

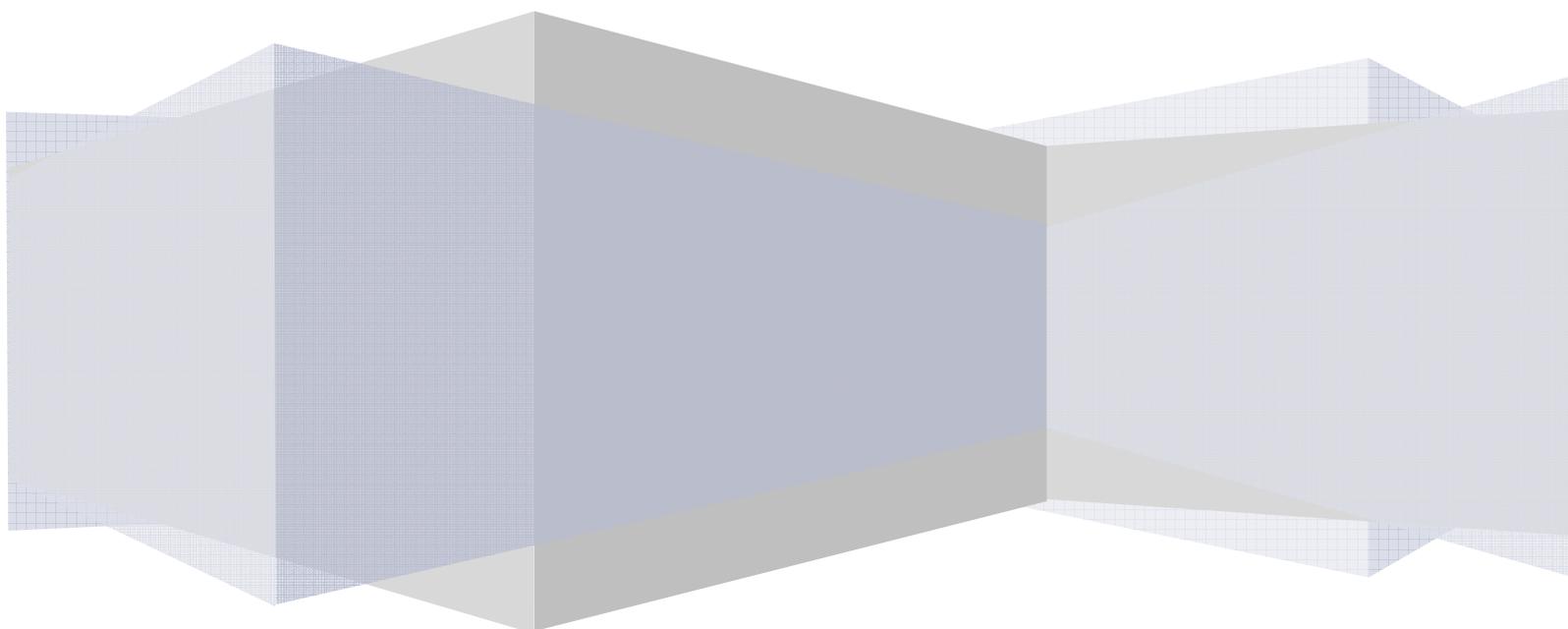


Attorney General
& Justice

NSW Domestic Violence Death Review Team

ANNUAL REPORT

2012-2013



NSW Domestic Violence Death Review Team
ANNUAL REPORT
2012-2013

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).

Published in Sydney by the
Domestic Violence Death Review Team
PO Box 309
CAMPERDOWN BC 1450

www.lawlink.nsw.gov.au/coroners

© Domestic Violence Death Review Team, Sydney, 2015

Copyright permissions

This publication may be copied, distributed, displayed, downloaded and otherwise freely dealt with for any personal or non-commercial purpose, on the condition that proper acknowledgement is included on all uses.

However, you must obtain permission from the Domestic Violence Death Review Team if you wish to:

- charge others for access to the publication (other than at cost);
- include all or part of the publication in advertising or a product for sale; or
- modify the work.

Disclaimer

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

Readers are responsible for making their own assessment of this publication and should verify all relevant representations, statements and information with their own professional advisers.

ISSN 1839-8073 (Print)
ISSN 1839-8219 (Online)

CONVENOR'S MESSAGE



This is the third annual report of the NSW Domestic Violence Death Review Team and is the second to include substantive data findings, case reviews and recommendations.

Due to a number of factors, all beyond the control of the team, there has been a delay in tabling this report. Notwithstanding this delay, the work of the team has progressed significantly since the last report. In the last 18 months the team has developed mechanisms for enhanced data reporting and negotiated with government agencies to facilitate increased use of research tools and improved information sharing. The work of the team has informed the development of the Domestic Violence Safety Assessment Tool, which is a central part of the new whole of government domestic and family violence reforms. The team has also contributed to the development of the Second National Plan to Reduce Violence Against Women and their Children.

I was appointed as Convenor of the team in March 2014 following the retirement of the inaugural Convenor, former State Coroner Mary Jerram. New members were appointed in November 2014, following the expiry of inaugural team memberships in February 2013. At this point, I would like to thank the inaugural team members and Convenor, who contributed significantly to the development of this report and the work of the team since its establishment in 2011.

This report contains 23 recommendations developed from an in depth analysis of all domestic violence homicide cases that occurred in the case review period, in combination with ten years of data findings. It also includes a new research chapter which monitors the uptake of the recommendations made by the team. In light of the whole of government response to the second annual report, this report also includes a focused data chapter which highlights issues around the deaths of children who were killed by their parents in a context of domestic violence (including in a context of child abuse).

Domestic violence, and particularly violence against women, remains a significant social problem in our community. As highlighted by the data contained in this report, women are overrepresented as victims of domestic violence and are often most at risk at the point of separation from their abusive partners. Deaths occurring in a domestic violence context are unacceptable tragedies, and we must strive to learn from these events. Therefore, it remains the role of death review teams, like this one, to examine the circumstances surrounding all domestic violence deaths with a view to identifying opportunities for intervention and prevention aimed at addressing the root causes of such violence in our community.

I look forward to working closely with the team going forward, including to produce the team's next annual report to be tabled during 2015. The next report will further develop analysis concerning trends and patterns in domestic violence deaths, and will include the review of all 40 domestic violence homicides in the reporting period.

I would like to take this opportunity on behalf of both the team and myself to extend my sincere condolences to the families of those individuals whose cases are considered in this report. It is our hope that by continuing to review and analyse these deaths our responses to domestic violence will improve resulting in a reduction in the prevalence of domestic violence homicides and domestic violence more generally.

A handwritten signature in black ink, appearing to read 'M Barnes'.

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

CONTENTS

Convenor's Message	iii
List of Figures	v
Executive Summary	vi
Recommendations	x
Chapter 1. Introduction	1
Chapter 2. Complete Dataset Findings, Domestic Violence Homicide, 2000-2010	4
Chapter 3. Case Review Findings, Domestic Violence Homicide, 2009-2010	11
Chapter 4. Data Focus: Children killed by a parent in a domestic violence context, 2000-2010	15
Chapter 5. Findings and Recommendations	21
Chapter 6. Monitoring Recommendations	35
Appendix A Chapter 9A, Coroners Act 2009 (NSW)	50
Appendix B Definitions	56
Appendix C Graphs/tables – Domestic Violence Homicide, 2000-2010	59
Appendix D Case Review Summaries, Domestic Violence Homicide, 2009-2010	76
Appendix E Graphs/tables – Children killed by a parent in domestic violence context 2000-2010	97
Appendix F Team Members	102

LIST OF FIGURES

Intimate partner homicide

Page

59	FIGURE 1: All homicide victims by domestic violence context, 2000-2010
59	FIGURE 2: Intimate partner homicide victims (domestic violence context) by gender, 2000-2010
60	FIGURE 3: Relationship of homicide perpetrator to female intimate partner homicide victim, 2000-2010
60	FIGURE 4: Intimate partner homicide victim by domestic violence victim/abuser in relationship, 2000-2010
61	FIGURE 5: Relationship of homicide perpetrator to male intimate partner homicide victim, 2000-2010
61	FIGURE 6: Intimate partner homicide victim by separation, 2000-2010
62	FIGURE 7: Age of intimate partner homicide victim, 2000-2010
62	FIGURE 8: Intimate partner homicide victim by NSW Police Force Region, 2000-2010
63	FIGURE 9: Intimate partner homicide victim by country of birth, 2000-2010
64	FIGURE 10: Intimate partner homicide victim by manner of death, 2000-2010
64	FIGURE 11: Intimate partner homicide victim by location of fatal episode, 2000-2010
65	FIGURE 12: Age of intimate partner homicide perpetrator, 2000-2010
66	FIGURE 13: Intimate partner homicide perpetrator by country of birth, 2000-2010
67	FIGURE 14: Intimate partner homicide perpetrator by outcome, 2000-2010

Relative/kin homicide

67	FIGURE 15: Relationship of perpetrator to adult relative/kin homicide victim, 2000-2010
68	FIGURE 16: Age of adult relative/kin homicide victim, 2000-2010
68	FIGURE 17: Adult relative/kin homicide victim by NSW Police Force Region, 2000-2010
69	FIGURE 18: Adult relative/kin homicide victim by country of birth, 2000-2010
69	FIGURE 19: Adult relative/kin homicide victim by manner of death, 2000-2010
70	FIGURE 20: Adult relative/kin homicide victim by location of fatal episode, 2000-2010
70	FIGURE 21: Age of adult relative/kin homicide perpetrator, 2000-2010

71 **FIGURE 22:** Adult relative/kin homicide perpetrator by country of birth, 2000-2010

71 **FIGURE 23:** Adult relative/kin homicide perpetrator by outcome, 2000-2010

'Other' domestic violence homicide

72	FIGURE 24: Age of 'other' domestic violence homicide victim, 2000-2010
72	FIGURE 25: 'Other' domestic violence homicide victim by NSW Police Force Region, 2000-2010
73	FIGURE 26: 'Other' domestic violence homicide victim by country of birth, 2000-2010
73	FIGURE 27: 'Other' domestic violence homicide victim by manner of death, 2000-2010
73	FIGURE 28: 'Other' domestic violence homicide victim by location of fatal episode, 2000-2010
74	FIGURE 29: Age of 'other' domestic violence homicide perpetrator, 2000-2010
74	FIGURE 30: 'Other' domestic violence homicide perpetrator by country of birth, 2000-2010
75	FIGURE 31: 'Other' domestic violence homicide perpetrator by outcome, 2000-2010

Children killed by a parent in a domestic violence context

97	FIGURE 32: All children killed by a parent by domestic violence context, 2000-2010
97	FIGURE 33: Children killed by a parent in a domestic violence context by age, 2000-2010
98	FIGURE 34: Relationship of parent homicide perpetrator (domestic violence context) to child victim, 2000-2010
98	FIGURE 35: Children killed by a parent (domestic violence context) by manner of death, 2000-2010
99	FIGURE 36: Parent homicide perpetrator (domestic violence context) by age, 2000-2010
99	FIGURE 37: Characteristics of parents who killed their child/ren in a domestic violence context, 2000-2010
100	FIGURE 38: Parents who killed their child/ren in a domestic violence context by outcome, 2000-2010
101	FIGURE 39: Family service contact, 2000-2010

EXECUTIVE SUMMARY

Chapter 1: Introduction

The Domestic Violence Death Review Team was established in July 2010 under the *Coroners Act 2009* (NSW) to systematically review domestic violence related deaths. The scope of 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 and facilitate improvements in systems and services.

The scope of the Team's work includes examination not only of domestic violence related homicides, but also domestic violence related suicides and fatal accidents which occur in a domestic violence context.

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 term 'domestic violence homicide' is used by the Team to describe homicides which occur following an identifiable history of domestic 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 relationship between the homicide victim and homicide perpetrator, but the death nonetheless occurs in a domestic violence context. These include, for example, cases where a bystander is killed intervening in 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 collecting information and reporting on domestic violence homicides, which produces two distinct but related sets of data:

1. The **complete dataset findings** – which provides quantitative data analysis in relation to all homicides occurring in a domestic violence context in NSW. The data reporting period for the complete dataset findings in this report covers all closed homicide cases between 1 July 2000-30 June 2010 (a ten year period); and
2. The **case review findings** – which provides detailed qualitative analysis in relation to domestic violence homicides which have been subjected to in depth review by the Team. The case review period in this report is 1 July 2009-30 June 2010 (a 12 month period).

To develop the **complete dataset findings** (tier 1), the Team identifies and examines every homicide that occurs in NSW, capturing detailed demographic information and case characteristics for every case. Every homicide that occurs in NSW is examined to determine the domestic violence context, if any, of that death. This domestic violence context data 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.

This report presents the complete dataset findings in relation to the 238 domestic violence homicides that occurred within the data reporting period (1 July 2000-30 July 2010).

To develop the **case review findings** (tier 2), the Team conducts comprehensive in depth reviews of individual cases which occur over a designated 12 month 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.

This report presents the case review findings for all 19 closed domestic violence homicides which occurred within the case review period (1 July 2009-30 June 2010).

Chapter 2: Complete Dataset Findings – Domestic Violence Homicides, 1 July 2000-30 June 2010

During the ten years between 1 July 2000 and 30 June 2010 there were a total of 877 homicides in NSW, and of these homicides, 238 (27%) occurred in a context where there was an identifiable history of domestic violence.

Of the 238 homicide victims who were killed in a domestic violence context:

- 137 were female (which represents 48% of all female homicide victims); and
- 101 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 they also include 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 Homicides

- Of the 238 male and female homicide victims who were killed in a domestic violence context in the data reporting period, 143 (60%) were killed by their current or former intimate partner.
- Of these 143 intimate partner homicide victims, the overwhelming majority (N=108, 76%) were women. Men comprised slightly less than a quarter of homicide victims in this category (N=35, 24%).
- All 108 women killed in this category were killed by a current or former *male* intimate partner.
- Of the 35 men killed in this category, 29 were killed by a current or former *female* intimate partner (83%) and 6 were killed by a current or former *male* intimate partner (17%).
- Almost all of the 108 women who were killed by their male intimate partner in a domestic violence context had been the domestic violence victim in the relationship (N=105, 97%).

- Most women in this category were killed by their current intimate partner (N=69, 64%) however, in just under half of these cases, one or both parties to the relationship had indicated an intention to end the relationship within three months of the killing.
- Approximately one third of women in this category (N=39, 36%) were killed by a former partner. Of these women, 24 (62%) had ended the relationship with the domestic violence abuser within three months of the killing.
- Of the 108 female intimate partner homicide victims, 12% identified as Aboriginal (N=13).
- Of the 35 male intimate partner homicide victims, over one-third identified as Aboriginal (N=12, 34%).

Relative/Kin Homicides

- Of the 238 male and female homicide victims who were killed in a domestic violence context in the data reporting period, 77 (32%) were killed by a relative/kin in a context of domestic violence. Of the 77 homicide victims in this category, 55 (71%) were children under the age of 18 years, and 22 (29%) were adults.
- Of the 55 children killed by a relative/kin in a domestic violence context, the vast majority were killed by a parent (including biological and non biological parents) (N=53, 96%). These cases have been subject to an increased data capture in **Chapter 4** of this report (*Data Focus: Children killed by a parent in a domestic violence context*).

Relative/kin Homicides - Adult victims

- Of the 22 adults who were killed by a relative/kin in a domestic violence context, 16 were men (72%) and 6 were women (27%).
- Half of all women (N=3, 50%) and one-quarter of all men (N=4, 25%) killed by a relative/kin in a domestic violence context were killed by their son/step-son (including de facto step-son).
- One woman (17%) and three men (19%) in this category were killed by their daughter/step-daughter.
- Of the 22 adult homicide victims killed by a relative/kin domestic violence context, 11 were victims of domestic violence who were killed

by an abuser and 10 were domestic violence abusers who were killed by their victim.

'Other' Domestic Violence Homicides

- There were 23 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 domestic violence context.
- All 23 homicide victims in this category were men.
- There were 24 homicide perpetrators in this category, all of whom were men.
- Most homicide victims in this category were 'new intimate partners' (N=16, **70%**) who were killed by their wife/girlfriend's former abusive male partner.

Chapter 3: Case Review Findings Domestic Violence Homicide NSW, 1 July 2009 – 30 July 2010

This chapter provides an overview of the findings derived from the Team's in depth case review process.

The 19 domestic violence homicides which occurred in the case review period are categorised as follows:

12 Intimate Partner Homicides

- 9 women killed by their abusive male partners; and
- 3 male domestic violence abusers killed by their female intimate partners.

5 Relative/kin Homicides

- **3 child relative/kin homicides** (one girl killed by her mother who was the victim of domestic violence by the girl's father; and one boy and one girl killed by their grandfather, who was a domestic violence abuser); and
- **2 adult relative/kin homicides** (one woman killed by her abusive nephew and one woman killed by her abusive son).

2 'Other' Domestic Violence Homicides

- 2 males killed by their girlfriend's ex-partner.

Key themes emerging from these 19 cases included that:

- Females killed by their intimate partners were domestic violence victims and males killed by their intimate partners were domestic violence abusers.
- Domestic violence abuser behaviours prior to the homicide did not always include physical violence.
- In most cases there were no apprehended violence orders applied for, or in place, at the time of the homicide.
- Separation (actual or pending) was a feature in a high proportion of cases, particularly where a woman was killed by her abusive male partner
- In all cases of intimate partner homicide, the homicide perpetrator and deceased were living together.
- In one-third of intimate partner homicides, there was an escalation of violence by the domestic violence abuser in the lead up to the homicide.
- In a high number of cases, there were surviving children under 18 years of age, who had a parent killed in a domestic violence homicide.
- In every intimate partner homicide case someone outside the relationship was aware of the violence being perpetrated by the domestic violence abuser.

Chapter 4: Children killed by a parent in a domestic violence context

Chapter 4 of this report provides a comprehensive data analysis in relation to all children who were killed by a parent/s in a domestic violence context in NSW between 1 July 2000 and 30 June 2010. This data focus was developed in response to the Whole of Government Response to the Team's *2011/12 Annual Report*.

Having reviewed every case from the 10 year review period, it was determined that of the 56 cases where a parent killed a child/ren (resulting in 69 deaths) there were 40 cases (52 deaths) where a child was killed in a domestic violence context.

Accordingly, **75%** (N=52) of all children killed by a parent in the data review period were killed in a domestic violence context.

Characteristics of these cases included the following:

- In **52%** of cases (N=27) the child had never been a direct target of child abuse, but was exposed to intimate partner violence between their parents (usually their father perpetrating domestic violence against their mother). In 38% of cases (N=20), the child was a victim of direct abuse, and intimate partner violence behaviours co-occurred within the family and in 10% of cases (N=5) the child was a direct victim of child abuse only and there was no history of intimate partner violence between the parents.
- The 52 child homicides perpetrated by a parent in a domestic violence context were committed by 42 perpetrators (25 male parents and 17 female parents).
- Of the 52 children who were killed by a parent in a domestic violence context, most were killed by a biological parent (N=40, **77%**). Eleven child victims (**21%**) were killed by a step-parent (10 step-fathers and 1 step-mother).
- Of the 52 child victims, **15%** (N=8) identified as Aboriginal. All eight Aboriginal children were between 0-4 years of age. There were a total of 37 child victims in this age category and accordingly, almost one-quarter (**22%**) of all child victims in the 0-4 years dataset were Aboriginal.
- Of the 25 male parents who killed their child/ren in a domestic violence context, most were perpetrators of domestic violence against a current or former intimate partner (N=20, **80%**).
- Almost all of the 17 female parents who killed their child/ren in domestic violence context were victims of domestic violence from a current or former intimate partner (N=16, **94%**).
- Over half of the male parents who killed their child/ren in a domestic violence context reported being a victim of violence and abuse during their childhood (N=14, **56%**). Over half of the female parents who killed their child/ren in a domestic violence context reported being

a victim of violence and abuse during their childhood (N=10, **59%**).

- Services involved with families within 6 months of the homicide included: healthcare (**74%**); child protective services (**50%**); schools (**40%**); and NSW Police Force (**39%**).

Chapter 5: Key Findings and Recommendations

This Chapter provides a synthesis of the Team's analysis of quantitative and qualitative data, and presents a discussion of themes and issues arising from the Team's review processes. This section also outlines 23 recommendations to various Government and non-Government agencies, derived from data and case review findings contained in this report.

RECOMMENDATIONS

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.

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.

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?

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.

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.

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.

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.

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.

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.

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.
- 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).

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.

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.

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.

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.

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.

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.

This work should be undertaken in partnership with key stakeholders including local councils, sporting and voluntary groups and Aboriginal communities.

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.

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.

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.

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).

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;
- 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.

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 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 or family 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, but also by parents against children (child abuse), adult children against parents, between siblings and other family members/kin. The term family violence has achieved mainstream usage in many jurisdictions as it is believed to expand the focus of violence beyond that which occurs between intimate partners to encompass violence between immediate and extended family members. In particular the phrase is said to more accurately reflect cultural notions of kinship in Aboriginal and Torres Strait Islander communities, which may not be included in more restrictive definitions. However, in New South Wales 'domestic violence' remains the common term used in the criminal and civil legislation to describe the broad range of violence behaviours and relationships captured and is accordingly used throughout this report as a broad definition.¹

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.² The vast majority of domestic violence is perpetrated by men against women.³ This has led to an understanding of domestic violence as a gendered crime, invoking issues of patriarchy and control and inviting the examination of social and community norms.

Despite changing community attitudes regarding the criminality of this behaviour, 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.

Domestic violence related homicides are considered to exhibit predictable patterns and aetiologies.⁴ 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 analyses of domestic violence homicides. Such teams undertake a careful examination of the circumstances

²M. 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.

³Australian 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.

⁴Neil 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 Feb 2015.

¹*Crimes (Personal and Domestic Violence) Act 2007* (NSW).

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,⁵ from the early 2000s, advocates and various Government agencies began campaigning for a domestic violence death review process to be established in NSW.⁶

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.⁷ 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;⁸

⁵For 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.

⁶NSW Ombudsman, *Domestic Violence: Improving Police Practice*, Sydney, 2006.

⁷Report of the Domestic Violence Advisory Panel 2009, [http://www.lawlink.nsw.gov.au/lawlink/Corporate/ll_corporate.nsf/vwFiles/251109_domestic_violence.pdf/\\$file/251109_domestic_violence.pdf](http://www.lawlink.nsw.gov.au/lawlink/Corporate/ll_corporate.nsf/vwFiles/251109_domestic_violence.pdf/$file/251109_domestic_violence.pdf), last accessed October 2013.

⁸*Coroners Act 2009* (NSW) s101B(2),

- 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.⁹

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. Additional information on the Team's background and establishment can be found in the Team's *2010/11* and *2011/12 Annual Reports*.

Methodology

The Team adopts a two tier approach to collecting information and reporting on domestic violence homicides, which produces two distinct but related sets of data:

1. The **complete dataset findings** – which provides quantitative data analysis in relation to all homicides occurring in a domestic violence context in NSW. The data reporting period in this report covers all closed homicide cases between 1 July 2000 – 30 June 2010 (a ten year period)¹⁰ and
2. The **case review findings** – which provides detailed qualitative analysis in relation to domestic violence homicides which have been subject to in depth review by the Team. The case review period in this report is 1 July 2009 – 30 June 2010 (a 12 month period).

To develop the **complete dataset findings** (tier 1), the Team identifies and examines every homicide that occurs in NSW, capturing detailed demographic information and case characteristics for every case.

From this dataset of all homicides, each case is reviewed to determine the relationship between the deceased and the perpetrator and whether or not the death occurred in a domestic violence context.

⁹*Coroners Act 2009* (NSW) s101F(1).

¹⁰This end date is selected to ensure that the maximum number of closed cases can be included in the analysis.

Where a death is determined to have occurred in a domestic violence context, an in depth review is undertaken, capturing extensive quantitative and qualitative information in relation to each domestic violence homicide.

This domestic violence context data 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.

For this report, quantitative data analysis is presented in relation to the 238 domestic violence homicides that occurred within the data reporting period.¹¹

To develop the **case review findings** (tier 2), the Team conducts comprehensive in depth reviews of individual cases which occur over a designated 12 month 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.

This report provides data in relation to all 19 homicides occurring in a domestic violence context in the case review period. This report also builds on the Team's findings from case reviews examined in the *2011/12 Annual Report* in Chapters 3 and 5.

Domestic violence homicide – case categorisation

Every domestic violence homicide identified by the review process is examined and 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/kinhomicide:** 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).

Identifying a domestic violence context

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

Material reviewed includes:

- 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.¹²

It is acknowledged that 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.

¹¹While captured by the Team, the data analysis of non-domestic violence related homicide is not included in this report, see the Team's *2011/12 Annual Report* for an analysis of non-domestic violence homicide between, 1 July 2000 and 30 June 2009.

¹²*Coroners Act 2009* (NSW) s101L.

2 COMPLETE DATASET FINDINGS

DOMESTIC VIOLENCE HOMICIDE 2000–2010

This chapter presents data analysis in relation to the complete dataset - all 238 closed domestic violence homicides that occurred in NSW in the ten years between 1 July 2000 and 30 June 2010. The 238 domestic violence homicides are considered in three distinct groups: intimate partner homicides, relative/kin homicides, and 'other' domestic violence homicides.

Introduction

During the ten years between 1 July 2000 and 30 June 2010 (the 'data reporting period') there were a total of 877 victims of homicide in NSW.¹³ Of the 877 homicide victims:

- 283 were female;
- 593 were male; and
- 1 homicide victim identified as transgender.

Of the 877 homicides, 238 (27%) occurred in a context where there was an identifiable history of domestic violence. Of the 238 homicide victims who were killed in a domestic violence context:

- 137 were female (which represents 48% of all female homicide victims); and
- 101 were male (which represents 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 Homicides (Domestic Violence Context)

Incidence

Of the 238 homicide victims who were killed in a domestic violence context in the data reporting period, 143 (60%) were killed by their current or former intimate partner.

Of these 143 intimate partner homicide victims, the overwhelming majority (N=108, 76%) were women. Men comprised slightly less than a quarter of homicide victims in this category (N=35, 24%) (Fig. 2).

¹³Excluding open cases.

The 143 intimate partner homicides were perpetrated by 143 offenders of which 114 perpetrators were men and 29 perpetrators were women.

Intimate Partner Homicide – Female victims

All 108 women killed in this category were killed by a current or former *male* intimate partner (Fig. 3).

Almost all of the 108 women who were killed by their male intimate partner in a domestic violence context had been the domestic violence victim in the relationship (N=105, 97%). There were no cases where a woman was a domestic violence abuser who was killed by a male domestic violence victim (Fig. 4).¹⁴

Intimate Partner Homicide – Male victims

Of the 35 men killed in this category, 29 were killed by a current or former *female* intimate partner and 6 were killed by a current or former *male* intimate partner (Fig. 5).

Almost all of the 29 men who were killed by their female intimate partner in domestic violence context had been the domestic violence abuser in the relationship (N=26, 90%). There were no cases where a woman was a domestic violence abuser who killed a male domestic violence victim.¹⁵

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

¹⁴In three cases where a woman was killed by her male intimate partner, there had been physical violence in the relationship perpetrated by both parties, but there was no clear historical pattern of coercion and control evident.

¹⁵In two cases where a man was killed by his female intimate partner, there had been physical violence in the relationship perpetrated by both parties, but there was no clear historical pattern of coercion and control evident. 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.

Intimate partner homicide (domestic violence context) – relationship status

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 and not by reference to who was the domestic violence abuser in the relationship.

Current Intimate Partner relationships

Of the 108 women in this category, most were killed by their *current* intimate partner (N=69, 64%) (**Fig. 6**).

This included cases where women were killed by their husband/de facto husband (N=63, 58%), and a smaller number of women who were killed by their boyfriend (N=5). One woman was killed by a man with whom she was having a long term affair.

Although the relationships were current, in just under half of these cases one or both parties had indicated an intention to end the relationship within three months of the killing (N=32, 46% of all current relationships). This meant that although the parties remained together at the time of the homicide, separation was contemplated or, in some cases, imminent (**Fig. 6**).

Of the 35 male homicide victims in this category, almost all were killed by their *current* intimate partner (N=33, 94%). This included three cases where one or both of the parties had indicated an intention to end the relationship within three months of the killing (but the relationship remained ongoing), and one case where the relationship was characterised by intermittent periods of separation (**Fig. 6**).

Former intimate partner relationships

Of the 108 women who were victims of intimate partner homicide, 39 (36%) were killed by a *former* partner. This included 33 cases where women were killed by their former husbands/de facto husbands and 6 cases where women were killed by their former boyfriends (**Fig. 6**).

It is important to note that of the 39 women killed by their former intimate partner, 24 (62%) had ended the intimate relationship with the domestic violence abuser within three months of the killing.

Again, noting that most women who were killed were domestic violence victims killed by their abuser, this supports evidence that the period immediately following separation may be

particularly dangerous for women who leave a violent partner.¹⁶

Of the 35 male intimate partner homicide victims, only two were killed by a *former* intimate partner (one former girlfriend and one former boyfriend) (**Fig. 6**).

Intimate partner homicide (domestic violence context) – victim characteristics

Age

Most women killed in this category were between the ages of 25-44 years (N=69, 64%). The youngest woman killed by an intimate partner was 15 years old and the oldest was aged 80 years.

Most men killed in this category were between the ages of 25-49 years (N=22, 63%). The youngest was 19 years and the oldest was aged 71 years (**Fig. 7**).

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 police region in which the victim was ordinarily resident at the time they were killed. 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=24, 22%), followed by the Northern Region (N=21, 19%).

The highest number of men killed in this category were ordinarily resident in the Northern Region (N=9, 26%), followed by the Central Metropolitan (N=7, 20%) and the Southern Region (N=7, 20%).

Overall, the highest number of intimate partner homicide victims were ordinarily resident in the Northern Region (N=30, 21%) (**Fig. 8**).

Country of birth

The rationale for collecting data in relation to country of birth accords with considerations around

¹⁶T 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.

the availability of culturally and linguistically appropriate services for perpetrators and victims of violence.

Most female (N=73, 68%) and most male (N=29, 83%) intimate partner homicide victims were born in Australia (including Aboriginal Australians, discussed below).

Other countries of birth included: New Zealand, Lebanon, India and Serbia (**Fig. 9**).

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.¹⁷

Of the 108 female intimate partner homicide victims, 12% identified as Aboriginal (N=13).

Of the 35 male intimate partner homicide victims, over one-third identified as Aboriginal (N=12, 34%).

This data demonstrates a significant overrepresentation of Aboriginal victims of intimate partner homicide.

Intimate partner homicide (domestic violence context) – case

characteristics

Manner of death

One-third of women killed in this category died as a consequence of stab wounds (N=36, 33%). The second most common manner of death was assault (24%), followed by shooting (18%) (**Fig. 10**).

Most men in this category died as a consequence of stab wounds (N=25, 71%). The second most common manner of death was shooting (14%), followed by assault (9%). It is noted that all cases involving the fatal assault (without weapon) of a male homicide victim were perpetrated by the victim's male intimate partner (**Fig. 10**).

Location of death

Most women were killed in their home (N=81, 75%), followed by a public place (N=14, 13%) (**Fig. 11**).

Most men were killed in their home (N=22, 63%), 5 were killed at the perpetrator's home (14%) and 5 were killed at another residence (14%) (**Fig. 11**).

Multiple Homicide Events

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

Of the nine multiple homicide events:

- **6** involved the homicide perpetrator killing their intimate partner together with one or more children;
- **1** involved the homicide perpetrator killing his former wife and her new intimate partner; and
- **2** involved the homicide perpetrator killing their intimate partner and another relative.

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

Intimate partner homicide (domestic violence context) – perpetrator characteristics

Age

Of the 114 men who killed their intimate partner, the highest proportion were aged between 30-44 years (N=59, 52%). The youngest was 17 years old and the oldest was aged 87 years.

Of the 29 women who killed their intimate partner, the highest proportion were aged 40-44 years (N=7, 24%) (**Fig. 12**).

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

Country of birth

Most men (N=73, 76%) and most women (N=26, 74%) who killed their intimate partner were born in Australia (including Aboriginal Australians, discussed below).

Other countries of birth included: New Zealand, Lebanon, India and Serbia (**Fig. 13**).

Aboriginal and Torres Strait Islander status

Approximately 10% of men who killed their female partner in a context of domestic violence identified as Aboriginal (N=11).

¹⁷Australian Bureau of Statistics, *Australian demographic statistics, March quarter 2013*. Canberra: Australian Bureau of Statistics 2013.

Just under a third of all women who killed their male intimate partner in a context of domestic violence identified as Aboriginal (N=9, 31%).

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

Intimate partner homicide (domestic violence context) – criminal court/coronial outcomes

Perpetrator suicide

Of the 143 intimate partner homicide perpetrators, 24 (17%) committed suicide after killing their intimate partner (coronial finding) (**Fig. 14**).

This included 20 intimate partner homicide perpetrators who suicided within 24 hours of the homicide, and four who suicided in a period greater than 24 hours after the homicide.

Of the homicide perpetrators who committed suicide after killing their intimate partner, 23 were men (96%). Accordingly, 20% of all male intimate partner homicide perpetrators committed suicide.

Criminal court outcomes

Just over half of the 114 male perpetrators of intimate partner homicide were convicted of murder (N=58, 51%) (**Fig. 14**).

The second most prevalent criminal court outcome for men who killed their intimate partners was a guilty verdict/guilty plea manslaughter (N=23, 20%).

Almost half of all women who killed their male intimate partners were convicted of manslaughter (N=14, 48%) and one-quarter were acquitted (N=7, 25%) (**Fig. 14**).

Relative/kin Homicides (Domestic Violence Context)

Incidence

Of the 238 homicide victims who were killed in a domestic violence context in the data reporting period, 77 were killed by a relative/kin in a context of domestic violence.

Of the 77 homicide victims in this category, 55 were children under the age of 18 years, and 22 were adults.

Relative/Kin Homicide – Child victims

Of the 55 children who were killed by a relative/kin in a domestic violence context, the vast majority were killed by a parent (including biological and non biological parents) (N=53, 96%). A more detailed data analysis in relation to these deaths is set out in **Chapter 4** of this report.¹⁸

The only child homicide in this category that was perpetrated by a relative who was not a parent, involved a grandfather killing both his grandchildren in the context of ongoing domestic violence against his wife and a history of domestic violence against his children. The grandfather had not been violent towards his grandchildren prior to the homicide. The details of this case, *Case Review 2974*, are set out in **Appendix D**, and the case is further discussed in the context of all case reviews in **Chapters 3 and 5**.

Relative/Kin Homicide – Adult victims

Of the 22 adult homicide victims killed by a relative/kin in a domestic violence context, six were women and 16 were men.

The 22 homicides in this category were perpetrated by 17 men and five women – noting that in one case a woman killed both her parents and in one case a woman was killed by her son and daughter acting together.

Adult relative/kin homicide (domestic violence context) – relationship type

Half of all women (N=3, 50%) and one-quarter of all men (N=4, 25%) killed by a relative/kin in a domestic violence context were killed by their son/step-son (including de facto step-son).

One woman (17%) and three men (19%) in this category were killed by their daughter/step-daughter (**Fig. 15**).

Of the 22 adult homicide victims who were killed by a relative/kin in a domestic violence context, 11 were victims of domestic violence who were killed by a domestic violence abuser. Ten homicide victims were domestic violence abusers.¹⁹

¹⁸ Note that one case where a child victim was killed by a parent in a domestic violence context was not reviewed for purpose of focused research in Chapter 4 due to a delay in the criminal justice process.

¹⁹ The remaining case involved a man killing his adult son in circumstances where there had been physical and psychological violence in the relationship perpetrated by both parties.

Adult relative/kin homicide (domestic violence context) – victim characteristics

Age

Adult homicide victims in this category were aged between 23 and 84 years, the highest proportion being aged between 35 and 44 years (N=8, 36%) (Fig. 16).

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=8, 36%), followed by the North West Metropolitan Region (N=5, 23%) (Fig. 17).

Country of birth

Over half of all the adult homicide victims in this category were born in Australia (N=13, 59%). Other countries of birth included: New Zealand, the United Kingdom, Italy, Romania, Iraq, Lebanon and India (Fig. 18).

Aboriginal and Torres Strait Islander status

Of the 22 adult relative/kin homicide victims killed in a domestic violence context, 14% (N=3, all female) identified as Aboriginal.

Accordingly, of the six female victims in this dataset, 50% were Aboriginal.

Adult relative/kin homicide (domestic violence context) – case characteristics

Manner of death

The highest proportion of homicide victims in this category died as a consequence of stab wounds (N=9, 41%), followed by shooting (N=7, 32%) and assault (N=2, 9%) (Fig. 19).

Compared to the overall prevalence of shooting as a manner of death across all categories of domestic violence homicide (17% of all domestic violence homicides), shooting was highly represented in this category (Fig. 19).

Location of death

All female (N=6) and most male (N=17) homicide victims in this category were killed in their home (Fig. 20).

Men were also killed in public/open places, other residences, and at the perpetrator's residence (Fig. 20).

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 woman and her father were killed by her abusive ex-partner.
- 1 case where an abusive man killed his intimate partner and her brother.
- 1 case where an abusive man killed his two children and his father-in-law, and
- 1 case where an elderly man and woman were killed by their adult daughter.

Adult relative/kin homicide (domestic violence context) – perpetrator characteristics

Age

The youngest male perpetrator in this category was 18 years and the oldest was aged 55 years (Fig. 21).

The five women in this category who killed an adult victim were aged between 13 years and 70 years (Fig. 21).

Country of birth

Most male (N=11, 73%) and most female (N=4, 80%) perpetrators 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. 22).

Aboriginal and Torres Strait Islander status

Of the 22 relative/kin homicide perpetrators who killed an adult victim, 3 identified as Aboriginal (18%, all male).

Adult relative/kin homicide (domestic violence context) – criminal court/coronial outcomes

Perpetrator suicide

Two of the male homicide perpetrators in this category committed suicide immediately after the homicide (coronial finding) (Fig. 23).

Criminal court outcomes

Most male perpetrators were convicted of manslaughter (N=5, 29%), followed by being found not guilty by reason of mental illness (N=4, 24%).

Of the five female perpetrators: two were convicted of murder, one was convicted of manslaughter, one was found not guilty by reason of mental illness, and one was acquitted (**Fig. 23**).

‘Other’ domestic violence homicides

Incidence

Between 1 July 2000 and 30 June 2010, there were 23 homicide victims who were 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 23 homicide victims in this category were men.

There were 24 homicide perpetrators in this category, all of whom were men.

In one case a man was killed by both the husband and son of a women with whom he was having an affair. All other cases involved a single perpetrator and single victim.

‘Other’ domestic violence homicides – relationship characteristics

Most homicide victims in this category were ‘new intimate partners’ (N=16, 70%) who were killed by their wife/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 her entry into a new relationship intensified the abuser’s ongoing domestic violence against 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;

- 2 cases where a man killed his current wife/girlfriend’s former domestic violence abuser; and
- 1 case where a domestic violence abuser was killed by a contract killer who was hired by his wife.

‘Other’ domestic violence homicides – victim characteristics

As noted above, all 23 homicide victims in this category were men.

Age

Homicide victims in this category were aged between 24 and 58 years, with the highest proportion being aged between 25-29 years (30%) (**Fig. 24**).

Region where victim ordinarily resided

The highest number of homicide victims in this category were ordinarily resident in the Central Metropolitan Region (N=5, 22%), followed by the Northern Region, Western Region and Southern Region, each of which had four homicide victims (17%) (**Fig.25**).

Country of birth

Most homicide victims in this category were born in Australia (N=17, 74%), with other countries of birth including Malaysia, Cook Islands, Fiji, the United Kingdom, the Netherlands, and Korea (**Fig.26**).

Aboriginal and Torres Strait Islander status

One homicide victim in this category identified as Aboriginal (4%).

‘Other’ domestic violence homicides – case characteristics

Manner of death

Most homicide victims in this category died as a consequence of stab wounds (N=15, 65%), followed by shooting (N=7, 30%) and assault (N=1, 4%).

Compared to the overall representation of shooting as a manner of death across all categories (17% of all domestic violence homicides), shooting was highly represented in this category (**Fig. 27**).

Location of death

Most homicide victims in this category were killed at either their home (N=8, 35%) or the perpetrator’s residence (N=8, 35%) (**Fig. 28**).

*'Other' domestic violence homicides –
perpetrator characteristics*

As noted above, all 24 homicide perpetrators in this category were men.

Age

Homicide perpetrators in this category were aged between 16 and 56 years, with the highest proportion being aged 40-49 years (N=8, 33%) **(Fig. 29)**.

Country of birth

Over half of all the homicide perpetrators in this category were born in Australia (N=14, 58%).

Other countries of birth included: Cook Islands, Fiji, United Kingdom, the Netherlands, Hungary, Lebanon, the Philippines, and Indonesia **(Fig. 30)**.

Aboriginal and Torres Strait Islander status

One perpetrator in this category identified as Aboriginal (4%).

*'Other' domestic violence homicides –
criminal court/coronial outcomes*

Criminal Court Outcomes

Half the perpetrators in this category were convicted of murder (N=12, 50%), and almost half were convicted of manslaughter (N=10, 42%) **(Fig. 31)**.

No perpetrators in this category committed suicide after perpetrating the homicide.

3 CASE REVIEW FINDINGS

DOMESTIC VIOLENCE HOMICIDE 2009 – 2010

This chapter provides an overview of the key findings derived from the Team's in depth case reviews of the 19 domestic violence homicides that occurred in NSW between 1 July 2009 and 30 June 2010.

Introduction

Having outlined an overview of preliminary data derived from homicides occurring in the ten year data reporting period (1 July 2000-30 June 2010) in **Chapter 2**, this Chapter provides a more comprehensive review of the 19 domestic violence context homicides which occurred in NSW between the 12 month period - 1 June 2009 and 30 June 2010. The 19 homicide victims were killed by 17 perpetrators.

Summaries of the 19 cases considered in this Chapter are outlined at **Appendix D** of this report. Also included is commentary which seeks to identify some of the key issues and themes arising from the Team's in depth analysis. **Chapter 5** synthesises this information with the data findings included in Chapter 2, in order to develop 23 recommendations.

In accordance with its legislative function, each case in this case review period has been reviewed in depth by the Team. This review process has been undertaken with a view to examining interactions with support services and identifying failures in systems or services that may have contributed to, or failed to prevent, the domestic violence death.²⁰ In practice, the Team adopts a holistic approach to reviewing cases, applying a 'no blame' philosophy to the study and review of individual cases.

Case review—domestic violence homicide type

The 19 domestic violence homicides examined by the Team in this case review period are categorised as follows:

12 intimate partner homicides

- **9** women killed by their abusive male partners; and
- **3** male domestic violence abusers killed by their female intimate partners.

5 relative/kin homicides

- **3 child relative/kin homicides** (one girl killed by her mother who was the victim of domestic violence by the girl's father; and one boy and one girl killed by their grandfather, who was a domestic violence abuser); and
- **2 adult relative/kin homicides** (one woman killed by her abusive nephew and one woman killed by her abusive son).

2 'other' domestic violence homicides

- 2 males killed by their girlfriend's ex-partner.

Case Reviews – intimate partner homicides (domestic violence context)

There were a number of common characteristics across all 12 intimate partner homicide cases in a domestic violence context, discussed below.

Females killed by their intimate partner were domestic violence victims; Males killed by their intimate partner were domestic violence abusers

In each of the nine cases reviewed by the Team where a woman was killed by her intimate partner, the woman had been a victim of domestic violence and was killed by her abusive male partner.

In each of the three cases reviewed where a man was killed by his intimate partner, the man had been the domestic violence abuser in the relationship and was killed by his domestic violence victim.

The domestic violence history in the relationship generally, but not always, included physical violence

In 11 out of the 12 intimate partner homicides, the identifiable history of domestic violence in the relationship involved some form of physical abuse

²⁰Coroners Act 2009 (NSW) s101G.

against the female domestic violence victim prior to the homicide.

In one case where a male killed his female intimate partner, there had been no identifiable physical violence and the abuse manifested as non-physical domestic violence behaviours including restricting access to money, jealous and possessive behaviour, as well as psychological abuse (for example, threatening suicide/attempting suicide when the victim indicated that she was intending to separate from the abuser).

In most cases there had been no police involvement in relation to domestic violence, but in some cases there had been police involvement in relation to other matters

In one-third of cases of intimate partner homicide there had been contact with police in relation to domestic violence. In two cases this contact had occurred within six months of the homicide.

In two cases there had been police involvement in relation to other non-domestic violence matters (in one case police became involved following a suicide attempt by the abuser after he had separated from the victim, and in another case, there had been police contact in the context of numerous driving offences by the domestic violence abuser).

In most cases there were no apprehended violence orders applied for, or in place, at the time of the homicide

In 2 of the 12 intimate partner homicide cases reviewed by the Team, there was a current AVO in place against the homicide perpetrator (naming the female victim as the person in need of protection).

In one case there was an expired AVO between the female homicide victim and her abusive intimate partner.

All intimate partner homicides occurred in relationships greater than 1 year in length

All cases of intimate partner homicide reviewed by the Team involved a relationship that had been ongoing for longer than a year, with most occurring in relationships over two years in length.

Separation (actual or pending) was a feature in a high proportion of cases, particularly where a woman was killed by her abusive male partner

In 8 out of the 12 intimate partner homicides reviewed by the Team, the relationship was current and ongoing at the time of the killing.

Intention to separate or actual separation was a characteristic in 4 of the 12 cases, all of which involved a woman being killed by her abusive partner.

Accordingly, separation (actual or pending) was a characteristic of 44% of the cases reviewed where a woman was killed by her abusive male intimate partner.

In all cases of intimate partner homicide, the homicide perpetrator and deceased were living together

Notwithstanding actual or pending separation (discussed above) all 12 intimate partner homicide victims and perpetrators were living in the same residence at the time of the homicide.

In two cases where a woman was killed by her abuser, the relationship had ended some time prior to the homicide but both the domestic violence victim and domestic violence abuser continued to live in the same house (occupying different bedrooms). In two cases where a woman was killed by her abuser in circumstances where separation was imminent, the couple were living together at the time of the homicide.

In one-third of intimate partner homicides, there was an escalation of violence by the domestic violence abuser in the lead up to the homicide

In 4 of the 12 intimate partner homicides reviewed by the Team there were circumstances in the case which appeared to precipitate an escalation of violence by the domestic violence abuser in the lead up to the homicide, including:

- 1 case where there was an upcoming court date;
- 1 case where in all likelihood the domestic violence abuser was going to be returning to gaol for breaching community service orders;

- 1 case involving the dissolution of the relationship between domestic violence abuser and victim; and
- 1 case involving proximal and increasingly serious accusations of sexual assault by the domestic violence abuser against the couple's child.

In 8 of the 12 intimate partner homicides reviewed by the Team, there was no clear escalation of violence prior to the homicide, but rather violence by the abuser was ongoing against the domestic violence victim.

All male domestic violence abusers killed by female domestic violence victims died as a consequence of a single stab wound

As noted above, 3 of the 12 intimate partner homicides reviewed by the Team, involved a female domestic violence victim killing her abusive male partner. In all 3 of these cases the abuser died as a result of a single stab wound.

Conversely, of the 9 female domestic violence victims killed by their abusive male partner, most died as a result of a prolonged physical assault, often involving the use of multiple weapons (including blades, blunt objects and in one case a gun) to inflict multiple injuries.

In a high number of cases, there were surviving children under 18 years of age, who had a parent killed in a domestic violence homicide

This was a feature in 5 of the 12 intimate partner homicides examined by the Team in the case review period.

In every intimate partner homicide case someone outside the relationship was aware of the violence being perpetrated by the domestic violence abuser

In every intimate partner homicide reviewed by the Team, friends, family, colleagues, or neighbours ('bystanders') were aware of the domestic violence being perpetrated by the abuser in the relationship.

In 3 of the 12 cases, there was evidence that various bystanders had taken proactive steps to help the victim of domestic violence, for example, by calling police, offering accommodation or offering support and advice.

In 9 of the 12 cases, while there was an awareness of the abuse, there was an apparent reluctance from the various bystanders to become involved in the matter in any way. From the material reviewed in the cases, it appeared that there were many and varied reasons as to why bystanders were reluctant to take more proactive steps to support victims of violence, including:

- That friends and family did not know what to do to assist and support the domestic violence victim;
- That the seriousness of the abuser's conduct was underestimated;
- That abuse was normalized within the family and/or community;
- Family pressures for the domestic violence victim to 'sort it out' with the abuser; and
- Attitudes that domestic violence is 'a private matter'.

Case review findings – Child relative/kin homicides (domestic violence)

In the case review period, three children were killed in a context of domestic violence, including two children killed by their grandfather, and one child killed by her mother.

In all cases, the child had never been a target of child abuse prior to the homicide. In *Case Review 2974* the homicide perpetrator had a history of violence against his wife and adult children and in *Case Review 3010* the homicide perpetrator was a victim of violence by her intimate partner.

More data findings in relation to children killed by a parent are set out in **Chapter 4** of this report.

Case review findings – Adult relative/kin homicides

There were two cases reviewed by the Team involving a male domestic violence abuser who killed another family member – one male who killed his aunt, and one male who killed his mother. In these cases, both the domestic violence abusers and victims were Aboriginal.

There had been police involvement in both cases, and extensive involvement with the criminal justice system. There were cumulative social issues in both cases, including drug and alcohol use, a history of violence, and poverty.

Case review findings – ‘Other’ domestic violence homicides

Two cases reviewed by the Team were ‘Other’ domestic violence homicides which involved the death of a new boyfriend, who was killed by his girlfriend’s former abusive partner.

In both cases, there was a long history of domestic violence between the girlfriend and her former intimate partner, and there had been extensive contact with the criminal justice system.

In one case, at the time of the killing, the homicide perpetrator was on parole in relation to an assault against his former intimate partner. In the other case, the perpetrator was on a community service order for offences (including obtain money by deception) at the time of the killing.

4 DATA FOCUS

CHILDREN KILLED BY A PARENT IN A DOMESTIC VIOLENCE CONTEXT 2000-2010

This chapter provides a comprehensive data analysis in relation to all children who were killed by a parent/s in a domestic violence context in NSW between 1 July 2000 and 30 June 2010. This data focus was developed in response to the Whole of Government Response to the Team's 2011/12 Annual Report.

Background to data focus

In Australia, approximately 10% of homicides involve child victims under the age of 18,²¹ and the overwhelming majority of these homicides are perpetrated by a parent.²²

It has been estimated that an average of 25²³ to 27 children per year are killed by a biological or non-biological parent/s in Australia.²⁴

While many studies - both in Australia and internationally - have investigated various issues related to children who are killed by a parent, including: the role of mental illness and psychosis,²⁵ parental separation,²⁶ perpetrator gender,²⁷

perpetrator suicidality;²⁸ and victim age,²⁹ there has been little methodologically robust research examining the relationship between domestic violence and parents who kill their children.

Research has shown that a history of domestic violence is a feature in an overwhelming majority of homicides involving family members, and domestic violence as a factor in cases where parents kill their children has been suggested.³⁰ However, few studies have considered the characteristics of these cases occurring within a domestic violence context in any comprehensive detail.

The broad term 'domestic violence' can include direct violence against the child such as child abuse, which is an area traversed by much of the literature.³¹ However, the term domestic violence can also include exposure to other family violence such as violence between the child's parents.

Although this report uses the term 'domestic violence' to broadly describe these different experiences of violence, the data findings will distinguish between the different kinds of violence and their occurrence and co-occurrence where relevant.

²¹Dearden J & Jones W 2008. Homicide in Australia: 2006–07 National Homicide Monitoring Program annual report. Monitoring report no.1. Canberra: Australian Institute of Criminology.
<http://www.aic.gov.au/publications/current%20series/mr/1-20/01.aspx> [accessed 3 August 2013].

²²Kirkwood, D 2012, Just Say Goodbye: Parents who kill their children in a context of separation, Discussion Paper 8, Domestic Violence Resource Centre Victoria.

²³Mouzos, J. and Rushforth C. 2003. Family Homicide in Australia, Trends & Issues no. 255, Australian Institute of Criminology, Canberra.

²⁴Kirkwood, D 2012, Just Say Goodbye: Parents who kill their children in a context of separation, Discussion Paper 8, Domestic Violence Resource Centre Victoria.

²⁵Bourget D., Grace J. and Whitehurst L. 2007. A Review of Maternal and Paternal Filicide, *Journal of the American Academy of Psychiatry and the Law Online* 35(1):74-82; Spinelli, M G. 2004. Maternal infanticide associated with mental illness: Prevention and the promise of saved lives, *American Journal of Psychiatry* 161(9) 1548-1557; Resnick PJ. 1969. Child murder by parents: A psychiatric review of filicide, *American Journal of Psychiatry* 126(3): 325-334.

²⁶Brown T. and Tyson D. 2012. An Abominable Crime: Filicide in the Context of Parental Separation and Divorce, *Children Australia* 37(4):151-160.

²⁷Hatters Friedman S and Resnick P J, 2007. Child Murder By Mothers: Patterns and Prevention, *World Psychiatry* 6(3): 137-141; Bourget D and Gagne P. 2002. Maternal filicide in Quebec, *Journal of the American Academy of*

Psychiatry and the Law Online 30; 345 – 351; Silverman R. and Kennedy L. 1988. Women who kill their children, *Violence and Victims*, 3(2):121-135.

²⁸Appleby L. 1996. Suicidal behaviour in childbearing women, *International Review of Psychiatry* 8: 107-115.

²⁹Resnick PJ. 1970. Murder of the Newborn: A Psychiatric Review of Neonaticide, *American Journal of Psychiatry* 126(10): 1414-1420.

³⁰Mouzos, J. and Rushforth C. 2003. Family Homicide in Australia, Trends & Issues no. 255, Australian Institute of Criminology, Canberra; Office of the Chief Coroner Province of Ontario. 2012. 2011 Annual Report: Domestic Violence Death Review Committee, Office of the Chief Coroner: Ontario, Canada.

³¹Alder C and Polk K. 2001. *Child Victims of Homicide*, Cambridge University Press: Cambridge, United Kingdom.

Further research into these cases is necessary in order to better understand the nature of these deaths and inform appropriate intervention and prevention strategies in relation to domestic violence.

This research has been undertaken in response to the Whole of Government Response to the Team's 2011/12 Annual Report and prepared by the Secretariat of the Team in accordance with its legislative research mandate.

Methodology

This chapter uses a 10 year consecutive case sample (1 July 2000-30 June 2010) of all closed cases of child homicide by a parent (56 cases resulting in 69 deaths) occurring in New South Wales. This represents the complete dataset of all closed cases of this type during this period.

The dataset includes the killing of any child aged under 18 years by a parent/s where the outcome was a coronial finding (where the perpetrator has suicided or otherwise died after killing their child/children) and cases where a perpetrator was found guilty of murder, manslaughter or infanticide in relation to the death of the child. The review also includes all cases where the perpetrator was found not guilty by reason of mental illness.

Cases where a child homicide was recorded but the perpetrator is unknown are not included in the dataset.

For the purposes of this study, the term 'parent' is used to describe a biological parent, a step-parent (including a de facto step-parent), the boyfriend or girlfriend of a child's parent, or an adoptive parent or foster carer.

To develop its dataset the Secretariat identified and collected information in relation to every closed case where a child was killed by a parent in NSW during the data reporting period. Case identification was undertaken using a combination of coronial information systems, court and caselaw databases and police information.

Following case identification, the complete prosecutorial or coronial brief of evidence was reviewed, capturing extensive demographic, case characteristic and service contact information (both proximal and distal to the homicide). Where further information was required, this was called for pursuant to the *Coroners Act 2009* (NSW).

Having identified the complete dataset (N=69), each case was reviewed to determine whether the case occurred in a domestic violence context.

Children killed by a parent in a domestic violence context

Incidence

Having reviewed every case from the 10 year review period, it was determined that of the 56 cases where a parent killed a child/ren (resulting in 69 deaths) there were 40 cases (52 deaths) where a child was killed in a domestic violence context. Accordingly, 75% (N=52) of all children killed by a parent in the data review period were killed in a domestic violence context (**Fig. 32**).

As noted above, the domestic violence context of these deaths may reflect:

- the child's exposure to intimate partner violence in the family but no direct child abuse;
- the child's exposure to intimate partner violence in the family as well as direct child abuse against the child; or
- direct child abuse.

In 52% of the cases (N=27) the child had never been a direct target of child abuse, but was exposed to intimate partner violence behaviours between their parents (usually their father perpetrating domestic violence against their mother).

In 38% of cases (N=20), the child was a victim of direct abuse, and intimate partner violence behaviours co-occurred within the family.

In 10% of cases (N=5) the child was a direct victim of child abuse only and there was no history of intimate partner violence between the parents.

Child Victim Characteristics (N=52)

This section provides an overview of children who were killed by a parent in a domestic violence context (N=52, 75%).

Gender

Boys had a slightly higher representation as victims (N=30, 58%) compared to girls, who accounted for 42% of the dataset (N=22).

Age

Half of all child victims were under two years of age (50%) at the time of the homicide. The youngest

child victim in the dataset was aged one month and the oldest was 14 years old (**Fig. 33**).

Country of birth

Of the 52 child victims, almost all were born in Australia (N=51) and one child was born in India.

Aboriginal and Torres Strait Islander status

Of the 52 child victims, 15% (N=8) identified as Aboriginal.

All eight Aboriginal children were between 0-4 years of age. There were a total of 37 child victims in this age category and accordingly, almost one-quarter (22%) of all child victims in the 0-4 years dataset were Aboriginal.

As at 30 June 2011,³² Aboriginal children aged 0-4 years accounted for approximately 5.6% of the total 0-4yrs population in NSW.

These figures indicate a concerning overrepresentation of Aboriginal children who were killed by a parent in a domestic violence context, and, in particular, very young Aboriginal children.

Relationship of perpetrator to child

The 52 child homicides perpetrated by a parent in a domestic violence context were committed by 42 perpetrators (25 male parents and 17 female parents) (**Fig. 34**). This reflects the fact that in a number of cases a parent killed multiple children.

Biological parent

Of the 52 children who were killed by a parent in a domestic violence context, most were killed by a biological parent (N=40, 77%).

Of the 40 children killed by a biological parent in a domestic violence context, 22 (42%) were killed by their biological father and 16 (31%) were killed by their biological mother.

In two cases, the child homicide was perpetrated by a biological father and mother acting together.

Step parent

Of the 52 children killed by a parent in domestic violence context, 11 (21%) were killed by a step-parent (ten step-fathers and one step-mother).

Accordingly, step-fathers accounted for 19% of all perpetrators in the dataset.

Adoptive/foster parent

Of the 52 children killed by a parent in a context of domestic violence, one (2%) was killed by a foster mother.

Manner of death

The most common manner of death was fatal assault (excluding assault with a weapon) (N=16, 31%) including actions such as shaking, hitting, kicking or dropping/throwing onto a surface. All children who were killed by fatal assault were under 4 years of age (**Fig. 35**).

Other common manners of death included suffocation/strangulation (N=9, 17%), poisoning/exposure to noxious substance (N=9, 17%), multiple causes (N=4, 8%), drowning (N=3, 6%), shooting (N=3, 6%), fire (N=2, 4%), stab wounds (N=2, 4%) and terminal neglect (N=1, 2%). In three cases (6%) the manner of death was unknown.

The characteristics of parents who killed their children in a domestic violence context (N=42)

As noted above, the 52 child victims were killed by 42 perpetrators – 25 male parents and 17 female parents. This section provides a discussion of the characteristics of parents who killed their children in a domestic violence context.

Male parents (N=25)

Age

The 25 male parents who killed their children in a domestic violence context ranged in age from 18 to 53 years, with the highest proportion being aged between 30-34 years (N=11, 44%) (**Fig. 36**).

Country of birth

Most male parents were born in Australia (N=19, 76%). Other countries of birth included: India, Thailand, Iran, Egypt, United Kingdom, and Tonga.

Aboriginal and Torres Strait Islander status

Of the 25 male parents who killed their children in a domestic violence context, five identified as Aboriginal (20%).

As noted above, in NSW, Aboriginal Australians account for around 2.9% of total population.

³² Australian Bureau of Statistics (2013) *Australian demographic statistics, March quarter 2013*. Canberra: Australian Bureau of Statistics

Accordingly, there was a significant overrepresentation of Aboriginal male parents in this dataset.

Domestic violence history

Of the 25 male parents who killed their children in a domestic violence context, most were perpetrators of domestic violence against a current or former intimate partner (N=20, 80%). No male parents were victims of domestic violence by a current or former intimate partner (**Fig. 37**).

Other characteristics

In over one-third of all cases where a child was killed by a male parent (N=9, 36%), there was evidence of relationship breakdown between the male perpetrator and the child's mother (**Fig. 37**).

Child custody issues proximal to the child homicide were also a feature in approximately a third of cases (N=8, 32%).

Over half of all male parents in the dataset were experiencing financial issues (N=14, 60%), and approximately half were unemployed (N=13, 52%).

Over half of the male parents who killed their child/ren in a domestic violence context reported being a victim of violence and abuse during their childhood (N=14, 56%).

Other perpetrator characteristics included:

- excessive drug or alcohol use (N=12, 48%);
- mental health issues (N=10, 40%);
- suicidal ideation (N=9, 36%);
- a history of suicide attempts (N=7, 28%);
- an upcoming court date (N=3, 12%); and
- history of neglecting the child (N=2, 8%) (**Fig. 37**).

Female parents (N=17)

Age

The 17 female parents who killed their children in a domestic violence context were aged between 18 and 39 years, with the highest number being between 20-24 years of age (N=5, 29%) (**Fig. 36**).

Country of birth

Most female parents were born in Australia (N=15, 88%). One female perpetrator was born in New Zealand and one was born in Vietnam.

Aboriginal and Torres Strait Islander status

None of the 17 female perpetrators identified as Aboriginal or Torres Strait Islander.

Domestic violence history

Almost all female parents who killed their child/ren in a context of domestic violence were victims of domestic violence from a current or former intimate partner (N=16, 94%). No female homicide perpetrators had previously been a perpetrator of domestic violence against a current or former intimate partner (**Fig. 37**).

Other characteristics

Over half of the female parents who killed their child/ren in a domestic violence context reported being a victim of violence and abuse during their childhood (N=10, 59%) (**Fig. 37**).

Other prevalent characteristics in the female perpetrator dataset included:

- unemployment (N=15, 88%);
- financial stressors identified within the family (N=11, 65%);
- relationship breakdown (N=11, 65%);
- mental health issues (N=10, 59%);
- postnatal depression (N=7, 41%);
- social isolation (N=6, 35%); and
- evidence of suicidal ideation prior to the homicide (N=6, 35%) (**Fig. 37**).

Criminal Court/Coronial Outcomes

Perpetrator suicide

Just under one-quarter of parents who killed their child/ren in a domestic violence context committed suicide (N=10, 24%) (**Fig. 38**).

Of the 10 parents who committed suicide, 8 were male (7 biological fathers and 1 step-father) and 2 were female (both biological mothers).

In 7 of these cases, the perpetrator committed suicide after killing 2 or more victims.

In one case, the perpetrator died accidentally as a consequence of burns (he killed his intimate partner and child by deliberately setting fire to the house).

Criminal court outcomes

For all parents who killed a child/ren in a domestic violence context, the most common criminal court outcome was guilty plea manslaughter (41%), followed by, guilty verdict murder (10%), guilty verdict manslaughter (10%), guilty plea murder (10%), no billed (2%) and infanticide (2%) (**Fig. 38**).

Service Contact

Reviewing service contact information for cases where a child was killed by a parent in a domestic violence context can provide a valuable insight into the behaviours of homicide perpetrators and victims both proximal and distal to the fatal event. This information can help identify intervention and prevention opportunities in relation to domestic violence.

Service contact can include help-seeking behaviours and service contact in relation to domestic violence with intervention agencies including police, child protective services and domestic violence agencies. However, relevant service contact can also include contact with providers which does not arise in a context of domestic violence, such as contact with healthcare professionals in relation to medical issues, education providers by virtue of a child or children attending school and contact with other services.

Such contact may not directly relate to domestic violence but may nonetheless provide an intervention opportunity.

Service contact information was reviewed for 38 of all 40 cases where a child/ren was killed by a parent in a domestic violence context. 'Service contact' includes contact by any member of the family unit (for example, by one or both parents, any child including a child not deceased) (**Fig. 39**).

In two cases, this information was unavailable at the time of publication.

Service contact findings

Child protection agencies

In over half of all cases reviewed where a child was killed by a parent in domestic violence context, the family unit had service contact with child protective services within 3 years of the fatal event (N=21, 55%) and in almost every case, this contact had taken place within 6 months of the homicide (N=19, 50%). This contact all related to concerns around domestic violence including child abuse, neglect or other concerns involving the welfare of the child within the family.

NSW Police

In over 65% of cases reviewed, the family had contact with the NSW Police Force within 3 years of the homicide (N=25). In 39% of all cases, there had been contact with police within 6 months of the homicide occurring (N = 15). Some of this contact related to issues other than domestic violence, but

domestic violence was nonetheless ongoing in the family.

Counselling services

In over a quarter of cases, someone in the family had contact with a counsellor within 3 years of the homicide (N=11, 29%). Most of this contact occurred within 6 months of the homicide (N=9, 24%).

Domestic violence specialist services

In just under a quarter of cases, someone in the family had contact with domestic violence specialist services within 3 years of the homicide (N=9, 24%) and in under 10% of all cases, there was contact within 6 months of the homicide (N=3, 8%). Such specialist domestic violence services included domestic violence refuges, crisis services and other specific domestic violence agencies.

Sexual assault services

In three cases there had been contact with specialist sexual assault services within 6 months of the homicide (N=3, 8%), and in 2 cases this contact had been ongoing for over 12 months prior to the homicide (5%).

Men's behaviour change services

In one case, there had been contact with a men's behaviour change service within 3 years of the homicide (3%). No cases involved contact with such a service within 6 months of the homicide.

In addition to service contact in relation to domestic violence behaviours, there were also high levels of service contact across a number of different agencies that did not specifically relate to domestic violence help-seeking. In these cases, it was evident that there were opportunities for identification, intervention or enhanced domestic violence screening.

Healthcare services

In over two-thirds of all cases reviewed, someone in the family had contact with a healthcare professional within 6 months of the homicide (N=28, 74%). In all cases reviewed, the family had had contact with a healthcare professional within 3 years of the homicide (N=38, 100%).

School/Education services

In over a third of cases, there was contact with schools within 6 months of the homicide (N=15, 40%).

Social welfare services (Centrelink)

In almost half of all reviewed cases, there was ongoing contact with social and welfare payment services (Centrelink) including within 6 months of the homicide (N=18, 47%).

Social housing providers

The family had contact with a social housing provider recorded in over a third of all cases within 6 months of the homicide (N=15, 40%), all of which had been ongoing for a period exceeding 12 months.

Corrective services/probation and parole services

In over a quarter of all cases reviewed, someone in the family was in contact with parole services within 3 years of the homicide (N=10, 26%) and in half of these cases, this contact was ongoing within 6 months of the homicide (N=5, 13%).

Other service contact included contact with:

- *courts and tribunal services* (N=12, 32%);
- *legal practitioners* (N=7, 18%);
- *mental health services* (N=7, 18%)
- *religious leaders/churches* (N=4, 11%);
- *drug and alcohol services* (N=4, 11%);
- *culturally specific welfare services* (N=1, 3%); and
- *immigration services* (N=1, 3%).

Concluding Remarks

The importance of recognizing domestic violence as a factor in the deaths of children has not been extensively explored by the existing literature on this topic.

Domestic violence within relationships can be identified by a range of service providers, where processes are designed to identify and respond to violence. This includes in cases where a child within the family is the direct target of abuse, but also cases where a child's parent is experiencing or perpetrating violence against their intimate partner.

This examination represents a first step in a plan to more broadly investigate and understand the homicides of children by parents occurring in a context of domestic violence.

Although this examination has presented some preliminary data in relation to domestic violence behaviours within families (including to distinguish between the co-occurrence of different forms of family violence), this will be the subject of expanded data capture in subsequent reports.

Further, it is anticipated that in future reports, examination of classification systems/typologies in relation to the deaths of children killed by a parent/s, will be undertaken.

5 FINDINGS & RECOMMENDATIONS

This Chapter provides a synthesis of the Team's analysis of quantitative and qualitative data, and presents a discussion of themes and issues arising from the Team's two tier review processes. This section also outlines 23 recommendations to various Government and non-Government agencies, derived from data and case review findings contained in this report.

NOTE: *This report was initially drafted in late 2013 and recommendations developed from the cases reviewed at this time. Due to the delay in finalising this report, it is acknowledged that issues identified and recommendations made in response to issues arising may have been actioned or addressed by agencies during the intervening period. This report therefore reflects the state of policies and procedures within agencies as at October 2013, and may not reflect current practice and procedure. It is further noted that during the period between the initial draft of this report and the finalisation of this report there has been a change in the constitution of the Team. The constitution of both the former Team and the current Team membership is outlined at Appendix F.*

Introduction

In this report, the Team has used a synthesis of case review findings (qualitative analysis) and complete dataset findings (quantitative analysis) to derive a number of strategic recommendations aimed at enhancing and developing:

- intervention and prevention strategies ;
- identification and referral strategies;
- individual agency responses to domestic violence; and
- strategies for supporting communities to prevent and address violence.

The Team would like to recognise and commend all agencies who work to reduce the incidence of domestic violence, and reiterate that the recommendations contained in this report are designed to support agencies, communities and individuals in these endeavours.

Supporting Police in Responding to Domestic Violence

A common theme in the case reviews, and also explored in the **Chapter 4**, was victims and perpetrators of domestic violence homicides having contact with NSW Police Force either in relation to such violence, or for reasons unrelated to domestic violence.

The NSW Police Force is a frontline agency and responding to domestic violence constitutes a significant proportion of their day to day operations.

Domestic violence is complex. While physical violence is often a feature in domestic violence cases, in some of

the cases reviewed by the Team there was no recorded history of physical violence prior to the homicide. In cases such as *Case Review 2998* and *Case Review 2974*, relationships were characterised by non-physical coercive and controlling behaviours, such as controlling money and isolating the victim from family and friends. In other cases, the perpetrator of domestic violence would use threats or acts of self-harm as a way of manipulating and controlling the emotions and actions of the victim (*Case Review 2998* and *Case Review 3004*).

For frontline agencies, the complexity of these cases makes responding difficult, and can present ongoing challenges for officers who meet multi-stratum barriers in their attempts to provide assistance to victims and perpetrators. In some cases, victims do not characterise the behaviours they are experiencing as domestic violence (for example, *Case Review 3000*, *Case Review 2974*). In some families and communities violence is also a part of daily life (*Case Review 3019*).

Furthermore, in many cases, the pattern of coercive and controlling behaviour that characterises domestic violence can result in victims feeling unable to leave a violent relationship. Victims may be perceived as 'accepting violence' in cases where police or other intervention is rejected, and this resistance, and the perception that such intervention is futile, can have a negative impact on police officers.

In recognition of the complexities of domestic violence, as well as the extent to which police officers face challenges in responding to such violence, the Team recommends:

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.*

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.

Risk identification: separation, cohabitation and court proceedings

In two-thirds of all intimate partner homicides where a female was killed, the victim and perpetrator had either recently separated or were in the process of separating.

The period directly after separation therefore appears to be high-risk for females in relationships involving domestic violence.

In two of the in depth case reviews, the homicide victim continued to live with their abuser following the breakdown of the relationship. In both of these cases, the victim was killed by that domestic violence abuser in their shared home.

Continuing to live with a domestic violence abuser post-separation may therefore be a factor that increases the risk of further violence for victims. Frontline responders to domestic violence, in particular police officers, need to work closely with domestic violence victims to promote awareness of this risk.

Another characteristic in a high number of cases was a proximal, or upcoming court date and/or an ongoing legal dispute affecting the victim and perpetrator (see, for example, *Case Review 3004*, *Case Review 3296*, *Case Review 3000*, *Case Review 3019*, *Case Review 2584* and *Case Review 2593*).

These findings indicate the need for frontline responders to work with victims of violence to promote awareness of the risks that upcoming or ongoing criminal, family or other legal proceedings may pose in a context of domestic violence.

The Team accordingly recommends:

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?*

Informal help-seeking: safe internet usage

Victims of domestic violence may engage in formal and informal help-seeking behaviours. With the increasing availability of online internet resources concerning domestic violence, it is extremely important to protect the safety of victims who are accessing these resources.

In many of the cases reviewed, victims of violence were closely monitored in their day to day activities by their abusive partners (*Case Review 2321*, *Case Review 2998*, *Case Review 2974*, *Case Review 3004*, *Case Review 3032*, *Case Review 3023*). It is therefore important to ensure that victims can safely and quickly exit websites containing domestic violence information and safely remove their internet browsing history. It is the perspective of the Team that in cases where victims of violence are 'caught' looking at domestic violence information by a domestic violence abuser, this may compromise their safety.

Accordingly, the Team recommends:

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.

Best practice policing: recording of information

In most cases where individuals experiencing domestic violence came into contact with the NSW Police Force, they came into contact on more than one occasion. Due to the nature of police work, on many occasions individual officers will respond to domestic violence callouts where they do not have first-hand knowledge of the circumstances surrounding the case.

In these situations, it is extremely important for officers to have access to comprehensive records which clearly set out the perpetrator and victim's history of contact with the NSW Police Force. This assists officers in making risk assessments and appropriate referrals for victims. This approach is also considered best practice policing.

The importance of maintaining a comprehensive record of all police contact extends to cases where assessments are made as to the mental health of perpetrators or victims. In one case reviewed (*Case Review 3019*), officers assessed the mental health of the perpetrator earlier in the evening prior to the homicide and decided to send him home. Police in this case made no record of this contact and assessment. Earlier in the evening, the officers had also provided directions and instructions to the perpetrator in the context of his bail conditions and similarly, no COPS event was recorded.

It is the perspective of the Team that in accordance with the need to maintain an accurate record of dealings with perpetrators and victims of domestic violence, that COPS Events must be made where officers make a mental health assessment under the *Mental Health (Forensic Provisions) Act 1990* (NSW), and in cases where the police give instructions to a person who is on bail.

Accordingly, the Team recommends:

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.*

In accordance with the above recommendation noting the importance of maintaining accurate police records in relation to domestic violence contact, the Team notes the importance of supporting officers to respond to domestic violence in accordance with best practice policing principles.

In *Case Review 3019*, as well as some of the cases reviewed in the Team's *2011/12 Annual Report (Case Review 2965, Case Review 2969)*, there were instances where police were called to and attended domestic violence callouts, but no COPS Event was recorded.

Similarly, in the Team's *2011/12 Annual Report*, a case was reviewed wherein a child custody dispute (involving a male domestic violence abuser refusing to return their child to his former wife, a domestic violence victim) arose and was mediated over the phone by an officer, the day before the homicide. No record was made of this contact and the next day, the man killed his former wife (*Case Review 2964*).

It is the perspective of the Team that if record-keeping was enhanced, service responses in relation to domestic violence would be improved.

Therefore, in order to better support officers responding to domestic violence, it is recommended that NSW Police Force remind officers of best practice policing for domestic violence cases, through developing a communication strategy which will reiterate the importance of thorough record keeping in these matters.

Achieving this will also require some adjustments to the NSW Police Force Complaints Management system, c@tsi.

Accordingly, the Team recommends:

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.*

Promoting police engagement with Aboriginal victims and perpetrators of domestic violence

As consistently demonstrated in the case review and data findings, there is a concerning overrepresentation of Aboriginal victims and perpetrators of domestic violence homicide.

In many of these cases, there had been significant involvement with NSW Police Force, and in many cases, officers demonstrated behaviours consistent with a formed belief that police intervention was futile.

The reasons for the overrepresentation of Aboriginal victims and perpetrators in a context of domestic violence are many and varied. By reviewing these homicide cases, the Team has developed a complex picture of the lives of victims and perpetrators, revealing the many layers of disadvantage and hardship characteristic of these cases. Many cases involve fractured kinship networks, the remnants of historical dispossession and other cumulative social issues including inter-generational violence, substance abuse and poverty.

Further support needs to be given to officers in understanding some of the unique issues affecting the Aboriginal population in NSW. It is the Team's perspective that an informed education strategy may assist officers in responding appropriately to domestic violence within Aboriginal communities, and will promote more effective outcomes in responding to and preventing future violence.

There are many existing programs which may provide the basis for rolling out this education strategy. For example, the *2013 Judicial Commission Education Program*, the *Ngara Yura Program Seminar*:

Understanding Kinship, run by senior academics at the Koori Centre, University of Sydney.

Accordingly, the Team recommends:

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.

Supporting youth on bail

As illustrated in **Chapter 2** of this Report, a significant number of victims and perpetrators of domestic violence homicide are young people.

In many of these cases, the homicide follows a history of criminal offending (for example, *Case Review 2584*).

In cases where the young person comes from a family wherein a culture of violence or crime is normalised (for example, *Case Review 2275*), being granted bail and returning home can be counterproductive to addressing offending behaviours.

Similarly, in some cases, there is simply no safe alternative to custody for young people, and being granted bail may result in reduced access to accommodation or access to food.

Most seriously however, in some cases (for example, *Case Review 3019*) being granted bail to live with a specific family member following an offence against that person may put that person at risk.

Consequently, the Team supports moves to increase utilisation of the bail assistance line for young people. Further, the Team believes that in regional areas, such as the area in *Case Review 3019*, the need for the BAL to be utilised by officers may be even more urgent.

Accordingly, the Team recommends:

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.*

Intergenerational violence and the impact of domestic violence homicide on children

As described in **Chapter 4**, at least half of all homicide perpetrators who killed their child in a domestic violence context reported experiencing violence during their own childhood. Few were provided with any supports during their childhood to help them cope with their experiences of violence and this cycle of violence continued against their intimate partners, relatives or their own children later in life.

Further, in two cases reviewed by the Team in this report (*Case Review 2275* and *Case Review 3014*) there was evidence of intergenerational homicide offending. In both cases, the homicide perpetrator had a parent who also perpetrated a homicide either during the perpetrator's childhood or prior to their birth. In one case, the homicide perpetrator's mother had spent a significant period of his childhood in gaol for a manslaughter conviction.

A case reviewed for the Team's *2011/12 Annual Report* (*Case Review 2965*), involved the homicide of a woman by her abusive intimate partner. The woman had a number of young and teenage children and the Team has recently found out that the woman's son has been charged and convicted of killing his girlfriend.

Finally, there was a case in the 2001 (which has been reviewed for inclusion in the Team's historical dataset) involving an abusive husband who killed his wife in front of their young child 'J'. A decade after witnessing his mother's violent homicide, 'J' planned and executed a brutal rape and homicide of his young female neighbour. This followed an extensive criminal history of sexual assault, robbery delinquency by 'J' which commenced shortly after his mother died and while his father was incarcerated for her murder.

These cases only represent a small percentage of those cases wherein child victims of violence have grown up to become victims or perpetrators of further violence. This problem, it seems, is pervasive.

In five of the 19 cases reviewed by the Team for this report, there were surviving children (less than 18 years old) of homicide victims and/or perpetrators. In one of these cases (*Case Review 2321*), FACS were not aware that the children's biological father had been killed by his girlfriend, as the children only saw their father via informal parenting orders (which was not

captured in the FACS system). Their mother was not amenable to FACS intervention and had never sought counselling for the children to deal with their grief. While these children had therefore been offered counselling through their school, they have never received any formal counselling in relation to their father's death.

The Team considers that there is scope for improvement in handling intergenerational violence cases, particularly as a start by reviewing and improving policies around the provision of counselling services for child survivors of domestic violence homicide.

Accordingly, the Team recommends:

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.

Domestic violence identification and referral: Emergency healthcare context

In a number of cases reviewed for this annual report, victims of domestic violence, who later became victims of homicide, had a history of presenting at hospital and ambulance services with domestic violence related injuries (*Case Review 3018*, *Case Review 3417*, *Case Review 3296*).

In one of these cases, the domestic violence abuser had thrown a rock at the domestic violence victim, causing her to drop her baby. She and the baby were both injured in the assault, both were transported by ambulance to a public hospital accident and emergency department. The victim's discharge notes indicated that she had been '*injured by a rock*', and were not

indicative of an assault injury. No referral information was provided and the victim returned home to her abusive husband who some months later killed her.

In another case, the victim was taken to hospital by police, claiming that she had been assaulted by her intimate partner, a domestic violence abuser. She had no obvious injuries, and was heavily intoxicated on presentation. She became frustrated and demanded to go home. She was discharged into the care of the abuser who killed her the following day.

In the third case, the victim presented at an accident and emergency department having been transported there via ambulance, suffering injuries she had sustained as a consequence of domestic violence. She claimed that she had simply fallen over. The victim was quite intoxicated, and was discharged with no referral or other information in relation to domestic violence. She sustained fatal injuries some months later as a consequence of a domestic violence assault.

NSW Accident and Emergency departments are traditionally considered to be extremely busy departments providing crisis healthcare to often seriously injured patients in short timeframes. There is normally a short period spent in Accident and Emergency facilities and consequently, domestic violence identification and referral procedures are challenging to implement.

In some cases, including the third case discussed above, healthcare contact is the only contact domestic violence victims have.

Healthcare screening is recognised as an important aspect in the suite of domestic violence screening and prevention measures, and is regularly practiced, particularly in a pre-natal setting. While screening at an emergency room level may be inappropriate, it remains that for many victims of violence who present with domestic violence related injuries, careful identification and referral by appropriately trained staff could help support these victims of domestic violence.

For Ambulance staff who, in the course of their employment, regularly attend domestic violence callouts, they can provide crucial information which can facilitate the appropriate triaging and handling of domestic violence injuries in Accident and Emergency Departments.

The Team believes that there is scope to enhance the handling of domestic violence within NSW Accident and Emergency rooms and within Ambulance NSW.

Accordingly, the Team recommends:

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.***
- 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.

Access to justice: use of interpreters and translators

This report has presented data around the country of birth for both domestic violence homicide victims and perpetrators. Although most domestic violence homicide victims in the Team's dataset were born in Australia, a significant proportion (just under 30%) were born overseas, in over 25 different countries.

This diversity is illustrative of the need for available interpreters educated to understand the complexities and dynamics of domestic violence.

In one of the cases reviewed (*Case Review 3018*), the victim was being screened for domestic violence in a pre-natal setting using an interpreter. Although little information is provided about who this interpreter was – for example, whether the translator was male or female, of the same ethnic background, of the same age or similar – it was clear from the clinical notes that the victim had not disclosed her experiences of violence, despite the fact that she had been in contact with police about such violence recently.

This case is illustrative of some of the specific barriers that may arise in the context of domestic violence screening when using interpreters.

As illustrated above, a challenge for responders to domestic violence is that in many cases women do not characterise the behaviour they experience as extraordinary, or violent. For some, violence has become normalised and to the extent a woman is asked whether she is experiencing domestic violence, many will say 'no'.

The Team believes that there is scope to improve existing policies around domestic violence at the level of training for interpreters, policies in place with agencies (for example, NSW Health) and the use of educational aids for victims (to assist in the process of self-identification as well as remove barriers to disclosure).

The Team accordingly recommends:

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:*
 - c) *Wherever possible, the patient is consulted as to their preferences for an interpreter in relation to gender; and*
 - d) *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).*

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.

Recommendation 13

That the Community Relations Commission incorporate into its induction training for all interpreters and translators, a mandatory unit examining to the dynamics and behaviours of domestic violence.

Legal professionals, the judiciary and domestic violence

In many of the cases reviewed by the Team for this (and the last) report, victims and perpetrators of domestic violence were in the process of seeking legal assistance in a period proximal to the homicide.

For many, contact with lawyers related to separation and the distribution of assets, divorce processes and child custody/maintenance arrangements (for example, *Case Reviews 2964, 2978, 2995, and 2976* from the Team's *2011/12 Annual Report*; *Case Review 3032*).

For others, contact with legal professionals related directly to domestic violence charges (*Case Review 3296*).

In all the cases identified above, there were disclosures made by clients to legal professionals which indicated that domestic violence was being perpetrated or experienced by the client and/or their children. In every case the lawyer handled the disclosure inappropriately, either failing to make any recommendation for referral or failing to acknowledge that the violence the client was experiencing was, in fact, violence.

The role of lawyers in identifying and responding to domestic violence is a challenging one. Recently, the Commonwealth Attorney-General launched the *Family Law Doors (Detection of Overall Risk Screening) Framework* which is designed to help professionals in the family law system to identify safety risks for clients and particularly risks to those families experiencing domestic violence. Although this framework provides guidance to lawyers, the screening processes it implements are time-consuming and it is not mandatory to complete this screening in NSW at present.

Accordingly, the Team has considered potential avenues for engaging the legal sector in the identification and referral of domestic violence cases. Given that intake screening may be an inappropriate time to screen new clients as it may be too soon in the process to expect disclosure (as well as time consuming for practitioners), the Team resolved to engage the Law Society in implementing appropriate

referral processes (in place on the website) as well as incorporating domestic violence training in specialist accreditation schemes.

In recognition of the central role of legal practitioners in identifying and responding to domestic violence, the Team, in future annual reports, will aim to further develop recommendations which incorporate more specialised training for young, or non-specialised, practitioners.

The Team accordingly recommends:

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.***

In a significant number of cases reviewed in depth in this report, and also in the Team's *2011/2012 Annual Report*, the Team raised concerns about the language used by higher court judicial officers when describing domestic violence in their remarks on sentence.

A number of examples are as follows:

- In *Case Review 3019*, despite the history of psychological abuse, destruction of property and police callouts, there was no mention of 'domestic violence' in the remarks on sentence. This was also the case for *Case Review 3417*, where despite a significant history of physical assaults and hospital visits, the language of domestic violence was not used in remarks on sentence.
- In *Case Review 3010*, despite the significant history of serious emotional and physical abuse against the perpetrator by her de facto partner (the child victim's father), the relationship between the two was described as '*disastrous*' and again there was no mention of domestic violence in the judgment. Furthermore, the homicide perpetrator was described as having a '*yummy mummy*' complex, due to her preoccupation with having an orderly and clean household. In fact, this

preoccupation was the perpetrator's coping mechanism for dealing with the serious abuse she was experiencing from her de facto who regularly berated her for being a 'bad mother'.

- In *Case Review 2593*, there was no mention of domestic violence in the judgment and the judgment also incorporated the phrase: *'[the victim] terminated her relationship with the offender motivating him to threaten to kill her and to wield an axe at her car causing very considerable damage'*. This statement inappropriately attributes fault to the victim of domestic violence although this was undoubtedly not the intention of the judicial officer making the statement.
- In many cases, including *Case Review 2978* (2011/2012 Annual Report), a male homicide perpetrator is described as 'snapping' when he perpetrated the homicide. In some cases this term is used in inverted commas, and in other cases it is not.
- In many cases the domestically violent relationship is described as 'troubled' or 'volatile', which attributes the violence to a 'relationship', and minimises perpetrator accountability.

The Team acknowledges the significant role of the judiciary in the criminal justice response to domestic violence and considers it critical that all judicial officers approach the issue in a way that promotes awareness and understanding of domestic violence, and appropriately condemns the criminal behaviour.

The Team notes that the *Judicial Commission of NSW* has developed a number of education seminars and publications addressing the issue of domestic violence. The focus to date, however, has been to assist judicial officers sentencing domestic violence offenders and the Team notes that this primarily takes place in the local court jurisdiction.

The *Sentencing Benchbook* addresses the topic of domestic violence in numerous places and is currently being updated to incorporate the statement of 6 members of the High Court in *Munda v Western Australia* [2013] HCA 38 (2 October 2013) at [55]:

"A consideration with a very powerful claim on the sentencing discretion in this case, is the need to recognise that the appellant, by his violent conduct, took a human life, and, indeed, the life of his de facto spouse. A just sentence must accord due recognition to the human dignity of the victim of domestic violence and the legitimate interest of the general community in the denunciation and punishment of a brutal, alcohol-fuelled, destruction

of a woman by her partner. A failure on the part of the state to mete out a just punishment of [sic] violent offending may be seen as a failure by the state to vindicate the human dignity of the victim; and to impose a lesser punishment by reason of the identity of the victim is to create a group of second class citizens, a state of affairs entirely at odds with the fundamental idea of equality before the law. '

While this statement relates to sentencing considerations, the Team notes the importance of using the remarks on sentence as a mechanism of condemning domestic violence and importing social norms in relation to such violence.

The Team believes that the judiciary plays an important role in responding to domestic violence and providing public guidance in relation to acceptable social norms.

Accordingly, the Team recommends:

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.***

Healthcare contact and domestic violence identification and referral

Many victims of domestic violence do not seek help from police, domestic violence services or other frontline responders to violence for many and various reasons. This is one of the many rationales for the implementation of screening processes in relation to domestic violence through pre-natal healthcare and in other healthcare contexts.

In one of the cases that arose during this review period (*Case Review 3032*) the victim was engaged in assisted reproductive technology processes during the period in which she was experiencing extreme violence. The victim did not make any domestic violence disclosures to assisted reproductive technology providers and her medical records did not reveal any pre-natal screening. She otherwise had no contact with other agencies.

For many women who are experiencing violence, fertility issues and/or issues around pregnancy can increase levels of stress in the relationship with their violent partner, exposing them to greater risk of harm. Although this recommendation should not be interpreted as stigmatising women or men who access assisted reproductive technology, it instead reflects the Team's ideology that in cases such as *Case Review 3032*, the absence of identification and referral procedures through assisted reproductive services providers represented a missed opportunity for addressing the violence the victim was experiencing.

The Team considers that there is an opportunity for providers of assisted reproductive services in NSW to further promote awareness and understanding around domestic violence. The Team further considers that it is important that staff of assisted reproductive services ensure appropriate referral for its clients when domestic violence is disclosed or identified.

Accordingly the Team recommends:

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.

Community Responses to Domestic Violence

In every case reviewed by the Team for this report, friends and family were aware of domestic violence but did not respond for a range of reasons including:

- not recognising abusive behaviours as domestic violence/normalisation of violence in the community;
- not knowing how to support and assist the victim of violence; and
- considering domestic violence a private matter between the victim and abuser.

The Team recognises the challenges that domestic violence presents to friends and family, including the difficulties of knowing how to respond to victims when they themselves appear to be 'accepting' of the violence they are experiencing. In most cases reviewed, victims do not ask friends or family for help directly, but instead present with injuries or complain of abuse, but

may minimise the violence they are experiencing. This reflects the primary challenge for friends and family responding to domestic violence, intervening in a private relationship to address the violence the victim is experiencing, from a position proximal to that relationship.

In many cases reviewed, neighbours were aware of domestic violence but did not call police, nor attempt to help victims of violence in other ways. For example, in *Case Review 3019*, the neighbour on the evening of the killing heard the perpetrator yelling to the victim that he was going to 'kill her', but rather than calling the police, stood outside his house and yelled that the perpetrator and victim needed to 'quieten down'

In other cases, such as *Case Review 3417*, neighbours' assistance was sought in relation to domestic violence injuries, but the neighbours did not respond by calling police. In other cases, such as *Case Review 3000*, neighbours stood on their balconies and watched episodes of domestic violence between the victim and abuser.

As evidenced by the data contained in Chapters 2 and 4 of this report, the prevalence of domestic violence in Aboriginal communities is also of particular concern to the Team.

In the *2011/12 Annual Report* the Team made a recommendation in relation to public education around domestic violence, aimed at addressing the unique challenges such violence poses to family, friends and neighbours of the victim and perpetrator. This recommendation received in principle support but as yet, there has been no action to implement this recommendation.

In the past few years there have been a number of effective programs implemented which are designed to enhance supports available for communities in responding to violence. An example of this is the DEC program *Tackling Violence*.

Therefore, in order to facilitate implementation of this recommendation, and in recognition of the importance of educating and empowering communities to support victims and perpetrators of violence, the Team recommends:

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.

This work should be undertaken in partnership with key stakeholders including local councils, sporting and voluntary groups and Aboriginal communities.

Office of Communities should co-ordinate with Women NSW to promote the positive evaluation findings from this initiative.

Parenting Programs for Aboriginal Fathers

As illustrated by the data analysis in Chapter 4 of this report, there is an overrepresentation of male Aboriginal parents who killed a very young child.

The reasons for the overrepresentation of male Aboriginal perpetrators of violence are manifold. As discussed above, all of the perpetrators were suffering from serious social disadvantage including in many cases poverty, substance abuse issues, violent coping mechanisms, intergenerational violence and the residual effects of social historical dispossession. Fractured kinship networks and losses of culture and support networks due to geographical, social or other reasons were also common characteristics across this dataset.

The Team notes that Community Services has developed a range of parenting programs – including *Raising them Strong* and *Growing up Strong*. Some of these programs are developed for Aboriginal parents - which are outlined on their website.

In recognition of the cumulative social disadvantage suffered by many Aboriginal males, any approach to developing parenting programs for this group need to be informed by an accurate understanding of the life traumas experienced by these males.

The Team recommends that a trauma-informed parenting program be implemented in the context of the community program outlined in **Recommendation 17**.

Accordingly, the Team recommends:

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.

Information and support for victims of violence

Many victims of domestic violence homicide had contact with NSW schools, either directly as a student or parent, or through siblings or other persons.

In some cases (for example *Cases 2969, 2579*, and also *Case Review 2626* from the *2011/12 Annual Report*), members of the family unit were directly in contact with schools in relation to domestic violence. Further, in the data analysis discussion in **Chapter 4**, victims and perpetrators of child homicides were regularly in contact with schools.

Due to the increasing use of the internet as a resource for domestic violence services information, it is recommended that the NSW DEC prioritise domestic violence information for both students and parents in a highly visible, easy-to-use portal.

Furthermore, in some cases reviewed in depth, victims of domestic violence were employed for various NSW Government agencies (such as *Case Review 2257*) or were otherwise using NSW Government websites. The Team reviewed the available information on these websites and concluded that whilst in many cases information was available, it was often difficult to find or sent the user on a 'referral roundabout'.

The Team determined that the NSW Government (Women NSW) domestic violence portal available at www.domesticviolence.nsw.gov.au would be a useful resource for conveying easily accessible identification and referral information for victims of domestic violence.

Accordingly, the Team recommends:

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.**

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.

Supporting older victims of violence

A significant proportion of homicide victims who were killed by their intimate partner or a relative/kin in NSW were over the age of 60.

The Seniors Card NSW website houses significant information in relation to a wide range of issues of interest to older Australians including travel, events, computing for seniors, health, housing and accommodation. There is currently no accessible and current information on the website about abuse of older Australians or intimate partner violence as experienced by older Australians.

In recognition of the increasing importance of the internet as a resource for older Australians, and the use of the Seniors Card by individuals in this age group, the Team recommends:

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 noted previously, a significant proportion of homicide victims who were killed by their intimate partner or a relative/kin in NSW were over the age of 60.

The Team recognises that victims in this age group face specific barriers including social, geographical, economic and physical barriers in accessing information, services and responding to domestic violence.

In recognition of the difficulties for older victims of domestic violence in 2012 the NSW Whole of Government Ageing Strategy was released. As a part of this strategy the NSW Steering Committee on the Prevention of Abuse of Older People was constituted to provide expert advice and develop key initiatives aimed at reducing the incidence of older people experiencing abuse. One such initiative was the implementation of the *NSW Elder Abuse Helpline and Resource Unit* which commenced operation in March 2013.

As these initiatives dealing with domestic violence against older people in NSW were developed and implemented recently, the Team recommends that monitoring of the use and outcomes of the service be undertaken in order to identify any strengths, gaps and weaknesses in current service delivery models.

Accordingly, the Team recommends:

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;*
- 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.*

As many older women may not seek help in relation to domestic violence from frontline responders such as police, it is important that other service providers to undertake appropriate domestic violence screening and referral for this group of women.

While many younger woman are provided with information about and screened for domestic violence in the context of the provision of healthcare services (for example, pre-natal screening) there may be reduced opportunities for similar contact with older women.

Accordingly, the Team determined that information should be provided to women when mammogram screening is undertaken.

It is the Team's perspective that this opportunity will help educate and inform women in an age group that is otherwise rarely receiving this information through non-healthcare sources.

Accordingly, the Team recommends:

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.

Additional Commentary

Sexual assault allegations reported to Community Services

The Team raised specific concerns in relation to one case reviewed for this report and specifically in relation to FACS' response to allegations of sexual assault made by a girl against her father who continued to care for the complainant's two young siblings.

In *Case Review 3000*, two reports were made by counsellors in relation to allegations of serious sexual abuse made by a 16 year old girl against her biological father. After making disclosures in relation to the abuse, the 16 year old daughter moved out of home, leaving her two younger siblings in the care of her mother and her father, the alleged abuser. These reports were never actioned and the children remained in the care of the alleged abuser for upwards of 6 months. It was not until the daughter herself made disclosures directly to FACS in relation to the abuse that the case was referred to a JIRT and reports were actioned. Even at this time, the children continued to reside with the perpetrator and their mother. The JIRT investigation date was set for 2 weeks, and in the intervening period between the daughters self-report and the JIRT date, the father fatally assaulted his wife (the children's mother).

The Team raised two primary concerns with FACS' response in this case. Firstly, the Team was concerned that the initial reports made by the counsellor did not reach the threshold for screening into child protection systems despite the very serious sexual assault allegations being made by a 16 year old girl, who also raised concerns for her younger siblings' welfare. Secondly, the Team was concerned with the process whereby a JIRT investigation was convened for a period of 2 weeks after the 16 year old self-reported to FACS, but the two younger siblings remained in the care of the alleged abuser.

The Team was advised that prior to January 2010 the decision whether the information reported constituted 'Risk of Harm' and the subsequently allocated response priority level were based purely on a professional judgment model. The decision was made by an

individual caseworker in consultation with their team leader.

Since the introduction of the SCRPT (Screening and Response Priority) SDM (Structured Decision Making) tools in January 2010, Helpline staff are now subject to a clear direction that all children in a household must be considered when assessing any child of that household. These cases are also now accorded a <24 hour response priority.

The Team also notes that in September 2012 Community Services (FACS) commenced rollout of an action learning program '*Working with Child Sexual Assault*'.

The program was implemented to enhance the skills and knowledge of Community Services' frontline staff in recognising and managing child sexual assault cases.

Four key learning areas include:

- child sex offender grooming tactics;
- children's process of disclosure;
- understanding non-offending parents' reactions to disclosure, supporting non-offending parents capacity to believe and protect their child; and
- understanding children who display problematic sexual behaviour.

Sessions are attended by a local NSW Health colleague who contributes expertise and presents information about sexual assault services and referral processes.

The Team welcomes the developments of Community Services in relation to this extremely important issue.

Provocation

The Team raised specific concerns in relation to the defence of provocation (specifically, how it was successfully argued by a domestic violence abuser who killed his wife - *Case Review 3023*.)

During 2012 the Team made a submission to the *Legislative Council Select Committee on the Partial Defence of Provocation (Inquiry)*, limited to data in relation to the use of the defence in homicide cases occurring in a context of domestic violence.

The *Report of the Select Committee on the Partial Defence of Provocation* was released in April 2013 and included 11 recommendations outlining amendments to the application of the partial defence.³³

³³The Select Committee on the Partial Defence of Provocation, *The Partial Defence of Provocation*, 2013, Available at:

The Team supports the proposed amendments to the operation of the partial defence of provocation outlined in the report.

Corrective Services NSW

In May 2013, Corrective Services NSW introduced the Community Impact Assessment tool to complement the LSI-R by providing a basis for determining intervention and monitoring levels.

This Tier assessment is intended to provide a more consistent means of placing offenders within the appropriate category of consequence of reoffence on the risk assessment matrix.

The Tier concept was, in part, inspired by the model of risk assessment used by probation services in the UK, which employs a form of risk assessment matrix methodology considering both risk of re-offence and risk of harm. In the same way that the LSI-R rating is based on the cumulation of scoring across multiple items such as employment, alcohol and drug use, the Tier assessment is also based on cumulative factors.

Under the new supervision (service delivery) standards, additional provision has also been made for all newly released parolees to receive increased supervision for the first 8 weeks following release, including increased contacts and field visits. The intent of the model is to both ensure a higher level of integrity to the supervision of higher consequence offenders, to ensure high risk / high consequence offenders are prioritised, and to provide a more consistent means of making judgements about consequence.

When preparing the report, Community Corrections uses the results from the Level of Service Inventory-Revised (LSI-R) actuarial risk assessment tool. The LSI-R scores the offender's risk of reoffending as low, medium-low, medium, medium-high, or high based on the offender's static and dynamic risk factors.

It also identifies the offender's criminogenic needs to establish the level of supervision and service provision that the offender requires and whether the offender's risk factors can be adequately addressed. The LSI-R has been found to have predictive validity for the reoffending of NSW offenders and Corrective Services NSW uses it for many purposes, including security classification decisions and to determine an offender's treatment needs and eligibility for programs.

Although the LSI-R provides a measure of an offender's risk of reoffending, it does not differentiate between types of reoffending. Offenders likely to commit a serious violent offence may have a similar LSI-R result to offenders that are likely to commit burglary.

Corrective Services NSW has recently developed the Community Impact Assessment tool to complement the LSI-R by providing a measure of the consequences of the reoffending of a particular offender. The two scores can be put together to make a combined result.

It is noted that Corrective Services NSW is only in the initial stages of implementing the Community Impact Assessment and the tool has not yet been validated.

Firearms Registry

In relation to *Case Review 2998*, the Team raised concerns in relation to procedures around firearms licensing and reinstatement of licences following suicide attempts. The Team raised these issues with the *NSW Firearms Registry* and determined that in the period between the homicide and the review process, procedures around the reinstatement of firearms had been improved, requiring certification from a psychologist, rather than a general practitioner.

http://www.parliament.nsw.gov.au/Prod/parliament/committee.nsf/0/61173c421853420aca257b5500838b2e/%24FILE/Partial%20defence%20of%20provocation_Final%20report.pdf, accessed October 2013.

6 MONITORING RECOMMENDATIONS

This chapter sets out the Whole of Government response to the Team's 2011/12 Annual Report and monitors the progress of the 14 recommendations made in that report.

NOTE: This report was initially drafted in late 2013 and recommendations developed from the cases reviewed at this time. Due to the delay in finalising this report, it is acknowledged that issues identified and recommendations made in response to issues arising may have been actioned or addressed by agencies during the intervening period. This report therefore reflects the state of policies and procedures within agencies as at October 2013, and may not reflect current practice and procedure.

ANNUAL REPORT 2011/2012	WHOLE OF GOVERNMENT RESPONSE	ACTION/COMMENTARY
<p><u>RECOMMENDATION 1</u></p> <p>That section 101B(1) of the <i>Coroners Act 2009</i> (NSW) be amended as follows:</p> <p>‘domestic violence death’ means:</p> <p>(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, <u>and the death occurs in the context of domestic violence; or</u></p> <p>(b) <u>the death of a person that is a third party to a domestic relationship, and the death occurs in the context of domestic violence.</u></p> <p><u>RECOMMENDATION 2</u></p> <p>That section 101C(1)(d) of the <i>Coroners Act 2009</i> (NSW) be amended to omit the words <u>and there have been previous episodes of domestic violence between them.</u></p>	<p>Recommendations 1 and 2: SUPPORTED</p> <p><i>Commentary in Whole of Government Response</i></p> <p><i>‘These recommended amendments to the Coroners Act 2009 (NSW) are supported.</i></p> <p><i>The Department of Attorney General and Justice is currently conducting a statutory review of the Crimes (Domestic and Personal Violence) Act 2007 and will consider recommendation 1 with the aim of creating consistency across the two Acts while recognising that the definitions serve different purposes.’</i></p>	<p>ACTION: IN PROGRESS</p> <p>As at 30 June 2013, the amended legislation was being prepared in a Draft Bill.</p>

ANNUAL REPORT 2011/2012	WHOLE OF GOVERNMENT RESPONSE	ACTION/COMMENTARY
<p><u>RECOMMENDATION 3</u></p> <p>That Part 9A(2) [s101E] of the <i>Coroners Act 2009</i> (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).</p>	<p>Recommendation 3: SUPPORTED</p> <p><i>'The amendment to the Coroners Act 2009 (NSW) to include a representative from Correctional Services NSW in the DVDRT is supported [sic].'</i></p>	<p>ACTION: IN PROGRESS</p> <p>As at 30 June 2013, the amended legislation was being prepared in a Draft Bill.</p>
<p><u>RECOMMENDATION 4</u></p> <p>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:</p> <p>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;</p> <p>b) assistance/advice is sought in relation to making an application for an ADVO; and</p> <p>c) assistance/advice is sought in relation to a breach of an ADVO.</p>	<p>Recommendation 4: SUPPORTED</p> <p><i>Commentary in Whole of Government Response</i></p> <p><i>'The recommendation is supported but implementation will require a systems modification to the Computerised Operational Police System (COPS).</i></p> <p><i>Once the systems modification has occurred the Domestic & Family Violence Standard Operating Procedures will be updated to reflect this recommendation and a communications strategy will be developed to ensure compliance with the recommendation.</i></p> <p><i>The communications strategy will include correspondence from the Corporate Spokesperson for Domestic & Family Violence to Region Commanders and Local Area Commanders informing them of this new practice. Further communications to the field will occur through dissemination of a Nemesis message, an article in the Police Monthly, creation of a 'Hot Topic' and a banner message on the intranet; as well as messages to Domestic Violence Liaison Officers, Regional Domestic Violence Sponsors and Coordinators through their mail distribution list.</i></p> <p><i>Updates to relevant domestic violence training courses and workshops will be made by Education and Training Command to reflect this new practice.'</i></p>	<p>ACTION: NO ACTION</p> <p>As at 30 June 2013, there had been no action in relation to this recommendation.</p> <p><i>Team Commentary</i></p> <p>The Team is currently seeking an update on the progress of this recommendation, including:</p> <ul style="list-style-type: none"> - the systems modification - the update to Standard Operating Procedures - the development and progress of the Communications Strategy, and - any updates to training courses and workshops by the Education and Training Command.

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)?

Recommendation 5: SUPPORTED.***Commentary in Whole of Government Response***

'This recommendation is supported. It is important to note however, that work has commenced on developing a new approach to the identification, assessment and management of risk for domestic and family violence.

The NSW Police Force is a partner agency in work towards developing a common risk identification and management approach to be used by government and non government agencies. As a partner agency, NSW Police Force is helping to develop an agency specific risk identification tool using agreed upon common risk indicators.

The tool has been drafted and incorporates the questions that this recommendation requests be added to the Domestic Violence Related Checklist.'

ACTION: IN PROGRESS

As at 30 June 2013, the new risk and identification tool was in the process of being drafted. This draft incorporates the questions identified by the Team in this recommendation.

Team Commentary

The Team seeks an update as to the progress of the Risk Assessment and Management Project and the incorporation of the questions identified in this Recommendation.

ANNUAL REPORT 2011/2012	WHOLE OF GOVERNMENT RESPONSE	ACTION/COMMENTARY
<p><u>RECOMMENDATION 6</u></p> <p>That the NSW Police Force incorporate into its existing domestic and family violence Standard Operating Procedures the requirements that:</p> <ul style="list-style-type: none"> 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. 	<p>Recommendation 6: SUPPORTED</p> <p>Commentary in Whole of Government Response</p> <p><i>'This recommendation is supported. As per recommendation 5, consideration is being given to replacing the Domestic Violence Related Checklist with a common risk identification, assessment and management approach for use by government and nongovernment agencies in the second half of 2013.</i></p> <p><i>With respect to the second dot point, Government supports the physical provision of brief contact information (phone number or web address) to victims. This is a precaution against leaving comprehensive contact information, such as names of staff and addresses of services, which may be accessed by offenders. There have been previous incidents where offenders have intimidated or threatened service providers because they had access to detailed contact information.</i></p> <p><i>To ensure statewide consistency, the Government proposes that generic information is provided to victims in the form of the NSW Police Force Domestic & Family Violence Fact Sheet and a card for the 24/7 statewide telephone service, the Domestic Violence Helpline, operated by FACS [sic].'</i></p>	<p>ACTION: IN PROGRESS</p> <p>As at 30 June 2013, the new risk and identification tool was in the process of being drafted.</p> <p>Team Commentary</p> <p>The Team seeks an update as to the progress of the Risk Assessment and Management Project.</p> <p>The Team seeks an update in relation to the extent to which the NSW Police Force Domestic & Family Violence Fact Sheet and a card for the 24/7 state-wide telephone service, the Domestic Violence Helpline, operated by FACS, is being provided to victims of domestic violence.</p>

ANNUAL REPORT 2011/2012	WHOLE OF GOVERNMENT RESPONSE	ACTION/COMMENTARY
<p><u>RECOMMENDATION 7</u></p> <p>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.</p> <p>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.</p>	<p>Recommendation 7: SUPPORTED</p> <p>Commentary in Whole of Government Response</p> <p><i>'This recommendation is supported, noting aspects of this recommendation are already being implemented. The current Domestic & Family Violence Standard Operating Procedures give advice to police officers on the need to provide victims with relevant domestic violence support and referral information, including where the victim is reluctant to pursue legal pathways.</i></p> <p><i>As per recommendation 6, to ensure statewide consistency Government proposes that generic information is provided to victims in the form of the NSW Police Force Domestic & Family Violence Fact Sheet and a card for the 24/7 statewide telephone service, the Domestic Violence Line, operated by FACS.'</i></p>	<p>ACTION: NO ACTION</p> <p>Team Commentary</p> <p>The Team seeks an update in relation to the extent to which the NSW Police Force Domestic & Family Violence Fact Sheet and a card for the 24/7 state-wide telephone service, the Domestic Violence Helpline, operated by FACS, is being provided to victims of domestic violence, even in cases where police entry to the premises is refused or where the victim presents as uncooperative.</p>

ANNUAL REPORT 2011/2012	WHOLE OF GOVERNMENT RESPONSE	ACTION/COMMENTARY
<p><u>RECOMMENDATION 8</u></p> <p>That the NSW Police Force commission a review of the implementation of legislation within the <i>Crimes (Domestic and Personal Violence) Act 2007</i> (NSW) that requires police officers to apply for ADVOs wherever they have fears for the safety of victims.</p> <p>This review should ascertain the extent to which this provision is used, particularly with regards to Indigenous victims of domestic violence.</p>	<p>Recommendation 8: NOT SUPPORTED</p> <p><i>Commentary in Whole of Government Response</i></p> <p><i>‘This recommendation is not supported. The NSW Police Force routinely applies for provisional ADVOs through an online application system. This system has a 96 per cent success rate which would suggest that police are applying for orders in the appropriate circumstances.</i></p> <p><i>The Police information management system (COPS) does not readily allow ‘free text’ data to be searched. As a consequence, the grounds relied upon to support an application by police for an ADVO could only be identified by conducting a manual examination of every ADVO application and COPS event. It would also rely on Aboriginal and Torres Strait Islander victims of domestic violence identifying as Aboriginal and Torres Strait Islander.</i></p> <p><i>The recommended legislation has recently been reviewed and is proposed to be amended to protect the victims of domestic and family violence. NSW Police will be given powers to issue on the spot ADVOs and immediately detain offenders for two hours wherever they have fears for the safety of victims. Any police officer with the rank of Sergeant or higher will be able to issue the AVDO without Court approval [sic].’</i></p>	<p>ACTION: NO ACTION</p> <p><i>Team Commentary</i></p> <p>The Team acknowledges that there a number of changes currently being implemented in relation to police issued ADVOs.</p> <p>This issue will continue to be an area of focus for the Team in subsequent reporting periods, and the Team will consider alternative avenues for addressing these concerns.</p>

ANNUAL REPORT 2011/2012	WHOLE OF GOVERNMENT RESPONSE	ACTION/COMMENTARY
<p><u>RECOMMENDATION 9</u></p> <p>That as part of the NSW Ageing Strategy, the NSW Ministerial Advisory Committee on Ageing give strong consideration to using case reviews 8 and 9 of the 2011/2012 NSW Domestic Violence Death Review Team Annual Report to inform the development of training resources for the new NSW helpline dedicated to abuse of older people and the corresponding resource unit.</p>	<p>Recommendation 9: SUPPORTED</p> <p>Commentary in Whole of Government Response</p> <p><i>‘This recommendation is supported and it is noted that it aligns with the Government’s commitment to addressing elder abuse under the NSW Ageing Strategy. The DVDRT Report highlights that between July 2000 and June 2009, 19 per cent (41 cases) of all victims of domestic and family violence related death were aged 60 years or older.</i></p> <p><i>The Abuse of Older People Helpline and Resource Unit of FACS established as part of the Ageing Strategy has plans in place to use case reviews, such as case reviews 8 and 9 of the Report, to support a range of resources to be used in the development of training resources for Helpline staff. FACS also intends to use case reviews and vignettes to inform the development of other education and training materials, and as part of a wider education and training package to service providers and the community. Catholic Healthcare has been contracted to run the Helpline with Government oversight by FACS. The Helpline began operation on 28 February 2013.</i></p> <p><i>Therefore, there is an opportunity to build on this recommendation by expanding the focus beyond training for Helpline staff to encompass a range of agencies and responses including:</i></p> <ul style="list-style-type: none"> - <i>public education and communications strategies;</i> - <i>service provider training;</i> - <i>streamlined access to integrated services; and</i> - <i>the development of specific services for older people where gaps exist.</i> <p><i>A high level advisory committee (NSW Steering Committee on the Prevention of Abuse of Older People) will oversee a coordinated approach to addressing the abuse of older people in the community. The membership of the committee includes FACS, NSW Police, NSW Health, the Department of Attorney</i></p>	<p>ACTION: IN PROGRESS</p> <p>Team Commentary</p> <p>The Team seeks an update in relation to the activities of the NSW Steering Committee on the Prevention of Abuse of Older People in relation to this specific recommendation and further avenues for collaboration with the DVDRT.</p> <p>The Team further seeks specific comment in relation to the use and nature of enquiries being received through the Abuse of Older People Helpline.</p>

General and Justice, key non-Government organisations and Commonwealth agencies. The Steering Committee will lead:

- *future state wide policy directions and decision making;*
- *oversee the growth of the Helpline;*
- *monitor local and regional policies and programs for consistency and relevance;*
- *respond to trends as they arise; and*
- *provide reports to the Interdepartmental Committee on Ageing.'*

ANNUAL REPORT 2011/2012	WHOLE OF GOVERNMENT RESPONSE	ACTION/COMMENTARY
<p><u>RECOMMENDATION 10</u></p> <p>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:</p> <ul style="list-style-type: none"> • 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. <p>The strategy should draw on international research, and should aim to educate the community about the nature and dynamics of domestic violence, including:</p> <ul style="list-style-type: none"> • 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. 	<p>Recommendation 10: SUPPORTED</p> <p><i>Commentary in Whole of Government Response</i></p> <p><i>‘This recommendation is supported. The case reviews highlighted several instances where family and friends, spiritual leaders, and school staff were reluctant to report domestic and family violence and/or engage legal pathways. The reluctance to report domestic and family violence and engage legal pathways is of particular concern for Aboriginal and Torres Strait Islander Women.</i></p> <p><i>A primary prevention plan is under active consideration as part of the proposed new NSW Domestic and Family Violence Reforms. This includes consideration of a focus on community and family based education and awareness, including Aboriginal and Torres Strait Islander communities. Specific elements of recommendation 10 have been considered further in developing this aspect of the Domestic and Family Violence Reforms, which are proposed to be released for public consultation in mid 2013.’</i></p>	<p>ACTION: IN PROGRESS</p> <p><i>Team Commentary</i></p> <p>The Team seeks specific comment in relation to the ways in which the NSW Domestic and Family Violence Reforms have addressed the issue of encouraging victims, family, friends and neighbours to report domestic violence.</p> <p>Comment is also sought in relation to the ways in which these reforms have addressed the specific concerns of Indigenous women, young women and older women, as well as women who speak languages other than English.</p> <p>The Team notes that this recommendation is incorporated in this annual report in the form of a proposal for a specific strategy designed to address issues around domestic violence in Indigenous communities at a number of pilot sites.</p>

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.

ANNUAL REPORT 2011/2012	WHOLE OF GOVERNMENT RESPONSE	ACTION/COMMENTARY
<p><u>RECOMMENDATION 11</u></p> <p>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:</p> <ul style="list-style-type: none"> • encourage and support Indigenous victims to report family violence; • facilitate continued participation of Indigenous victims throughout legal processes; • strengthen access to relevant specialist Indigenous and mainstream services; • ensure training is made available for police and other professionals in relation to the dynamics impacting on the reporting of violence by Indigenous victims; • improve connections between Indigenous health services and domestic and family violence services; • improve the response to victims and perpetrators who have complex needs, including needs arising from drug and alcohol misuse, mental illness and homelessness; and • introduce and implement a family violence prevention program aimed at Indigenous youth. 	<p>Recommendation 11: SUPPORTED</p> <p>Commentary in Whole of Government Response</p> <p><i>'As the DVDRT highlighted, there is a disproportionate rate of domestic and family violence in Aboriginal and Torres Strait Islander communities. The intent of this recommendation is supported, although the scope will be refined.</i></p> <p><i>This is a very broad and general recommendation about an already well-researched area and the challenge will be bring a new approach to the area. For example, Nancarrow (2006) reports on the findings of a previous taskforce investigation comparing justice responses to domestic and family violence against Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander women. While there are few evaluations describing 'what works' in domestic and family violence primary prevention in Aboriginal and Torres Strait Islander communities, there are publications describing elements of good practice that can also be drawn on. Therefore while this recommendation is supported, the preference is to put what is already known into action and evaluate the effectiveness of programs used by Aboriginal and Torres Strait Islander women. Any further research that is conducted needs to be carefully considered so that it focuses on gaps in the existing body of research, in particular focusing on the development of whole of family and community strategies in response to domestic and family violence and not just strategies aimed at Aboriginal and Torres Strait Islander women.</i></p> <p><i>The development of strategies relating to improved reporting, access to specialist and mainstream services, and the improved integration of services for Aboriginal and Torres Strait Islander women facing domestic violence is being considered as part of the of the new Domestic and Family Violence Reforms.'</i></p>	<p>ACTION: NO ACTION</p> <p>Team Commentary</p> <p>Whilst the Team recognises the importance of focusing on the development of whole of family and community strategies in response to domestic and family violence, it also notes that the specific issues affecting Aboriginal and Torres Strait Islander women in NSW warrant particular attention.</p> <p>This report introduces further data which again demonstrates the significant overrepresentation of Aboriginal women as victims and perpetrators of domestic violence homicide.</p> <p>Furthermore, a number of the in depth case reviews in this report demonstrate the unique issues affecting Aboriginal women, particularly in the context of fractured kinship relations and intergenerational violence.</p> <p>Consequently, the Team reiterates the importance of the NSW Government working with Aboriginal women in NSW to action this specific recommendation as a research priority.</p>

ANNUAL REPORT 2011/2012	WHOLE OF GOVERNMENT RESPONSE	ACTION/COMMENTARY
<p><u>RECOMMENDATION 12</u></p> <p>That the NSW Government develop and implement an inter-faith working party on the issue of domestic violence. Such a party should:</p> <ul style="list-style-type: none"> • 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. 	<p>Recommendation 12: SUPPORTED</p> <p>Commentary in Whole of Government Response</p> <p><i>‘The case reviews highlighted that individuals who experience domestic and family violence might seek assistance from religious leaders. The Report extends this by noting that victims often seek help from cultural and religious leaders. The overall intent of this recommendation appears to be support for communities to work collaboratively to address the complex issues relating to domestic and family violence. This intent is supported by the Government.</i></p> <p><i>The proposed Domestic and Family Violence Reforms for NSW are actively considering the experiences of domestic and family violence in culturally and linguistically diverse (CALD) and religious communities. The Reforms are being developed in close consultation with government agencies and the non-government sector. This includes a series of regional consultations across NSW to capture the views of a broad cross-section of the population.</i></p> <p><i>At this stage it is not proposed to fund a specific working group, but the Domestic and Family Violence Reforms will include:</i></p> <ul style="list-style-type: none"> - <i>how to identify whether domestic and family violence is occurring in their community;</i> - <i>the legal status of domestic and family violence in Australia;</i> - <i>skills for productive conversations about managing religious and cultural obligations in the Australian cultural and legal context; and</i> - <i>how to provide culturally effective support for the victims, and perpetrators, of domestic and family violence.’</i> 	<p>ACTION: NO ACTION</p> <p>Team Commentary</p> <p>The Team seeks comment in relation to the ways in which the NSW Domestic and Family Violence Reforms have specifically sought to educate religious leaders and engage with religious organisations.</p> <p>The Team developed this recommendation in the context of several cases where victims engaged in informal help-seeking behaviour with their religious leaders. Neither case involved persons from a CALD background.</p> <p>The Team reiterates that these considerations are relevant across different religious and cultural groups.</p> <p>Thus the Team reiterates the need for an inter-faith working party of the type suggested to be funded and implemented in NSW, in order to facilitate the appropriate development and roll-out of education and management/referral processes for leaders and within organisations.</p>

ANNUAL REPORT 2011/2012	WHOLE OF GOVERNMENT RESPONSE	ACTION/COMMENTARY
<p><u>RECOMMENDATION 13</u></p> <p>That the NSW Government encourage the Commonwealth Department of Immigration and Citizenship (DIAC) to:</p> <ul style="list-style-type: none"> • 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. 	<p>Recommendation 13: SUPPORTED</p> <p>Commentary in Whole of Government Response</p> <p><i>‘This recommendation is supported as it addresses a serious concern for victims of domestic and family violence on temporary partner visas. The issue of entitlements and crisis support eligibility for women and children on partner visas is a complex issue. Newly arrived women often depend on their partners for financial support and require access to social security assistance in order to access crisis payments that would support leaving a violent relationship. Between 1 January 2012 and 30 June 2012 there were 263 calls to the NSW Domestic Violence Line from non-permanent residents with 69 victims accompanied by 63 children requesting emergency accommodation. It is likely that the actual number of women on temporary partner visas who need immediate support and assistance is under-reported due to fear of having spousal sponsorship withdrawn.</i></p> <p><i>Since 2008 – 2009 there have been amendments to the Migration Act [sic] to streamline the evidence that applicants need to provide when making a non-judicial claim of family violence by their partner. The family violence provisions enable women who have applied for permanent residency before they become the victim of family violence to still be considered for permanent residency and continue to access welfare support. Therefore, unless these women make a judicial claim of family violence or receive charitable support they are unlikely to receive support and may be reluctant to leave the relationship for fear of deportation.</i></p> <p><i>Given the complexity of welfare eligibility for women on partner and prospective marriage visas and the precarious situation these women can be in, the recommendation is supported with no further comment.</i></p>	<p>ACTION: NO ACTION</p> <p>Team Commentary</p> <p>The Team seeks an update as to the outcomes of the Minister for Family and Community Services and Women’s discussions with Commonwealth Government representatives in relation to seeking advice on this issue.</p>

As noted by the DVDRT, the recommendation also aligns with recommendations in the Australia LegalReform Commission Report on Family Violence and Commonwealth Laws.

The Minister for Family and Community Services and Women will seek advice from the Commonwealth Government on this issue.'

ANNUAL REPORT 2011/2012	WHOLE OF GOVERNMENT RESPONSE	ACTION/COMMENTARY
<p><u>RECOMMENDATION 14</u></p> <p>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.</p>	<p>Recommendation 14: SUPPORTED</p> <p><i>Commentary in Whole of Government Response</i></p> <p><i>‘This practice-based recommendation is supported. The recommendation was formulated by Housing NSW in response to the one of the case studies highlighted in the Report that involved a social housing tenant[sic]. The Housing Services Directorate will be sending a Client Service notice to all frontline staff before the end of April 2013.’</i></p>	<p>ACTION: NO ACTION</p> <p><i>Team Commentary</i></p> <p>The Team seeks confirmation that The Housing Services Directorate sent a Client Service notice to all Frontline staff before the end of April 2013.</p>

APPENDIX A: Chapter 9A, *Coroners Act 2009*(NSW)

CORONERS ACT 2009 (NSW) - Chapter 9A Domestic Violence Death Review Team(as at 30 June 2013)

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 7A of the [Commission for Children and Young People Act 1998](#).

Convenor means the person appointed as Convenor of the Team under this Chapter.

domestic violence death means the death of a person that is caused directly or indirectly by a person who was in a domestic relationship with the deceased person.

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 a deceased person if the person:

- (a) was or had been married to the deceased person, or
- (b) was or had been a de facto partner of the deceased person, or
- (c) had or has had an intimate personal relationship with the deceased 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 deceased person and there have been previous episodes of domestic violence between them, 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 deceased person according to the Indigenous kinship system of the person's culture, or
- (f) was in any other relationship with the deceased person of a kind prescribed by the regulations.

(2) For the purposes of this Chapter, a person was a **relative** of a deceased 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 deceased person, or of the spouse or a de facto partner of the deceased 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 Human Services,
 - (b) the Department of Health,
 - (c) the Department of Premier and Cabinet,
 - (d) the NSW Police Force,
 - (e) the Department of Education and Training,
 - (f) the Department of Justice and Attorney General,
 - (g) Community Services, within the Department of Human Services,
 - (h) Aboriginal Affairs NSW, within the Department of Human Services,
 - (i) Housing NSW, within the Department of Human Services,
 - (j) Juvenile Justice, within the Department of Human Services,
 - (k) Ageing, Disability and Home Care, within the Department of Human Services.
- (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 Human 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.

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 cohabit.

'Case Review Period' is 1 July 2009 – 30 June 2010 (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 2010 (inclusive).

'De facto Relationship' describes where two persons cohabit 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).

'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 cohabit.

'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 the death 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 court and 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.

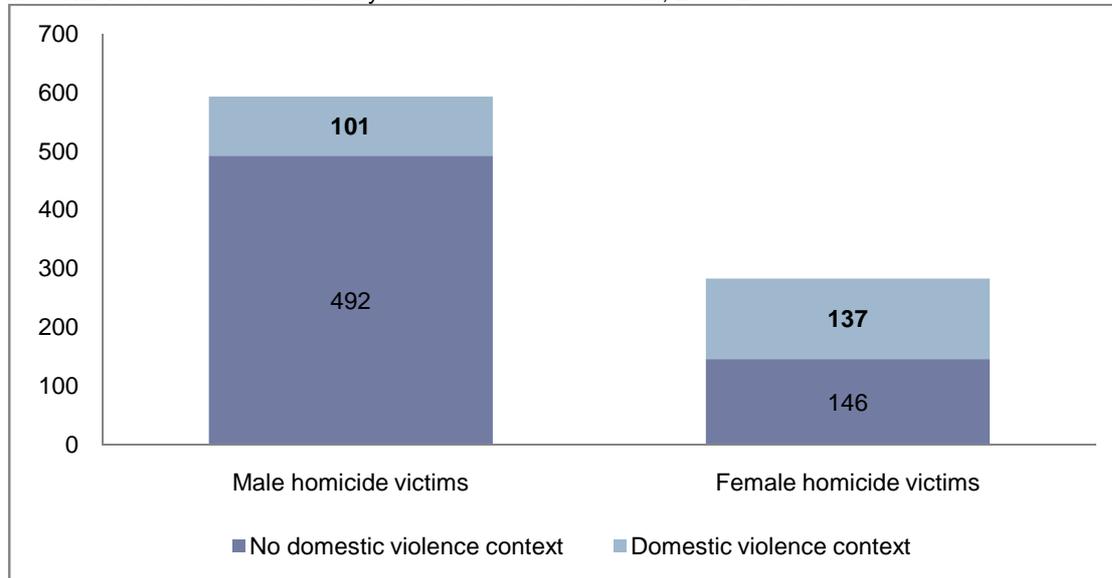
'Suicide >24 hours' describes where the perpetrator commits suicide in a period longer than 24 hours after causing fatal injury to the deceased.

'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 Homicides in NSW, 2000-2010

FIGURE 1: All homicide victims by domestic violence context, 2000-2010*



* There was one transgender homicide victim who was not killed in domestic violence context

FIGURE 2: Intimate partner homicide victims (domestic violence context) by gender, 2000-2010

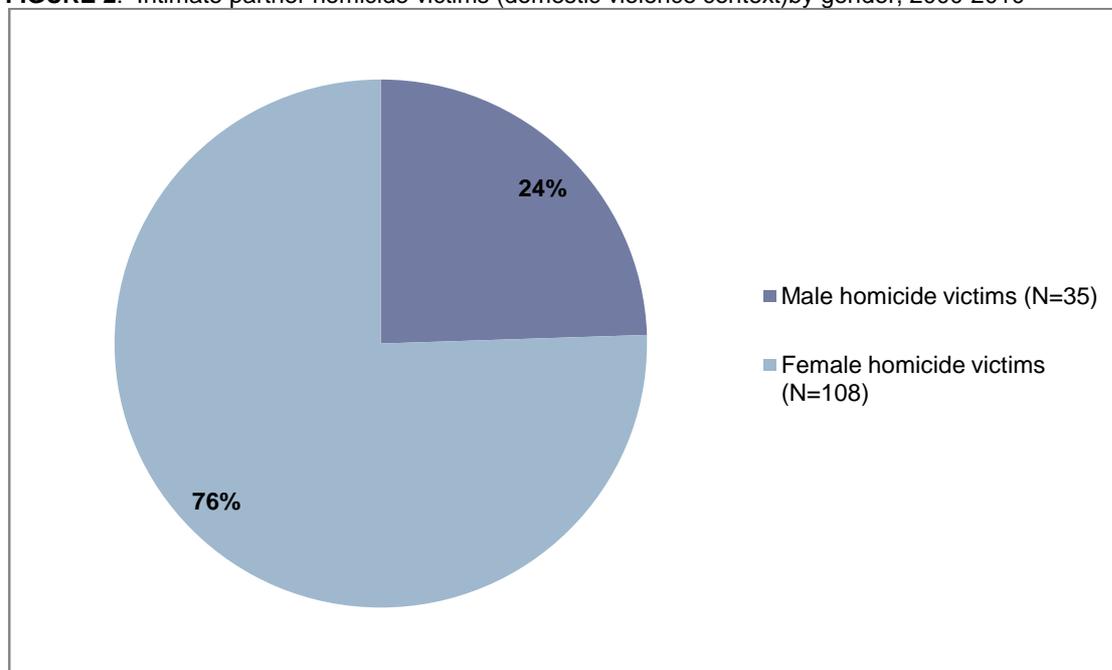


FIGURE 3: Relationship of homicide perpetrator to female intimate partner homicide victim, 2000-2010

RELATIONSHIP TYPE	FEMALE INTIMATE PARTNER HOMICIDE VICTIM	%
HUSBAND	28	26%
DE FACTO HUSBAND	35	32%
BOYFRIEND	5	5%
DIVORCED/ESTRANGED EX HUSBAND	18	17%
FORMER DE FACTO HUSBAND	15	14%
FORMER BOYFRIEND	6	5%
3 RD PARTY TO INTIMATE RELATIONSHIP	1	1%
TOTAL	108	100%

FIGURE 4: Intimate partner homicide victim by domestic violence victim/abuser in relationship, 2000-2010

	MALE INTIMATE PARTNER HOMICIDE VICTIM	FEMALE INTIMATE PARTNER HOMICIDE VICTIM
DOMESTIC VIOLENCE VICTIM	6*	105
DOMESTIC VIOLENCE ABUSER	25	0
EVIDENCE OF VIOLENCE AND ABUSE USED BY BOTH PARTIES WITH NO CLEAR COERCION AND CONTROL	3	3
NEITHER DOMESTIC VIOLENCE VICTIM NOR ABUSER	1#	0
TOTAL	35	108

* All six 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, 2000-2010

RELATIONSHIP TYPE	MALE INTIMATE PARTNER HOMICIDE VICTIM	%
WIFE	5	14%
DE FACTO WIFE	20	57%
GIRLFRIEND	1	3%
DE FACTO HUSBAND	4	11%
BOYFRIEND	1	3%
FORMER GIRLFRIEND	1	3%
FORMER BOYFRIEND	1	3%
3 RD PARTY TO INTIMATE RELATIONSHIP	1	3%
OTHER	1	3%
TOTAL	0	100%

FIGURE 6: Intimate partner homicide victim by separation, 2000-2010

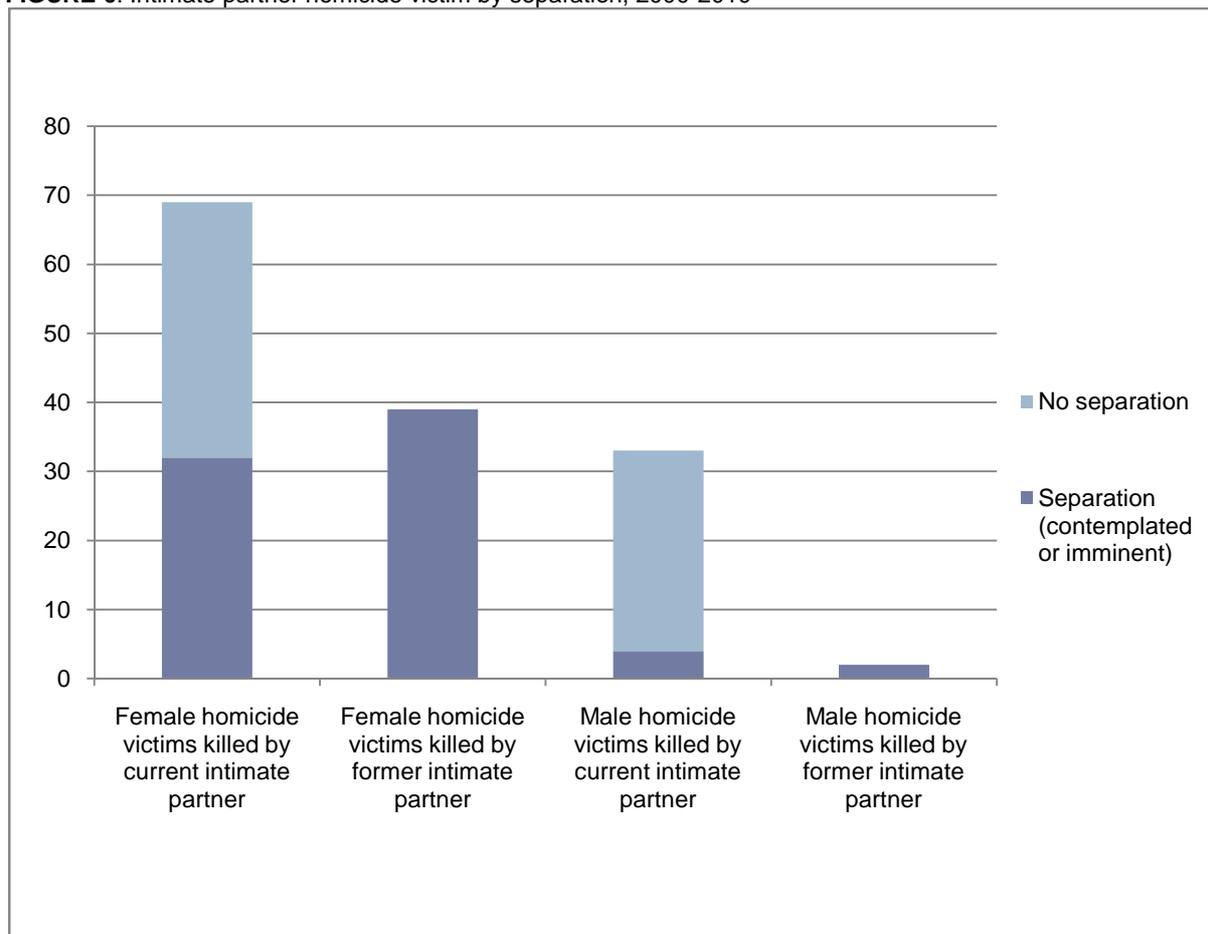


FIGURE 7: Age of intimate partner homicide victim, 2000-2010

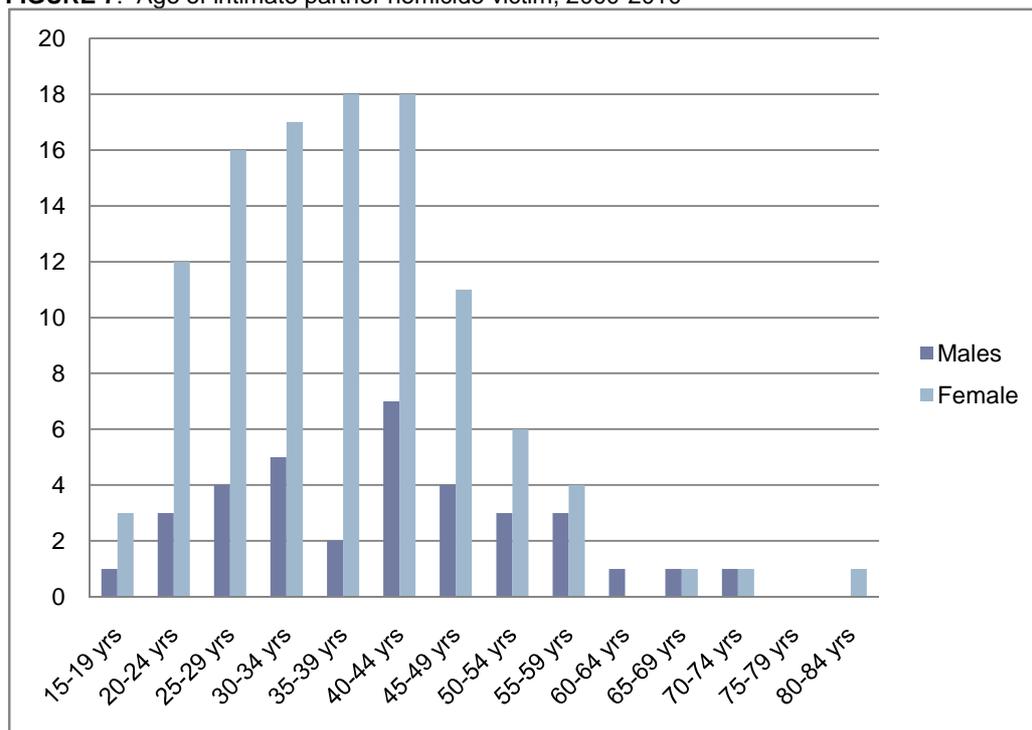


FIGURE 8: Intimate partner homicide victim by NSW Police Force Region, 2000-2010

NSW POLICE FORCE REGION	MALE	FEMALE	TOTAL	%
CENTRAL METROPOLITAN	7	16	23	16%
NORTH WEST METROPOLITAN	3	24	27	19%
SOUTH WEST METRO	3	17	20	14%
NORTHERN REGION	9	21	30	21%
SOUTHERN REGION	7	14	21	15%
WESTERN REGION	5	12	17	12%
INTER STATE	0	3	3	2%
NO FIXED ABODE	1	1	2	1%
TOTAL	35	108	143	100%

FIGURE 9: Intimate partner homicide victim by country of birth, 2000-2010

COUNTRY OF BIRTH	MALE	FEMALE	TOTAL
AUSTRALIA	29	73	102
NEW ZEALAND	1	4	5
LEBANON	0	4	4
INDIA	0	3	3
SERBIA	0	2	2
FIJI	1	1	2
SCOTLAND	0	1	1
BRITAIN	0	1	1
ITALY	1	0	1
MALTA	0	1	1
CROATIA	0	1	1
ROMANIA	1	0	1
RUSSIA	0	1	1
EGYPT	0	1	1
SUDAN	0	1	1
TURKEY	0	1	1
VIETNAM	0	1	1
INDONESIA	0	1	1
MALAYSIA	0	1	1
CHINA	0	1	1
KOREA	0	1	1
SRI LANKA	0	1	1
ARGENTINA	0	1	1
BRAZIL	0	1	1
CHILE	0	1	1
UNKNOWN	2	4	6
TOTAL	35	108	143

FIGURE 10: Intimate partner homicide victim by manner of death, 2000-2010

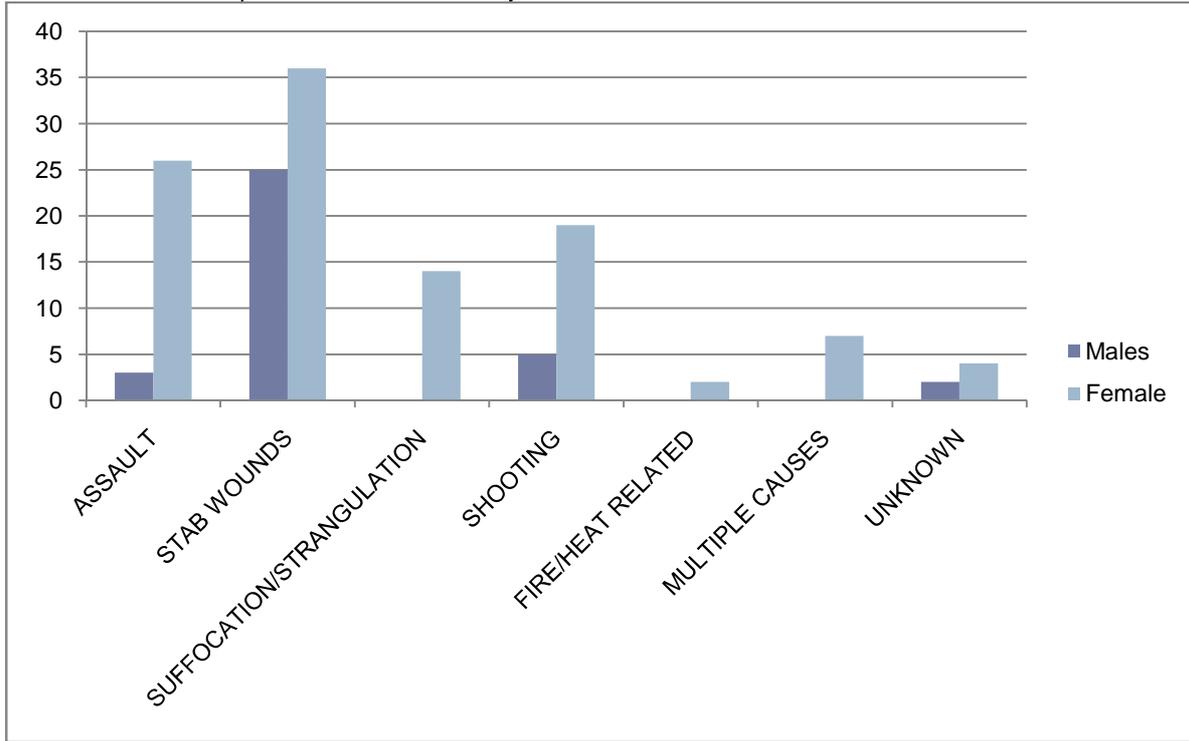


FIGURE 11: Intimate partner homicide victim by location of fatal episode, 2000-2010

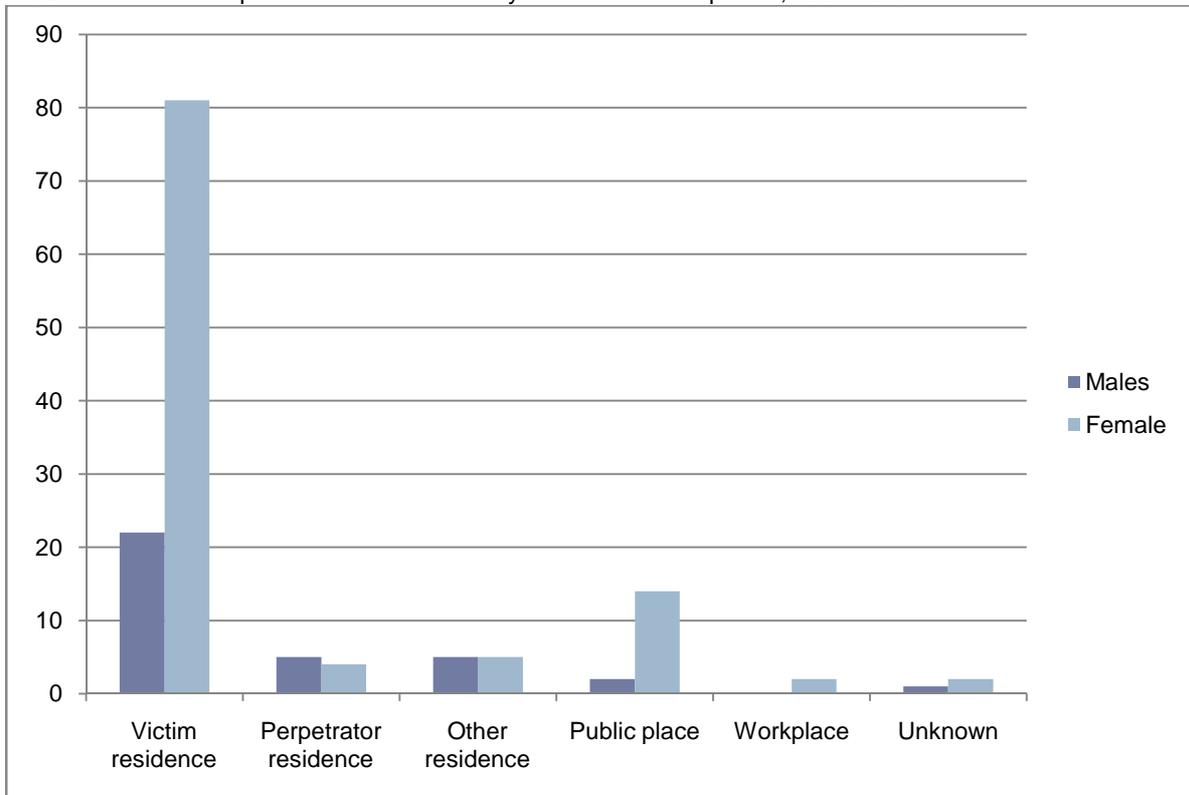


FIGURE 12: Age of intimate partner homicide perpetrator, 2000-2010

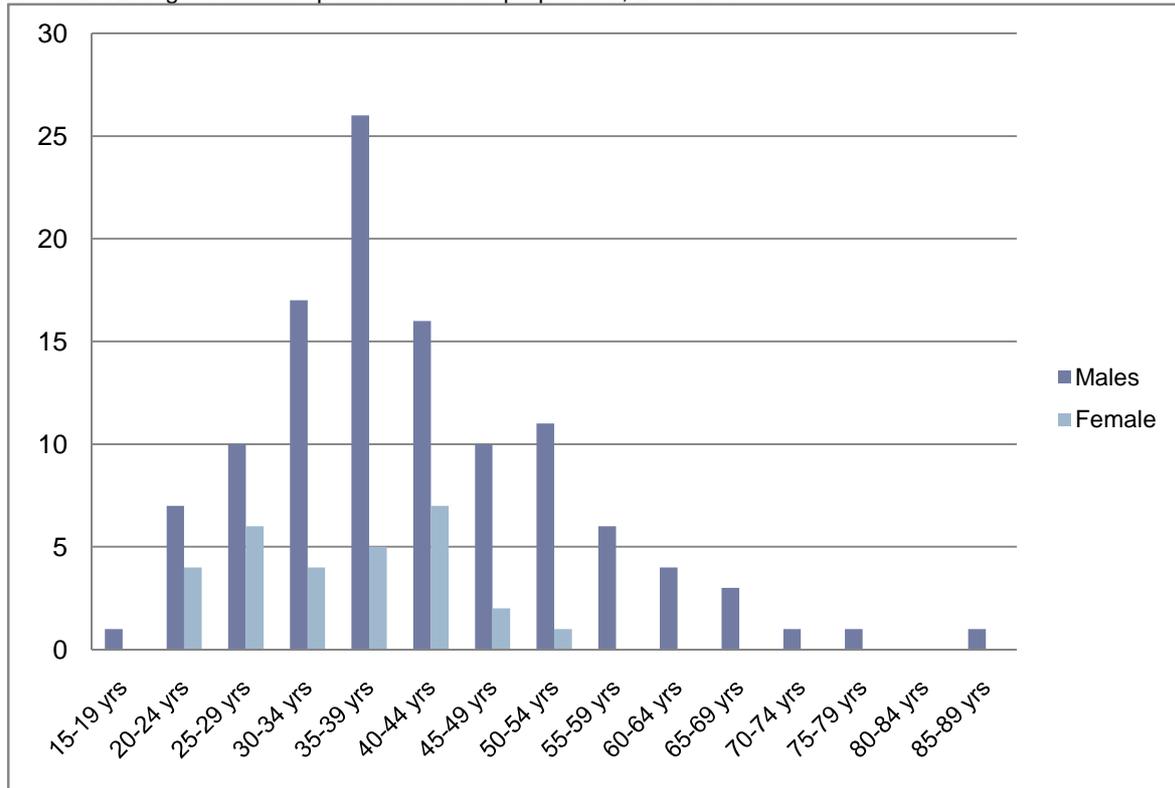


FIGURE 13: Intimate partner homicide perpetrator by country of birth, 2000-2010

COUNTRY OF BIRTH	MALE	FEMALE	TOTAL
AUSTRALIA	73	26	99
NEW ZEALAND	3	0	3
LEBANON	4	0	4
INDIA	3	0	3
SERBIA	2	0	2
CZECHOSLOVAKIA	1	0	1
FIJI (FIJIAN INDIAN)	1	1	2
SAMOA	1	0	1
IRELAND	1	0	1
AUSTRIA	1	0	1
FRANCE	1	0	1
CROATIA	2	0	2
EGYPT	3	0	3
SUDAN	1	0	1
TURKEY	2	0	2
VIETNAM	2	0	2
INDONESIA	1	0	1
MALAYSIA	1	0	1
CHINA	1	0	1
KOREA	1	0	1
SRI LANKA	1	0	1
ARGENTINA	1	0	1
BRAZIL	1	0	1
CHILE	1	0	1
UNKNOWN	5	2	7
TOTAL	114	29	143

FIGURE 14: Intimate partner homicide perpetrator by outcome, 2000-2010

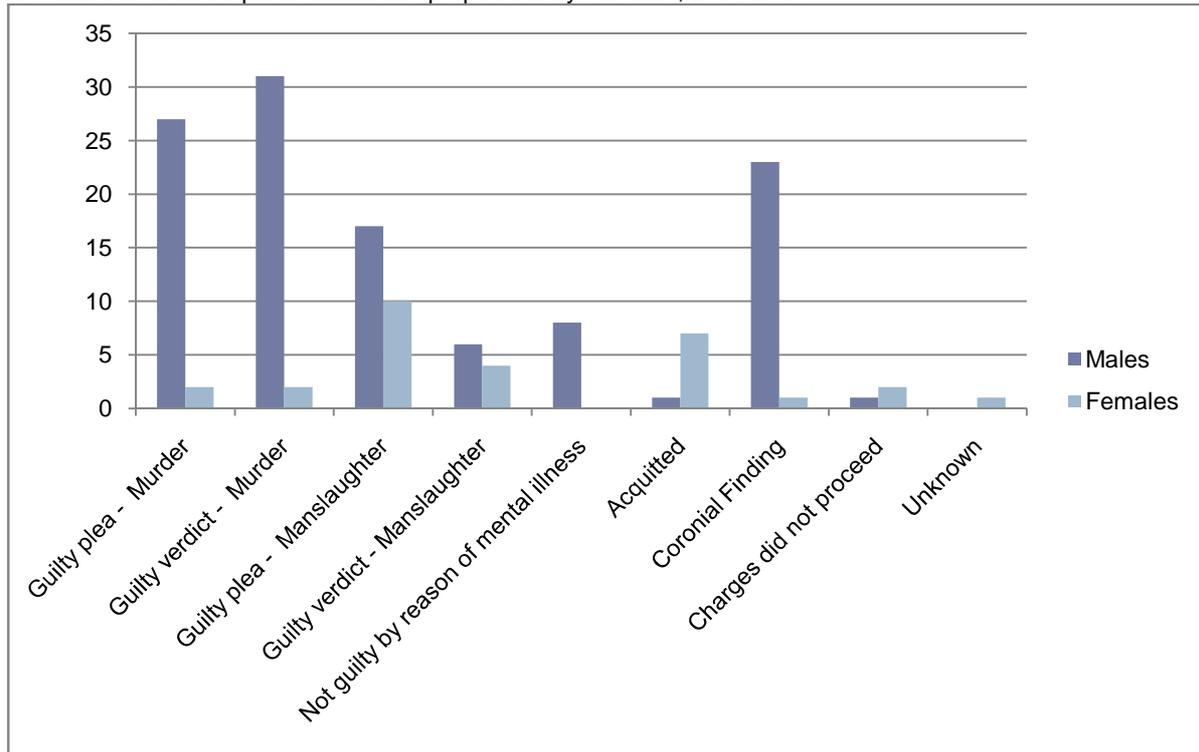


FIGURE 15: Relationship of homicide perpetrator to adult relative/kin homicide victim, 2000-2010

RELATIONSHIP OF HOMICIDE PERPETRATOR TO DECEASED	MALE	FEMALE	TOTAL
SON/STEP-SON	4	3	7
DAUGHTER/STEP-DAUGHTER	3	1	4
SON & DAUGHTER (ACTING TOGETHER)	0	1	1
BROTHER	2	0	2
BROTHER IN LAW	2	0	2
FATHER	1	0	1
MOTHER-IN-LAW	1	0	1
NEPHEW	0	1	1
SON-IN-LAW (INCL. DE FACTO)	3	0	3
TOTAL	16	6	22

FIGURE 16: Age of adult relative/kin homicide victim, 2000-2010

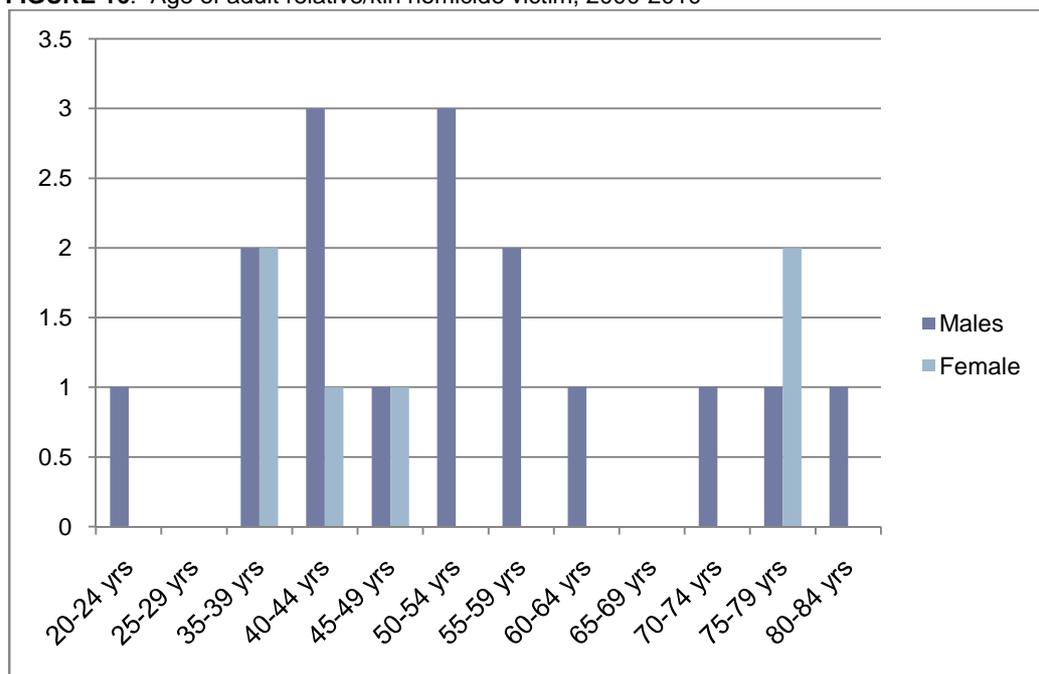


FIGURE 17: Adult relative/kin homicide victim by NSW Police Force Region, 2000-2010

NSW POLICE FORCE REGION	N	%
CENTRAL METROPOLITAN	0	0%
NORTH WEST METROPOLITAN	5	23%
SOUTH WEST METROPOLITAN	7	32%
NORTHERN REGION	8	36%
SOUTHERN REGION	1	4.5%
WESTERN REGION	1	4.5%
TOTAL	22	100%

FIGURE 18: Adult relative/kin homicide victim by country of birth, 2000-2010

COUNTRY OF BIRTH	MALE	FEMALE	TOTAL
AUSTRALIA	8	5	13
LEBANON	2	0	2
UNITED KINGDOM	2	1	3
NEW ZEALAND	1	0	1
ITALY	1	0	1
ROMANIA	1	0	1
IRAQ	1	0	1
TOTAL	16	6	22

FIGURE 19: Adult relative/kin homicide victim by manner of death, 2000-2010

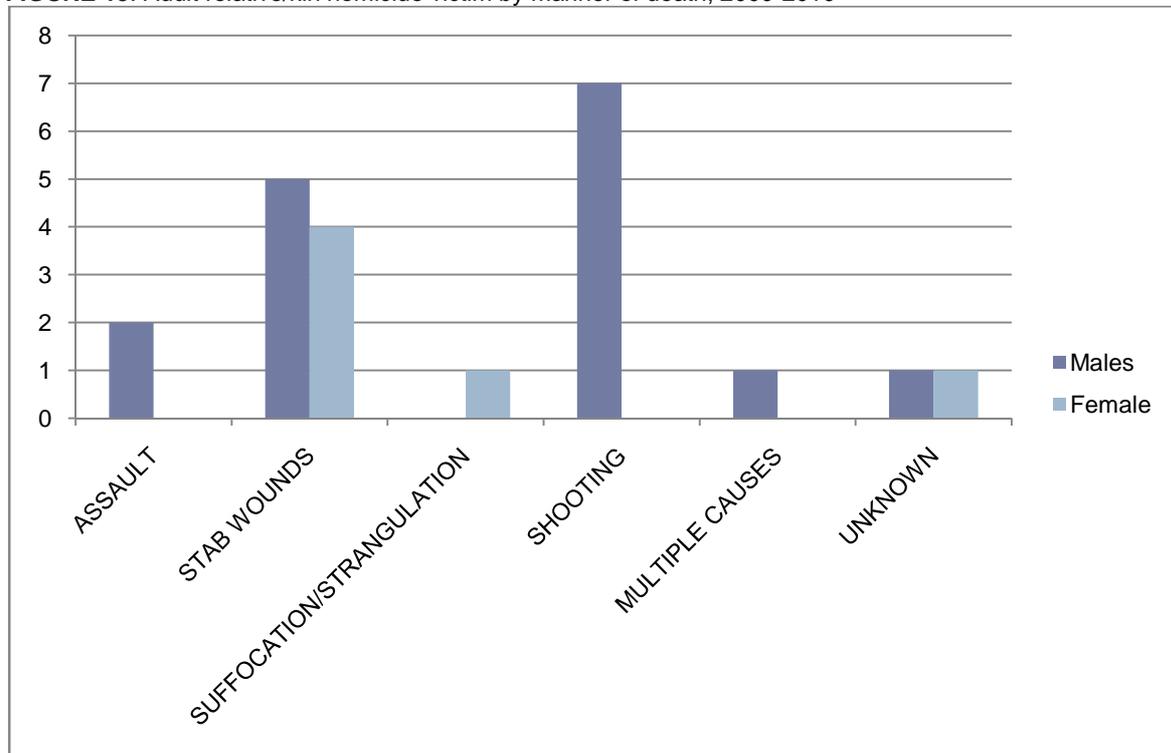


FIGURE 20: Adult relative/kin homicide victim by location of fatal episode, 2000-2010

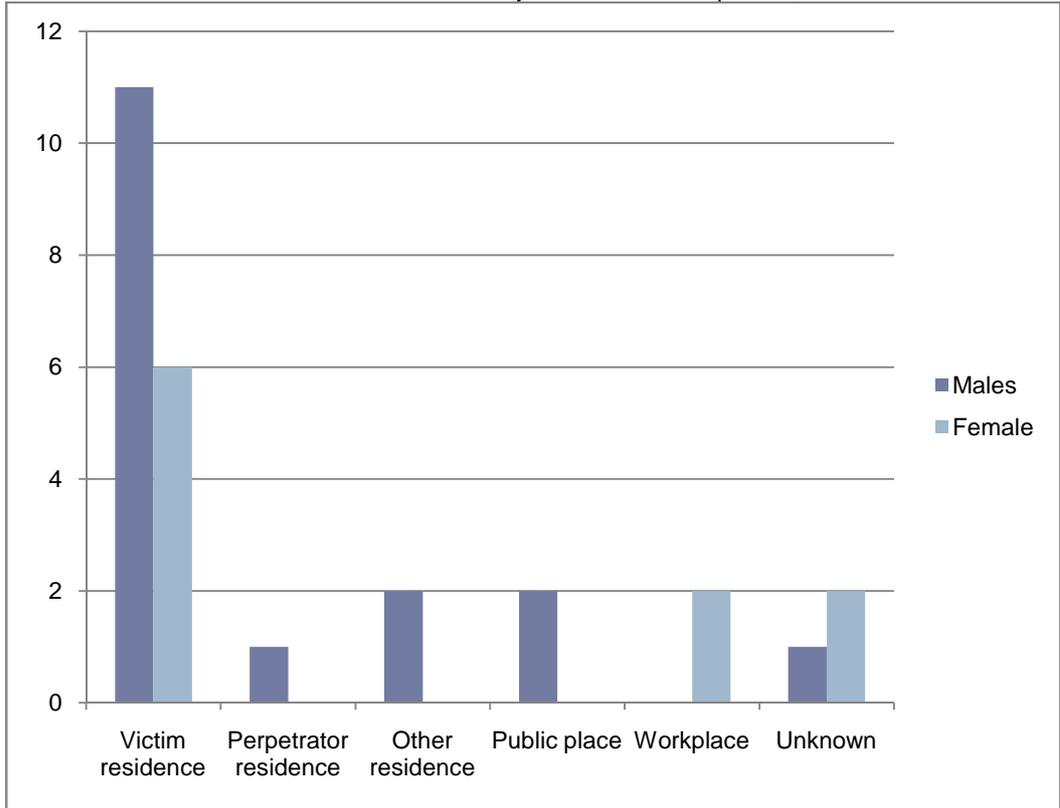


FIGURE 21: Age of adult relative/kin homicide perpetrator, 2000-2010

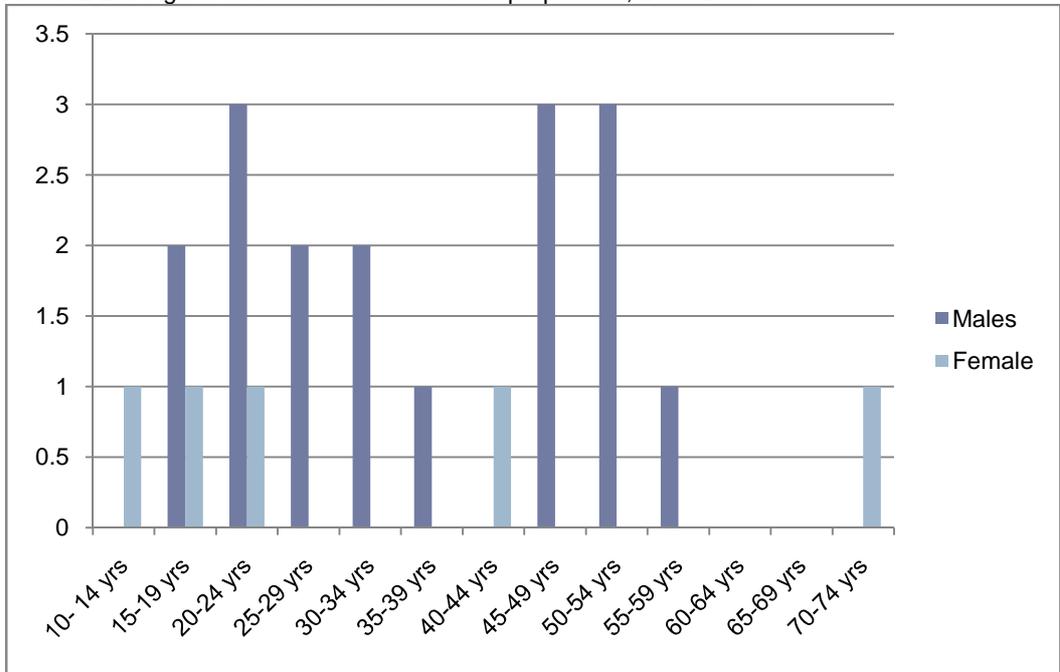


FIGURE 22: Adult relative/kin homicide perpetrator by country of birth, 2000-2010

COUNTRY OF BIRTH	MALE	FEMALE	TOTAL
AUSTRALIA	11	4	15
LEBANON	2	0	2
UNITED KINGDOM	0	1	1
ITALY	1	0	1
ROMANIA	1	0	1
IRAQ	1	0	1
THAILAND	1	0	1
TOTAL	17	5	22

FIGURE 23: Adult relative/kin homicide perpetrator by outcome, 2000-2010

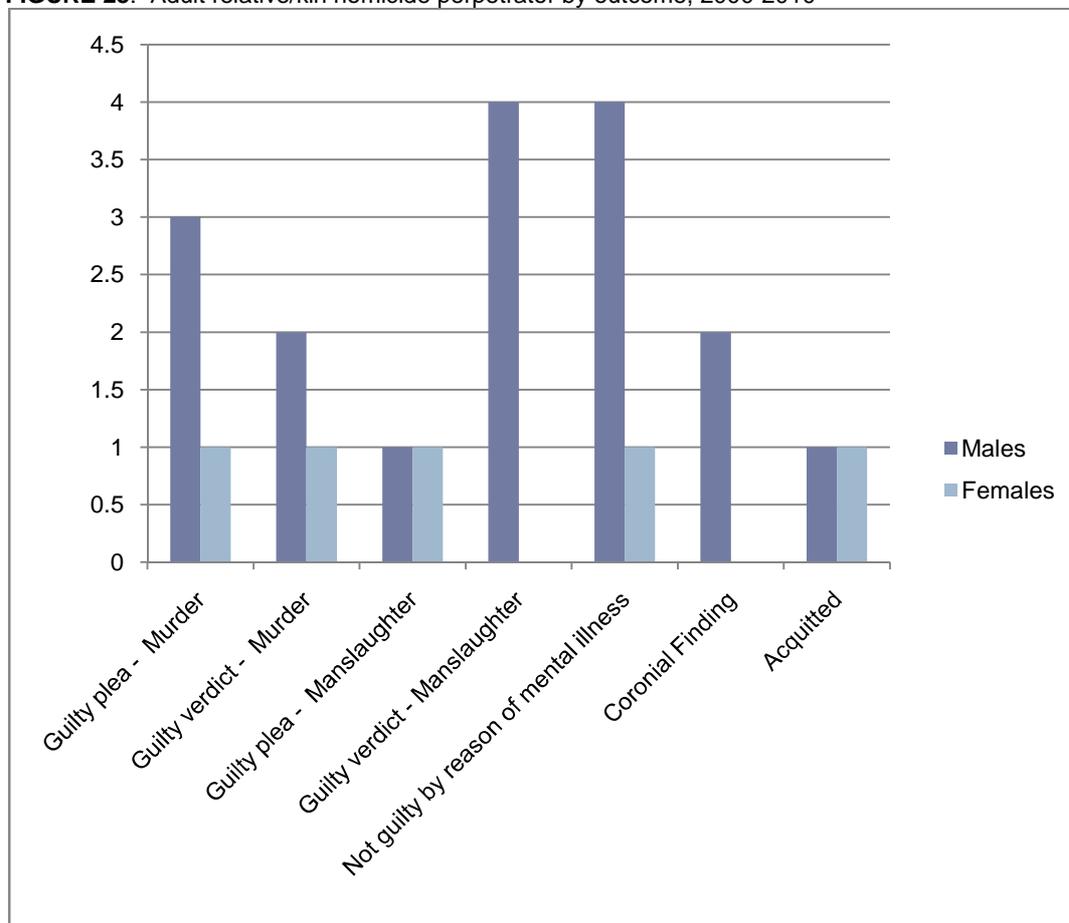


FIGURE 24: Age of 'other' domestic violence homicide victim, 2000-2010

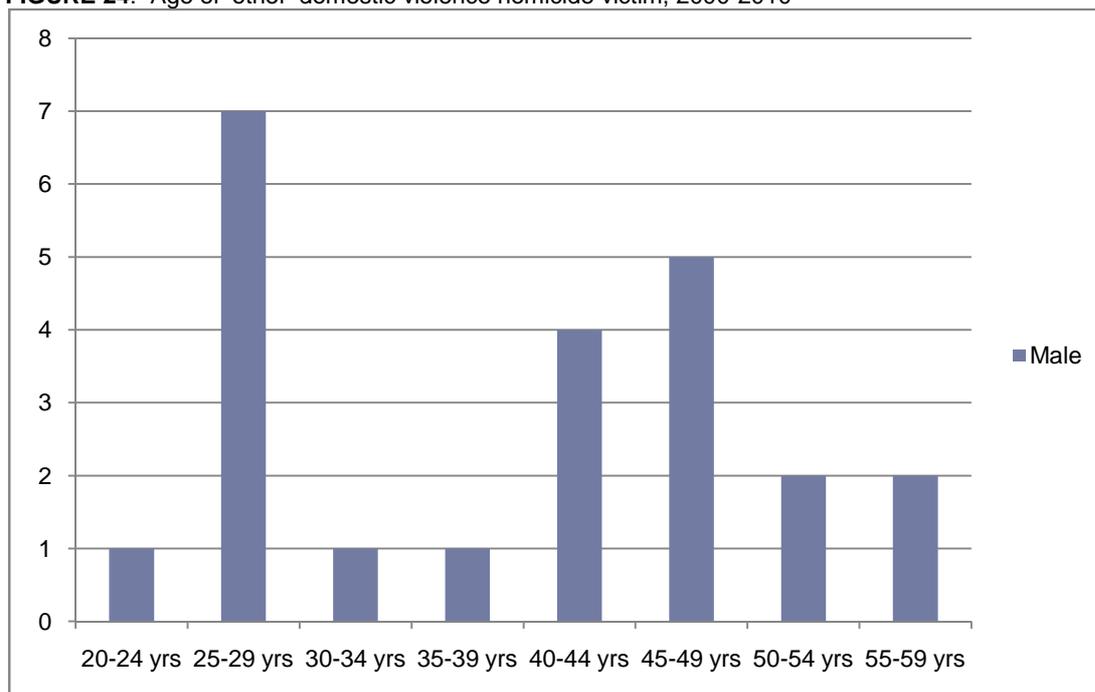


FIGURE 25: 'Other' domestic violence homicide victim by NSW Police Force Region, 2000-2010

NSW POLICE FORCE REGION	N	%
CENTRAL METROPOLITAN	5	22%
NORTH WEST METROPOLITAN	2	9%
SOUTH WEST METROPOLITAN	3	13%
NORTHERN REGION	4	17%
SOUTHERN REGION	4	17%
WESTERN REGION	4	17%
INTERSTATE	1	4%
TOTAL	23	100%

FIGURE 26: 'Other' domestic violence homicide victim by country of birth, 2000-2010

COUNTRY OF BIRTH	N
AUSTRALIA	17
MALAYSIA	1
COOK ISLANDS	1
FIJI	1
UNITED KINGDOM	1
NETHERLANDS	1
KOREA	1
TOTAL	23

FIGURE 27: 'Other' domestic violence homicide victim by manner of death, 2000-2010



FIGURE 28: 'Other' domestic violence homicide victim by location of fatal episode, 2000-2010

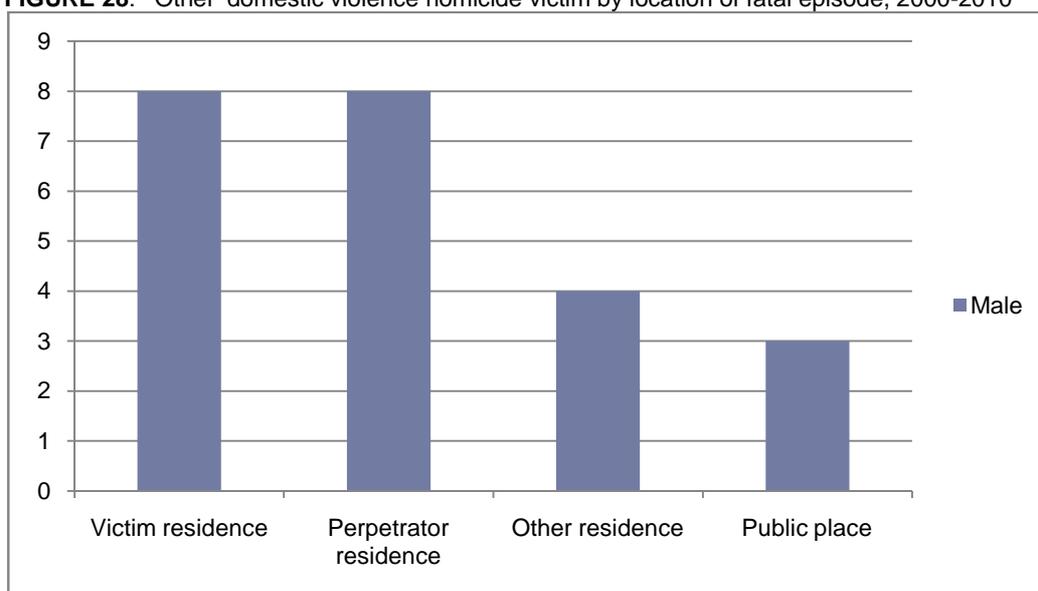


FIGURE 29: Age of 'other' domestic violence homicide perpetrator, 2000-2010

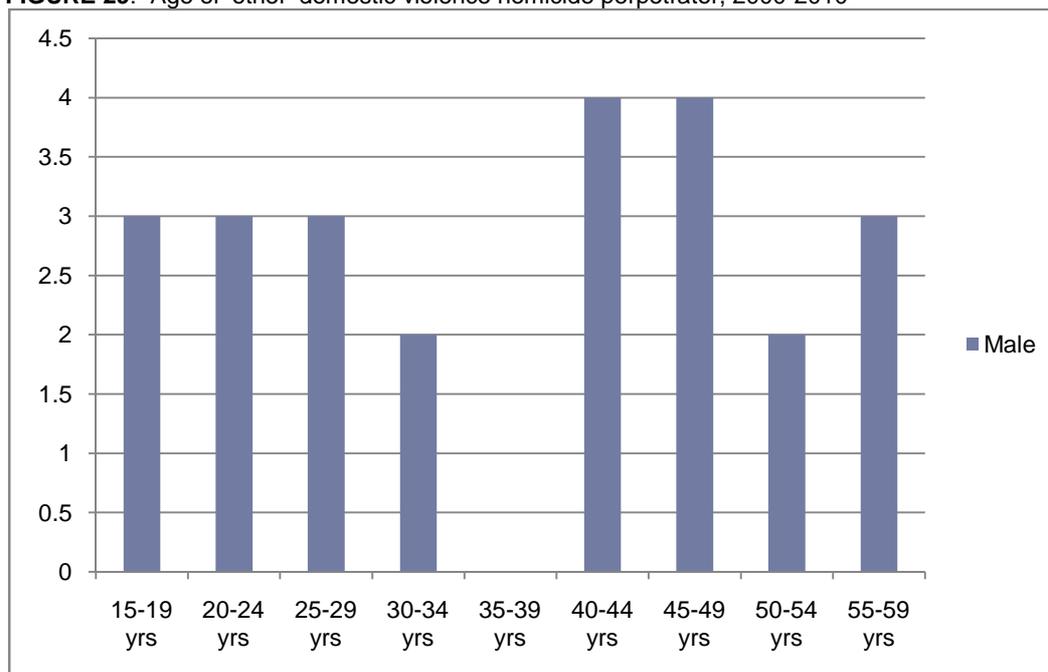
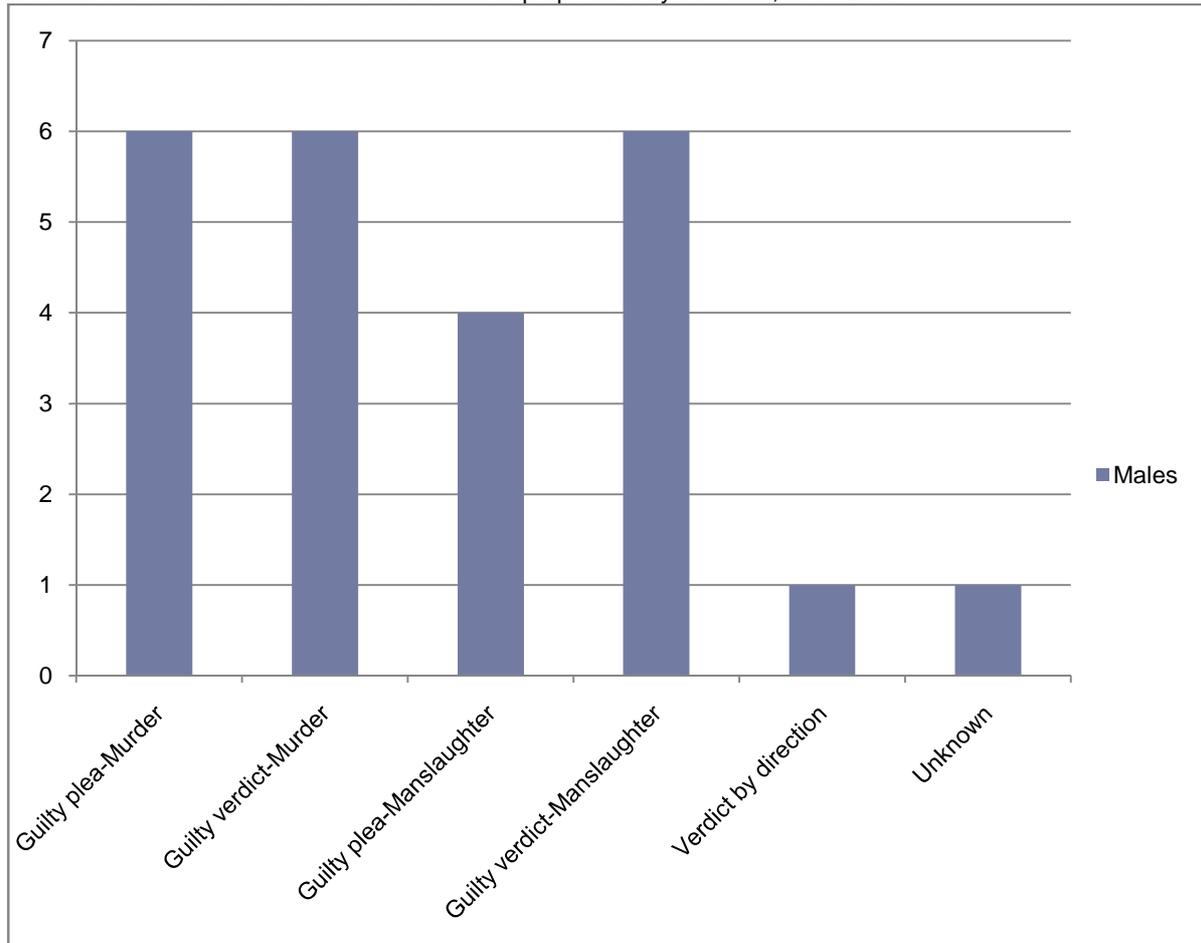


FIGURE 30: 'Other' domestic violence homicide perpetrator by country of birth, 2000-2010

COUNTRY OF BIRTH	N
AUSTRALIA	14
INDONESIA	2
LEBANON	1
COOK ISLANDS	1
FIJI	1
BRITAIN	1
NETHERLANDS	1
KOREA	1
HUNGARY	1
PHILIPPINES	1
TOTAL	24

FIGURE 31: 'Other' domestic violence homicide perpetrator by outcome, 2000-2010



APPENDIX D: CASE REVIEW SUMMARIES

Domestic Violence Homicides, 2009-2010

This appendix sets out case summaries of all 19 domestic violence homicides that occurred in NSW between 1 July 2009 and 30 June 2010. Each case was reviewed by the Team in order to identify common themes, issues and areas for recommendation. Each case review is followed by commentary that identifies some of the key issues and themes identified by the Team through this in depth analysis.

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 summaries and attached commentary are also designed to demonstrate the ways in which the Team developed its recommendations contained in this annual report. 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 loss of life.

CASE REVIEW 3004

This case involved the killing of a 26 year old woman ('Jill') by her male former intimate partner ('Terry'³⁴). The couple had been in a relationship, off and on, for a period of 5 years. At the time of the killing they were separated, but living together in Jill's residence in a town in Western NSW.

Friends and family members described Terry as very jealous and controlling of Jill. He would check her phone to see who she had been contacting and tried to limit her seeing particular friends. Jill disclosed her experiences of violence to one friend, Alisha, and Alisha had also seen Jill with physical injuries on a number of occasions. On one occasion, Terry killed Jill's cat during an argument by hitting it against a wall.

About 18 months prior to her death, Jill was arrested and charged with 'supplying false information' to the police as well as a number of serious traffic offences.

In the first offence, Jill was charged with one count of reckless driving. Subsequently, closed circuit television footage proved that Terry was in fact driving the car at the time of the offence. Jill refused to change her story and as a consequence was charged with supplying false information. In the second incident, Jill was charged with reckless driving offences and had her license revoked. Jill subsequently told friends and family that Terry had in fact been driving and she had been covering for him so that he would not go back to gaol.

A history of violence, including assaults, coercive and controlling behaviour and 'covering' behaviours in relation to driving offences, had also characterized Terry's relationship with his ex-girlfriend (in his relationship prior to the relationship with Jill).

There was evidence that Terry had been abused as a child, and had regularly witnessed his father perpetrating domestic violence against his mother. Jill did not experience violence during her childhood, and had not been in other violent relationships prior to her relationship with Terry.

About 15 months before the homicide, Terry was sentenced to 12 months imprisonment in relation to traffic offences. During this time, Terry's family went to Jill's house to search for an illegal firearm they believed that Terry owned. After searching the premises, no weapon could be located.

While Terry was in custody, Jill commenced an intimate relationship with a man called Jason, who moved in with her. When Terry completed his custodial sentence, Jason moved out of Jill's residence and the relationship ended. Terry was placed on parole and was required to complete community service hours.

Some months after Terry's release from prison, Jill reconnected with Jason, contacting him via third parties so that Terry would not find out. Around this time, Jill also became aware that Terry had been lying about completing his community service hours and that his parole was likely to be revoked.

³⁴To protect the identity of people involved, names have been changed for each case review.

Jill ended the relationship with Terry, however they continued to live together at Jill's residence, sleeping in separate rooms.

Jill recommenced her relationship with Jason and during this time Terry started to threaten suicide and also asked Jill how she would feel if Jason were to die. On one occasion, Jill was leaving her father and step-mother's home and she said to her step-mother, 'If you don't hear from me [when I get home] you know I'm dead'.

On the day of the killing, Terry phoned his father and indicated that he believed he would be returning to gaol as he had not been complying with his parole conditions. Jill spent the day with Jason at his premises. Later that day after Jill returned home, Jill and Terry started consuming alcohol. During the evening, they were seen to be 'wrestling' playfully, before Terry retrieved a shotgun, firstly shooting Jill and then shooting himself. The homicide was witnessed by Jill's sister who was staying at the house at the time.

Team Commentary: 3004

The Team made a number of observations in relation to this case.

The Team discussed the different manifestations of coercive and controlling behaviour by domestic violence abusers against victims in domestically violent relationships (for instance, where one partner covers or is forced to cover for another partner's criminal offending) and the intersection of these behaviours with criminal justice responses such as the police. The Team considered how these issues are understood by police officers, and whether there was scope to enhance training around this issue – given the unique examples of coercive and controlling conduct raised by this case. These discussions, as well as an overview of data derived from case reviews, led to the development of **Recommendation 1**.

The Team also discussed the ways in which intergenerational violence manifests in domestic violence homicide cases. In this case, Terry had been a victim of child abuse and also witnessed intimate partner violence between his parents throughout his childhood. There was no evidence of any support being provided to Terry in dealing with these experiences, and Terry had become a perpetrator of domestic violence as an adult. The Team discussed this theme extensively, and collated data from case reviews as well as the dataset of children killed by a parent in the context of domestic violence (discussed in Chapter 4) to further examine the prevalence of historical

domestic violence victimisation amongst perpetrators and victims of domestic violence homicide. This factored in to the development of **Recommendation 9**.

The Team also discussed the extent to which in this, and other cases, friends and family were aware of domestic violence behaviours but did not characterize such behaviours as 'violence' or did not address disclosures of violence.

This was a theme across cases, and was acknowledged in the inclusion of **Recommendation 10** concerning a public education strategy in the Team's 2011/12 Annual Report. That recommendation received in principle support but has not yet been implemented. In this Report, the Team has included **Recommendation 17**, which provides a more targeted strategy aimed at addressing the specific issues raised for communities (including friends and families) in responding to domestic violence.

The Team considered the issue of the domestic violence abuser and victim living together post-separation as a characteristic in this case which appeared to heighten the risk to the victim, given the perpetrator's history of coercive and controlling behaviour. The Team also identified many additional 'stressors' in this case (including the threat of parole revocation and the presence of Jill's new partner).

As continuing to live together was identified as a characteristic in several of the cases reviewed, and the Team's dataset indicates that separation was a characteristic of many homicides in a domestic violence context (see Chapter 2), the team developed **Recommendation 3**.

CASE REVIEW 3417

This case involved the killing of a woman ('Lisa') by her boyfriend ('John'). The couple had been in a relationship for almost 2 years at the time of the fatal assault in 2005, and Lisa died in 2010 having survived in a persistent vegetative state for 5 years. The couple did not live together, and both were 52 years of age at the time of the fatal assault.

The relationship was characterized by domestic violence perpetrated by John towards Lisa, but there was no history of AVO's or criminal charges in relation to any assaults. Friends and family had seen Lisa with injuries on a number of occasions, including black eyes, wounds and bruising on her face, arms, torso and legs. However, Lisa refused to talk about her experiences of violence. Lisa presented at hospital emergency rooms on two

occasions displaying injuries consistent with domestic violence (including on one occasion via ambulance). On both occasions she was heavily intoxicated on admission.

At the time of the killing Lisa and John were staying at John's holiday home in a coastal town in NSW. Neighbours reported hearing daily verbal arguments and seeing Lisa with bruising and swelling around her face. No reports were ever made to the police, despite neighbours' concern for Lisa's welfare.

On the day of the killing, Lisa's daughter Cara called John and asked to speak to her mother. John said 'Sorry Cara, but I've hit her... I went whack, whack, whack, and she's got two black eyes.' Cara demanded that her mother be put on the phone and she was, but Cara could not understand her as Lisa was heavily intoxicated. Cara then called her sister and Lisa's brother Stanley, to talk to them about her conversation with John. There was much discussion about what to do, and it was decided that after work Stanley and his wife would go to the holiday home to see Lisa.

During the afternoon Lisa was seen sitting on the veranda with a heavily swollen face and black eyes. She also went to her neighbour's house telling him that John had hit her, and that her left eye 'really hurt'. She asked him to look at her eye. The neighbour did not call the police or help Lisa to seek medical treatment. She appeared intoxicated at this time.

Throughout the afternoon and into the evening, neighbours heard Lisa and John arguing. Later that evening Stanley and his wife arrived at John's holiday home. John said 'I'm sorry I've hit Lisa. You'll get a shock when you see her.' They went upstairs and Stanley found Lisa who was covered in blood, unconscious and naked from the waist down. An ambulance was called and Lisa was conveyed to the hospital. She was recorded to have a blood alcohol concentration level that exceeded 0.323.

John maintained that he only hit Lisa twice in the right eye, to 'quieten her down' as she was hitting him and yelling at him. He claimed that the rest of Lisa's injuries were self inflicted due to her level of intoxication. Blood staining was noted along the walls of the bedroom, on the bed, on the floor, in the kitchen and other locations around the house, and down the stairs.

As Lisa remained alive, John was convicted of GBH and sentenced to 9 years in prison for this offence.

Over the next 5 years, Lisa continued to live in a coma. She never regained consciousness after the assault. She passed away following an infection in January 2010.

John was subsequently tried and convicted of manslaughter. The remarks on sentence did not refer to 'domestic violence' in the relationship.

Team Commentary: 3417

The Team made a number of observations in relation to this case.

The Team firstly considered what ordinarily happens when victims of domestic violence present with injuries at Accident and Emergency Departments at NSW Public Hospitals. The Team then raised a number of questions as to how these injuries (and the violence itself) could be better addressed by these departments. For many victims, Lisa included, these contacts were some of the only service contact points in relation to domestic violence and the absence of appropriate handling represented a missed opportunity to respond to and address victims' experiences of violence.

Similarly, these issues extended to domestic violence victims presenting to NSW Ambulance Officers and the Team considered how these presentations could be better addressed by this service provider.

The Team discussed the complexities around Lisa's presentation to these services, having regard to the extent to which she was intoxicated when interacting with these services.

Whenever Lisa presented with injuries, these appeared to be treated as related to her intoxication and alcoholism, and the Team raised questions as to whether more could be done to ensure that staff in Accident and Emergency Departments and Ambulance officers are trained to identify domestic violence in the presence of other cumulative social issues.

These discussions in relation to the procedures of NSW Accident and Emergency Departments and NSW Ambulance led to the development of **Recommendation 10**.

The case also raised a number of issues in relation to the characterization of violence as 'domestic violence' where individuals have non-conventional intimate relationships. The remarks on sentence in this case contained no reference to 'domestic violence'.

The importance of using the language of domestic violence is necessary to assist the broader community to understand, characterize and respond to domestic violence. By reviewing the remarks on sentence in this, and other cases, the Team developed **Recommendation 15** to highlight the importance of training for senior judicial officers in relation to the dynamics of domestic violence.

As per Case Review 3004, this case also raised issues around friends, family and neighbours responding to domestic violence. Accordingly, the Team developed **Recommendation 17** to address the issue of better responding to domestic violence within communities.

CASE REVIEW 2321

This case involved the killing of a 27 year old Aboriginal Australian man ('Tom'), by his 28 year old de facto wife ('Selena'). Tom and Selena had been in a de facto relationship for 7 years at the time of the killing and lived together on the NSW coast. Tom had two biological children from a previous relationship who regularly spent time with the couple.

The relationship between Tom and Selena was characterized by significant domestic violence perpetrated by Tom against Selena.

There were a number of reported episodes of domestic violence from 2005-2008 including: an episode in 2005 where Selena told friends that Tom had threatened her with a machete, and told her that he was going to kill her; an episode in 2006 where friends observed Selena with significant bruising around her eyes following an assault by Tom; an episode in 2006 where the Tom's mother observed a fight between Tom and Selena at a family barbeque where Tom hit Selena in the face, causing her to fall over unconscious on the lawn; numerous reports by neighbours in 2005/2006 regarding loud arguments and 'smashing' of belongings; Tom perpetrating a serious assault on Selena on Anzac Day in 2007 which resulted in Tom being arrested and charged with assault and an AVO being put in place; and another serious assault against Selena in January 2008 which again resulted in Tom being charged with assault and breaching his AVO.

Following this last episode, Selena refused to press charges against Tom and retracted her earlier statements against him in a written statement to the police. Despite the various episodes which resulted in NSW Police Force involvement with the family, no reports were ever filed with FACS in relation to Tom's children's exposure to domestic violence.

In 2009, Selena and Tom became engaged. In 2009 Tom and Selena had a fight which resulted in Tom 'cutting up' Selena's wedding dress. Around the same time, Selena and Tom travelled overseas on a holiday with friends, who observed Tom hitting Selena, breaking her makeup containers and verbally abusing her.

Tom had serious substance abuse issues and alcohol was frequently, but not always, a factor in his domestic violence against Selena. Tom would also control the clothes that Selena wore, who she spoke to and would call her obsessively when she went out without him.

Tom was physically abused by his stepfather during his childhood. He subsequently developed a significant juvenile record for crimes including larceny, robbery, drug offences and assault. He had spent a period in juvenile detention and after his release, started a relationship with a woman which resulted in the birth of 2 sons. After the couple broke up, the woman took out an AVO against Tom, due to his violent behaviours. Tom was also a defendant in an AVO protecting his mother. Tom continued to have access visits with the children most weekends pursuant to an informal parenting arrangement. They would come and stay with him and Selena every few weekends.

Selena had not previously been in a domestic violence relationship and had been raised in a non-violent family environment throughout her childhood.

The night of the killing, Tom and Selena went to a friend's house for dinner, both consuming a significant quantity of alcohol. When they returned home they began to argue about access arrangements in relation to Tom's two sons. During the argument, Tom started to threaten Selena, at which time she grabbed a knife from the kitchen and stabbed Tom once in the chest. Selena was incredibly distressed and immediately called the ambulance, however, Tom died at the scene.

FACS was not notified in relation to Tom's death and no support services made available to Tom's two surviving children.

Selena was charged with Tom's murder, but was acquitted at trial on the grounds of self-defence.

Tom's biological children continue to reside with Tom's ex-partner and her new intimate partner. There is evidence that they continue to be exposed to domestic violence, and are known to Community Services in the context of the new relationship.

Team Commentary: 2321

The Team made a number of observations in relation to this case.

As per *Case Review 3004*, this case raised issues of intergenerational violence (in this case where a childhood victim of violence became a perpetrator of violence during his adulthood) and the supports available to children experiencing violence at home.

This led to the development of **Recommendation 9**, **Recommendation 18** and also factored into the development of **Recommendation 17** as a preventative mechanism addressing violence.

Many of the recommendations touch on the issue of intergenerational violence and acknowledge that addressing violence before or when it occurs is fundamental to putting an end to this destructive cycle.

In this case the Team noted that there was a lack of communication between the NSW Police Force and FACS in relation to the children, including in relation to the domestic violence matters in 2007 and 2008, and the homicide. Although Tom's children were not ordinarily resident with Tom and Selena, they spent a great deal of time in the household pursuant to informal parenting orders. The Team considered whether there was scope for FACS to better capture the complexity of family trees, including where biological (but non-custodial) parents perpetrate violence and are known to police. The Team considered whether these systems could be improved to help NSW Police Force and FACS identify exposure to domestic violence within families and deal with this appropriately. Commentary in relation to this issue is discussed in Chapter 5 of this report.

This case was also a primary catalyst for the implementation of **Recommendation 9**, which considers notification, triaging processes and specific support mechanisms for children who lose a parent to a domestic violence homicide. In this case FACS was unaware that Tom had died, leaving behind two surviving children. The Team accordingly considered whether there was scope to improve communications between police and FACS, including scope to provide enhanced support for surviving children of homicide victims – perhaps through Victims Services – helping children to cope with their loss.

CASE REVIEW 3296

This case involved the killing of a 40 year old woman ('Sarah') by her 44 year old de facto partner ('Jeff').

Sarah and Jeff had been in an on/off de facto relationship for approximately 14 years and, at the time of the killing, lived together in metropolitan Sydney. The first period of their relationship was during the 1990s and at this time their relationship was marked by serious substance abuse by both parties, including illicit drug and alcohol use. The relationship initially ended after Jeff was taken into mental health treatment following an unsuccessful suicide attempt. There was one recorded domestic violence incident in 1998 which resulted in Jeff being charged with assaulting Sarah.

Sarah and Jeff again commenced a relationship in 2005. At this time both parties were sober, and both were managing to hold down regular employment.

In 2009 Sarah lost her job and soon began using drugs again. This apparently caused tension in the relationship between Sarah and Jeff, as Jeff continued to be sober. Sarah also started working as a prostitute to support her drug habit around this time.

In October 2009 Jeff seriously assaulted Sarah - tying her up with cable ties and tape, jumping on her chest and beating her. Sarah went to the police the following day with evidence of the assault, an AVO was put in place and Jeff was remanded in custody with bail refused.

In November 2009 the court date for the assault charge was vacated until April 2010 and Jeff was released on bail. At this time, Jeff and Sarah again recommenced their relationship and resumed living together in their shared flat - although Sarah was also seeing another man, Tony, at the time, and would occasionally stay at his house. The relationship deteriorated further and Sarah indicated to police officers that she was worried about giving evidence against Jeff in the upcoming assault trial the following April.

One week before the assault trial, Sarah transferred her car registration into Jeff's name.

Two days before the assault trial, Sarah called the police alleging that Jeff had struck her over the head with a wheel clamp. Police attended but rejected Sarah's account, believing that she had fabricated the story to 'get Jeff in trouble'. They could not visibly identify any injuries to her face and

could not get a clear version of events from her as she was too intoxicated.

Sarah was taken to the Accident and Emergency department of the local hospital by police, but due to delays in the waiting room, she became agitated and demanded to leave. Staff at the hospital assessed her, and released her into the care of the police officers, who dropped her home to the flat she shared with Jeff. She asked officers to drop her around the corner from the apartment so that Jeff would not see them arriving and become angry. The officers dropped her around the corner from her premises and left the scene.

The following evening, Sarah went to a neighbour's house and told her neighbour that Jeff was 'going to kill her', and that she was 'bleeding from her teeth'. That evening (17 April) Sarah also called her bank at 12.30am to organise new bank cards, as she claimed her 'wallet had been stolen'. During these calls the operator spoke to both Sarah and Jeff, and while Jeff seeming calm and relaxed, Sarah was hysterical and was often crying.

Sarah was not seen after the evening of 17 April and it is believed that Jeff killed Sarah between 17-18 April.

Jeff attended court on 19 April but Sarah did not appear to give evidence and the hearing was adjourned. Sarah was reported missing by her new intimate partner Tony on 23 April and the police made inquiries at Jeff's house, locating a bag of Sarah's belongings in plastic bags by the door in their flat.

Jeff was arrested and charged with murder, and Sarah's dismembered body was located in bushland 5 months after she was reported missing.

Although he initially denied killing Sarah, at trial Jeff claimed that Sarah had accidentally died, and that as it 'looked so bad for him' due to the proximity of the court date and circumstances, that he decided to dismember her body and dispose of it in bushland.

Jeff was found guilty of Sarah's murder.

Team Commentary: 3296

This Team made a number of observations in relation to this case.

As per Case Review 3417, this case raised issues about the presentation of domestic violence victims in NSW Accident and Emergency Departments. It also raised additional issues around the ways in

which such departments facilitate discharge of victims after treatment. Sarah presented at hospital displaying cumulative social issues including poly-substance abuse, and despite allegations of violence, no supports or referrals were offered, and she was discharged into the care of the perpetrator.

The Team felt this was suggestive of a need for further training in identifying and responding to domestic violence in NSW Accident and Emergency Departments in Public Hospitals, as well as improved policies around facilitating discharge of patients into safe environments. This factored into the development of **Recommendation 10**.

In this case, the killing occurred the day before Sarah was due to testify against Jeff in an assault trial where she was the victim. This appeared, to some extent, to be a catalyst for the homicide.

The Team also noted that on the 16-17 of April, NSW Police were aware of the court date, as well as the fact that Sarah would be testifying against Jeff the following day, however they dismissed her accusations of violence as her 'lying' and 'trying to get Jeff in trouble'. These issues factored into the development of **Recommendation 3**, but also relate to the training of police in relation to domestic violence behaviours, which considered in **Recommendation 1**.

The Team also discussed the police response to 'complex' victims. Sarah had a history of police involvement, and often presented with cumulative social issues, which made her a sometimes challenging client for police officers to deal with.

The Team noted that the very characteristics that made her 'difficult' for police to manage also increased her vulnerability as a victim of violence.

The Team considered the importance of supporting police officers in their work with clients in the development of **Recommendation 2** and **Recommendation 6**.

CASE REVIEW 2974

This case involved a 69 year old man ('Paul') who killed his 53 year old wife ('Maureen'), and two young grandchildren ('William' and 'Bella'), who were 5 and 7 years of age respectively. He also attempted to kill his daughter ('Elizabeth') – the children's mother - in the attack.

Paul had a history of being emotionally as well as physically abusive towards his wife and his children. Paul was described by his daughter Elizabeth (a policewoman) as being the 'authoritarian' and

'leader' of the family. While his children were growing up, he would often beat them with a belt for minor transgressions or disobedience. On one occasion, Elizabeth recalled Paul kicking her repeatedly causing her to wet herself in fear. Elizabeth described her brothers as bearing the brunt of Paul's abusive behaviour, in particular her youngest brother Albert, who later committed suicide.

There is no evidence that abuse was ever directed towards his two grandchildren William and Bella.

Throughout his relationship with Maureen, Paul had always been extremely controlling of his wife, particularly in relation to money. There is an unreported history of domestic violence between Paul and Maureen, and there were some indications that in the weeks prior to the killings, Maureen had indicated an intention to leave the relationship. This echoed an event some years before, where Maureen had left the relationship temporarily, run away and attempted suicide. This was apparently due, in part, to Paul's controlling behaviours.

Interestingly, in the year prior to the killings, Paul's brother, who lived in the United Kingdom, stabbed his wife to death and suffocated their young child. According to Elizabeth, Paul was 'obsessed' with his brother's case, and kept newspaper clippings and articles related to the homicides.

The night prior to the killings, Paul's daughter Elizabeth dropped her two children off to stay the night at their grandparents' house.

Early in the morning on the Monday, Paul reported hearing voices whilst he was in the bath. After getting out of the bath he killed Maureen by striking her with a 7 pound hammer shaft and stabbing her multiple times. He then drowned Bella in the bathtub. He put her back in the bed and woke up William. He struck William on the head and struck him on the head with the hammer shaft. Paul put William in the bath to drown him and then placed him back in bed.

Later that morning, Paul phoned the children's school to inform them that the children were not well and would not be attending school that day.

Later that afternoon, Elizabeth returned to the house and found Paul sitting in the lounge room drinking a cup of tea. She noticed that her mother was lying on the floor in the bedroom, and asked Paul whether there was something wrong with her. Paul informed her that Maureen was feeling unwell

and had decided to lie down. Thinking that her posture and the situation was unusual, Elizabeth enquired whether her mother was, in fact, 'alive' at this point. Paul replied that yes, she was alive.

There was a clean axe on the table next to Paul and he indicated to Elizabeth that he had been using it to do a number of chores.

Elizabeth noticed that her children's school uniforms were still laid out on the lounge and Paul indicated that they had gone to school wearing plain clothes. Elizabeth became concerned for the welfare of her children, and went to check the children's room where she located Bella deceased on the bed.

Paul then attacked Elizabeth, striking her on the head repeatedly with the axe. Elizabeth pleaded with him to let go of the axe and he indicated that he would not, as later that evening he was going to drive to Newcastle to kill Elizabeth's ex-husband.

After some further struggle, Elizabeth managed to run outside and to a neighbour's house, where she barricaded the house and attempted to call the police. She called 000 and arranged for the dispatch of officers to the scene.

When police arrived they found William, Bella and Maureen deceased in the bedrooms. Also located was the family's dog, which had been drowned.

After leaving the family residence, drove along the coast, stopped at a motel and booked into a room for the night. The owner of the motel called police having recognised Paul from a police alert on television and Paul was apprehended.

Paul pleaded guilty to the murder of his wife and two grandchildren.

Team Commentary: 2974

There were a number of issues evident to the Team in this case.

In relation to Maureen, the Team considered that there were many barriers facing older women leaving relationships coupled with an apparent lack of support for such women. For older females, such as Maureen, service contact points were limited to providers such as medical professionals. Maureen did not disclose her experiences of domestic violence to any services, but was nonetheless engaged with some providers for reasons unrelated to such violence.

The Team discussed the potential for domestic violence screening and/or awareness raising in a

healthcare context for older women. These considerations factored into the development of **Recommendations 21, 22 and 23**, which propose new strategies for responding to domestic violence affecting older Australians.

Again, the awareness of domestic violence behaviours amongst friends and family was an apparent and troubling issue in this case. In particular, this case raised issues as to the extent to which family members had 'normalised' domestic violence and accordingly failed to acknowledge that the abuse they were experiencing or witnessing was domestic violence. This was considered in the development of **Recommendation 17**.

As with a number of other cases reviewed, the remarks on sentence for this case made no reference to the perpetrator's domestic violence behaviours towards Maureen and contained no reference to the prolonged history of child abuse by the perpetrator towards his children. The importance and opportunity for senior judicial officers to communicate the dynamics of domestic violence where appropriate was considered in the development of **Recommendation 15**.

CASE REVIEW 2275

This case involved a 28 year old woman ('Kirra') who killed her 30 year old abusive intimate partner ('Leroy'). The couple met and commenced a relationship in about November 2008 at a methadone clinic and both had a history of chronic poly-substance abuse. They had been together for approximately 1 year at the time of the homicide.

The couple had no fixed abode and would stay with friends or in emergency accommodation.

Leroy had a lengthy criminal history (including violence offences) and had a long history of substance abuse issues with drugs and alcohol. He had an unstable childhood and lived a nomadic lifestyle. He had served a number of short custodial sentences, and a more lengthy sentence for arson which concluded in 2008, prior to meeting Kirra.

Kirra had been the victim of sexual abuse during her childhood, which resulted in her becoming homeless at 15 years of age and having no further formal education. Kirra had a history of drug and alcohol abuse and a history of mental health issues, which resulted in her being hospitalised at a psychiatric institution when she was 22 years old.

Kirra's criminal history consisted of a number of larceny and damage property offences. Her record did not disclose any previous charges for violent

offences. Her mother had previously served a custodial sentence for manslaughter. Kirra had given birth to four children, from three different fathers, all of whom had been removed by Child Protective Services.

Kirra reported (in the context of sentencing proceedings) that her relationship with Leroy was marked by conflict, that he was regularly physically abusive towards her. Kirra reported to a psychiatrist that she had been subjected to physical violence by Leroy, and that she tried to avoid doing anything that would inflame his temper.

On the morning of the homicide, Kirra and Leroy attended the Neighbourhood Centre in the town they were staying, seeking emergency accommodation.

Centre staff described Leroy as being 'a bit agitated', and 'cranky' with Kirra. Staff witnessed the couple arguing viciously while they were completing emergency housing forms, with one or the other storming off at various times.

Kirra complained of being unwell and stated that she may have been pregnant. The staff offered to call an ambulance however Leroy told staff that there was 'no need' and that Kirra was being a 'fucking drama queen'.

When the couple were unsuccessful in securing emergency accommodation, Leroy verbally abused staff. At about 3:45 pm Leroy and Kirra left the centre and, according to various witness statements, were yelling at each other and anybody around them.

Later that night Kirra and Leroy were seen arguing in the grounds of the Neighbourhood Centre and one witness reported that: 'I remember the male yelling at her ... the male sounded angry when he was yelling at the female'. Kirra crossed the road and approached the witness, asking for directions while Leroy 'continued to yell at her ... yelling quite loudly at her.'

At around 11:30PM Kirra stabbed Leroy once in the left thigh. Kirra immediately called 000 however Leroy was pronounced dead on arrival at hospital a short time later.

Kirra initially maintained that an unknown assailant had stabbed Leroy in the course of a robbery but later made admissions to police, saying 'I've stabbed my husband and I hit a main artery and he's died. I didn't mean to kill him but, I've tried to

wrap him, I tried CPR on him, I was just sick of him beating the shit out of me all the time'.

Kirra was found guilty of manslaughter.

Team Commentary: 2275

This Team made a number of observations in relation to this case.

As with other cases, this case raised serious issues of intergenerational violence, as Kirra had been a victim of sexual abuse, homelessness, substance abuse and exposed to significant domestic violence from a young age. She had dropped out of school at 15 due to her significant social issues – and according to records, the school never sought to assist with these issues - and as a homeless teenager she became extremely vulnerable. Kirra's lack of appropriate supports meant that she continued to live within a cycle of violence during her adult life, as a victim of domestic violence and later, as a homicide perpetrator.

Furthermore, when Kirra was younger, her mother had perpetrated manslaughter, and Kirra had not been offered any support to deal with her serious emotional and psychological issues arising from these experiences. These considerations factored into the development of **Recommendation 9**.

This case provoked discussion around the need to improve preventative domestic violence strategies for young peoples, and provide support for children and young people who are exposed to domestic violence, abused or affected the loss of a parent or parents. This was factored into the development of a number of recommendations in this report, including **Recommendations 9 and 17**.

It also provoked discussion around the need for triaging of domestic violence victims through a Whole of Government response to domestic violence. This is discussed in the commentary provided in Chapter 5.

CASE REVIEW 2257

This case involved the killing of a 43 year old man ('Matthew') by his 44 year old de facto wife ('Sally').

Both Matthew and Sally identified as Aboriginal and lived together in a rural town in NSW. Both had issues with drugs and alcohol, but were both employed at the time of the homicide - Sally as a government employee in the ageing and disability sector and Matthew as a casual employee at a funeral parlour.

Sally and Matthew began an intimate relationship in the early 1980s. From a relatively early stage in the relationship Matthew abused Sally both physically and psychologically. The abuse was sporadic but it persisted throughout the relationship.

From the early 2000s Sally would disclose details about the abuse to a number of colleagues at work. She would often show signs of injury and pain at work and was told by her colleagues to leave the relationship and that she was 'too intelligent to put up with a man treating her that way.'

Matthew would also frequently attend Sally's workplace and be disruptive and abusive. On one occasion in 2004, the police were called as the manager was concerned for Sally's safety and the safety of other employees. It is unclear whether the police attended or provided any referral information/advice to Sally.

Sally initially told friends and family that she couldn't leave the relationship with Matthew because she loved him too much. In later years she disclosed that she had been paying the mortgage on their house for years but did not appear on the title documents and was concerned that if she left she would lose the house.

In the year leading up to the homicide Matthew began to accuse Sally of being unfaithful to him. These accusations were unfounded. During this period the physical and verbal abuse escalated.

On the evening of the homicide Matthew attended a party while Sally stayed home, retiring to bed at about 11:00 pm.

Matthew returned home at some stage during the night and at about 2:30 am a text message was sent to Sally's mobile phone. Matthew woke Sally. Matthew was drunk and angry, calling her a 'slut' and a 'moll' and demanded to know who had sent the message and who she was 'running around with'. He pushed her off the bed and she fell to the floor. He told her to get out of the bedroom because she was not sleeping in the bed that night.

Sally got dressed and left the bedroom, intending to sit in the lounge room and watch television. Matthew intercepted her in the hallway at a point very close to the kitchen. Matthew pushed Sally again causing her to fall to the floor. Matthew stepped over Sally on the floor and, thinking that he was going to continue to assault her, Sally grabbed a knife from the kitchen and stabbed Matthew once in the abdomen.

Sally ran outside to look for somewhere to hide, fearing that Matthew would come after her. She went back inside the house a short time later and called her son who was at a party nearby. The son described Sally's voice as scared and panicked. The son attended a short time later and both he and Sally called 000.

Sally pleaded guilty to manslaughter.

Team Commentary: 2257

The Team made a number of observations in relation to this case.

It was of concern to the Team that Sally was a government employee in NSW who had regular engagement with domestic violence information and services, yet did not seem to recognize or respond to the violence she was experiencing within her own relationship. Furthermore, it was of concern to the Team that her workplace was aware of the violence – her Manager on one occasion called the police in relation to Matthew's violence – yet the mechanisms were not in place to provide Sally sufficient support in relation to the domestic violence she was experiencing.

The Team considered this case in the development of **Recommendations 19 and 20**.

This case also raised serious issues in relation to the actions of friends, family and colleagues, who, for many and varied reasons, did not provide sufficient support to Sally in responding to the domestic violence she was experiencing. This factored into the development of **Recommendation 17**.

CASE REVIEW 2998

This case involved the killing of a 58 year old woman ('Ania') by her 60 year old estranged husband ('Lleyton'). The couple lived on a rural property and Lleyton owned a petrol station, while Ania worked at a supermarket bakery. The couple had a number of grown children who lived nearby and shared a close relationship with their parents.

Throughout their 41 year marriage, Lleyton was psychologically abusive, controlling and jealous of Ania, however, there was no reported history of physical domestic violence in the relationship.

The relationship between Ania and Lleyton started to break down in 2008, with Lleyton becoming increasingly jealous and resentful of Ania's new found independence, including her new job working

at a supermarket and her regular participation in local dance activities.

Around this time Lleyton started having an extra-marital affair with another woman. Ania found out about the affair and confided in her children, who decided that in support of their mother, they would confront Lleyton about his transgressions. The family confronted Lleyton about his behaviour after which he made an apparent suicide attempt. Police were called to respond to the attempted suicide and his gun license was revoked and weapons removed from the property.

Despite his apparent suicide attempt, two weeks later Lleyton was assessed by his GP as being suitably stable to continue to hold his gun license and his license and weapons were reinstated.

After the suicide attempt Lleyton resided for some weeks with his daughter but following some difficulties, moved back onto the family property he shared with Ania a short time later. He continued to reside on the property in a caravan which was located at the rear of the house near a shed.

On an evening in February 2009, following an argument with Ania and the children (which resulted in a physical altercation between Lleyton and his son), Lleyton entered Ania's home and killed her by striking her repeatedly with an iron bar he had removed from the shed. It is noted that the guns were locked in a cabinet in the bedroom of the main house at the time of the homicide. A police standoff ensued and Lleyton, in the front paddock of the family home, continued to 'lean' on a knife that he had taken from the family kitchen. Eventually Lleyton was arrested and charged with Ania's murder.

Lleyton was found guilty of murder.

Team Commentary: 2998

The Team identified a number of issues from reviewing this case.

The Team considered the many and varied barriers impacting on the ability of older women to access domestic violence services or supports. As with Case Review 2974, this factored into the development of **Recommendations 21, 22 and 23**.

The Team also considered the domestic violence victims and abusers living together post-separation as a risk factor in this case, and considered this in the development of **Recommendation 3**.

The Team also conducted further research around certification processes for reinstatement of firearms and licenses in exploration of the firearms issue identified in this case. These findings are discussed in Chapter 5.

CASE REVIEW 3000

This case involved the killing of a 35 year old Chilean woman ('Camilla') by her 36 year old Chilean husband ('Eduardo') in their shared home in metropolitan Western Sydney. The couple had been married since 1996 and had three children - a 17 year old girl ('Mara'), an 11 year old girl ('Sofie') and an 8 year old boy ('David').

Throughout the relationship Eduardo physically, sexually and emotionally abused Camilla. Despite the long history of domestic violence in the relationship, there were no reports of violence made to the police aside from a sexual assault charge against Eduardo (in relation to Camilla). There was no history of AVOs between the couple.

Camilla was seen by friends and family on a number of occasions with black eyes, and friends were aware that Eduardo would constantly accuse Camilla of being unfaithful to him. Despite this, the relationship between Eduardo and Camilla was described by friends and family as both 'loving' and 'normal'.

In around June 2008, the eldest daughter Mara made disclosures to a therapist, claiming that Eduardo – who was her biological father - had been sexually assaulting her for a number of years. Mara then left the family home and the therapist reported the sexual assault allegations to Family and Community Services (FACS) with reports received in September 2008 concerning Mara, as well as the younger children Sofie and David. The reports were not actioned by FACS and the two youngest children, Sofie and David continued to reside with Eduardo and Camilla.

When the sexual assault allegations were made both Camilla and Eduardo stridently denied them. During this time, many family members attempted to talk to Mara and 'expose her lies'. Mara lived variously with different family members, many of whom did not believe her and called her a liar.

About two weeks before the killing, on Thursday 2 April 2009, Mara, with the support of a family mediator, made a statement to FACS in relation to the alleged sexual assault. A few days prior to the homicide, Camilla indicated to several friends that she had started believing her daughter and was intending to leave Eduardo.

During the following two weeks, the relationship between Eduardo and Camilla disintegrated and there was an escalation in psychological, and physical, abuse.

The morning of the killing, Eduardo and Camilla were at home with David and Sofie. At around 8 am, Eduardo attacked Camilla, beating her a number of times with a tool. A can containing fuel was also found at the scene, which Eduardo later told police he was intending to use. The children, despite being at home at the time of the killing, were not aware of it as they were downstairs. After killing Camilla, Eduardo took the children to their Aunt's house and returned to the family home.

Later in the day a neighbour reported to police that Eduardo was acting suspiciously at home, and he was arrested and charged with Camilla's murder.

Eduardo was found guilty of the murder of Camilla and was also subsequently found guilty of the sexual assault of Mara.

Team Commentary: 3000

The Team identified a number of issues from reviewing this case.

This case raised issues around the ways in which FACS handle sexual assault allegations, particularly when young children remain in the care of the alleged perpetrator. In this case the Team raised concerns about the fact that Sofie and David remained with Eduardo and Camilla and no investigations were made into the case. It was not until Mara self-reported to FACS that a team was convened to investigate her case, and notwithstanding this, the two younger children remained in the care of Eduardo and were present in the home when he killed Camilla.

The Team considered this issue, including subsequent developments in FACS' policies and practices in this area, the discussion of which is set out in Chapter 5 of this report.

The attitudes within the family unit were troubling in this case, as there was a culture of acceptance of violence and many family members were pushing Mara to recant her sexual assault allegations against Eduardo. This reiterated the need for improved public awareness of domestic violence, including sexual violence, addressing community attitudes which promote patriarchy and condone violence. This factored into the development of **Recommendation 17.**

CASE REVIEW 3032

This case concerned a 45 year old woman ('Justine') who was killed by her de facto husband ('Ken')

Ken and Justine lived in a town on the Central Coast, NSW, with their newborn son, and Justine's teenage son from a previous relationship ('Cody'). Ken and Justine met in about 2002 and commenced an intimate relationship sometime thereafter. From the outset of the relationship, friends and family described Ken as a controlling and moody person with few friends.

In his twenties, Ken was diagnosed as suffering from a social anxiety disorder and was prescribed numerous medications. At the time of the killing, Ken continued to take various medications to deal with his anxiety including Xanax, Serepax and Stilnox. Ken was also an alcoholic.

For a number of years Ken ran a successful financial planning business and in 2004 Justine and Cody moved into Ken's house and she began working in the business.

In about 2006 Ken and Justine, having been unable to conceive naturally, commenced IVF treatment using donor eggs. In late 2007 Justine fell pregnant but suffered from a miscarriage at 16 weeks. Following this, the relationship between Ken and Justine began to deteriorate. Ken blamed Justine for the financial problems they were experiencing, would restrict the amount of money she was 'allowed' and would closely monitor her spending.

In September 2009 after another round of IVF, Justine found out she was pregnant. Ken began accusing Justine of infidelity and claiming that the baby was not his. By the end of 2009 Ken was becoming increasingly paranoid and was asserting significant control over all aspects of Justine's life.

Four months before the homicide Ken and Justine were arguing and Ken slapped Justine, who was approximately 7 months pregnant, across the face and pushed her to the floor. Cody tried to intervene but Ken hit Justine a further four times around the head and again pushed her to the ground. Ken ordered Justine and Cody out of the house and they went to stay at a nearby hotel where they remained for approximately 1 week before the couple reconciled and they returned home. While staying at the hotel, Justine, in a conversation with her mother, described her life with Ken as 'like living in a prisoner of war camp'.

The couple's baby was born approximately 6 weeks before the homicide. Almost immediately after the baby was born Ken demanded a paternity test. This confirmed he was the father.

On the day of the killing Ken, Justine and their newborn son were home alone. At some stage Justine was lying in bed and Ken struck her numerous times in the head with a hammer and stabbed her multiple times. Ken then took a large dose of his anxiety medication.

Cody came home from school and discovered his mother's body and Ken laying unconscious over her. Cody ran to his friends house (which Justine had pre-designated some period earlier as a 'safe' house if anything bad were to happen) and from there he alerted police who attended the scene and detained Ken, who was still alive.

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

Team Commentary: 3032

The Team identified a number of areas of concern in this case.

In this case Justine was involved in both antenatal care and IVF technologies while she was experiencing significant domestic violence in the home. The Team researched further into these areas, and considered whether there was scope within existing practices to improve identification and referral processes for domestic violence cases through assisted reproductive technology services. This case was considered in the development of **Recommendation 16**.

In this case the victim's son Cody was a teenage boy who was regularly attending school and being exposed to extreme domestic violence in the home. The team considered the ways in which schools are currently handling education and support processes involving exposure to domestic violence, and whether this could be potentially improved. The Team considered whether this information could be prioritized on the website. Enquiries continue into how these issues could best be incorporated into the new national curriculum.

These issues were considered in the development of **Recommendations 19 and 20**.

As with many other cases, the responses of friends and family to domestic violence in this case were considered in the development of **Recommendation 17**.

CASE REVIEW 3023

This case involved the killing of a 29 year old woman ('Nida') by her 22 year old husband ('Dev'). Dev and Nida were both Indian nationals. Nida was on a student visa, while Dev was on a spousal visa. They lived in metropolitan Sydney. Nida worked at a café and Dev was employed sporadically in various casual roles.

Dev and Nida met in India in 2008 while undertaking an English language course. They started a relationship and married in September 2008. The marriage was informally arranged (with no dowry exchange).

On 30 January 2009 Nida moved to Australia to commence studying a diploma of business management at university, living for 3 months with her sister and brother-in-law. Dev came to Australia on a spousal visa on 12 May 2009 and the couple moved into share accommodation in Western Sydney. Nida's friends and family reported that she was extremely happy and excited about Dev's arrival in Australia.

Soon after Dev arrived in Australia however, the couple began to fight about financial matters. Nida would regularly call her family in a distressed state, indicating that Dev was pressuring her to send more money to his family. On the contrary, statements from Dev's family indicate that it was Nida who was pressuring Dev to send more money to her family.

Nida also indicated to friends and family on a number of occasions that Dev was extremely jealous and possessive, was accusing her of infidelity and would regularly check her mobile phone to see who she was speaking to. At trial Dev also gave evidence that he was suspicious that Nida was being unfaithful, but there was no evidence to substantiate this accusation.

Nida's friends and family also noted that on many occasions Nida was displaying signs of physical abuse, including bleeding teeth and black eyes. One of the couple's flat mates also recalled an argument where Dev hit Nida a number of times across the face and head.

On 28 December 2009 Nida and Dev went to work. Dev finished work at 11 am and, at Nida's request, went to Nida's workplace to pick her up at 2.15 pm. Dev waited for Nida outside her work place for two to three hours. During this time Nida came out of the premises to tell him that she had to continue working. At 5 pm Nida told Dev to go home without her as she was working overtime.

Nida returned home at approximately 9:30 pm. Dev questioned Nida about her whereabouts. Dev gave evidence that Nida said that she had already told him that she was at work and that she also said if the offender continued to question her she would kick him out of the house and out of the country.

Dev gave evidence that the argument left him extremely upset and concerned about his situation if Nida followed through with her threats.

On the following day, Tuesday 29 December 2009, Dev withdrew \$1500 from a joint bank account that he had opened with Nida. He gave evidence at trial that this was motivated by a fear that he would have nowhere to live and no money if Nida left him.

That evening, Nida confronted Dev about the withdrawal of the funds from the joint bank account and a heated argument ensued. Nida left her room and went to the room of her female flatmate. Nida was distressed and crying. She told the flat mate that she would be moving in with her sister the following day.

Nida rang her sister from the flatmate's bedroom and told her that she was coming to live with her the following day and that she no longer wanted to live with Dev.

While Nida was in the flatmate's room, Dev called a family friend and told her that Nida was abusing him. The family friend told Dev to 'settle the dispute lovingly, and that every husband and wife have disagreements'.

Nida returned to her bedroom some time after 10:00PM and a short time later was heard screaming in the Punjabi language 'Save me, save me' and 'I won't do it again'. She was also heard to call out 'sorry, sorry' and exclaim 'ahh'. There is evidence that at this time Dev slit her throat multiple times with a box cutter, and also strangled and punched her.

Dev then left the premises and fled to Melbourne.

Nida died at the scene from stab and blunt force injuries to the neck. There were also indicators of manual strangulation.

Dev was convicted of manslaughter, having successfully raised the defence of provocation.

Team Commentary: 3023

The Team identified a number of issues in this case.

Firstly, the use of the provocation defence in this case raised a number of issues for the Team. Discussion of this issue and subsequent policy developments since this case was finalised are contained in the commentary section of Chapter 5.

This case also raised questions around understandings of domestic violence within the judiciary, specifically relating to senior judicial officers. This case was considered in the development of **Recommendation 15**.

The responses of friends and family in this case were considered in the development of **Recommendation 17**.

CASE REVIEW 3018

The deceased, Rita, was a 24 year old Sudanese woman residing in Western Sydney with her 30 year old Sudanese husband ('Hadil') and their two infant children, aged 18 months and 6 weeks at the time of the killing.

Rita came to Australia as a refugee, arriving with Hadil on 27 February 2006. Aside from two of Hadil's brothers and their families, Rita had no family in Australia.

In 2000, while still residing in the Sudan Hadil was diagnosed as suffering from severe mental illness and in 2002 was hospitalised in Egypt for a six-month period. Following his release from hospital, Hadil attended weekly outpatient psychiatric clinics at that hospital. He was informed by his doctor in Egypt that he suffered from schizophrenia. Hadil continued to experience significant mental health issues and had not worked since arriving in Australia in 2006.

When Hadil arrived in Australia, Rita immediately arranged for him to be scheduled at a mental health hospital and treated for his schizophrenic condition. Over the next three years there were numerous instances of abusive, controlling and violent behaviour towards Rita which occurred typically in the context of Hadil's acute psychotic episodes. Hadil was scheduled on a number of occasions to mental health facilities.

In 2008 a bystander observed Hadil physically assault Rita and her baby. The police were called and a provisional AVO was applied for by police.

In 2009 there was an occasion where Hadil assaulted Rita's sister in law and inflicted damage to her house. Police attended and Hadil was charged with stalk/intimidate, destroy or damage property and common assault. A provisional AVO was issued.

Hadil's brother, who saw the couple almost every day, reported regular verbal and physical fights and indicated that Hadil was always the aggressor. The brother stated that he saw Hadil hitting Rita around the face and body while she was pregnant with their first child.

Family members in Australia offered for Rita to come and live with them so she could get away from Hadil. However, family members overseas had previously encouraged her to stay with Hadil as they stated it was her duty as his wife. Rita also indicated that she wanted to stay with him. On numerous occasions the family confronted Hadil about his abusive behaviour and he told them not to get involved.

On 26 August 2009, Hadil attended a psychiatric consultation with Rita. It was clear to the doctor that Hadil had ceased taking his medication. The doctor asked Hadil if he could ask Rita some questions to which Hadil replied 'No, you have no right to ask her anything. All the information is in the notes in front of you.'

The doctor concluded that there were no obvious signs of mania and whilst he continued to have concerns about Hadil's risk factors in the long term there was nothing to suggest there was an imminent risk of an adverse outcome.

At about 10pm on 27 August 2009, Hadil, Rita and their children were seen outside their home. Smoke was billowing from inside the house.

Rita, who appeared badly burnt, was talking to 000 on a mobile telephone. Her neighbour took the phone, spoke to the telephone operator and gave the address so that the emergency services could attend.

Police were called to the scene. Rita had extensive burns to most of her body. She was treated at the scene and taken to hospital by ambulance.

Before she was taken to hospital, Rita spoke to police and told them that 'He tried to kill me. In the shower ... he put oil on me, he put oil of the car, he smoke it'. At the time she was saying this, Rita used her right hand to make a flicking motion with her right thumb and first finger.

Police spoke to Hadil at the scene. While he had only limited English language skills, he admitted to the police that he had set Rita on fire. He was asked how the fire started and he told police that he had done it.

A cigarette lighter was found on the hallway floor outside the bathroom in the house. The bathroom smelled strongly of petrol and there were melted remnants of a plastic container on the bathroom floor.

Hadil was found not guilty by reason of mental illness at trial.

Team Commentary: 3018

The Team made a number of observations in relation to this case.

There was an apparent lack of support mechanisms available for Rita in the context of her acting as Hadil's carer, while also being a victim of his domestic violence behaviours. Rita was very capable, and managed to have Hadil scheduled very quickly upon their arrival in Australia. There was a great deal of service contact in relation to Hadil's mental illness, but very few enquiries made into how Rita was coping. This is discussed in the commentary in Chapter 5.

As with other cases, prior to the homicide Rita was transported via Ambulance to a NSW Emergency Department at a public hospital having been assaulted by Hadil (when he threw a rock at her while she was holding the baby and the police attended). Medical records indicated that by the time Rita was discharged, the episode was being described in the notes as Rita having been 'hit by a rock', rather than as an assault. This indicated to the Team that there is a need to improve systematic responses to domestic violence within NSW Accident and Emergency Departments, including adopting referral mechanisms to domestic violence services. This factored into the development of **Recommendation 10**.

This case raised questions around the use of interpreters in domestic violence screening/domestic violence related police engagement. Rita received antenatal screening for domestic violence through an interpreter, but it is unclear whether her interpreter was appropriate to Rita's culture and gender. This enquiry resulted in the Team conducting further research around the issue of the use of interpreters in domestic violence screening both in a medical context and in the context of police engagement. This inquiry factored

into the development of **Recommendations 11, 12 and 13**.

CASE REVIEW 3019

This case involved the killing of a 36 year old disabled Aboriginal woman ('Audrey') by her 20 year old Aboriginal nephew ('Brian').

Audrey and Brian had been living together for approximately 1 month at the time of the killing. Audrey was a double amputee (as a consequence of complications of diabetes) and also had to undergo dialysis several times per week. She was in poor health and had a carer who would visit her daily.

At the time of the killing Brian was on bail for a number of offences including stealing Audrey's medication. Audrey was set to testify against Brian in an upcoming hearing for this offence. Nonetheless, he was bailed to reside with Audrey in her social housing accommodation in Western NSW.

Brian had a history of mental illness. He had previously been scheduled under the Mental Health Act. He was prone to acute psychotic episodes and had a history of depression and schizophrenia.

Brian had a lengthy criminal record and had prior convictions including assault, break and enter, breach AVO and multiple drug offences throughout his childhood and early adulthood.

The relationship between Brian and Audrey, despite its short duration, was marked by frequent loud arguments. In the week before the killing a neighbour reported one such argument to police. Police arrived approximately 1.5 hours after the call was made and the argument had, by this time, settled down. It does not appear that any COPS entry was made of this contact and it is thus unclear whether any referrals were made.

On the day of the killing, Brian consumed both alcohol and cannabis and was seen to be acting irrationally throughout the day, indicating that he 'wanted to kill someone' and that he had previously 'served in the army in Iraq'. Brian later attended a football match and, at the pub afterwards, was involved in a brawl in which he sustained an injury to his face.

At about 11.00pm, after leaving the pub, Brian attended the local police station, complaining that he had been assaulted. He appeared upset and moderately intoxicated, and quickly became agitated, again telling police that he had served in

Iraq and had recently been discharged from the army. Police assessed Brian as not meeting the criteria to be scheduled under the Mental Health Act. The police told him to go home and come back in the morning after he had 'sobered up'. No COPS report was made of this contact.

Brian returned home and shortly thereafter started arguing with Audrey. Some witness reports indicate that this fight continued for over 15 minutes and that Brian was heard yelling 'I am going to kill you'. Audrey began screaming, which led a neighbour to climb up on the fence between the two houses and yell out 'Shut the fuck up, some of us are trying to sleep'. The argument continued for a few more minutes, and Brian was again heard yelling 'I am going to kill you, I am going to stab you'. Unbeknownst to witnesses, Audrey was then stabbed multiple times by Brian as she sat on her bed. She tried to defend herself but could not fight him off.

Brian left the scene and was apprehended several days later in a nearby town.

Brian was found not guilty by reason of mental illness.

Team Commentary: 3019

The Team made a number of observations in relation to this case.

The Team considered the appropriateness of Brian being bailed to live with Audrey, given that she was set to testify against him in an upcoming court date and that she was extremely socially disadvantaged and physically vulnerable. The Team considered the use of the Bail Assistance Line and whether this could have been used to secure more appropriate accommodation for Brian given the circumstances of the case. The Team considered that this case raised issues that had broad application and accordingly developed **Recommendation 8**.

The Team raised specific concerns around the lack of COPS records being made in relation to the assessment of Brian's mental state on the night of the homicide, and the absence of a COPS record for the domestic violence callout several days prior to the homicide. The Team understands that such records can be influential for officers in the context of making risk assessments in particular cases. The Team accordingly developed **Recommendations 5 and 6**.

This case was complex and involved a very disadvantaged young Aboriginal perpetrator. The Team considered this case (as well as other cases

discussed here), and the prevalence of Aboriginal perpetrators and victims of violence in its broader dataset, in developing **Recommendation 7**.

The Team considered that in this case Audrey was extremely vulnerable, particularly due to her physical disability and isolation. She was experiencing domestic violence in her home. There were few support mechanisms available or accessible to Audrey.

The Team considered whether special consideration should be given to the issue of particularly vulnerable victims, for instance older women or women with a disability.

These considerations were factored into the development of **Recommendations 22 and 23**.

CASE REVIEW 3010

This case involved a 24 year old female ('Jackie') killing her 17 month old daughter ('Kiara') at their home in a city on the South Coast of NSW. The killing followed a significant history of emotional and psychological abuse perpetrated by Kiara's father ('David') towards Jackie. There was no history of direct abuse against Kiara, and by all accounts Jackie was a loving mother. The relationship between David and Jackie was breaking down at the time of the killing, and Jackie was aware that David was both dating her, and another woman ('Melanie').

Jackie met David when she was around 21 years old. From the outset David perpetrated constant emotional and psychological abuse against Jackie. Even prior to Kiara's birth, David and Jackie would argue relentlessly, with arguments often resulting in David banging his fists against his head, driving his head into walls, speeding off in his car (sometimes with Kiara in the car) and threatening Jackie that he would drive over a cliff. David, on occasion, would also hold Jackie against the wall by her arms. David would also constantly criticise Jackie, denigrating her capacities as a mother and housekeeper.

From 2001, throughout the duration of her relationship with David, Jackie suffered depression as a consequence of his controlling, violent and abusive behaviour and his alleged infidelity. Nonetheless, David and Jackie conceived and continued, for a time at least, to live as a family following Kiara's birth in 2008.

Jackie's mental condition deteriorated when David moved away to live and work in Queensland a few months after Kiara's birth. Although, for David, this seemed to signify the end of the relationship, he

continued to 'lead' Jackie on, often telling her that he wanted to be together with her, and then retracting those statements, telling Jackie that he wanted to be single.

Around Christmas in 2008 David moved back to the NSW South Coast, where Jackie's mother described his behaviour as 'appalling'. David was initially staying with Jackie, but left her apartment on Boxing Day 2008 after an argument. After leaving, David met a woman called Melanie and within a matter of days he had taken Melanie on a holiday to Bali that he had originally invited Jackie to share with him. David told Jackie that the holiday had to be cancelled due to his work commitments, and continued to speak to Jackie over the phone without telling her that he was, in fact, in Bali with Melanie.

A short time after David returned from Bali, Jackie discovered photos of the holiday on his laptop and confronted him. David indicated that he loved Jackie and wanted to reconcile. This calculating behaviour and mistreatment continued for a number of months where David continued to have a relationship with Jackie and Melanie at the same time. During this time Jackie also suffered a miscarriage, which she was left to deal with by herself, while David continued to compare her adversely to Melanie, using words such as 'fat whore, slut, bitch, dog, lazy, hopeless, worthless and going nowhere in life'.

Jackie suffered increasing depression as a consequence of David's conduct, and due to her ongoing fear and concerns for her custody over Kiara.

In July, Jackie started to research starting a new life in Cairns, which led David to threaten to take custody of Kiara away from her. This seriously affected Jackie, who became deeply depressed. Around this time David went on another holiday with Melanie, and Jackie started researching suicide methods and composed long letters to David and her mother (which she did not deliver) that were designed to be read after she and Kiara were dead.

On 21 July 2009, Jackie was at home with Kiara. She placed Kiara in the bath, turned on the taps and went outside, shutting the door to the bathroom. Kiara drowned in the bathtub. Jackie retrieved Kiara and lay in the bed with her for 2 days. There is evidence that she had a number of attempts on her own life during this time including cutting her arm with a Stanley knife, ingesting pills and alcohol. Jackie then went to Sydney to inform David that Kiara was dead, and while there she

visited the Gap in Sydney and threw flowers and letters into the water.

Jackie was found guilty of the manslaughter of Kiara.

Team Commentary: 3010

The Team identified one primary issue arising from this case review. In this case, the remarks on sentence described Jackie as suffering from a 'yummy mummy complex' due to her obsessive cleaning of the house and constant quest to be the perfect parent.

This problematic use of language failed to recognize the underlying dynamics of domestic violence characterizing Jackie and David's relationship, and recognize that this manifestation of behaviour was related to that violence.

This suggested to the Team the need for further exploration of the issue of domestic violence and its recognition within the judiciary.

This was taken into consideration in the development of **Recommendation 15**.

CASE REVIEW 3014

This case involved the killing of a 44 year old Aboriginal female ('Janice') by her 27 year old Aboriginal son ('Scott'). The relationship between Janice and Scott was characterized by a history of domestic violence and alcohol abuse, punctuated by criminal activity.

At the time of the killing, Janice and Scott lived separately in public housing accommodation. Scott had a stable work history having worked as an arborist and labourer. Janice was on a pension. Both Scott and Janice had significant substance abuse issues.

Janice had an extensive criminal record including a prior charge of manslaughter resulting from a crime she perpetrated while pregnant with Scott (this was later no-billed). Also, from the time Scott was around 10 years old, Janice was imprisoned for a number of years as a result of a conviction of malicious wounding and attempted robbery of a taxi driver.

Janice raised Scott by herself until she was sent to gaol. When Janice was sent to gaol, Scott moved in with his maternal grandparents and they raised him for the remainder of his childhood. Once Janice was released from prison, Scott began to spend time with her, but the two didn't live together again until

around 2005. After Janice stopped working and started receiving a disability pension, Scott and his girlfriend moved in with Janice, living with her off and on, for several years.

Janice and Scott's relationship was characterized by ongoing arguments and violence, including an episode in 2005 where the police arrested Janice for damaging Scott's girlfriend's car and hitting Scott's girlfriend in the face with a hammer and tyre iron.

Sometime between 12 am and 4 am on the 16th October, Scott killed Janice by stabbing her with a knife from her kitchen. It appears that during the course of an argument, Scott lost his temper, stabbing his mother in the chest a number of times. He then slit the throats of two of her cats.

Neighbours did not report hearing the argument, but heard loud music coming from Janice's home in the early hours of the morning. This was not unusual as Janice often would play loud music at night.

After the killing, Scott walked around the neighbourhood knocking on neighbours doors and windows to try and raise someone to help.

At trial, Scott was found guilty of the manslaughter of Janice.

Team Commentary: 3014

The Team made a number of observations in relation to this case.

This case was representative of a common theme across many cases involving Aboriginal perpetrators, namely, fractured kinship networks. The Team considered the impact of social and cultural dispossession, and cumulative social issues on the life path of individuals. These considerations were taken into account in the development of **Recommendations 7, 17 and 18.**

This case also raised issues around intergenerational violence as Janice had a history of resorting to violence. This was also a characteristic of Scott's behaviour towards his mother. Interestingly, Janice had been previously charged with a homicide and served a significant custodial sentence for GBH offences. Her son followed a similar path in his offending. This reiterated the need for **Recommendation 9.**

The Team noted that there were few support mechanisms available to Janice as an older female victim of domestic violence. She was having very little service contact other than with her housing

provider, healthcare providers and pension providers. The Team considered whether there were any missed opportunities for service intervention in this case. This was considered in the development of **Recommendations 22 and 23.**

CASE REVIEW 2584

This case involved a 21 year old Aboriginal male ('Tim') who killed his ex-girlfriend 'Jodie's intimate partner ('Nathan', a 26 year old Aboriginal male). Nathan lived with his parents in a small town in regional NSW. Nathan knew Jodie socially and they attended the same methadone clinic in the regional town they lived in.

Tim and Jodie began their relationship in 2001 when they were both about 14 years old. They had 4 children together. The two youngest children resided with Jodie and the two eldest lived with Tim's mother. Tim had an extensive criminal record. Tim and Jodie also used marijuana and heroin.

Tim had a long history of perpetrating violence against Jodie. In May 2005 Tim physically assaulted Jodie and was ordered to undertake two years' supervision. In October 2007 Tim again physically assaulted Jodie by attempting to strangle her. He was ordered to undergo 200 hours' community service. Jodie was pregnant at the time. Jodie was also extremely scared that Tim was going to kill her.

2-3 weeks prior to the killing, in late July 2008, Jodie and Tim separated and Tim moved out of their shared residence to live with his family.

At about 10AM on 10 August 2008, Tim and Jodie attended a local hospital to receive methadone. Nathan was also present at the clinic and he and Jodie spoke briefly. She indicated to Nathan that Tim was jealous of their friendship and Nathan offered to speak to Tim about it but Jodie said that it 'should be alright'.

At about 2:30PM that afternoon Nathan went to Jodie's house and together with other friends they consumed alcohol and cannabis.

At about 4:30PM Tim arrived at the house to collect some of his belongings.

When Tim saw Nathan he became extremely angry. As Tim was leaving, Nathan said to him 'Mate we are not trying to cut your grass. Why don't you sit down and have a drink with us bro?' Tim and Jodie began to argue and Tim started threatening to take custody of their young daughter. As Tim was leaving he said to Nathan 'I'm going to come back

here and shank you. You should not be in my house with my woman.'

At about 8:00pm Nathan and Jodie were alone together in the house.

Jodie locked the house and went with Nathan to the bedroom to have sex.

At around 10pm Jodie heard the glass sliding door start to shake and saw Tim entering the lounge room. She ran to the bathroom and put on some clothes. She could hear the sound of a fight and when she left the bathroom she was met by Tim at the top of the stairs. He said 'Why did you do this? I loved you'. She saw Nathan lying motionless on his back in the lounge room. Tim walked over to Nathan and kicked him in the groin several times.

Jodie ran to a neighbour and asked her to call the police and then went back inside the house. Tim said to her 'Come on. We gotta go. I think I killed him.' Jodie again went to the neighbour's house to get help.

Tim was then seen dragging Nathan by his ankles down the veranda steps into the front yard. Tim then kicked Nathan in the head and body a few times. One neighbour lifted Nathan's shirt and saw that he had a stab wound in his chest. Tim denied stabbing him and said that Nathan had come at him with a knife. An ambulance arrived a short time later but Nathan was already dead.

An examination of the crime scene revealed the knife that was used to stab Nathan matched one that was missing from a knife block at the Tim's house.

Tim pleaded not guilty to murder and was found guilty of manslaughter on the basis of provocation.

Team Commentary: 2584

The Team considered that this case involved cumulative social disadvantage and issues. This was a common theme in many cases and the issue of complex families was considered in the development of a number of recommendations.

The Team considered whether this case could be used as an example of 'complex families' in informing broader understandings of domestic violence. The Team is continuing to develop information and data around this issue, but has incorporated these understandings into a number of recommendations.

The Team considered the role of schools in supporting students who are pregnant, or who become pregnant under the age of consent was discussed. While policies are in place in relation to notifications to FACS and police, it was unclear as to whether these were observed due to school records being unavailable in this case. This is discussed in the commentary at Chapter 5.

The Team also considered the use of the defence of provocation in this case. Subsequent policy developments in relation to the use of this defence are discussed in the commentary in Chapter 5.

CASE REVIEW 2593

This case involved the killing of a 50 year old man ('Ian') by his current girlfriend's 44 year old ex-de facto partner ('Fred'). Ian and his current girlfriend 'Denise' had been in a relationship for only several months at the time of the killing. Fred became aware of the relationship between Ian and Denise while he was in gaol serving a custodial sentence for an assault against Denise. Fred killed Ian 3 days after he was released from gaol on parole. Fred and Ian knew each other, and all parties lived in the same small town in Western NSW.

Fred had perpetrated significant domestic violence against Denise as well as his other intimate partners. Prior to entering into a relationship with Denise, Fred had previous convictions for breaching AVO's against former intimate partners and had previously been imprisoned for 6 years in Queensland for attempting to murder his former wife.

In 2006, Fred commenced a relationship with Denise which was characterized by his significant physical violence and psychological abuse. There were a number of reported and unreported episodes of violence, and a history of AVOs. Denise reported to a health worker that Fred kept a knife at the home they shared during the relationship that had 'Denise' carved into it's handle. Fred would sharpen the knife in front of her and threaten to use it to kill her. The relationship lasted only several months until Fred was charged with maliciously damaging Denise's car, as well as breaching the AVO between them. He was imprisoned in April 2007 for these offences.

Prior to his imprisonment, Fred began to suspect that Ian, who was his flat mate at the time, wanted to commence a relationship with Denise. Fred moved out of Ian's residence and indicated while in gaol that upon his release from prison he intended to kill Ian if he commenced a relationship with Denise.

While Fred was in prison, Ian and Denise commenced a relationship. Fred became aware of the relationship and started sending threatening messages and making threatening phone calls via third parties to Ian. Ian was very fearful of Fred, as was Denise.

As Fred's October 2008 parole date was approaching, he became increasingly aggressive - telling multiple people that Ian's 'days were numbered', including a corrective services officer in the prison. Fred also had a disciplinary action arising from an incident where he attacked a female corrective services officer in August 2008.

Fred did not attend any domestic violence offenders courses or similar in prison.

Ian and Denise, conscious that Fred would be released on 2 October 2008, were in regular contact with Victims Services Registry, the local police station and a social worker through the local area Health Services. There was apparently some liaison between the social worker and parole services in relation to Fred and his death threats against Ian. In the months preceding Fred's release, Ian and Denise also engaged in safety planning measures and Ian composed a will, as he believed that Fred would kill him. Against the advice of the police, Ian continued to live in his house in the small town, and refused to apply for a PVO against Fred, as he believed that such a measure would be 'futile' given the level of anger displayed by Fred towards him.

Fred was released on parole on 2 October 2008 to reside the small town at his friend's house. The next day Fred attended a parole meeting, wherein he indicated that he had no remorse for his actions against Denise (related to the malicious damage and breach AVO charge) and that he wished he had 'bashed her head in, instead of the car'. The parole officer apparently raised some concerns with local police following this meeting, but no further action was taken and Fred remained on parole.

Over the next two days there were a number of instances where Fred would stalk or harass Denise and Ian, who at this time had decided to stay away from each other, so as not to inflame Fred's temper. Denise reported a number of stalking incidents (such as Fred driving by the house) to the police, who encouraged her to take note of the details of any such episodes in a notebook. Denise did not make any official police reports in relation to these behaviours. She had sent her two children to a friend's house as she was so concerned about Fred's release from prison.

On the evening of October 5, Fred attended Ian's home and shot him in the neck with Ian's own rifle. It is believed that Fred's friend 'Lou', and another friend 'Todd', were also present at the scene. The gunshot injury was not fatal and Ian was then subjected to a sustained and brutal attack which resulted in his death from blunt force head trauma.

The day after the killing Fred's friend Lou committed suicide, and within a few days, Fred was arrested and charged with murdering Ian.

Fred was convicted of murder.

Team Commentary: 2593

The Team considered the appropriateness of releasing Fred into the same area where Ian and Denise were living, given that Corrective Services were aware of Fred's stated intentions to harm the deceased. The Team sought clarification from Corrective Services NSW in relation to policies that currently apply in relation to these issues and the content of this response is contained in Chapter 5 commentary.

The Team questioned why Fred remained on Parole after indicating that he wished he had more seriously injured Denise in the attack which resulted in his imprisonment. The Team also considered issues around why parole may not have been revoked in this case. Issues around parole are discussed in Chapter 5 commentary.

The tension between the value of supervising a parolee for a designated period, or letting the prisoner serve out their sentence and enter the community unsupervised was considered by the Team.

In this case, there were numerous reasons to expect that Fred would reoffend, including that he stated he would. Although parole was granted, Fred stated on numerous occasions that he didn't want parole and would not comply with his parole conditions. Communications from Corrective Services indicated that Fred had changed his mind in relation to parole prior to his release and that they believed it was preferable to have a period of supervision rather than release Fred into the community unsupervised at the end of his sentence.

It was noted by the Team that the police officers in this case were giving poor directions to Denise in relation to reporting breaches of the AVO. This suggested the need for further training, or the need to remind officers in relation to processes surrounding breaches of AVOs.

This was considered in the development of
Recommendations 2 and 5.

APPENDIX E: Children killed by a parent in a domestic violence context, NSW, 2000-2010

FIGURE 32: All children killed by a parent by domestic violence context, 2000-2010

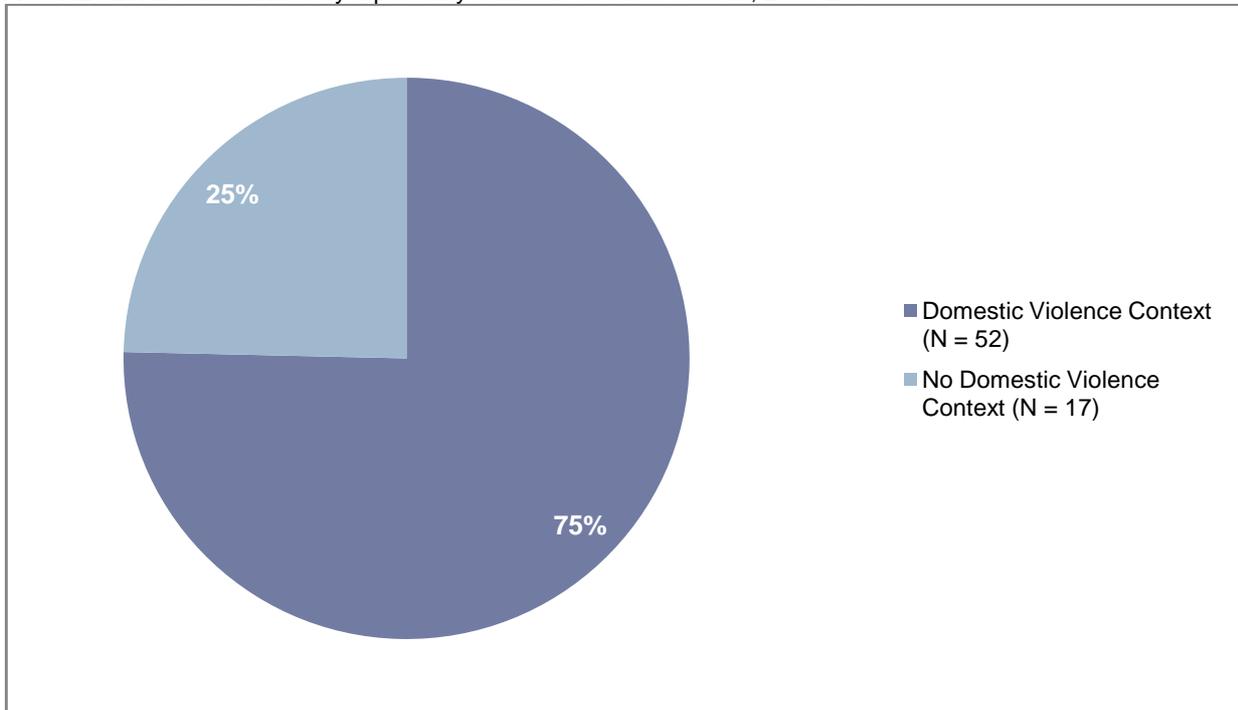


FIGURE 33: Children killed by a parent in a domestic violence context by age, 2000-2010

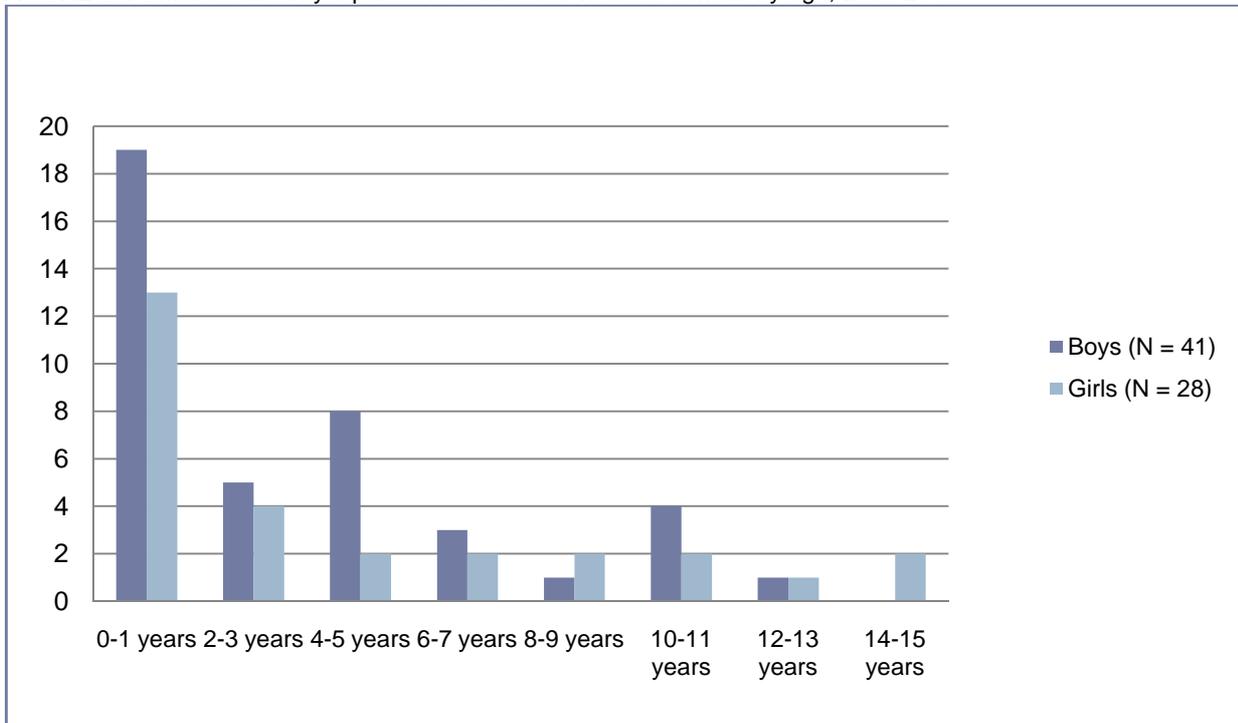


FIGURE 34: Relationship of parent homicide perpetrator to child victim, 2000-2010

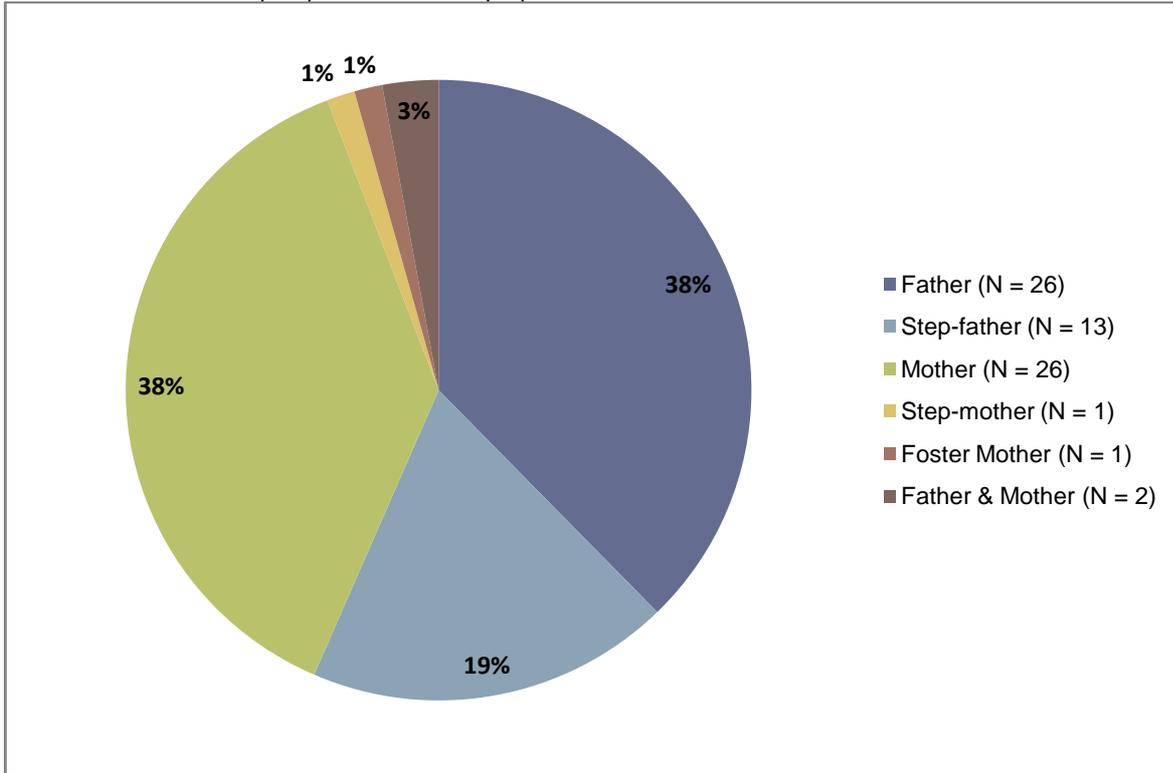


FIGURE 35: Children killed by a parent in a domestic violence context by manner of death, NSW, 2000 – 2010

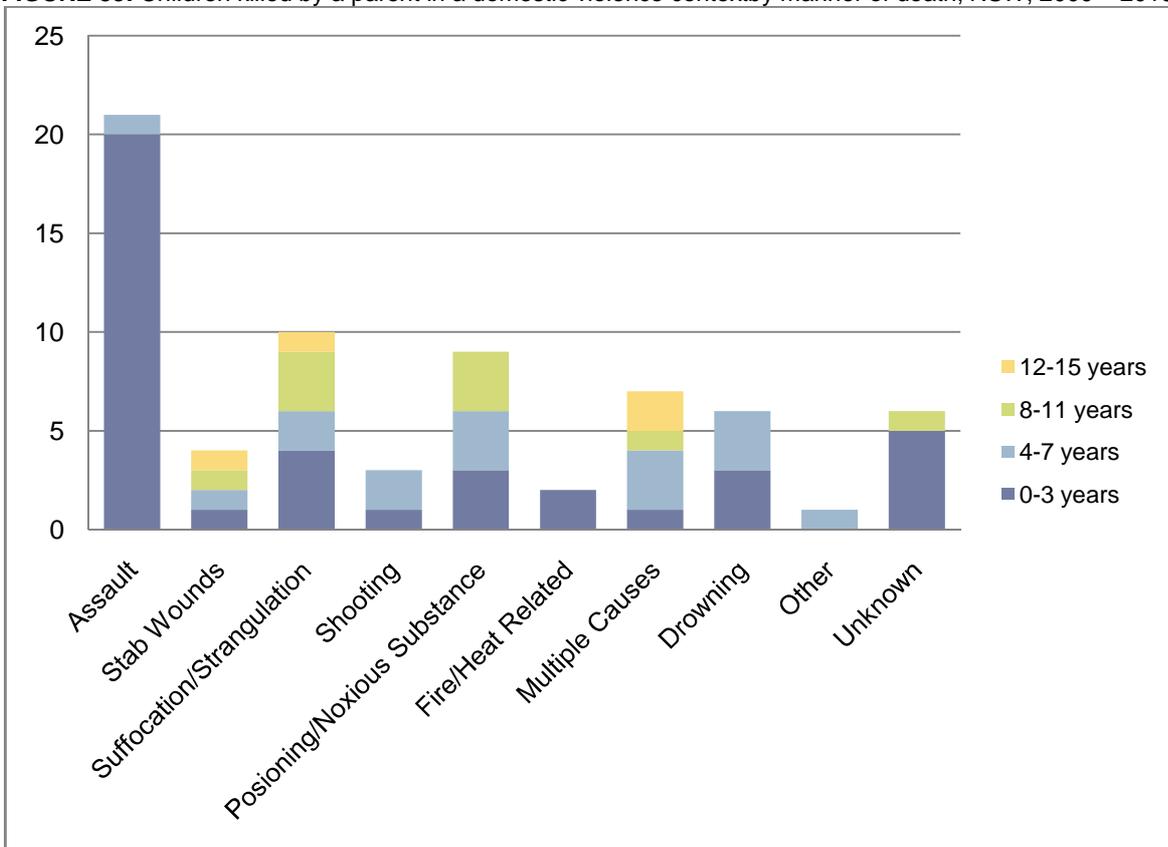


FIGURE36: Age of child homicide perpetrator, 2000-2010

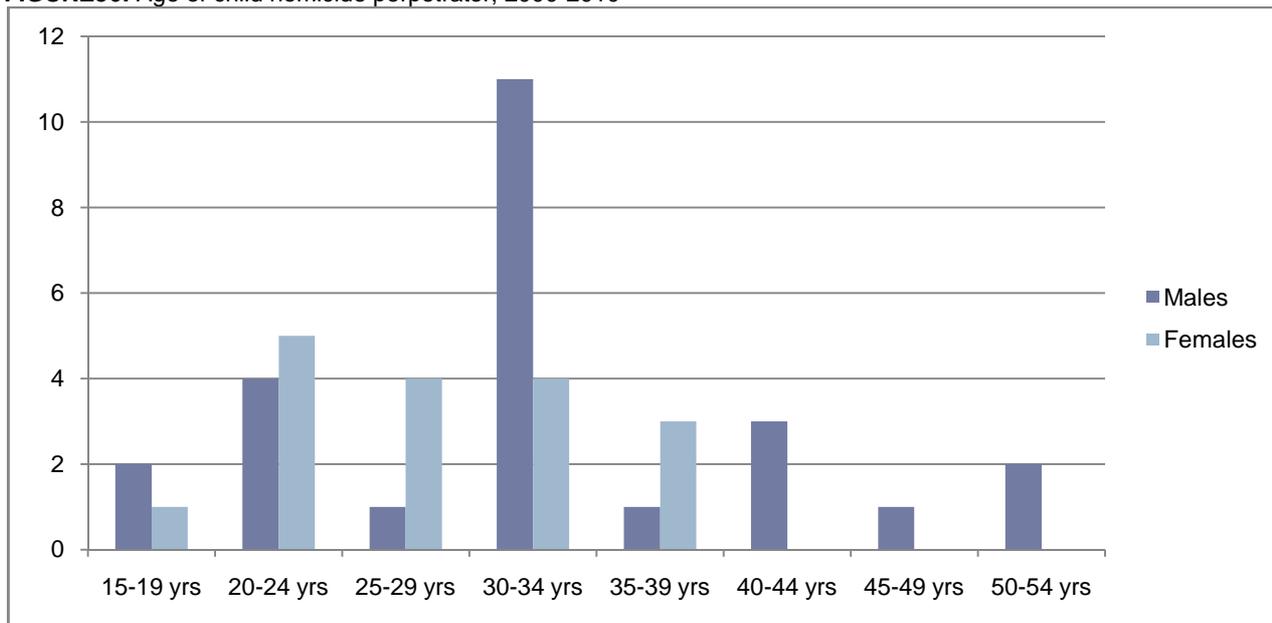


FIGURE 37: Characteristics of parents who killed their child/ren in a domestic violence context, 2000-2010

CHARACTERISTIC (N = 38)	FEMALE	MALE
	PERPETRATOR (N = 17)	PERPETRATOR (N = 25)
HOMICIDE PERPETRATOR WAS A DOMESTIC VIOLENCE VICTIM	16	0
HOMICIDE PERPETRATOR WAS A DOMESTIC VIOLENCE ABUSER	0	21
HOMICIDE PERPETRATOR HAD SUFFERED POST-NATAL DEPRESSION	7	0
HOMICIDE PERPETRATOR WAS SOCIALLY ISOLATED	6	8
HOMICIDE PERPETRATOR HAD NEGLECTED CHILD	5	2
PROXIMAL RELATIONSHIP BREAKDOWN OF CHILD'S 'PARENTS'	11	10
PROXIMAL CHILD CUSTODY DISPUTE BETWEEN CHILD'S 'PARENTS'	4	8
HOMICIDE PERPETRATOR WAS A VICTIM OF ABUSE/VIOLENCE DURING CHILDHOOD	10	14
HOMICIDE PERPETRATOR HAD HISTORY OF SUICIDE ATTEMPTS	4	5
HOMICIDE PERPETRATOR HAD PROXIMAL SUICIDAL IDEATION	9	6
HOMICIDE PERPETRATOR WAS UNEMPLOYED	16	16
HOMICIDE PERPETRATOR HAD A HISTORY OF DRUG/ALCOHOL ABUSE	8	13
UPCOMING COURT DATE	3	3
HOMICIDE PERPETRATOR HAD CURRENT MENTAL HEALTH ISSUES	10	10
HOMICIDE PERPETRATOR WAS EXPERIENCING FINANCIAL STRESSORS	10	19

FIGURE 38: Parents who killed their child/ren in a domestic violence context by outcome, 2000-2010

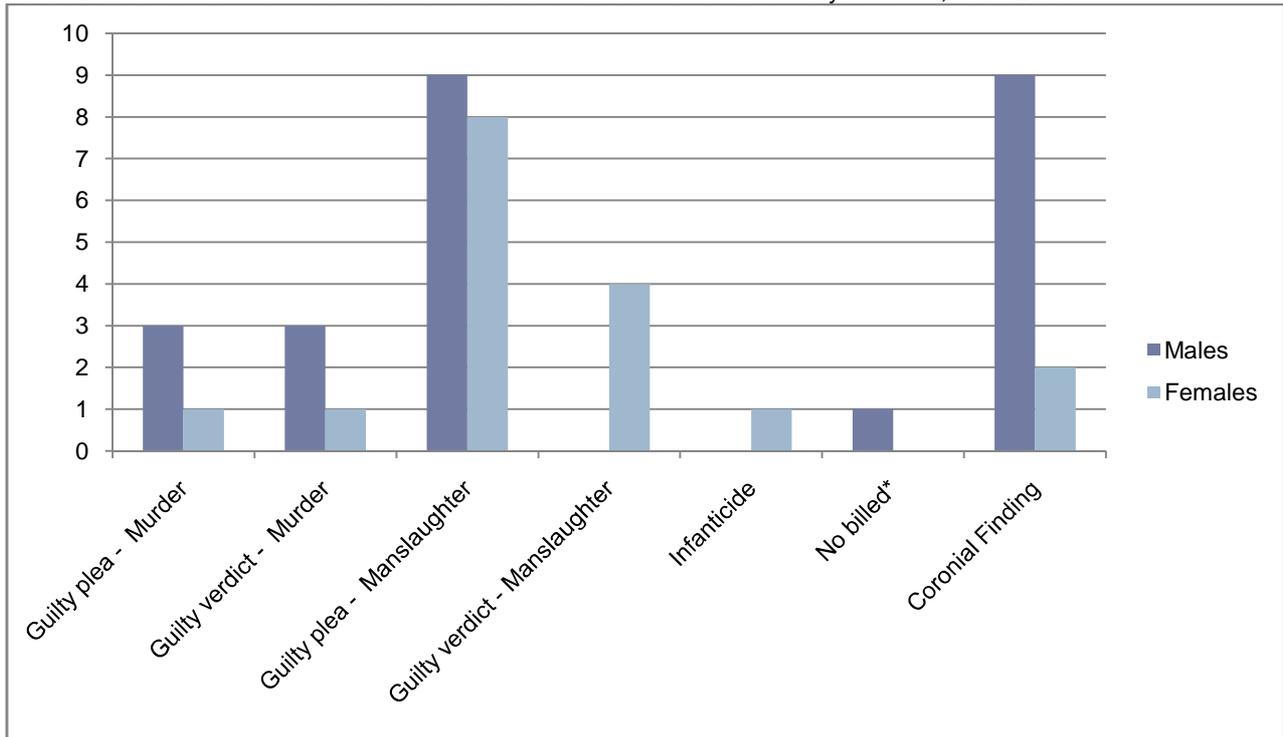
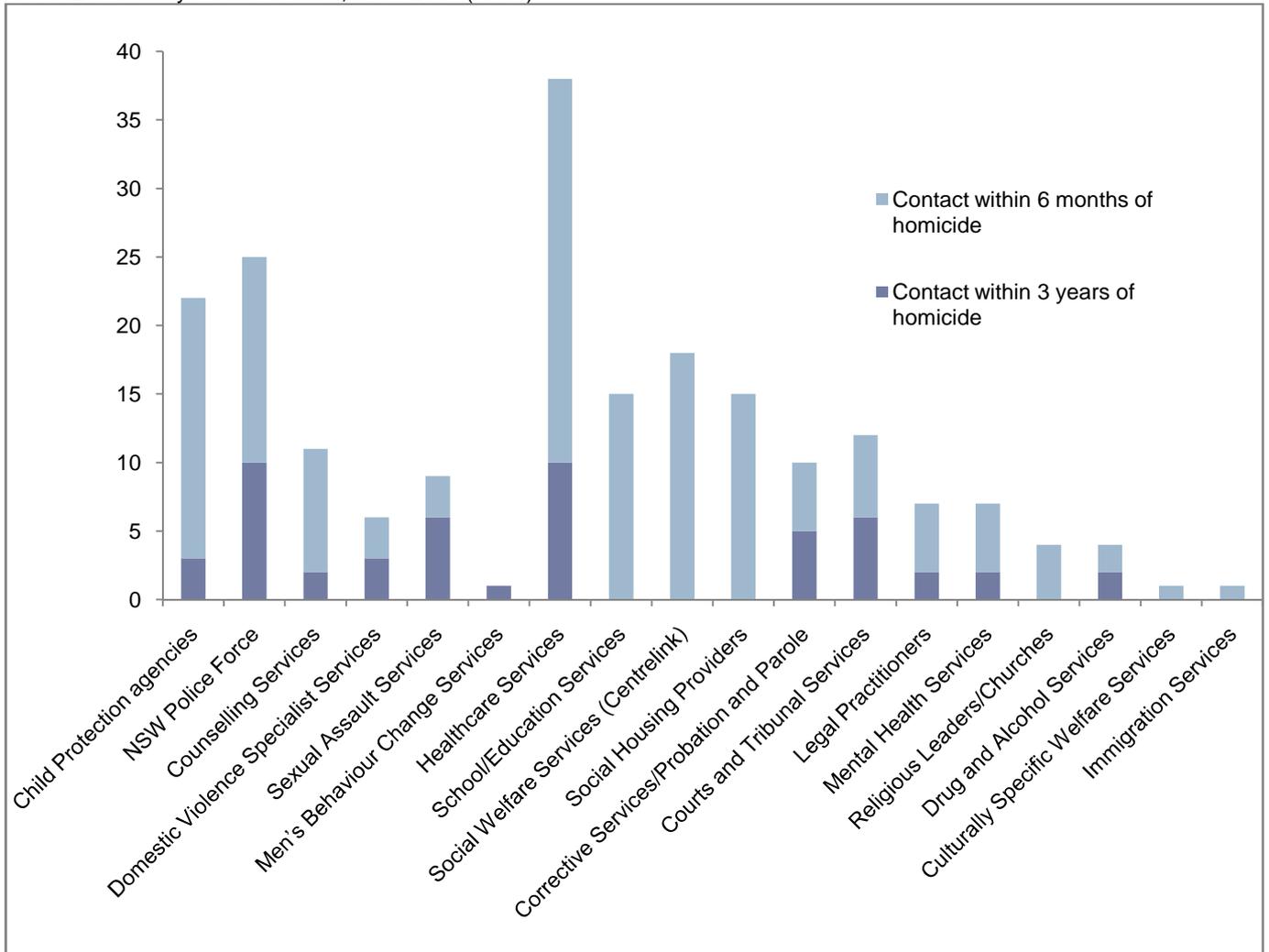


FIGURE 39: Family service contact, 2000-2010 (N=38)



APPENDIX F: Domestic Violence Death Review Team

The Domestic Violence Death Review Team members in 2012-2013 were:

Statutory members

Magistrate Mary Jerram
NSW State Coroner
Convenor

Assistant Commissioner Mark Murdoch
Commander, Central Metropolitan Region
Corporate Spokesperson Domestic and Family Violence
NSW Police Force

Trisha Ladogna
Team Leader, Child Wellbeing Unit
Department of Education and Communities

The Hon James Wood AO QC
Chairperson, NSW Law Reform Commission
Department of Attorney General and Justice

Carolyn Thompson
Manager, Domestic and Family Violence, Crime Prevention Division
Department of Attorney General and Justice

Pam Swinfield
Assistant Director, Child Deaths and Critical Reports Community Services

Peter Swain
Director, Strategic Policy
Aboriginal Affairs NSW

Vivian Hanich
Director, Service Development Strategy
Housing NSW

Valda Ruisis
Deputy Chief Executive (Operations)
Juvenile Justice

Melinda Smith
Assistant Director, Police and Practice Team
Ageing, Disability and Home Care

Betty Green
Manager
Liverpool Women's Health Centre

Dixie Link-Gordon
Chief Executive Officer
Mudgin-Gal Aboriginal Corporation Women's Centre

Dr Lesley Laing
Senior Lecturer
Faculty of Education and Social Work
University of Sydney

Martha Jabour
Executive Director
Homicide Victims Support Group (Aust) Inc.

Team-related persons

Linda Matthews
Executive Director
Women NSW (FACS)

Mailin Suchting
Director, Child Protection and Violence Prevention
NSW Kids & Families (NSW Health)

Lou-Ann Lind
Acting Director, Strategic Policy
Aboriginal Affairs NSW

Officers of the Domestic Violence Death

Review Team

Anna Butler
Manager

Emma Buxton
Research Analyst

Donna Schriever
Administrative Assistant

The current Domestic Violence Death Review
Team members are:

Statutory members

Magistrate Michael Barnes
NSW State Coroner
Convenor

Joanna Holt
Chief Executive
NSW Kids and Families
NSW Health

Assistant Commissioner Mark Murdoch APM
Commander, Central Metropolitan Region
Corporate Spokesperson Domestic and Family
Violence
NSW Police Force

Trisha Ladogna
Regional Director, Child Wellbeing Unit
Department of Education and Communities

Peter Swain
Director Reform and Strategy
Aboriginal Affairs NSW (DEC)

Nada Nasser
Director Homelessness Service Reform
Housing NSW (FACS)

Valda Ruisis
Chief Executive
Juvenile Justice NSW

Miriam Williamson
Senior Policy Officer
Policy & Practice Team
Clinical Innovation & Governance
Ageing Disability and Home Care (FACS)

Christine Foran
Executive Director
Women NSW (FACS)

Rosemary Caruana
Assistant Commissioner
Community Offender Management
Corrective Services NSW

The Hon James Wood AO
Chairperson, NSW State Parole Authority
NSW Law Reform Commissioner

Carolyn Thompson
Manager, Domestic and Family Violence
Crime Prevention and Community Programs
Department of Attorney General and Justice

Donna Mapledoram
Assistant Director, Child Deaths and Critical Reports
Community Services (FACS)

Christine Robinson
Coordinator
Warringa Baiya Aboriginal Women's Legal Service

Susan Smith
Coordinator
Sydney Women's Domestic Violence Court Advocacy
Service

Associate Professor Lesley Laing
School of Social Work and Policy Studies, University of
Sydney)

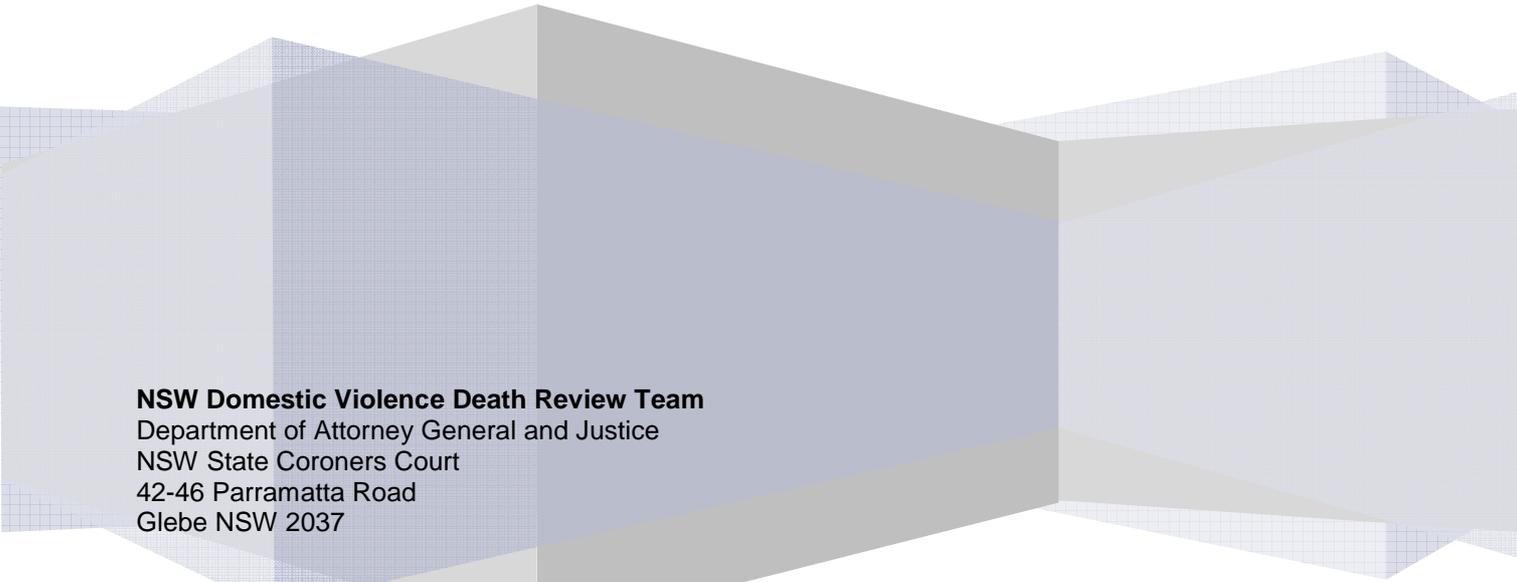
Dr Jane Wangmann
Senior lecturer, Faculty of Law, University of
Technology Sydney)

Officers of the Domestic Violence Death Review Team

Anna Butler
Manager

Emma Buxton
Research Analyst

Donna Schriever
Administrative Assistant



NSW Domestic Violence Death Review Team

Department of Attorney General and Justice
NSW State Coroners Court
42-46 Parramatta Road
Glebe NSW 2037

General enquiries: (02) 8584 7712
Facsimile: (02) 9660 7594
www.lawlink.nsw.gov.au/coroners