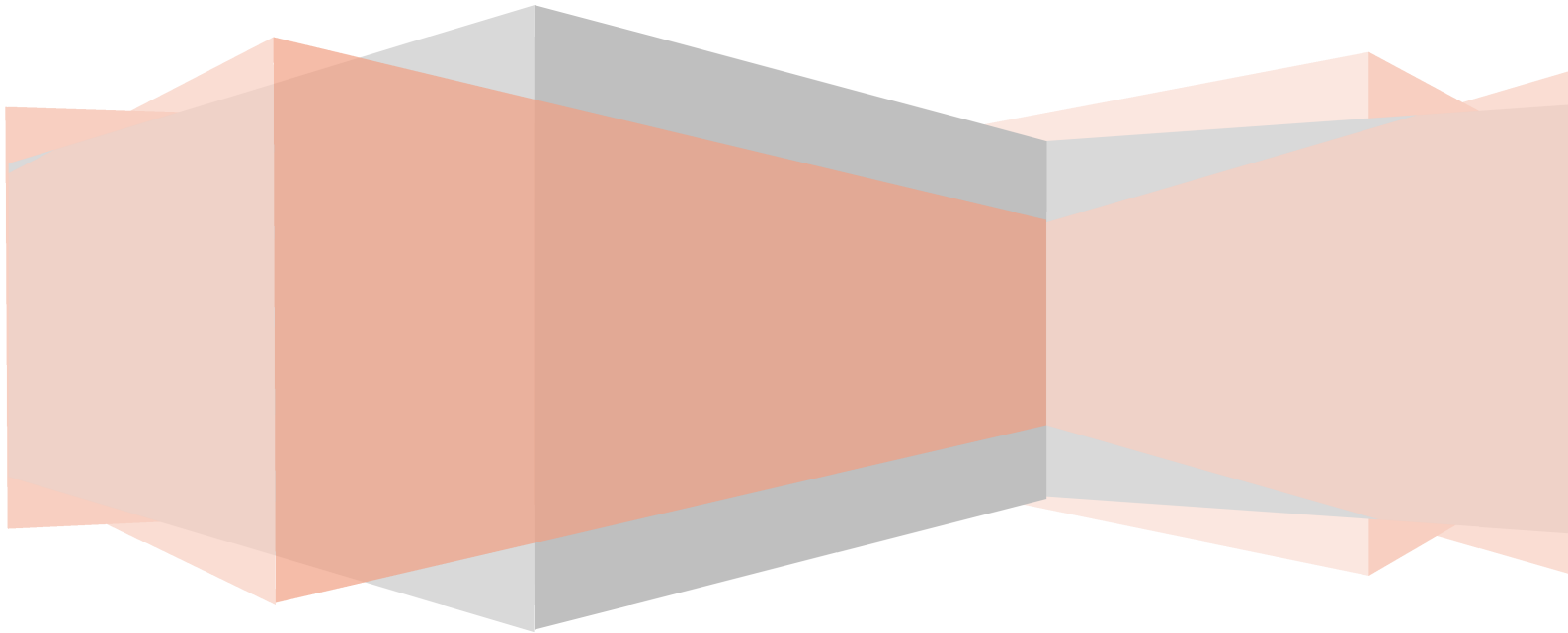
NSW GOVERNMENT | Justice

NSW Domestic Violence Death Review Team

ANNUAL REPORT 2013-2015



NSW Domestic Violence Death Review Team

ANNUAL REPORT 2013-2015

A report of the Domestic Violence Death Review Team

A report of the Domestic Violence Death Review Team pursuant to section 101J(1) of the *Coroners Act 2009* (NSW).

The views expressed in this report do not necessarily reflect the private or professional views of individual Team members or the views of their individual organisations. A decision of the majority is a decision of the Domestic Violence Death Review Team– Schedule 3, clause 11 Coroners Act 2009 (NSW).

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CONVENOR'S MESSAGE

This is the fourth annual report of the NSW Domestic Violence Death Review Team. This report covers the reporting period from July 2013 – June 2015, and presents case reviews, data and recommendations derived from the Team's quantitative and qualitative research functions.

Domestic and family violence continues to be a leading cause of homicide in our jurisdiction and its prevalence casts a dark shadow over our nation. In the past few years, our collective understanding of domestic violence has been significantly enhanced by the tireless work of individuals and organisations committed to supporting victims and holding perpetrators to account.

With the announcement of Rosie Batty as Australian of the Year in 2015, we have seen an even more profound focus on the way in which violence affects our community and in particular women. As demonstrated in this report, women continue to be overrepresented as victims of domestic violence, suffering not only physical abuse, but other coercive and controlling behaviours such as verbal, social, financial and emotional violence. In some of the cases examined in this report, women were killed in circumstances where there had been no history of physical violence – but their abuser had exercised almost total control over all aspects of their lives. Given this, it seems all too cruel that domestic violence victims are often most at risk when they try to leave the abuser.

The strength of our review process lies in the Team's ability to look in depth at individual closed cases of domestic violence homicide, and look across cases to identify opportunities for intervention and prevention. This rigorous process creates a strong evidence base for recommendations – which can be derived from either a single case review (in a way that is similar to coronial processes) or derived from issues identified across multiple cases.

As such, this report 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 twelve years of data. It is our hope that the recommendations and information contained within this report will further reiterate the importance of a strong, collaborative approach towards intervention and prevention in this space.

On behalf of both the Team and myself, I would like to take this opportunity to extend my condolences to the families of those individuals whose cases are examined in this report. With our mandate to review and analyse these deaths, we hope to contribute to strengthening and informing responses to domestic violence in our community and preventing future losses of life.

Magistrate Michael Barnes
Convenor, Domestic Violence Death Review Team
State Coroner

TEAM MEMBERS

Statutory members (as at 30 June 2015)

Magistrate Michael Barnes
NSW State Coroner
Convenor

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Chief Executive
NSW Kids and Families
NSW Health

Assistant Commissioner Mark Murdoch APM
Commander, Central Metropolitan Region
Corporate Spokesperson Domestic and Family Violence
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Women NSW (FACS)

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Community Offender Management
Corrective Services NSW

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Officers of the NSW Domestic Violence Death Review Team

Anna Butler
Manager

Emma Buxton
Research Analyst

Donna Schriever
Administrative Assistant

CONTENTS

LIST OF FIGURES

Intimate partner domestic violence homicide

Relative/kin domestic violence homicide – child victims

Relative/kin domestic violence homicide – adult victims

‘Other’ domestic violence homicide

EXECUTIVE SUMMARY

Chapter 1: Introduction

The Domestic Violence Death Review Team was established in July 2010 under the *Coroners Act 2009* (NSW) to review domestic violence related deaths. The scope of the Team's review includes both individual case analyses and the maintenance of a comprehensive database from which research data is derived. Using these analyses, the Team develops recommendations which aim to prevent or reduce the likelihood of such deaths by facilitating improvements in systems and services.

The scope of the Team's work includes examination of domestic violence related homicides, domestic violence related suicides and fatal accidents which occur in a domestic violence context. This report focuses only on domestic violence homicides, however, the development of a methodology for the review of domestic violence related suicides will be progressed by the Team in 2016.

The term 'domestic violence homicide' is used by the Team to describe homicides which occur following an identifiable history of domestic or family violence, including unreported and anecdotal histories. The scope of review facilitates examination of intimate partner homicides occurring in a domestic violence context. However, it also facilitates review of all family homicides which occur in a domestic violence context, including the deaths of children following exposure to intimate partner violence between their parents and/or direct child abuse.

Additionally, the Team also examines cases where there is no domestic relationship between the homicide victim and homicide perpetrator, but the death nonetheless occurs in a domestic violence context. These homicides include, for example, cases where a bystander is killed intervening in domestic violence, or cases where a person is killed by their intimate partner's abusive former partner. Accordingly the Team reviews and develops recommendations in relation to a broad range of homicides occurring in a domestic violence context.

An examination of homicides which occur in a domestic violence context identifies where systems could be improved to better address the needs of domestic violence victims and abusers, but also more generally assists in understanding the broader dynamics and issues around domestic violence in the community.

Methodology

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

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

  To develop this dataset the Team identifies and examines every homicide that occurs in NSW, capturing detailed demographic information and case characteristics for every case. The Team then reports in relation to those cases that are determined to have occurred in a context of domestic violence.

  For this report, quantitative data analysis is presented in relation to the 280 domestic violence homicides that occurred within the data reporting period. For this report the data reporting period is 1 July 2000 – 30 June 2012.[1]

- ***Tier 2***: Analysis of **in-depth case reviews** – which provide detailed *qualitative case analysis* in relation to all homicides occurring in a domestic violence context in NSW within the case review period, which for this report is 1 July 2010 – 30 June 2012 (a 2 year period).

From a synthesis of information derived from Tier 1 and Tier 2, the Team develops recommendations which aim to facilitate improvements in systems and services to promote better outcomes for victims of domestic violence and hold abusers accountable for this behaviour.

This report provides in depth analysis of the 30 domestic violence homicides which occurred in NSW between 1 July 2010 and 30 June 2012, and includes quantitative data concerning all homicides that occurred in NSW between 1 July 2000 and 30 June 2012.

[1] This end date is selected to ensure that the maximum number of closed cases can be included in the analysis.

Chapter 2: Complete Dataset Findings – Domestic Violence Homicide in NSW 2000-2012

During the twelve years between 1 July 2000 and 30 June 2012, there were a total of 995 homicides in NSW, and of these homicides, 280 (**28%**) occurred in a context where there was an identifiable history of domestic violence.

Of the 280 homicide victims who were killed in a domestic violence context:

- 164 were female (which represents **51%** of all female homicide victims); and
- 116 were male (which represents **17%** of all male homicide victims).

This data includes the deaths of both domestic violence victims and domestic violence abusers, and includes the deaths of children and adults.

This data is considered below in three distinct groups: intimate partner homicides; relative/kin homicides; and 'other' domestic violence homicides.

Intimate Partner Domestic Violence Homicide

- Of the 280 male and female homicide victims who were killed in a domestic violence context between 1 July 2000 – 30 June 2012, 165 (**59%**) were killed by their current or former intimate partner.

- Of these 165 intimate partner homicide victims, the majority (N=129, **78%**) were women. Men comprised slightly less than a quarter of homicide victims in this category (N=36, **22%**).

- All 129 women killed in this category were killed by a current or former *male* intimate partner.

- Of the 36 men killed in this category, 31 were killed by a current or former *female* intimate partner (**86%**) and 5 were killed by a current or former *male* intimate partner (**14%**).

- Almost all of the 129 women who were killed by their male intimate partner in a domestic violence context had been the domestic violence victim in the relationship (N=127, **98%**).

- Most women in this category were killed by their current intimate partner (N=81, **63%**) however, in just under half of these cases (N=35), one or both parties to the relationship had indicated an intention to end the relationship within three months of the killing.

- Just over one third of women in this category (N=48, **37%**) were killed by a former partner. Of these women, 30 (**63%**) had ended the relationship with the domestic violence abuser within three months of the homicide.

- Of the 129 female intimate partner homicide victims, **12%** identified as Aboriginal (N=15).

- Of the 36 male intimate partner homicide victims, over one-third identified as Aboriginal (N=11, **31%**).

Relative/Kin Domestic Violence Homicide

- Of the 280 male and female homicide victims who were killed in a domestic violence context between 1 July 2000 and 30 June 2012, 88 (**31%**) were killed by a relative/kin.

- Of the 88 homicide victims in this category, 60 (**68%**) were children under the age of 18 years, and 28 (**32%**) were adults.

Relative/kin Homicide – Child victims

- Of the 60 children who were killed by a relative/kin in a domestic violence context, 58 were killed by a biological or non-biological parent **(97%)** and 2 children were killed by their grandfather.

- Of the 58 children killed by a parent, 36 children were killed by a male parent acting alone (**62%),** 18 children were killed by a female parent acting alone (**31%)** and 4 children were killed by their parents acting together (**7%).**

- The majority of children who were killed by a parent acting alone were killed by a biological parent (N=41, **71%**). Of the 41 children killed by a biological parent, most were killed by their biological father (N=25, **61%**).

Relative/kin Homicide - Adult victims

- Of the 28 adults who were killed by a relative/kin in a domestic violence context, 19 were men (**68%**) and 9 were women (**32%**).

- Just under half of all women (N=4, **44%**) and almost a third of all men (N=6, **32%**) killed by a relative/kin in a domestic violence context were killed by their son/step-son (including de facto step-son).

- Two women (**22%**) and three men (**16%**) in this category were killed by their daughter/step-daughter.

'Other' Domestic Violence Homicide

- There were 27 homicide victims who had no direct domestic relationship with the homicide perpetrator but the death nonetheless occurred in domestic violence context.

- All 27 homicide victims in this category were men.

- There were 28 homicide perpetrators[2] in this category, 27 of whom were men.

- Most homicide victims in this category were 'new intimate partners' (N=18, **67%**) who were killed by their wife or girlfriend's former abusive male partner.

Chapter 3: Case Review Summaries – Domestic Violence Homicide in NSW, 2010-2012

Chapter 3 of this report sets out de-identified case summaries for all 30 closed domestic violence homicides that occurred between 1 July 2010 and 30 June 2012.[3]
Each case was reviewed by the Team in a series of full day workshops to identify common themes, issues and areas for recommendation.

Chapter 4: Intimate partner homicide (domestic violence context) data focus

Chapter 4 of this report presents a focused quantitative data analysis of all intimate partner domestic violence context homicides that occurred between 10 March 2008 and 30 June 2012 (N=40). Each case has been subject to an in-depth case review by the Team (Tier 2 methodology).

Quantitative data has been collected from these reviews to facilitate increased reporting around domestic violence context (including types of violence, ADVO histories, prior domestic violence histories), criminal histories, mental health histories, drug and alcohol abuse and childhood experiences of violence/abuse. Additional homicide characteristics are included.

It is anticipated that this approach to quantitative data analysis will continue to be developed and extended to the broader dataset in future reports.

Key findings in this Chapter include:

- All men in the dataset were domestic violence abusers in the relationship and all women were domestic violence victims.

- 80% of cases involved the domestic violence abuser killing the domestic violence victim, and 20% of cases involved the domestic violence victim killing their abuser.

- All cases involved male abusers using a range of coercive and controlling behaviours towards the female domestic violence victim prior to the homicide. Disclosed behaviours included verbal abuse (98%), physical abuse (90%), express threats to kill (45%), social control and isolation (40%), financial abuse (40%) and stalking (43%). Stalking was a characteristic of cases not only when the relationship had ended, but also while the relationship was on foot. This also included evidence of technology-facilitated stalking.

- Sexual abuse was disclosed in only 5% of cases, however the Team suspects this is an underrepresentation of its true prevalence.

- A high proportion of men had been violent in previous relationships, but this violence was often not reported to police and few had been previously convicted of domestic violence offences.

- 15% of women were protected by an ADVO with the abuser at the time of the homicide and 15% of women had previously been protected by an ADVO (but it was not in force at the time of the homicide). Overall, just under a third of women had a history of being protected under an ADVO with the abuser.

[2] One case involved a man acting together with his son to kill his wife's extramarital partner.
[3] The report also includes cases from previous case review periods that closed during the current case review period.

- The average age of domestic violence abusers at the time of the homicide was 43 years old and the average age of victims at the time of the homicide was 41 years old.
- Just under half of all abusers had a history of diagnosed or undiagnosed mental health issues.
- 50% of all abusers had a criminal record for violence, but only 28% had been convicted of assaults against former partners.
- Nearly half of all abusers had a history of drug abuse and half had a history of alcohol abuse.
- Just over a quarter of abusers had experienced family violence during their childhood.

Chapter 5: Recommendations and Commentary

Chapter 5 of this report presents a discussion of themes and issues derived from the Team's case analysis and review process. This section also outlines 15 recommendations made to various Government and non-Government agencies, derived from data and case review findings contained in this report.

This Chapter considers issues including:

- the role of legal professionals and the judiciary in relation to domestic violence;
- the importance of promoting consistent and supportive responses to domestic violence across services;
- the intersection of mental health issues, substance abuse issues and domestic violence;
- the role of healthcare responders in relation to domestic violence;
- promoting public awareness and understanding of domestic violence through public education;
- media accountability, best practice and domestic violence;
- co-occurrence of domestic violence and family law issues; and
- supporting older and/or vulnerable victims of domestic violence.

RECOMMENDATIONS

Recommendation 1

That the NSW Domestic Violence Death Review Team and the NSW Judicial Commission work collaboratively to:

a) improve learnings around domestic violence and victim visibility in remarks on sentence/judicial commentary; and

b) develop an information sharing protocol in relation to referring judgments and remarks on sentence to the Commission for consideration where the representation of domestic violence, including perpetrator accountability and victim visibility, could be improved.

Recommendation 2

That the NSW Domestic Violence Death Review Team work collaboratively with the Victim Impact Statement Working Group, convened by Victims Services NSW (NSW Department of Justice), to examine ways in which victim visibility may be enhanced through the process of preparing and providing Victim Impact Statements to the Court.

Recommendation 3

That the NSW Domestic Violence Death Review Team work collaboratively with the Office of the Director of Public Prosecutions (NSW), the NSW Bar Association, the Law Society of NSW and the NSW Public Defenders' Office to develop appropriate strategies to better support lawyers in recognising and responding to domestic violence.

Recommendation 4

That NSW Health work collaboratively with the NSW Domestic Violence Death Review Team to:

a) identify all homicides occurring in NSW from March 2008 where the perpetrator had received care or treatment from a NSW Health service for mental health issues within 6 months of the homicide;

b) provide to the Team all final Severity Assessment Code 1 Root Cause Analysis Reports prepared in relation to the cases identified in the audit process foreshadowed in a);

c) provide to the Team all de-identified thematic analyses prepared by the Clinical Excellence Commission in relation to the cases identified in the audit process foreshadowed by a); and

d) develop an information sharing mechanism whereby the Team may seek input from the CEC in relation to cases where mental health issues are identified.

Recommendation 5

That the NSW Domestic Violence Death Review Team and the NSW Health Mental Health Drug and Alcohol Office work collaboratively to develop an information sharing mechanism whereby the Team may seek input from that Office in relation to cases where mental health and/or drug and alcohol issues are identified.

Recommendation 6

That the NSW government give consideration to expanding the current membership of the Team to include:

a) a permanent member with expertise in the area of Mental Health treatment and service provision; and

b) a permanent member with expertise in the area of Drug and Alcohol treatment and service provision.

Recommendation 7

That Ageing, Disability and Home Care (ADHC) (Department of Family and Community Services) give consideration to developing mandatory internal reporting protocols to enable action to be taken when staff suspect clients are at risk from domestic violence in the home.

That consideration also be given to establishing a notification process between frontline FACS housing teams and ADHC operated and funded services when staff suspect that domestic violence is occurring. This may be modelled on the current notification obligations of maintenance workers who identify child protection issues in their contact with tenants. This notification triggers a client service visit from tenancy team staff to enable support, information and appropriate referrals to be made.

Recommendation 8

That the NSW Government approach the Commonwealth to highlight *Recommendation 10* of the Team's *11/12 Report* and suggest it be taken into account in public awareness campaigns including that being progressed through the Commonwealth of Australian Governments, and that any future NSW campaigns are also informed by that recommendation.

Recommendation 9

That the NSW Police Force investigate additional strategies and processes that will promote increased compliance with policies concerning ADVOs and breaches of ADVOs and report to the Team in relation to these initiatives. Strategies and processes should include the use of the Team's case reviews to inform existing training in relation to ADVO compliance.

Recommendation 10

That the NSW Department of Justice continue to work closely with the NSW Domestic Violence Death Review Team in identifying and informing future evaluations of the Domestic Violence Safety Assessment Tool (DVSAT).

Recommendation 11

That the Department of Family and Community Services – Housing NSW work collaboratively with the NSW Police Force to develop an information bulletin regarding the rights and rules pertaining to social housing tenants. This bulletin should be circulated state-wide within 12 months.

Recommendation 12

That the Department of Family and Community Services – Housing NSW develop a z-card for tenants that identify their status as a "head" tenant with the right to request removal of unauthorised occupants of the property. This z-card should be distributed by Housing NSW to new and existing tenants.

Recommendation 13

That the Minister for Domestic and Family Violence convene an interfaith roundtable within the next 12 months with a view to progressing *Recommendation 12* of the Team's *11/12 Report*.

Recommendation 14

That the Family Court of Australia and the Federal Circuit Court of Australia:

a) update their webpages concerning family violence to incorporate a quick close button to facilitate the safe and rapid exit from the webpage;

b) give consideration to updating information in relation to safety and separation included on their respective websites; and

c) give consideration to including family violence referral information in their brochures '*Marriage, Families & Separation*' (prescribed brochure) and '*Separated but living under one roof?*'.

   This referral information should be reflected in both the online and hardcopy versions of these brochures, and should include referrals to 1800 RESPECT.

Recommendation 15

That the NSW Ombudsman gives consideration to developing a protocol which will enable deaths involving both domestic violence and child protection issues to be subject to a joint meeting between the NSW Ombudsman's Office and the NSW Domestic Violence Death Review Team. The purpose of this meeting will be to share learnings in relation to child protection and domestic violence issues.

1 INTRODUCTION

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

Why review domestic violence homicides?

'Domestic violence' (or 'intimate partner violence') is a term used to describe a pattern of behaviour whereby a person intentionally and systematically uses violence and abuse to gain and maintain power over another person with whom they share (or have shared) an intimate relationship. At the heart of this definition is the abuser's use of coercion and control to assert and maintain power and dominance over the victim.

Manifestations of domestic violence can include:

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

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

In NSW, however, the term 'domestic violence' is used broadly in the criminal and civil legislation to include violence behaviours not only between intimate partners but also between family members and kin.[6] Accordingly, this report uses the term 'domestic violence' to refer to both domestic violence and family violence. This report also recognises that children who witness or live with domestic violence in the home are victims of domestic violence.

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

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

Research has found that an identifiable history of domestic violence is a common feature in a high proportion of homicides. This is particularly the case for women, a high proportion of whom are killed by a domestic violence abuser in a context of ongoing coercion and control.[7]

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

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

Domestic violence death review teams are collaborative multi-agency committees which conduct in-depth

[4] National Council of Australian Governments, *The National Plan to Reduce Violence Against Women and their Children 2010-2022*,released February 2011, Available at: <https://www.dss.gov.au/sites/default/files/documents/08_2014/national_plan1.pdf> last accessed October 2015.

[5] Australian Bureau of Statistics, *Personal Safety Survey Australia 2005*, ABS cat.no 4906.9 Canberra, 2006; Chan A & Payne J, 2013, 'Homicide in Australia: 2008-09 to 2009-10 National Homicide Monitoring Program annual report', Monitoring report, no. 21, *Australian Institute of Criminology*, Canberra; Dobash R, Dobash R, Wilson M & Daly M, 1992, 'The myth of sexual symmetry in marital violence', *Social Problems*, vol. 39, issue 1, p. 71-91; Grech K & Burgess M (eds.) 'Trends and patterns in domestic violence assaults: 2001 to 2010', Issues Paper, no. 61, *NSW Bureau of Crime Statistics and Research*, Sydney, 2011.

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

[7] M. Alderidge & K. Browne, 2003, Perpetrators of Spousal Homicide: A Review 4(3) *Trauma, Violence & Abuse*; M Virueda & J Payne, Homicide in Australia: 2007-2008 National Homicide Monitoring Program Annual Report, Monitoring Report No 13 *Australian Institute of Criminology*, Canberra, 2010.

[8] Neil Websdale et al, 1999, Domestic Violence Fatality Reviews: From a culture of Blame to a culture of safety, *Juvenile and Family Court Journal* (Spring), 61; Office of the Chief Coroner for Ontario, 'Domestic Violence Death Review Committee 2012 Annual Report', 2014, Available at; <http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/PublicationsandReports/DVDR/DVDR.html> last accessed June 2015.

analyses of domestic violence homicides. Such teams undertake a careful examination of the circumstances surrounding these homicides with a view to providing a better understanding of agencies' roles and constraints in responding to domestic violence, as well as other barriers and limitations (*qualitative analysis*).

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

Examining homicides which occur in a domestic violence context identifies where systems could be improved to better address the needs of domestic violence victims and abusers, but also more generally assists in understanding the broader dynamics and issues around domestic violence in the community.

The NSW Domestic Violence Death Review Team

Background and establishment

Recognising the long history of death review processes operating in other jurisdictions,[9] from the early 2000s, advocates and various government agencies began campaigning for a domestic violence death review process to be established in NSW.[10]

In December 2008, the NSW Government convened the Domestic Violence Homicide Advisory Panel, which considered the merit, key elements and best practice model of any ongoing review mechanism for NSW.[11] The panel handed down its report in mid-2009, unanimously recommending that a permanent domestic violence death review team be established and identifying its key features and functions.

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

The functions of the Team are to:

- review and analyse individual closed cases of domestic violence related deaths;[12]
- establish and maintain a database so as to identify patterns and trends relating to such deaths; and
- develop recommendations from qualitative and quantitative data and undertake research that aims to prevent or reduce the likelihood of such deaths.[13]

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

While an examination of domestic violence related suicides and accidental deaths will represent a future direction in the work of the Team, this report focuses only on domestic violence homicides.

The Team's establishing legislation is set out in Appendix A.

Methodology

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

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

  For this report, quantitative data analysis is presented in relation to the 280 domestic violence homicides that occurred within the data reporting period, which for this report is 1 July 2000 – 30 June 2012.[14]

- ***Tier 2***: Analysis of **in-depth case reviews** – which provide detailed *qualitative case analysis* in relation to all homicides occurring in a domestic violence context in NSW within the case review period, which for this report 1 July 2010 – 30 June 2012 (a 2 year period).

From a synthesis of information derived from Tier 1 and Tier 2, the Team develops recommendations which aim to facilitate improvements in systems and services and promote better outcomes for victims of domestic violence.

[9] For example, in the United States and Canada, such processes have existed since the 1990s, N. David, 2007, Exploring the Use of Domestic Violence Fatality Review Teams, *Australian Domestic & Family Violence Clearinghouse* Issues Paper No. 15, Sydney.
[10] NSW Ombudsman, Domestic Violence: Improving Police Practice, Sydney, 2006.
[11] Report of the Domestic Violence Advisory Panel 2009, Available at <http://www.lawlink.nsw.gov.au/lawlink/Corporate/ll_corporate.nsf/vwFiles/251109_domestic_violence.pdf/$file/251109_domestic_violence.pdf> last accessed June 2015.
[12] *Coroners Act 2009* (NSW) s101B(2),
[13] *Coroners Act 2009* (NSW) s101F(1).
[14] This end date is selected to ensure that the maximum number of closed cases can be included in the analysis.

Tier 1 Methodology

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

This dataset is developed with a view to determining overall trends and patterns in relation to domestic violence context deaths, using a comparative dataset (where appropriate) of all non-domestic violence context deaths.[15]

From the total homicide dataset, each case is examined to determine the relationship between the homicide victim and the perpetrator and whether or not the death occurred in a domestic violence context.

When determining whether or not a homicide occurred in domestic violence context, case material is examined to identify any evidence (reported or anecdotal) of domestic violence behaviours.

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

Every domestic violence homicide is categorised into one of three categories:

- **Intimate partner homicide**: where a person is killed by a current or former intimate partner in a domestic violence context;
- **Relative/kin homicide**: where a person is killed by a non-intimate family member in a domestic violence context; and
- **'Other' domestic violence homicide**: where there is no relationship between the perpetrator and deceased, but the homicide nonetheless occurs in a domestic violence context (for example, cases where a bystander is killed intervening in domestic violence, or cases where a new partner is killed by their intimate partner's abusive former partner).

Tier 2 Methodology

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

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

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

- police reports to the Coroner;
- the brief of evidence (prosecutorial or coronial);
- post mortem and toxicology reports;
- remarks on sentence;
- coronial findings;
- media reports; and
- any additional information called for by the Team.[16]

In conducting the review, a case review report is prepared which sets out, in as much detail as possible, information including:

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

[15] While this data is captured by the Team, the data analysis of non-domestic violence related homicide is not included in this report.

[16] *Coroners Act 2009* (NSW) s101L.

any services and systems, and any failures that may have contributed to, or failed to prevent, the death.

Each case review report is examined by the Team in a series of workshops to identify common themes, issues and areas for recommendation.

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

This report provides in depth reviews of the 30 domestic violence homicides which occurred in NSW between 1 July 2010 and 30 June 2012.

The Australian Domestic and Family Violence Death Review Network

The Secretariat of the NSW Domestic Violence Death Review Team are members (and the current chair) of the Australian Domestic and Family Violence Death Review Network.

This Network was established in 2011 and is comprised of representatives from each jurisdiction with an operational death review process. Current membership includes NSW, Victoria, South Australia, Western Australia and Queensland. The ACT (pilot) and New Zealand processes are special observers to the Network.

The Network's goals are to:

- better understand the context and circumstances in which domestic and family violence related deaths occur;
- identify practice and system changes that may prevent or reduce the likelihood of domestic and family violence 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 recommendations.

Attached to this report are the Network's Terms of Reference, Homicide Consensus Statement and the National Data Collection Protocol (**Annexure D**).

2 COMPLETE DATASET FINDINGS
DOMESTIC VIOLENCE HOMICIDE IN NSW 2000–2012

This chapter presents data analysis in relation to the Team's complete dataset - all 280 closed domestic violence homicides that occurred in NSW in the twelve years between 1 July 2000 and 30 June 2012. The 280 domestic violence homicides are considered in three distinct groups: intimate partner homicides, relative/kin homicides, and 'other' domestic violence homicides.

Introduction

During the twelve years between 1 July 2000 and 30 June 2012 (the 'data reporting period') there were a total of 995 victims of homicide in NSW.[17]

Of the 995 homicide victims:

- **324** were female;
- **670** were male; and
- **1** homicide victim identified as transgender.

Of the 995 homicides, **280 (28%)** occurred in a context where there was an identifiable history of domestic violence. Of the 280 homicide victims who were killed in a domestic violence context:

- **164** were female (51% of all female homicide victims); and
- **116** were male (17% of all male homicide victims) (Fig. 1).

These figures include the deaths of both domestic violence victims and domestic violence abusers, and they also include the deaths of children and adults.

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

Intimate Partner Domestic Violence Homicide

Incidence – all intimate partner domestic violence homicides

Of the 280 homicide victims who were killed in a domestic violence context in the data reporting period, 165 (59%) were killed by their current or former intimate partner.

Of these 165 intimate partner homicide victims, the majority (N=129, 78%) were women. Men comprised slightly less than a quarter of homicide victims in this category (N=36, 22%) (Fig. 2).

The 165 intimate partner homicides were perpetrated by 165 offenders; 134 men and 31 women.

Intimate partner domestic violence homicide – Female victims

All 129 women killed in this category were killed by a current or former male intimate partner (Fig. 3).

Almost all of the 129 women who were killed by their male intimate partner in a domestic violence context had been the domestic violence victim in the relationship (N=127, 98%). There were no cases where a woman was a domestic violence abuser who was killed by a male domestic violence victim (Fig. 4).[18]

Intimate partner domestic violence homicide – Male victims

Of the 36 men killed in this category, 31 were killed by a current or former female intimate partner and 5 were killed by a current or former male intimate partner (Fig. 5).

Almost all of the 31 men who were killed by their female intimate partner in a domestic violence context had been the domestic violence abuser in the relationship (N=28, 90%). There were no cases where a woman was a domestic violence abuser who killed a male domestic violence victim.[19]

[17] Excluding open cases.

[18] In two cases where a woman was killed by her male intimate partner, there had been domestic violence in the relationship perpetrated by both parties.

[19] In two cases where a man was killed by his female intimate partner, there had been domestic violence in the relationship perpetrated by both parties. In one case a female perpetrator (acting together with her abusive husband) killed a man she was having an affair with. The male homicide victim was neither a domestic violence abuser nor domestic violence victim.

All 5 men who were killed by their male intimate partner had been victims of domestic violence in the relationship (Fig. 4).

Intimate partner domestic violence homicide – relationship characteristics

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

Current intimate partner relationships

Of the 129 women in this category, most were killed by their current intimate partner (N=81, 63%) (Fig. 6).

Of the 81 women killed by their current intimate partner, 47% (N=38) were killed by their de facto husband, 42% (N=34) were killed by their husband, and 10% (N=8) were killed by their boyfriend.

One woman was killed by a man with whom she was having a long term affair.

Although the relationships were current at the time of the homicide, in over a third of these cases one or both parties had indicated an intention to end the relationship within three months of the killing (N=35, 43% of all current relationships). This meant that although the parties remained in a relationship at the time of the homicide, in a significant proportion of cases separation was contemplated or, in some cases, imminent (Fig. 6).

Of the 36 male homicide victims in this category, almost all were killed by their current intimate partner (N=31, 86%). This included two cases where one or both of the parties had indicated an intention to end the relationship within three months of the killing (but the relationship remained ongoing) (Fig. 6).

Former intimate partner relationships

Of the 129 women who were victims of intimate partner homicide, 48 (37%) were killed by a former partner (Fig.6). This included 40 cases where a woman was killed by her former husband/de facto husband and 8 cases where a woman was killed by her former boyfriend (Fig. 3).

It is important to note that of the 48 women killed by their former intimate partner, almost two-thirds had ended the intimate relationship with the domestic violence abuser within three months of the killing (N=30, 63%).

As has been noted in previous reports, the data findings for this category of domestic violence homicide continue to support evidence that the period immediately following separation may be particularly dangerous for women who leave an abusive partner.[20]

Of the 36 male intimate partner homicide victims, five were killed by a former intimate partner (Fig.6) (one former wife, two former de facto wives, one former girlfriend, and one former boyfriend) (Fig. 5).

Relationship length

Of the 129 women who were killed in a domestic violence context, almost half were killed by an intimate partner with whom they had been in a relationship for 5 years or less (N=63, 49%). Relationships of less than 12 months duration made up 27% (N=17) of this group (Fig.7).

Almost a quarter of women were killed by an intimate partner where the relationship had been ongoing for longer than 15 years (N=29, 22%).

Of the 36 men in this homicide category, almost two-thirds were killed by an intimate partner with whom they had been in a relationship for 5 years or less (N=23, 64%). Relationships of less than 12 months duration made up 26% (N=6) of this group (Fig.7).

Just over 10% of men were killed by an intimate partner where the relationship had been ongoing for longer than 15 years (N=4, 11%) (Fig. 7).

Intimate partner domestic violence homicide – homicide victim characteristics

Age

Most women killed in this category were between the ages of 25 and 44 years (N=78, 60%). The youngest woman killed by an intimate partner was 15 years old and the oldest was aged 80 years (Fig. 8).

[20] T Hotton, 2001, Spousal Violence After Marital Separation 21(7) *Statistics Canada* – Catalogue no. 85-002-XIE available at http://publications.gc.ca/collections/Collection-R/Statcan/85-002-XIE/0070185-002-XIE.pdf> last accessed February 2014; J Campbell et al, 2003, Risk factors for femicide in abusive relationships: results from a multisite case control study 93(7) *American Journal of Public Health* 1089, 1090.

Most men killed in this category were between the ages of 25 and 49 years (N=24, 67%). The youngest was 19 years and the oldest was aged 68 years (Fig. 8).

Region where victim ordinarily resided

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

The highest number of women killed in this category were ordinarily resident in the North West Metropolitan Region (N=30, 23%), followed by the Northern Region (N=28, 22%) (Fig.10).

The highest number of men killed in this category were ordinarily resident in the Northern Region (N=10, 28%), followed by the Central Metropolitan (N=6, 17%) and the Southern Region (N=6, 17%) (Fig.10).

Overall, the highest number of intimate partner homicide victims were ordinarily resident in the Northern Region (N=38, 23%) (Fig.10).

Country of birth

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

Most female (N=91, 71%) and most male (N=30, 83%) intimate partner homicide victims were born in Australia (including Aboriginal Australians, discussed below) (Fig.11).

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

Aboriginal and Torres Strait Islander status

New South Wales has the largest Aboriginal and Torres Strait Islander population in Australia (approximately 208,476 permanent residents) which represents approximately 2.9% of the total New South Wales population.[21]

Of the 129 female intimate partner homicide victims, 12% identified as Aboriginal (N=15).

Of the 36 male intimate partner homicide victims, over one-third identified as Aboriginal (N=11, 31%).

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

Intimate partner domestic violence homicide – case characteristics

Manner of death

Just under one-third of women killed in this category died as a consequence of stab wounds (N=40, 31%). The second most common manner of death was assault (N=31, 24%), followed by shooting (N=22, 17%) (Fig.12).

Most men in this category died as a consequence of stab wounds (N=27, 75%). The second most common manner of death was shooting (N=5, 14%), followed by assault (N=2, 6%) (Fig.12).

Location of death

Most women were killed in their home (N=99, 77%), followed by a public place (N=15, 12%) (Fig.13).

Most men were killed in their home (N=23, 64%), 6 were killed at the homicide perpetrator's home (17%), 3 were killed at another residence (8%), and 3 were killed in a public place (8%) (Fig.13).

Multiple Homicide Events

In this category there were 9 multiple homicide events involving a perpetrator killing their intimate partner as well as another person/s. Of the 9 multiple homicide events, 8 were perpetrated by men and one by a woman.

Of the 9 multiple homicide events:

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

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

[21] Australian Bureau of Statistics,'Australian demographic statistics, March quarter 2013'. Canberra: *Australian Bureau of Statistics* 2013.

Intimate partner domestic violence homicide – homicide perpetrator characteristics

Age

Of the 134 men who killed their intimate partner, the highest proportion were aged between 30 and 44 years (N=65, 49%). The youngest was 17 years old and the oldest was aged 87 years (Fig. 14).

Of the 31 women who killed their intimate partner, the highest proportion were aged between 40 and 44 years (N=8, 26%) (Fig. 14).

The youngest female homicide perpetrator was 20 years old and the oldest was aged 53 years.

Country of birth

Most men (N=93, 69%) and most women (N=27, 87%) who killed their intimate partner were born in Australia (including Aboriginal Australians, discussed below) (Fig.15).

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

Aboriginal and Torres Strait Islander status

Approximately 9% of men who killed their female partner in a context of domestic violence identified as Aboriginal (N=12).

Just under a third of all women who killed their male intimate partner in a context of domestic violence identified as Aboriginal (N=9, 29%).

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

Intimate partner domestic violence homicide – criminal/coronial outcomes

Of the 134 male perpetrators of intimate partner domestic violence homicide, 105 were dealt with by way of criminal proceedings and 29 were subject to coronial proceedings.

Of the 31 female perpetrators of intimate partner domestic violence homicide, 30 were dealt with by way of criminal proceedings and 1 was subject to coronial proceedings.

Criminal proceedings

Of the 105 male perpetrators of intimate partner domestic violence homicide who were dealt with by way of criminal proceedings, two-thirds were convicted of murder (N=70, 67%) (Fig. 16).

The second most prevalent criminal court outcome for men who killed their intimate partners was a guilty verdict/guilty plea manslaughter (N=24, 23%) (Fig.16).

Of the 30 female perpetrators of intimate partner homicide who were dealt with by way of criminal proceedings, half were convicted of manslaughter (N=15, 50%) and almost one-quarter were acquitted (N=7, 23%) (Fig.16).

Coronial findings (perpetrator suicide)

Of the 30 homicide perpetrators who committed suicide after killing their intimate partner, 29 were male and one was female. Accordingly, 22% of all male intimate partner homicide perpetrators committed suicide, and 3% of all female intimate partner homicide perpetrators committed suicide (Fig. 16).

Relative/kin Domestic Violence Homicide

Incidence – all relative/kin domestic violence homicides

Of the 280 homicide victims who were killed in a domestic violence context in the data reporting period, 88 (31%) were killed by a relative/kin in a domestic violence context.

Relative/Kin domestic violence homicide – Child victims

Of the 88 homicide victims killed by relative/kin in a domestic violence context, 60 (68%) were children under the age of 18 years.

Of the 60 children killed by a relative/kin in a domestic violence context, 34 (57%) were boys and 26 (43%) were girls.

Relative/Kin domestic violence homicide – Adult victims

Of the 88 homicide victims killed by relative/kin in a domestic violence context, 28 (32%) were adults over the age of 18 years.

Of the 28 adults killed by a relative/kin in a domestic violence context, 19 (68%) were men and 9 (32%) were women.

Child relative/kin domestic violence homicide – relationship type

Of the 60 children killed by a relative/kin in a domestic violence context, the vast majority were killed by a biological or non-biological parent (N=58, 97%) (Fig.17).

Of the 58 children killed by a parent, most were killed by a biological parent acting alone (N=41, 71%) (Fig. 17).

Of the 41 children killed by a biological parent, most were killed by their father (N=25, 61%). Sixteen children (39%) were killed by their biological mother (Fig. 17).

Of the 58 children killed by a parent, in 13 cases (22%) the child was killed by a non-biological parent acting alone, including their step-father (N=3), de facto step-father (N=8), step-mother (N=1) and foster mother (N=1) (Fig.17).

Three children were killed by their biological mother and father acting together, and one child was killed by her biological mother and de facto step-father acting together.

Two children were killed by their grandfather (Fig. 17).

Child relative/kin domestic violence homicide –victim characteristics

Age

The 60 child homicide victims in this category were aged between 4 weeks and 14 years. Almost two-thirds of all children killed in a domestic violence context were aged between 0 and 4 years (N=38, 63%) (Fig.18).

Of the 38 children killed in the 0-4 year group, the highest proportion were aged under 2 years (N=26, 68%) (Fig.18).

Region where victim ordinarily resided

The highest proportion of the 60 child relative/kin homicide victims killed in a context of domestic violence were ordinarily resident in the Northern Region (N=17, 28%), followed by the South West Metropolitan Region (N=12, 20%) and Southern Region (N=11, 18%) (Fig.19).

Country of birth

All but one of the child homicide victims in this category were born in Australia (N=59, 98%), with the other country of birth being India (Fig. 20).

Aboriginal and Torres Strait Islander status

Of the 60 child homicide victims in this category, 17% (N=10) identified as Aboriginal.

Child relative/kin domestic violence homicide – case characteristics

Manner of death

Almost one-third of the 60 child homicide victims in this category died as a consequence of a physical assault (N=19, 32%), followed by poisoning/noxious substance (N=10, 17%) and suffocation/strangulation (N=9, 15%) (Fig.21).

Location of death

Three-quarters of the 60 children killed by a relative/kin in a domestic violence context were killed in their home (N=45, 75%). Eight children were killed at the perpetrator's residence (13%); 5 children were killed in public/open spaces (8%) and 2 children were killed at another residence (3%) (Fig.22).

Multiple Homicide Events

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

Of the 10 multiple child homicide events, 6 were perpetrated by the children's biological father, 3 by the children's biological mother and one by the children's biological grandfather.

Child relative/kin domestic violence homicide – perpetrator characteristics

The 60 child homicide victims in this category were killed by 51 perpetrators: 32 males and 19 females.

Age

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

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

Country of birth

Most male (N=24, 75%) and almost all female (N=17, 89%) perpetrators who killed a child in this category were born in Australia (including Aboriginal Australians, see below) (Fig.24).

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

Aboriginal and Torres Strait Islander status

Of the 51 homicide perpetrators who killed a child in this category, 6 (12%) identified as Aboriginal – 5 males (16% of all male perpetrators) and 1 female (5% of all female perpetrators in this category).

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

Of the 32 male perpetrators who killed a child in this category, 20 were dealt with by way of criminal proceedings and 11 were subject to coronial proceedings. In one case, the male homicide perpetrator died before the matter went to trial and, accordingly, the proceedings were discontinued.

Of the 19 female perpetrators who killed a child in this category, 17 were dealt with by way of criminal proceedings and 2 were subject to coronial proceedings.

Criminal proceedings

Of the 20 male homicide perpetrators who were dealt with by way of criminal proceeding, 60% (N=12) were convicted of manslaughter; 35% (N=7) were convicted of murder; and 1 (5%) was found not guilty by reason of mental illness (Fig.25).

Of the 17 female homicide perpetrators who were dealt with by way of criminal proceedings, 71% (N=12) were convicted of manslaughter; 24% (N=4) were convicted of murder; and 1 (6%) was found guilty of infanticide (Fig. 25).

Coronial findings (perpetrator suicide/death)

A quarter of all homicide perpetrators who killed a child relative/kin in a domestic violence context committed suicide[22] (N=13, 25%).

This included 11 males (34% of all male perpetrators in this category) and 2 females (12% of all female homicide perpetrators in this category) (Fig. 25).

[22] This included one perpetrator who died accidentally as a consequence of burns after he killed his intimate partner and her son.

Adult relative/kin domestic violence homicide – relationship type

Of the 28 adults killed by a relative/kin in a domestic violence context, 19 (68%) were men and 9 (32%) were women.

Of the 19 men killed by a relative/kin in a domestic violence context, 32% (N=6) were killed by their son/step-son. In the other 13 cases the man was killed by his:

- daughter/step-daughter (N=3, 16%);
- son-in-law (N=3, 16%)
- brother (N=2, 11%);
- brother-in-law (N=2, 11%);
- father (N=1, 5%);
- mother-in-law (N=1, 5%); and
- nephew (N=1, 5%) (Fig.26).

Of the 9 women killed by a relative/kin in a domestic violence context, 44% (N=4) were killed by their son/step-son. In the remaining 5 cases the woman was killed by her:

- daughter/step-daughter (N=2, 22%);
- brother-in-law (N=1. 11%);
- nephew (N=1, 11%); and
- son and daughter acting together (N=1, 11%) (Fig.26).

Of the 28 adult homicide victims who were killed by a relative/kin in a domestic violence context, 14 were victims of domestic violence who were killed by a domestic violence abuser. Ten homicide victims were domestic violence abusers.

In three cases the homicide victim was neither a domestic violence victim nor abuser but was killed by an abusive relative in the context of a multiple fatality event (where the abuser's victim was also killed).

The remaining case involved a man killing his mother in circumstances where there had been physical and psychological violence perpetrated by both parties.

Adult relative/kin domestic violence homicide – victim characteristics

Age

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

Most male victims were aged between 40 and 54 years (N=8, 42%) while most female victims were aged 45-49 years (N=4, 44%) (Fig. 27).

Region where victim ordinarily resided

The highest proportion of adult relative/kin homicide victims killed in a context of domestic violence were ordinarily resident in the Northern Region (N=10, 36%), followed by the South West Metropolitan Region (N=8, 29%) (Fig. 28).

Country of birth

Over half of all the adult homicide victims in this category were born in Australia (N=17, 61%). Other countries of birth included: New Zealand, the United Kingdom, Italy, Romania, Iraq, Lebanon and India (Fig.29).

Aboriginal and Torres Strait Islander status

Of the 28 adult relative/kin homicide victims killed in a domestic violence context, 14% (N=4; 1 man, 3 women) identified as Aboriginal.

Accordingly, of the 9 female homicide victims in this category, one-third identified as Aboriginal.

Adult relative/kin domestic violence homicide – case characteristics

Manner of death

Half of all adult homicide victims killed by a relative/kin in a domestic violence context died as a consequence of stab wounds (N=14, 50%). Other manners of death for adult homicide victims in this category included:

- shooting (N=7, 25%);
- assault (N=3, 11%);
- suffocation/strangulation (N=1, 4%); and
- multiple causes (N=1, 4%).

In two cases (7%) the cause of death was unknown (Fig.30).

Location of death

All female (N=9) and most male (N=14, 74%) homicide victims in this category were killed in their home (Fig.31).

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

Multiple Homicide Events

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

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

Adult relative/kin domestic violence homicide – perpetrator characteristics

The 28 adult homicides in this category were perpetrated by 28 perpetrators: 22 male perpetrators and 6 female perpetrators.

Age

The youngest male perpetrator in this category was 18 years and the oldest was aged 55 years (Fig.32).

The 6 female perpetrators who killed an adult in this category were aged between 13 years and 70 years (Fig.32).

Country of birth

About two-thirds of male perpetrators (N=14, 64%) and almost all female perpetrators (N=5, 83%) who killed an adult relative were born in Australia (including Aboriginal Australians, see below).

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

Aboriginal and Torres Strait Islander status

Of the 28 relative/kin homicide perpetrators who killed an adult victim, 4 identified as Aboriginal (14%, all male).

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

Of the 22 male perpetrators who killed an adult in this category, 20 were dealt with by way of criminal proceedings and 2 were subject to coronial proceedings.

Of the 6 female perpetrators who killed an adult in this category, all were dealt with by way of criminal proceedings.

Criminal proceedings

Of the 20 male homicide perpetrators who were dealt with by way of criminal proceedings, almost half were found not guilty by reason of mental illness (N=9, 45%). Of the other 11 perpetrators, 30% (N=6) were convicted of murder; 25% (N=5) were convicted of manslaughter; and two (10%)

were acquitted on the basis of self-defence (Fig.34).

Of the 6 female homicide perpetrators, 2 (33%) were convicted of murder, 2 (33%) were convicted of manslaughter, 1 (17%) was found not guilty by reason of mental illness and 1 (17%) was acquitted on the basis self-defence (Fig.34).

Coronial findings (perpetrator suicide)

Of the 28 homicide perpetrators in this category, 2 (7%, both male) committed suicide immediately after the homicide (Fig.34).

'Other' domestic violence homicide

Incidence – all 'other' domestic violence homicides

Between 1 July 2000 and 30 June 2012, there were 27 homicide victims who had no direct domestic relationship with the homicide perpetrator but the circumstances of the death were such that it was determined to have occurred in a context of domestic violence.

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

All 27 homicide victims in this category were men.

There were 28 homicide perpetrators in this category, noting that one man was killed by both the husband and son of a woman with whom he was having an affair. All other cases involved a single perpetrator and single victim.

All but one of the 28 homicide perpetrators in this category were men.

'Other' domestic violence homicide – relationship characteristics

Most homicide victims in this category were 'new intimate partners' (N=18, 67%) who were killed by their wife or girlfriend's former abusive male partner.

In these cases, the coercion and control exercised by the homicide perpetrator against his former female partner continued after the dissolution of the relationship, and the domestic violence victim's entry into a new relationship intensified the abuser's ongoing domestic violence towards her.

Other relationships in this category included:

- **2** cases where the homicide victim was a bystander intervening in domestic violence between the perpetrator and his female partner;
- **2** cases where the homicide victim was killed by their daughter's abusive boyfriend;
- **3** cases where the homicide perpetrator killed their current wife/girlfriend's former domestic violence abuser;
- **1** case where a man was killed by his abusive flatmate;
- **1** case where a domestic violence abuser was killed by a contract killer who was hired by his wife.

'Other' domestic violence homicide – victim characteristics

As noted above, all 27 homicide victims in this category were men.

Age

Homicide victims in this category were aged between 24 and 64 years, with the highest proportion being aged between 25-29 years (N=7, 26%) (Fig.35).

Region where victim ordinarily resided

The highest number of homicide victims in this category were ordinarily resident in the the Northern Region (N=6, 22%), followed by the Central Metropolitan Region (N=5, 19%), then the North West Metropolitan Region, Southern Region and Western Region, each of which had 4 homicide victims (15%) (Fig.36).

Country of birth

Most homicide victims in this category were born in Australia (N=21, 78%),with other countries of birth including Malaysia, the Cook Islands, Fiji, the United Kingdom, the Netherlands, and Korea (Fig.37).

Aboriginal and Torres Strait Islander status

Two homicide victims in this category identified as Aboriginal (7%).

'Other' domestic violence homicide – case characteristics

Manner of death

Most homicide victims in this category died as a consequence of stab wounds (N=16, 59%), followed by shooting (N=10, 37%) and assault (N=1, 4%) (Fig.38).

Compared to the overall representation of shooting as a manner of death across all categories (N=42, 15% of all domestic violence homicides), shooting was more highly represented in this category (Fig. 38).

Location of death

Most homicide victims in this category were killed at their own home (N=11, 41%), followed by the perpetrator's residence (N=8, 30%) (Fig.39).

'Other' domestic violence homicide – perpetrator characteristics

As noted above, 27 homicide perpetrators in this category were men and one homicide perpetrator was a woman.

Age

Homicide perpetrators in this category were aged between 16 and 69 years, with the highest proportion being aged 40-49 years (N=9, 32%) (Fig.40).

Country of birth

Almost two-thirds of all the homicide perpetrators in this category were born in Australia (N=18, 64%).

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

Aboriginal and Torres Strait Islander status

Two homicide perpetrators in this category identified as Aboriginal (7%).

'Other' domestic violence homicide – Criminal /Coronial outcomes

Of the 28 perpetrators, 27 were dealt with by way of criminal proceedings (26 male perpetrators and 1 female perpetrator) 1 was subject to coronial proceedings.

Criminal proceedings

Just under half the perpetrators in this category were convicted of murder (N=13, 46%).

Of the 28 homicide perpetrators, 11 (39%) were convicted of manslaughter.

Three (11%) perpetrators in this category were acquitted, one on the basis of self-defence (4%) and two on the basis of defence of another (7%)(Fig. 42).

Coronial findings (perpetrator suicide)

One male perpetrator in this category committed suicide after the homicide (Fig. 42).

3 CASE REVIEW SUMMARIES
DOMESTIC VIOLENCE HOMICIDE 2010 – 2012

This chapter sets out case summaries of the 30 domestic violence homicides that occurred in NSW between 1 July 2010 and 30 June 2012. Each case was reviewed by the Team in a series of full day workshops in order to identify common themes, issues and areas for recommendation.

WARNING: These case summaries include some information that readers may find distressing. The details in these summaries are included to assist readers in understanding the complex dynamics of domestic violence and the characteristics of these cases. The Team hopes that these commentaries can help readers to understand more about these tragedies, so we can learn from these deaths and prevent future losses of life. To protect the identity of people involved, names have been changed for each case review.

Intimate partner domestic violence homicide

Domestic violence victim killed by domestic violence abuser

CASE REVIEW 3043

This case concerned the homicide of Sophia, a woman in her late 20s, by her abusive former de facto husband, Jason (aged in his early 30s). Sophia and Jason had been in a relationship for 6 years and had separated about 2 months before the homicide.

Sophia met Jason, her first boyfriend, when she was around 20 years old.

Jason had a long history of domestic violence against former partners. He was described by former partners as being possessive, jealous, violent and controlling. His abusive behaviours included stalking, verbal and physical violence (including strangulation). He was a prior defendant in an ADVO with his former partner, Fiona.

Shortly after meeting, Sophia and Jason moved in together. From the outset, Jason was verbally abusive towards Sophia. He would regularly stalk her by checking her phone and would also accuse her of cheating on him. The couple broke up early in the relationship, but Jason harassed Sophia until she once again commenced a relationship with him.

Jason was also physically violent towards Sophia – mainly by pushing and shoving her. He was controlling in every aspect of the relationship, including in terms of finances and controlling who Sophia could socialise with. There is also evidence that Jason was sexually abusive towards Sophia.

Sophia became pregnant early in their relationship. Sophia and Jason had two sons, close together in age. Jason regularly criticised Sophia's parenting skills and did not help care for the children.

Sophia indicated that she was intending to leave Jason in late 2010. After breaking up and getting back together a few times, Sophia ended the relationship in early 2011. After the relationship ended, Jason continued to threaten Sophia and sent her continuous abusive text messages. Jason also physically assaulted her on at least two occasions, including one episode where he hit her and kicked her in the stomach when she dropped off their older son to Jason's house for a contact visit (pursuant to informal care arrangements).

A few weeks before the homicide, Jason sent Sophia a text message saying 'you can have the kids, I don't want them'. Sophia told her older son's day care that she wanted to remove Jason's name from the list of people authorized to collect her son from the centre. The director explained that she would need copies of court orders to prevent the child's father from picking him up. The director asked if everything was ok at home. Sophia told her that Jason had keyed her car and smashed her phone. The director said if there was anything she could do to help Sophia should let her know. Around the same time, Sophia also commenced a relationship with a new partner.

A few days after the conversation at the day care centre, Jason assaulted Sophia at her home and she called the police. By the time police arrived, Jason had left. The officer asked if Sophia wanted to apply for an ADVO but she declined. Sophia denied being afraid of Jason. The officer gave her a

domestic violence referral card and informed Sophia to call the police she needed anything further.

Several days later Sophia again contacted the police after Jason tried to break into her house. Again, Jason had left the property by the time police arrived. One of the officers checked that Sophia and the children were all ok and Sophia was again given domestic violence referral information.

Around the same time Jason also threatened Sophia's landlord to try and get Sophia kicked out of the property.

A few days prior to the homicide, Sophia sought family law advice. She planned to file documents at the Family Court concerning parenting arrangements for the children on the day of the homicide.

On the morning of the homicide, Jason called into work saying he was sick as he had been drinking throughout the night. He emailed Sophia, asking her to bring their youngest child over to his house. When Sophia came to the house, Jason asked her how she was going with her internet dating. He admitted that he had been contacting her on dating sites using a false name.

Jason then assaulted and strangled Sophia. After he killed Sophia, Jason texted her new boyfriend and told him that he would 'never see' Sophia again. Jason withdrew money from the ATM and went and picked up his eldest son from day care.

Jason took the children to a remote location and made several phone calls to family members. Police – now aware of Sophia's homicide – located Jason a few hours later and, after a short discussion, Jason handed the children over to police.

Jason was convicted of Sophia's murder.

CASE REVIEW 3367

This case concerned the homicide of a woman in her 40s (Amy) by her abusive de facto partner of 12 months, Shaun (who was aged in his 20s).

Amy was born in New Zealand and had lived in Australia for a number of years in a coastal town. She had an older teenage son from a previous relationship who continued to reside in New Zealand. Amy was described by friends and family as a bubbly and kind woman, and she remained close with her family and friends.

After arriving in Australia on a visa and securing a job, Amy was diagnosed with cancer. Soon after commencing treatment she lost her job. As a consequence of her growing medical bills, she started working as a sex worker while she looked for work in the hospitality industry. Shaun was one of Amy's clients.

Shaun was born in Australia. He had a long history of abusing alcohol and drugs (this commenced when he was around 12 years old, when he started smoking 100 cannabis cones per day). He also had a long criminal history which included violence and drug offences. From the age of about 15 or 16 Shaun became homeless when his mother moved interstate. He had a history of mental illness including hospitalisation for schizophrenia.

Shaun was on bail at the time of the homicide and there was a warrant outstanding for his arrest (pertaining to a number of drug offences and firearms charges). In the months prior to the homicide Shaun had stopped using cannabis, and commenced using steroids. He was still abusing alcohol.

Soon after meeting, Shaun and Amy commenced a relationship. From the outset Shaun was abusive towards Amy - he called her names and was physically violent. Shaun was very jealous, possessive and manipulative in his behaviours; he would present Amy with gifts following episodes of violence, and would apologise profusely for his violent behaviours. Shaun would accuse Amy of infidelity on a regular basis and would stalk Amy by checking her phone and deleting her male contacts.

On at least one occasion Shaun threatened to kill Amy. Amy had also disclosed to friends that Shaun had threatened her with a knife to her throat on at least one occasion some months prior to the homicide.

There was no police contact in relation to Shaun's domestic violence towards Amy. In the period leading up to the homicide Amy was in contact with a neighbourhood centre, seeking assistance in relation to gaining work. Amy disclosed her experiences of verbal abuse to staff at the centre. The worker at the centre advised Amy that 'she should consider finding someone who would value her'.

While she was in a relationship with Shaun, Amy commenced a job at a local café. Three days before the fatal episode of violence Amy arrived at work with significant facial injuries. She disclosed to her manager that Shaun had assaulted her and had

deleted all the male contacts from her phone. Amy's colleagues advised her to contact the police but she indicated that Shaun had threatened her with violence if she were to do so.

The following day at work Amy told her manager that she had argued with Shaun the previous evening and had told him to leave. Shaun had left the house with his belongings.

The following night Shaun returned to Amy's house and killed her.

The precise details of the homicide are unknown. Shaun was heavily intoxicated at the time of the fatal episode of violence and there is evidence he perpetrated a protracted assault against Amy which led to her death. After killing Amy, Shaun drove her body to his brother's house and sought assistance to 'dispose of the evidence'. Shaun's brother refused, and later that evening he went to the police station to report the homicide.

Shaun left Amy's body at his brother's house and left the premises in his car. He was pulled over by police and arrested for driving under the influence of alcohol. He was conveyed to the police station, where he was arrested on the outstanding warrants. He was subsequently charged with Amy's murder.

Shaun pleaded guilty to murdering Amy.

CASE REVIEW 3265

This case concerned the homicide of woman aged in her early-20s (Leila) by her boyfriend of 6 months who was aged in his mid-20s (Drew). Both Leila and Drew lived in a metro area in social housing and both were heavy drug and alcohol users.

Throughout Drew's childhood, he was a victim of domestic violence by his father. Drew's elder siblings were removed from the family when he was young, but Drew remained in the care of his mother, who was also a domestic violence victim. Drew had a long criminal record which commenced when he was a teenager, and included several periods of imprisonment. He also had psychiatric problems which were diagnosed when he was a teenager and these coincided with his drug use. Drew had previously been hospitalised suffering from schizophrenia.

Leila was born in North America, and her and her siblings were removed from her mother and father's care at a young age, to live with other family members. When she was around 14 years old Leila started a relationship with an older boy. The boy was abusive towards her and also used drugs and alcohol. Leila's carer thereafter moved to Australia and took Leila and her siblings with her.

When she arrived in Australia, Leila refused to go to school as she said she did not want to have to make new friends. Eventually Leila's carer and the other siblings decided to return to North America but Leila chose to stay in Australia.

Leila started living in social housing premises and was unemployed. She had a minor criminal record in Australia, primarily for stealing offences.

Leila started a relationship with Drew. Drew had a history of violence against previous partners, including assault convictions and historical ADVOs. Some months prior to the homicide, Drew attempted to strangle Leila in front of friends. One of Leila's friends reported this assault to police, but recanted his statement the following day.

There was no other reported history of violence between Leila and Drew, but she had indicated to friends that she was afraid of him.

On the night of the homicide both Drew and Leila consumed a large quantity of alcohol and illicit drugs. Later that night, Drew attempted to leave Leila's apartment, and when she pleaded with him to stay, he twisted the scarf she was wearing around her neck. She collapsed and remained unconscious. Drew left the unit later and called his brother to indicate what had happened.

Leila was found deceased the following morning by her neighbour.

Drew initially lied to police about what had happened that evening. He was eventually charged with Leila's murder. He offered to plead guilty to manslaughter but this was rejected. The case proceeded to trial, and the jury found him guilty of manslaughter.

The judge in sentencing described this case as being one of the 'least culpable' cases of manslaughter in his experience.

CASE REVIEW 3302

This case concerned the homicide of a 50 year old woman, Judy, by her 50 year old boyfriend, Lars. The couple had only known each other for about 3 months at the time of the homicide and, of that time, had only spent about 8 days living together. Judy

lived in a regional area and Lars lived in the city. Lars had been born overseas in Europe, but had lived in Australia for a number of years.

Judy met Lars in 2011 at a pub. They exchanged phone numbers and commenced a long distance relationship. Both Lars and Judy would drink heavily on a daily basis. Lars had a significant criminal record for DUI offences, but Judy had no criminal record. They both had adult children from previous relationships.

A few months after they commenced a long distance relationship, Lars came and stayed with Judy for 4 days. Lars described the relationship as 'going well' but acknowledged that they were arguing about 'trivial things'. After this first visit Lars and Judy decided that they would get married and began to plan for a wedding in a few months' time.

After their engagement, Judy told friends that Lars was 'bombarding' her with text messages and that she was thinking of changing her mobile number. There are reports that she was excited about the wedding at times, but at other times she wanted to call the wedding off.

Lars moved into Judy's house a week before the homicide. Around this time Judy phoned a friend and told her that the wedding was off, but phoned again the next day to say that it was back on.

The day before the homicide, a tradesman came to Judy's flat and said that she seemed 'extremely frightened' of Lars and that she appeared to 'tread carefully' around him. He heard the couple arguing and said that Lars appeared 'agitated' and 'on edge'. He also stated that Lars made a number of derogatory comments to Judy, for example, about her lack of cooking skills.

There is otherwise no history of reported or anecdotal domestic violence between Lars and Judy.

On the day of the homicide, Lars did some work in the garden. In the afternoon, he and Judy walked to the small local shopping centre where they purchased food, tobacco, and a bottle of rum. By early evening, they had drunk the bottle of rum and Lars returned the shops and purchased a large cask of wine.

Lars was back at Judy's flat by about 9:15pm. He made a phone call, and Judy cooked dinner.

While Judy was cooking, Lars struck Judy several times from behind using a wooden baton that she kept in the flat for her own protection. Judy attempted to escape from the kitchen into the front yard via the glass sliding door, but she was unable to do so and collapsed on the kitchen floor. There is evidence she tried to get away from Lars, but he continued to attack her.

She died of a number of blunt force trauma injuries including a skull fracture.

After a few hours, Lars called the police. When the officers attended he told them he had arrived back from the shops to find Judy brutally murdered by an unknown assailant.

Lars pleaded not guilty to Judy's murder and maintained that she had been killed by some unknown perpetrator. He was found guilty of her murder at trial.

CASE REVIEW 3303

This case involved the homicide of a woman in her late 20s, Denise, by her abusive de facto partner Michael (aged in his mid-20s). Both Denise and Michael identified as Aboriginal.

Michael grew up in a regional area of NSW and his childhood was characterised by ongoing domestic violence by his step-fathers against his mother and himself, his sister and brother. Michael had no relationship with his biological father as he was in prison for the majority of Michael's childhood. At the time of the homicide Michael's natural father was in custody for the attempted murder of his de facto wife. In 2008 Michael's mother was killed by her de facto partner (Michael's step-father) following a long history of domestic violence. This case was reviewed by the NSW DVDRT for the *12/13 Report*, *Case Review 2965*.

In addition to experiencing significant domestic violence throughout his childhood, Michael developed significant drug and alcohol problems from an early age and he smoked cannabis daily from the age of 12. He had an anecdotal history of hearing voices, and was diagnosed after the homicide as suffering from foetal alcohol spectrum disorder.

Michael described having a loving and stable relationship with his grandmother and his aunties, and finished school during year 11. After finishing school he held a number of jobs.

Michael was a domestic violence abuser against his former partners and at the time of the homicide he

was on a good behaviour bond for an assault against his former girlfriend. He had previously perpetrated physical violence against partners and had threatened to kill his former girlfriend. He also had a history of ADVOs (as a defendant) with former partners.

No information was available about Denise's childhood or background.

During Denise's adult life she received treatment for bipolar spectrum disorder. She was prescribed antipsychotics. She also had a history of self-harm and had previously experienced a psychotic episode.

Denise had a short criminal history including one driving offence and a violence offence against her mother (perpetrated in the context of her mental illness).

At the time of the homicide Michael and Denise had been in a relationship for approximately 12 months. There was a long history of Michael abusing Denise, and there was significant police contact in relation to Michael's domestic violence against her.

Denise had disclosed her experiences of violence to many friends and family and she had also been seen with injuries on many occasions.

In the days prior to the homicide, Michael's cousin described visiting Denise and Michael and sighting 'healing bruises' around Denise's eyes. He didn't intervene as he believed it was 'personal business'.

On the evening of the homicide both Michael and Denise were smoking cannabis and drinking beer and spirits with some friends. During the evening Michael and Denise began to argue over a text message Michael had received. Over a number of hours Michael physically abused Denise. When Denise's friends arrived later they saw Denise with black eyes and significant injuries, and noted that Michael had injuries visible on his arms.

Friends witnessed the fatal assault, which involved Michael punching Denise in the face. After Michael realised that Denise was seriously injured and unconscious, he called 000. Michael was arrested at the scene and Denise died later that morning in hospital.

Michael pleaded guilty to Denise's murder.

CASE REVIEW 3301

This case concerned the murder of a woman in her late 40s, Georgia, by her 60 year old husband Fred. The couple lived together in the city and had been married for over 25 years. There is evidence that their relationship was breaking down at the time of the homicide.

Fred was born in Eastern Europe into a 'close knit' and 'religious' family. Fred described his childhood as happy. After he finished school, Fred moved to Australia where he studied a trade. After obtaining his qualification, he returned to Europe where he met Georgia.

Little evidence was available concerning Georgia's family background and childhood.

Fred and Georgia married in Europe during the early 1980s, when Georgia was 19 years old. The couple moved to Australia 2 years after they were married and had two children.

Fred worked part time in a furniture store and Georgia owned her own service industry business. From time to time Fred would help out Georgia with her business. There was evidence that in the years before the homicide Fred became increasingly aggressive towards Georgia and the quality of his work declined.

In the years leading up to the homicide, Georgia was becoming increasingly independent and successful in her work. A number of her employees interviewed after the homicide indicated that Fred and Georgia would regularly fight, and that Fred would drink on the job from time to time. Most indicated that they believed Fred was 'harmless' due to his 'small stature' and 'retiring nature', and most described Georgia as the 'active' and 'independent' one in the relationship.

In the months prior to the homicide, Fred suspected that Georgia was having an affair with an owner of another business; an allegation that Georgia denied. The man she was suspected of having an affair with denied the affair, but noted that Georgia had told him that Fred was 'nasty'. There was no other evidence that Georgia was having an affair. Neither Fred nor Georgia had a criminal record at the time of the homicide.

In the months prior to the homicide there was evidence that the relationship between Georgia and Fred was breaking down and that Fred's threats and violence were escalating. There was no police contact in relation to domestic violence between

Fred and Georgia, but friends and family reported that Georgia disclosed on a number of occasions that Fred was violent towards her. Fred was socially controlling and possessive of Georgia, and would control who she could see and what she could wear.

Georgia disclosed to her daughter that she was scared of Fred. Georgia also disclosed to her daughter that Fred had attempted to strangle her while she was sleeping.

There was also evidence that Fred had threatened to kill Georgia.

Several days before the homicide, Georgia was at work and told her colleague that 'if you don't see me again you know I'm dead'.

The morning of the homicide Fred told his son that he was planning on divorcing Georgia. Georgia and Fred's daughter also reported hearing her parents arguing, and heard her father threaten her mother.

The couple's daughter left the house but the son remained at home.

A short time later, Fred came into his son's room and told him he had killed Georgia. Fred called 000. Fred had stabbed Georgia over 30 times and there was evidence that he had savagely assaulted her.

Fred offered to plead guilty to manslaughter but the Crown did not accept his plea. Fred was found guilty of murder.

CASE REVIEW 3298

This case concerned the homicide of a woman in her mid-40s, Ella, by her estranged husband Benny who was aged in his mid-50s. After killing Ella, Benny killed himself. The relationship between Ella and Benny had broken down some months prior to the homicide and in the lead up to the homicide Ella was progressing the couple's divorce.

Ella was described by friends and family as 'highly social' and 'extroverted'.

Ella met and married her first husband during the 1980s. After that relationship ended, she had a number of partners before meeting Benny in the early 1990s.

Benny grew up in Queensland and had been married during the 1980s. Benny also had a son from a previous relationship.

There was no evidence that Benny was abusive with other partners or family members. Benny's former partner described him as a 'gentle' and 'quietly spoken' man who did not like conflict.

Benny and Ella married in the early 1990s and around this time Ella began to raise the idea of having a baby. Without any discussion or consultation with Ella, Benny had a vasectomy. When Ella spoke about this with friends she was visibly upset but said, 'look there is nothing I can do about it now, so there is no point talking about it.' This kind of behaviour characterised Benny's violence towards Ella – he was known for being passive aggressive and controlling in his behaviours, and there was no history oh physical violence disclosed prior to the homicide.

The relationship between Benny and Ella began to deteriorate in the late 2000s and by early 2009 Ella was telling friends that she and Benny were 'still living in the same house but not as a married couple.' When asked why they were still living together Ella said, 'obviously he hasn't got anywhere, I can't afford to move out. I don't want to sell the house. If we sell the house nobody wins. At least with the house we've got somewhere to live.'

In early 2009, Ella sent Benny an email annexing the Family Court of Australia fact sheet *'Separated but living under one roof?'* By this time, Ella and Benny were living together but not sleeping in the same room. They were conducting almost totally separate lives.

In late 2009 Ella started seeing a new partner. This relationship lasted a few months and Benny was aware of Ella's new partner as she often brought him to the house.

In early 2011, Ella sent Benny an email with the subject 'divorce'. This email contained a link to further family law information from the Family Court of Australia website.

In mid-2011, Ella told her sister that she was putting in the paperwork for the divorce. She said the plan was to buy a property for Benny to move into and then, in about five years, he would sign the house over to her and she would sign the new property over to him. She said 'by helping him, nobody loses out and it ends amicably. '

Around this time Ella told a friend that she had asked Benny to sign the divorce papers but he was refusing to do so. She told friends that Benny felt it

'was all happening too fast' and that they didn't have to get divorced and could 'try again.'

About 12 years prior to the homicide Ella had undergone hip surgery and she was receiving regular treatment for ongoing complications at the time of the homicide.

A few weeks before the homicide, Ella found out that her health fund was not going to cover the cost of her corrective hip surgery (approximately $15,000) and she obtained an extension of the mortgage to pay for the procedure. Around this time Ella also made a new profile on RSVP and continued to search for a partner. In the lead up to the homicide, Ella's 19 year old cat also died. Both Ella and Benny were very upset.

The night of the homicide Benny sent an email to his brother with a word document attached stating that 'I have taken Ella's life to stop the pain, and then my own' and then setting details regarding the couple's various assets.

Benny also emailed his son apologising for 'what he had done'.

Benny then called the local police station and indicated that there was about to be a homicide at the couple's address.

When police arrived they found Benny and Ella deceased. Benny had shot Ella earlier in the evening and then had killed himself after sending the emails. There were four firearms registered to Benny and Ella and they were kept in a safe in the house. Benny used one of the registered firearms to kill Ella and then kill himself.

CASE REVIEW 3310

This case involved the homicide of a woman in her late 20s, Bridgette, by her former boyfriend Steven (aged in his early 30s). Bridgette and Steven had been in a relationship about ten years prior to the homicide, but there is evidence that patterns of coercion and control continued after separation.

Little is known about Bridgette's childhood. Bridgette had a mild intellectual disability but received no support or assistance in relation to this and as a consequence, struggled at school. There was evidence that Bridgette had suffered child abuse and domestic violence throughout her childhood. She left high school early and was never engaged in paid employment.

Bridgette had a long history of involvement with Child Protection Services, both as a child herself and later as an adult in relation to her own children.

Bridgette had no criminal record at the time of the homicide, and she had three young children all of whom were in the care of Child Protection Services.

She had a long history of using drugs and alcohol.

Little is known of Steven's childhood. He had a criminal record at the time of the homicide. In the early 2000s he had been defendant under an ADVO which protected Bridgette. There were no criminal charges associated with the ADVO.

Steven used alcohol and drugs, and he would borrow money from friends and associates in order to fund his substance use habits.

Despite breaking up almost ten years prior to the homicide, Bridgette and Steven continued to see one another. There is evidence that Bridgette continued to be frightened of Steven, and that Steven would borrow money off her to fund his drug and alcohol use. There are suggestions that Steven used physical violence against Bridgette on a number of occasions over the ten years prior to the homicide, but these were never reported to police. There is also evidence that Steven would seek out highly vulnerable women as partners, and was violent towards these women, within the ten years after he and Bridgette ended their relationship.

The night of the homicide Steven saw Bridgette at the local pub. Later in the night Bridgette disclosed to a friend that Steven was harassing her. Over the next few hours, Steven called Bridgette a number of times. Bridgette left the pub with Steven and her friend Kyle and she went straight to Kyle's house.

In the early hours of the next morning Bridgette left Kyle's house and went to Steven's house in a taxi.

Bridgette was reported missing several days later after she failed to answer her phone.

Over the next few weeks Steven indicated to a number of friends that he had 'killed someone', and that he was 'scared'. He indicated that he had killed an intruder, and that he had blacked out and found the body at his home. These disclosures were not reported to police.

Just under a month later, Bridgette's body was found in a car on the side of a quiet street.

Steven was questioned over the homicide and told police that Bridgette had come over to his house in a taxi that night, and then they had argued about money that she owed him. He claimed that he 'blacked out' and killed her. He claimed he 'panicked' and attempted to dispose of the body by wrapping it in plastic. He then put it in the trunk of his car, changed the numberplates of his car to avoid detection and left his car on the side of a street after it broke down.

After a period of time Steven pleaded guilty to Bridgette's murder.

CASE REVIEW 3434

This case concerned the homicide of a 50 year old paraplegic Aboriginal woman, Kimberley, by her abusive boyfriend, Mark. Mark was in a relationship with his de facto wife Brenda at the same time, and they lived together on the other side of town.

Mark was the eldest of 15 children. Mark did not report witnessing any violence or experiencing any abuse during his childhood. He never received any formal qualifications and finished school at the end of Year 8. He would drink to excess 4-5 nights per week from about the age of 18. He had a lengthy criminal record which included a current enforceable ADVO against his partner Brenda, driving offences, stalking, malicious damage, breaches of ADVO, sexual assaults, child sexual assault and other offences. He had served several periods of imprisonment for these offences.

Mark was a long term domestic violence abuser against his female partners, including his first wife. His abusive behaviours included physical, psychological and verbal abuse, and he also had a history of sexually abusing his biological children.

At the time of the homicide, Mark was on bail for assaults against Brenda and was required to report to a local police station daily as part of his bail conditions. There was an upcoming court date for this assault scheduled to take place a few weeks after the homicide.

Mark was unemployed at the time of the homicide and Kimberley was on a disability pension.

Little is known of Kimberley's childhood. She suffered from spastic paraplegia which had confined her to a wheelchair for the last 20 years of her life. She received homecare daily, and was living in social housing.

The relationship between Mark and Kimberley had been on foot for 14 months at the time of the homicide. There was significant evidence of domestic violence between Mark and Kimberley. Kimberley was frequently seen by her community nurse with significant bruising. There is no evidence that this issue was ever raised directly with Kimberley, nor any referrals or investigations made into the cause of those injuries. Kimberley's sister also saw injuries to her face and deduced that Mark had caused them. Kimberley indicated that if her sister called the police, she would lie about Mark's violence and deny that he had caused the injuries.

Both Kimberley and Mark were alcoholics and would regularly drink together.

The night of the homicide Kimberley and Mark were at Kimberley's house drinking. During the course of the evening, Mark set Kimberley on fire using methylated spirits as an accelerant. While he claimed that Kimberley had goaded him into doing so, this was rejected by the court at his trial. Mark left Kimberley and went home, where he disclosed to Brenda that he had set Kimberley on fire. In the meantime, Kimberley contacted a neighbour who called police and ambulance. Kimberley died from extensive burns.

Mark pleaded guilty to murder.

CASE REVIEW 3308

This case concerned the death of Frieda who was killed by her current husband of over 30 years, Gareth. Both Gareth and Frieda were aged in their mid-50s. Gareth had a long history of domestic violence against Frieda, and he also had a long history of mental illness.

Frieda and Gareth met and married in the 1980s and had a number of children. Gareth started showing signs of mental illness early in the relationship and saw a psychologist for a very short period of time. Gareth regularly accused Frieda of having affairs, including with his brother-in-law Ted. Over the next 10 years Gareth continued to threaten and harass Ted and his family, including making threats on Ted's life. On one occasion he also forced Frieda to prove (through hypnosis) that she was being faithful to him. The whole family attended this appointment, but Gareth did not believe the hypnotherapist when he said that Frieda was being faithful.

In the late 1980s the family moved to a property in rural NSW.

In January 1990 Gareth was admitted to hospital with paranoid delusions, suicidal and aggressive behaviour. The hospital records noted that Gareth had a history of 'unprovoked violent episodes' during which he had threatened to kill himself and other family members. The records also noted that Gareth was 'violent towards children'. Gareth was prescribed medication and discharged himself from hospital.

Between 1990 and 1997 Gareth continued to threaten Ted and his wife. In 1991 the police were called in relation to a domestic violence assault against Frieda by Garethbut no action was taken. In September 1997, Gareth assaulted Frieda with a butcher's knife and accused her of 'being up to her old tricks'. He accused her and their neighbour, Solomon, of having an affair, and confronted Solomon with the butcher's knife, telling him to 'stop driving by their house so slowly.'

Solomon denied that he was having an affair with Frieda.

The same week both Solomon and Frieda applied for ADVOs as protected persons with Gareth as a defendant. Police conducted a property search and located a rifle, Gareth was charged with possession of an unregistered firearm and was later convicted, and the ADVOs were finalised. Gareth was not charged in relation to the assaults.

The following month Gareth purchased a shop in a large regional centre some distance from the family property. He would originally commute daily from the family property to work but later started spending the weeknights living above the shop and commuting back to the property on the weekends.

Over the next ten years Gareth remained 'suspicious' of Frieda but was not demonstrating significant mental health issues and sought no treatment.

Gareth and Frieda's three children all noted that their parents would regularly argue and would 'push' and 'shove' one another.

In 2010 Frieda's father passed away suddenly. This profoundly affected Gareth who had a close relationship with his father-in-law. From this point, family members noted a decline in Gareth's mental health. Family and friends noted that Gareth was acting strangely, and Frieda raised concerns that he was going 'off the rails' again. Gareth began to make enquiries with customers in relation to Frieda's alleged infidelities. He told customers he believed Frieda was having 'orgies with bikies'. He also started disclosing to friends and customers that he was keeping a black sealed envelope in his car which was 'filled with incriminating documents' concerning Frieda's alleged infidelity.

It coming months it became clear that the farm and shop were having some financial issues. Gareth blamed Frieda for monetary mismanagement, and believed she was stealing money from the shop and farm. There was no evidence this was the case. Around this time Frieda made Gareth visit a doctor and he was prescribed anti-depressants.

The night of the homicide Frieda stayed at the shop with Gareth while she was en route to visit her mother down the coast. During the night Gareth attacked Frieda, hitting her a number of times with a hammer, and stabbing her with a knife. He then attached notes to her body with the names of the bikies he believed she was sleeping with.

The following morning a security officer located Gareth's car on a bridge near town and alerted authorities. The keys were in the ignition, and the doors were open, but Gareth was nowhere to be found. After a short while authorities located Gareth.

At trial Gareth was found not guilty by reason of mental illness.

CASE REVIEW 3306

This case concerned the homicide of a woman in her late 50s, Kate, by her abusive husband Roger, also aged in his late 50s. Roger committed suicide after killing Kate and their pet dog.

Kate met Roger when she was 18 and they married when she was 19. Kate and Roger were unable to have children, and they had been foster carers during the 1990s. They also both loved animals, and Kate especially loved her dogs.

Roger was the eldest of four siblings, but was not close to his family. He was also described as quiet and withdrawn, but he also was known for having an 'explosive temper'. Roger worked as a handyman and gardener.

Kate had also worked most of her adult life in administrative roles. At the time of the homicide she was working at a nursing home. Kate was described as a very private person.

Roger had a long history of mental illness. He had been receiving ongoing mental health care for bipolar disorder since the 1990s when he was first

hospitalised for the condition. He had subsequently been medicated but had ceased taking his medication in the months prior to the homicide.

Both Kate and Roger were religious and regularly attended church throughout the 1990s and 2000s. Kate met her best friend Lilly through church. Lilly described Roger as a 'nice friendly person' up until the early 1990s at which time he became 'argumentative' about religious and current affairs. Roger started to write to church pastors on points of conflict and he started to fall out with the church. The couple started to 'socially withdraw from society'. People in the community found it increasingly difficult to cope with Roger's belligerent behaviour.

Kate and Lilly would meet on a weekly basis to discuss 'religious issues', their families and personal thoughts. They would pray in respect of these issues. Through these meetings Lilly became aware that Roger had been diagnosed with bipolar disorder and that sometimes he would not take his medication. On a number of occasions over the years Kate would say to Lilly 'Please pray that Roger will take his medication'.

Lilly had observed Roger to be verbally abusive towards Kate. This intensified when Roger was off his medication. Lilly indicated that Kate would rarely talk about her private life. However, on one occasion Lilly became concerned about Kate's safety and asked her if she was frightened to go home. Kate said she was and the two women prayed for Kate's safety.

Kate also disclosed to Lilly that Roger wanted to control all of the finances and there were a number of episodes when he withdrew large sums of money and purchased strange items. Kate indicated concerns about her money and future being 'wasted away'. Again the two women would pray, this time for protection of Kate's finances.

About 18 months prior to the homicide, Kate and Roger moved to the coast. Kate remained in regular phone contact with Lilly and told her that she was enjoying her new job and was planning to start some distance education. Kate said she and Roger were having difficulty settling in to the community. She said that she and Roger had attended numerous churches within the local area but couldn't find a church that Roger was comfortable with. Kate was happy that the move had brought her closer to her mother.

Lilly visited Kate at the new house several months after she moved. Lilly said Kate seemed 'homesick' and she encouraged Kate to get in touch with a church community regardless of what Roger wanted to do. She described Kate as seeming 'lonely and isolated'. Kate and Roger did not really know any of their neighbours and did not have any friends.

There was evidence that the couple were sleeping in different rooms.

One day in January Kate was rostered on to work however she did not show up. This was out of character. Roger similarly failed to attend work as scheduled and this was also considered to be extremely out of character. When Kate again failed to show for work the next day, colleagues became worried and went to her house. Colleagues located Roger deceased in the home and called police.

When police attended Kate was also located deceased in the house along with her dog. She had been violently killed, and had suffered blunt force trauma to the head. She also had defensive injuries. Her dog had also been killed by blunt force trauma.

Roger was located hanging from a rafter in the garage near the main house.

CASE REVIEW 3292

This case concerned the homicide of a woman in her late 50s, Ashley, by her husband Peter, aged in his early 60s. The couple had been married for over 30 years, and lived in a regional area of NSW on a farming property. The couple had 3 children, none of whom were living at home at the time of the homicide. While Ashley was extremely close to all three of her children, the children had a poor relationship with their father Peter, who was violent towards both the children and Ashley.

Ashley and Peter met through mutual friends when Ashley was in her late teens and Peter was in his early 20s. Friends described the couple as 'loving at the start' but said the relationship 'deteriorated' over the years. Peter was financially and socially abusive towards Ashley, and he would regularly denigrate her – calling her names and belittling her. As part of his abusive behaviour Peter would threaten to kill himself, and would verbally and physically assault both Ashley and the children. He was very manipulative and controlling, and would not let Ashley turn the heater on if it was cold, and would not let her 'go against' his instructions or his opinions.

Ashley had worked as a hairdresser prior to the birth of her first child, but had not been engaged in

paid work since. In the years prior to the homicide Ashley was Peter's carer as he suffered from a medical condition. Ashley also looked after the family farm single handed. She was described by friends and family as a kind, resilient and generous woman and was well regarded in the community.

Peter had a long working history including various skilled and unskilled jobs, and he had retired in 2007 (and commenced receiving a disability pension). Peter was described as being very dependent, with an overbearing, controlling and rude personality.

In 2003, the couple separated for 6 months, after which time they resumed living together and sought marriage counselling. Shortly after this time Ashley started sending money to financially support one of the couple's children who had left the home to go to university. Ashley did not want Peter to find out about this financial arrangement, so asked the postman not to give bank statements to Peter.

The couple stopped sleeping in the same room in 2010. Ashley had told her neighbour that she intended to leave Peter, but also indicated that she was not sufficiently independent to do so. She told her neighbour that if Peter was left to look after the farm the farm would fall into disrepair and nobody would to look after the animals

Ashley had been taking antidepressants for some time and would often abuse alcohol. In the months leading up to the homicide, Peter also started abusing alcohol and his mental illness (and mood) declined.

The day of the homicide Peter drank 4 beers. He had an argument with Ashley and he smothered her with his hands. He attempted to kill himself but was unsuccessful. Police attended and charged Peter with Ashley's murder.

Peter pleaded guilty to murder.

CASE REVIEW 3291

This case concerned the homicide of Yvonne, a woman in her mid-50s by her abusive husband Aleksander who was aged in his late 50s. They had been married for 28 years at the time of the homicide.

Aleksander was born in Eastern Europe. His childhood was allegedly characterised by extensive violence and abuse by both his father and mother. As a young adult, Aleksander was a domestic violence abuser against his first wife and the relationship ended when he was imprisoned for assaulting her.

Following his divorce Aleksander and Yvonne met and were soon married. The couple migrated to Australia in the early 1980s, and the following year Yvonne gave birth to their first son Istvan. Aleksander was angry with Yvonne for falling pregnant so quickly. Over a year later, the couple had a daughter, Hana.

When Istvan was a young boy he was injured in a car accident. As a consequence, Istvan suffered significant brain damage, hemiplegia and spent many months in hospital. Aleksander blamed Yvonne for the accident. After the accident, Yvonne told friends that Aleksander had 'disowned' Istvan.

Yvonne had a long working history in Australia which commenced soon after she arrived. She worked as a medical assistant and supported the family financially. Aleksander had worked a number of jobs after arriving in Australia but had stopped working in the years before the homicide.

Yvonne developed a very close relationship with one of her work colleagues, Jana. Jana witnessed Aleksander's abuse against Yvonne directly and Yvonne would also regularly disclose her experiences of abuse to Jana. On several occasions Yvonne told Jana that Aleksander had threatened to kill her, and would denigrate her capabilities as a wife and as a mother (for example by throwing food at her that he deemed inadequate).

The children regularly witnessed Aleksander's abuse against Yvonne and on many occasions tried to protect her from their father's violence.

Aleksander called Yvonne constantly at work, and demanded that Yvonne bring her work rosters home so he could check these against her movements. On one occasion in the mid-1990s Yvonne did not answer her phone at work. Aleksander suspected Yvonne was having an affair and believed that her workmates were covering for her. He brought this up regularly to provoke arguments with Yvonne.

Jana regularly saw Yvonne with physical injuries and Yvonne told Jana that Aleksander would set 'traps' for her around the house designed to 'catch' her cheating on him. Aleksander eventually forbid Yvonne from working night shifts in an attempt to control her movements.

Aleksander would regularly pick fights with Yvonne, and would film these fights on his video camera. When questioned about why he would do this, Aleksander would say that it was in case he ever needed to show how abusive Yvonne was towards him. He hid these tapes in the family home.

There is also evidence that Aleksander would monitor where Yvonne was going, what she was wearing, and he would control her use of the family car. When the couple travelled, he would confiscate Yvonne's passport so that she couldn't attempt leave him while they were on holiday.

Due, at least in part, to Aleksander's abuse and control, Yvonne was diagnosed with anxiety and depression in the early 2000s. Yvonne saw a psychiatrist who prescribed her medication. Yvonne disclosed Aleksander's abusive and controlling behaviours to the psychiatrist who told her that Aleksander clearly suffered from 'morbid jealousy syndrome'. The psychiatrist never met Aleksander and provided this explanation to Yvonne in light of her domestic violence disclosures. Yvonne continued to receive mental health treatment for around 12 months.

Several years later, Yvonne disclosed to her GP that Aleksander was paranoid about her fidelity. She disclosed that he had made her request her pay sheets to prove that she had been at work. No support or counselling/referrals were provided by the GP.

Later the same year Aleksander physically attacked Yvonne and she and the children left the house and went to the hospital. Yvonne presented at the hospital with suicidal thoughts. She indicated she felt guilty for contemplating suicide due to her children. She was kept in overnight, and screened in relation to domestic violence. She made disclosures that she was frightened and had been abused by Aleksander. She indicated she was not safe to return home.

The next day, police interviewed Yvonne at the hospital for the purpose of applying for an ADVO. Police attempted to apply for an interim ADVO but this was rejected by the magistrate on the grounds that there was insufficient evidence of danger to Yvonne to warrant the granting of such an ADVO. Police nonetheless undertook to pursue an ADVO (in the absence of an interim order). The following day Yvonne attended the station and withdrew her compliant. After being discharged from hospital, Yvonne and the children stayed with friends for a day or two, before returning to the family home.

Two years later Yvonne called the police after Aleksander assaulted her with a knife. Aleksander was arrested, charged with assault and an interim ADVO was ordered. However, before the application for a final order was heard Aleksander forced Yvonne and the children to recant their claims and prepare false statements. Charges against the offender were dropped and the interim ADVO was revoked.

Yvonne attended the Family Court of Australia to file for a divorce in 2007 or 2008 but she was told by someone at the court that she and Aleksander had not fulfilled the legal requirements for a divorce.

Despite his obsession with Yvonne's fidelity, Aleksander was regularly unfaithful to Yvonne. He used significant amounts of pornography and regularly hired prostitutes. He also had another girlfriend for a period of time in the mid-2000s.

Yvonne considered leaving the offender on a number of occasions during their 28 year marriage but was fearful that if she left he would kill her (as he had told her he would do previously). She had written two suicide notes which were included in evidence in the trial – one from 2004 and another from 2010. She believed that there was nowhere safe for her to go, and she was concerned for the welfare of Istvan if she were to leave.

The morning of the homicide, Aleksander attacked Yvonne and stabbed her multiple times. Aleksander claimed that this followed an argument about Yvonne's infidelity. Istvan attempted to intervene to protect his mother but was also stabbed. Police attended and arrested Aleksander at the scene. Yvonne died at the scene and Istvan was treated for his injuries.

Aleksander was found guilty of Yvonne's murder at trial.

CASE REVIEW 3024

This case concerned the homicide of a young woman in her early 20s, Kiki, who was stabbed and killed by her abusive husband, Nik who was aged in his late 20s. Their 3 month old baby was present at the homicide but was unharmed. The couple lived in a regional area in NSW.

Kiki had a 'loving' and normal childhood. However, she was described by family members as having low self-esteem and very little confidence growing up. Kiki's first relationship was with a man called Terrence, who was extremely physically,

emotionally and verbally abusive towards Kiki. When Kiki was 17 she became pregnant with Terrence's child and Terrence forced her to have an abortion. They broke up soon after.

When Kiki was 18 she and her friend were gang raped by three men on a night out. The matter was reported to police however Kiki stated that she did not want to tell her family about the attack, so charges were not progressed. She began self-harming and, throughout 2005, had contact with various healthcare providers in relation to mental health issues.

Nik was the youngest of 3 children born to a close family in India. He left India in 2005 and was on a spousal bridging visa at the time of the homicide. He worked in various low-paid jobs until the time of the homicide. Nik had drinking problems and smoked 10 cones of cannabis daily until the time of the homicide. He had a limited criminal history for driving offences. He described a history of experiencing paranoia and mental illness. He had previously been treated for depression but was not receiving treatment at the time of the homicide.

In late 2008, Kiki and Nik met at a local pub. They became friends and soon entered into a relationship. Soon after the relationship commenced, Kiki realised she was pregnant and the couple moved in together.

Kiki was reportedly very excited about the pregnancy, however Nik was not. He told his sister that he had encouraged Kiki to have an abortion but she would not do so. Friends and family described Nik as being uninterested in anything to do with the pregnancy.

Over the next few months friends and family became aware that Nik was very controlling of Kiki. Friends and family described Nik as being 'very religious' and Kiki had told her sister that Nik wanted her 'to convert' to his religion but that she did not want to. Many of Kiki's family expressed to her their concerns that Nik was' using her' to get Australian citizenship.

Kiki and Nik married in secret in 2009. Kiki told her mother that Nik wanted her to act 'more like an Indian wife' and was extremely critical of the way she 'kept the house'. At times the 'arguments' would become 'very bad' and Kiki would go and stay with her mother.

In 2009, Kiki's father was killed in a car accident. She became very depressed and told her mother that she was having thoughts about hurting herself.

Soon after her father died, Kiki and Nik's son, Luke, was born. Nik was jealous of the baby, and refused to help Kiki with his care. Nik also refused to give Kiki any money to buy food or groceries for her and the baby, and friends would have to bring her food. She disclosed only one incident of physical abuse, where Nik had hit her in the back. No other disclosures of physical violence were made before the homicide.

Nik claimed that when they were fighting, Kiki would threaten to self-harm and would also threaten to drop Luke off the balcony. Nik would threaten to report Kiki to Child Protection Services.

In December 2009 Kiki told her sister that she was feeling 'controlled' by Nik. Her sister told her she should leave the relationship and Kiki responded saying 'if I leave, Nik has threatened to take Luke and that I will never see him again.' Kiki's sister indicated that Kiki seemed very scared.

In mid-December 2009, Kiki contacted mental health services in relation to self-harming behaviours. She attended hospital for this.

The morning of the homicide, neighbours heard Kiki and Nik fighting. A neighbour reported hearing Kiki yelling that she would not go to India with him. Later that day, Kiki's friend Eliza visited her at home. Kiki told Eliza she was suffering from post natal depression and that she was getting no help from Nik with the baby. Eliza noted that both Kiki and Nik seemed drunk.

Later that afternoon, Kiki spoke to her mother on the phone and told her that Nik was threatening to take the baby to India. Kiki's mother spoke to Nik who repeated the threat to take the baby. The argument escalated. Kiki's mother heard Kiki yelling in the background and heard her make a comment about 'dobbing in the farm workers'. Nik started screaming at Kiki and then she could hear Kiki screaming, 'No, I won't do it, please don't.' Kiki's mother heard Nik screaming and 'grunting' and could also hear Luke crying. Kiki's mother jumped in the car to go to the house, but by the time she arrived emergency services were there and Kiki was dead. Nik had stabbed her 41 times. Luke was unharmed. Nik handed himself in to the police later that afternoon.

Nik was found not guilty by reason of mental illness.

CASE REVIEW 3037

This case concerned the homicide of a woman in her late 40s, Tegan, by her abusive de facto husband Maurice, who was aged in his early 40s. The couple had been in an on-off relationship for about 13 months at the time of the homicide and lived in regional NSW.

Tegan and Maurice met in mid-2009 while Tegan was still married. After Tegan separated from her husband, Maurice moved into Tegan's house, where she lived with her teenage daughter Sally, the youngest of Tegan's 5 daughters.

Maurice was born in the United Kingdom and his family migrated to Australia when he was about 8 years old. Maurice had had a number of relationships starting in his late teens. Every time one of Maurice's relationships would end he would become extremely depressed, would abuse alcohol and cannabis and his employment would suffer. It was in the context of relationship break ups that he twice attempted suicide and sought assistance from his GP and other medical professionals. He had received continuous treatment throughout his adult life for anxiety and depression. He had been prescribed various antidepressant and anti-anxiety medications, and was taking these medications at the time of the homicide.

Tegan's mother and father described Maurice as being 'lazy', 'abusive' and 'rude' towards them and Tegan. He would stalk Tegan by incessantly sending text messages to see where she was and who she was with, would change the locks in the house, would belittle Tegan in front of her family, and denigrate her family. Maurice was described by Tegan's family as 'controlling', 'aggressive' and 'obsessive' towards Tegan.

About 9 months into the relationship, Maurice forced Tegan and Sally to move to regional NSW, away from her family and friends. Neighbours described Tegan as quiet and shy and said they did not often see her leave the house. They also described Maurice as being controlling. After moving, Sally, who was about 14 years old, stopped attending school.

One month after the move, Tegan's step-mother came to visit. She said that Maurice was complaining that Tegan had not yet found work, would constantly 'nag' Tegan about her appearance and told her that she needed to wear 'country clothing' to fit in and be more 'talkative and friendly to people'. Tegan told her step-mother that Maurice was not taking his medication and that he was constantly 'at her' and putting her down.

Two months after the move, Tegan told family members that she and Sally were moving out of Maurice's house and that she had found her own rental premises nearby. On the morning she was moving out Maurice stopped her from entering the house to collect her belongings. Tegan called the police who attended and spoke to them both and then Maurice allowed her to collect her things.

After she moved out, Tegan was observed by a family member with an injury to her wrist which Tegan said had been caused by Maurice grabbing her. Not long after this, Tegan told family members about an incident where her power had cut out suddenly one night. She found that the power had been turned off from the mains and she believed that Maurice was responsible. Following this there were a number of episodes where Maurice was threatening and abusive towards Tegan. On a number of occasions he turned up at the pub when Tegan was there with friends and family and would sit nearby and stare at her. On another occasion he told everyone in the pub that Tegan 'had HIV'. Around this time Tegan disclosed to a number of friends and family that she was frightened of Maurice and that he had been following her around and 'basically stalking' her. Tegan told her brother that she was afraid of Maurice and 'did not know what he was capable of.'

Two weeks before the homicide, Tegan and Maurice reconciled. She told family members that she had given Maurice '4 years to get his act together' and that they had agreed that they would not live together until Sally was 18 years old. Tegan's daughters were extremely angry about the reconciliation and were not speaking to her. Sally left to stay with relatives in another state.

Three days before the homicide Maurice spoke with his mother in a 'stressed and agitated' state. His parents drove some distance from where they lived to see him. He was behaving erratically and said it was because he didn't know what was happening with his relationship with Tegan. His parents urged him to go and see his doctor.

The day before the homicide, Tegan and Maurice had spent the day together and he had stayed the night at Tegan's house.

The morning of the homicide, according to Maurice, the couple began to argue after looking at each other's mobile phones, each accusing the other of infidelity. Maurice punched Tegan in the face and

grabbed a kitchen knife. Tegan tried to grab the knife from him and sustained a cut to her hand after which the fight ended and they agreed that he should take her to the hospital to have her hand attended to.

They got in the car and Maurice began driving, but in a direction away from the hospital. Tegan tried to stop the car by pulling on the handbrake. This caused the car to veer on to the opposite side of the road and spin before coming to a stop. Tegan tried to get out of the car and Maurice, who had taken the knife from the house with him, stabbed Tegan over 60 times.

Maurice returned to his house with Tegan's body in the car and consumed a quantity of alcohol. He cut himself a number of times with the knife. After a significant period of time, he called his mother and called 000.

Maurice was found guilty of murder.

Intimate partner domestic violence homicide

Domestic violence abuser killed by domestic violence victim

CASE REVIEW 3510

This case concerned the homicide of a man called Tony, who was fatally shot by a hit man called Pete in rural NSW in 2009. Pete was hired by Tony's wife, Andrea, to kill Tony. Andrea's mother, Doreen, was also involved in the plan to kill Tony, and her sister Sina, was an accessory to the murder.

Tony and Andrea, both aged in their late 40s, had been in a relationship since the mid-1990s. They were estranged at the time of the homicide. Both Tony and Andrea were having relationships with other people, but continued to live in separate residences on the same rural property. The couple had a young teenage daughter, Ondine, who lived in the house with her mother.

There was a history of domestic violence by Tony against Andrea. There is evidence that on one occasion Tony pushed Andrea through a gyprock wall on one occasion. This assault was witnessed by Ondine. Tony also claimed that Andrea was abusive towards him. There was no police contact in relation to domestic violence.

About 6 weeks before the homicide, Tony assaulted Ondine. Ondine told her school counsellor that her she and Tony were arguing and he shoved her, causing her to fall over and bruise her back. Police were notified of the assault and they applied for a provisional ADVO naming Ondine and Andrea as protected persons and Tony as the defendant. When speaking with the police officers, Ondine indicated that there had been many unreported domestic violence incidents by Tony against herself and her mother Andrea, and she indicated she was scared of Tony. When the order was served, Tony moved out of the main house and commenced living in a shipping container on the family property.

Around this time Andrea and her mother and sister sought to find someone to kill Tony. They paid Pete a substantial amount of money to kill Tony.

Late on the night of the homicide Pete went to the family property and shot Tony outside the container where Tony had been living. Tony's body was discovered the following morning by a neighbour who called police. Andrea denied any responsibility for Tony's death however during the course of the police investigation, Andrea and Doreen's involvement in hiring Pete was discovered and all three were arrested.

Andrea, Doreen and Pete were each found guilty of murder at trial.

CASE REVIEW 2347

This case concerned the homicide of a man in his late 40s, Zhang, by his former de facto wife, Liu, aged in her early 40s. Both Liu and Zhang were born in China and migrated to Australia in the late 1980s. Both were Australian citizens. At the time of the homicide Zhang was living in China but would visit Australia regularly.

Liu came to Australia when she was aged in her mid-20s and started working in real estate. A few years later, Liu began a relationship with a man called Wei and the couple married. The couple had a son, Peter, and despite the relationship coming to an end, they remained close.

Liu had experienced periods of depression as a young adult and when she was about 20 years old, following a dispute with her parents, she attempted suicide. After Peter's birth she was again experiencing depression and her GP referred her to a psychiatrist who she saw intermittently for a number of years. She was prescribed antidepressants.

In the early 2000s, Liu met and commenced a relationship with Zhang after placing an advertisement in a local newspaper seeking a companion with a son of a similar age to Peter. Around this time Liu stopped seeing her psychiatrist but continued to see her GP in relation to sleeping difficulties.

Zhang moved into Liu's house, but later she asked him to leave for a few months until his son returned from China. A few months later, Zhang and his son both moved in with Liu and Peter. Zhang's son left a few months later, and while Liu considered asking Zhang to leave, she found out she was pregnant. Liu wanted to terminate the pregnancy, but Zhang told her she would develop cancer if she had a termination. This was contrary to medical advice, but Zhang was persistent and Liu did not terminate the pregnancy.

The couple's son, Tim, was born in 2004 and Liu described this period of the relationship as 'good'. After Tim's birth the couple started a successful import/export business together. This was financed primarily by Liu but Zhang registered the business in his name only. When Liu confronted him about this he assured her that 'everything was ok'.

Against Liu's wishes, Zhang began to take regular business trips to China, supposedly to expand their business. Over the next 2-3 years Zhang spent more and more time overseas and told Liu he was pursing various business and job opportunities in China. She provided him with over $600,000 for these various pursuits but over time began to realise that Zhang was lying to her. Liu confronted Zhang and he became abusive and violent, saying that she was a 'crazy bitch' and punching her in the face. Liu felt humiliated and trapped and attempted to commit suicide by burning bbq fuel on the stove. Zhang found her and said 'if you want to kill yourself do it when I'm not here'.

Liu became extremely depressed. Her older son, Peter, went to live with his father full time and it was agreed that Zhang would take Tim to live with him in China for about 12 months. Around this time, Liu began to see another psychiatrist and resumed taking antidepressants.

Zhang and Tim visited Australia in early 2009. Tim wanted to stay with his mother however Zhang insisted that he return to China. Liu begged Zhang to leave Tim with her and said that he was kidnapping their son. Zhang told Liu that if she tried to stop him he would tell the police about her prior suicide attempts.

Over the next 12 months Liu travelled to China regularly to see Tim and continually begged Zhang to return her son. On one visit she searched Zhang's house for Tim's passport but was unable to locate it. The following day she returned to Zhang's house and could hear Tim crying, saying 'please don't daddy, please don't'. When she went in she found Tim tied up and Zhang was holding a stick and was about to hit him. She put herself between them and Zhang hit her across the head and back with the stick. Zhang told Liu he wanted to money to buy a unit and threatened to 'sell' Tim if she didn't provide funds. Liu sought legal advice and was advised that she could not recover her son and would not be able to obtain a new passport for him without both parents' signatures.

At the end of 2009 Zhang returned to Australia with Tim and informed Liu that he would not be taking Tim back with him to China. Around the same time, Liu found out that Zhang had attempted to sell her house and she put a caveat on the property.

In early 2010, Zhang visited Tim at Liu's house. After he had left she found that he had stolen a significant amount of money. Liu confronted Zhang at his hotel. The police were called police who attended and stated that unless she had a record of the serial numbers on the bank notes they could not help her. The same day Zhang attended a police station and made a complaint against Liu which resulted in two officers attending her house at 1:30am to conduct a welfare check on the children.

Over the next 12 months Liu had very limited contact with Zhang and her anxiety and depression abated significantly. However, in early 2011, Zhang visited the family to see Tim. Zhang immediately began pressuring Liu to remove the caveat on the house. He began making threats about taking Tim with him back to China. Liu was feeling nervous and panicky and asked him to leave but he said he would not leave until after dinner.

Liu served Zhang a meal which was laced with crushed up sleeping tablets. Zhang fell asleep on the couch and Liu and her sons went upstairs to bed. Around midnight Liu tied Zhang up while he was still sleeping. Zhang woke up in the early hours of the morning and, following an argument, Liu stabbed Zhang a number of times in the groin and attempted to castrate him. She then called 000. Zhang died later in hospital.

Liu pleaded guilty to manslaughter on the basis of substantial impairment.

CASE REVIEW 3552

This case concerned the homicide of a man in his 30s, Andrew, by his de facto wife, Marta, also aged in her 30s. The couple had been in a relationship for 10 months at the time of the homicide, and lived together in the city.

Andrew and Marta commenced a relationship in 2010 and Andrew moved in with Marta and her two young children (from a previous relationship) soon after.

After Andrew moved in, all surrounding neighbours reported regularly hearing loud, violent fights between Andrew and Marta. Neighbours also described witnessing physical violence. On one occasion, during a fight, Marta was seen throwing ornaments at Andrew in the backyard. A neighbour described helping Marta to 'clean up' the smashed ornaments after this fight and stated that 'it was obvious they were having family problems'. On another occasion, during an argument, Andrew smashed the glass door at the rear of the couple's home. Neighbours reported hearing and seeing this, and subsequently saw that Marta was crying and upset. The police were never called in relation to domestic violence.

There was also evidence that Andrew was jealous and controlling towards Marta.

Andrew would regularly drink to excess. There is also evidence that Marta and Andrew would use cocaine, and it was suggested by several witnesses that on the night of the homicide Marta was trying to obtain cocaine for the couple at the party they attended.

Andrew had a criminal history in relation to driving offences and had a pending court date in relation to further driving offences at the time of the homicide.

In the months before the homicide, Marta contacted Andrew's brother who was living overseas, asking for help and advice in relation to Andrew. She said that not only was Andrew having serious substance abuse issues but he was also depressed, and this was impacting upon his ability to keep his job. Marta asked for Andrew's mother to be sent from overseas to help with Andrew. This did not occur.

In the weeks leading up to the homicide the relationship between Andrew and Marta deteriorated even further and there was evidence that Andrew was intending to end the relationship. According to Marta's family and friends, Marta was 'almost at her wit's end' with Andrew, and suspected he was being unfaithful. One of Marta's friends said that Andrew would show Marta pictures of women he had met and socialized with to 'get her going' and the two would fight.

The afternoon of the homicide Andrew, Marta and her two children attended a family function where Andrew consumed two bottles of wine. When they returned home the couple began arguing and Andrew threw a drink over Marta's head. The argument escalated and Andrew became increasingly aggressive. The scene was witnessed by a next door neighbour through a window. The neighbour described seeing Marta's children cowering around her legs in the kitchen. In response to Andrew's aggressive behaviours, Marta grabbed a knife from the kitchen counter. Andrew lunged at her and she pushed the knife into his chest. She grabbed the children and locked herself and the children in the laundry. She called 000, and Andrew called a friend to come and help him.

Andrew passed away in hospital a few days later.

Marta was tried for Andrew's murder and was acquitted on the basis of self-defence.

CASE REVIEW 3508

This case concerned the homicide of man aged in his early 40s, Archie, by his former de facto wife, Adelaide, aged in her early 30s. The couple had been in an on-off relationship for about 12 years. Both Archie and Adelaide identified as Aboriginal.

Archie and Adelaide commenced a relationship in the late 1990s. From the outset, Archie was extremely physically, verbally and emotionally abusive towards Adelaide. On at least three occasions he had served custodial sentences for violence offences against Adelaide. The first recorded episode of violence was in 1997. In this episode the couple were arguing and Archie pushed Adelaide against a window frame, knocking her unconscious. She was taken to hospital received medical treatment. Adelaide notified the police and Archie was charged and later convicted of assault.

Adelaide became pregnant about a month into the relationship and the couple's son Jim was born at the end of 1997. Between 1997 and the homicide there were over 20 recorded events on the NSW COPS system in relation to Archie's violence against Adelaide. There had been 4 previous ADVOs protecting Adelaide, and there was a current ADVO in place protecting Adelaide at the time of the homicide.

Adelaide and Archie would generally break up when Archie was in gaol, and would get back together when he was out of custody.

Archie had significant substance abuse issues and was described by friends and family as a 'heavy drinker' and 'heavy cannabis user.'

In mid-2009 Adelaide, Jim and her two other children moved into social housing premises in regional New South Wales. Neighbours described hearing regular, physical fights between Archie and Adelaide. One neighbour stated that when he would hear them fighting he would shut the door so 'his kids didn't have to hear that.' Neighbours rarely called the police.

By late 2009, Jim was beginning to get in trouble with the police and at school. He was referred to local police youth command which worked with young people involved, or are at risk of becoming involved, in the criminal justice system. A few months prior to the homicide Jim was assessed as suitable for youth case management. Contact with this service was ongoing at the time of the homicide.

In the weeks leading up to the homicide, domestic violence had become an issue of increasing concern to Jim's case manager. Adelaide and all her children were deemed by the case management team to be at high risk of domestic violence at the hands of Archie.

As part of Jim's case management, arrangements were being made to find alternate accommodation for Adelaide and her children so that they could get away from Archie.

A week before the homicide, Archie was served with an ADVO protecting Adelaide which included an order that Archie not approach Adelaide within 12 hours of drinking alcohol. Two days after the ADVO was served Adelaide was socialising and drinking with friends when Archie arrived. They began arguing. Archie punched Adelaide in the face, she called the police and he left the area.

Police attended and observed Adelaide to have a split and swollen bottom lip and dried blood on her neck. She was observed to be moderately affected by alcohol. The officer enquired where Archie was living and Adelaide replied that he was living with her. The officer admonished Adelaide for 'letting' Archie live with her and she appeared embarrassed. The officer reminded Adelaide that the conditions of the ADVO precluded Archie from going near her when he was drinking. He asked Adelaide why, given the ADVO, she was still drinking with Archie. Adelaide became frustrated and asked the officer to take her home. The officer indicated in his statement that he believed Adelaide had called the police so that she could get a lift home.

The officer asked Adelaide more questions about the assault and she became upset and swore at the officer.

A police alert was issued in relation to Archie but he was not found.

On the morning of the homicide Archie arrived at his cousin's house, which was across the road from Adelaide's house. He had been drinking and smoking cannabis continuously for a number of days. Archie became more agitated and irate and called out across the road to his son Jim, telling hi, to come and speak with him. Archie asked Jim who had stayed at the house the previous night and Archie told Jim that he was going to 'bash Adelaide' and burn the house down. Jim relayed these threats to his mother.

Archie's cousin stated that he didn't want to get involved because it was a private matter.

Archie became more aggressive and angry and was reportedly 'obsessing' over the idea that a man had spent the night with Adelaide. He went across the road to 'confront' Adelaide about this imagined infidelity. A neighbour heard Archie screaming at Adelaide about 'having men in the house' and saw Archie punch Adelaide in the face a number of times. The neighbour stated that when he realised what was going on he went back inside.

Adelaide had her handbag with her, the contents of which spilled onto the ground during the assault. This included a fold up pocket knife that Adelaide had confiscated from Jim two weeks earlier. Adelaide grabbed the knife and ran to the carport to get away from Archie. He chased her and picked up a child's scooter and made threatening gestures with it. Archie lunged at Adelaide with the scooter and Adelaide stabbed him in the chest with the pocket knife. Archie tried to hit her again and she stabbed him again in the chest after which he collapsed to the ground. Adelaide called 000.

Adelaide admitted to police she had stabbed Archie and was arrested and taken into custody.

Adelaide was charged with murder. She was refused bail and remanded in custody for a period of 9 months.

The matter was ultimately no-billed (charges dropped).

Relative/kin domestic violence homicide

Child homicide victims

CASE REVIEW 3307

This case concerned the homicide of a 6 year old girl, Olive, who was killed by her mother Peta and her step-father Fred. Both Peta and Olive identified as Aboriginal.

Peta grew up in regional NSW with her brother Tommy, her mother Kay and her father Paul. Kay met Paul through her sister, and from the outset Paul was extremely abusive. Over their first few years together, the couple had two children, Peta (the eldest) and Tommy. Paul's ongoing abuse – including catastrophic physical violence - against Kay was credited with her developing epilepsy.

Due to Kay's illness, Peta took on a parental role in relation to Tommy despite the fact that she was less than 10 years old. Peta and Tommy regularly saw their mother being strangled, abused and assaulted by Paul. Paul also abused Peta and Tommy. Paul served time for a wide range of criminal offences while the children were young, although there was no police involvement in relation to domestic violence.

Peta recalls that for much of her childhood she, Kay and Tommy were 'on the run' from Paul. They moved constantly from place to place in an attempt to escape Paul's violence. As a consequence, Peta did not receive proper schooling. Peta also suffered from a mild intellectual disability which was not managed.

When Peta was 10 years old her mother Kay had a significant epileptic seizure. Peta and Tommy were terrified and hid in a cupboard. During the seizure, Kay passed away. Peta blamed herself for failing to save her mother's life.

After Kay's death, as Paul was imprisoned at the time, Peta and Tommy were taken into temporary care with their mother's sister and grandmother. Kay's family was unable to manage Peta and Tommy's care, and the children were taken into the care of Child Protection Services who placed them into foster care. Peta was interviewed and it was discovered that she had an extreme fear of Aboriginal people following years of her father's abuse. It was also clear that Peta was suffering significant trauma due not only to the death of her mother, but also due to the profound influence of domestic violence on her life to date. There is no indication that she was ever offered counselling for these issues as a child.

The following year the Children's Court ordered that Peta and Tommy be placed in non-Indigenous foster care due to Peta's fear of Aboriginal people. Notwithstanding this order, Child Protection Services placed Peta and Tommy in a group home for Aboriginal children. The children were visited on several occasions by Kay's family, who observed that Peta was struggling with the placement. From an early age Peta developed substance abuse issues and started having unprotected sex. She was severely bullied and received almost no education from the age of 13. Peta became homeless in her mid-teens and became involved in crime.

When Peta was 18 she started a relationship with a man called Toby. Toby was a drug abuser and was also violent towards Peta. Peta became pregnant and had a baby, Quentin. Nurses involved in the birth reported the child to Child Protection Services over concerns that Peta was abusive towards staff and did not have the capacity to care for her baby. There were a number of further reports to Child Protection Services and attempted home visits over the next month. However, when Quentin was 6 weeks old, he died. The forensic pathologist was not able to determine the direct cause of death and Quentin's death was ruled by the Coroner to be a SIDS death.

Following Quentin's death Toby and Peta's relationship deteriorated and his abusive behaviour escalated.

Within a few months of Quentin's death Peta became pregnant with her second child, Olive.

When Olive was only 2 months old, Peta went to stay in a refuge with Olive after Toby severely assaulted Peta. Child Protection Services were notified, an ADVO was put in place protecting Peta, and after a short period, Peta and Olive returned to live with Toby. Police were aware that Toby breached the ADVO within 2 months of the order, but he was not charged in relation to the breach. In 2005 the police refused to apply for a further ADVO as they believed that Peta would 'let Toby into the home', and would call police when he refused to leave. There were a number of further notifications

to Child Protection Services in relation to domestic violence and concerns for Olive's welfare. Whenever Child Protection Services attempted to conduct a home visit, Peta would pretend not to be home. She was terrified that Child Protection Services would remove Olive.

Child Protection Services were again notified when Olive was about 1 year old in relation to an episode of violence where Peta assaulted Olive. The assault occurred in the context of an argument between Toby and Peta, where Peta allegedly picked up Olive by the neck, threw her and bit her on the shoulder. Toby reported the assault to police, and they charged Peta with Assault Occasioning Grievous Bodily Harm. Olive was removed from her mother's care and an ADVO was put in place protecting Olive.

At court Toby told Peta's court caseworker that his had made up the story about Peta abusing Olive to get back at her. The court caseworker told Toby to rescind the ADVO as he was 'hurting Olive by lying'. He refused to do so. Peta was convicted of assaulting Olive and was placed on a good behaviour bond. Olive was placed in the interim care of the Minister and arrangements made for supervised contact with Peta.

Around this time Toby and Peta ended their relationship, and Peta started a relationship with a man called Fred. Fred was a drug abuser and had a significant criminal record. Peta rarely attended contact visits with Olive and was not meeting the stipulated requirements to have Olive returned to her care.

Despite Peta's non-compliance with conditions under the temporary care plan, Child Protection Services sought an order in the Children's Court to have Olive reinstated to Peta's care over the next 6 months. During the 6 months following this order Peta did not comply with the majority of conditions set out in the order, and breached her good behaviour bond by committing a number of serious traffic offences. She also continued to miss the majority of scheduled contact visits with Olive.

Despite not fulfilling conditions under the Care Plan, Olive was returned to her mother's care prior to Christmas, and Child Protection Services commenced a 12 month supervision order. Despite the supervision order, Olive was not seen by Child Protection Services for 5 months as Peta would pretend not to be home when they arrived for visits.

During the supervision period Peta became pregnant with her third child. During the supervision period, there was also a report made to Child Protection Services concerning Olive's welfare, and at a meeting following this report, Olive disclosed to workers that her mother had injured her. Peta claimed the injury was accidental. Child Protection Services deemed the injuries to be consistent with Peta's explanation rather than Olive's.

After only a few contacts over the 12 month period, the supervision concluded.

A few months after supervision concluded, Peta gave birth to her daughter, Penny. Reports were made to Child Protection Services in relation to issues identified at the birth.

After Peta was discharged from hospital, Child Protection Services attempted to visit on numerous occasions but Peta would again pretend not to be home. Health support workers contacted Child Protection Services when Peta failed to attend a number of appointments, including an appointment to c-section stitches removed.

More reports were made in relation to alleged domestic violence, child abuse and neglect and there were many more attempted home visits, but few were successful.

Peta began to disengage from all services.

Despite a significant number of notifications, including many that were not actioned due to competing priorities, Olive's case file with Child Protection Services was closed when she was 5 years old. Child Protection Services indicated that they received a positive mental health report and progress report from Olive's preschool before closing the case.
A short time after her file was closed, Olive started school. In the first week Olive attended, Peta threatened another mother at school with a knife and a few days later Olive's teacher noticed Olive had unusual bruising to her face. When questioned, Olive could not explain it. Around this time, Olive stopped attending school. Child Protection Services were not notified in relation to this incident.

Olive's non-attendance at school was referred to the Home School Liaison Officer who was unable to progress the case as Olive was not yet 6 years old. The school attempted to contact Peta on a number of occasions, and spoke to both Fred's mother and Peta, who lied about why Olive was not attending. There were a couple of attempted home visits by the Home School Liaison Officer, where Peta and the family pretended not to be home. Once Olive turned 6 years old, at around the start of term 2, the

Department of Education sent a letter to Peta threatening prosecution in relation to Olive's non-attendance at school. This prosecution was not progressed prior to Olive's disappearance.

By the middle of the year Peta was nearing the end of her pregnancy with her fourth child, Jake.

While Peta was in hospital following Jake's birth, hospital staff observed her to be abusive towards them and noted that Olive seemed withdrawn and scared of her mother. The hospital social worker contacted Child Protection Services to enquire as to whether there were any concerns with the family. Child Protection Services has no record of this contact but is clearly reflected in hospital records. The hospital social worker's notes indicated that Child Protection Services had no concerns in relation to the family.

A few weeks after Jake's birth, Olive went missing. Several months after her disappearance, Peta disclosed that she had killed Olive and that she and Fred had disposed of her body. Olive's body was located in bushland some months later.

Fred pleaded guilty to manslaughter and Peta pleaded guilty to murder.

CASE REVIEW 3558

This case concerned the homicide of a boy, Andrew (aged in his early teens) by his father, Jason, aged in his early 40s, who then killed himself. The relationship between Jason and his wife Ophelia was breaking down at the time of the homicide and Jason was a domestic violence abuser against Ophelia. Jason had never been violent towards the children until he killed his son.

Jason grew up in regional NSW and he had two older sisters. When he was young his father was hospitalised with a near fatal illness. Due to tension within the family following his father's sickness, his parents separated. The period following the separation was difficult, and the family was poor, but Jason maintained strong relationships with his mother and sisters. Around this time Jason began to excel at sports. He finished school and moved to the city to start playing sport professionally.

Before he moved to the city to play sport, Jason met Ophelia. Ophelia was a teacher. Together they relocated to Sydney where they worked for a while in their respective jobs, and Jason started training as an engineer. As his sporting career was coming to an end the couple moved back to regional NSW where Jason took up an engineering apprenticeship.

Their first son Andrew was born in the late 1990s and a few years later the family moved to a different area so that Jason could take up another engineering job. Ophelia started work at another school and she and Jason had two more children, the last child being born in 2003.

In the early 2000s, Jason started seeking treatment for depression. He had treatment from time to time until the homicide, including periodically being treated with taking anti-depressants.

Ophelia described that her relationship with Jason was 'perfect' until after the birth of their third child in 2003. After 2003, Ophelia described numerous episodes of physical violence, including punching, smashing household items and one incident where Jason kicked the wall during a fight and broke his toe.

Jason attended counselling in 2011. This focused on his relationship with Ophelia, and he discussed anger management strategies with the counsellor. By 2011 Jason and Ophelia were sleeping in different rooms and Jason told his sister that Ophelia wanted to kick him out of the house.

In early 2012 Ophelia disclosed to the principal at her school that things 'weren't good with Jason'. The principal asked if Ophelia and the children were safe and she indicated that they all were, but that she may need to take some time out for family matters. Around this same time Jason started telling his work colleagues that he thought Ophelia was having an affair. According to a family member, Jason also started asking Andrew which parent he would 'go with' in the event that Jason and Ophelia broke up. Andrew indicated that he would go with his father.

In 2012 Jason started seeing a psychiatrist. He said that his relationship with Ophelia was breaking down, and that he was attending the appointment to 'appease her'. Jason acknowledged that he was physically and psychologically abusive towards Ophelia. He described himself as experiencing 'great storms'. In subsequent sessions the psychiatrist and Jason discussed anger management strategies and Jason indicated that he wanted to salvage what was left of his marriage. He said that Ophelia would 'shut him out' and that he would 'explode at her' as a consequence. The psychiatrist contacted Ophelia, expressing concern about Jason's mental state, and requested she

attend the next appointment which was scheduled to take place 3 days prior to the homicide.

About a week before the homicide, Jason told his family that he believed Ophelia would not let him do anything with the children and he perceived that she was attempting to control when and how the children saw him. Jason expressed frustration at this.

Three days before the homicide Jason attended his final appointment at the psychiatrist, and Ophelia attended with him. Before the consultation, the psychologist described witnessing a 'tense moment' in the waiting room where Ophelia asked if she could start the session with the doctor alone. Jason refused to let this happen and the session commenced with both Jason and Ophelia. The doctor described the session as 'very tense and emotionally charged'. Ophelia told the psychiatrist that the relationship was 'terrible' and that Jason was extremely verbally abusive. She also recounted a number of physical assaults that Jason had perpetrated against her during their marriage. The psychologist directly asked if Ophelia intended on staying in the marriage, and she indicated that she did not; that the marriage was over and had been 'over for 7 years'. The psychiatrist asked Ophelia to leave and spoke to Jason, who indicated that he was going to try to save the marriage. Jason was prescribed anti-depressants.

Two days before the homicide Jason visited family lawyers in relation to the dissolution of his relationship with Ophelia. At this meeting Jason appeared teary and indicated an intention to continue to fight for his marriage.

In the early morning of the day before the homicide, while Ophelia was in the shower, Jason made a video where he walked around the family home, providing commentary around his family, his sleeping arrangements with Ophelia, and the family home, indicating what he believed he would lose if the relationship ended.

During the day Ophelia and Jason had a number of discussions about ending the relationship and making plans for Jason to move out of the family home. Jason attended an appointment with his GP and presented as agitated and complained of insomnia. Jason discussed the problems in his marriage and described his realisation that there was not going to be a positive change in his relationship with Ophelia. The doctor was not concerned about Jason's mental health during this consultation but prescribed him sleeping tablets.

Later the same day, Ophelia spoke to the Acting Principal at her school and indicated that she needed to take some days off as her due to problems in her relationship. The Acting Principal asked after her safety and the safety of the children, and she indicated that everyone was 'ok'. The Acting Principal then relayed this information to the Principal, who called Ophelia again later that evening. She confirmed with the Principal that she and Jason were going to separate, and reassured him that she and the children were safe. The Principal then offered Ophelia support through the Employment Assistance Program.

The next morning Ophelia woke up in the early hours of the morning and wrote a letter to Jason's psychiatrist expressing concerns about his mental illness and questioning why his treatment had focused on marriage counselling rather than Jason's condition. Jason woke up and the two of them discussed the relationship break down. Ophelia returned to bed. It is unclear whether Jason saw the letter.

Several hours later Ophelia awoke to the sound of her youngest two children screaming. She went to Andrew's bedroom and found that he had been stabbed. Ophelia grabbed the two younger children and ran to a neighbour's home. When the police and ambulance attended they found Andrew and Jason both deceased, Jason having committed suicide.

CASE REVIEW 2341

This case concerned the homicide of a 4 year old boy, Henry, by his abusive de facto step-father Justin. Justin was also extremely abusive towards Henry's mother Annie (aged in her mid-20s), and her two other children. Henry, Annie and Justin identified as Aboriginal, and both Annie and Justin had been victims of domestic violence and child abuse during their childhood.

Annie grew up in a regional area of NSW in the care of her mother and step-father, who were also foster carers for Child Protection Services. Annie had her own child protection history involving allegations against her mother and family. Annie was reported to Child Protection Services eight times between the ages of 14 and 16, including reports that her mother had stabbed her, that two males tried to sexually assault her, that she was engaging in 'casual sex' with much older men, and that she was in a relationship with an older boyfriend, Kieron.

When she was about 16 years old, Annie became pregnant to Kieron and a report to Child Protection Services following an incident in which Annie was assaulted by her step-father when she disclosed that she was pregnant. Annie's step-father slapped and pushed her, causing her to fall to the ground. Annie presented to hospital and police and Child Protection Services were contacted by hospital staff.

Following the assault, Annie's step-mother told Child Protection Services that Annie's step-father had been abusive towards Annie over a very long period, but that this abuse had not been reported to police.

Shortly after she became pregnant, Annie and Kieron broke up.

In 2006, when she was about 4 months pregnant, Annie started an intimate relationship with a man called Xander. After her son Henry was born, Xander cared for him as if Henry was his own son. Not long after Henry was born, Annie became pregnant to Xander. Around this time, Annie contacted Kieron to inform him she wanted to seek full custody of Henry. Kieron became verbally abusive towards Annie and Annie contacted police. Child Protection Services were notified, but the report was closed without action.

In late 2008 Annie's second baby, Lucy, was born and she quickly became pregnant again. After the birth of her third child, Ollie, in mid-2010, Annie and Xander broke up. At the time family and friends were concerned that Annie was not caring properly for her children, and that she may have been working informally as a sex worker. Xander continued to see Annie and the children every weekend, and hoped that he and Annie would reconcile.

In late 2010, Annie met Justin and the two commenced a relationship.

Justin described his childhood as 'dysfunctional and nomadic'. He was homeless for substantial periods of time, was exposed to significant domestic violence and was subject to extreme abuse (including sexual abuse) as a child. He was known to Child Protection Services for the majority of these issues. When Justin was 11 he sexually assaulted a 5 year old girl. He finished school in year 7 and became known to Child Protection Services again when he was found living with a known paedophile. These reports were unallocated and closed.

Justin started using cannabis in his mid-teens and used cannabis daily until the time of the homicide. Justin also started using methamphetamines and other drugs and had a criminal record in relation to drug offences in Queensland. In 2008, Justin was also convicted of assaulting a security guard and was placed on a supervised bond. As a condition of the bond, Justin received treatment for depression, anxiety and grief due to his extensive trauma history.

Soon after they met, Justin moved in to live with the Annie and the children. Annie immediately started losing contact with friends and family. Justin was using drugs and regularly abusing Annie, including on one occasion attempting to strangle her. Annie told friends that she felt like she was under house arrest, and indicated that Justin had threatened to kill her dog. There were many noise complaints to police, and one neighbour reported to police that she had seen Justin dragging Annie back into the house. Other neighbours reported seeing Justin break windows by punching them. Annie lost weight and became withdrawn and friends felt that she had 'stopped looking after herself'.

Neighbours also witnessed Justin abusing Henry and the other children. The children were often seen with injuries such as black eyes and bleeding noses. Annie would make up excuses for her and the children's injuries. A family friend also reported hearing Justin say that he would end up killing Henry one day. One of Justin's friends also reported having seen Justin sexually abuse Ollie. No reports were made to Child Protection Services.

In early 2011, Xander and his mother picked up Ollie and Lucy from Annie and Justin's house. Henry was staying with Annie's mother and step-father at the time. When Xander and his mother arrived, the children were described as appearing 'neglected' and 'unkempt'. Ollie also had a badly swollen and bruised eye. Justin verbally abused Xander and told him he could not take the children.

Xander took the children to the hospital, where reports were made to Child Protection Services. Ollie's eye injury was initially reported by the hospital staff to Child Protection Services as being either 'inflicted' or 'the result of medical neglect'.

Child Protection Services liaised with the family, and forwarded reports in relation to Henry, Lucy, and Ollie to three different CSCs based on the geographical location of each child.

Henry's report was forwarded to a CSC that was closed due to lack of staff. It was then forwarded to

another CSC where it was closed without assessment. Lucy's report was forwarded to another CSC and Ollie's report was accepted by the JIRT investigation team and an investigation was commenced.

Inadequate information sharing between the different CSCs resulted in Henry being returned to Annie and Justin's care while Ollie's case was still being investigated. A video 'walkthrough' taken by the police around this time showed that Annie and Justin's house was extremely dirty and untidy, strewn with dirty clothes, dishes, food and furniture. There was a breakdown in communication between police and Child Protection Services that meant this video was not viewed by Child Protection Services. The homicide occurred approximately 3 weeks after Henry was returned to Annie's care.

Three days before the homicide, Annie and Justin, accompanied by Justin's family, took Henry to the hospital. Henry presented with two black eyes, and injuries to his nose and forehead. Justin told staff that Henry had fallen over. Henry was assessed, and discharged to return home. No report was made to Child Protection Services by the hospital.

The day of the homicide, Justin used a significant amount of methamphetamine during the early hours of the morning. Henry was unwell during the day, experiencing diarrhoea and vomiting. He was also suffering from a persistent urinary tract infection. Later in the day, Justin started to 'come down' from the methamphetamine, and became 'angry and frustrated'.

Later that night, Henry called out to Annie that he had wet the bed. Annie changed the bed and Justin bathed Henry. While Justin was in the bathroom with Henry, Annie heard a number of loud noises and Justin shouting angrily at Henry. Annie went to the bathroom and saw Henry, who appeared unsteady and unable to stand. She carried Henry to his bedroom and noticed that he had 'glassy eyes' and was not able to walk unassisted.

Justin yelled at Annie to leave the bedroom and go to the living room. Justin joined her a few minutes later, stating that Henry was 'fine and going to sleep'. A short time later, Justin returned to Henry's room and found that he was 'floppy' and unresponsive. Justin shook Henry and tried to resuscitate him.

Annie contacted 000 and, on Jason's instructions, texted his parents who lived nearby. Justin's parents arrived a short time later and Justin and his father took Henry to the hospital. Other members of Justin's family took Annie to the hospital a few minutes later.

Henry died shortly after arriving at the hospital.

Justin told hospital staff that Henry had fallen below the water while in the bath. Justin's family would not let Annie speak to staff or the police.

The post-mortem revealed that Henry died as a result of multiple injuries. There was some suggestion that he had been sexually abused, but this was not pursued at trial. The final autopsy report was prepared by a different forensic pathologist to the one that had conducted the post mortem (as the first forensic pathologist was stood down prior to completing the final report).

Justin was arrested and charged with murder.

Justin eventually pleaded guilty to manslaughter.

Relative/kin domestic violence homicide

Adult homicide victims

CASE REVIEW 3038

This case concerned the homicide of a woman aged in her late 40s, Brooke, by her daughter Kaylah who was aged in her mid-20s. Brooke had a long history of abusing Kaylah, and she had been a victim of domestic violence by Kaylah's father.

Brooke had a long history of drug abuse and was using drugs at the time of the homicide. Brooke regularly used methamphetamines and had a long criminal offending history, primarily for drug offences, but also for violence offences. This included a custodial sentence for supplying drugs which she served during the 1990s when Kaylah was young.
There is evidence that Brooke abused Kaylah when she was a child, including physical, verbal and psychological abuse. Brooke also blamed Kaylah for the 'removal' of her other children (who went to live with other family members). Kaylah also witnessed domestic violence between her parents, was neglected, was denied basic essentials during her childhood, and had poor social modelling.

Kaylah attended a primary school for children with special needs and was semi-illiterate. She was educated until year 9, when she left school to have her first child. She stayed in a relationship with the

child's father until she was around 20 years of age. When the couple broke up, Kaylah started using drugs including cannabis, methamphetamine, heroin and alcohol. She entered into a new relationship and had two more children when she was aged in her early 20s.

In 2007 Kaylah attempted suicide. She was hospitalised for depression. She was not receiving treatment at the time of the homicide.

For the three months prior to the homicide, Kaylah was staying with Brooke and the three children in Brooke's house. There is evidence that Brooke had attacked Kaylah while she was holding one of her children, and had punched and kicked her. Brooke would also regularly smash things in an 'angry rage'. Sometimes Kaylah would fight back against Brooke, but there is no evidence of Kaylah ever initiating violence. There was no history of Kaylah ever abusing or neglecting her own children.

Like her mother Brooke, Kaylah had never been engaged in paid employment. She had a short criminal offending history including for offensive language, resisting arrest and some minor drug offences.

On the night of the homicide Brooke was looking after Kaylah's children. Kaylah returned home in the early hours of the morning and entered the kitchen where she prepared some food.. Brooke came out of the lounge room, appearing drug affected and intoxicated. Brooke and Kaylah started to argue and Brooke attacked Kaylah, stabbing her once with the knife she was cooking with.

Kaylah remained in the house for a few minutes, collected her children and Brooke called 000.

Kaylah left the home and disposed of the knife before going to her boyfriend's house. Brooke died before the ambulance arrived

Kaylah was found guilty of manslaughter on the basis of excessive self-defence.

CASE REVIEW 3039

This case involved the homicide of a woman in her late 40s, Aulia, by her abusive brother-in-law, Rama, aged in his mid-50s. Aulia was married to Rama's brother Aldo and all three lived together in an apartment in the city.

Aulia was born in South-East Asia and moved to Australia in the mid-1990s where she started a relationship with Aldo. Aldo was also from South-East Asia, but had been married previously in Australia to a woman called Sophia. Aldo had adult children from that relationship. Sophia and Aldo remained good friends after their divorce and Sophia also had a good relationship with Aulia.

Aulia was described by all who knew her as incredibly loving and gracious.

Rama was also born in South-East Asia, and he had lived permanently in Australia for a number of years.

From 2000 onwards, Rama was increasingly abusive towards Aulia, and was psychologically as well as physically violent. Aulia would often plead with Aldo to kick Rama out of the apartment, but Aldo indicated that he felt he had a duty to look after his brother. Aldo was described by his friends and family as a kind and gentle man, whereas his brother Rama was described as jealous, abusive and lazy. Aldo described the way in which Rama would spend his money, trash the house and eat their food. Notwithstanding this, Aldo continued to feel responsible for looking after his brother and continued to allow him to live in his and Aulia's home.

There was police contact in relation to some episodes of abuse by Rama against Aulia, but there were also a number of episodes of violence which were not reported to police. This included an assault where Rama chased Aulia and threatened her with a knife.

Rama was unemployed, had no anecdotal or reported mental health history, had no drug and alcohol issues and denied any history of problem gambling. However, he was described as having a very violent temper, so much so that Sophia had banned Rama from living with the family when she was married to Aldo during the 90s. Sophia described Rama as 'having problems with women' and Aldo's daughter Maria described him as a 'horrible, violent person'. Maria often saw Rama abusing Aulia, and at the time of the homicide had cut off all contact with him due to his verbal abuse towards both Aulia and herself.

There were also a number of episodes where police attended Rama, Aldo and Aulia's residence in relation to suspected domestic violence, although on each of the three occasions police attended, no offence was detected. Rama was the POI in each incident.

In 2009 Rama was convicted of an assault against Aulia. In this episode of violence, Rama attacked Aulia when she woke him up in the morning by shutting the door in the apartment. Rama spat on Aulia and pulled her by the hair, and threatened that if she told the police he would 'kill her straightaway'. She called the police when she managed to escape the unit, and they came and arrested Rama.

Rama was convicted and sentenced to a supervised 12 month good behaviour bond. An ADVO was put in place with an exclusion order preventing Rama from living with Aulia. After the ADVO was finalised, Rama moved out of the apartment and started living in backpacker accommodation in another suburb in the city. After a few months, supervision was discontinued and Rama moved back in to live with Aulia and Aldo in breach of the ADVO. Aldo told Rama he could live with him and Aulia as he had nowhere else to go.

At some point after Rama moved back into the premises, someone close to the family called the police to report that Rama was breaching the conditions of the ADVO. Police attended the apartment and spoke to Aldo (and possibly also Rama) about Rama continuing to live at the house. No COPS event was recorded on the police system and no breach was recorded despite clear contravention of the ADVO conditions.

In late 2010 Aldo found out he was being retrenched from work. Around this time there was an argument between Aulia and Rama, and Aulia asked Aldo why Rama had to continue to live with them. Aldo told Aulia that it was because Rama had nowhere to go and could not afford to live on his own. Aldo then spoke to Rama and told him to start working. Rama told him that 'everything will be fixed up tomorrow, you wait and see'. Everybody went to bed at approximately 11.30 pm. In the early hours of the next morning, Aldo went to work.

During the day, Rama attacked Aulia with a knife while she was getting dressed. He stabbed her in the back and neck 16 times. Rama also wrote a suicide note and took several Xanax. He claimed he had no memory of killing Aulia.

When Aldo arrived home he found Aulia's deceased body as well as Rama, who was still alive, but was groggy and unwell. The ambulance and police attended and charged Aldo with Aulia's murder and breach of ADVO in relation to the exclusion order.

Rama pleaded guilty to murder. He attempted to withdraw the plea but was unsuccessful. He also pleaded guilty to breach of ADVO.

CASE REVIEW 2335

This case concerned the homicide of a man aged in his early 50s, Ken, by his abusive, mentally ill son Lino (aged in his 20s). The homicide followed a long history of violence by Lino against both Ken and his housemate Harry. Ken, Lino and Harry lived together in a shared residence in a coastal town.

Lino was born in the South-East Asia and when he was about 12 years old he moved back to Australia with his father Ken. Ken was married to a woman named Mari, and they had lived as a family in the South-East Asia for a number of years. Upon returning to Australia, Ken worked as an educator and would send money back to the South-East Asia to support his wife and other son Opi.

Lino had a long history of mental illness. From as early as 2003, Lino openly denied that Ken was his father and called Ken 'an imposter'. Lino would carry around old photos and new photos of Ken, inviting people to compare the 'ears' of the two photos and agree with him that Ken was 'a fake'. Lino had trouble keeping down a regular job due to his unusual behaviours and was unemployed for most of his adult life.

There were ongoing arguments between Ken and Lino, and Lino was often violent towards his father. In 2006 Lino assaulted Ken in the course of an argument and he was arrested by police. He was convicted of Assault ABH and was given a 12 month good behaviour bond. An ADVO was put in place naming Ken as the person in need of protection. Ken and Lino continued to live together.

Three days after Lino's good behaviour bond expired (in 2007) Lino stabbed Ken in the head. Lino was conveyed to a mental health facility for treatment. He claimed to staff that his father was poisoning his food and reported that he was regularly assaulted by his father. Lino was assessed as having experienced paranoid feelings for over 2 years. Staff arranged for Lino to start receiving a government pension so that he would be more financially independent and would not have to be discharged from hospital to live with Ken and Harry.

Lino was discharged several days later and, after a few days of living with friends, returned to live with Harry and Ken. An ADVO was also put in place protecting Harry.

Other violence included a number of incidents where Lino poured methylated spirits into the milk in the fridge hoping to poison his father, and, on a

number of occasions, he initiated physical fights with Ken. Ken and Harry were both scared of Lino. Harry had erected a makeshift barricade in his room to prevent Lino from being able to enter. Harry and Ken also attempted to 'starve' Lino out of the house by removing cooking appliances and locking the fridge.

In 2010 Ken changed his will to prioritise Opi's inheritance over Lino's, as he expressed concern that Lino was becoming increasingly erratic and violent towards him. It is unclear whether or not Lino was aware of the amendment to Ken's will.

One evening in late 2010, Lino was out drinking at a hotel with some friends. They all left at closing time and returned to a friend's house to continue drinking and socialising. The owner of the house did not know Lino very well, and thought he was acting strangely, so she asked him to leave. Lino refused. A fight broke out and Lino assaulted the owner and another guest. Lino sustained some injuries to his face.

Lino left the premises by taxi. The taxi driver described Lino's overall demeanour as alternating between friendly and agitated and noted he had serious head injuries and was bleeding from the mouth. Lino told the driver that he had been kidnapped, and claimed that his real father was dead. He stated that he was going to kill his father or brother with an iron bar. The taxi driver dropped him off at the police station at about 6 am, in accordance with Lino's request.

Lino spoke to police and claimed he had been assaulted earlier that evening. Police took photographs of his injuries. Lino then showed the Senior Constable at the station several photos of Ken and indicated that Ken had kidnapped him. Lino kept on saying, 'look at the ears on my dad … this not my father.' Lino at one stage asked the police officer to call his mother as she would tell him about the kidnapping.

After taking the photographs, police made arrangements for Lino to be transported by taxi to the local hospital so that his injuries could be assessed. In the waiting room he told a member of cleaning staff that he was planning on killing his father. After being assessed for his physical injuries, Lino was collected by another taxi from the hospital and conveyed back to the police station. Lino told the taxi driver that he was planning on killing his father with a gun when he finally returned home.

After spending a short period at the police station, another taxi arrived and conveyed Lino back to his father's home. That driver noted that Lino seemed angry, and told him he was going to kill his father.

When he arrived home, Lino started an argument with Ken. Harry heard the commotion, removed the barrier over his door, and he heard Lino yell out that he was going to kill Ken. Harry crept out of his room and saw Lino frantically cleaning in the ensuite. Harry climbed out of a window and ran to a neighbour's house where he called Police. Ken had been stabbed by Lino and died at the scene.

Lino was found not guilty by reason of mental illness.

CASE REVIEW 3405

This case concerned the homicide of a man in his mid-60s, Tom, by his abusive and mentally ill son Will, aged in his mid-30s.Tom and Will lived in neighbouring houses in a town in regional NSW. Both Tom and Will identified as Aboriginal.

Will was the youngest of 9 children, and described a happy and loving childhood. Tom and his wife Pam had a good relationship and there was no anecdotal or reported history of domestic violence. It should be noted that later Will made disclosures that his father had sexually abused him as a child, although it is unclear whether this was in the context of Will's mental illness.
Will left school after year 10 and worked as a seasonal fruit picker. He was unemployed at the time of the offence and receiving a disability support pension. Will had previously had two children from earlier relationships, whom he saw during school holidays. Will had been a domestic violence abuser against their mother and had been a defendant under two ADVOs with her previously. He also had a history of breaching ADVOs.

Will began drinking and smoking cannabis at 13 and was drinking and smoking heavily from his early 20s until the time of the homicide. Will also had an extensive criminal record which commenced when he was 13 years old, and included custodial sentences for violence. He had previously been a victim of an attempted murder during the early 2000s. In this attack he was stabbed by strangers. He suffered ongoing trauma and PTSD following this assault.

Will gave a history of experiencing depression from the age of about 11 and had attempted suicide during his early teens. He gave a history of hearing voices and seeing 'ghostly figures' and first saw a mental health worker as a teenager.

In 2005 Will had his first psychiatric admission and he was diagnosed as suffering from a 'brief reactive psychosis' and prescribed antipsychotic medication.

In 2006 he was again hospitalised and diagnosed with schizophrenia and poly-substance abuse disorder.

In addition to a long history of mental illness, there was a long history of violence between Will and Tom, where Will was the primary aggressor. Will would regularly physically and verbally abuse Tom and damage his property. Family and friends described seeing Tom with various injuries that had been caused by Will. Friends and family were aware that Tom would padlock his bedroom door at night when Will was living with him. Tom indicated to police that that he was scared of Will, although on other occasions he denied being afraid.

Between 2005 and 2011 there were 11 COPS events in relation to Will's violence and abusive behaviours towards Tom. Tom was a protected person under historical ADVOs and there was an ADVO protecting Tom from Will in place at the time of the homicide. There is evidence that police considered Tom to be resistant to police contact, as on one occasion Tom became frustrated with police following a delay in the police removing Will, who was drunk and abusive, from his home.

In 2011 Tom asked for help from a family member who was also the Aboriginal Community Liaison Officer (ACLO) at the local police station. Tom told the ACLO that Will's mental health had deteriorated and that he needed to go to hospital. The ACLO took Will to the hospital where he disclosed his belief that his father had been sexually abusing him, that he was being poisoned and that his family had put cameras in the ceiling. Will also began making allegations to family members that his father and a nephew had sexually interfered with his children from about 2010 onwards. This was regarded by the family members to be a manifestation of Will's mental illness, rather than a truthful allegation.

In his last statement to police, a few months prior to the homicide, Tom said he was afraid of Will when he Will was drunk. He stated that he did not want Will to come near him when he had been drinking.

Around September, Will moved out of his father's house and stopped taking his antipsychotic medication. The family noted a few weeks prior to the homicide that Will was 'going off again' and indicated that they needed to get him some help. A few days prior to the homicide, Will called his ex-partner alleging that Tom had molested the children. She reassured him that the children were fine and had not been interfered with in any way.

Three days prior to the homicide, Tom approached Will's Aboriginal Health Worker, and told him that he needed help managing Will's mental health. Tom asked for the mental health team to visit and they visited later that day. Will said he was fine and had sufficient medication to last over the Christmas break. He did not disclose that he had stopped taking his medication. Tom also spoke to Will's ex-partner around this time and told her not to send the kids for the holidays as Will was not well.

On Christmas eve in the afternoon Tom asked the ACLO to help him with Will as he was 'going off'. The ACLO encouraged Tom to contact police, but Tom said he didn't want to as it was Christmas eve.

The ACLO visited Will's house and saw Will howling at the sky. The ACLO returned to the police station and told the police that he needed an officer to urgently come and help him with Will as he was extremely unwell. The police officers did not appear to recognise the urgency of the situation and the ACLO became increasingly frustrated with their response. The ACLO asked the officer on duty to check Will's criminal record to determine whether there was an exclusion order in place. The officer did not do this.

The police officers advised the ACLO to return to Tom's place and get further instructions from Tom. Will. It is unclear what course of action was taken by the ACLO at this point.

Within the hour, Will went to Tom's house with a knife and stabbed him several times. Tom died in the hospital.

Will was found not guilty by reason of mental illness.

CASE REVIEW 3046

This case concerned the homicide of a woman in her late 40s, Adele, by her teenage son Jacob. At the time of the homicide Adele and Jacob lived together in regional NSW.

Adele had a history of using and selling drugs dating back to the early 1980s and had a number of criminal convictions, including custodial sentences, relating to possession and supply (as well as other offences). For a number of years prior to the homicide Adele had owned and run a cleaning business.

In the early 1990s Adele commenced a relationship with Jacob's father, Reza, who was also involved in dealing drugs. When Jacob was about 2 or 3 years old Adele and Reza's relationship ended. Jacob lived with his mother until he was about 5 years old at which time Adele was sentenced to a full time custodial sentence and Jacob was placed in foster care. Jacob remained in foster care until he was 12 years old at which time he went to live with Reza.

Jacob began smoking cannabis and binge drinking in his early teens. When Jacob was about 14 years old Reza went missing and was presumed to have been murdered. Soon after his father went missing, Jacob left school and returned to live with Adele. Jacob's mental and psychological health deteriorated after the disappearance of his father and he was first diagnosed with early onset/drug induced psychosis when he was about 15 years old. Jacob's medical notes from this time indicate that the police called and spoke to Jacob to advise that his father's body had been found 'burnt and with 3 bullet holes in his head'. This was said to have further exacerbated Jacob's mental health issues.

In the two years that Jacob and Adele were living together before the homicide, Jacob was regularly physically violent towards his mother and neighbours reported regular loud and violent arguments coming from the house. In the months leading up to the homicide, Adele told her landlord that she was scared of Jacob and that he regularly pushed and shoved her and damaged her property. Adele also disclosed to friends that Jacob had previously held a knife to her throat. Adele's business partner regularly observed Adele with bruises and grazes caused by Jacob and another friend had heard Jacob threatening to kill Adele.

In the 12 months leading up to the homicide Jacob had numerous hospital admissions in relation to his mental health as well as regular outpatient treatment. Adele told various mental health workers involved with Jacob that she was afraid of Jacob and what he was capable of. However, notes indicate that Adele was regarded by many staff as being an 'unreliable historian'.

Until 6 months prior to the homicide, Jacob was generally compliant with his medication. However in the 6 months leading up to the homicide Jacob was resisting treatment and would regularly refuse anti-psychotic injections.

In the weeks prior to the homicide, Jacob's behaviour was becoming increasingly erratic. He was picked up by police for breaking into homes to sleep and shower (he had 18 showers a day) and was admitted to hospital as an involuntary patient. Two days later Jacob absconded from the mental health unit of the hospital. Police were notified and the hospital lodged a missing patient form with police.

Police advised Adele that Jacob had absconded. Adele agreed that she would contact police as soon as she heard from him. Police records indicate that police contacted the mental health unit 12 days later and were advised that Jacob was still missing but he had been discharged and was 'no longer classified as an abscondee'. This advice is similarly reflected in the notes of Jacob's community mental health worker, John, who was advised by the mental health unit that Jacob had been 'discharged', because he was 'wasting a bed'.

Medical notes also indicated that Jacob had been present at a consultation and received a Risperidone injection while he was missing. This was clearly an error, as Jacob had never attended this appointment.

Two weeks after absconding from the mental health unit Jacob returned home. Adele contacted Jacob's community mental health worker, John, and requested that he come and assess Jacob's mental health with a view to having him re-scheduled. John was required to be accompanied by a mental health worker to undertake this kind of assessment and none were available. A visit by the mental health team was scheduled for three days later however this visit was rescheduled for 2 days later, by which time Adele was dead.

The day before the homicide Adele rang a friend in a highly distressed state. She stated that she and Jacob had argued about some missing money and that she had been awake all night as Jacob had been coming in and out of the house with a knife.

On the day of the homicide, neighbours were woken in the early hours of the morning by a loud argument between Adele and Jacob. They heard Adele screaming: 'Stop. Jacob, you're killing me; you're going to kill me. Stop, Jacob. You're killing me.' None of the neighbours contacted police at the time but one mentioned hearing a loud fight to a friend of Adele's later that morning. The friend was concerned and contacted police who attended and conducted a cursory search of the property but found nothing to report. Later the same day, the concerned friend gained entry to the house and found Adele's body wrapped in carpet on the floor of a small toilet/shower area inside the garage. The carpet was covered with a large number of towels all of which were heavily soiled with blood. The

post mortem later revealed that Adele had died as a consequence of multiple stab wounds.

Jacob was located by police two days later and after initially denying that he had killed Adele, made full admissions describing various command auditory hallucinations telling him he should kill his mother.

Jacob was found not guilty by reason of mental illness.

CASE REVIEW 3436

This case concerned the homicide of Deon, a man in his mid-60s, by Luka, his 40 year old nephew.

Deon and his brother Ivan (Luka's father) were born in Europe and migrated to Australia in the late 1960s. Deon married when he arrived in Australia and had one daughter. Ivan was also married and had two sons, one of whom was Luka. The two families were very close and saw each other frequently.

Luka reported a good childhood, free from neglect or trauma. It is noted, however, that when being psychologically assessed after the homicide he claimed that he had tried to drown himself when he was about 11 years old and that he had been molested by his uncle, Deon.

Luka had a minor criminal record. He also worked odd jobs throughout his late teens and early 20s, after which he was the recipient of a disability support pension due to his mental health problems. Luka had been a heavy cannabis user throughout his 20s and his early 30s but was not using drugs at the time of the homicide.

Luka reported first hearing voices from about 5 years of age and had experienced ongoing auditory hallucinations for most of his adult life. In his early 20s Luka was diagnosed with schizophrenia and was receiving continuous treatment for this until the homicide. He had a history of hospitalisation and outpatient care, and at the time of the homicide was under the care of the local mental health team.

Luka's mother described that Luka had regular 'violent outbursts'. He would smash furniture and threaten family members with violence. Family members would call police during these episodes.

When Luka was in his early 30s he seriously assaulted his mother, punching her in the face and threatening her with a knife. Ivan called the police and when they attended Sara said that she was frightened for her life and feared that one day Luka would kill her. Luka was charged with assault occasioning actual bodily harm and was served with an ADVO naming his mother as the PINOP. He received a 2 year good behaviour bond with supervision.

A number of years before the homicide, Luka was convicted of Assault Occasioning Actual Bodily Harm in relation to a serious assault on his brother, for which he received a community service order.

In the months leading up to the homicide, Luka became increasingly hostile towards his brother, stating to family members that he wanted to kill him and his niece. His brother was said, by family members, to be 'scared to death of Luka.'

About 6 weeks before the homicide, Luka went to his uncle Deon's house with a hand written letter addressed to Deon and his aunt, threatening to hit them on the head with a hammer.

Deon gave the letter to Luka's mother and the family agreed that they did not want to get the police involved. Luka's mother told family members that Luka was not sleeping and that 'she was very scared'.

Luka's mother brought the letter to the attention of Luka's mental health case worker and his treating psychiatrist. A clinical decision was made to attempt to manage Luka in the community. This was to entail close involvement of the case manager with the family, with prompt admission to hospital if the case manager or family felt it was necessary. Luka's medication was increased and the case was set down for review in three weeks, with the understanding that Luka would be seen earlier if necessary.

Deon and his wife saw Luka on two occasions without incident after he had given them the letter.

A review 3 weeks before the homicide indicated that Luka was experiencing ongoing florid symptoms of psychosis but he was not considered to be an acute risk.

The morning of the homicide, Luka's parents left home to visit a relative. After they were gone, Luka, armed with a hammer, walked to Deon's home. Luka attacked Deon with the hammer, by striking him on the head. A neighbour called police and ambulance who attended and arrested Luka. Deon died in hospital as a consequence of head injuries.

Luka was found not guilty by reason of mental illness.

'Other' domestic violence homicide

CASE REVIEW 3280

This case involved the shooting death of a domestic violence abuser, James, by an older man, Rodney, who was intervening in domestic violence between the abuser and his girlfriend, Lana. Rodney was employed as a caretaker on the rural property owned by Lana. Rodney shot and killed James while he was holding a knife to Lana's throat and threatening to kill her.

James and Lana first met in about late 2008. Lana had previously been married and had one child to that marriage who lived with her on the property. James was very jealous of Lana's ongoing friendship with her estranged husband and pressured Lana to have divorce papers drawn up.

James worked in the city but would come and stay with Lana on weekends and sometimes through the week. James was a heavy drinker and regularly became physically and verbally abusive towards Lana when drunk. Lana had asked James to leave on a number of occasions due to his abusive behaviour.

About 4 months before the homicide Lana told James' sister about an incident where she and James were arguing and he tried to strangle her. Around the same time James assaulted Lana's estranged husband at a function. Police attended but no charges were laid. Lana told friends that she wanted to leave James.

Lana stated that James had not previously used weapons to assault her but would regularly 'lose it' and physically assault her. She had not reported this abusive behaviour to police.

Rodney said that James was physically and verbally abusive to both Lana and her daughter. Rodney also told a friend that James was violent and cruel to Lana's animals.

Rodney lived in a caravan about 60m from the main house and was paid to work on the property. He was aged in his late 60s.

Rodney said that Lana and James would 'argue all the time', particularly when James was drinking. Rodney said he 'stayed out of it' and 'did not want to interfere'.

The day of the homicide, James, Rodney and Lana did some work on the property. James began drinking at about midday and by that evening was significantly intoxicated. Lana and James had an argument during the evening, and Rodney left after dinner and returned to his caravan on the property.

After dinner James became increasingly angry towards Lana, and Lana's daughter ran to get help from Rodney. When Rodney went up to the house, James was swinging an axe at Lana and chased her into the kitchen. James held a knife to Lana's throat and Rodney grabbed a rifle. Rodney fired a warning shot in the air, and as this had no effect, shot James once in the shoulder and once in the head.

James died at the scene.

Rodney's matter was heard in a judge alone trial and he was acquitted of James' murder on the basis of defence of another.

CASE REVIEW 2343

This case concerned the homicide of a man aged in his mid-30s, Todd, by his 40 year old flatmate, Jax. The case occurred in a domestic violence context due to abusive behaviours by the deceased, Todd, against the perpetrator, Jax. There was significant police contact in the 12 hours prior to the homicide. Jax identified as Aboriginal.

Jax was born in a regional area in NSW. When he was 3 years old, he and his brother were removed from his mother's care and placed with non-Indigenous foster carers in the city. Both children described their childhood as very good – the foster carers were very respectful of the children's culture and maintained ongoing relationships with their birth mother.

Jax had a number of health issues during his childhood. He had some hearing problems which meant that he started to fall behind at school. He was bullied and told he was 'stupid'.

When the boys were in their early teenage years, the family had to move away from the city due to the foster father's health issues. They moved to the country, where they were able to have ongoing contact with the children's extended kin, as well as their birth mother. Jax had some difficulty fitting in

tended to hang out with naughty kids. He started using drugs and alcohol in his early teens.

In year 8, Jax had a meeting with the school's careers advisor, who told him that he should leave school at the earliest opportunity, as he was not keeping up and would be better off learning a trade or working. As soon as he was able, in year 9, Jax finished school. He moved back to the city to work. He had a strong work ethic and he was enthusiastic, friendly and dedicated. He would regularly travel home to see his family, and would bring many gifts, especially for his younger brother.

When Jax moved to the city he started developing problems with alcohol and his mental health declined.

He had a short criminal record for minor public order offences. He had no history of violence offences at the time of the homicide.

Jax continued to work and developed strong ties with the Aboriginal community in Redfern. He also was involved in several Indigenous education programs and was described as being committed and passionate.

Between the late 1980s and the homicide, Jax had 39 contacts with mental health or medical services. He spent short periods in hospital, and was medicated for schizophrenia and polydrug substance abuse problems on a number of occasions. The evidence available indicates that many of these admissions were short, and designed to ensure Jax continued to be compliant with medication.

In late 2010 Jax met the deceased, Todd, at a community centre. Jax offered both Todd and his friend a place to stay, and charged them each a small fee to sublet in his social housing premises. This was in contravention of the terms and conditions of his lease.

Once Todd and his friend moved in, there were some ongoing fights and issues within the home. Several more people moved into the flat, and Jax's mental health started to rapidly deteriorate.

Todd had a significant criminal record, and had serious drug and alcohol abuse problems.

The day of the homicide Jax kicked Todd and his friends out of the house. Todd and his friends broke into the apartment to find Jax inside. There was an altercation and Jax was screaming at Todd and his friends to leave the unit. A neighbour saw Jax on the phone telling police that someone was trying to kill him, however, this 000 record was not included on the brief and police did not attend.

Jax returned to the unit and shortly thereafter a neighbour logged a call to police regarding noise. After police did not attend she called again to report a loud argument taking place in Jax's unit, and police attended sometime later. Police statements indicated that Jax was bleeding from the head, and Jax told them that Todd had 'bottled' him. The officers believed Jax was extremely intoxicated, despite the fact that he had had little to drink. Ambulance attended and attended to the wound on Jax's head.

Jax told the police officers that Todd had assaulted him and Todd claimed he had fallen over. The officer told Jax that they would not press assault charges as the stories were inconsistent, but said that they would apply for an ADVO to protect him. Jax was conveyed by ambulance to hospital to have his injuries attended to. Todd and his friends were left in Jax's house.

Over the next few hours neighbours called police several times in relation to loud 'smashing' noises and loud music. Police attended and stood on the road. Not hearing any noise, the officers left the premises. They returned after further calls and told Todd to turn the music down. They did not look inside the unit.

At about 3.30am Jax called the police from the hospital to indicate that he wanted to use his cab charge to come to the station and make a statement about his head injury. According to hospital notes, the injuries were assessed as being consistent with his explanation (assault) as opposed to Todd's claim that they were sustained in a fall. The police told Jax not to attend.

Around 4 am the neighbour heard Jax arrive home and open the door. The music in the unit was turned up and she heard Todd shout out 'I want to kill him he's a liar' and Todd's friend say 'don't worry we'll fix it'. Jax then ran out of the unit and down to the car park.

Todd's friend chased Jax. While he was running Jax called 000 and reported he was being chased by men with knives. Police soon received a second broadcast, as Jax had called 000 a second time. Three constables drove towards the scene and came upon Todd's friend Kip. They searched Kip and found no weapons. He indicated that he was walking home (despite the fact that his bags were still at Jax's house). Police then found Jax, who

indicated that Kip had been chasing him after he had walked in on his unit to find it trashed. Jax said he thought that Todd and Kip had trashed his house, but police told him he 'had no proof'.

Jax also told police that he wanted Todd and Kip removed from his house. Police told him that they could not remove Todd from the house and that Jax would need to speak to the 'Department of Housing' or the 'Tenant's Tribunal'.

The police left and soon after received notification that Kip had returned to Jax's unit. Jax had called 000.

Police attended and found Kip and his girlfriend in the unit. Kip and his girlfriend indicated they were leaving. Police also saw Todd lying on a chair in the unit. Police asked if Kip could take Todd with him, and Kip said no and left. Police indicated that they spoke to both Jax and Todd, and asked whether 'there would be any further issues' once police left. They indicated that there would be no further issues.

Jax asked the police officer in attendance why nobody was taking any photos of the property damage in his unit. The officer indicated that this was 'being managed by the police who attended earlier in the evening'. Jax was agitated and said it was not, and that he was going to 'call the Ombudsman'.

Police statements indicate that Jax continued to be aggressive and state that there was a lack of action on the part of the police and that he was going to call 'the police of the police.'

Jax walked outside the unit and called 000 while the police officers were still at the unit. Jax was agitated and asked for the operator to put him through to 'the police of the police' as he was not receiving an adequate response. The 000 operator asked to speak to the officer in attendance and Jax handed over the phone. The 000 operator and police officer laughed and discussed what a 'nightmare' the evening had been. The officer ended the call and Jax left the house and went to the police station.

The police officers left the unit and returned to the station.

At 6 am Jax attended the police station to complain about his treatment. After a period of waiting, Jax left the premises and returned home.

After returning home, Jax had an altercation with Todd and Jax stabbed Todd once in the chest with a knife.

Jax pleaded guilty to manslaughter.

4 DATA FOCUS
INTIMATE PARTNER DOMESTIC VIOLENCE HOMICIDE 2008-2012

This chapter provides an enhanced data analysis in relation to all intimate partner homicides occurring in a domestic violence context in NSW between 10 March 2008 and 30 June 2012. Each case in this dataset has been reviewed in depth by the Team.

Introduction

Domestic, or intimate partner, violence describes a spectrum of behaviours whereby a person intentionally and systematically uses violence and abuse to gain and maintain power over another person with whom they share (or have shared) an intimate relationship. At the heart of this definition is the abuser's use of coercive and controlling behaviours to assert and maintain power and dominance over the victim.

Research has demonstrated that the vast majority of domestic or intimate partner violence is perpetrated by men against women.[23] This has led to an understanding that domestic violence is a gendered harm.

The Team acknowledges that domestic or intimate partner violence requires particular consideration in light of these characteristics and accordingly has used this report to further develop data in relation to this pressing social issue.

To date the Team has undertaken reviews of all 40 intimate partner domestic violence homicides between 10 March 2008 and 30 June 2012. The Team has been uniquely placed in this report to undertake enhanced data analysis derived from these reviews, including to consider violence histories, domestic violence abuser criminal histories and ADVO histories between the domestic violence victim and abuser.

This chapter, accordingly, provides further data in relation to all 40 intimate partner domestic violence homicides between 10 March 2008 and 30 June 2012

Intimate partner domestic violence homicide – Focus dataset

Between 10 March 2008 and 30 June 2012 there were 52 intimate partner homicides in New South Wales. Of these 52 homicides, 77% (N=40) were classified by the Team as having occurred in a domestic violence context.

For the 12 homicides that were categorised as *not* occurring in a domestic violence context, there was no identifiable history of domestic violence prior to the fatal episode. These cases instead occurred in circumstances, including:

- suicide pact/assisted suicide where the homicide victim had a chronic illness (N=2);
- sexual misadventure/ accident (N=2);
- financial motivation (N=1);
- dementia/mental illness (N=2); and
- where there was otherwise no identifiable history of domestic violence (N=4).

Given the limitations inherent on relying on the brief of evidence, including the affidavits and statements of friends, family members and often the accused, it is acknowledged that there may have been undisclosed histories of domestic violence in cases excluded from the domestic violence context dataset.

Accordingly, it is acknowledged that the recorded figures may represent an undercount of intimate partner homicides occurring in a domestic violence context.

[23] Australian Bureau of Statistics, *Personal Safety Survey Australia 2005*, ABS cat.no 4906.9 Canberra, 2006; Chan A & Payne J, 2013, 'Homicide in Australia: 2008-09 to 2009-10 National Homicide Monitoring Program annual report', Monitoring report, no. 21, *Australian Institute of Criminology*, Canberra; Dobash R, Dobash R, Wilson M & Daly M, 1992, 'The myth of sexual symmetry in marital violence', *Social Problems*, vol. 39, issue 1, p. 71-91; Grech K & Burgess M (eds.) 'Trends and patterns in domestic violence assaults: 2001 to 2010', Issues Paper, no. 61, *NSW Bureau of Crime Statistics and Research*, Sydney, 2011.

Intimate partner domestic violence homicides – victim/abuser status and gender

Of the 40 homicides in this focus dataset, 80% (N=32) involved a domestic violence abuser killing their intimate partner (the domestic violence victim), and 20% involved a domestic violence victim killing their abuser (N=8).

All domestic violence victims in this dataset were women, and all domestic violence abusers were men. Accordingly, this dataset is comprised of 32 female victims of domestic violence who were killed by an abusive male current/former partner, and 8 abusive males who were killed by their current/former female intimate partner (the domestic violence victim).

Relationship status

In 26 cases the domestic violence victim and domestic violence abuser were in a current relationship at the time of the homicide (65%). This included 5 cases where the domestic violence victim had indicated to friends, family or the abuser that she was intending to leave the abuser (19%). In each of these cases the domestic violence victim was killed by the abuser.

In the remaining 14 cases (35%), the domestic violence victim and domestic violence abuser were no longer in a relationship at the time of the homicide. In 7 of these cases, the relationship had ended within 3 months of the homicide (50%). This included 2 cases where the victim was killed the day after she ended the relationship with the abuser.

Overall, separation (actual or intended) was a characteristic in 48% of all intimate partner domestic violence context homicides (N=19).

Violence/abuse histories

In all 40 cases in the focus dataset (100%), the relationship between the domestic violence victim and the domestic violence abuser was characterised by the abuser's use of coercion and controlling behaviours towards the victim. In every case the domestic violence abuser perpetrated various forms of abuse against the victim including psychological abuse and emotional abuse.

Verbal abuse

Of the 40 cases, 39 (98%) involved the domestic violence abuser using verbally abusive behaviours towards the victim.

This included the abuser using language that was belittling, derogatory, humiliating, and insulting towards the victim, or otherwise using language in ways with the intention of undermining the victim's self-esteem and self-empowerment.

In the single case that did not include reported histories of such behaviours, passive aggressive behaviours towards the victim (including emotionally abusive actions) formed part of the abuser's coercive and controlling behaviours.

In 18 of these cases (46%) verbally abusive behaviours included a history of the domestic violence abuser directly threatening to kill the domestic violence victim.

Social abuse

Of the 40 cases, 16 (40%) involved the domestic violence abuser exercising social control over the domestic violence victim.

This included such behaviours as preventing the victim from seeing friends and family, systematically isolating the victim by way of being abusive or rude to friends and family, and the domestic violence abuser intentionally relocating the victim away from support networks, friends and family.

Financial abuse

Of the 40 cases, 16 cases (40%) involved the domestic violence abuser exercising financial control over the domestic violence victim.

This included such behaviours as withholding and controlling use of bank cards, cash and other forms of money, controlling access to bank accounts, scrutinising the victim's spending and setting unrealistic expectations for the cost of groceries and other necessary expenditures.

Other cases included the domestic violence abuser preventing the victim from working or seizing and controlling the victim's earnings from her work.

Physical abuse

In 36 of the 40 cases (90%), physically abusive behaviours formed part of the domestic violence abusers coercive and controlling behaviour towards the domestic violence victim.

Behaviours ranged from one or two assaults reported to friends and family, to extensive and

sustained patterns of physical abuse and physical torture by the abuser against the victim.

In 35 of the 36 cases (97%), the physical abuse included the domestic violence abuser hitting, slapping or striking the domestic violence victim with fists (physical assaults without weapon).

In 12 of the 36 cases (33%) the physical abuse included the domestic violence abuser using a weapon to assault the domestic violence victim.

In 10 of the 36 cases (28%) there was evidence that the domestic violence abuser had attempted to strangle the domestic violence victim prior to the fatal episode of domestic violence.

Sexual abuse

In only 2 cases (5%) histories of sexual violence by the domestic violence abuser towards the domestic violence victim were disclosed.

This is a significantly lower figure than other total population estimations which suggest that between 40-45% of women who are physically abused are also sexually abused by their intimate partner.[24] It is therefore suspected that the figure derived from this dataset may not reflect the true prevalence of sexual violence in these relationships.

There are a number of reasons this could be the case including that the domestic violence victim may not have disclosed histories of sexual violence to friends and family or other service providers (whose testimonies are relied upon for the review process) prior to the homicide. Additionally, it has been recognised that victims may not recognise or characterise the abuse they are experiencing from their partners as sexual violence.[25]

Similarly, it is recognised that sexual violence may attract particular stigma and victims may be more unlikely to disclose these experiences to others.

Stalking

In 17 of the 40 cases (43%) stalking behaviours formed part of the domestic violence abuser's coercive and controlling behaviours towards the victim prior to the fatal episode of domestic violence.

In 10 of these cases this formed part of the domestic violence abuser's coercive and controlling behaviours while the relationship was on foot, in 3 of these cases the domestic violence abuser commenced stalking the victim only after the relationship had broken down and in 4 cases the domestic violence abuser stalked the victim while the relationship was ongoing and after the relationship had ended.

In 7 of these cases stalking behaviours disclosed included the abuser using technology to stalk the victim, including persistent text messaging and checking the domestic violence victim's phone etc. In all of these cases this formed part of the domestic violence abuser's behaviour while the relationship was current. In the two cases (out of the 7) where the relationship had ended, the domestic violence abuser continued to stalk the victim using technology.

Prior domestic violence offending histories

For 9 of the domestic violence abusers (23%) the relationship with the victim was their only significant intimate relationship (i.e. they had no other partners).

For the remaining 31 cases, 22 of the domestic violence abusers had prior histories of violence against other intimate partners (71%) – meaning that they had previously been abusers in prior relationships. In 11 of these cases (50% of cases where there was an identifiable history of offending against prior partners) the abuser had been convicted of assaults against a prior partner.

ADVO histories

Domestic Violence Victim ADVO history with abuser

Six domestic violence victims were protected under current ADVOs, where the domestic violence abuser was the defendant, at the time of the homicide (15%).

Six domestic violence victims had previously been protected under ADVOs where the domestic violence abuser was the defendant, although the ADVO had expired at the time of the homicide (15%).

[24] Wall, L 'Asking women about intimate partner sexual violence' *Australian Centre for the Study of Sexual Assault: Australian Institute of Family Studies* (June 2012) Available at: http://www3.aifs.gov.au/acssa/pubs/sheets/rs4/rs4.pdf: last accessed October 2015.

[25] Wall, L 'Asking women about intimate partner sexual violence' *Australian Centre for the Study of Sexual Assault: Australian Institute of Family Studies* (June 2012) Available at: http://www3.aifs.gov.au/acssa/pubs/sheets/rs4/rs4.pdf: last accessed October 2015.

Altogether, 12 domestic violence victims (30%) had histories of being protected under ADVOs (either current or expired) with the domestic violence abuser.

Domestic violence abuser ADVO history with victim

Six domestic violence abusers were defendants under current ADVOs, where the domestic violence victim was protected, at the time of the homicide (15%).

Four domestic violence abusers had previously been a defendant under an ADVO's where the domestic violence victim was protected, although the ADVO had expired at the time of the homicide (10%).

Altogether, 10 domestic violence abusers had histories of being defendants under ADVOs (either current or expired) with the domestic violence victim.

Domestic violence abuser ADVO history with other intimate partners

As noted previously, for 31 of the domestic violence abusers the relationship with the domestic violence victim was not their first significant relationship and in 22 of these cases the domestic violence abuser had been a repeat domestic violence abuser.

Of these 22 cases, in 15 cases the domestic violence abuser had a history of ADVOs with prior intimate partners (68%).

Characteristics of domestic violence abusers

Age

Of the 40 domestic violence abusers, all 40 in this dataset were male. They ranged in age from 22 to 87 years, with a mean age of 43 years.

ATSI status

Of the 40 domestic violence abusers, 7 identified as Aboriginal (18%).

CALD status

Of the 40 domestic violence abusers, 9 were from a CALD background (23%).

Those from a CALD background came from India (N=3), China (N=1), Finland (N=1), Poland (N=1), Chile (N=1), Macedonia (N=1) and Sudan (N=1).

Linguistic barriers to seeking help were evident in only one case, which involved a couple who arrived from Sudan 3 years prior to the homicide as refugees. In all other cases there was no evidence of linguistic barriers.

One domestic violence abuser had moved to Australia within 12 months of the homicide, and the remainder (8) had been in Australia for longer than 3 years.

Criminal convictions

Of the 40 domestic violence abusers, 27 had been previously convicted of a criminal offence (68%). For 20 of these 27 abusers, this criminal history included convictions for violence offences (50% of all abusers). 11 abusers had been convicted of an assault against a prior partner (28% of all abusers).

14 of the abusers in this dataset had served custodial sentences, and all had served at least 2 custodial sentences. The average number of custodial sentences served across those who had been imprisoned was 5.1.

Mental health history

Of the 40 domestic violence abusers, 19 (48%) had a history of mental health issues.

Of the 19 domestic violence abusers who had a history of mental health issues, 7 (37%) were receiving current mental health treatment at the time of the fatal episode of violence. Mental health issues included: depression (4), bipolar disorder (1), schizophrenia (1) and paranoid delusions (1).

7 (37%) had previously been treated for mental health issues.

In the remaining 5 cases, the history of mental health issues was undiagnosed/anecdotal, including reports of auditory hallucinations, depression and histories of suicidal ideation/attempts.

Childhood experiences of violence/abuse

Of the 40 domestic violence abusers, 11 abusers (28%) reported experiencing family violence during their childhood.

Drug and Alcohol abuse

Of the 40 domestic violence abusers, 17 had a history of drug abuse (43%). This included Cannabis (N=13, 76%), Amphetamines (N=5, 29%), Heroin (N=4, 24%) and Steroids (N=1, 6%).

Of the 17 domestic violence abusers with a history of drug abuse, 11 were using drugs at the time of the fatal episode of violence (65% of domestic

violence abusers with a history of drug abuse; 28% of domestic violence abusers in the total dataset).

Of the 40 domestic violence abusers, half had a history of alcohol abuse (N=20, 50%).

Half of all domestic violence abusers were using alcohol at the time of the fatal episode of violence (N=20, 50%) and this included 18 domestic violence abusers who had a history of alcohol abuse. Only 2 domestic violence abusers were using alcohol at the time of the fatal episode of violence in circumstances where they had no prior history of alcohol abuse.

Of the 40 domestic violence abusers, 15 had a history of co-occurrence of drug and alcohol abuse (38%). All 15 had a history of criminal offending including violence offences (N=11), drug offences (N=5), driving offences (N=5) and larceny (N=2).

Of the 15 abusers who had histories of concurrent drug and alcohol abuse, 9 had reported trauma histories. This included 7 abusers who had reported histories of experiencing family violence victimisation during their childhood.

In 4 cases the trauma history of the abuser was unknown and in 2 cases there was no identifiable trauma history.

Concurrent drug and alcohol abuse was a characteristic for 6 out of all 7 domestic violence abusers who identified as Aboriginal.

Characteristics of domestic violence victims

Age

All 40 domestic violence victims in this dataset were female. They ranged in age from 20 to 80 years, with a mean age of 41 years.

ATSI status

Of the 40 domestic violence victims, 6 identified as Aboriginal (15%).

CALD status

Of the 40 domestic violence victims, 8 were from a CALD background (20%). Those from a CALD background came from India (N=2), Macedonia (N=1), Chile (N=1), Poland (N=1), Armenia (N=1), Sudan (N=1) and China (N=1). 6 out of 8 victims from a CALD background were permanent Australian residents, 1 victim was on a spouse visa and 1 was on a student visa.

Linguistic barriers were evident in only one case, which involved a couple who arrived from Sudan 3 years prior to the homicide as refugees. In all other cases there was no evidence of linguistic barriers.

One domestic violence victim had moved to Australia within 12 months of the homicide, and the remainder (N=7) had been in Australia for longer than 3 years.

Mental health history

Of the 40 domestic violence victims, 11 (28%) had a history of mental health issues.

Of the 11 domestic violence victims who had a history of mental health issues, 2 (18%) were receiving current mental health treatment at the time of the fatal episode of violence and 7 (64%) had previously been treated for mental health issues.

In the remaining 2 cases, the history of mental health issues was undiagnosed/anecdotal, including reports of auditory hallucinations, depression and histories of suicidal ideation/attempts.

Childhood experiences of violence/abuse

Of the 40 domestic violence victims, 4 victims self-reported experiencing family violence during their childhood (10%).

Drug and alcohol abuse

Of the 40 domestic violence victims, 6 had a history of drug abuse (15%). This included Cannabis (N=5, 83%), Amphetamines (N=2, 33%) and Heroin (N=2, 33%).

Three domestic violence victims were using drugs at the time of the fatal episode of violence (50% of drug abusers, and 8% of the total dataset).

Of the 40 domestic violence victims, 13 had a history of alcohol abuse (33%).

Of the 40 domestic violence victims, 13 were using alcohol at the time of the fatal episode of violence (33%) and this included 10 domestic violence victims who had a history of alcohol abuse. Only 3 domestic violence victims were using alcohol at the time of the fatal episode of violence who had no prior history of alcohol abuse.

Of the 40 domestic violence victims, 5 had a history of co-occurrence of drug and alcohol abuse (13%). Four of these 5 domestic violence victims had a history of criminal offending including violence offences (N=1), drug offences (N=2), driving offences (N=3) and larceny (N=2). One of these

victims reported being exposed to family violence during their childhood.

5 FINDINGS & RECOMMENDATIONS
QUALITATIVE AND QUANTITATIVE ANALYSIS

This Chapter provides a synthesis of the Team's quantitative and qualitative data, and presents a discussion of themes and issues arising from the Team's review processes. This section also outlines 15 recommendations to various government and non-government agencies, derived from data and case review findings.

It is noted that the whole-of-government response to the Team's 12/13 report is currently being prepared, and this response, as well as integrated monitoring, will be reported in the Team's 15/16 Report.

Supporting the judiciary in recognising and discussing domestic violence

The Team acknowledges the significant role of the judiciary in responding to domestic violence. From magistrates who deal with the vast majority of domestic violence offences, through to judicial officers of higher courts who may encounter fewer, but potentially very serious, domestic violence offences, all members of the judiciary have an important role to play in naming and recognising the damaging behaviours associated with domestic violence.

The Team considers it critical that all judicial officers respond to domestic violence in a way that promotes awareness and understanding of the dynamics of domestic violence and its impact on victims. This issue was discussed in the Team's *12/13 Report* and insights in that report led to the development of *Recommendation 15* (set out in Chapter 6, Table 1). The Team would like to reinforce the need for consideration to be given to this recommendation and the need for updated information to be furnished to the Team as part of the forthcoming whole-of-government response to the Team's *12/13 Report*.

Of particular interest to the Team in this report was the issue of remarks on sentence and judgments delivered in the NSW Supreme Court, and, where applicable, in the NSW Court of Criminal Appeal. It is the perspective of the Team that remarks on sentence are examined by those involved in the legal profession, and are often discussed in the media once they are handed down in court. Accordingly, remarks on sentence should accurately reflect the dynamics of domestic violence where these behaviours are a feature of the case.

Coronial findings and/or case commentary provided within the coronial jurisdiction is similarly influential. Murder-suicide cases may be heard in this jurisdiction and coroners must be similarly equipped to identify, and respond to, domestic violence behaviours.

In a number of cases examined in this reporting period, as well as in earlier reports, the remarks on sentence/coronial commentary demonstrated a sophisticated understanding of the dynamics of domestic violence and appropriately condemned and named domestic violence behaviours where applicable. However, in other cases, remarks on sentence/coronial commentary did not adequately reflect the dynamics of domestic violence within the cases or adequately recognise or condemn the abuser's domestic violence behaviours.

These cases included examples where judges:

- Used mutualising language such as 'volatile relationship' or 'stormy relationship' to describe cases where a domestic violence abuser had a long history of using violence against the victim. Variations of this terminology were evident in a number of cases, and served to minimise perpetrator accountability for violent behaviours.

- Described a case as 'one of the least culpable cases of manslaughter' in his experience, when the homicide followed a history of domestic violence between the victim and the perpetrator.

- Described stalking behaviours as the abuser 'making a nuisance of himself', or similar. Use of such language minimises the fear induced by such behaviours and fails to recognise the coercive and controlling dynamics of the abuser's violence against the domestic violence victim.
- Used victim-blaming terms such as 'yummy mummy complex' where behaviours displayed by the domestic violence victim (fastidious

housekeeping/cleaning etc.) were reactive to the abuser's psychological control.

- Suggested that a domestic violence abuser would be less of a risk to future partners when he was older. This reinforces stereotypes around domestic violence as an issue affecting younger women and men, and reinforces perceptions that domestic violence may be synonymous with physically abusive behaviours (as opposed to coercion and control).

- Described a domestic violence abuser as being 'ill-equipped to deal with the changing relationship with his wife and the fact that she was bringing the relationship to an end'. This statement minimises perpetrator accountability for the homicide, and mischaracterises the abuser's history of violence towards the victim.

- Described a domestic violence abuser as being in a state of 'jealous anger' when he set his girlfriend on fire. This language minimises perpetrator accountability and minimises the abuser's intentionally harmful behaviours.

- Described relationships as 'happy' and 'normal' despite evidence of domestic violence behaviours forming part of the remarks on sentence. This was particularly evident in cases where the history of domestic violence was anecdotal or primarily non-physical.

- Described that there was 'no evidence' or 'plausible explanation' to indicate why a homicide occurred, notwithstanding clear evidence that the homicide perpetrator (a domestic violence abuser) killed his son in the context of his marriage ending.

In a number of cases it was also of concern that the homicide victim (who, in the majority of cases, was also the domestic violence victim) was not adequately reflecting the experiences in the remarks on sentence. It is the perspective of the Team that in order to better appreciate the dynamics of domestic violence it is necessary to recognise the impact the abuser's behaviour had on the domestic violence victim. The Team also believes it is important to recognise the loss and value of their life.

The Team acknowledges that improving victim visibility in this context requires engagement with other agencies, including the Office of the Director of Public Prosecution, the Public Defender's Office and Victims Services (within the Department of Justice), as is discussed below in relation to Recommendation 3.

In light of these considerations, the Team has consulted with the NSW Judicial Commission to explore opportunities for the Team and the Commission to work collaboratively to further enhance the way in which judges and magistrates discuss domestic violence, particularly in the context of remarks on sentence, and within the coronial jurisdiction. This collaboration will commence within the next 12 months and may include provision of Case Review examples, research and articles for the Commission.

The Team would also like to commend the Commission on increasing the availability of domestic violence related information for judicial officers, including, through:

- conference and seminar presentations;

- publications in the *Judicial Officers' Bulletin*;

- updates through the *Recent Law* platform; and

- the *Sentencing*, *Criminal Trial Courts*, and *Equality Before the Law Bench Books*.

The Team would also like to acknowledge the important work being undertaken by Professor Heather Douglas at the TC Beirne School of Law at the University of Queensland in developing the *National Family Violence Benchbook* in partnership with the Australasian Institute of Judicial Administration. This bench book is currently in development, and aims to promote best practice and consistency in judicial decision making in cases involving family violence. The bench book aligns with the *National Plan to Reduce Violence Against Women and their Children*. The Team welcomes the opportunity to contribute to the development of this publication.

In addition to promoting collaboration, the Team has sought to develop an information sharing protocol with the Judicial Commission whereby it can refer judicial commentary to the Commission for its consideration.

Accordingly the Team recommends:

Recommendation 1

That the NSW Domestic Violence Death Review Team and the NSW Judicial Commission work collaboratively to:

a) improve learnings around domestic violence and victim visibility in remarks on sentence/judicial commentary; and

b) develop an information sharing protocol in relation to referring judgments and remarks on sentence to the Commission for consideration where the representation of domestic violence, including perpetrator accountability and victim visibility, could be improved.

Victim visibility in Remarks on Sentence

As noted in the commentary surrounding *Recommendation 1*, through the case review process the Team has identified that in remarks on sentence the homicide victim is often discussed in narrow terms, with no real sense of who they were or the extent of the harm suffered by the community in losing that individual to domestic violence.[26]

The Team recognises that one of the purposes of the sentencing process is to recognise the harm to the victim and the community. Accordingly, the Team believes that the victim should not be marginalised in remarks on sentence.
One of the primary mechanisms through which victims and families participate in the criminal justice process is through Victim Impact Statements.[27] These statements provide a written account of the impact that a crime has had on a victim or a deceased victim's family. In homicide cases, the statement relates to the impact the victim's death has had on the family members, and provides them with an opportunity to provide further information about the victim's life.

In homicide cases, when a Victim Impact Statement is prepared by a family member, the court must receive a Victim Impact Statement and acknowledge its receipt.[28] The court may make any comment on it that the court considers appropriate.[29]

Victim Services NSW co-ordinate the preparation of Victim Impact Statement Information Packages which provide guidance to victims of crime and their families in relation to the preparation of Victim Impact Statements. Victims Services NSW also provides guidance as to how these statements are used in the criminal justice process.

A Victim Impact Statement Working Group has recently been convened by Victim Services NSW to review the use of Victim Impact Statements in NSW Courts. Victim Services NSW has indicated that the input of the Team is welcomed into this process, particularly given the Team's expertise in homicide cases. Given that in homicide cases Victim Impact Statements will be prepared by secondary victims (as the primary victim of crime is deceased), this may give rise to unique and distinctive issues in the preparation of statements.

Accordingly the Team recommends:

Recommendation 2

That the NSW Domestic Violence Death Review Team work collaboratively with the Victim Impact Statement Working Group, convened by Victims Services NSW (NSW Department of Justice), to examine ways in which victim visibility may be enhanced through the process of preparing and providing Victim Impact Statements to the Court.

The importance of informed legal practice in relation to domestic violence

Following from *Recommendation 1* (above), it is recognised that the evidence and information presented by other professionals practicing within the criminal justice system – including the prosecution and the defence – shape remarks on sentence. At a foundational level, this information is also shaped by the evidence gathered by police officers in the course of criminal investigations.

For the purposes of this report, the Team was particularly interested in examining the role of lawyers in relation to domestic violence in two respects.

Firstly, the Team noted the role of lawyers in the context of providing legal advice to clients and prioritising their clients safety/providing referrals where appropriate (following from recommendations made in the Team's *12/13 Report*). Secondly, the Team sought to examine the role of the defence and prosecution in shaping the presentation and construction of stories in homicide cases.

[26] *Crimes Sentencing Procedure Act 1999* (NSW) s3A(g).
[27] *Crimes Sentencing Procedure Act 1999* (NSW) Part 3 Division 2.
[28] *Crimes Sentencing Procedure Act 1999* (NSW) s28(3).
[29] *Crimes Sentencing Procedure Act 1999* (NSW) s28(3).

The role of lawyers in providing advice and referral to clients experiencing, or perpetrating, domestic violence

The Team notes the importance of lawyers in recognising and responding to domestic violence where this is disclosed by their clients. This can include domestic violence disclosures by either victims or perpetrators.

In the Team's Intimate Partner Focus Dataset set out in Chapter 4, in 40% of cases (N=16) domestic violence abusers and/or victims were in contact with lawyers in relation to domestic violence (such as seeking ADVOs or being represented in court for domestic violence offences). Overall, in 22 of the cases (55%) the victim or abuser had been in contact with lawyers in relation to any legal issues.

In *Case Review 3043* the victim had separated from her abusive partner two months prior to the homicide. Two days prior to the homicide, the domestic violence victim sought legal advice in relation to parenting arrangements. This followed a number of episodes where the abuser tried to break into the victim's house in the middle of the night to 'check-up' on the children.

The Team understands that the victim disclosed the abuser's history of domestic violence to her lawyers, however, the Team was not able to review the complete records as they attracted legal privilege. Notwithstanding a lack of knowledge with respect to the specific advice given, it was the Team's perspective that *Case Review 3043* demonstrates the importance of lawyers being equipped to provide referral and safety planning information to clients where domestic violence is disclosed.

This reinforces the need for *Recommendation 14* of the Team's *12/13 Report* (set out in Chapter 6, Table 2).

The role of lawyers' in communicating domestic violence narratives

Through the case review process, it has become clear to the Team that case narratives used in judgments often reflect the agreed statement of facts presented to the Court. The Team recognises that holistic changes to perceptions of domestic violence within the Courts and legal profession are a multi-stratum issues which necessarily involve a range of actors. Accordingly, recommendations seeking to affect change within this sphere need to target multiple levels of practice. An integral component of this is identified in *Recommendation 1* of this report.

It is recognised that the practice of the law is shaped by a range of considerations. Lawyers are bound by ethical obligations to their clients and the courts. At times it can be challenging, and indeed give rise to conflicting duties, to name and reflect the seriousness of domestic violence behaviours in the context of legal proceedings. However, it is important for lawyers involved in these processes – particularly in homicide trials, but also in every case concerning domestic violence – to be equipped with the skills to recognise and appropriately discuss domestic violence.

This includes lawyers being equipped to:

- Recognise the range of behaviours that constitute domestic violence;
- Promote victim visibility and avoid victim blaming;
- Recognise that victims of domestic violence may be at increased risk when they separate from a domestic violence abuser; and
- Refer clients where domestic violence victimisation or perpetration is identified.

These issues reinforce the need for *Recommendation 14* of the Team's *12/13 Report* and also highlight the importance of the Team working collaboratively with the Department of Public Prosecutions, the NSW Bar Association, the Law Society of NSW and the NSW Public Defenders' Office in relation to developing and informing practice and policy concerning domestic violence. This collaboration needs to recognise the range of needs and issues affecting legal professionals in these different agencies and departments, and accordingly, needs to be tailored and appropriate to each agency's specific needs. It is appropriate for this collaboration to emphasise the identification of practice issues related to domestic violence, the development of strategies to address these issues and the ongoing monitoring of success and compliance.

Accordingly the Team recommends:

Recommendation 3

That the NSW Domestic Violence Death Review Team work collaboratively with the Office of the Director of Public Prosecutions (NSW), the NSW Bar Association, the Law Society of NSW and the NSW Public Defenders' Office to develop appropriate strategies to better support lawyers in recognising and responding to domestic violence.

The importance of supporting community organisations in relation to domestic violence disclosures

The help-seeking behaviours of domestic violence victims and perpetrators is of great interest to the Team. It has been evident from the review to date that in many cases domestic violence victims seek assistance from friends, family or colleagues in lieu of formal or specialist organisations, such as police or domestic violence service providers. In some cases, victims may also make disclosures to organisations they are involved with for other purposes, for instance healthcare providers, workplaces, childcare centres or educational institutions.

These observations are also reinforced by cases in this review period. In *Case Review 3367* the domestic violence victim made disclosures to a community centre in the context of receiving assistance with job-seeking. In this case the victim disclosed that her boyfriend had been extremely abusive towards her. The community worker in this case is said to have responded to this disclosure by telling the victim to find someone who loved her and would treat her appropriately.

Another case reviewed by the Team involved the victim and perpetrator engaging with a faith based community organisation in relation to homelessness (*Case Review 2275, 12/13 Report*) in circumstances where domestic violence behaviours were not recognised by organisational staff or adequately managed.

The importance of consistent community responses to domestic violence and consistent referral pathways for victims has long been discussed. In NSW, this is reflected in the NSW government's domestic and family violence framework for reform - *It Stops Here* - co-ordinated by Women NSW.

An integral aspect of this framework has been the implementation of *Safety Action Meetings (SAMs)* which represent a collaborative, multi-agency approach to early identification and safety management of domestic violence victims and their families. SAMs are local meetings wherein government and non-government organisations co-ordinate to share information and manage appropriate referral pathways for victims of domestic violence.

SAMs are supported by the use of the *NSW Domestic Violence Safety Assessment Tool* (DVSAT) and local co-ordination referral points. The SAM process uses referral pathways from community organisations (where disclosures are made and the DVSAT is used) and also refers to community organisations through SAMs where appropriate.

SAMs are currently being rolled out state-wide through a staged process. This suite of reforms is being supported by training and information provision to local community organisations, including community centres, in relation to referral pathways for victims or abusers who make domestic violence disclosures and the use of the DVSAT.

Comment

The Team acknowledges the implementation of the SAMs and seeks to reinforce the importance of supporting this process to be rolled out in rural and regional areas, given the particular challenges facing women and their children in these communities.

The Team will continue to collaborate with those involved in these processes with a particular focus on implementation, evaluation and findings.

The role of emergency healthcare providers in relation to domestic violence

As discussed in the Team's *12/13 Report*, domestic violence victims and abusers often present at hospital Emergency Departments with domestic violence related injuries. Acknowledging the importance of strong and holistic responses to domestic violence, the Team developed *Recommendation 10* in collaboration with *NSW Health* (set out in Table 2, Chapter 6). This recommendation concerned identification and referral processes within NSW Emergency Departments, in collaboration with NSW Ambulance Services and the Education Centre Against Violence (ECAV).

The need for appropriate identification and referral pathways in the context of emergency healthcare is reinforced by cases reviewed in this report.

In *Case Review 2341*, a mother (domestic violence victim) and her partner (domestic violence abuser), together with a number of members of his family, brought the mother's 4 year old child into an Emergency Department in a regional hospital. The child presented with two black eyes, significant injuries to his nose and abrasions to his forehead. The mother's partner told hospital staff that the child

had hit his face on the bed after tripping over. The mother's partner gave a history of the accident having occurred about 5 hours prior to presentation at the hospital. Hospital staff did not engage with the child's mother at the hospital.

After checking the child's injuries and ruling out the need for further treatment, the hospital staff discharged the child to return home.

At the time of the hospital presentation the family was involved in a Child Protection Services investigation in relation to suspected physical injuries and/or neglect of the child's siblings. Within three days of his presentation, the child had been killed by the mother's partner.

In other cases – such as *Case Review 3024*, *Case Review 3291, Case Review 3018 (12/13 Report), Case Review 3417 (12/13 Report),* and *Case Review 3296 (12/13 Report)* – victims of domestic violence presented in emergency healthcare settings following episodes of physical abuse. In each of these cases, emergency healthcare providers were uniquely placed to identify and respond to the needs of domestic violence victims, including to promote appropriate referral pathways and consider the safety of victims before they leave the healthcare service.

In light of these findings, the Team examined the way in which cases such as *Case Review 2341* may be dealt with differently in the current policy environment.

The Team understands that *NSW Health* – through the *Clinical Excellence Commission* (CEC) – is currently rolling out updated paediatric observation charts for use in emergency healthcare settings. Originally developed in April 2013, these recent updates prompt staff to give specific attention to issues around neglect and risk assessment when children of all ages present in NSW Emergency Departments. In the event that risks are identified, the chart prompts appropriate reporting and notifications to relevant services.

This enhancement to the paediatric observation chart is welcomed by the Team, and the Team will continue to collaborate with *NSW Health* in relation to training, knowledge and information around this tool.

In 2013, *NSW Health* also implemented changes to all emergency department observation charts concerning 'safety upon discharge', and it is understood this may address some of the issues identified in earlier case reviews – such as *Case Review 3296 (*in the Team's *11/12 Report)*. Again, the Team welcomes this advancement.

Additionally, there is currently significant work being undertaken in relation to the development of domestic violence screening tools in NSW Emergency Departments, including trials in Northern NSW and further research being undertaken by Dr Jo Spangaro pursuant to a *NSW Health* grant.

Comment

The Team commends NSW Health on progressing initiatives regarding consistent and early identification of domestic violence in the context of the provision of emergency healthcare.

The Team congratulates NSW Health for taking a strong and informed position in relation to domestic violence related issues arising within its jurisdiction.

Concurrent mental health issues and domestic violence perpetration or victimisation

In a high proportion of the Team's cases mental health issues were either an associated factor with domestic violence, or a feature of either the domestic violence victim or abuser's lives. In every case review involving mental health issues, these issues created additional and particular barriers in relation to domestic violence help-seeking.

In the Team's case review process, mental health issues have manifested in cases in a range of different ways including:

- The domestic violence abuser using the domestic violence victim's mental illness as a tool of coercion and control in relation to parenting arrangements (*Case Review 2347*). This included threats to disclose the victim's history of prior suicide attempts to police if the victim were to contact police in relation to domestic violence.

- The domestic violence abuser's violent behaviours being considered only in the context of their mental illness by the NSW Police Force and healthcare providers, and a failure to recognise that abusers were using violence when they were well and responding to this accordingly (*Case Review 3046, Case Review 3405, Case Review 3436, Case Review 3018 (*in the Team's*12/13 Report*),

*Case Review 2985 (*in the Team's *11/12 Report)).*

- A related lack of support from healthcare providers for the partners and families of individuals who were suffering from mental illness and using domestic violence behaviours against those family members.

- The domestic violence abuser's mental health issues operating to further isolate the domestic violence victim. This included cases where the abusive behaviours were mischaracterised, or underestimated in terms of risk, given the perpetrator's concomitant mental health issues (*Case Review 3405, Case Review 3046, Case Review 2335, Case Review 3436*).

- Cases where domestic violence victims were managing the abuser's mental health as an outpatient in the home. This often included cases where the abuser was a son, nephew or other family member. In some of these cases the victim was reluctant to seek help from agencies such as the police, given the particular implications this may have for the abuser's hospitalisation or criminal record (*Case Review 3405, Case Review 3436*). This also included a case where the victim did not want to anger his son (the abuser) by forcing him out of the house, despite having fears for his own safety (*Case Review 2335*).

- As a further barrier facing domestic violence victims and abusers suffering cumulative social issues and disadvantage (such as poverty, drug and alcohol addiction and homelessness). In many cases mental health issues were not adequately identified or managed by responders, such as the NSW Police Force (*Case Review 3304, Case Review 2343*, *Case Review 3296, Case Review 2335, Case Review 3019).* In a number of these cases, the domestic violence victim had their experiences of domestic violence ignored or poorly managed due to their mental illness and other cumulative social issues.

Given the diversity of issues in and across cases, it became evident to the Team that it lacks sufficient expertise to understand and critically analyse cases arising at the intersection of domestic violence and mental health issues.

While the Team has identified many of the challenges facing victims and abusers in relation to domestic violence and mental health, the importance of examining these cases in holistic, comprehensive and informed ways must be reiterated. This accords with the current approach adopted in the context of SAMs, where mental health professionals are included as an integral component of these meetings.

A related issue considered by the Team relates to homicide cases where there is a history of mental illness or mental health issues prior to the homicide, but no identifiable history or context of domestic violence. As the Team's objective is to review 'domestic violence related deaths', cases such as these are not subjected to in-depth review by the Team. This raises the issue of the systemic review of mental health related homicides in NSW.

The Team is aware that from 2002 - 2008, the *New South Wales Mental Health Sentinel Events Review Committee* (SERC) independently reviewed cases where suicide victims or suspected homicide perpetrators had been involved with public mental health services prior to the death or 'sentinel event'. The objective of SERC was to identify systemic problems and improve safety and quality of mental health service delivery in NSW.

In 2008 the administrative function of SERC was transferred to the *Clinical Excellence Commission* (CEC) under *NSW Health*.

Pursuant to the current policy regime within NSW Health, in cases where suspected homicide perpetrators have received care or treatment from a NSW Health service for mental health issues within 6 months of the homicide (or there are reasonable grounds to suspect a connection between the homicide and the care provided by that service) the case will be classified as a 'sentinel event' and a root cause analysis (RCA) will be conducted. This analysis is undertaken by an appointed team of representatives from NSW Health and will include representatives from the relevant Local Health District who have intimate knowledge of care processes and practice in the local area as well as a senior mental health clinician, independent of the service involved in care.

Upon completion, the RCA report is submitted to the Ministry of Health for review and then to the CEC where it is examined by one of four RCA Review Committees, most likely the Mental Health RCA Review Committee. This review aims to identify any systemic issues, inclusive of patient and human factors, with a view to examining state-wide trends.

Additionally, the Team notes that the *NSW Mental Health Commission* (MHC) was established in 2012 as an independent statutory agency responsible for monitoring, reviewing and improving mental health and wellbeing for people in NSW. The MHC examines systemic issues arising in the mental health sector and drives reform.

The Team believes that its work will be enriched by the learnings provided from the CEC in exercising its review function, and the expertise within the agency generally.

Similarly, the Team believes that future collaboration with the MHC may further improve the Team's ability to recognise and respond to those unique barriers facing victims and perpetrators of violence who are also experiencing concurrent mental health issues.

To date, the Team has not had the benefit of this expertise, and is of the perspective that further collaborative work and information sharing should be facilitated.

Accordingly, with a view to capacity-building within the Team, the Team recommends:

Recommendation 4

That NSW Health work collaboratively with the NSW Domestic Violence Death Review Team to:

a) identify all homicides occurring in NSW from March 2008 where the perpetrator had received care or treatment from a NSW Health service for mental health issues within 6 months of the homicide;

b) provide to the Team all final Severity Assessment Code (SAC)1 Root Cause Analysis Reports prepared in relation to the cases identified in the audit process foreshadowed in a);

c) provide to the Team all CEC de-identified thematic analyses of the cases identified in the audit process foreshadowed by a); and

d) develop an information sharing mechanism whereby the Team may seek input from the CEC in relation to cases where mental health issues are identified.

Recommendation 5

That the NSW Domestic Violence Death Review Team and the NSW Health Mental Health Drug and Alcohol Office develop an information sharing mechanism whereby the Team may seek input from that Office in relation to domestic violence homicides where mental health and/or drug and alcohol issues are identified.

Recommendation 6

That the NSW government give consideration to expanding the current membership of the Team to include:

a) a permanent member with expertise in the area of Mental Health treatment and service provision; and

b) a permanent member with expertise in the area of Drug and Alcohol treatment and service provision.

Substance use and domestic violence co-occurrence

An ongoing concern for the Team is the prevalence of drug and alcohol use in domestic violence homicide cases. Drug and alcohol use at the time of the homicide and historical drug and alcohol abuse, were present in a significant number of the Team's cases during this reporting period (set out Chapter 3).

As discussed in the findings of the Intimate Partner Focus Dataset in Chapter 4, 50% of domestic violence abusers had a history of abusing alcohol, as did 33% of victims. Additionally, 43% of domestic violence abusers had a history of drug use, as did 15% of victims. At the time of the homicide, 50% of abusers and 33% of victims were using alcohol and 28% of abusers and 8% of victims were using drugs.

Historically, 38% of domestic violence abusers and 13% of domestic violence victims were addicted to both drugs and alcohol.

There has been a substantial amount of work undertaken in relation to the co-occurrence of substance abuse and violence. The *Personal Safety Survey* collects significant information in relation to the co-occurrence of substance abuse and the most recent incident of violence experienced by the surveyed victim, divided according to gender. However, this survey has some limitations in terms of capturing historical drug and alcohol abuse information.

Australia's National Research Organisation for Women's Safety (ANROWS) is also progressing research in this area under *Research Priority 1.4: Interventions linking service responses for domestic violence and/or sexual assault with drug and/or alcohol use/abuse*. ANROWS released its first State

of Knowledge paper concerning this Research Priority in July 2015, examining the connection between alcohol and other drug use and sexual victimisation. This paper identified a growing consensus within the literature that service provision for both alcohol and other drug (AOD) users and sexual assault services sector must be integrated and co-ordinated given the large number of clients shared by both sectors.

Comment

The Team supports the work being undertaken by ANROWS and acknowledges its important role in enhancing the research base in relation to domestic violence and sexual assault, thereby contributing to informed policy development and improved service delivery responses.

The Team welcomes the recent publication examining the connection between alcohol and other drug use and sexual victimisation and looks forward to ANROWS' future work in relation to the co-occurrence of domestic violence and AOD abuse.

The Team also acknowledges that in 2014 the NSW Government established the Violent Domestic Crimes Taskforce*, with the express mandate to examine the link between alcohol and domestic violence. The Team looks forward to such reports that the Taskforce may produce in relation to this issue.*

The Team will continue to collect further quantitative data and undertake qualitative analysis concerning the co-occurrence of domestic violence and substance abuse. This issue will therefore be monitored and may be the subject of recommendations in subsequent reports.

Domestic violence victims receiving home care services: supporting women with disability

One specific issue that the Team identified in this case review period derived from further investigation undertaken in relation to a particular case.

In *Case Review 3434* the victim of domestic violence was an Aboriginal woman aged in her 50s who had been confined to a wheelchair for over 20 years as a result of a degenerative paraplegia. She lived in social housing in a regional area. For many years she had been receiving government funded home care more than once daily through a non-government service provider serving Aboriginal identified clients. Her abusive boyfriend, who later killed her, had been visiting her in her home almost daily for around 2 years. The victim's sister noted that on many occasions over the two year period she had seen her with serious physical injuries to her face and body. The home care workers had also been present and had evidently seen the victim with significant facial and other injuries.

Given that home care workers were in attendance daily – often more than once – the Team sought to determine what, if any, records were being kept in relation to injuries, issues or domestic violence. The Team also considered why no action was taken in relation to evidence that this particularly vulnerable woman was suffering domestic violence.

Upon requesting additional information, the Team identified that the extent of the records being collected by the home care provider (over the 2 year period the victim was in a relationship with the abuser) were limited only to a log of dates and times when home care workers attended. There were no original intake documents, no assessments of the injuries or indications that any further notes or reports had been made in relation to the victim. The only other information on file for the victim indicated that for an apparently significant period of time prior to 2007 (and perhaps after), the victim was unable to exit the social housing premises she had been provided without assistance as her wheelchair would not fit through any of the external door frames in the house. There was no documentation of any subsequent change in accommodation, although it is clear that at some point she had moved to new premises.

There was no evidence of notes in relation to the victim's experiences of domestic violence.

The Team was concerned with the lack of record keeping and sought to clarify whether any protocols were in place concerning record keeping, particularly in relation to suspicious injuries and/or suspected abuse. It was determined that detailed policies and protocols have been in place (and subsequently amended multiple times) in relation to suspected abuse and neglect. It was also determined that there are general record management policies in place for all relevant staff who are employees of Ageing, Disability and Home Care (ADHC) operated non-government services. It would appear that none of these policies were being complied with across all staff who provided homecare services to the victim through the non-government service provider.

The Team also identified that there were inadequate mechanisms in place to support staff to respond to apparent or suspected domestic abuse against vulnerable clients.

After consultation with ADHC, it was determined that this case raised issues regarding non-compliance with existing policies and demonstrated a need to develop additional protocols and pathways to support staff to help clients experiencing domestic violence.

In light of this, the Team recommends that:

Recommendation 7

That Ageing, Disability and Home Care (ADHC) (Department of Family and Community Services) give consideration to developing mandatory internal reporting protocols to enable action to be taken when staff suspect clients are at risk from domestic violence in the home.

That consideration also be given to establishing a notification process between frontline FACS housing teams and ADHC operated and funded services when staff suspect that domestic violence is occurring. This may be modelled on the current notification obligations of maintenance workers who identify child protection issues in their contact with tenants. This notification triggers a client service visit from tenancy team staff to enable support, information and appropriate referrals to be made.

Public understandings of domestic violence

Non-physical manifestations of domestic violence

It is recognised that domestic violence behaviours include both physical and non-physical manifestations of coercion and control. While public perceptions of domestic violence may focus on physical manifestations of violence, a high proportion of domestic violence is not physical in nature.

This observation is reinforced by the findings of the Team in the Intimate Partner Focus Dataset, where in 10% of cases (N=4) there was no disclosed history of physical violence prior to the homicide. This reinforces the need to recognise the seriousness of non-physical manifestations of domestic violence.

Similar observations in the Team's *11/12 Report* led to the development of *Recommendation 10* (set out in Table 1, Chapter 6) which concerned both physical and non-physical manifestations of violence.

Comment

It is the perspective of the Team that the findings of this report, together with findings and recommendations made in previous reports, reinforce the need to better support both the community and service providers in recognising and responding to all manifestations of violence, including non-physical abusive behaviours.

Stalking and technology-facilitated stalking

In a high number of cases in the Focus Dataset, the Team identified stalking behaviours.[30]

Manifestations of stalking behaviours ranged from the abuser physically following and intimidating the victim, to the abuser continuously sending the victim text messages, monitoring the victim's phone usage, and deleting phone contacts. A common observation across these cases was that in the majority of cases, the abuser stalked the victim while the relationship was on foot.[31] This is an interesting finding that may redress misconceptions that stalking behaviours usually only manifest after the relationship has ended.

It has been the observation of the Team that victims of stalking behaviours, particularly in the context of ongoing relationships, may not recognise the seriousness of the abuser's behaviour, and may not make the connection between behaviours such as monitoring mobile phone use, constant messaging or the abuser constantly 'checking up' on the victim, and domestic violence.

In 2015, the *Council of Australian Governments* (COAG) announced a $30 million dollar campaign to reduce violence against women and their children. This will consider strategies to tackle the increased use of technology to facilitate abuse against women.

The Team is also aware that *Women's Legal Services NSW* (WLS NSW) has undertaken research in relation to technology facilitated stalking and are continuing to develop resources to raise awareness about this kind of abuse and to provide

[30] 17 cases or 43% of all domestic violence homicide cases discussed in Chapter 4.

[31] N=14, 35% of all cases; in 82% of these cases the abuser stalked the victim while the relationship was on foot.

guidance for domestic violence victims in relation to using technology safely.

WLS NSW has also been involved in a joint project, *Recharge: Women's Technology Safety*[32], which has developed a national resource for women experiencing technology facilitated abuse. The resource, which was published in July 2015 (at www.smartsafe.org.au) includes legal guidelines for each jurisdiction, technology-safety toolkits, and advice for family and friends trying to assist someone experiencing technology-facilitated stalking.

Comment

It is the Team's perspective that raising awareness about technology facilitated abuse will not only assist in addressing this particular type of domestic violence, but will also improve broader community understandings in relation to non-physical manifestations of domestic violence.

The Team welcomes COAG's commitment to addressing domestic violence in Australia.

Public awareness of domestic violence

It is the perspective of the Team that supporting the public in understanding the dynamics of domestic violence requires recognition of the vital role of friends, family and bystanders in responding to domestic violence.

In the Team's Intimate Partner Focus Dataset, in 100% of cases (N=40) a friend, family member, neighbour or colleague was aware of the violence the victim was experiencing. This reinforces the need to strongly support and inform the whole community in relation to acceptable and non-acceptable behaviours in relationships, including non-physical manifestations of domestic violence.

It is also recognised that in recent years there has been a wholesale move towards recognising the importance of timely, accessible and culturally acceptable information in relation to domestic violence. This has been widely supported, including through the efforts of agencies such as NSW Health Education Centre Against Violence (ECAV), and is strongly reflected in the practice of all government and non-government agencies working to reduce the incidence of domestic violence.

Initiatives such as the plain English review of ADVOs also reinforce the government's commitment to increasing the understanding of legal remedies available for domestic violence victims.

In addition to the COAG research agenda described above, there continues to be a strong need for targeted and informed awareness campaigns at a State level. It is vital that the work of the Team continue to inform this process.

In light of these issues, the Team recommends:

Recommendation 8:

That the NSW Government approach the Commonwealth to highlight *Recommendation 10* of the Team's *11/12 Report* and suggest it be taken into account in public awareness campaigns including that being progressed through the Commonwealth of Australian Governments, and that any future NSW campaigns are also informed by that recommendation.

NSW Police Force responses to ADVO breaches

The NSW Police Force are primary responders to domestic violence in our community.

As evidenced by the findings in the Intimate Partner Focus Dataset, in almost two-thirds of cases (N=25, 63%) the abuser had been in contact with police in relation to domestic violence.

Responding to domestic violence constitutes a significant proportion of day to day police work in NSW. Police often come into contact with domestic violence victims and abusers at points of crisis, and victims and abusers may come into contact with the criminal justice system in relation to domestic violence – including with police and courts – on more than one occasion.[33] The importance of training, and compliance with practice and procedure, cannot be overstated.

There were a number of compliance issues identified in cases reviewed by the Team for this report, including several instances where police did not record breaches of enforceable ADVOs. This

[32] Together with the Domestic Violence Resource Centre Victoria (DVRCV), The Women's Services Network (WESNET) and in partnership with the Australian Communications Consumer Action Network (ACCAN).

[33] NSW Attorney General and Justice, 'NSW Domestic Violence Justice Strategy: improving the NSW criminal justice system's response to domestic violence 2013-2017', Available at¨ http://www.crimeprevention.nsw.gov.au/domesticviolence/Documents/The%20Domsetic/jag2391_dv_strategy_book_online.pdf> (last accessed October 2015), at page 15.

reflects concerns that have been raised in a number of reports previously including the *NSW Legislative Council Standing Committee on Social Issues Report: Domestic Violence Trends and Issues in NSW* (2012) and NSW Ombudsman's report *Domestic Violence: Improving Police Practice* (2006).

In *Case Review 3039*, the victim of domestic violence was protected under an ADVO which named her brother-in-law, the abuser, as the defendant.. The ADVO had been applied for by NSW Police Force officers following an assault by the abuser against the victim at the residence they shared with the victim's husband (the abuser's brother). The ADVO had an exclusion clause which meant that the women's brother-in-law was required to live elsewhere. In the months prior to the homicide, police were informed that the abuser was once again permanently residing with the victim at the residence she shared with her husband. Police officers attended the residence and spoke to the victim's husband and apparently also the abuser. Despite the fact that there was an enforceable ADVO in place, no breach was actioned or recorded on the COPS system. The abuser continued to reside in the family home until he killed the victim some months later.

In *Case Review 3508*, the NSW Police Force had a long history of contact with the domestic violence abuser and domestic violence victim, both of whom identified as Aboriginal. There were more than 20 COPS (police database) events in relation to the abuser's domestic violence against the victim, there was a current enforceable ADVO (with an exclusion order) and there had been 4 previous ADVOs between the victim and abuser. The abuser had also served 3 custodial sentences in relation to violence against the victim.

Four days prior to the homicide the victim was socialising with a group of people and the abuser arrived. They began arguing and the abuser punched the victim in the face. The victim called police and the abuser left the scene. When police officers attended they reprimanded the victim for allowing the abuser to live and drink with her. They said "Why are you allowing him to live with you" and "why are you drinking with him?" The police officers did not locate the abuser following the callout, or charge him with breaching the ADVO. Four days later the victim killed the abuser when he attacked her in her home.

A range of compliance issues have also been identified by the Team in case reviews included in earlier reports.

The NSW Police Force has a structure for the oversight - and continued improvement- of responses to domestic and family violence. At a corporate level this structure includes; a Corporate Sponsor for Domestic & Family Violence, Regional Domestic Violence Sponsors, Regional Domestic Violence Coordinators and the Domestic & Family Violence Team. Compliance is enforced by oversight from; internal and external supervisors, domestic violence liaison officers and Duty Officers (Inspectors) at Local Area Commands. In addition, reporting processes and requirements are premised on ensuring maximum compliance.

The Team notes that the NSW Police Force is committed to consistent responses to domestic and family violence. The Team acknowledges the importance of the NSW Police Force identifying deficiencies and implementing new strategies to improve responses to reports of domestic and family violence.

Accordingly, the Team recommends:

Recommendation 9

That the NSW Police Force investigate additional strategies and processes that will promote increased compliance with policies concerning ADVOs and breaches of ADVOs and report to the Team in relation to these initiatives. Strategies and processes should include the use of the Team's case reviews to inform existing training in relation to ADVO compliance.

Evaluations of the NSW Domestic Violence Safety Assessment Tool (DVSAT)

As discussed previously, the *It Stops Here Safer Pathway* Service Delivery Model, including local co-ordination points and SAMs, is being rolled out across NSW in stages.

SAMs are collaborative, multiagency meetings chaired by NSW Police Force. SAMs aim to case manage domestic violence cases (identified through the DVSAT or otherwise referred) where the victim is assessed as being at serious threat. SAMs bring together local service providers (government and non-government) for fortnightly meetings wherein information is shared pursuant to Chapter 13A of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) and tailored safety action plans are developed.

The SAMs were initially piloted in Waverley and Orange and are subsequently being rolled out

across the State in a staged process. SAMs have recently commenced operation in Bankstown, Parramatta, Tweed Heads and Broken Hill.

The initial process evaluation of the pilot sites has been undertaken by *NSW Bureau of Crime Statistics and Research* (BOCSAR) and findings are expected to be released in due course.

As noted previously, the SAMs are further supported by the implementation of the DVSAT. The DVSAT includes 25 questions about the victim and abuser's domestic violence experiences and background. The DVSAT is used by the police, government agencies and non-government service providers as a referral and safety assessment tool.

Recommendation 3 of the Team's *12/13 Report* suggested that the DVSAT be amended to include questions concerning:

- whether the victim and abuser continue to live together in the same residence, despite the dissolution of the relationship; and
- whether or not there were any criminal, family law, or other relevant legal proceedings pending.

This recommendation was derived from the Team's case review findings, and is further reinforced by findings in this report. In the Team's Intimate Partner Focus Dataset, there were 9 cases where the victim and abuser continued to live together while the relationship was breaking down or after the relationship had ended (47% of all cases where the relationship was breaking down or had ended).

It was the perspective of the Team that in the course of completing the DVSAT, disclosures that the victim and abuser continued to live together may indicate a heightened risk to the victim's safety.

In the Team's case reviews, reasons that victims and abusers continued to live together for various reasons, including that:

- the abuser could not afford to move out;
- the abuser pleaded with the victim to stay until they could sort out alternative accommodation;
- the abuser sought to continue to exercise coercion and control over the victim by residing with the victim;
- the victim did not have access to money (due, often, to the abuser maintaining control over finances) and could not afford to move elsewhere;
- the victim perceived that there was nowhere to go and had limited informal social networks through which to seek alternative accommodation;[34]
- the victim tried to leave but was unable to secure shelter accommodation because of a dependent child; and
- the victim perceived that if they left the property this may affect their entitlements under family law proceedings.

In each of the examples described above the victim of violence was killed. Timely advice and support in each of these cases could have ameliorated the risk of further abuse towards the victim.

It remains necessary to reiterate the importance of recognising the risk of continued cohabitation after relationship breakdown and reflecting this in either the DVSAT questions, or in the professional judgment component of the tool.

Concerning *Recommendation 3*, and specifically the importance of querying whether or not legal proceedings (including criminal, family law or other relevant proceedings) are on foot, the Team acknowledges that the DVSAT includes some – but not all – of these considerations.

The DVSAT contains a question under the category of 'children' that queries whether there is conflict between the victim and abuser regarding 'child contact or residency' and/or whether there are 'current Family Court proceedings'. The DVSAT, in enquiring as to the abuser's background, also queries whether the abuser is on bail or parole, and queries whether the abuser has been recently released from custody for violence offences. The DVSAT also includes further questions around whether the abuser has historically been charged with breaching an ADVO. Together, these comprise a narrow view of applicable legal proceedings in the included questions, although there remains the opportunity for victims to be assessed as being at serious threat through the professional judgment component of the DVSAT.

There is also a numerical threshold built into the DVSAT, at which point the victim is considered to be 'at serious threat' and is automatically referred into a SAM for case management. This threshold is reached when the victim answers 'yes' to at least 12

[34] In NSW, specialist homelessness services (SHS) provide services to people experiencing or at risk of homelessness, including people who are experiencing domestic violence. Services include prevention services, rapid rehousing, crisis and transition responses, and intensive responses for clients with complex needs. Telephone information, assessment and referral services are also available via Link2Home and the NSW Domestic Violence Line which is operational 24/7.

out of the possible 25 questions in the DVSAT. It is noted, however, that of the 25 questions, 5 are relevant only to victims who are pregnant or have dependent children. As the DVSAT is not a weighted tool, this may have an impact on the numbers of women with adult or no children being identified as 'at serious threat'.

In the Team's Intimate Partner Focus Dataset, in over a quarter of all cases neither the victim nor abuser had any children (N = 11, 28%) and in a further 7 cases the victim or abuser had adult children who were not living with them.

Notwithstanding their DVSAT score, victims may nonetheless be assessed as being at serious threat under the professional judgement component of the tool. It is important for subsequent evaluations of the DVSAT and the SAMs to analyse and report on the way in which the tool is being used in relation to victims who do not have children, or may be older with non-dependant, or absent, children.

The Team reiterates the need to consider *Recommendation 3* from the 2012/13 Report when evaluating the use of the DVSAT in NSW, and suggests that this evaluation also examine the way in which the tool is being used (including to examine whether cases are being referred into SAMs via the numerical tool, via the professional judgment component of the tool or by other means).

In addition to the forthcoming BOCSAR evaluation, the Team welcomes the opportunity to contribute to future evaluations of the DVSAT

Accordingly the Team recommends:

Recommendation 10

That the NSW Department of Justice continue to work closely with the NSW Domestic Violence Death Review Team in identifying and informing future evaluations of the Domestic Violence Safety Assessment Tool (DVSAT).

Ensuring Aboriginal specialist support at Safety Action Meetings (SAMs)

The Team continues to be concerned with the overrepresentation of Aboriginal women experiencing domestic violence in its dataset. In the Intimate Partner Focus Dataset, 15% of domestic violence victims identified as Aboriginal. Aboriginal domestic violence abusers and victims also continue to be killed at disproportionate rates compared to non-Aboriginal victims and abusers.

In progressing the rollout of the SAMs the Team seeks to reinforce the importance of these processes engaging with the needs and interests of Aboriginal victims of domestic violence. There can be particular challenges facing Aboriginal Australians in accessing culturally appropriate support services, including in smaller communities where conflicts of interest may arise between those seeking support and support workers. Thus, it is extremely important for these processes to prioritise the wishes of Aboriginal victims in relation to support, ensuring processes are maximally inclusive, appropriate and focused on developing equal and respectful partnerships between government agencies and local Aboriginal services and specialists.

Commentary

Accordingly, it is important for the SAMs rollout to prioritise the safety of Aboriginal women and children by ensuring culturally appropriate support is available in all areas, and encouraging partnerships between service providers and government.

Tenancy issues in social housing in the context of domestic violence

In examining *Case Review 2343* the Team identified issues related to social housing tenancy in the context of domestic violence.

In this case the domestic violence abuser was the flatmate of the domestic violence victim pursuant to an informal agreement between them in relation to the victim's FACS (Housing NSW) unit.

In the 12 hours leading up to the homicide, the domestic violence victim called 000 in excess of 20 times, seeking assistance to have the domestic violence abuser removed from his unit. The domestic violence abuser was being physically aggressive, was damaging the victim's property, and had threatened to kill the victim. Police officers attended the unit on a number of occasions (including when the ambulance was also in attendance to convey the victim to hospital). Police officers applied for an ADVO protecting the victim, but indicated that they could not remove the abuser from the premises and that the victim would need to go to the Tenants Tribunal to have the abuser

evicted. Further enquiries would have revealed that the domestic violence abuser was an unauthorised tenant under social housing rules.

This case raised issues in relation to NSW Police Force awareness of tenancy rules related to social housing properties. The Team discussed the importance of NSW Police Force officers being supported to understand the rights and rules pertaining to social housing tenants, particularly where there are informal sublease arrangements between parties. The Team was of the perspective that further support for police officers in this area would improve responses to episodes of violence between flatmates, families or intimate partners.

Accordingly the Team recommends:

Recommendation 11

That the Department of Family and Community Services – Housing NSW work collaboratively with the NSW Police Force to develop an information bulletin regarding the rights and rules pertaining to social housing tenants. This bulletin should be circulated state-wide within 12 months.

Recommendation 12

That the Department of Family and Community Services – Housing NSW develop a z-card for tenants that identify their status as a "head" tenant with the right to request removal of unauthorised occupants of the property. This z-card should be distributed by Housing NSW to new and existing tenants.

Media responses to domestic violence

Media reporting of domestic violence homicides

The media reports widely on the majority of homicides in Australia, and domestic violence homicides are no exception. The Team acknowledges that the media has a particular role in disseminating learnings and reinforcing standards in relation to identifying and naming domestic violence behaviours.

The media's scrutiny around domestic violence has sharpened in recent years for a number of reasons. These have included: a number of high profile domestic violence homicide cases; the announcement of Rosie Batty as Australian of the Year in 2015; and as a result of the implementation of NGO sector initiatives, such as *Destroy the Joint's* Counting Dead Women Project, which aims to draw attention to the prevalence of all violence against women in Australia by counting victims of femicide.

Despite increased media attention in relation to domestic violence, there remain concerns that the media does not always engage in a productive dialogue concerning domestic violence. Due to the nature of the news cycle, cases are often reported on heavily in the immediate aftermath of the homicide, when only limited information is available. This frequently results in cases being misrepresented and, in the absence of any substantive information, sees the reliance on gratuitous or titillating case details.

Unless a case is particularly high-profile, there is rarely any detailed media reporting of the case as it moves through the criminal justice or coronial processes and, accordingly, the true facts and circumstances of the case are lost to the broader community.

For instance, in *Case Review 3367*, the victim of domestic violence was killed by her abuser. She had formerly been engaged in informal sex work, and she and the abuser had started a relationship with when he was her client. When the abuser was charged with murdering the victim one of Australia's leading newspapers published an article referring to the abuser as the victim's 'toy boy'. After the abuser was found guilty of her murder, a leading regional newspaper published an article wherein the victim was described as the abuser's *'sex worker girlfriend'* and the title of the article was '*Sex Worker Murder'*. The Team was of the perspective that this reporting was disrespectful to the homicide victim and minimised perpetrator accountability.

The Team also considered that journalists would regularly report in ways which were disrespectful towards the deceased, or would emphasise the salacious or gratuitous details of violence in cases without discussing domestic violence in a nuanced, informative or respectful way (or at all).

One case reviewed by the Team for this report, involved an abuser who killed his victim and then committed suicide. The following day, an article was published in one of Australia's leading newspapers with the title '*He loved his wife to death'* and stated that the abuser's '*despair' ended with 'two bullets'*. The article also incorrectly stated that the victim had been diagnosed with a terminal illness, and described this as the motivation for the homicide. At inquest it was determined that the victim was not suffering from a terminal illness and that the homicide occurred in the context of the victim

attempting to finally end the relationship with her abusive husband.

The Team also noted that domestic violence referral information was rarely included at the bottom of articles, despite significant and often gratuitous detail about fatal episodes of domestic violence.

The 'Our Watch' initiative

Our Watch was established in 2013 as an independent not-for-profit organisation to drive nationwide change in the culture, behaviours and attitudes that underpin and create violence against women and children. An integral aspect of *Our Watch* is the *National Media Engagement Project* which aims to engage '*media to increase quality reporting of violence against women and their children, and building awareness of the impacts of gender stereotyping an inequality*'.[35]

This initiative recognises the important role the media plays in shaping community attitudes, perceptions and knowledge of violence against women. This project operates to:

- improve foundational training for journalists;
- develop tools for the media to promote good practice when reporting on violence against women;
- provide resources and tools for survivors of violence; and
- implement a National awards scheme to recognise and reward good reporting around violence against women.

In September 2014 Our Watch launched a number of media guides including a guide for *Reporting on Domestic Violence* and a guide concerning *Reporting on Family Violence in Aboriginal & Torres Strait Islander Communities*. The Team highly recommends these guides as best practice media reporting in relation to domestic violence.

One of the recommendations included in both sets of Our Watch Guidelines was that referral information be embedded into all media reporting of domestic and family violence. This should include information for local services where appropriate, and should always include referrals to 1800 RESPECT. It was also noted that this should include specific information for appropriate services for Aboriginal and Torres Strait Islander Australians.

Comment

The Team supports the work being undertaken by Our Watch *and commends the guidelines to media professionals as well as anyone seeking guidance in the best practice for discussing domestic and family violence issues.*

The Team strongly supports the Our Watch *recommendation that appropriate referral information be embedded into all media reporting of domestic and family violence reporting in NSW, and in Australia.*

State-based media initiatives

There have also been several initiatives at the State level including in Victoria through initiatives such as Domestic Violence Victoria's Eliminating Violence Against Women Media Awards (the EVAs), in NSW through *Respectful Reporting: Victims of Violent Crime Media Strategy* and work in other jurisdictions, including Western Australia,[36] and the Australian Capital Territory.[37]

The Team will continue to monitor the quality of media reporting in relation to cases within its dataset. This may form the basis of future targeted recommendations, including in relation to domestic violence homicides and media reporting.

Victim and abuser help-seeking behaviours: religious organisations

Recommendation 12 in the Team's *11/12 Report*, considered the issue of victims' informal help-seeking behaviour from religious leaders and their religious community.

The recommendation was derived from *Case Review 2968* (*11/12 Report*) where the victim of violence disclosed to her local church Minister her experiences of domestic violence by her abusive de facto husband. The Minister attempted to provide the couple with counselling. Three weeks prior to

[35] Our Watch (2015) available at: www.ourwatch.org.au/what-we-do(1)/national-media-engagement-project (last accessed October 2015).

[36] Government of Western Australia, Department for Child Protection and family Support, *Reporting Family and Domestic Violence: Resource for Journalists* (Family and Domestic Violence Unit, 2014) available at:https://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Documents/Reporting%20family%20and%20domestic%20violence_Resource%20for%20Journalists.pdf (last accessed October 2015).

[37] Women's Centre for Health Matters, *Reporting on Domestic Violence: A guide for ACT media* (Women's Centre for Health Matters, 2014) available at: http://www.wchm.org.au/resources-for-media/guides-to-reporting-on-violence-against-women/ (last accessed October 2015).

the homicide, the victim asked the Minister to attend the couple's home to intervene in an argument. The Minister attempted to calm the situation and encouraged the abuser to manage his depression and take his medication. The Minister then encouraged the couple to work through their relationship issues in group prayer.

The night of the homicide, the victim called the Minister as she was intending to separate from the abuser, but was scared and concerned about the way he would react. She disclosed this to the Minister's wife and asked if her children could stay the night at the Minister's house. The Minister's wife agreed. After the children were conveyed to the Minister's house, the abuser killed the victim.

It was the Team's perspective that this case demonstrated the unique relationship between religious leaders and their congregations, and also indicated the Minister's lack of awareness regarding the dynamics of domestic violence within his religious community.

In *Case Review 3306*, reviewed by the Team for this report, the victim's support network was primarily comprised of her religious community. In this case, the victim disclosed violence to a close friend from the church, and together the victim and her friend prayed that the violence would stop. It was the perspective of the Team that although this case did not implicate religious leaders, it nonetheless illustrated the importance of congregations being informed around appropriate and available responses to domestic violence. The church in this case presented another avenue through which education and knowledge surrounding violence could be disseminated to the community.

Recommendation 12 of the Team's *11/12 Report* was supported in principle in the whole-of-government response, but currently no action has been taken.

In further examining this issue, the Team conducted further research into earlier initiatives which have sought to engage religious organisations in relation to domestic violence issues.

In 1991 the *Joint Churches Domestic Violence Prevention Project* was established to respond to the needs of victims and perpetrators of domestic violence within the church community. The Project acknowledged that in many instances, these needs were not adequately or appropriately being addressed. The Project sought to address this issue through the development of literature and training materials for clergy and church communities.

Following from this initial project, the Office of the Status of Women in Queensland and the Office for Women's Policy in NSW (as it then was) co-funded the Pilot project '*Domestic Violence and the Churches'* which sought to educate the clergy in relation to domestic violence (including appropriate responses to disclosures), and equip key members of the clergy with the skills to pass this information to other religious leaders and their congregations.

The Team has been advised that the program was delivered to over 300 participants throughout NSW and while it received excellent feedback was not continued beyond 12 months.

Accordingly, to progress previous recommendations made by the Team in this area, the Team recommends:

Recommendation 13

That the Minister for Domestic and Family Violence convene an interfaith roundtable within the next 12 months with a view to progressing Recommendation 12 of the Team's 11/12 Report.

Family law contact, separation and domestic violence

In developing this Report the Team also considered the intersection of domestic violence and family law issues. Given the role of the Family Courts in relation to separation and at the point of relationship breakdown, the Team seeks to emphasise the importance of strong, consistent responses to domestic violence disclosures and concerns for safety arising in this context.

The Team has previously made *Recommendation 14* in its *12/13 Report* in recognition of the role of family lawyers in relation to DV. This recommendation concerned providing referral information for lawyers in the context of domestic violence disclosures, and providing additional education for specialists (including family law specialists). Findings included in this report reinforce the need for this recommendation to be actioned.

The Team's cases reviewed to date have traversed a range of family law issues. Some cases have included informal family law issues and others have involved contact with family lawyers or the Family Court of Australia. This contact has included;

- victims and abusers seeking advice in relation to parenting arrangements from family lawyers;
- victims and abusers accessing publications and resources including from the Family Court of Australia website;
- victims physically attending the Family Court of Australia to obtain information about divorce or seeking advice;
- victims and abusers obtaining legal advice in relation to the dissolution of their marriage and their property settlement; and
- victims and abusers lodging papers at the Family Court of Australia to finalise their divorce.

The Family Court and the Federal Circuit Court of Australia should be commended for prioritising information in relation to domestic and family violence on their websites. Both websites contain easily accessible referral information including to 1800 RESPECT. Both Courts have also developed the *Family Violence Plan 2014-2016* which seeks to better protect victims of family violence, particularly children.

The Team also commends the Family Court and the Federal Circuit Court of Australia for providing links to family violence information when users seek information about separation on these websites.

As indicated in the Team's *12/13 Report*, separation is a characteristic in a high proportion of domestic violence homicides. This is also reinforced by findings in the domestic violence literature, which indicate that separation may increase risk of further violence to women who leave an abusive partner.[38]

Although separation may include the victim or abuser physically leaving the relationship to reside in another location or premises, as discussed previously, in a significant number of the Team's cases, the victim and abuser continued to live together as their relationship was ending, or after it had ended.

In the Team's Intimate Partner Focus Dataset, in 9 cases the victim and abuser continued to live together while the relationship was breaking down or after the relationship had ended (47% of all cases where the relationship was breaking down or had ended).

The websites for both the Family Court and the Federal Circuit Court of Australia contain information concerning women's safety after separation. This information is not always easy to navigate, and some of the links to information are broken. It is the Team's perspective that these Courts should consider updating this information on their websites, and should acknowledge that continuing to live in the same residence with an abusive spouse after separation may present particular risks for victims of violence. The updated information should provide referral information accordingly, and should be easy to navigate for individuals who seek to access it.

The Team also notes that there is currently no quick close button on the Family or Federal Circuit Courts' of Australia websites. It is the perspective of the Team that this should be included in accordance with best practice standards for the provision of domestic and family violence information online and to protect victims.

It is also recognised that not every person who contacts the Family Court of Australia will do so via the website. Hard copy brochures are available in registries and also available to be sent out to those who request them. For this report the Team is particularly interested in two of the Family Court of Australia brochures/fact sheets, namely:

- *Marriage, Families & Separation* (prescribed brochure); and
- *Separated but living under one roof?*

Given the findings contained in this report, the Team recommends that consideration be given to updating these brochures to include family violence referral information including contact information for 1800 RESPECT. This is particularly important given that separation may present unique risks to victims of domestic violence.

Accordingly the Team recommends:

Recommendation 14

That the Family Court of Australia and the Federal Circuit Court of Australia:

[38] Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., Gary, F., Glass, N. McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S. A., Mangello, J., Xu, X., Schollenberger, J., Frye, V. & Laughton, K., 2003, 'Risk factors for femicide in abusive relationships: Results from a multisite case control study', vol. 93, no. 7 *American Journal of Public Health*, , pp. 1089-97.

a) update their webpages concerning family violence to incorporate a quick close button to facilitate the safe and rapid exit from the webpage;

b) give consideration to updating information in relation to safety and separation included on their respective websites.; and

c) give consideration to including family violence referral information in their brochures '*Marriage, Families & Separation*' (prescribed brochure) and '*Separated but living under one roof?*'.

This referral information should be reflected in both the online and hardcopy versions of these brochures, and should include referrals to 1800 RESPECT.

Enhancing collaboration between Child Death Review mechanisms and the Domestic Violence Death Review Team

In this case review period there were a number of cases where homicides followed both a history of domestic violence between the child's parents, and involvement with Family and Community Services. This included *Case Review 2341* and *Case Review 3307*, both of which involved complex practice issues concerning the NSW Child Protection System.

In light of these cases, the Team considered that there was capacity to enhance the relationship between death review teams operating in NSW. In particular, the Team was of the opinion that the review mechanism of the Child Death Review Team, the Reviewable Child Deaths Team, the Serious Case Review (FACS) and the NSW Domestic Violence Death Review Team could be enhanced by further collaboration between these review mechanisms at pivotal stages of the review process (beyond the information-sharing that currently exists).

Accordingly, the Team recommends:

Recommendation 15

That the NSW Ombudsman gives consideration to developing a protocol which will enable deaths involving both domestic violence and child protection issues to be subject to a joint meeting between the *NSW Ombudsman's Office* and the *NSW Domestic Violence Death Review Team*. The purpose of this meeting will be to share learnings in relation to child protection and domestic violence issues.

6 MONITORING RECOMMENDATIONS

This chapter outlines the recommendations made to date by the Team and provides information and commentary in relation to the response to the recommendations.

It is noted that the whole-of-government response to the Team's 12/13 report is currently being prepared, and this response, as well as integrated monitoring, will be reported in the Team's 15/16 Report.

Table 1: 2012-2013 Annual Report – Recommendations and commentary

2012/13 ANNUAL REPORT RECOMMENDATIONS	WHOLE OF GOVERNMENT RESPONSE/ACTION
Recommendation 1 That the NSW Police Force review and revise their recruitment and field based domestic violence operational skills training materials to ensure that such materials: a) promote a comprehensive understanding and awareness of the broad spectrum of domestic violence behaviours, including non-physical manifestations of domestic violence; b) include specific training concerning where non-physical domestic violence behaviours manifest as coercive and controlling conduct by the perpetrator; and *c)* address and acknowledge the professional challenges which officers may experience in the context of responding to domestic violence in the community, in particular responding to repeat offenders and victims of domestic violence.	**The whole-of-government response to the Team's 12/13 report is currently being prepared.** **This response, as well as integrated monitoring, will be reported in the Team's 15/16 Report.**
Recommendation 2 That the NSW Police Force give consideration to developing a mentoring program whereby Region Domestic Violence coordinators provide strategic support and assistance to all officers to help acknowledge and address the professional challenges and barriers presented by repeat offenders and victims of domestic violence.	**As above**
Recommendation 3 That the NSW Police Force incorporate into its Domestic and Family Violence Safety Assessment Tool the following questions: a) Do the perpetrator and victim continue to live at the same residence after the relationship has ended? **b)** Are there any criminal, family law or other relevant proceedings on foot?	**As above**
Recommendation 4 That the Domestic and Family Violence home page on the NSW Police Force corporate internet site be updated to incorporate a quick close button to facilitate the safe and rapid exit from the webpage. This website should also contain easily accessible information concerning how to delete internet history from the browser.	**As above**

2012/13 ANNUAL REPORT RECOMMENDATIONS	WHOLE OF GOVERNMENT RESPONSE/ACTION
Recommendation 5 That the relevant and appropriate NSW Police Force policies and procedures be amended to create a requirement for police to complete a COPS Event in all cases where: a) Officers make an assessment as to whether an individual needs to be detained under the *Mental Health (Forensic Provisions) Act 1990* (NSW); or b) Officers issue any directions/provide any advice to a person who is on bail.	**As above**
Recommendation 6 1. That the NSW Police Force develop a communication strategy to reiterate to officers the operational requirements set out in the Domestic Violence Standard Operating Procedures, and in particular the requirements that officers: a) Record all domestic and family violence incidents reported to them; b) Refer all parties involved, who give written consent, to appropriate services; and c) Investigate all domestic and family violence incidents coming to their notice, by gathering background information and physical evidence, including pictures, video recordings, clothing and statements from all victims and witnesses. **2.** That the NSW Police Force update its Complaints Management System (c@tsi) to include domestic violence as an 'associated factor' to ensure that any complaint that is domestic violence related can be readily identified.	**As above**
Recommendation 7 That the NSW Police Force review and revise both its recruitment and field based domestic violence operational skills training materials to ensure that such materials promote an understanding of kinship and an appreciation of the unique challenges that Aboriginal people may face when interacting with the legal system.	**As above**
Recommendation 8 1. That the NSW Police Force and Juvenile Justice (DAGJ) co-ordinate to train police officers, and implement procedures whereby in all suitable cases involving bail, the Bail Assistance Line (BAL) is used to arrange appropriate accommodation for young people, particularly in cases involving violent offences and/or offences against family members. 2. That NSW Department of Attorney General and Justice conduct a feasibility study in relation to expanding the BAL to regional centres in NSW.	**As above**

2012/13 ANNUAL REPORT RECOMMENDATIONS	WHOLE OF GOVERNMENT RESPONSE/ACTION
Recommendation 9 That the NSW Police Force amend its Domestic and Family Violence policy to provide that when any domestic homicide event occurs, police should notify FACS of any known biological or non-biological surviving children of the deceased or perpetrator (including children who may not be ordinarily resident with the deceased or perpetrator). Once a notification is made, FACS should co-ordinate with agencies including DEC and Victims Services to ensure that counselling and services appropriate to the specific trauma experience, age and geographic location of the child/ren is made available to those children in a timely fashion. Victims Services, DEC and FACS should co-ordinate to develop a strategy and develop additional support services tailored for this group of child victims, in cases where their families or carers are reluctant to engage with counselling and support services.	**As above**
Recommendation 10 That NSW Health co-ordinate the development and implementation of a domestic violence identification and referral strategy for the Ambulance Service of NSW and all NSW Hospital Emergency Departments. This strategy should include: a) The development of policies and procedures by NSW Health to ensure that timely and effective information exchange occurs between NSW Ambulance staff and Emergency Department staff to facilitate the identification of and response to injuries sustained from domestic violence. b) That NSW Ambulance staff are encouraged to utilize the functionality within the Electronic Medical Record (eMR) form to record incidents of domestic violence, particularly when the victim, police or other informant has stated that the injury was sustained as a result of domestic violence. c) The adoption and implementation by NSW Health of the proposed NSW government Domestic and Family Violence Reforms to facilitate the identification of high-risk victims who have sustained injuries resulting from domestic violence, and referral (through Emergency Department Social Work Teams) to Safety Action Meetings (SAMs) when a victim(s) is identified as 'high-risk'. d) The development of targeted professional development and mandatory training for all persons working within NSW Emergency Departments and Ambulance Services in relation to domestic violence. This training should: i. Include the identification of domestic violence dynamics, and explore issues of safety (for both patients and staff); and ii. Address responding to patients who present with cumulative social issues (including being drug and/or alcohol affected) or are otherwise difficult patients.	**As above**

2012/13 ANNUAL REPORT RECOMMENDATIONS	WHOLE OF GOVERNMENT RESPONSE/ACTION
(Recommendation 10 continued) e) The development and implementation of a policy promoting and facilitating the discharge of patients into a safe environment free from domestic violence. This policy should recommend that those patients suspected of sustaining injuries as a result of domestic violence receive the *Domestic Violence Hurts Your Health* Z-Card, produced by the Education Centre Against Violence (ECAV). This policy may incorporate the provision of referral information where necessary, including in relation to emergency accommodation and other services.	
Recommendation 11 **1.** That NSW Kids and Families (NSW Health), liaise with Priority Programs, Integrated Care (Ministry of Health) on the planned review of its Policy Directive *Interpreters - Standard Procedures for Working with Health Care Interpreters [PD 2006_053],* to ensure that: a) Wherever possible, the patient is consulted as to their preferences for an interpreter in relation to gender; and b) All patients are made aware of their right to an accredited interpreter who has professional obligations to uphold patient confidentiality and impartiality. 2. That NSW Kids and Families (NSW Health), in undertaking a review of Policy Directive *Domestic Violence - Identifying and Responding [PD2005_413]*, enhances policies and procedures to ensure that: a) Where possible, prior to any domestic violence screening being undertaken, information about domestic violence is provided to the woman being screened in her own language (for instance, by providing her with the *Domestic Violence Hurts Your Health* Z-Card published by ECAV); b) Where possible, the medical professional, through an appropriate interpreter, discusses with the patient the range of behaviours that may constitute domestic violence, as well as asking questions of the patient in a way which respects her culture; and c) Medical professionals use accredited interpreters who are trained and adhere to standards of confidentiality and impartiality to identify and/or reduce the potential for power imbalances or other issues arising between the patient being screened and the interpreter (for example, ethnic conflict between the interpreter and patient; conflict on the basis of age or gender; and confidentiality issues).	**As above**
Recommendation 12 That the National Accreditation Agency for Translators and Interpreters (NAATI) encourage the development of, and participation in, programs for practitioners certified by NAATI, which examine the dynamics and behaviours of domestic violence. This should also constitute part of any continuing professional development programs offered by NAATI.	**As above**

2012/13 ANNUAL REPORT RECOMMENDATIONS	WHOLE OF GOVERNMENT RESPONSE/ACTION
Recommendation 13 That the Community Relations Commission incorporate into its induction training for all interpreters and translators, a mandatory unit examining the dynamics and behaviours of domestic violence.	**As above**
Recommendation 14 1. That the Law Society of New South Wales develop and host on its website information to assist practicing solicitors to make appropriate referrals in response to domestic violence disclosures made by clients. Once developed, this information should be publicised in *Monday Briefs* and the *Law Society Journal*; and 2. That the Specialist Accreditation Scheme Advisory Committees for Children's Law, Criminal Law, Dispute Resolution and Family Law, include the identification of and response to domestic violence disclosures in the assessments to be set for the Scheme in future years.	**As above**
Recommendation 15 That the NSW Judicial Commission develop and implement training and guidelines for all NSW judicial officers in relation to domestic and family violence, which: a) promotes awareness and understanding in relation to the dynamics of domestic violence and the broad spectrum of relationships that may be characterised by such violence; and b) emphasises and supports the use of a common language in relation to domestic violence that does not minimise violence.	**As above**
Recommendation 16 That the Fertility Society of Australia together with the Australian and New Zealand Infertility Counsellors Association and the Fertility Nurses of Australasia, develop a communication strategy which ensures that practitioners providing assisted reproductive services (including doctors, nurses and counsellors) are recognising and providing appropriate referral information to clients who are experiencing or demonstrating domestic violence behaviours.	**As above**
Recommendation 17 In order to facilitate the implementation of Recommendation 10 from the NSW Domestic Violence Death Review Team's *2011/12 Annual Report*, it is recommended that the Office of Communities (DEC) expand the *Tackling Violence* program into five new regional locations. *Tackling Violence* is a successful and evaluated education and prevention program that uses regional rugby league clubs to deliver anti domestic violence messages. A model for implementing *Tackling Violence* in the western suburbs of Sydney - for possible further expansion in other Sydney metro areas - should also be developed.	**As above**

2012/13 ANNUAL REPORT RECOMMENDATIONS	WHOLE OF GOVERNMENT RESPONSE/ACTION
(Recommendation 17 continued) This work should be undertaken in partnership with key stakeholders including local councils, sporting and voluntary groups and Aboriginal communities. The Office of Communities should co-ordinate with Women NSW to promote the positive evaluation findings from this initiative.	
Recommendation 18 That, as part of the Aboriginal Child Youth and Family Strategy, FACS develops and implements a trauma-informed parenting program aimed at educating and supporting Aboriginal fathers. Consideration could be given to co-ordinating with the Office of Community Services for rollout of this program through the initiative discussed in Recommendation 17.	**As above**
Recommendation 19 That the NSW DEC homepage be updated to ensure clear and accessible links to domestic violence and referral information is available, aimed at both: a) students, if they are experiencing or exposed to domestic violence within the home, and/or they are aware that someone they know is being exposed to or experiencing domestic violence; and b) parents, if they are experiencing domestic violence.	**As above**
Recommendation 20 That NSW Health, DEC and NSW Department of Attorney General and Justice co-ordinate to prioritize the provision of domestic violence information (including referral information) on their various intranet home pages through an easily accessible portal. It is suggested that these agencies work in connection with Women NSW to formulate each information and referral portal, or link to the following portal: www.domesticviolence.nsw.gov.au. This should be undertaken as a priority within the next 12 months.	**As above**
Recommendation 21 That FACS develop, incorporate and prioritise on the Seniors Card NSW website a module outlining information about domestic violence including intimate partner violence and elder abuse (including referral information).	**As above**
Recommendation 22 That the NSW Steering Committee on the Prevention of Abuse of Older People, through Women NSW, report to the NSW Domestic Violence Death Review Team in relation to the use of the NSW Elder Abuse Helpline and Resource Unit. This information should be contained in a report which includes: a) demographic information of users;	**As above**

2012/13 ANNUAL REPORT RECOMMENDATIONS	WHOLE OF GOVERNMENT RESPONSE/ACTION
(Recommendation 22 continued) b) nature of enquiry/service being sought; c) any details of the abuse being experienced (including relationship); and d) outcomes and referrals made in each case.	
Recommendation 23 That the Cancer Institute (NSW Health), in consultation with NSW Kids and Families (NSW Health), co-ordinate the distribution of domestic violence information to every woman in NSW who has a mammogram.	**As above**

Table 2: 2011-2012 Annual Report – Recommendations and commentary

2011/2012 ANNUAL REPORT RECOMMENDATIONS	WHOLE-OF-GOVERNMENT RESPONSE/ACTION
Recommendation 1 That section 101B(1) of the *Coroners Act 2009* (NSW) be amended as follows: 'domestic violence death' means: (a) the death of a person that is caused directly or indirectly by a person who was in a domestic relationship with the deceased person, *and the death occurs in the context of domestic violence; or* (b) *the death of a person that is a third party to a domestic relationship, and the death occurs in the context of domestic violence.*	**RECOMMENDATION 1:** **SUPPORTED** **ACTION:** **COMPLETE**
Recommendation 2 That section 101C(1)(d) of the *Coroners Act 2009* (NSW) be amended to omit the words *and there have been previous episodes of domestic violence between them*.	**RECOMMENDATION 2:** **SUPPORTED** **ACTION:** **COMPLETE**
Recommendation 3 That Part 9A(2) [s101E] of the *Coroners Act 2009* (NSW) relating to the Constitution and Procedure of the Domestic Violence Death Review Team be amended to include a representative from Corrective Services NSW (CSNSW).	**RECOMMENDATION 3:** **SUPPORTED** **ACTION:** **COMPLETE**
Recommendation 4 That the NSW Police Force incorporate into the existing domestic and family violence Standard Operating Procedures a requirement whereby a COPS event must be promptly created by the responding officer/person handling the inquiry, within his or her shift, any time: a) assistance/advice is sought in relation to a child custody issue, regardless of whether or not the child is considered to be at risk of harm; b) assistance/advice is sought in relation to making an application for an ADVO; and **c)** assistance/advice is sought in relation to a breach of an ADVO**.**	**RECOMMENDATION 4:** **SUPPORTED** **ACTION:** **Progress update will be provided in Team's 2015/2016 Report**

2011/2012 ANNUAL REPORT RECOMMENDATIONS	WHOLE-OF-GOVERNMENT RESPONSE/ACTION
Recommendation 5 That the NSW Police Force include each of the following questions in the standard 'Domestic Violence Related Checklist': a) Has the perpetrator previously threatened to commit suicide? b) Has the perpetrator previously attempted to commit suicide? c) Has the perpetrator previously threatened to kill the victim **and/or** other family members? d) Has the perpetrator previously threatened or assaulted the victim and/or other family members with a weapon? e) Are there any child custody issues (ask victim)? f) Are there any child custody issues (ask perpetrator?)	**RECOMMENATION 5:** **SUPPORTED** **ACTION:** **Progress update will be provided in Team's 2015/2016 Report**
Recommendation 6 That the NSW Police Force incorporate into its existing domestic and family violence Standard Operating Procedures the requirements that: • in cases where the standard 'Domestic Violence Related Checklist' reveals the presence of any listed domestic violence risk factors, the police must inform the victim of the increased risk of lethality posed to them; and • responding officers physically provide referral information to the domestic violence victim in the form of the Domestic Violence referral kit.	**RECOMMENDATION 6:** **SUPPORTED** **ACTION:** **Progress update will be provided in Team's 2015/2016 Report**
Recommendation 7 That the NSW Police Force develop specific Standard Operating Procedures for responding officers in domestic violence cases where the victim is reluctant to pursue legal pathways. These Standard Operating Procedures should include the requirement that responding officers leave domestic violence support and referral information at the premises where the domestic violence incident occurred, even in cases where police entry to the premises is refused or where the victim presents as uncooperative.	**Recommendation 7:** **SUPPORTED** **ACTION:** **Progress update will be provided in Team's 2015/2016 Report**
Recommendation 8 That the NSW Police Force commission a review of the implementation of legislation within the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) that requires police officers to apply for ADVOs wherever they have fears for the safety of victims. This review should ascertain the extent to which this provision is used, particularly with regards to Indigenous victims of domestic violence.	**Recommendation 8:** **NOT SUPPORTED** **ACTION:** **NIL**
Recommendation 9 That as part of the NSW Ageing Strategy, the NSW Ministerial Advisory Committee on Ageing give strong consideration to using case reviews 8 and 9 of the 2011/2012 NSW Domestic Violence Death	**Recommendation 9:** **SUPPORTED**

2011/2012 ANNUAL REPORT RECOMMENDATIONS	WHOLE-OF-GOVERNMENT RESPONSE/ACTION
(Recommendation 9 continued) Review Team Annual Report to inform the development of training resources for the new NSW helpline dedicated to abuse of older people and the corresponding resource unit.	**ACTION:** **Progress update will be provided in Team's 2015/2016 Report**
Recommendation 10 That the NSW government commission the development and implementation of a public education strategy aimed at improving the reporting of domestic violence, including physical violence and controlling and coercive behaviour. This should be targeted at reporting by: • victims; • family, friends and neighbours of victims; and • specific groups such as Indigenous women, young women and older women, and women who speak languages other than English. The strategy should draw on international research, and should aim to educate the community about the nature and dynamics of domestic violence, including: • the times when victims are most at risk such as at the point of separation, when disputes arise in relation to child custody and during pregnancy; • the presence of risk factors such as stalking behaviour, coercive and controlling behaviour or economic abuse, which may fall outside of the paradigm of traditional physical domestic violence; and • education regarding teen dating violence, healthy relationships, cyber abuse and identifying when conduct becomes serious criminal behaviour requiring police intervention. The strategy should provide practical advice to victims, family, friends and neighbours and specific groups about: • how to respond to domestic violence; • where assistance can be sought including domestic violence help lines and the police; and • how and when to contact police and emergency services.	**RECOMMENDATION 10:** **SUPPORTED** **ACTION:** **Progress update will be provided in Team's 2015/2016 Report**
Recommendation 11 That the NSW government commission or undertake a study into Indigenous women's experiences of domestic and family violence. This study should inform the development of strategies to: • encourage and support Indigenous victims to report family violence; • facilitate continued participation of Indigenous victims throughout legal processes; • strengthen access to relevant specialist Indigenous and mainstream services; • ensure training is made available for police and other professionals in relation to the dynamics impacting on the reporting of violence by Indigenous victims; **(Recommendation 11 continued)** • improve connections between Indigenous health services and domestic	**Recommendation 11:** **SUPPORTED** **ACTION:** **Progress update will be provided in Team's 2015/2016 Report**

2011/2012 ANNUAL REPORT RECOMMENDATIONS	WHOLE-OF-GOVERNMENT RESPONSE/ACTION
and family violence services; • improve the response to victims and perpetrators who have complex needs, including needs arising from drug and alcohol misuse, mental illness and homelessness; and • introduce and implement a family violence prevention program aimed at Indigenous youth.	
Recommendation 12 That the NSW government develop and implement an inter-faith working party on the issue of domestic violence. Such a party should: • develop consistent strategies, policies and organisational plans within religious organisations for responding to domestic violence when such violence is suspected or apparent within the congregation or religious community; • develop and implement training and education materials for religious leaders around issues of responding to and reporting domestic violence where such violence is suspected or apparent within the congregation or religious community; and • develop and implement training and education materials for congregations or religious communities around domestic violence.	**RECOMMENDATION 12:** **SUPPORTED** **ACTION:** **Progress update will be provided in Team's 2015/2016 Report**
Recommendation 13 That the NSW government encourage the Commonwealth Department of Immigration and Citizenship (DIAC) to: • develop training programs for its agents/officers regarding the nature and dynamics of domestic violence, including the vulnerability caused by the actual/threatened withdrawal of sponsorship; • adopt a proactive approach whereby all claims for the family violence provision are referred to an independent expert in family violence matters, and are not rejected or otherwise assessed in the negative by any agent or representative of DIAC other than an independent expert in family violence; • require agents/officers who may be adjudicating claims for family violence provisions or who are responding to enquiries made in relation to such provisions to make appropriate referrals to law enforcement and social service agencies; • ensure victims of domestic violence who make an application to DIAC for family violence provision have access to emergency funding or limited government benefits irrespective of their visa status; and • require the agents/officers of DIAC to interview female and male partners separately in any cases where domestic violence is reported or suspected.	**RECOMMENDATION 13:** **SUPPORTED** **ACTION:** **Progress update will be provided in Team's 2015/2016 Report**
Recommendation 14 That the Department of Family and Community Services – Housing NSW remind operational staff to inform tenants of domestic violence services, where appropriate, when they become aware of domestic or family violence occurring within a public housing property.	**RECOMMENDATION 14:** **SUPPORTED** **ACTION:** **Progress update will be provided in Team's 2015/2016 Report**

APPENDIX A:
Chapter 9A *Coroners Act 2009* (NSW)

Coroners Act 2009 No 41

Chapter 9A Domestic Violence Death Review Team

Part 9A.1 Preliminary

101A Object of Chapter

The object of this Chapter is, through the constitution of the Domestic Violence Death Review Team, to provide for the investigation of the causes of domestic violence deaths in New South Wales, so as to:
(a) reduce the incidence of domestic violence deaths, and
(b) facilitate improvements in systems and services.

101B Interpretation

(1) In this Chapter:

Child Death Review Team means the Child Death Review Team established under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

Convenor means the person appointed as Convenor of the Team under this Chapter.

domestic violence death means 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.

Team means the Domestic Violence Death Review Team.

(2) For the purposes of this Chapter, a case of a domestic violence death is ***closed*** if:
(a) the coroner has dispensed with or completed an inquest concerning the death, and
(b) any criminal proceedings (including any appeals) concerning the death have been finally determined (as defined in section 79 (4)).

101C Meaning of "domestic relationship"

(1) For the purposes of this Chapter, a person was in a ***domestic relationship*** with another person if the person:
(a) was or had been married to the other person, or
(b) was or had been a de facto partner of the other person, or
(c) had or has had an intimate personal relationship with the other person, whether or not the intimate relationship involved or had involved a relationship of a sexual nature, or
(d) was or had been a relative of the other person, or
(e) in the case of an Aboriginal person or a Torres Strait Islander, was or had been part of the extended family or kin of the other person according to the Indigenous kinship system of the person's culture, or

(f) was in any other relationship with the other person of a kind prescribed by the regulations.

(2) For the purposes of this Chapter, a person was a ***relative*** of another person if the person was or is:
(a) a father, mother, grandfather, grandmother, step-father, step-mother, father-in-law or mother-in-law, or
(b) a son, daughter, grandson, grand-daughter, step-son, step-daughter, son-in-law or daughter-in-law, or
(c) a brother, sister, half-brother, half-sister, step-brother, step-sister, brother-in-law or sister-in-law, or
(d) an uncle, aunt, uncle-in-law or aunt-in-law, or
(e) a nephew or niece, or
(f) a cousin,
of the other person, or of the spouse or a de facto partner of the other person.

Part 9A.2 Constitution and procedure of the Team

101D Establishment of Team

The Domestic Violence Death Review Team is constituted by this Act.

101E Members of Team

(1) The Team is to consist of the Convenor of the Team and other persons appointed by the Minister.
(2) The Minister is to appoint as Convenor of the Team the State Coroner, a Deputy State Coroner or a former State Coroner or Deputy State Coroner.
(3) The Team is to include representatives of each of the following:
(a) the Department of Family and Community Services,
(b) NSW Health,
(c) the NSW Police Force,
(d) the Department of Education and Communities,
(e) the Department of Attorney General and Justice,
(f) Community Services, within the Department of Family and Community Services,
(g) Aboriginal Affairs, within the Department of Education and Communities,
(h) Housing NSW, within the Department of Family and Community Services,
(i) Juvenile Justice NSW, within the Department of Attorney General and Justice,
(j) Ageing, Disability and Home Care, within the Department of Family and Community Services,
(k) Women NSW, within the Department of Family and Community Services,
(l) Corrective Services NSW, within the Department of Attorney General and Justice.
(4) Each representative referred to in subsection (3) is to be nominated by the Minister responsible for the organisation concerned.
(5) In addition, the Team is to include the following persons:
(a) 2 non-government service provider representatives,
(b) 2 persons who, in the opinion of the Minister, have expertise appropriate to the functions of the Team.
(6) The Minister is to appoint 1 person who is an Aboriginal person or a Torres Strait Islander and who is a non-government service provider representative as a member of the Team.
(7) The Team must consist of not less than 15 members (in addition to the Convenor) and not more than 19 members (in addition to the Convenor) at any one time.
(8) A person who is a member of the Legislative Council or the Legislative Assembly is not eligible to be a member of the Team.
(9) Schedule 3 contains provisions with respect to the members and procedure of the Team.

Part 9A.3 Functions of the Team

Division 1 General functions

101F Functions of Team

(1) The Team has the following functions:
(a) to review closed cases of domestic violence deaths occurring in New South Wales,

(b) to analyse data to identify patterns and trends relating to such deaths,
(c) to make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths,
(d) to establish and maintain a database (in accordance with the regulations) about such deaths,
(e) to undertake, alone or with others, research that aims to help prevent or reduce the likelihood of such deaths.

(2) The Team may review a domestic violence death even though the death is or may be the subject of action by the Child Death Review Team.
(3) Any function of the Team with respect to domestic violence deaths may be exercised with respect to the death of a person who dies outside New South Wales while ordinarily resident in New South Wales.
(4) The Convenor may enter into an agreement or other arrangement for the exchange of information between the Team and a person or body having functions in another State or Territory that are substantially similar to the functions of the Team, being information relevant to the exercise of the functions of the Team or that person or body.

101G Matters to be considered in reviews

(1) In carrying out a review of closed cases of domestic violence deaths, the Team is to consider the following matters:
(a) the events leading up to the death of the deceased persons,
(b) any interaction with, and the effectiveness of, any support or other services provided for, or available to, victims and perpetrators of domestic violence,
(c) the general availability of any such services,
(d) any failures in systems or services that may have contributed to, or failed to prevent, the domestic violence deaths.

(2) This section does not limit the matters that the Team may consider or examine in any review of closed cases of domestic violence deaths.

101H Referral of cases for review to Team

(1) The Team may select the domestic violence death cases that are to be the subject of a review by the Team.
(2) Any person may refer a closed case of a domestic violence death to the Team for inclusion in a review. The Team may, but is not required to, select any such case for review.

101I Appointment of expert advisers

(1) The Convenor may, otherwise than under a contract of employment, appoint persons with relevant qualifications and experience to advise the Team in the exercise of its functions.
(2) A person so appointed is entitled to be paid such remuneration and allowances (including travelling and subsistence allowances) as may be determined by the Minister in respect of the person.

Division 2 Reports by Team

101J Reports

(1) The Team must prepare, within the period of 4 months after 30 June in each year, and furnish to the Presiding Officer of each House of Parliament, a report on domestic violence deaths reviewed in the previous year.
(2) Without limiting subsection (1), the report may include the following:
(a) identification of systemic and procedural failures that may contribute to domestic violence deaths,
(b) recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths,
(c) details of the extent to which its previous recommendations have been accepted.

101K Reporting to Parliament

(1) A copy of a report furnished to the Presiding Officer of a House of Parliament under this Part must be laid before that House on the next sitting day of that House after it is received by the Presiding Officer.

(2) The Team may include in a report a recommendation that the report be made public forthwith.
(3) If a report includes a recommendation that a report be made public forthwith, a Presiding Officer of a House of Parliament may make it public whether or not that House is in session and whether or not the report has been laid before that House.
(4) A report that is made public by a Presiding Officer of a House of Parliament before it is laid before that House attracts the same privileges and immunities as if it had been laid before that House.
(5) A Presiding Officer need not inquire whether all or any of the conditions precedent have been satisfied as regards a report purporting to have been furnished in accordance with this Part.
(6) In this Part, a reference to a Presiding Officer of a House of Parliament is a reference to the President of the Legislative Council or the Speaker of the Legislative Assembly. If there is a vacancy in the office of President, the reference to the President is taken to be a reference to the Clerk of the Legislative Council and, if there is a vacancy in the office of the Speaker, the reference to the Speaker is taken to be a reference to the Clerk of the Legislative Assembly.

Part 9A.4 Access to and confidentiality of information

101L Duty of persons to assist Team

(1) It is the duty of each of the following persons to provide the Team with full and unrestricted access to records that are under the person's control, or whose production the person may, in an official capacity, reasonably require, being records to which the Team reasonably requires access for the purpose of exercising its functions:

(a) the Department Head, chief executive officer or senior member of any department of the Government, statutory body or local authority,
(b) the Commissioner of Police,
(c) a coroner,
(d) a medical practitioner or health care professional who, or the head of a body which, delivers health services,
(e) a person who, or the head of a body which, delivers welfare services.

(2) A person subject to that duty is not required to provide access to records if the person reasonably considers that doing so may prejudice an existing investigation or inquiry of a matter under an Act being undertaken by or for the person.
(3) Access to which the Team is entitled under subsection (1) includes the right to inspect and, on request, to be provided with copies of, any record referred to in that subsection and to inspect any non-documentary evidence associated with any such record.
(4) A provision of any Act or law that restricts or denies access to records does not prevent a person subject to a duty under subsection (1) from complying, or affect the person's ability to comply, with that subsection.
(5) The regulations may make provision with respect to the duty to provide access to records under subsection (1), including prescribing limitations and conditions on that duty.
(6) In this section, ***record*** means any document or other source of information compiled, recorded or stored in written form or on film, or by electronic process, or in any other manner or by other means.

101M Confidentiality of information

(1) A Team-related person must not make a record of, or directly or indirectly disclose to any person, any information (including the contents of any document) that was acquired by the person by reason of being a Team-related person, unless:

(a) the record or disclosure is made in good faith for the purpose of exercising a function under this Chapter, or
(b) the record or disclosure is authorised to be made by the Convenor in connection with research that is undertaken for the purpose of helping to prevent or reduce the likelihood of domestic violence deaths in New South Wales, or
(c) the record or disclosure is made by the Convenor for the purpose of:
    (i) providing information to the Commissioner of Police in connection with a possible criminal offence, or
    (ii) reporting to the Director-General of the Department of Family and Community Services that a child or class of children may be at risk of harm, or
    (iii) providing information to the State Coroner that may relate to a death that is within the jurisdiction of the State Coroner, whether or not the death has been the subject of an inquest under this Act, or

(iv) providing information to the Child Death Review Team in connection with that Team's functions, or

(v) providing information to the Ombudsman concerning the death of a person that is relevant to the exercise of any of the Ombudsman's functions, or

(vi) giving effect to any agreement or other arrangement entered into under this Chapter or with coroners in other jurisdictions for the exchange of information, or

(vii) providing information to a national database compiled for the purposes of, and contributed to by, coroners of States and Territories, or

(d) the record or disclosure is made by a member of the Team to a Minister, or to a Department Head, chief executive officer or senior member of any department of the Government or a statutory body, in connection with a draft report prepared for the purpose of this Chapter.

Maximum penalty: 50 penalty units or imprisonment for 12 months, or both.

(2) A Team-related person who makes a record or disclosure that is authorised under this section in connection with research that is undertaken for the purpose of helping to prevent or reduce the likelihood of domestic violence deaths in New South Wales must ensure that the information does not identify a person who is the subject of the information.

(3) A Team-related person is not required:

(a) to produce to any court any document or other thing that has come into the person's possession, custody or control, or

(b) to reveal to any court any information that has come to the person's notice,

by reason of being a Team-related person.

(4) Any authority or person to whom any information referred to in subsection (1) is revealed, and any person or employee under the control of that authority or person:

(a) is subject to the same obligations and liabilities under subsections (1) and (2), and

(b) enjoys the same rights and privileges under subsection (3),

in respect of that information as if he or she were a Team-related person who had acquired the information for the purpose of the exercise of the functions of the Team. Failure to comply with obligations and liabilities referred to in this subsection is taken to be a contravention of subsection (1).

(5) In this section:

court includes any tribunal or person having power to require the production of documents or the answering of questions.

produce includes permit access to.

Team-related person means a member of the Team, a member of staff of the Team and any person engaged to assist the Team in the exercise of its functions, including persons appointed under section 101I.

Part 9A.5 Miscellaneous

101N Execution of documents

A document required to be executed by the Team in the exercise of its functions is sufficiently executed if it is signed by the Convenor or another member authorised by the Convenor.

101O Protection from liability

(1) A matter or thing done or omitted by the Team, a member of the Team or a person acting under the direction of the Team does not, if the matter or thing was done or omitted in good faith for the purposes of executing this or any other Act, subject the member of the Team or person so acting personally to any action, claim or demand in respect of that matter or thing.

(2) However, any such liability attaches instead to the Crown.

101P Review of Chapter

(1) The Minister is to review this Chapter to determine whether the policy objectives of this Chapter remain valid and whether the terms of this Chapter remain appropriate for securing those objectives.

(2) The review is to be undertaken as soon as possible after the period of 3 years from the commencement of this Chapter.
(3) A report on the outcome of the review is to be tabled in each House of Parliament within 12 months after the end of the period of 3 years.

APPENDIX B: Definitions

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

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

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

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

'Case Review Period' is, for this report, 1 July 2010 – 30 June 2012 (inclusive).

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

'Data Reporting Period' is 1 July 2000 to 30 June 2012 (inclusive).

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

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

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

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

'**Domestic Violence Abuser** describes the perpetrator of domestic violence in the life of the relationship.

'Domestic Violence Victim' describes the domestic violence victim in the life of the relationship.

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

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

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

'**Homicide Victim'** describes the person who is killed by a perpetrator. This terminology does not import any information about who was the victim of domestic violence or the abuser of domestic violence, in recognition of the fact that a violence abuser ('homicide victim') may be killed by a victim of abuse ('homicide perpetrator')

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

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

'**Intimate Partner Violence'** means violence between intimate partners, see 'Intimate Partner'.

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

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

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

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

'Multiple Causes' see 'Manner of Death'.

'Multiple Homicide Event' describes cases where two or more people are killed in the one homicide event (excluding perpetrator suicides or unintentional perpetrator deaths).

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

'Criminal/Coronial outcomes' describes the judicial or Coronial outcomes of particular cases.

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

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

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

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

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

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

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

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

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

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

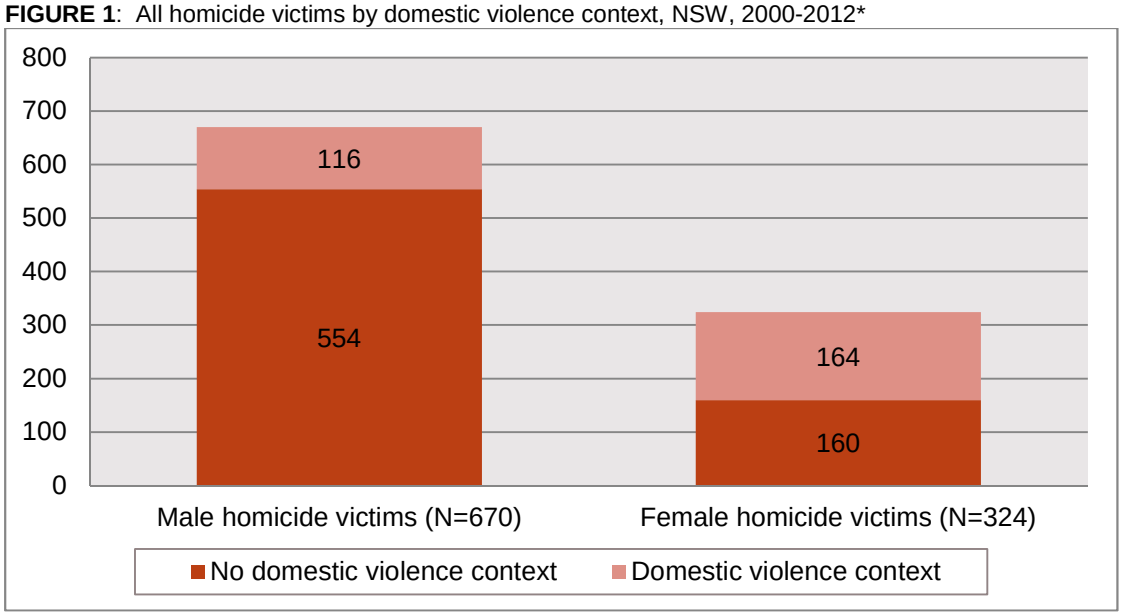
'Wife' describes a female person who is legally married to a male person (a husband), with that marriage being legally recognized or capable of being legally recognized in Australia.

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

APPENDIX C:
Domestic Violence Homicide in NSW, 2000-2012

Homicide in NSW, 2000-2012

FIGURE 1: All homicide victims by domestic violence context, NSW, 2000-2012*



*There was one transgender homicide victim who was not killed in domestic violence context

Intimate partner domestic violence homicide, NSW, 2000-2012

FIGURE 2: Intimate partner domestic violence homicide victims by gender, NSW, 2000-2012

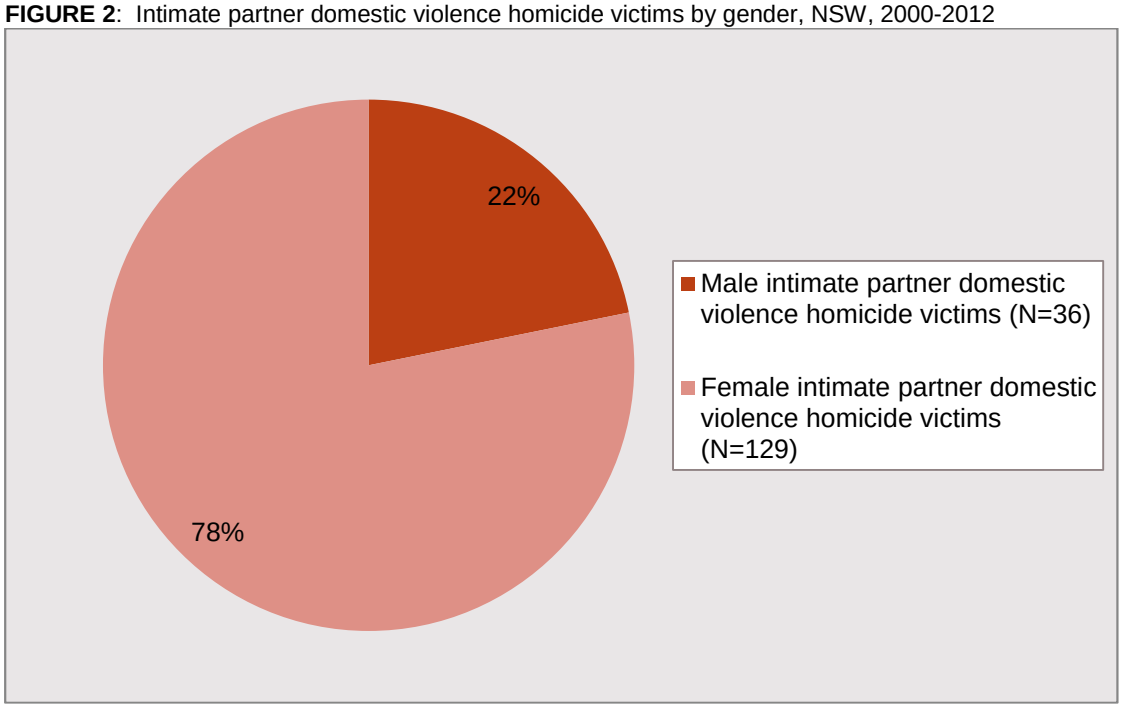


FIGURE 3: Relationship of homicide perpetrator to female intimate partner domestic violence homicide victim, NSW, 2000-2012

RELATIONSHIP TYPE	FEMALE INTIMATE PARTNER HOMICIDE VICTIM	%
HUSBAND	34	26%
DE FACTO HUSBAND	38	29%
BOYFRIEND	8	6%
DIVORCED/ESTRANGED EX HUSBAND	21	16%
FORMER DE FACTO HUSBAND	19	15%
FORMER BOYFRIEND	8	6%
3RD PARTY TO INTIMATE RELATIONSHIP	1	1%
TOTAL	**129**	**100%**

FIGURE 4: Intimate partner homicide victim by victim/abuser status in relationship, NSW, 2000-2012

DOMESTIC VIOLENCE 'STATUS'	MALE INTIMATE PARTNER HOMICIDE VICTIM	FEMALE INTIMATE PARTNER HOMICIDE VICTIM
DOMESTIC VIOLENCE VICTIM	5*	127
DOMESTIC VIOLENCE ABUSER	28	0
EVIDENCE OF VIOLENCE AND ABUSE USED BY BOTH PARTIES	2	2
NEITHER DOMESTIC VIOLENCE VICTIM NOR ABUSER	1#	0
TOTAL	**36**	**129**

* All 5 male intimate partner homicide victims who had been domestic violence victims in the life of the relationship were killed by a male intimate partner.
# One male was the extramarital intimate partner of a woman and was killed by her and her abusive husband acting together.

FIGURE 5: Relationship of homicide perpetrator to male intimate partner homicide victim, NSW, 2000-2012

RELATIONSHIP TYPE	MALE INTIMATE PARTNER HOMICIDE VICTIM (N=36)	%
WIFE	4	11%
DE FACTO WIFE	20	56%
GIRLFRIEND	2	6%
DE FACTO HUSBAND	3	8%
BOYFRIEND	1	3%
DIVORCED/ESTRANGED WIFE	1	3%
FORMER DE FACTO WIFE	2	6%
FORMER GIRLFRIEND	1	3%
FORMER BOYFRIEND	1	3%
3RD PARTY TO INTIMATE RELATIONSHIP	1	3%
TOTAL	**36**	**100%**

FIGURE 6: Intimate partner domestic violence homicide victim by relationship separation, NSW, 2000-2012

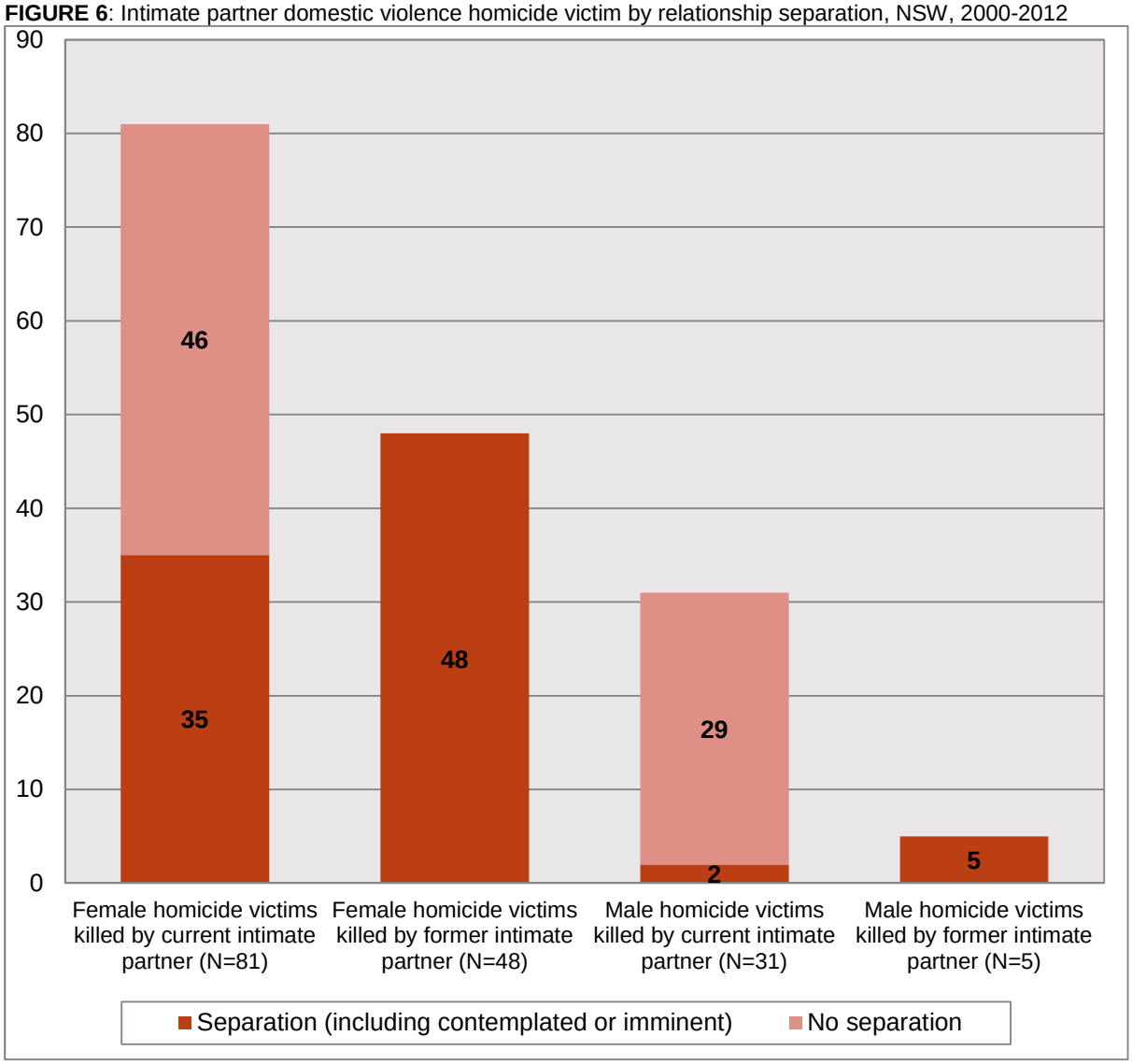


FIGURE 7: Intimate partner domestic violence homicide victim by relationship length, NSW, 2000-2012

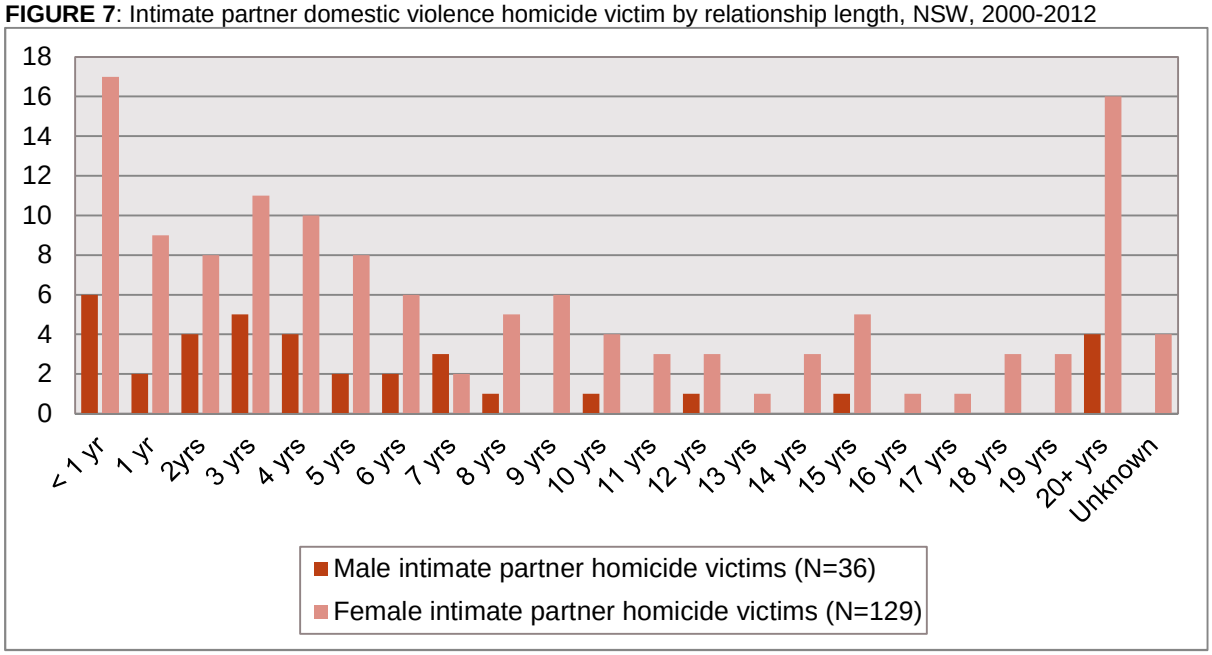


FIGURE 8: Age of intimate partner domestic violence homicide victim, NSW, 2000-2012

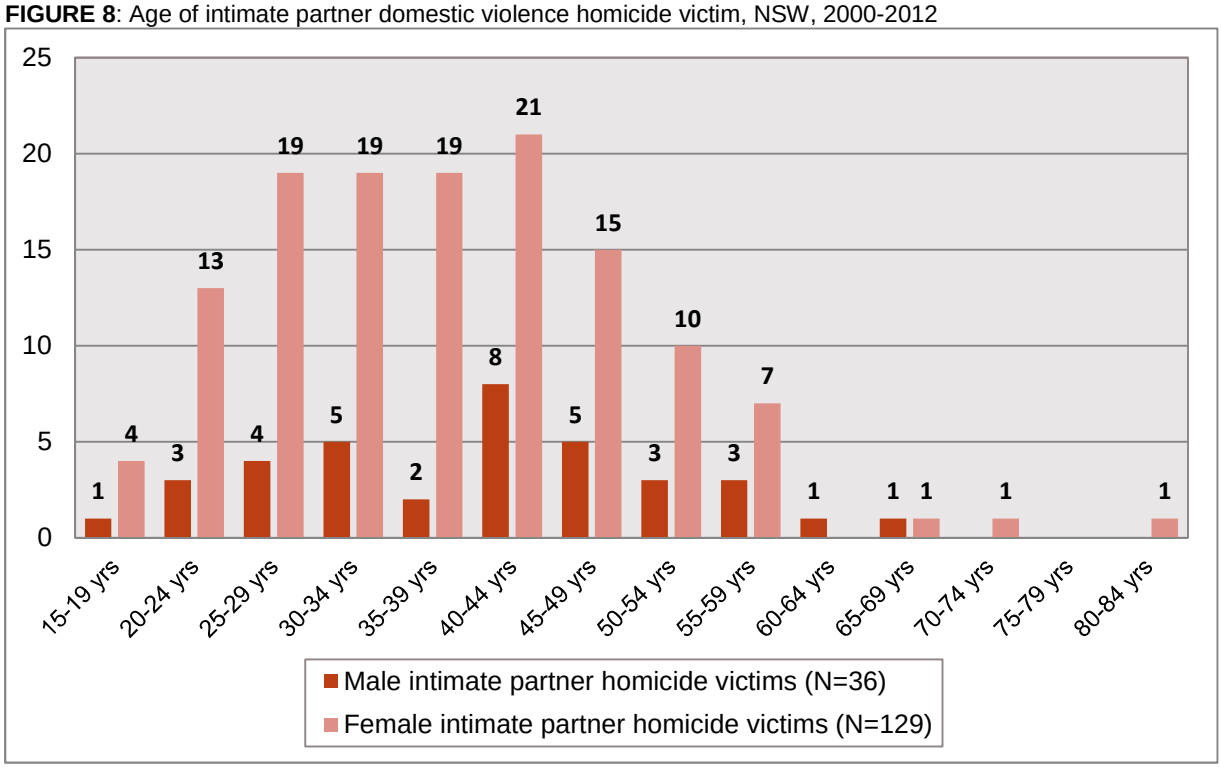


FIGURE 9: Map of NSW Police Regions and Local Area Commands

1 CENTRAL METROPOLITAN REGION
Botany Bay LAC
Eastern Beaches LAC
Eastern Suburbs LAC
Harbourside LAC
Kings Cross LAC
Leichhardt LAC
Miranda LAC
Newtown LAC
Redfern LAC
Rose Bay LAC
St George LAC
Surry Hills LAC
Sutherland LAC
Sydney City LAC

2 NORTH WEST METROPOLITAN REGION
Blacktown LAC
Blue Mountains LAC
Hawkesbury LAC
Holroyd LAC
Kuring Gai LAC
Mount Druitt LAC
North Shore LAC
Northern Beaches LAC
Parramatta LAC
Penrith LAC
Quakers Hill LAC
Ryde LAC
St Marys LAC
The Hills LAC

3 SOUTH WEST METROPOLITAN REGION
Ashfield LAC
Bankstown LAC
Burwood LAC
Cabramatta LAC
Camden LAC
Campbelltown LAC
Campsie LAC
Fairfield LAC
Flemington LAC
Green Valley LAC
Liverpool LAC
Macquarie Fields LAC
Marrickville LAC
Rosehill LAC

4 SOUTHERN REGION
Albury LAC
Cootamundra LAC
Deniliquin LAC
Far South Coast LAC
Griffith LAC
Lake Illawarra LAC
Monaro LAC
Shoalhaven LAC
The Hume LAC
Wagga Wagga LAC
Wollongong LAC

5 NORTHERN REGION
Brisbane Water LAC
Central Hunter LAC
Coffs-Clarence LAC
Hunter Valley LAC
Lake Macquarie LAC
Manning-Great Lakes LAC
Mid North Coast LAC
Newcastle City LAC
Port Stephens LAC
Richmond LAC
Tuggerah Lakes LAC
Tweed-Byron LAC

6 WESTERN REGION
Barrier LAC
Barwon LAC
Canobolas LAC
Castlereagh LAC
Chifley LAC
Darling River LAC
Lachlan LAC
Mudgee LAC
New England LAC
Orana LAC
Oxley LAC

FIGURE 10: Intimate partner domestic violence homicide victim by NSW Police Force Region, NSW, 2000-2012

NSW POLICE FORCE REGION	MALE INTIMATE PARTNER HOMICIDE VICTIMS (N=36)	FEMALE INTIMATE PARTNER HOMICIDE VICTIMS (N=129)	TOTAL	%
CENTRAL METROPOLITAN	6	18	24	15%
NORTH WEST METROPOLITAN	4	30	34	21%
SOUTH WEST METRO	3	19	22	13%
NORTHERN REGION	10	28	38	23%
SOUTHERN REGION	6	17	23	14%
WESTERN REGION	5	13	18	11%
NO FIXED ABODE	1	1	2	1%
INTER STATE/OVERSEAS	1	3	4	2%
TOTAL	**36**	**129**	**165**	**100%**

FIGURE 11: Intimate partner domestic violence homicide victim by country of birth, NSW, 2000-2012

COUNTRY OF BIRTH	MALE HOMICIDE VICTIM (N=36)	FEMALE HOMICIDE VICTIM (N=129)	TOTAL
AUSTRALIA	30	91	121
NEW ZEALAND	1	5	6
LEBANON	1	4	5
INDIA	0	4	4
SERBIA	0	2	2
FIJI	1	1	2
SCOTLAND	0	1	1
BRITAIN	0	1	1
CANADA	0	1	1
MALTA	0	1	1
CROATIA	0	1	1
MACEDONIA	0	1	1
ROMANIA	1	0	1
POLAND	0	1	1
RUSSIA	0	1	1
EGYPT	0	1	1
SUDAN	0	1	1
TURKEY	0	1	1
VIETNAM	0	2	2
INDONESIA	0	1	1
MALAYSIA	0	1	1
CHINA	1	1	2
KOREA	0	1	1
SRI LANKA	0	1	1
ARGENTINA	0	1	1
BRAZIL	0	1	1
CHILE	0	1	1
UNKNOWN	1	1	2
TOTAL	**36**	**129**	**165**

FIGURE 12: Intimate partner domestic violence homicide victim by manner of death, NSW, 2000-2012

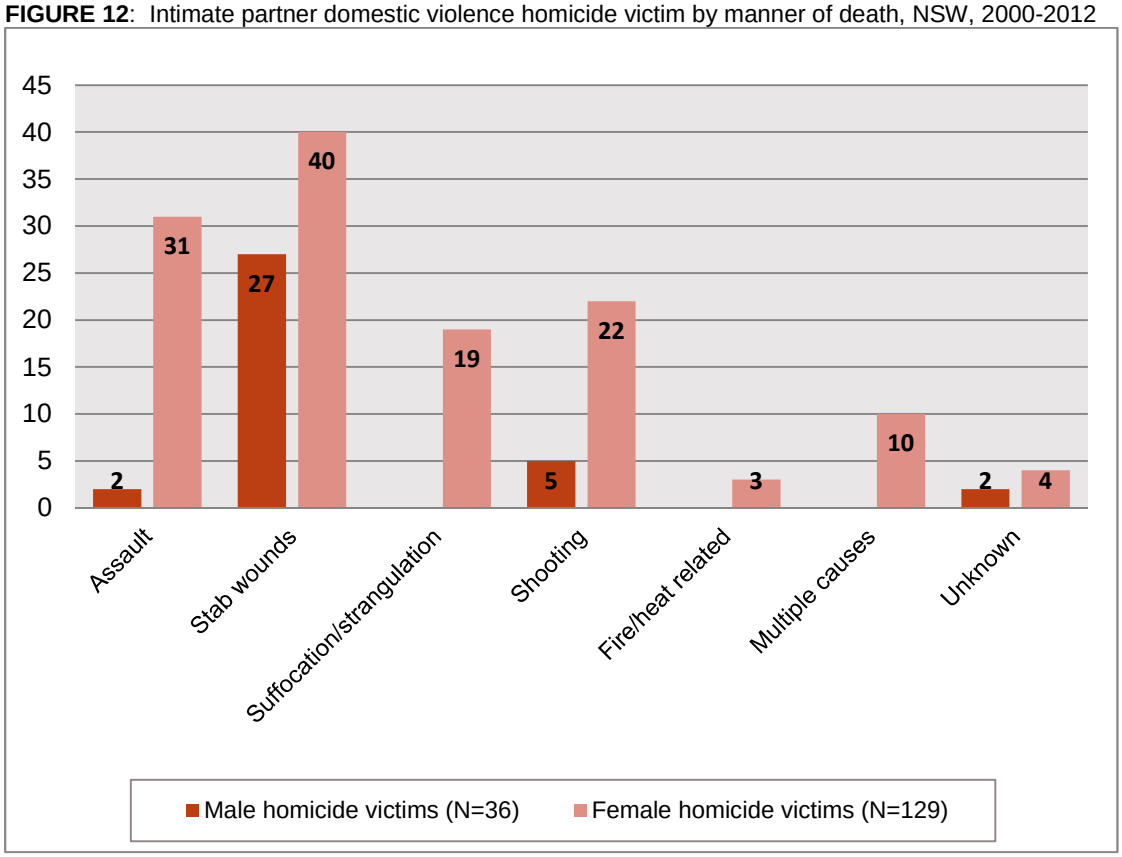


FIGURE 13: Intimate partner domestic violence homicide victim by location of fatal episode, NSW, 2000-2012

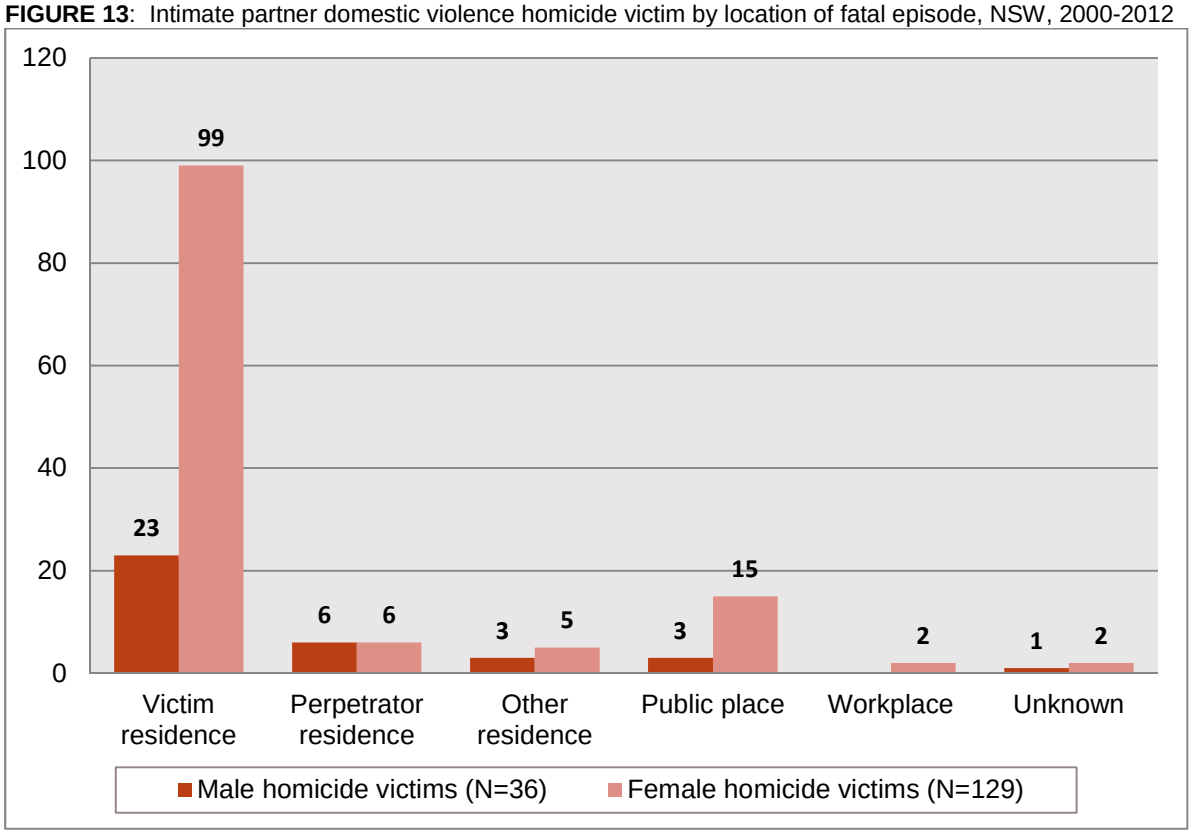


FIGURE 14: Age of intimate partner domestic violence homicide perpetrator, NSW, 2000-2012

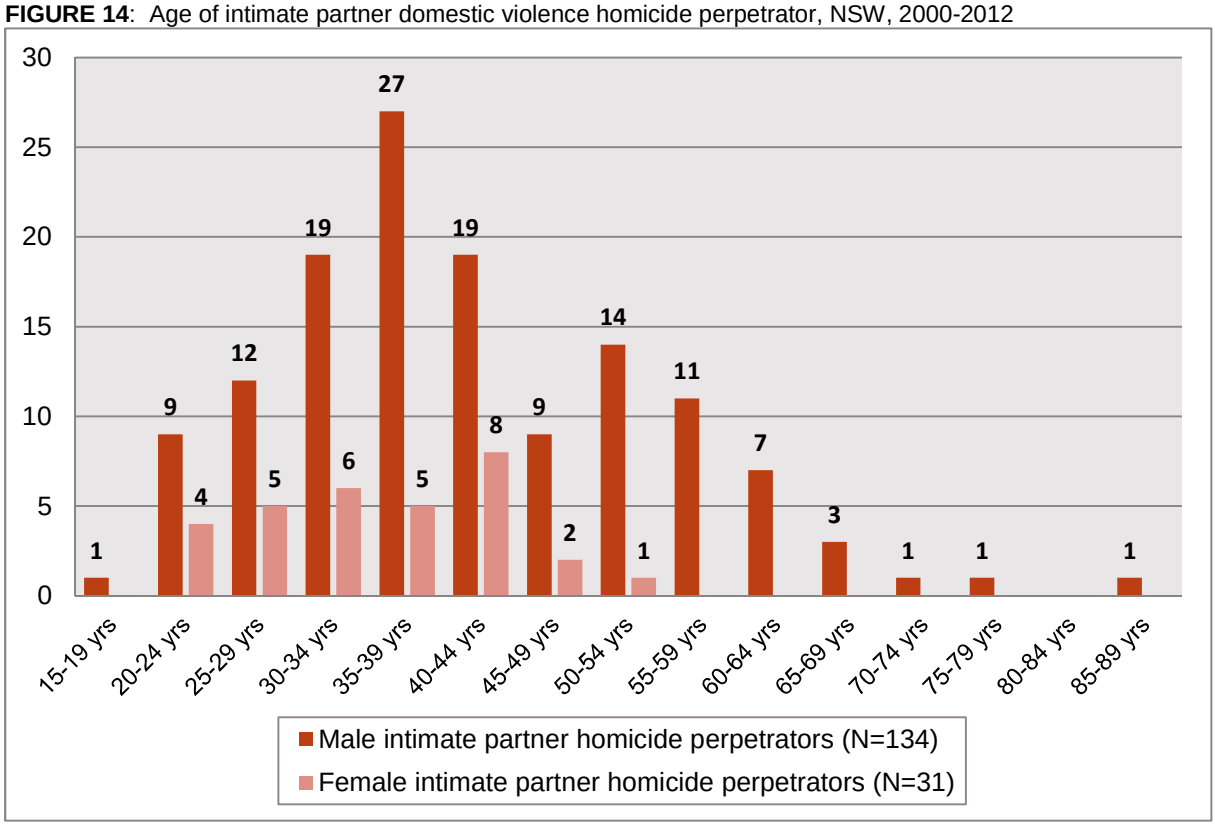
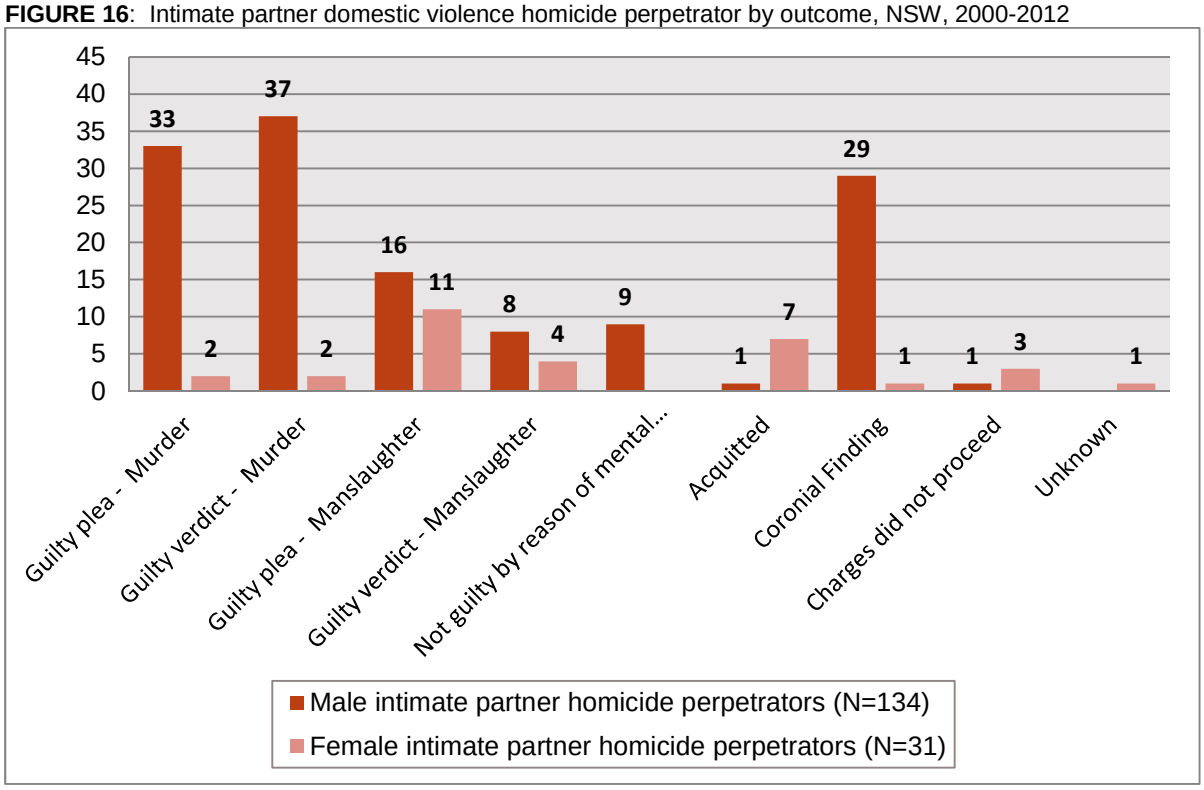


FIGURE 15: Intimate partner domestic violence homicide perpetrator by country of birth, NSW, 2000-2012

COUNTRY OF BIRTH	MALE INTIMATE PARTNER HOMICIDE PERPETRATOR (N=134)	FEMALE INTIMATE PARTNER HOMICIDE PERPERTRATOR (N=31)	TOTAL
AUSTRALIA	93	27	**120**
NEW ZEALAND	4	0	**4**
LEBANON	4	0	**4**
INDIA	4	0	**4**
SERBIA	2	0	**2**
CZECHOSLOVAKIA	1	0	**1**
ARMENIA	0	1	**1**
FIJI (FIJIAN INDIAN)	1	1	**2**
SAMOA	1	0	**1**
IRELAND	1	0	**1**
AUSTRIA	1	0	**1**
FRANCE	1	0	**1**
FINLAND	1	0	**1**
CROATIA	2	0	**2**
GREECE	1	0	**1**
MACEDONIA	1	0	**1**
EGYPT	3	0	**3**
POLAND	1	0	**1**
SUDAN	1	0	**1**
TURKEY	2	0	**2**
VIETNAM	2	0	**2**
INDONESIA	1	0	**1**
MALAYSIA	1	0	**1**
CHINA	0	1	**1**
KOREA	1	0	**1**
SRI LANKA	1	0	**1**
ARGENTINA	1	0	**1**
BRAZIL	1	0	**1**
CHILE	1	0	**1**
UNKNOWN	0	1	**1**
TOTAL	**134**	**31**	**165**

FIGURE 16: Intimate partner domestic violence homicide perpetrator by outcome, NSW, 2000-2012



Relative/kin domestic violence homicides, NSW, 2000-2012

Child homicide victim

FIGURE 17: Relationship of perpetrator to child relative/kin domestic violence homicide victim, NSW, 2000-2012

RELATIONSHIP OF HOMICIDE PERPETRATOR TO CHILD HOMICIDE VICTIM	N	%
BIOLOGICAL FATHER	25	42%
STEP-FATHER/DE FACTO STEP-FATHER	11	18%
BIOLOGICAL MOTHER	16	27%
STEP-MOTHER/FOSTER MOTHER	2	3%
GRANDFATHER	2	3%
BIOLOGICAL MOTHER & FATHER/STEP-FATHER ACTING TOGETHER	4	7%
TOTAL	**60**	**100%**

FIGURE 18: Age of child relative/kin domestic violence homicide victim, NSW, 2000-2012

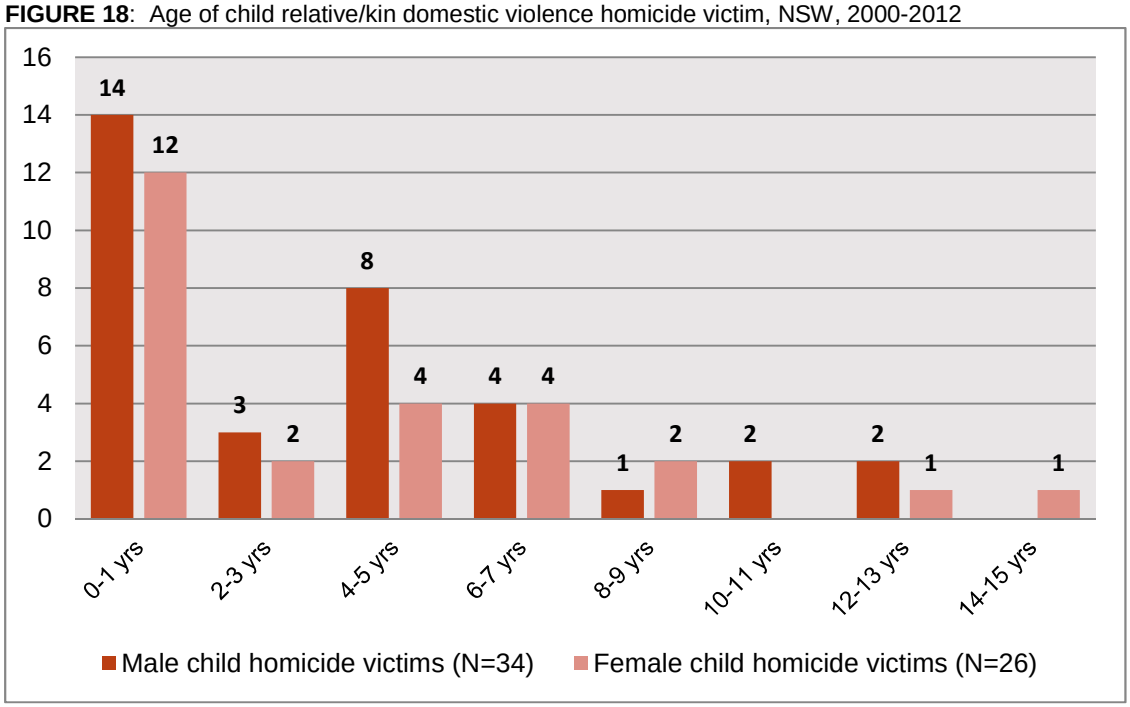


FIGURE 19: Child relative/kin domestic violence homicide victim by NSW Police Force Region, NSW, 2000-2012

NSW POLICE FORCE REGION	CHILD DOMESTIC VIOLENCE HOMICIDE VICTIM (N=60)	%
CENTRAL METROPOLITAN	6	10%
NORTH WEST METROPOLITAN	9	15%
SOUTH WEST METROPOLITAN	12	20%
NORTHERN REGION	17	28%
SOUTHERN REGION	11	18%
WESTERN REGION	4	7%
INTERSTATE/OVERSEAS	1	2%
TOTAL	**60**	**100%**

FIGURE 20: Child relative/kin domestic violence homicide victim by country of birth, NSW, 2000-2012

COUNTRY OF BIRTH	CHILD DOMESTIC VIOLENCE HOMICIDE VICTIM (N=60)	%
AUSTRALIA	59	98
INDIA	1	2
TOTAL	**60**	**100%**

FIGURE 21: Child relative/kin domestic violence homicide victim by manner of death, NSW, 2000-2012

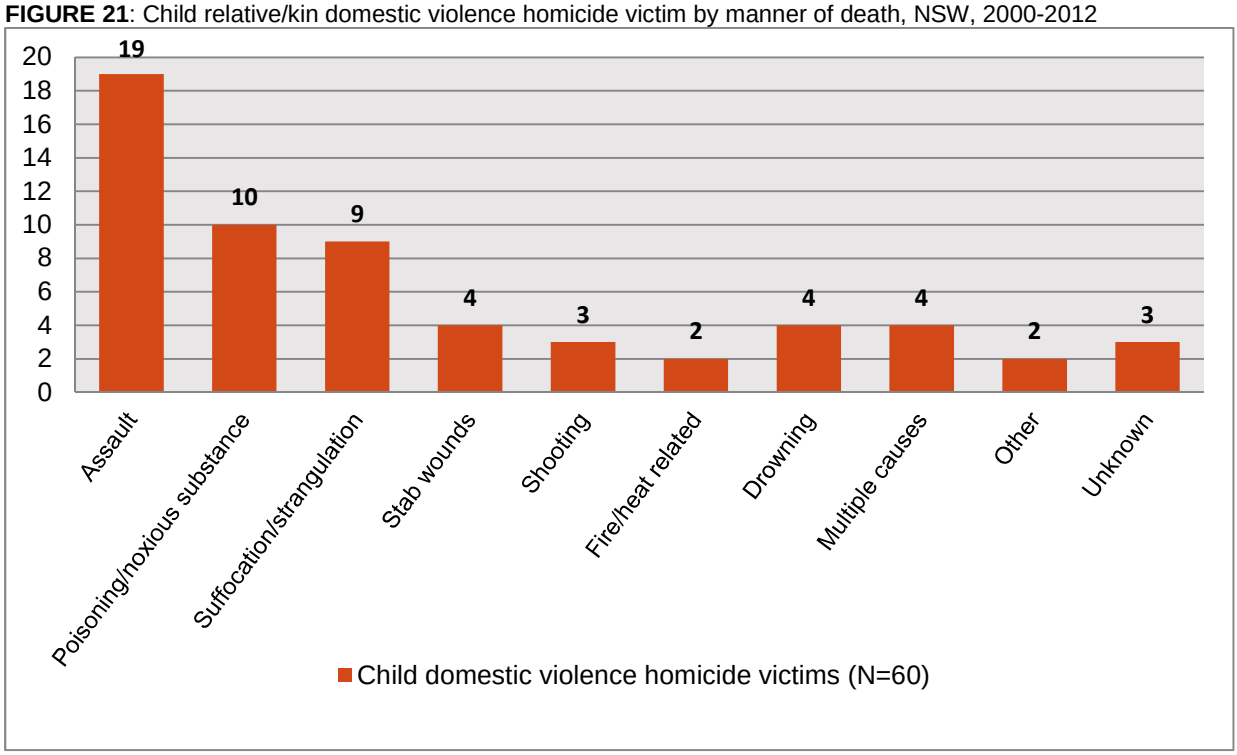


FIGURE 22: Child relative/kin domestic violence homicide victim by location of fatal episode, NSW, 2000-2012

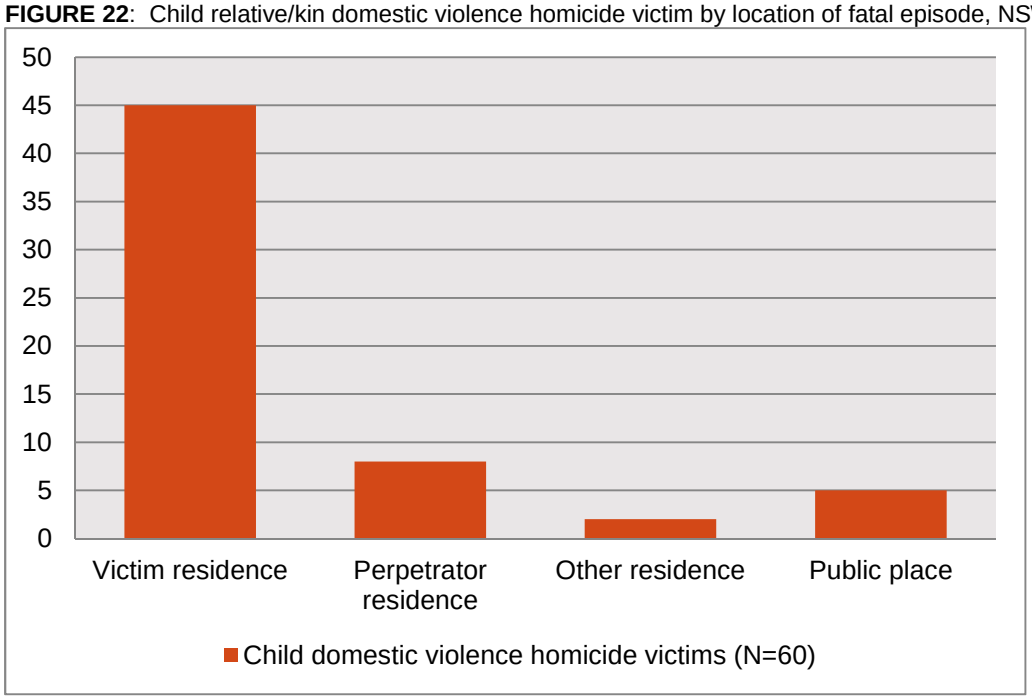


FIGURE 23: Age of child relative/kin domestic violence homicide perpetrator, NSW, 2000-2012

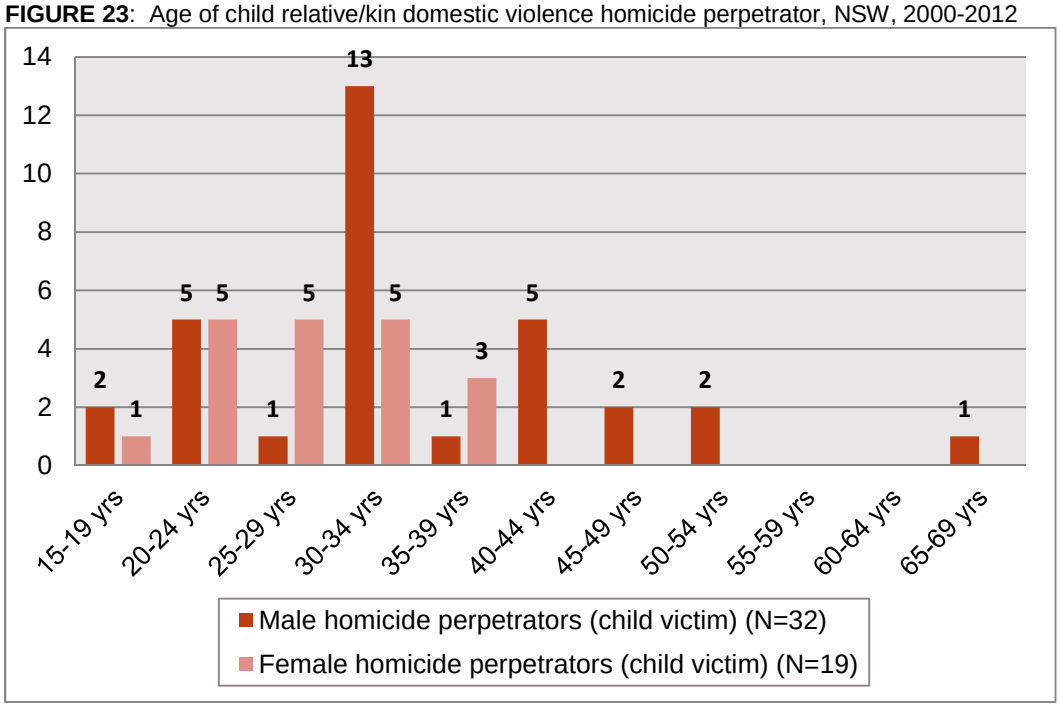
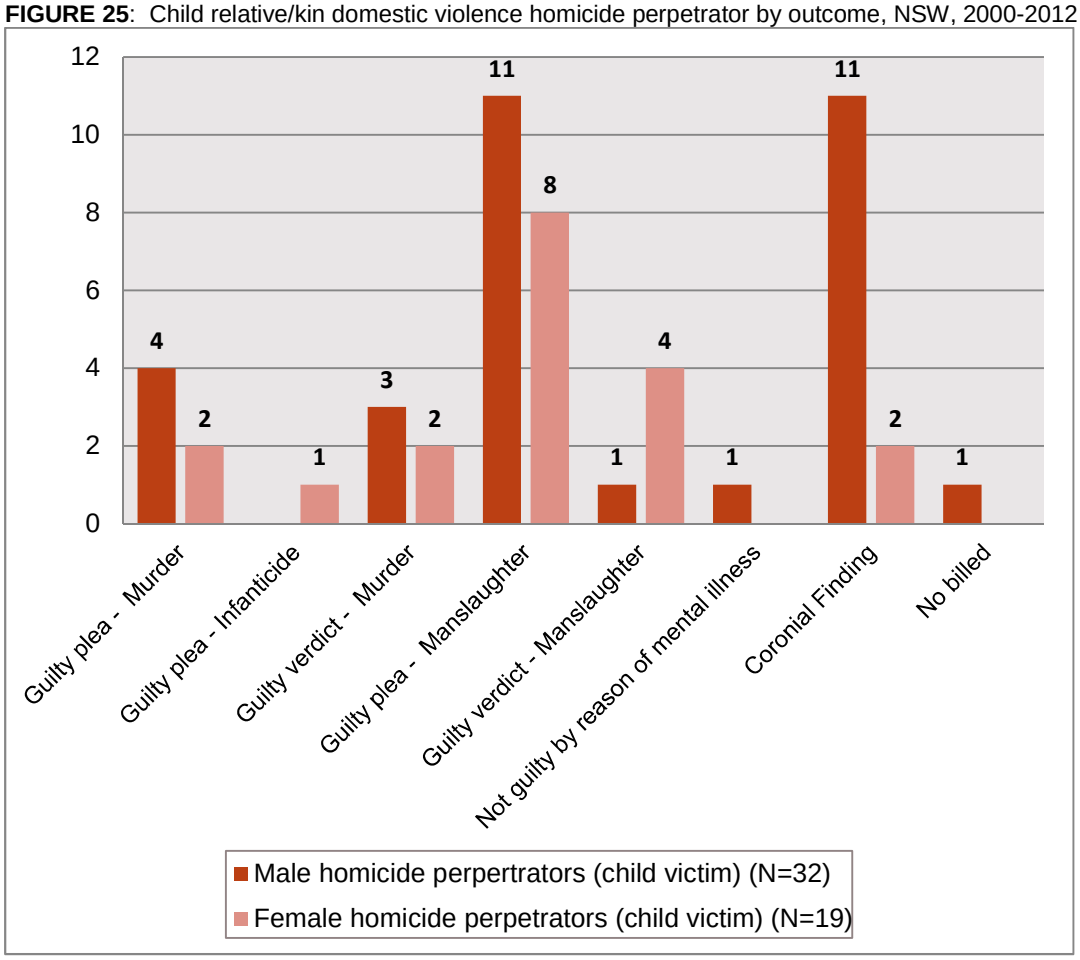


FIGURE 24: Child relative/kin domestic violence homicide perpetrator by country of birth, NSW, 2000-2012

COUNTRY OF BIRTH	MALE HOMICIDE PERPETRATOR (CHILD VICTIM)	FEMALE HOMICIDE PEREPTRATOR (CHILD VICTIM)	TOTAL
AUSTRALIA	24	17	41
NEW ZEALAND	1	1	2
TONGA	1	0	1
UNITED KINGDOM	1	0	1
IRELAND	1	0	1
EGYPT	1	0	1
IRAN	1	0	1
THAILAND	1	0	1
VIETNAM	0	1	1
INDIA	1	0	1
TOTAL	**32**	**19**	**51**

FIGURE 25: Child relative/kin domestic violence homicide perpetrator by outcome, NSW, 2000-2012



Relative/kin domestic violence homicides, NSW, 2000-2012

Adult homicide victims

FIGURE 26: Relationship of homicide perpetrator to adult relative/kin domestic violence homicide victim, NSW, 2000-2012

RELATIONSHIP OF HOMICIDE PERPETRATOR TO DECEASED	MALE HOMICIDE VICTIM (N=19)	FEMALE HOMICIDE VICTIM (N=9)	TOTAL
SON/STEP-SON	6	4	**10**
DAUGHTER/STEP-DAUGHTER	3	2	**5**
SON & DAUGHTER (ACTING TOGETHER)	0	1	**1**
BROTHER	2	0	**2**
BROTHER IN LAW	2	1	**3**
FATHER	1	0	**1**
MOTHER-IN-LAW	1	0	**1**
NEPHEW	1	1	**2**
SON-IN-LAW (INCLUDING DE FACTO)	3	0	**3**
TOTAL	**19**	**9**	**28**

FIGURE 27: Age of adult relative/kin domestic violence homicide victim, NSW, 2000-2012

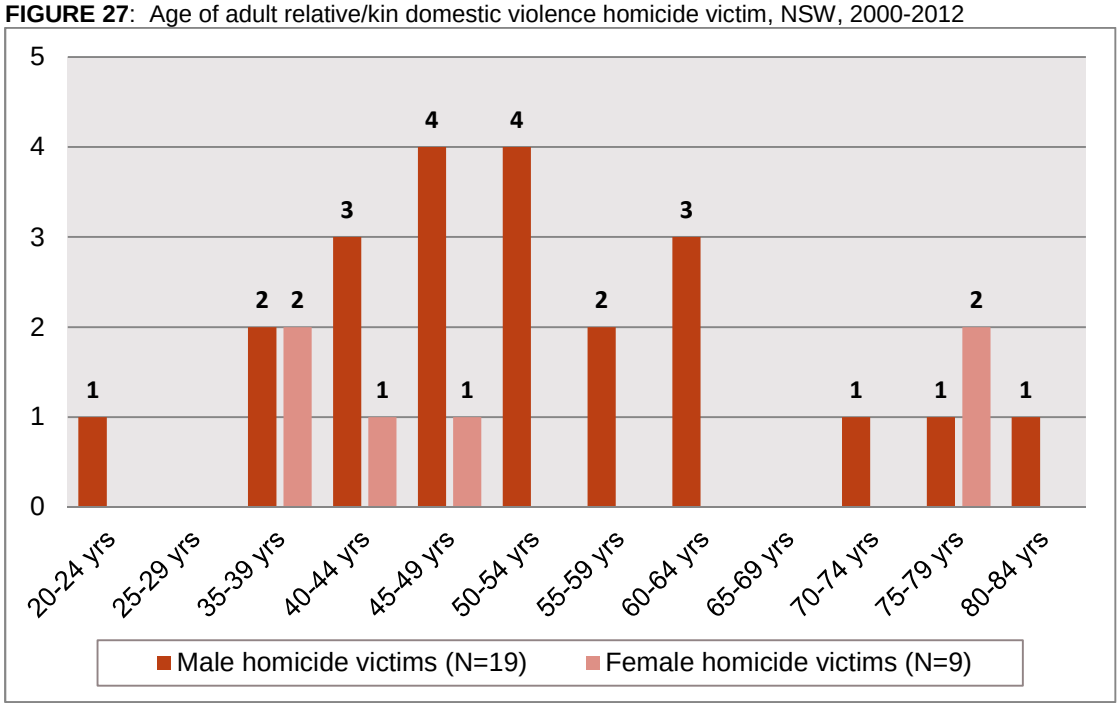


FIGURE 28: Adult relative/kin domestic violence homicide victim by NSW Police Force Region, NSW, 2000-2012

NSW POLICE FORCE REGION	ADULT RELATIVE/KIN DOMESTIC VIOLENCE HOMICIDE VICTIM (N=28)	%*
CENTRAL METROPOLITAN	1	4%
NORTH WEST METROPOLITAN	6	%
SOUTH WEST METROPOLITAN	8	29%
NORTHERN REGION	10	36%
SOUTHERN REGION	1	4%
WESTERN REGION	2	7%
TOTAL	**28**	

*percentages do not add to %100 due to rounding

FIGURE 29: Adult relative/kin domestic violence homicide victim by country of birth, NSW, 2000-2012

COUNTRY OF BIRTH	ADULT MALE RELATIVE/KIN DOMESTIC VIOLENCE HOMICIDE VICTIMS (N=19)	ADULT FEMALE RELATIVE/KIN DOMESTIC VIOLENCE HOMICIDE VICTIMS (N=9)	TOTAL
AUSTRALIA	10	7	17
LEBANON	2	0	2
UNITED KINGDOM	2	1	3
NEW ZEALAND	1	0	1
INDONESIA	0	1	1
ITALY	1	0	1
ROMANIA	1	0	1
IRAQ	1	0	1
CROATIA	1	0	1
TOTAL	**19**	**9**	**28**

FIGURE 30: Adult relative/kin domestic violence homicide victim by manner of death, NSW, 2000-2012

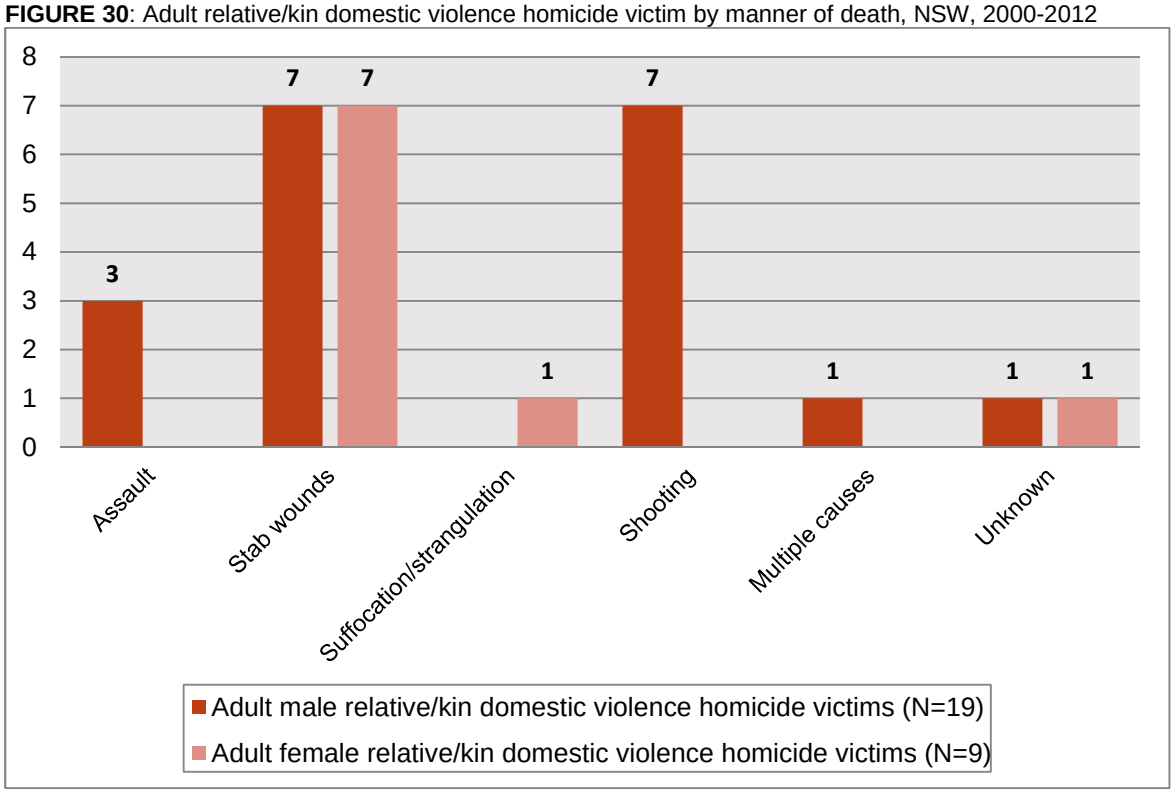


FIGURE 31: Adult relative/kin domestic violence homicide victim by location of fatal episode, NSW, 2000-2012

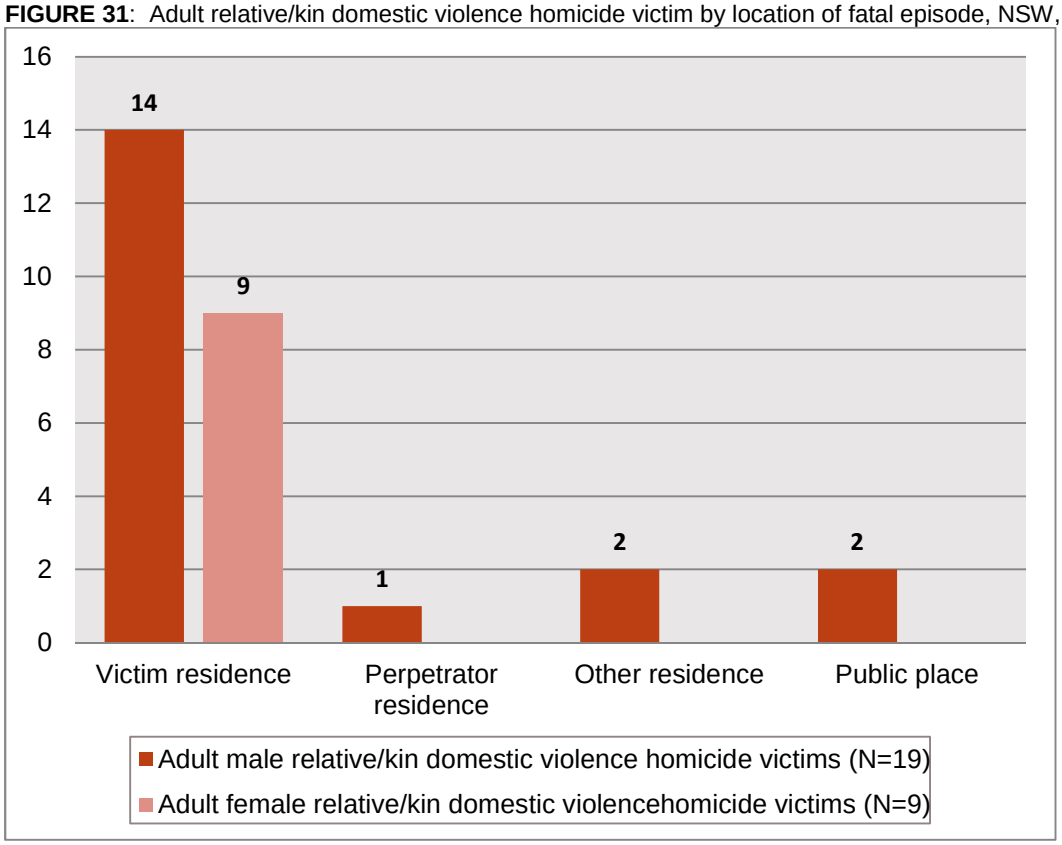


FIGURE 32: Age of adult relative/kin domestic violence homicide perpetrator, NSW, 2000-2012

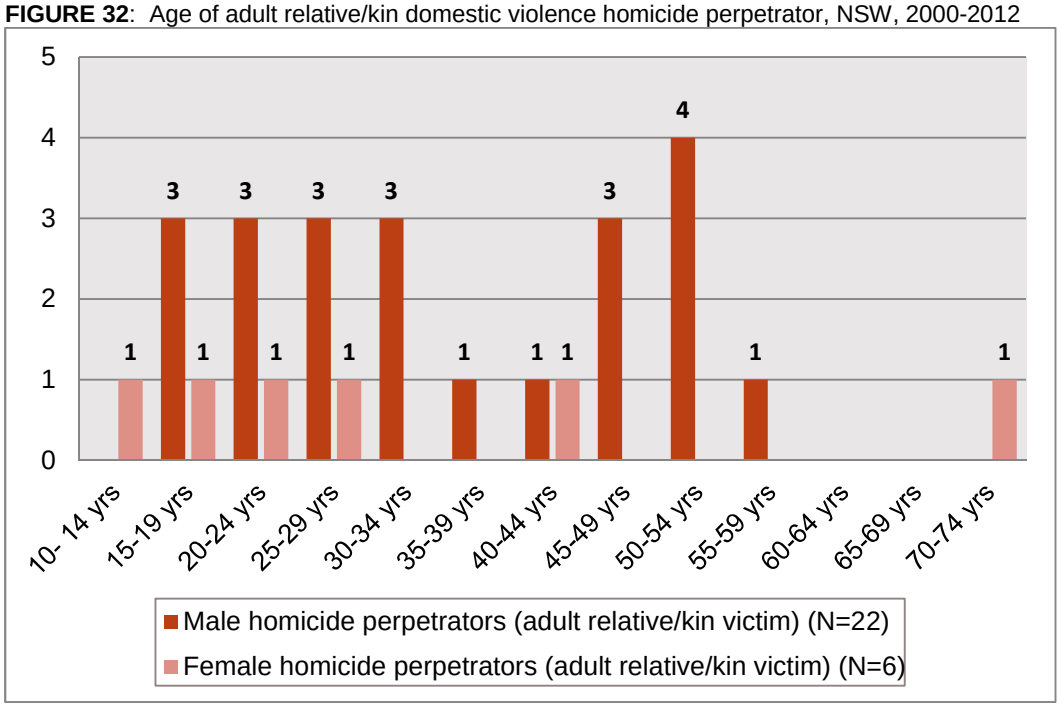
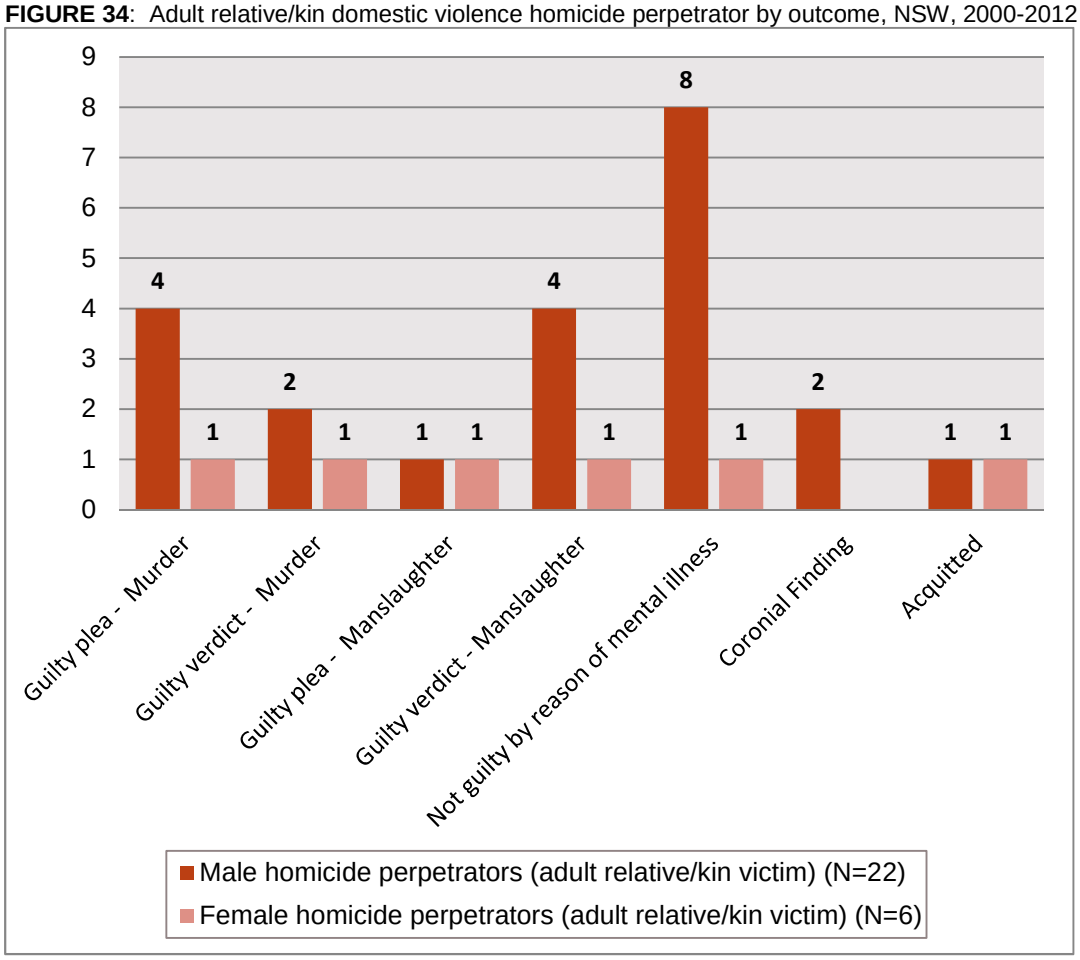


FIGURE 33: Adult relative/kin domestic violence homicide perpetrator by country of birth, NSW, 2000-2012

COUNTRY OF BIRTH	MALE HOMICIDE PERPETRATOR (ADULT RELATIVE/KIN VICTIM)	FEMALE HOMICIDE PERPETRATOR (ADULT RELATIVE/KIN VICTIM)	TOTAL
AUSTRALIA	14	5	19
UNITED KINGDOM	0	1	1
ITALY	1	0	1
ROMANIA	1	0	1
IRAQ	1	0	1
LEBANON	2	0	2
THAILAND	1	0	1
PHILLIPINES	1	0	1
INDONESIA	1	0	1
TOTAL	**22**	**6**	**28**

FIGURE 34: Adult relative/kin domestic violence homicide perpetrator by outcome, NSW, 2000-2012



'Other' domestic violence homicides, NSW, 2000-2012

FIGURE 35: Age of 'other' domestic violence homicide victim, NSW, 2000-2012

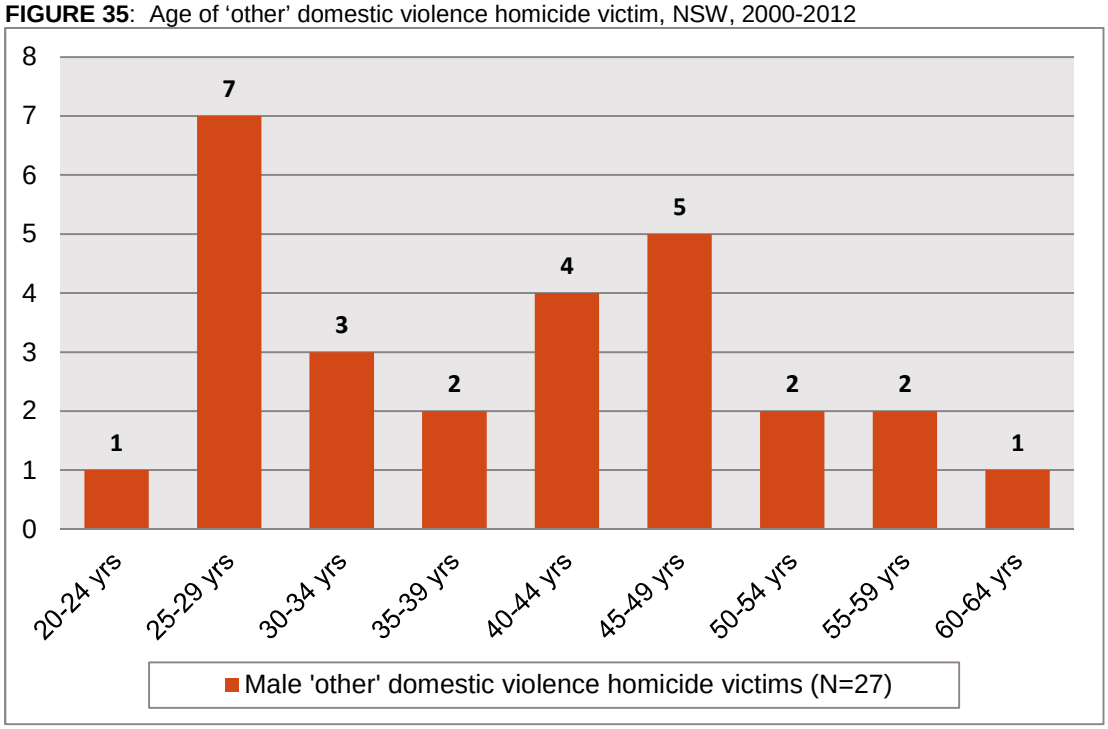


FIGURE 36: 'Other' domestic violence homicide victim by NSW Police Force Region, NSW, 2000-2012

NSW POLICE FORCE REGION	'OTHER' DOMESTIC VIOLENCE HOMICID VICTIM (N=27)	%
CENTRAL METROPOLITAN	5	18.5%
NORTH WEST METROPOLITAN	4	14.8%
SOUTH WEST METROPOLITAN	3	11.1%
NORTHERN REGION	6	22.2%
SOUTHERN REGION	4	14.8%
WESTERN REGION	4	14.8%
INTERSTATE	1	3.7%
TOTAL	**27**	**99.9***

* Figures don't add to 100 due to rounding.

FIGURE 37: 'Other' domestic violence homicide victim by country of birth, NSW, 2000-2012

COUNTRY OF BIRTH	'OTHER' DOMESTIC VIOLENCE HOMICIDE VICTIM (N=27)	%
AUSTRALIA	21	77.8%
MALAYSIA	1	3.7%
COOK ISLANDS	1	3.7%
FIJI	1	3.7%
UNITED KINGDOM	1	3.7%
NETHERLANDS	1	3.7%
KOREA	1	3.7%
TOTAL	**27**	**100%**

FIGURE 38: 'Other' domestic violence homicide victim by manner of death, NSW, 2000-2012

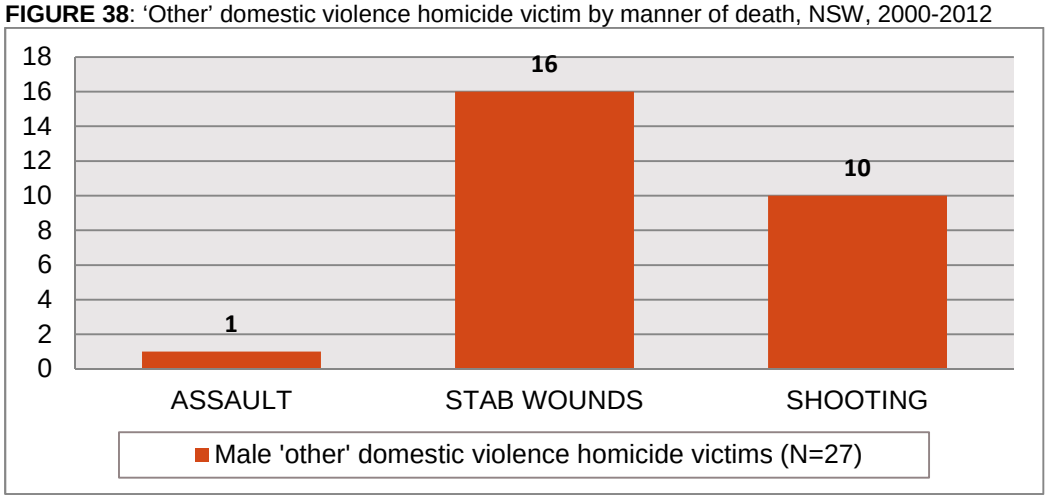


FIGURE 39: 'Other' domestic violence homicide victim by location of fatal episode, NSW, 2000-2012

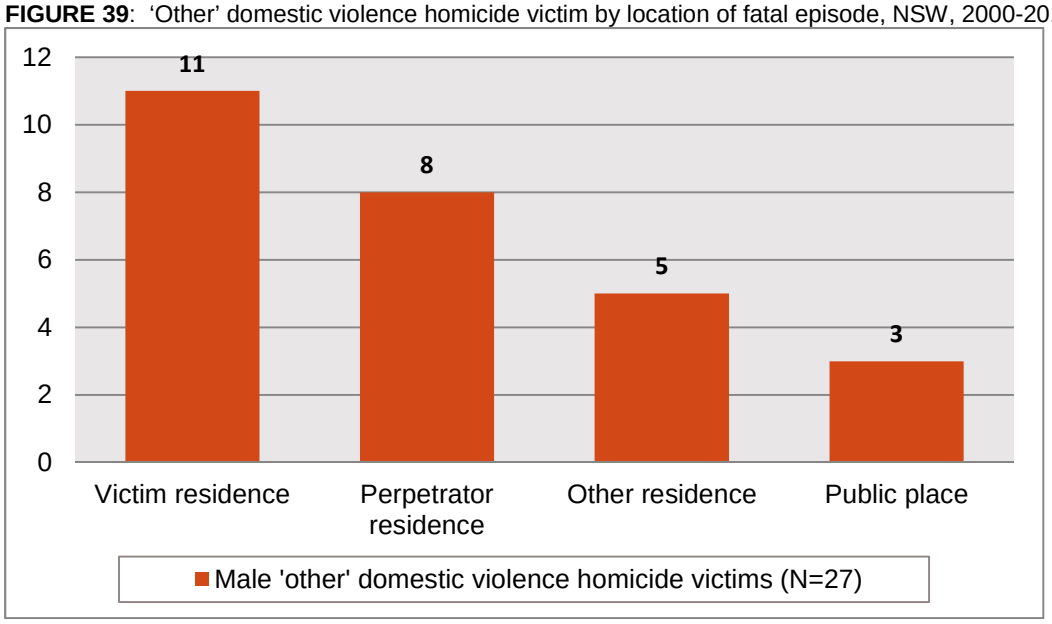


FIGURE 40: Age of 'other' domestic violence homicide perpetrator, NSW, 2000-2012

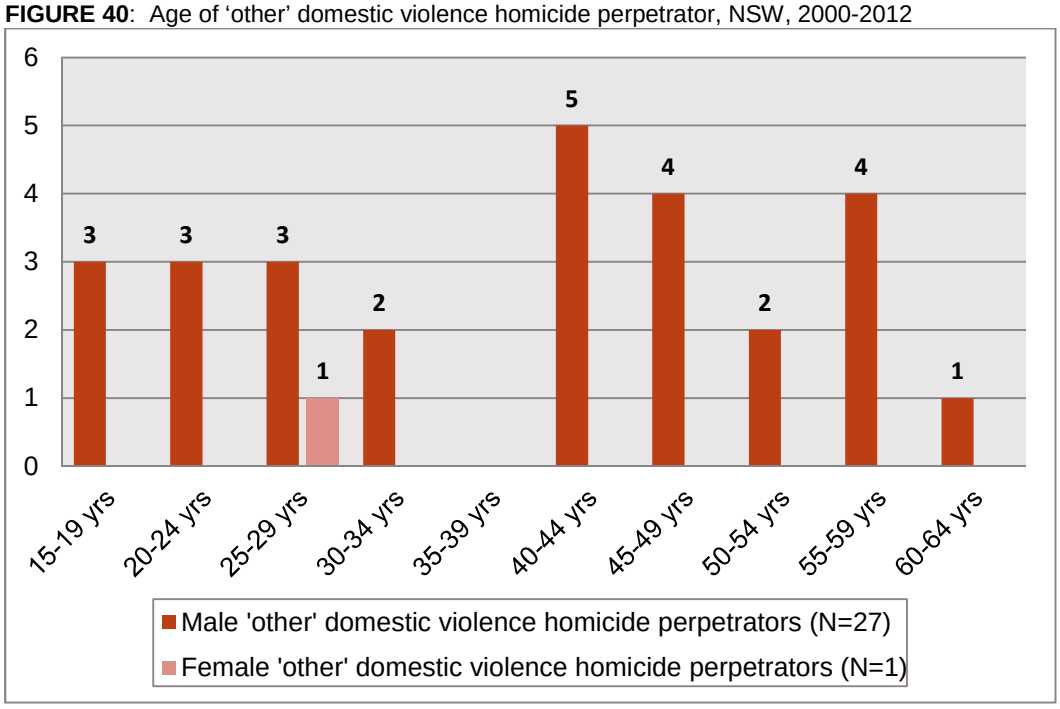
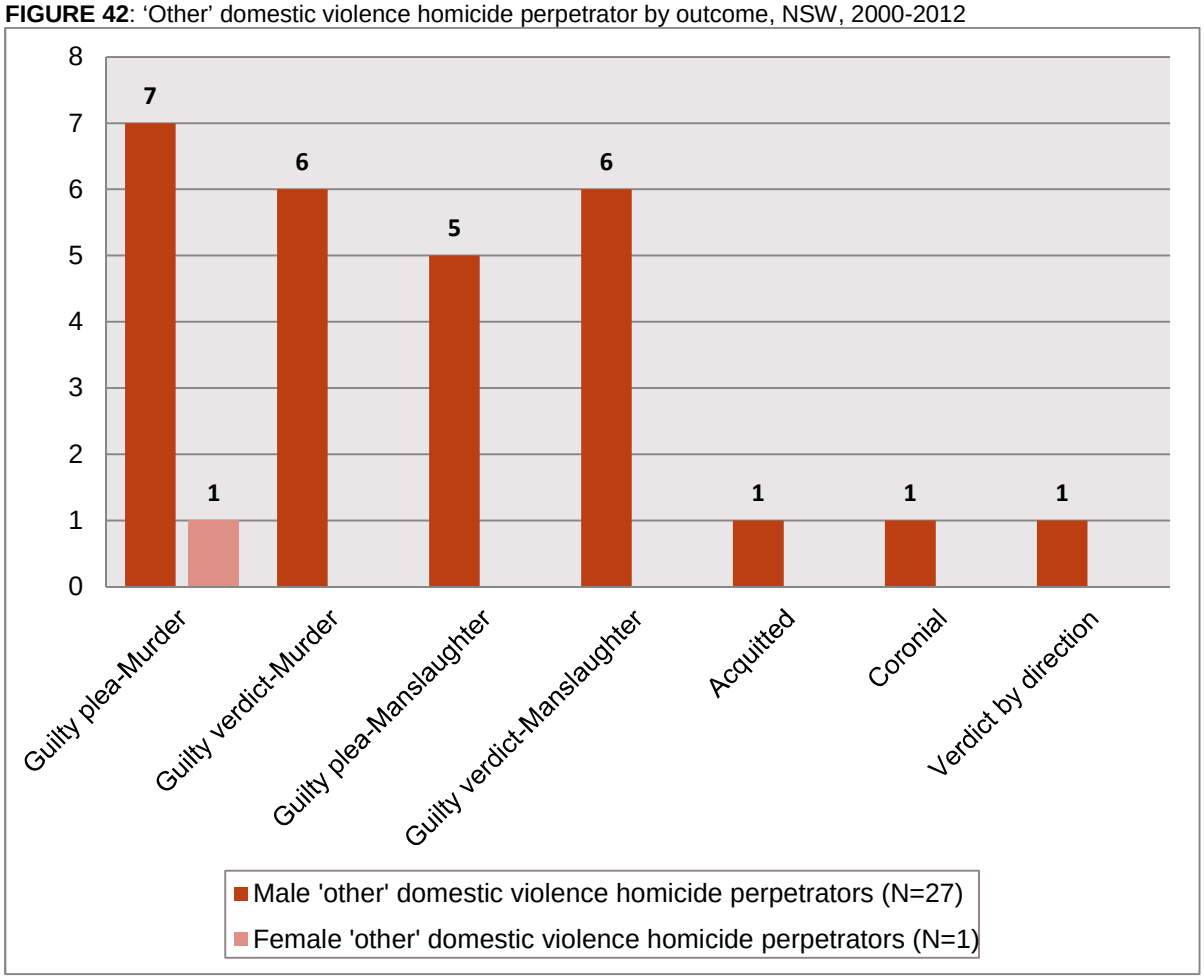


FIGURE 41: 'Other' domestic violence homicide perpetrator by country of birth, NSW, 2000-2012

COUNTRY OF BIRTH	MALE 'OTHER' DOMESTIC VIOLENCE HOMICIDE PERPETRATORS(N=27)	FEMALE 'OTHER' DOMESTIC VIOLENCE HOMICIDE PERPETRATORS (N=1)	TOTAL
AUSTRALIA	17	1	18
INDONESIA	2	0	2
LEBANON	1	0	1
COOK ISLANDS	1	0	1
FIJI	1	0	1
BRITAIN	1	0	1
NETHERLANDS	1	0	1
KOREA	1	0	1
HUNGARY	1	0	1
PHILIPPINES	1	0	1
TOTAL	**27**	**1**	**28**

FIGURE 42: 'Other' domestic violence homicide perpetrator by outcome, NSW, 2000-2012



APPENDIX D: Australian Domestic & Family Violence Death Review Network

AUSTRALIAN DOMESTIC AND FAMILY VIOLENCE DEATH REVIEW NETWORK TERMS OF REFERENCE

Background and position summary

Domestic and family violence has a devastating impact on individuals and communities. It is a complex phenomenon and includes: child abuse; violence between siblings; violence by adolescents against parents; elder abuse; carer abuse; violence between same-sex partners; and violence perpetrated by women against their male intimate partners. However, in the overwhelming majority of cases, domestic and family violence is perpetrated by males against their female intimate partner.

Domestic and family violence can also be fatal. A significant proportion of all homicide victims are killed by a person with whom they share or have shared a domestic relationship i.e. a current or former intimate partner or family member. Women are significantly over represented in this category of homicide.

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

Domestic and Family Violence Death Review Context

Background to establishment

Despite the prevalence of deaths that occur in the context of domestic and family violence, there has not, until recently, been a mechanism for the systematic review of these deaths in any Australian jurisdiction.

For well over a decade, domestic and family violence death review processes have been operational in a number of international jurisdictions, most notably in the United States where domestic violence fatality review teams were first established in the early 1990s. Since that time, domestic and family violence death reviews have also been established in Canada, the United Kingdom and New Zealand.

The broad objective of these reviews is to identify potential areas for improvement in systemic responses to domestic and family violence. Domestic and family violence death reviews operate with a view to identifying patterns and commonalities between deaths for the purposes of reform. Such processes are effective in identifying and addressing weaknesses in service delivery and systems related to domestic and family violence.

In the mid-2000s, there was a call for the establishment of domestic and family violence death review processes in Australia. Within the past five years, Victoria, Queensland, New South Wales, South Australia and Western Australia have each implemented a domestic and family violence death review function with dedicated resources. In 2015 a pilot death review process was commenced in the Australian Capital Territory.

National Policy Context

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

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

Existing Australian domestic and family violence death review mechanisms

Victoria

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

The VSRFVD has five main aims, which are to:

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

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

New South Wales

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

The DVDRT is convened by the NSW State Coroner and is constituted by representatives from 12 key government stakeholders, including law enforcement, justice, health and social services, as well as four representatives from non-government agencies.

The core legislative functions of the DVDRT are to:

- Review and analyse individual closed cases of domestic violence deaths (as defined in the *Coroners Act 2009*);
- Establish and maintain a database so as to identify patterns and trends relating to such deaths; and

- Develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths.

The DVDRT reports annually to the NSW Parliament.

Queensland

The Domestic and Family Violence Death Review Unit ('DFVDRU') was established in the Office of the State Coroner in January 2011 and provides assistance to coroners investigating domestic and family violence related deaths under the *Coroners Act 2003* with a view to ensuring the investigation examines the context in which the death occurred and identifies systemic shortcomings and opportunities to prevent future deaths. The DFVDRU assists coroners to formulate preventive recommendations for those investigations that proceed to inquest.
The DFVDRU undertakes research in relation to domestic and family violence, which can be used to contextualise and inform coronial findings and recommendations. The DFVDRU also maintains a dataset of domestic and family violence related homicides and suicides.

The DFVDRU's definitions align with the *Domestic and Family Violence Protection Act 2012*.

South Australia

In response to election commitments made by the current South Australian Government, the Office for Women and the SA Coroner's Court have undertaken a partnership to research and investigate domestic violence related deaths. The position of Senior Research Officer (Domestic Violence) was established in January 2011 as an initiative of the South Australian *A Right to Safety* ('ARTS') reform agenda.
This position works collaboratively with the ARTS reporting and advisory structure and reports on outcomes to the Chief Executive Group (chaired by the Minister for the Status of Women) which oversees ARTS outcomes.
The position is based within the South Australian Coroner's Office and works as part of the Coronial investigation team to:

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

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

Western Australia

On 1 July 2012, the Ombudsman commenced a new role to review family and domestic violence fatalities. For the purposes of this jurisdiction, a family or domestic relationship has the same meaning as given to it under section 4 of the *Restraining Orders Act 1997* (WA).
The Ombudsman has a number of functions in relation to the review of family and domestic violence fatalities:

- Reviewing the circumstances in which and why family and domestic violence deaths occur;
- Identifying patterns and trends that arise from reviews of family and domestic violence deaths; and
- Making recommendations to public authorities about ways to prevent or reduce family and domestic violence deaths.

The Ombudsman reports comprehensively on family and domestic fatalities.

Common elements of review teams

The following are common elements across all existing Australian domestic and family violence death review mechanisms.

- Each is underpinned by the view that domestic and family violence-related deaths are largely preventable.
- Each operates in accordance with State-based legislation and state determined governance structure.
- Each State clearly defines relationships and behaviours that amount to domestic and family violence.
- Each adopts review criteria which facilitate the review of homicides, homicide/suicides and suicides where such deaths have occurred in a context of domestic and family violence.
- Each review individual deaths with a domestic violence context as well as identifying data trends and patterns across multiple deaths.

ADFVDR Network Overview

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

- The Victorian Systemic Review of Family Violence Deaths (Vic)
- The Domestic Violence Death Review Team (NSW);
- The Domestic and Family Violence Death Review Unit (Qld);
- The Domestic Violence Unit (SA); and
- The Reviews Team (WA).

Special Observer Membership of the ADFVDRN

Special observers are invited to participate in discussions and Network processes but do not have formal voting rights. The addition of Special Observers recognises that domestic and family violence death review processes are established and operational outside of Australia and can contribute to the knowledge and development of the work undertaken by the ADFVDRN.

Special Observer Members

New Zealand

New Zealand's Family Violence Death Review Committee (FVDRC) was established in 2008 following a recommendation by the *Taskforce for Action on Violence within Families*, and support from the family violence sector. In April 2011, following amendments to the *New Zealand Public Health and Disability Act 2000* ('the Act'), the Committee became the responsibility of the Health Quality & Safety Commission ('HQSC'). The Committee is located in the Commission and operates in close collaboration with the Ministries of Health, Justice and Social Development, the New Zealand Police, and other key government and community agencies. The Committee operates under the Act and is accountable to the Commission.
The FVDRC's functions are to:

- Review and report on family violence deaths, with a view to reducing the numbers of deaths and to continuous quality improvement through the promotion of ongoing quality assurance programs;
- Develop strategic plans and methodologies that are designed to reduce family violence morbidity and mortality and are relevant to the Committee's functions; and
- Advise on any other matters related to family violence deaths that the HQSC specifies.

In order to fulfill these functions, the FVDRC collects data on family violence deaths, reviews selected deaths via a multi-sectoral review process, identifies trends and patterns over time and makes local and national recommendations.

Purpose

The overarching goals of the Network are to:

- Better understand the context and circumstances in which domestic and family violence-related deaths occur;
- Identify practice and system changes that may prevent or reduce the likelihood of domestic and family violence-related deaths;
- 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 recommendations at a National level.

Scope

The Scope of the activities of the Network includes:

- Using the learning and outcomes of State-based review processes to benefit the work of other Network members. This shall include comparing and reporting on findings across jurisdictions;
- Defining minimum case inclusion criteria and developing standardised minimum data sets across each jurisdiction to contribute to the development of minimum standard national data in relation to domestic and family violence-related deaths; and
- Sharing information and evidence relating to the identification of domestic and family violence risk factors.

  Some key areas of consideration may include:

  - Identifying common risk factors and system failures in the lead-up to a death; and
  - The development of policies and recommendations to State and Federal government.

Governance

Membership

- Membership consists of persons or agreed representatives from each State-based domestic and family violence death review.
- Membership is closed and new membership and special observer requests will be determined by standing members of the Network, based on the compatibility of the function or unit with the purpose of the Network.
- Membership decisions will be formally documented and relayed to the requesting person or authority in writing by the Chairperson.
- Network meetings are restricted to Network members, officially recognised special observers and, by agreement, invited guests.
- The Network can, by agreement, request advice, support and/or consult with outside agencies or individuals as required.

Confidentiality Provisions

- Maintaining confidentiality is critical to the functioning of the Network. Due to the sensitive nature of the information discussed, information discussed in the Network is confidential and non-disclosure requirements apply.
- Where the State-based death review is involved in reviewing open coronial matters there will be specific legislative confidentiality provisions required of each participant. It is the responsibility of individual members to be aware of and adhere to their particular legislative requirements regarding confidentiality.

Decision Making

- Each Member State is responsible for making decisions in line with their employment and legislative responsibilities. This includes seeking appropriate permission, advice and authority to advance information or participate in decision-making where necessary.
- Decisions will be made on the basis of unanimous consent. Where unanimous consent cannot be obtained a majority vote will carry a decision, with each Member State having one vote.
- All dissent to a majority-based decision will be formally documented and recorded. Where the decision is, by agreement, distributed beyond the Network, all dissent must accompany that conveyance.
- The Chairperson will document all decisions and actions arising from each Network meeting.
- All actions and decisions arising from each Network meeting will be recorded on a formal 'Action/Decision Running Sheet' and distributed to members in confidence prior to the next meeting.

Meeting Frequency

- Meetings will be held, either by teleconference or face-to-face, at least four times per year. Meetings may occur more frequently as determined by the needs of the Network.

Roles and Responsibilities

Members

- All members are responsible for seeking relevant permissions, advice or authority before participating in decision-making and agree to adhere to the statutory or legislative requirements of their role.
- All members agree to contribute and cooperate in good faith and declare any conflict of interest or other disclaimers at the first possible opportunity or realisation of that conflict.
- All members may submit agenda items and papers for consideration by the Network and should endeavour to do so in a timely fashion for inclusion in the meeting agenda.
- Each member is responsible for keeping their own records of discussion from meetings.

Chairperson

The position of Chairperson will rotate between members on an annual basis. Appointment of the Chairperson will be by agreement of the Network members at the end of each calendar year and should not be undertaken in consecutive years by any representative from the same State.

The roles and responsibilities of the Chairperson include:

- Preparing and disseminating the meeting agenda and relevant documents in a timely manner;
- Ensuring the Network operates in a manner consist and in alignment with the Terms of Reference;
- Moderating decision-making processes;

- Minuting all decisions and actions arising from each meeting and distribution of these minutes to members as soon as practicable after the conclusion of each meeting;
- Maintaining a history of all documents produced as part of the Network and transferring that catalogue of information to the next nominated Chairperson; and
- With prior agreement by the Network, distributing information about the Network, making comment on Network matters (as appropriate), responding to enquiries and correspondence, requests for membership or meeting attendance and other such matters.

Last updated September 2015

AUSTRALIAN DOMESTIC AND FAMILY VIOLENCE DEATH REVIEW NETWORK DOMESTIC AND FAMILY VIOLENCE HOMICIDE CONSENSUS STATEMENT

Background and Purpose

Following the implementation of domestic and family violence death review mechanisms in several Australian jurisdictions, the Australian Domestic and Family Violence Death Review Network ("the Network") was established in March 2011. The Network comprises representatives from each of the established Australian death review teams, namely:

- Domestic Violence Death Review Team (New South Wales);
- Domestic and Family Violence Death Review Unit (Queensland);
- Domestic and Family Violence Death Review (South Australia);
- Victorian Systemic Review of Family Violence Deaths (Victoria); and
- Review Team Ombudsman (Western Australia).

The overarching goals of the Network are to, at a national level:

- improve knowledge regarding the frequency, nature and determinants of domestic and family violence deaths;
- identify practice and system changes that may improve outcomes for people affected by domestic and family violence and reduce these types of deaths;
- identify, collect, analyse and report data on domestic and family violence-related deaths; and
- analyse and compare domestic and family violence death review findings and recommendations.

These goals align with the *National Plan to Reduce Violence Against Women and their Children 2010-2022*.

Definitions

This Consensus Statement defines the inclusion criteria adopted by the Network for domestic and family violence homicide. While there is no universally agreed definition of the behaviours that comprise domestic and family violence, in Australia it includes a spectrum of physical and non-physical abuse within an intimate or family relationship. Domestic and family violence behaviours include physical assault, sexual assault, threats, intimidation, psychological and emotional abuse, social isolation, and economic deprivation. Primarily, domestic and family violence is predicated upon inequitable relationship dynamics in which one person exerts power and coercive control over another. This accords with the definition of family violence contained in the *Family Law Act 1975* (Cth), which is adopted by the Network.

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.

Surveillance

The World Health Organization (2001) defines surveillance as:

> "… *systematic ongoing collection, collation and analysis of data and the timely dissemination of information to those who need to know so that action can be taken*."

Surveillance processes produce data that describe the frequency and nature of mortality and morbidity at the population level. This serves as a first step to the identification of risk factors to target preventive intervention. The Network applies these principles to ensure a consistent and standardised approach to data collection and analysis. To identify the target population and opportunities for intervention, surveillance of domestic and family violence homicide incidents is conducted both retrospectively and prospectively.

Categorisation

Identification and classification of domestic and family violence deaths is complex and needs to be conducted cautiously. The key considerations in this area are:

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).

Consideration 1: Case Type

Determination of case type (i.e. external cause, natural cause, unknown cause) is the first consideration for classification. An external cause death is any death caused, directly or indirectly, by an offender through the application of assaultive force or by criminal negligence. In cases where the cause of death is unknown, the death is monitored until further information is available.

Case Type	Definition	Inclusion
External Cause	Any death resulting directly or indirectly from environmental events or circumstances that cause injury, poisoning and / or other adverse effect.	Yes
Unexplained Cause	Deaths for which it is unable to be determined whether it was an external or natural cause.	No
Natural Cause	Any death due to underlying natural causes. Includes chronic illness due to long-term alcohol abuse / smoking.	No

Consideration 2: Intent

The second consideration is to establish the role of human purpose in the event resulting in the external cause death. In accordance with the WHO International Classification of Disease (ICD-10), the intent is coded according to the following categories.

Intent	Definition	Inclusion
Assault[39]	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 (For example, bystanders).	Yes
Complications of Medical or Surgical Care	Death which occurred due to medical misadventure, accidents or reactions in the administration of medical or surgical care drugs or medication.	No
Intentional Self-Harm	Injury or poisoning resulting from a deliberate violent act inflicted on oneself with the intent to take one's own life or with the intent to harm oneself.	No
Legal Intervention/ Operations of War	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.	Yes (only where DV context present)
Still Enquiring	Death under investigation whereby the intent or case type is not immediately clear based on the level of information available.	No
Undetermined Intent	Events where available information is insufficient to enable a person to make a distinction between unintentional, intentional self-harm and assault.	No
Unintentional	Injury or poisoning that is not inflicted by deliberate means (that is, not on purpose). This category includes those injuries and poisonings described as unintended or "accidental", regardless of whether the injury was inflicted by oneself or by another person.	No
Unlikely to be Known	Upon case completion, the coroner was unable to determine whether the death was due to Natural or External causes, therefore unable to make a determination on intent.	No

Consideration 3: Relationship

The third consideration for classification is whether a domestic or familial relationship existed between the deceased and the offender. The Network recognises the various state and federal legislative instruments that define and address deceased-offender relationship. In particular, it is acknowledged that the member jurisdictions operate within the following legislative frameworks:

- *Coroners Act 2009* (NSW);
- *Domestic and Family Violence Protection Act 2012* (QLD);

[39] Mortality classification systems refer to 'homicide' as 'assault'.

- *Family Violence Protection Act 2008* (Vic); and
- *Intervention Orders (Prevention of Abuse) Act 2009* (SA);
- *Restraining Orders Act 1997* (WA) *and Parliamentary Commissioner Act 1971* (WA).

Each review team recognizes current or former intimate partners (heterosexual and homosexual), family members (adults and children), and kin, as relevant relationships. To standardise the inclusion and categorisation of relationship type, the following definitions are adopted by the Network.

Relationship Type	Definition	Inclusion
Intimate[40]	Individuals who are or have been in an intimate relationship (sexual or non-sexual).	Yes
Relative[41]	Individuals, including children, related by blood, a domestic partnership or adoption.	Yes
Aboriginal and/or Torres Strait Islander kinship relationships	A person who under Aboriginal and/or Torres Strait Islander culture is considered the person's kin.	Yes
No relationship	There is no intimate or familial relationship between the individuals.	Yes (only where DV context present)
Unknown	Relationship is unknown.	No

Consideration 4: Domestic and Family Violence Context

Having determined that a homicide has occurred and that a domestic relationship exists between the deceased and offender, the final consideration for classification is whether the homicide occurred in a domestic or family violence context. Deaths that fulfil these criteria are defined as domestic and family violence homicides and are subject to review by each jurisdiction.

Each jurisdiction can also review deaths where no direct domestic relationship exists between the deceased and offender but the death nonetheless occurs in a context of domestic and family violence. For example, this might include a bystander who is killed intervening in a domestic dispute or a new partner killed by their current partner's former abusive spouse.

Similarly, the Network recognises that the existence of an intimate or familial relationship between a deceased and offender does not, in itself, constitute a domestic and family violence homicide. In these deaths, other situational factors determine the fatal incident, such as the offender experiencing an acute mental health episode. These deaths do not feature many of the characteristics known to define domestic and family violence, such as controlling, threatening or coercive behaviour; having previously caused the other person to feel fear; or evidence of past physical, sexual or other abuse.

TYPES OF ABUSE

In accordance with the Network's minimum dataset protocols the Network collects data concerning types of abuse used against victims, and specific abusive behaviours. The Network distinguishes between abuse types including to collect data in relation to psychological/emotional, physical, financial, sexual and social (including to map co-occurrence of abuse types).

[40] This includes current and former intimate relationships irrespective of the gender of the individuals.
[41] This includes formal and informal family-like relationships, and explicitly includes extended family-like relationships that are recognised within that individual's cultural group.

At a secondary level, the Network collects data around specific behaviours, such as threats to kill, threats to harm children, stalking including monitoring, surveillance, obsessive behaviours and harassment.

In addition to collecting information concerning domestic and family violence context, the Network Minimum Dataset protocol outlines the extensive data fields collected by the Network.

AUSTRALIAN DOMESTIC AND FAMILY VIOLENCE DEATH REVIEW NETWORK NATIONAL DATA COLLECTION PROTOCOL

The Australian Domestic and Family Violence Death Review Network ('the Network') has 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.

Stage 1 – Minimum dataset for Intimate Partner (Domestic Violence Context) Homicides

The preliminary data collection is proposed to cover all closed intimate partner domestic violence context homicides from 1 July 2012. This date has been selected to coincide with the commencement of the death review process in the office of the Ombudsman in WA. The selected commencement date will enable the reporting of consistent National data across all currently established death review processes.[42]

The preliminary dataset will examine every intimate partner homicide that occurred in a domestic violence context and will examine:

- Homicide details (including event details, location of death, manner of death, criminal/coronial outcome, whether homicide offender was domestic violence abuser or victim (or both) in the life of the relationship);
- Demographic details of domestic violence victim and domestic violence perpetrator (including residency, age, country of birth, Aboriginal or Torres Strait Islander status, occupation, disability status and immigration status);
- Case characteristics (including histories of protection orders, current family law proceedings, separation, financial issues, unemployment, mental health issues);
- Histories of violence (including types of violence - emotional/psychological, sexual, physical, verbal and social, and including disaggregated data where available
- Homicide victim and perpetrator characteristics (including psychiatric treatment history, substance abuse history, criminal record, service contact); and
- Relationship characteristics between homicide victim and offender.

The goal of this collection process is to develop a dataset of consistent national data concerning intimate partner homicides occurring in a domestic violence context. This data is currently unavailable, and in the spirit of the Network, review teams will collaborate to enhance learnings and information about this pressing social issue.

The Network will report publicly on this de-identified quantitative data in the Network's Annual Activities Report. The Network will commence testing this data collection process during 2015.

[42] There are currently no death review processes being undertaken in the Northern Territory or Tasmania; there is currently a pilot program operating in ACT.

Beyond Stage 1

Subsequent stages are anticipated in this process, including to generate shared collection protocols concerning;

- other family homicides (including the deaths of children and adults) (*Stage 2*);
- domestic violence context deaths where there is no relationship between the deceased and perpetrator (such as the death of new partners by a former abusive partner) (*Stage 3*); and
- domestic violence context suicides (*Stage 4*).

The Network will collaborate to develop these data protocols and roll out national data following successful testing and collection of data collection protocols in stage 1.

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