

**Statutory Review of Chapter 9A of the *Coroners Act*
2009**

The Domestic Violence Death Review Team



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1. Executive Summary

This paper is a report to the NSW Government following the statutory review of Chapter 9A of the *Coroners Act 2009* (the **Review**). Chapter 9A was inserted into the *Coroners Act 2009* (the **Act**) in 2010 and established the NSW Domestic Violence Death Review Team (**DVDRT**). The creation of a domestic violence death review mechanism was recommended by the 2009 Report of the Domestic Violence Homicide Advisory Panel.¹

This Review has been conducted in accordance with s101P of the Act which requires the Attorney General to conduct a statutory review of Chapter 9A three years after its commencement.

The policy objective of establishing the DVDRT is to examine domestic violence related deaths with a view to reducing the incidence of such deaths in NSW and facilitate improvements in systems and services. The prevalence of domestic and family violence in NSW is of significant concern. In 2012, there were 29,900 domestic violence-related assaults recorded by the NSW Police Force. Approximately 125,000 incidents are reported to the NSW Police Force annually, while 300,000 additional incidents are estimated to go unreported each year. In NSW, between 1 July 2000 and 30 June 2012, there were 280 victims of domestic violence related homicide - 164 females and 116 males. Of the 164 females killed in a context of domestic violence, 129 were killed by a current or former intimate partner; and 35 were killed by a relative or kin member (including 26 girls under the age of 18 years, and nine women aged over the age of 18 years).² In 2014, female homicide victims in NSW were four times more likely than male victims to be killed by someone with whom they were in a domestic relationship.³ Significantly, the estimated cost of domestic and family violence to the NSW economy is more than \$4.5 billion annually.⁴

The purpose of the DVDRT is to review cases of domestic violence deaths in NSW and identify patterns and trends relating to such deaths. The DVDRT identifies underlying themes and systemic issues relating to domestic violence deaths in NSW and recommends improvements to reduce the likelihood of future domestic violence deaths. A key focus of the DVDRT is to promote inter-agency collaboration, cooperation and communication in order to identify systemic and procedural deficiencies.⁵ Importantly, the DVDRT multi-agency reviews provide a broader understanding of domestic and family violence related deaths than may be provided by investigations of discrete deaths, and are therefore able to inform policy and systemic change in a way that other review processes cannot.

¹ *Report of the Domestic Violence Homicide Advisory Panel, 2009.*

² NSW Domestic Violence Death Review Team Annual Report 2012/2013.

³ BOCSAR, *NSW Recorded Crime Statistics*, unpublished (BOCSAR Reference: dg1412157)

⁴ NSW Government, *It Stops Here: The NSW Government's Domestic and Family Violence Framework for Reform*, 2014, p5.

⁵ NSW Domestic Violence Death Review Team Annual Report 2011/2012, p16.

In addition, the DVDRT examines and makes recommendations about its capacity to address its founding objectives. The DVDRT's inaugural Convenor, Ms Mary Jerram, retired as the State Coroner in November 2013. She remained as Convenor of the DVDRT until the appointment of NSW State Coroner Michael Barnes on 24 March 2014. New members were appointed to the DVDRT in November 2014, following the expiry of inaugural team memberships in February 2013. Further, due to a number of factors beyond the control of the DVDRT, there was a delay in tabling the 2012/2013 Annual Report, which was tabled on 20 March 2015. The 2012/2013 Annual Report contains 23 recommendations aimed at NSW Government agencies, which identify opportunities for intervention and prevention aimed at addressing the causes of domestic violence, with a view to preventing future deaths. The Team's 2013/2015 Annual Report was tabled on 30 October 2015. It contains 15 evidence-based recommendations developed from an in-depth analysis of all closed cases of domestic violence homicide that occurred within the case review period, in combination with 12 years of data.

The future direction for the DVDRT is to continue to build on its knowledge of the context and circumstances in which domestic violence deaths occur to identify changes to practices and systems that may assist in preventing future deaths. Identification of such issues by the DVDRT is aimed at enhancing and influencing systemic change in both NSW and at a national level.

This Report considers and analyses submissions of stakeholders to the review, and concludes with a number of recommendations for reform. All stakeholders to the Review submitted that the policy objectives of Chapter 9A of the Act remain valid. There was clear support for the objectives of the DVDRT and most stakeholders submitted that the current provisions of Chapter 9A of the Act are appropriate for securing Chapter 9A's policy objectives. Some stakeholders identified specific areas for improvement, such as strengthening the ability of the DVDRT to contribute to the review of open Coronial cases and make more immediate findings and recommendations for domestic violence policy in NSW, and strengthening collaboration with the Child Death Review Team. The Review agrees and concludes that the policy objectives behind Chapter 9A of the Act remain valid and the terms of Chapter 9A remain appropriate for securing those objectives. Specific recommendations have however been identified, to further enhance the DVDRT's vital role in reducing domestic violence in NSW.

2. Recommendations

Recommendation 1

Amend the definition of domestic relationship in the *Coroners Act 2009* to align with the corresponding definition in the *Crimes (Domestic and Personal Violence) Act 2007*.

Recommendation 2

Support the Coroner's proposed enhanced role of the Secretariat of the DVDRT (defined as the Manager and the Research Analyst of the DVDRT), which will be able to, on the request of the Coroner:

- (a) Provide assistance and support as required to the Coroner in review and research concerning open coronial cases; and
- (b) Undertake research in relation to domestic violence related deaths.

Recommendation 3

Amend Chapter 9A of the *Coroners Act 2009* to better reflect the organisational structures of the Department of Family and Community Services and NSW Health, to ensure representation of the portfolios of housing, child protection, women, and ageing, disability and home care, to be nominated by the responsible Ministers.

Recommendation 4

Amend Chapter 9A of the *Coroners Act 2009* to include an additional Indigenous representative on the DVDRT, either from a NSW government agency, a non-government service provider or a sector expert.

Recommendation 5

Amend Chapter 9A of the *Coroners Act 2009* to include the Commissioner of Victims Rights as a government member of the DVDRT, as an additional representative of the Department of Justice.

Recommendation 6

Amend Chapter 9A of the *Coroners Act 2009* to require the DVDRT to report every two years to Parliament.

Recommendation 7

Note the difficulties raised by the Coroner in monitoring progress and responses from NSW Government agencies to previous DVDRT Annual Report recommendations, and consider mechanisms to monitor their implementation, including by way of a Premier's Memorandum to require Ministers and government agencies to report back to the Attorney on any action being taken to implement the DVDRT's recommendations, within a reasonable timeframe.

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3. Introduction

Background to the establishment of the DVDRT

- 3.1 Chapter 9A was inserted into the Act by the *Coroners Amendment (Domestic Violence Death Review Team) Act 2010* and commenced on 16 July 2010, establishing the DVDRT. The Chapter provides that the DVDRT must include a number of representatives from NSW Government departments and agencies and other non-government organisations.⁶
- 3.2 The Chapter sets out the functions of the DVDRT⁷, and requires the Attorney General to review Chapter 9A within three years after its commencement.⁸
- 3.3 The former Government established a Domestic Violence Homicide Advisory Panel in 2008.⁹ This was against a background, in the early 2000s, of increased campaigning for a domestic violence death review process, increasing domestic and family violence, and with support from the NSW Ombudsman's 2006 Report on *Domestic Violence: Improving Police Practice*. The Panel's role was to review domestic violence related homicides in NSW and consider the establishment of a permanent domestic violence fatality review. In its 2009 Report¹⁰, the Panel recommended establishing a domestic violence homicide review team and made a number of recommendations relating to the functions of such a team.
- 3.4 The Advisory Panel Report considered international models of domestic homicide review processes, including those in Canada, the United States and the United Kingdom. These bodies had common features of a legislative basis, government and non-government membership, and a primary focus on prevention and early intervention. As well as analysing international models, the Panel also examined existing death review mechanisms in NSW, including the Child Death Review Team (convened by the NSW Ombudsman), the NSW Ombudsman's death review powers, the NSW Coroner, the Mental Health Sentinel Events Review Committee and the Department of Community Services' Child Death and Critical Reports Unit.
- 3.5 At the same time, similar reforms in the area of domestic violence homicide reviews were occurring in other Australian jurisdictions. In November 2008, the Victorian Government established a specialist support service to assist the Victorian State Coroner in the formulation of recommendations concerning the prevention of domestic violence homicides, as well as to assist in monitoring and evaluating the effectiveness of such

⁶ Section 101E *Coroners Act 2009*.

⁷ Section 101F *Coroners Act 2009*.

⁸ Section 101P *Coroners Act 2009*.

⁹ NSW Domestic Violence Death Review Team Annual Report 2010-11, p15.

¹⁰ Report of the Domestic Violence Advisory Panel (May 2009).

recommendations. Similarly, in 2009 the Queensland Government announced the establishment of an expert panel to conduct a review of coronial investigations into deaths that occurred in the context of domestic violence. Based on recommendations provided by the panel, the Queensland Government established the Domestic and Family Violence Death Review Unit, which commenced operation in the Office of the State Coroner in January 2011.¹¹

- 3.6 Since its establishment, the NSW DVDRT has tabled four Annual Reports. In its first Annual Report of 2010/2011, the DVDRT did not make any recommendations as it was still in its establishment phase. In its second Annual Report of 2011/2012, the DVDRT made 14 recommendations in relation to improving service delivery and legislative reform. The NSW Government supported in-principle all but one of the report's recommendations. Three required legislative amendment and these were passed in October 2013.¹² These amendments related to the definition of "domestic violence death" and the membership of the DVDRT. They are discussed in further detail below.
- 3.7 The 2012/2013 Annual Report was tabled on 20 March 2015 and makes 23 recommendations for NSW government agencies. The 2013/2015 Annual Report was tabled on 30 October 2015 and makes 15 recommendations for NSW government agencies. At the time of this review, the NSW Government is considering the recommendations in the Report.
- 3.8 The DVDRT currently consists of the Secretariat, being the Manager of the DVDRT and a Research Analyst, 12 government members and four non-government members. Pursuant to the Act, the Convenor is to call meetings and the DVDRT must meet no less than four times per year.¹³ The DVDRT currently operates within a broader sphere of domestic and family violence reforms in NSW that focus on prevention, early intervention and interagency cooperation. The *It Stops Here Domestic and Family Violence Framework for Reform*, released in February 2014, aims to improve the way government agencies and non-government organisations respond to and prevent domestic and family violence across NSW. Recent reforms enable focus on the immediate needs of the victim and improved service delivery to them. Similarly, the NSW *Domestic Violence Justice Strategy 2013-2017*, one of five elements under *It Stops Here*, provides NSW justice agencies with a framework to improve the criminal justice system's response to domestic violence, with fundamental objectives to make victims safer, hold perpetrators accountable and prevent domestic violence from reoccurring. Recent reforms allow NSW police to issue interim apprehended domestic violence orders, provide for evidence of domestic violence complainants to be given by way of a pre-recorded video statement, as well as amendments

¹¹ Lyndal Bugeja, Anna Butler, Emma Buxton, Heidi Ehrat, Michelle Hayes, Sara-Jane McIntyre and Carolyn Walsh, 'The Implementation of Domestic Violence Death Reviews in Australia' (2013) 17 *Homicide Studies* 353, 363.

¹² *Crimes and Courts Legislation Amendment Act 2013*.

¹³ At the time of this Review, the NSW Government is finalising the reappointment of the non-government members, and the Team is expected to meet before the end of 2014.

to facilitate the sharing of personal information and health information about victims and perpetrators of domestic violence for the purposes of providing domestic violence support services to victims.

- 3.9 Importantly, the Federal Government's Second Action Plan of *the National Plan to Reduce Violence against Women and their Children 2010-2022* contains 26 practical actions that all governments have agreed are critical for improving women's safety. The role and function of the NSW DVDRT is consistent with Action 19 of the Second Action Plan, which notes the importance of domestic homicide reviews, to identify the sequence of events leading to domestic violence related deaths, and to identify possible gaps in system responses to develop effective intervention points.¹⁴ As prioritised in the Second Action Plan, the NSW DVDRT continues to share information with other Australian jurisdictional domestic homicide and child death reviews, and other review mechanisms. This information and data sharing enhances the review processes and drives improvements to the way Federal, State and Territory systems work together, to identify and respond to women and children experiencing domestic and family violence and to prevent future homicides.¹⁵

Policy Objectives of Chapter 9A

- 3.10 Section 101A of the Act sets out the policy objectives of Chapter 9A. The object of this Chapter is, through the constitution of the Domestic Violence Death Review Team, to provide for the investigation of the causes of domestic violence deaths in New South Wales, so as to:
- (a) reduce the incidence of domestic violence deaths, and
 - (b) facilitate improvements in systems and services.
- 3.11 All respondents to the Review submitted that the policy objectives of Chapter 9A of the Act remain valid. The DVDRT stated that the qualitative and quantitative analysis undertaken by the DVDRT in its 2011/2012 Annual Report demonstrated that the objectives remain valid. FACS submitted that the DVDRT plays an integral role in assisting government agencies to understand and help prevent domestic violence incidents and deaths. These views were echoed by other stakeholders, including DoH, which submitted that the DVDRT is crucial to raising awareness regarding the circumstances and incidence of domestic violence.
- 3.12 Domestic violence is a complex social problem that most often occurs behind closed doors. It includes behaviour occurring in an intimate or familial relationship that is violent, threatening, coercive or controlling. It usually involves a continuing course of conduct or a pattern of behaviour by the

¹⁴ Department of Social Services, *Second Action Plan 2013-2016 of the National Plan to Reduce Violence against Women and their Children 2010-2022*, pp37-38.

¹⁵ Ibid.

abuser, which instils fear in the victim. Domestic violence carries a number of social costs including homelessness, death, disability, ill health, as well as significant economic costs.

- 3.13 Deaths occurring in a domestic violence context can be the result of a pattern of escalating violence in the relationship. The purpose of the DVDRT is to collect and analyse information on domestic violence deaths in order to identify possible early intervention points and establish and improve policies, procedures and services aimed at preventing continuation or escalation of domestic violence and minimising the incidence of deaths.
- 3.14 In its 2011/2012 Annual Report, the DVDRT examined 877 closed homicide incidents (283 females; 593 males and one transgender) in NSW from 1 July 2001 to 30 June 2010. The DVDRT found that 48% of females and 17% of males were killed in a context of domestic violence. The Annual Report included a detailed and comprehensive statistical analysis of these deaths as well as in-depth reviews of all domestic violence related homicides occurring between 30 March 2008 and 30 June 2009.¹⁶
- 3.15 These reviews are valuable to the NSW Government as they present up to date and in-depth information that highlights the prevalence of domestic and family violence related deaths, which are not otherwise available. These statistics and case reviews emphasise the seriousness of this issue. Critically, the DVDRT multi-agency reviews provide a broader understanding of domestic and family violence related deaths than may be provided by investigations of discrete deaths, and are therefore able to inform policy and systemic change in a way that other review processes cannot.
- 3.16 The Review concludes that the policy objectives of Chapter 9A of the Act and the establishment of the DVDRT remain valid.

Functions of the DVDRT

- 3.17 The functions of the DVDRT are provided for in s101F(1) of the Act. They are to:
- a) Review closed cases of domestic violence deaths occurring in New South Wales,
 - b) Analyse data to identify patterns and trends relating to such deaths,
 - c) Make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths,
 - d) Establish and maintain a database (in accordance with the regulations) about such deaths,
 - e) Undertake, alone or with others, research that aims to help prevent or reduce the likelihood of such deaths.

¹⁶ NSW Domestic Violence Death Review Team Annual Report 2011/2012, pp7-8.

3.18 A “domestic violence death” is defined in s101B as:

The death of a person caused directly or indirectly by a person (the perpetrator) where, at the time of the death:

- (a) the deceased person was in a domestic relationship with the perpetrator and the death occurred in the context of domestic violence, or
- (b) the deceased person was in a domestic relationship with a person who was or had been in a domestic relationship with the perpetrator and the death occurred in the context of domestic violence, or
- (c) the perpetrator mistakenly believed that the deceased person was in a domestic relationship with a person who was or had been in a domestic relationship with the perpetrator and the death occurred in the context of domestic violence, or
- (d) the deceased person was a witness to or present at, or attempted to intervene in, domestic violence between the perpetrator and a person who was or had been in a domestic relationship with the perpetrator.

3.19 Prior to October 2013, the definition of “domestic violence death” in s101B of the Act was “a death of a person that is caused directly or indirectly by a person who was in a domestic relationship with the deceased person”. The definition was expanded to include deaths of third parties to domestic relationships following a recommendation in the DVDRT 2011/2012 Annual Report. This was to enable the DVDRT to review the death of a person who was killed by their partner’s former partner, bystanders to domestic violence and other cases of domestic violence homicide where there is no domestic relationship between the deceased and the perpetrator. The definition was also amended to add the qualification that a domestic violence death is one which occurs in the context of domestic violence.

3.20 A “domestic relationship” is defined in s101C(1) of the Act to include intimate personal relationships whether or not the relationship was sexual, relationships between people who were, or had been, married or in a de facto relationship and relationships between relatives (or, in the case of an Aboriginal or Torres Strait Islander person, between extended family or kin). A “relative” is defined broadly in s101C(2). In October 2013, minor amendments were made to the definition to ensure consistency with the amended definition of “domestic violence death” in s101B.

3.21 The DVDRT is able to review a death even if it is the subject of action by the Child Death Review Team (s101F(2)) and in relation to the death of a person outside NSW who is ordinarily a resident of NSW (s101F(3)). The Convenor of the DVDRT is able to enter into an agreement or arrangement for the exchange of information between the DVDRT and any other agency in another State or Territory with functions substantially similar to the DVDRT (s101F(4)).

3.22 When reviewing a domestic violence death, the DVDRT is to have regard to the following matters (s101G(1)):

- (a) the events leading up to the death of the deceased persons,

- (b) any interaction with, and the effectiveness of, any support or other services provided for, or available to, victims and perpetrators of domestic violence,
- (c) the general availability of any such services,
- (d) any failures in systems or services that may have contributed to, or failed to prevent, the domestic violence deaths.

3.23 This list is non-exhaustive and the DVDRT may have regard to additional matters (s101G(2)).

3.24 The DVDRT may select a domestic violence death to review, or any person may refer a closed case of a domestic violence death to the DVDRT for inclusion in a review, but the DVDRT is not obliged to accept it (s101H).

4. Statutory Review

4.1. Definition of domestic relationship

Recommendation 1:

Amend the definition of domestic relationship in the *Coroners Act 2009* to align with the corresponding definition in the *Crimes (Domestic and Personal Violence) Act 2007*.¹⁷

- 4.1 A number of stakeholders submitted that the definition of domestic relationship in Chapter 9A of the Act should be aligned with the corresponding definition in the *Crimes (Domestic and Personal Violence) Act 2007* (NSW).
- 4.2 The definition of “domestic relationship” in the Act requires an intimate relationship or some sort of familial connection between the deceased and the perpetrator. The definition of “domestic relationship” in s5 of the *Crimes (Domestic and Personal Violence) Act 2007* is broader. It captures all the relationships that are covered by Chapter 9A of the Act as well as relationships involving:
- a person who lives or has lived in the same household as the other person,
 - a person who lives or has lived as a long-term resident in the same residential facility as the other person and at the same time as the other person, and
 - a person who has or has had a relationship involving his or her dependence on the ongoing paid or unpaid care of the other person.
- 4.3 Legal Aid, DoH and FACS submitted that the definition of domestic relationship in Chapter 9A of the Act should be consistent with the definition in the *Crimes (Domestic and Personal Violence) Act 2007*. Legal Aid, DoH and FACS noted that the *Crimes (Domestic and Personal Violence) Act 2007* is however currently the subject of a statutory review and amendments may be made to the definition of “domestic relationship” as a result of that review’s recommendations.
- 4.4 While the Domestic Violence Homicide Advisory Panel 2009 Report did not recommend a complete copy of the existing definition under the *Crimes (Domestic and Personal Violence) Act 2007*, it nevertheless recommended that, for the purposes of the review mechanism, the definition of ‘domestic violence homicide’ be re-assessed at a later date. Such assessment would

¹⁷ There is currently a statutory review of the *Crimes (Domestic and Personal Violence) Act 2007* and it is proposed that the definitions will be aligned in accordance with that statutory review.

consider broadening the definition in the future to include any deaths, which may have previously been excluded.¹⁸

- 4.5 There is considerable merit in maintaining consistency and a shared understanding of domestic and family violence across NSW legislation. Further, it is anomalous for a deceased person to come within the definition of a “person in need of protection” under the *Crimes (Domestic and Personal Violence) Act 2007* but for their death not to be reviewable due to a narrower definition of domestic relationship in Chapter 9A of the Act. The Review considers there is merit in having consistent definitions of “domestic relationship” in both Chapter 9A of the Act and the *Crimes (Domestic and Personal Violence) Act 2007*.
- 4.6 The Review concludes that the definition should be aligned but that this should occur following the Statutory Review’s recommendations in relation to the definition of “domestic relationship” in the *Crimes (Domestic and Personal Violence) Act*.

4.2. Closed cases/Open cases

- 4.7 The DVDRT is presently restricted to reviewing closed cases. These are defined as cases where the Coroner has dispensed with or completed an inquest concerning the death and any criminal proceedings concerning the death have been finally determined (s101B(2)). Inquests into individual deaths may take several months or longer to be finalised and, if they are referred to the DPP for criminal charges to be considered or brought, a coronial investigation is suspended until all criminal proceedings have been finalised. As a result, considerable time may pass before a review of the death is undertaken by the DVDRT.
- 4.8 Both Legal Aid and FACS proposed that the DVDRT should be able to review cases that are still the subject of coronial investigations, as occurs in the domestic violence death review mechanisms in Victoria, South Australia and Queensland. Legal Aid and FACS stated that allowing the DVDRT to review open coronial cases would allow for a more in-depth and, importantly, timely investigation of domestic violence deaths and that a wider range of information and evidence may be sought as part of the coronial process.
- 4.9 Legal Aid referred to a particular case in South Australia where the death did not initially present as a domestic violence death, but upon further investigation was identified as occurring in a domestic violence context. The Coroner was subsequently able to make recommendations in relation to improving police responses to domestic violence. Legal Aid submitted that this capacity to review open cases could increase the responsiveness of services and agencies by reducing delays in the review process.

¹⁸ *Report of the Domestic Violence Homicide Advisory Panel, 2009, p42.*

Review of open cases in other States

- 4.10 The Review notes that the domestic violence death review processes in Queensland, South Australia and Victoria are quite different to the NSW review mechanism. Review mechanisms in those states do not have an independent statutory basis but are embedded within the coronial investigation system, acting in an advisory capacity and assisting the Coroner in the investigation process.
- 4.11 In Queensland, the Domestic and Family Violence Death Review Unit is a multidisciplinary review team, which consists of a Principal Researcher and Coordinator role, and a Senior Advisor (Child Protection), who assist the Coroner in investigations and research related to domestic violence deaths.¹⁹
- 4.12 The Victorian Systemic Review of Family Violence Deaths (**VSRFVD**) commenced in January 2009 and is undertaken by the Coroner's Prevention Unit (**CPU**), located in the State Coroner's Office. The VSRFVD is made up of one dedicated investigator, who is able to draw on the expertise of other investigators and clinicians in the Coroners Prevention Unit. The VSRFVD is involved in case identification, investigation and information gathering, and provides analysis of policies, procedures and responses to a domestic violence related death, which informs the coronial recommendations. This early review process informs and guides coroner's findings regarding improvement of existing policies and procedures.²⁰
- 4.13 The South Australian Coroner's Court and the Office for Women jointly fund a Senior Research Officer to work as part of the coronial investigation team, focussing on matters within a domestic violence context, undertaking research and investigating specific cases. The Senior Research Officer identifies service delivery and/or policy issues and relevant service systems, builds the capacity of the coronial investigation by contributing to the investigation and inquiry process and makes recommendations, identifies trends and systemic improvements that may drive inter-agency approaches to domestic violence service delivery.
- 4.14 Since the review mechanisms of other states are located within the Coroner's office, they are able to review cases while they are under investigation within the Coronial jurisdiction. However, each jurisdiction requires or permits the Coroner to suspend an investigation or inquest if or when a person has been charged with an offence in respect of a death.²¹ Accordingly, these review mechanisms, like the DVDRT in NSW, are prevented from reviewing cases when criminal proceedings are on foot.

¹⁹ Bugeja, Butler, Buxton, Ehrat, Hayes, McIntyre and Walsh, 'The Implementation of Domestic Violence Death Reviews in Australia' (2013) 17 *Homicide Studies* 353, 363.

²⁰ Queensland Department of Communities, Child Safety and Disability Services, *Domestic and Family Violence Death review Panel Report 2010*, p53.

²¹ s23 *Coroners Act 2003* (Qld), s52 *Coroners Act 2008* (Vic), s21 *Coroners Act 2003* (SA).

The model in NSW and overseas

- 4.15 The review mechanisms in Victoria, South Australia and Queensland can be distinguished from that in NSW. While the other states' review mechanisms operate as part of the coronial investigation process, the NSW DVDRT is a distinct interagency team operating independently of a coronial inquest and pursuant to its statutory mandate. Unlike the other states, the NSW DVDRT's recommendations are set out in an Annual Report that is presented to Parliament and prompts Government consideration of the recommendations made.
- 4.16 The NSW Model, while unique in Australia, is reflected in similar multi-agency domestic violence death review models in overseas jurisdictions, including Ontario and British Columbia, Canada and the New Zealand Family Violence Death Review Committee.
- 4.17 In Ontario, the Domestic Violence Death Review Committee (**DVDRC**) sits within the Chief Coroner's Office, and is a multi-disciplinary advisory committee of representatives with expertise in domestic violence from law enforcement, the criminal justice system, the healthcare sector, social services and other public safety agencies and organisations.²² The purpose of the DVDRC is to assist the Office of the Chief Coroner in the investigation and review of deaths of persons that occur as a result of domestic violence, and to make recommendations to help prevent such deaths in similar circumstances.²³ Notably, reviews are conducted by the DVDRC only after all other investigations and proceedings – including criminal trials and appeals – have been completed. As such, DVDRC reviews often take place several years after the actual incident. When a domestic violence homicide or homicide-suicide takes place in Ontario, the relevant Regional Supervising Coroner notifies the Executive Lead of the DVDRC and the basic case information is recorded in a database. The Executive Lead, together with a police liaison officer assigned to the DVDRC, periodically verify the status of judicial and other proceedings to determine if the review can commence. Since cases involving homicide-suicides generally do not result in criminal proceedings, cases are reviewed following the conclusion of coronial proceedings.²⁴
- 4.18 The New Zealand Family Violence Death Review Committee is an independent committee that reviews and advises the Health Quality & Safety Commission on how to reduce the number of family violence deaths.²⁵ There are seven non-government members on the Committee, which are selected for their expertise in mortality review systems, social science research, family violence law, child abuse and protection issues, and service provisions in the social sector.²⁶ While it is not clear whether the New

²² Office of the Chief Coroner for Ontario, *Domestic Violence Death Review Committee 2012 Annual Report*, p4.

²³ *Ibid.*

²⁴ *Ibid.*

²⁵ Family Violence Death Review Committee, *Fourth Annual Report: January 2013 to December 2013*.

²⁶ *Report of the Domestic Violence Homicide Advisory Panel*, 2009, p27.

Zealand scheme reviews open or closed coronial cases, reviews are undertaken before criminal proceedings are complete.²⁷

Consideration of proposal concerning open cases

Recommendation 2:

Support the Coroner's proposed enhanced role of the Secretariat of the DVDRT (defined as the Manager and the Research Analyst of the DVDRT), which will be able to, on the request of the Coroner:

- (a) Provide assistance and support as required to the Coroner in review and research concerning open coronial cases; and
- (b) Undertake research in relation to domestic violence related deaths.

4.19 The NSW Domestic Violence Homicide Advisory Panel 2009 Report did not make any recommendations concerning whether the NSW review mechanism should be restricted to closed cases. However, the Panel noted that if the review mechanism was given the power to review cases that were the subject of criminal proceedings, there should be appropriate protections in place to prevent prejudice to those proceedings. None of the stakeholders consulted in the Review proposed any change to the current constraint on the DVDRT in reviewing cases the subject of criminal proceedings. Nor did any stakeholder to the Review suggest that the underlying model of the DVDRT be altered.

4.20 In considering whether the DVDRT should be able to review open coronial cases, a number of issues arise, such as whether the review should report directly to the Coroner, as occurs in other jurisdictions, rather than operating as an independent parallel process. Further, there is a risk that an independent parallel review process could prejudice the coronial investigation as agencies represented on the DVDRT are also likely to be parties to coronial investigations, and their concurrent involvement in reviewing a case would undermine the independence of the coronial inquiry. Such a review process may also expose the Coroner to the perceived influence of the DVDRT members, and may give rise to a perceived or actual conflict of interest. Further consideration would need to be given to the DVDRT's existing confidential review process, which is contrasted to the coronial investigation, being a public and transparent process. As such, any process which limits this transparency could detract from the independence and impartiality required of the Coroner. The Review therefore does not support allowing the DVDRT to review open coronial cases.

²⁷ Lyndal Bugeja, Myrna Dawson, Sara-Jane McIntyre and Carolyn Walsh, 'Domestic/Family Violence Death Reviews: An International Comparison' (2013) *Trauma, Violence & Abuse* (e-publication ahead of print), p7.

- 4.21 However, in light of these concerns, the Review has considered an alternative proposal whereby the Secretariat of the DVDRT (currently, the Manager and the Research Analyst), would act in an advisory capacity in reviewing open coronial cases, and to provide assistance and support in coronial inquests, as well as undertake research in relation to domestic violence related deaths. Currently, the Secretariat of the DVDRT conducts the quantitative function of the DVDRT and conducts individual case reviews for consideration by the Team. The opportunity for the DVDRT Secretariat to provide additional assistance, research and advice to the Coroner addresses the issue raised by Legal Aid concerning the benefit of early identification of domestic violence related deaths.
- 4.22 This enhanced role will utilise the expertise of the Secretariat, to ensure earlier identification of individual domestic violence related deaths and their targeted investigation in a coronial inquiry. Importantly, this additional advisory and support role of the Secretariat will not prevent the same matters being subsequently reviewed by the DVDRT in light of its broader purview at the conclusion of the coronial inquiry and any outstanding criminal proceedings.
- 4.23 The proposal enhances the underlying model of the DVDRT, while maintaining its existing benefits of independence, specific expertise of the group and interagency cooperation. It draws on the positive features of the review mechanisms in other jurisdictions, which act as an additional resource for the Coroner, and will allow the two review processes to function together.
- 4.24 The Convenor of the DVDRT has noted his support for this expanded role of the Secretariat, which will enable the Coroner to request assistance, support and research from the Secretariat without necessarily engaging the mechanism of the DVDRT itself. Allowing the Secretariat to undertake specific research functions, at the request of the Coroner, reflects the importance of enabling Coroners to request specific relevant research from the Secretariat, drawing upon their unique expertise to identify and address systemic issues concerning domestic violence. The Convenor has noted that this enhanced function conforms to the legislative intention of establishing such a review mechanism, and will ensure that the review process achieves the policy objectives of Chapter 9A.
- 4.25 Expanding the involvement of the Secretariat in this way is intended to go some way to addressing concerns about the timeliness of identification of issues and the need to ensure meaningful and relevant recommendations by the DVDRT. The impact of the Secretariat's enhanced role, together with the experience of the Secretariat, the Coroner and the Team, will assist in any further consideration of expanding the role of the DVDRT to consider open cases. The Team in its subsequent reports to the NSW Parliament will be able to consider further ways to improve the timeliness and utility of its recommendations. The Review considers that there is currently no legislative impediment to the Secretariat undertaking this enhanced role and therefore no legislative change is required.

4.3 Risk assessments and points of intervention

- 4.26 FACS submitted that the functions of, and matters to be considered by the DVDRT, should expressly include a requirement that the DVDRT address issues of risk and points of intervention. FACS submitted that specifically addressing these issues would strengthen the DVDRT's work.
- 4.27 One of the DVDRT's legislative functions is to make recommendations regarding legislation, policies, practices and services for implementation by government and non-government agencies and the community, to prevent or reduce the likelihood of domestic violence deaths (s101F(1)(c)). In carrying out reviews of domestic violence deaths, the DVDRT is required to consider any interaction with, and the effectiveness of, any support or other services provided for, or available to, victims and perpetrators of domestic violence, and the availability of such services and any failures in systems or services that may have contributed to, or failed to prevent, the death (s101G(1)(b)-(d)).
- 4.28 In the 2011/2012 Annual Report, the DVDRT conducted case reviews of 16 closed cases from 30 March 2008 to 30 June 2009. The case review process involves a comprehensive analysis of the reviewable case, including the characteristics of the victim and perpetrator, the history of domestic violence, significant life events prior to the homicide, any domestic violence risk and vulnerability indications and service contact history. The purposes of conducting this type of qualitative analysis is to identify limitations or weakness in service delivery, make recommendations to address those limitations and develop intervention and prevention strategies to reduce the likelihood of future deaths occurring in similar circumstances. The recommendations made by the DVDRT in its 2011/2012 Annual Report specifically address risk and intervention points. For example, the Report made a number of recommendations to improve documentation by Police with respect to domestic violence related inquiries or incidents. This included proposing refined requirements under the NSW Police Force domestic and family violence Standard Operating Procedures to immediately enter certain information into their computer system, and improved communication and referrals services to victims by first response police officers, even where the victim is reluctant to pursue legal pathways.
- 4.29 The Review supports the views expressed regarding the importance of addressing risk factors and intervention points in the DVDRTs findings. However, no recommendation is required to reform the functions of the DVRT, as these are currently consistent with, and can continue to be done, within the existing legislative framework.

4.4 Impact evaluation

- 4.30 FACS submitted that there should be a legislative requirement that the DVDRT undertake an evaluation of the impact of the DVDRT in reducing domestic violence deaths. FACS noted that evidence suggests that domestic violence death review mechanisms from other jurisdictions have had a

positive impact on reducing the number and manner of domestic violence deaths.

- 4.31 While there is some merit to evaluating the impact of the DVDRT on domestic violence homicides in NSW, it must be noted that numerous other factors will always affect the number of domestic violence related deaths, such as other changes in the law and policy, as well as broader demographic, social and cultural factors that shape domestic violence rates generally. A reduction in domestic violence deaths alone should not be the measure of the effectiveness of the DVDRT. Further, the Review considers that insufficient time has elapsed since the establishment of the DVDRT to collect enough data to inform an evaluation of its overall impact on domestic and family violence, or determine whether the DVDRT has had an impact on reducing domestic violence deaths. Such an evaluation may preferably be undertaken independently, and would need to be done in the context of other domestic violence reforms currently progressing in NSW given that, as noted above, its work cannot be considered in isolation.
- 4.32 While such an evaluation may be useful in the long-term, the Review concludes that it is not necessary to include it as a specific legislative function or matter for the DVDRT to consider. The Review considers that such an evaluation could be undertaken as part of research aimed to help prevent or reduce the likelihood of domestic violence deaths in s101F(1)(e), as part of future statutory reviews of the legislation, or as part of a government response to the DVDRT Annual Report recommendations.

4.5 Collaboration with the NSW Child Death Review Team

- 4.33 The DoH submitted that opportunities should be considered for closer collaboration with the NSW Child Death Review Team (**CDRT**) to facilitate the development of consistent recommendations across the two bodies and to enable recourse to particular paediatric expertise of the CDRT.
- 4.34 The CDRT reviews the deaths of children in NSW. The purpose of the CDRT is to prevent and reduce child deaths. The functions of the CDRT are:²⁸
- to maintain the register of child deaths occurring in New South Wales that has recorded such deaths since 1 January 1996,
 - to classify those deaths according to cause, demographic criteria and other relevant factors,
 - to analyse data to identify patterns and trends relating to those deaths,
 - to undertake, alone or with others, research that aims to help prevent or reduce the likelihood of child deaths,
 - to make recommendations, arising from the CDRT's maintenance of the register of child deaths and from its research, as to legislation, policies,

²⁸ Section 34D of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths,

- to identify areas requiring further research by the CDRT or other agencies or persons.

- 4.35 Chapter 9A of the Act contemplates sharing of information between the DVDRT and the CDRT. Section 101F(2) allows the DVDRT to review a domestic violence death even though the death is or may be the subject of review by the CDRT. Section 101M(1)(c)(iv) provides an exception to the confidentiality of information acquired by a member of the DVDRT and allows information to be disclosed to the CDRT. Similarly, the CDRT is able to provide information to the DVDRT under s34L(1)(c)(iv) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. There also exist Memorandums of Understanding between the Coroner and the NSW Ombudsman in regard to information sharing between the two review bodies.
- 4.36 Collaboration between the DVDRT and CDRT is important in relation to child deaths occurring in a domestic violence context. Such collaboration is largely permitted by the provisions of Chapter 9A of the Act. Further, s101G(2) provides that in exercising its functions, the DVDRT is not limited to consideration of the matters set out in s101G(1). The DVDRT may also appoint expert advisers with relevant qualifications and expertise to advise the DVDRT in the exercise of its functions. This would enable the appointment of an advisor with particular paediatric expertise, if required.
- 4.37 Since 2002 the NSW Ombudsman has also had the responsibility for reviewing deaths of certain children, being children in care, as defined in section 4(1) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. In these reviews, the Ombudsman considers child and family involvement with government and non-government agencies, particularly those that have responsibilities relating to the health, welfare and wellbeing of children.²⁹ There is also significant overlap in the cases that are reviewed as part of this process, and the deaths of children reviewed by the DVDRT, which is again facilitated by Memorandums of Understanding regarding information sharing.
- 4.38 The Review recognises that information sharing mechanisms between the DVDRT and the NSW Ombudsman are already in place, both in legislation and in agreements between the two bodies. The Review concludes that, while no legislative change is required at this time, the DVDRT may continue to review its existing information sharing capabilities between the Coroner and the NSW Ombudsman, to ensure timely and efficient linkages and information sharing between them.

²⁹ NSW Ombudsman, *Report of Reviewable Deaths in 2010 and 2011: Volume 1: Child Deaths*, p9.

4.6 Membership of the DVDRT

- 4.39 Section 101E(2) of the Act provides that the Attorney General is to appoint the State Coroner, a Depute State Coroner or a former State Coroner or Deputy State Coroner as Convenor of the DVDRT.
- 4.40 The DVDRT is to include representatives from each of the following NSW agencies:
- the Department of Family and Community Services (**FACS**),
 - NSW Health,
 - The NSW Police Force,
 - The Department of Education and Communities (**DEC**),
 - The Department of Attorney General and Justice (**DJ**),
 - Community Services, within FACS,
 - Aboriginal Affairs, within DEC,
 - Housing NSW, within FACS,
 - Juvenile Justice NSW, within DJ,
 - Ageing, Disability and Home Care, within FACS,
 - Women NSW, within FACS,
 - Corrective Services NSW, within DJ.
- 4.41 The DVDRT is to also include two representatives from non-government service providers and two people who the Attorney General believes have appropriate expertise (s101E(5)). The Attorney General is to appoint one Aboriginal or Torres Strait Islander person who is a non-government service provider representative (s101E(6)).
- 4.42 The DVDRT must consist of at least 15 members and not more than 19 members in addition to the Convenor (s101E(7)). Schedule 3 includes provisions regarding the members and procedure of the DVDRT.
- 4.43 In October 2013, the membership of the DVDRT was expanded to include a representative from Corrective Services NSW. This was in response to a recommendation of the DVDRT in its 2011/2012 Annual Report and recognised the valuable role Corrective Services plays in the development of intervention and prevention strategies to reduce domestic violence.

4.6.1 Consolidation of FACS membership

Recommendation 3:

Amend Chapter 9A of the *Coroners Act 2009* to better reflect the organisational structures of the Department of Family and Community Services and NSW Health, to ensure representation of the portfolios of housing, child protection, women, and ageing, disability and home care, to be nominated by the responsible Ministers.

- 4.44 FACS and DoH submitted that the membership of FACS representatives on the group could be consolidated. FACS submitted that the legislation need not specifically require membership of Housing NSW (**HNSW**) and Ageing, Disability and Home Care (**ADHC**) but that these agencies could instead provide input and expertise where required. Consolidating the memberships of FACS and reducing the membership of the DVDRT would enable greater efficiency in the functions of the DVDRT by only requiring key stakeholders to attend.
- 4.45 Since providing its submission to the Review, FACS has undergone a restructure. HNSW, ADHC Women NSW and Community Services no longer exist as separate agencies or divisions within FACS. Rather, their functions are captured within the divisions that seek to integrate better across disability, domestic and family violence, child protection and housing assistance. Further, Women NSW has also now shifted to the Health cluster.
- 4.46 The Review considers that legislative amendment is required, to better reflect the new organisational structure of FACS and other government agencies. The legislation should ensure that there are government members to represent the portfolios of housing, child protection, women, and ageing, disability and home care on the DVDRT. The number of government members and the nominations from FACS and Health should be determined by the responsible Ministers.

4.6.2 Additional Indigenous representation

Recommendation 4:

Amend Chapter 9A of the *Coroners Act 2009* to include an additional Indigenous representative on the DVDRT, either from a NSW government agency, a non-government service provider or a sector expert.

- 4.47 FACS submitted that Aboriginal Affairs NSW should be permitted to nominate additional Indigenous representation on the DVDRT.
- 4.48 In its 2011/2012 Annual Report, the DVDRT found that Aboriginal people were disproportionately represented as victims of domestic violence homicides. The Aboriginal population in NSW is approximately 1.9%-2.9%.

The DVDRT found that 12% of female homicide victims and 34% of male homicide victims identified as Aboriginal.

- 4.49 These figures are significant, and the DVDRT may benefit from additional Indigenous representation to assist in identifying gaps in service delivery, provide further information and expertise in relation to issues particularly affecting Indigenous populations and identify areas for reform. In light of recent moves in favour of non-government service delivery in NSW, the Review concludes that the Attorney General should have the ability to appoint to the DVDRT an additional Indigenous person from a government agency, a non-government service provider or sector expert. This will help to ensure that Indigenous representatives from the appropriate sector are involved in determining gaps in service delivery and implementing improvements. This is also consistent with the membership requirements of the Child Death Review Team, which requires the Minister to appoint two Indigenous persons to that body.³⁰

4.6.3 ODPP Representation

- 4.50 FACS also submitted that the DVDRT should include a representative from the Office of the Director of Public Prosecutions (ODPP).
- 4.51 The agencies represented on the DVDRT all provide services in some form to domestic violence victims. The ODPP prosecutes murder and manslaughter offences occurring in a domestic violence context. While the ODPP is a key stakeholder in domestic violence matters and has a role in providing witness assistance services, which provides support for families of deceased victims, its role as a prosecutor is quite different to the investigative and service delivery functions of other agencies represented on the DVDRT. Further, including the ODPP on the membership of the DVDRT may give rise to a potential conflict of interest, given its role as a prosecutor. The DVDRT is focused on reducing the incidence of domestic violence deaths, and facilitating improvements in systems and services; the ODPP does not play a core role in this regard.
- 4.52 The Review notes that Chapter 9A of the Act provides that the DVDRT has the capacity to request specific information from the ODPP, on a needs basis, and existing members can facilitate information sharing between the two. Consideration could be given by the DVDRT to establishing a liaison between the Secretariat of DVDRT, the DJ representative and the ODPP, to ensure a central contact point and efficient and timely access to information, to assist the DVDRT in its case reviews.
- 4.53 The Review does not propose at this stage to include the ODPP on the membership of the DVDRT.

³⁰ Section 34(C)(7) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

4.6.4 Victim's Representative

Recommendation 5:

Amend Chapter 9A of the *Coroners Act 2009* to include the Commissioner of Victims Rights as a government member of the DVDRT, as an additional representative of the Department of Justice.

- 4.54 The Review recognises the critical role that victim's services play in domestic and family violence policy and service delivery in NSW. The NSW Domestic Violence Justice Strategy contains a number of priorities in relation to victim's safety, support services, as well as empowerment in the criminal justice system. Similarly, Legal Aid NSW and the Office of the Director of Public Prosecutions also provide support services to victims and their families, including in the context of domestic violence offences. As such, victim's services play a crucial role in linking victims with appropriate support services and may therefore have significant expertise and knowledge to contribute to the work of the DVDRT.
- 4.55 The Review notes that the existing legislation does not prevent the Attorney General from appointing more than one government representative from each relevant agency. As such, the Attorney General may appoint an additional DJ representative, who specifically represents victim's rights.
- 4.56 There is however utility in specifically providing for the Commissioner of Victims' Rights as a member of the DVDRT. The current Commissioner is Ms Mahashini Krishna and her inclusion will serve as an important emphasis of the DVDRT's objectives; to reduce the numbers of people who become the victims of fatal incidents. It should however be made clear that in including the Commissioner as a member of the DVDRT, this position is to be drawn from the total government numbers and should not reduce the numbers of non-government members on the DVDRT.

4.6.5 Appointment of Deputy Members and replacements

- 4.57 A stakeholder submission noted difficulties in the appointment of members, specifically in relation to appointing replacements, where existing members had left the relevant agency. This was said to have affected the continuity of agency representation and disrupted the meetings.
- 4.58 Schedule 3 Clause 4 of the Act sets out the procedure for appointing deputies to the DVDRT. It states that the Attorney General may appoint a person to be the deputy of a member, and the Attorney General may revoke any such appointment. It is the responsibility of the relevant agency to write to the Attorney General, upon becoming aware of the vacancy, and nominate for a deputy to be appointed to the DVDRT. This process is intended as an immediate interim measure, until a replacement member can be formally appointed to the Team. Given the existing mechanism in place, the Review considers that no legislative change is required.

4.7 Reporting Requirements

4.7.1 The DVDRT's annual reporting requirements

Recommendation 6:

Amend Chapter 9A of the *Coroners Act 2009* to require the DVDRT to report every two years to Parliament.

- 4.59 The DVDRT is required to prepare annual reports on domestic violence deaths, which must be laid before the House on the next sitting day of each House of Parliament after it is received by its Presiding Officer (s101K(1)). The DVDRT may recommend that the report be made public forthwith (s101K(2)).
- 4.60 FACS submitted that consideration should be given to requiring annual reports to be made public, without a specific recommendation of the DVDRT to do so. FACS stated that this would support open and transparent information sharing and promote better access to information for relevant agencies.
- 4.61 Once the report is laid before each House of Parliament, as is required by Chapter 9A of the Act, it is a public document. The provision that the DVDRT may recommend the report be made public forthwith was included to ensure the report can be made publicly available by the Presiding Officer, even though Parliament is not sitting. In the absence of a recommendation that the report be made public forthwith, the annual report of the DVDRT will be publicly available once it is tabled in Parliament. The Review therefore concludes that no legislative change is necessary.
- 4.62 The Convenor of the DVDRT has further submitted that the current requirement to report annually to parliament does not allow sufficient time for the development of evidence-based policy recommendations within a collaborative, interagency framework. The Convenor of the DVDRT noted that the annual reporting requirement also leaves insufficient time to adequately monitor the implementation of the DVDRT's past recommendations. The Convenor of the DVDRT suggests that the Team report to Parliament every two years, rather than annually, to ensure it is able to fulfil its legislative function to the highest possible standard and better promote and facilitate meaningful interagency collaboration. Such biennial reporting requirements are consistent with similar bodies that report on qualitative and quantitative research, such as the NSW Ombudsman's Reviewable Child Deaths Report and the Australian Institute of Criminology's National Homicide Monitoring Program Report. The Review concludes that amending the Team's reporting requirement to biennial reporting will ensure the Team is able to effectively fulfil its legislative reporting requirement, while also facilitating increased interagency collaboration.

4.7.2 Government Agency Monitoring of DVDRT Recommendations

Recommendation 7:

Note the difficulties raised by the Coroner in monitoring progress and responses from NSW Government agencies to previous DVDRT Annual Report recommendations, and consider mechanisms to monitor their implementation, including by way of a Premier's Memorandum to require Ministers and government agencies to report back to the Attorney on any action being taken to implement the DVDRT's recommendations, within a reasonable timeframe.

- 4.63 The Convenor of the DVDRT has noted the need to consider the mechanism by which government agencies will communicate its responses to the DVDRT's Annual Report recommendations. Specifically, the Convenor has noted the difficulties experienced by the DVDRT in monitoring progress and responses from government agencies to previous DVDRT Annual Report recommendations, for inclusion in the DVDRT's subsequent Annual Reports.
- 4.64 The Review notes that section 101J(2)(c) of the Act provides that the Annual Report may include details of the extent to which its previous recommendations have been accepted. The Review agrees with the Convenor's submission that providing publically available information as to the acceptance and implementation of recommendations is a critical aspect of the DVDRT's reporting function, and one that is provided for in the current Act. The Review acknowledges that the most recent DVDRT Annual Report includes a chapter on monitoring the progress of recommendations by government agencies. The Review supports the ongoing inclusion of progress of its recommendations in the DVDRT's Annual reports as a significant function of the DVDRT and its oversight of domestic and family violence reforms resulting from those reviews.
- 4.65 The Review also notes that although there is no requirement for the DVDRT to provide a copy of the Report's recommendations to each relevant Minister³¹, there is no legislative impediment to prevent the Convenor from providing such information pursuant to the DVDRT Annual Reports. The Review understands that currently the DVDRT writes to Ministers to highlight relevant recommendations that relates to their agency. On this basis, the Review concludes that no legislative amendments are required.
- 4.66 There is already a Premier's Memorandum 2012-09 *Responding to Coronial Recommendations*. Under Premier's Memorandum 2012-09 Ministers and government agencies are required to write to the Attorney General outlining any action being taken to implement recommendations made by the Coroner in connection with an inquest (with such letter to be sent to the Attorney

³¹ Section 82(4) of the *Coroners Act 2009* requires the Coroner to ensure that a copy of a record that includes recommendations made under this section is provided, as soon as is reasonably practicable, to any other Minister (if any) that administers legislation, or who is responsible for the person or body, to which a recommendation in the record relates.

General within six months of receiving a coronial recommendation). The Attorney General arranges for a report to be posted on the DJ website every six months setting out responses received to recommendations. While the Review understands that this direction does not apply to the DVDRT, there is merit in considering the introduction of a Premier's Memorandum similar to Premier's Memorandum 2012-09. This would ensure that information as to the acceptance and implementation of the DVDRT's recommendations is publicly available, which is a critical aspect of the DVDRT's reporting function.

4.8 Information

- 4.67 Section 101L of the Act imposes an obligation on certain people to provide the DVDRT full and unrestricted access to records under their control, which are reasonably required for the DVDRT to exercise its functions. The people who have that obligation are:
- the Department Head, chief executive officer or senior member of any department of the Government, statutory body or local authority,
 - the Commissioner of Police,
 - a coroner,
 - a medical practitioner or health care professional who, or the head of a body which, delivers health services,
 - a person who, or the head of a body which, delivers welfare services.
- 4.68 A person is not required to provide access if to do so may prejudice an existing investigation or inquiry (s101J(2)).
- 4.69 Section 101M provides for the confidentiality of information and prohibits a DVDRT related person from disclosing any information acquired by the person by reason of them being a DVDRT- related person. A number of exceptions to disclosure are set out in s101M(1) and include a disclosure made in good faith for the purpose of exercising a function under Chapter 9A, or where the disclosure is authorised by the Convenor. A fine of \$5,500 and/or 12 months imprisonment applies to prohibited disclosures.
- 4.70 Stakeholders did not raise any issues with the operation of these provisions. They ensure the DVDRT is able to conduct comprehensive reviews of domestic violence deaths in NSW while maintaining appropriate protections against disclosure of confidential information. The Review concludes these provisions remain appropriate for securing the policy objectives of Chapter 9A of the Act.

5. Conclusion

- 5.1 The significant personal, social and economic costs of domestic and family violence cannot be underestimated. The statistics speak for themselves. Approximately three quarters of female homicides are classified as domestic homicides, involving victims who share a family or domestic relationship with the offender, while Indigenous women are six times more likely to be victims of domestic and family violence than non- Indigenous women.³²
- 5.2 Responding effectively to domestic violence is a priority not only for NSW, but nationwide. Domestic violence death review mechanisms play a crucial role in that response, through maintaining comprehensive databases, identifying early risk factors, and formulating recommendations aimed at minimising the incidence of future deaths.
- 5.3 The NSW DVDRT, drawing on the strengths of a multi-disciplinary team of experts from government and non-government stakeholders, plays a crucial role in reviewing domestic violence deaths. Rather than focusing on individual cases, the DVDRT's strength is its ability to review cases collectively, with a view to addressing broader systemic gaps and limitations in service response and delivery. The recommendations made as a result of this Review, if implemented, will enhance the role of the Secretariat, while also ensuring that the DVDRT's knowledge can be applied and drawn on in the continuing identification of systemic responses to domestic and family violence deaths.

³² NSW Government, *It Stops Here: The NSW Government's Domestic and Family Violence Framework for Reform*, 2014, p5.

ANNEXURE A

List of Agencies Invited to Make a Submission

Stakeholders contacted by letter

- Aboriginal Legal Service (NSW/ACT)
- Chief Judge at Common Law
- Chief Judge of the District Court
- Chief Justice of the Supreme Court
- Chief Magistrate
- Courts and Tribunal Services
- Coroner's Office
- Community Legal Centres NSW
- Corrective Services NSW
- Department of Health
- Department of Aboriginal Affairs
- Department of Family and Community Services
- Juvenile Justice
- Judicial Commission
- Ministry for Police and Emergency Services
- Legal Aid Commission
- NSW Commission for Children and Young People
- NSW Police Force
- Women NSW (Department of Family and Community Services)
- Office of the Director of Public Prosecutions
- NSW Bar Association
- Law Society of NSW
- Senior Public Defender
- Victims Advisory Board

Stakeholders contacted by email

- ACON
- NSW Women's Refuge Movement
- Inner City Legal Centre
- Women's Legal Services NSW
- Wirringa Baiya Aboriginal Women's Legal Centre
- NSW Rape Crisis Centre
- Immigrant Women's Speakout NSW Association
- F Collective
- Muslim Women's Association
- Older Women's Network
- Women's Domestic Violence Court Advocacy Services NSW
- Women's Health
- Domestic Violence Alliance
- NSW Domestic Violence Coalition

ANNEXURE B

List of Agencies Who Provided a Submission

- Domestic Violence Death Review Team (NSW)
- Director of Public Prosecutions (NSW)
- Legal Aid NSW
- Department of Family & Community Services NSW
- NSW Police Force
- NSW Department of Health
- Victims Services (NSW)