family violence death review resources in your jurisdiction?	• Attorney-General • Tasmanian Premier • Department of Justice • Department of Premier and Cabinet • Department of Police and Emergency Management Tasmania Police • The proposed multiagency, statewide collaborative unit, *Safe Families Tasmania* • Various nongovernment agencies	
1.5	Is there a particular role for NGOs in domestic and family violence death review processes? If so, how do you envisage the role?	Unsure. There has been no consultation with NGOs re domestic and family violence death review processes and we are unsure about what sort of roles they perform in other jurisdictions. This would need further research and discussion.	
1.6	What resources are required to develop the model and establish the death review function?	• Legislation • Domestic and Family Violence Death Review Team • Staff to collect, code, analyse and report on relevant family violence death data • Physical office and IT resources	
1.7	What type of advocacy is required to establish a domestic and family violence death review system in your State or Territory?	Advocacy about the benefits and costs of a domestic and family violence death review system (and the costs of not having one) to ministers and departmental heads. Such a system is not part of the domestic and family violence discourse at the moment, as expressed through *Safe Homes, Safe Families: Tasmania's Family Violence Action Plan 20152020*. Therefore, original research and benefit/cost analysis is needed, and relatively quickly too, to get the political decision makers to commit to the establishment of a domestic and family violence death review system.	
1.8	Other comments?		

[230] *Coroners Act 2009* (NSW) s82.
[231] *Coroners Act 2009* (NSW) s101J.
[232] *Coroners Act 2009* (NSW) s101K.
[233] NSW Dept. of Premier and Cabinet, *M2009-12: Responding to Coronial Recommendations* (2009) available at http://www.dpc.nsw.gov.au/announcements/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations
[234] *Coroners Act 2009* (NSW) s101J.
[235] *Coroners Act 2009* (NSW) s6.
[236] *Coroners Act 2009* (NSW) Chapter 9A.
[237] *Coroners Act 2008* (Vic) s72.
[238] *Coroners Act 2008* (Vic).
[239] *Family Violence Protection Act 2008 (Vic)* ss5-7.
[240] *Family Violence Protection Act 2008 (Vic)* ss8-10.
[241] *Coroners Act 2003* (SA) s25.
[242] *Coroners Act 2003* (SA).
[243] *Intervention Orders (Prevention of Abuse) Act 2009* (SA) s 8.
[244] *Coroners Act 2003* (QLD) s46.
[245] Queensland Government's annual responses can be found at http://www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications
[246] *Coroners Act 2003* (QLD) s 29.
[247] *Domestic and Family Violence Protection Act 2012 (QLD)* s8.
[248] *Domestic and Family Violence Protection Act 2012 (QLD)* ss 13 – 20.
[249] *Coroners Act 1996* (WA) s 25.
[250] *Coroners Act 1996* (WA) s 27(1).
[251] *Coroners Act 1996* (WA) s 27(3), (4).
[252] *Coroners Act 1996* (WA) s 27(2).
[253] *Restraining Orders Act 1997* (WA) ss 4; 6.
[254] *Coroners Act 1995* (Tas) s 28.
[255] *Coroners Act 1995* (Tas) s 30.
[256] *Coroners Act 1995* (Tas) s 69(1)-(2).
[257] *Coroners Act 1995* (Tas) s 69(3).
[258] Coroners Act 1995 (TAS) s 3.
[259] *Coroners Act 1995* (TAS) s 25.
[260] *Coroners Act 1993* (NT) s 26.
[261] *Coroners Act 1993* (NT) s 27.
[262] *Coroners Act 1993* (NT) s 35.
[263] *Coroners Act 1993* (NT) s 46A.
[264] *Coroners Act 1993* (NT) s 46B(1)-(2).
[265] *Coroners Act 1993* (NT) s 46B(3).
[266] *Coroners Act 1997* (ACT) s 52.
[267] *Coroners Act 1997* (ACT) s 57.
[268] *Coroners Act 1997* (ACT) s 57(5).
[269] *Coroners Act 1997* (ACT) s 75.
[270] *Coroners Act 1997* (ACT) s 76.
[271] *Coroners Act 1997* (ACT) s 102.
[272] *Coroners Act 1997* (ACT) s 58A.

Chart C is a letter from the Coroner of the Australian Capital Territory**.**

CANBERRA

Office of Chief Magistrate
Law Courts of the ACT
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 62059562
www.courts.act.gov.au

Professor Gillian Triggs
Australian Human Rights Commission
GPO Box 5218
SYDNEY NSW 2001

Dear Prof. Triggs

Thank you for your request for a response to a questionnaire in respect to your investigation into the possibility of all Australian jurisdictions establishing domestic and family violence death review functions to enable national reporting on such deaths.

Having reviewed the questions, I consider that these are not appropriate matters for a judicial officer to comment on. Some of the questions go to policy and resourcing issues. Others invite the respondees to speak to the views of other persons or organisations. These are not matters I am in a position to address.

If the ACT Coroner's Court can assist in some other way consistent with our function, you are welcome to get in contact again.

I wish you well in your project.

Yours sincerely

Lorraine Walker

Lorraine Walker
Chief Magistrate
15 October 2015