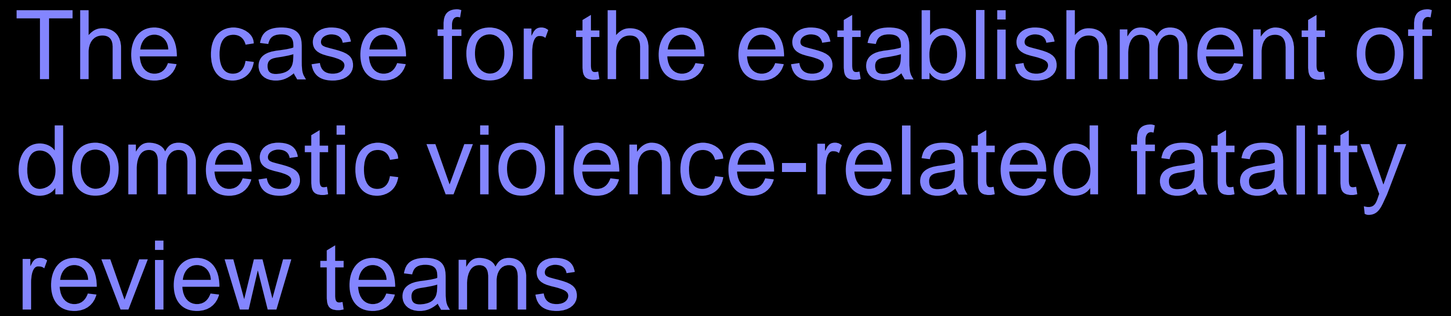

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What is it?

Domestic violence-related fatality review team:

A committee of senior Government officers and representatives of other relevant organisations committed to the process of examining the precipitating and preceding factors around the deaths of women, children and men which have occurred as a result of and on a background of domestic violence to understand why those deaths occurred and how they could be prevented

All domestic violence-related deaths are preventable

Definitions

- ‘Domestic violence fatality’: the death of a person brought about on a background of domestic violence

Definitions

This includes

- the homicide of a victim of domestic violence at the hands of the perpetrator
- the homicide of the domestic violence perpetrator at the hands of the victim
- the suicide of a victim of domestic violence
- the suicide of the homicide offender
- family annihilation
- the homicide of children who have witnessed domestic violence and/or been direct victims of violence, abuse and neglect
- the homicide of collateral victims, for example, a police officer attending a domestic violence incident, a friend or relative assisting the victim, a perceived sexual rival or the new partner of the offender's estranged former partner

Statistical indications

Based on available data from the Australian Institute of Criminology National Homicide Monitoring Program for 2005/2006 of 283 homicide incidents:

- 21% were intimate partner homicides
- 19% were family homicides
- 30% were 'friends or acquaintances' – this figure includes collateral victims, family members and friends of a victim of domestic violence

It is possible that half of all homicides in Australia are domestic violence-related

Definition of the domestic violence-related fatality review process

the deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence, for examination of the systemic interventions into known incidents of domestic violence occurring in the family of the deceased prior to the death, for consideration of altered systemic responses to avert future domestic violence deaths, or for development of recommendations for co-ordinated community prevention and intervention initiatives to eradicate domestic violence (Websdale and Moss 2001)

Why do we need this?

CONTEXT

- Domestic violence may be responded to by a range of agencies, government and non-government, to meet a range of needs – or not
- Generally responses to domestic violence are patchy, unco-ordinated, often ad hoc, often indadequate
- In general there is no common central co-ordinated policy to inform responses and service delivery

Whose problem?

All levels of government, all agencies (government and non-government) and professionals by virtue of their position should have some responsibility to preserve and promote basic human rights, particularly the rights of women and children to live safely within their own homes

- Health
- Welfare – includes counselling services
- Housing
- Police
- Courts
- Centrelink
- Settlement services
- Legal profession

- All agencies - and none

Whose responsibility to take the lead?

- Responsible responsive Government
- State/Territory Governments which determine policy and legislation and which provide funding for services responding to domestic violence

Responsibility

- Political will
- Funding
- Legislation
- Ongoing resources for the process
- Ongoing resources to implement recommendations to improve service delivery
- Commitment

Barriers

- Lack of understanding of domestic violence, its damaging effects, the complexity of responding to it
- Lack of recognition of the phenomenon of domestic homicide – the ultimate domestic violence
- Lack of rigorous research into the background of domestic homicides
- Lack of will to commit resources
- Lack of will to uncover problems

Why not a coronial inquest?

- Limited inquiry
- Identity, date and place, manner and cause of death
- Must occur if a homicide
- BUT suspended if there is a person of interest who has been or may be charged
- Factors too remote to be ‘causative’

Benefits of a domestic violence-related fatality review process

- Roundtable
- Information exchange
- Co-operative, collaborative approach to understanding limits and constraints to agencies' responses and responsibilities
- Mutual understanding
- Collaborative problem-solving
- To lead on to co-ordination and integration of services
- To work towards prevention of future fatalities due to domestic violence

Benefits (cont)

- No other means to examine what went wrong, what went right, what might be done better
- Limits of the coronial process
- No better means to examine what went wrong, what went right and what might be done better
- Positive outcomes

- Positive process

Key components

CRITICAL ISSUES TO BE DETERMINED

- Definitions
- Purpose
- Philosophy
- Terms of reference
- Which cases?
- Auspice
- Membership

Key components

CRITICAL ISSUES TO BE DETERMINED

- Sources of information
- Jurisdiction
- Resources
- Legislative base
- Relationship with child death reviews
- Process
- Operational issues
- Protocols

Key components

CRITICAL ISSUES TO BE DETERMINED

- Confidentiality, liability and immunity
- Reporting
- Recommendations
- Program for implementation of recommendations and reporting back
- Evaluation of effectiveness

Getting it right

- Research – quantitative data
- Legal research imperative
- Engagement and commitment of key agencies
- Legislative base
- Agreed philosophy and terms of reference
- Development of rigorous processes and protocols, including data collection and data protection

A model

MEMBERSHIP (Government)

- Ombudsman
- State Coroner
- Police
- Health
- Child Protection and Children's or Community Services
- Attorney-General

A model

MEMBERSHIP (non-Government)

- Representation from women's services
- Representation of Aboriginal communities
- Representation of CALD communities
- Ad hoc membership of experts

A model

- Auspice and membership
- Resources
- Legislation
- Reporting back
- Evaluation

Legislative base

Essential to operate effectively:

- to ensure independence
- to provide for membership and tenure
- to compel disclosure
- to protect disclosure
- to protect confidential deliberations
- to provide immunity from civil or criminal liability
- to provide for investigative powers
- to provide for accountability - reporting back to Parliament

Suggested terms of reference

- *to examine the events leading up to the deaths of people who died within the context of domestic violence in order to gain a better understanding of domestic violence and improved criminal justice and human services responses;*
- *to share information on the roles, policies, procedures and legislative requirements of services and Departments with other committee members;*
- *to work co-operatively with committee members to gain insight and better understanding of domestic violence and strategies to address domestic violence;*

Suggested terms of reference

- *to collaborate and learn in the spirit of collegiality as opposed to attributing blame for systems failures;*
- *to maintain confidentiality of all information brought to the notice of the committee in the context of its deliberations;*
- *to examine the contacts made with services for support and assistance by the victim and offender;*
- *to examine the appropriateness and quality of services and other relevant interventions available to the victim and offender;*
- *to examine issues of access to such services for the victim and offender;*

Suggested terms of reference

- *to identify barriers to access and other impediments to help-seeking;*
- *to identify gaps in systems and service delivery;*
- *to identify systems failures;*
- *to recommend improvements to service delivery and systems and law reform, as appropriate;*
- *to monitor progress in the implementation of recommendations;*
- *to report to Parliament annually on findings of death reviews, recommendations made and progress of implementation of previous recommendations made.*

Outcomes

- Identification of systems failures and problems
- Identification of gaps in service delivery
- Identification of duplication of services and contradictory or conflicting service responses
- Mutual understanding and respect of organisations' roles, constraints, limits

Remedies

- Strategies for service development and enhancement
- Legislative reform
- Co-operative service delivery
- Co-ordination of service responses, including legal responses
- Improved service delivery and responses
- Ongoing monitoring and evaluation

Accountability

- Reporting back annually to the Parliament on deaths reviewed and findings
- Reporting back annually on proposed remedies or recommendations
- Reporting back annually on progress and success of a program of implementation of proposed remedies or remedies from the previous year(s)