

Victoria's Systemic Review of Family Violence Deaths

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Outline

- Background and context
- Victorian Systemic Review of Family Violence Deaths
- Impressions and challenges

Background to VSRFVD

History of activism in Victoria leading to VSRFVD:

- **2001** - DVRCV and VWRADVS (ex- DV Vic) urged Victorian Attorney General Rob Hulls to review legal responses to family violence
- **2002** - AG made a referral to the Victorian Law Reform Commission for a review of family violence laws; project commenced August 2003.
- **2003-2005** - VLRC Consultation Paper released. Submissions called for and consultation process undertaken.
- **2006** - VLRC research and consultation resulted in Final Report that contained 153 legislative and system recommendations. The AG tabled the report in parliament on 1 March 2006.

Background to VSRLFVD

VLRC Final Report

- Recommendation 148:
 - *In consultation with the State Coroner, the Statewide Steering Committee to Reduce Family Violence should investigate and make recommendations to the government regarding the creation of a family violence death review committee in Victoria.*
- NGO's (led by FCLC and DV Vic) set up Victorian Family Violence Justice Reform Campaign, lobbying for adoption of 'The Whole Package' of VLRC recommendations by Govt.

Background to VSRFVD

- **2006** –Statewide Steering Committee to Reduce Family Violence – establishes a Working Group to explore a model for FVDR
- **2009** -AG announces plans for Victorian Systemic Review of Family Violence Deaths within the Coroners Court of Victoria
 - Coroners Prevention Unit operational
 - VSRFVD Reference Group established

Background to VSRFVD

- **2011** - First inquests held under the review:
 - findings posted on Coroners Court-dedicated family violence page on website from June 2012.
- **2012** – Baillieu government fails to commit funds for continuation of VSRFVD.
 - February 2012 twelve Victorian non-government organisations begin a campaign to urge state government to fund the VSRFVD.

Victorian Context

Family Violence Protection Act 2008

Definition of family violence (1)

a) behaviour by a person towards a family member of that person if that behaviour—

- is physically or sexually abusive; or
- is emotionally or psychologically abusive; or
- is economically abusive; or
- is threatening; or
- is coercive; or

in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person;

or

b) behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of the behaviour referred to in a).

- Family Violence Protection Act 2008 (Vic) s 5

Victorian Context

Definition of family violence (2)

- An issue focused around a wide range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur in families, kinship networks and communities. It extends to one-on-one fighting, abuse of Indigenous community workers as well as self-harm, injury and suicide.
 - Strong Culture, Strong Peoples, Strong Families
10 Year Plan 2008

Victorian Context

Coroners Act 2008

- Greater emphasis on prevention, including
 - A coroner may comment on any matter connected with the death, including matters **relating to public health and safety or the administration of justice**. [s 67(3)]
- Mandatory responses to coronial recommendations [s 72]

Victorian Systemic Review of Family Violence Deaths

- Conducted by State Coroner's Office = Coroner's Prevention Unit + State Coroner
- Supported by Systemic Review of FV Deaths Reference Group

Aims of the Review

- To examine the context in which FV deaths occur
- To examine risk factors associated with FV
- To examine current systemic responses to FV
- To identify patterns in FV-related deaths
- To formulate recommendations for the investigation, intervention and prevention of Family Violence

Role of Coroner's Prevention Unit

- Review individual cases of FV deaths
- Create a data set of FV deaths
- Provide information to coroners relating to FV
- Assist coroners in the development of prevention recommendations
- Assist in monitoring and evaluation of recommendations

Role of Reference Group

- Provide advice and information on systemic opportunities and barriers
- Provide opportunities to consult with individuals in areas of expertise
- Offer broad sector representation
- Facilitate collaboration, communication and cooperation among members

Cases & findings

Coroners Court of Victoria Annual Report 2010-2011:

- 1/1/09 – 30/6/11:
 - 150 suspected homicides in Victoria
 - of these, 41.3% / n62 identified as relevant to the VSRFVD.
 - 45.2% = intimate partner homicides
 - 33.8% = parent-child homicides
 - 21% (n13) homicides = other familial relationships or occurred in a context of family violence (i.e. involving a bystander to family violence)
- 2010-11: nine case review reports completed; one as an inquest finding in April 2011.

2011-2012:

- Coroners Court of Victoria has posted findings of 11 family violence investigations dated 16/8/11 – 27/7/12
 - 10 findings result of Inquest (1 x not as part of VSRFVD)
 - 1 without Inquest

<http://www.coronerscourt.vic.gov.au/home/investigations/family+violence+investigations/>

Osborne Findings

May 2012 - Victorian Coroner Judge Jennifer Coate delivered her findings of an inquest into a family violence murder/ suicide in Victoria.

On the 10th of April 2010, in Melbourne's north, Rajesh Osborne shot his nine year old son Jarius, his two daughters, twelve year old Asia and Grace who was seven, before he shot himself.

Osborne Findings

In delivering her findings, the Coroner read an edited version of Raj Osborne's suicide note, which she said was "*full of vitriol and anger*" towards his former partner, who was not the children's biological mother.

The Judge further stated:

Whilst the horror of what happened here is mercifully rare, the sentiment expressed by Mr Osborne is not ... this note bears the hallmarks of the family violence perpetrator who fails or refuses or is unable to take responsibility for his actions and indeed blames his horrendous final acts of violence against his children and himself on someone else for causing or provoking his actions.

Challenges

- Coroner-headed FV/DV Death Reviews are only as good as the coronial system eg implementation of recommendations
- CPU's family violence work is currently unfunded
- VSRFVD is not statutory