

CLC Conference Death Reviews

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29-31

SA - A Right to Safety

Women's Safety Strategy aims to reduce VAW
Regional approaches – VAW Collaborations &
Family Safety Frameworks

Coroner's Office – research position within
Coroner's Court – also reports to Office for
Women in the Attorney General's Department
and Chief Executive Group of department heads
chaired by Minister – Gail Gago.

NEW DV Laws in SA

- New Police Interim Intervention Orders in SA from December 2011. *Intervention Orders [Prevention of Abuse] Act 2009*.
- Police had issued 1014 orders to the end of June.
- 1668 court actions against DV offenders between December -June 14, compared with 535 court issued orders for the same period the previous year under the old legislation.

(Advertiser July 22 2012)

OSCAR Statistics

- Office for Crime Statistics and Research data shows that between July 2001 and June 2009 there were 45 domestic violence-related homicides in South Australia, of which 39 (87%) involved female victims and six male victims. (Advertiser July 22 2012).
- Government focus to reduce DV is a significant positive achievement.

Recent known DV Deaths in SA

- From July 08 to August 2012 SA has had 17 fatal events against a background of domestic violence
- 15 dead women + 2 dead children + 9 dead men + 1 stabbed woman + 1 stabbed baby = 24 dead people + 2 seriously injured in 3 years and 4 months.
- All the 15 dead women and children and the two injured were killed or injured by men.
- Seven of the dead men killed themselves, another was shot dead by Police and one died after being set alight by his wife after years of his domestic abuse of her.

SA Recent Frequency & Fatality Rates

- 2012 1 fatal event: 1 dead woman + 1 dead man
- 2011 3 fatal events: 3 dead women + 2 dead men
- 2010 = 2 fatal events. 2 dead women
- 2009 = 8 fatal events: 7 dead women + 3 dead men + 2 dead children = 12 dead people
- July 08 to the end of 2008 = 3 fatal events; 2 dead women + 2 dead men = 4 dead people.

Community Activism for DV Death Review Process

- Victim Support Services, WEAVE Inc., Women's Legal Services, YWCA, academics, Office for Women, Domestic Violence Services SA Coalition, family members of victims pushed for DV Death Reviews.
- Red Rose Rallies on Parliament House Steps when homicides occurred.
- Remembrance Quilt Project, state & national
- December 2009 DV Death Review Roundtable
- 2010 Forum by YWCA on DV Death Reviews.
- National Domestic Violence Death Review Action Group formation 2010.

National Quilt



2010 DV Death Review Forum SA



SA Coroner's Office

2010-11 Annual Report

- 2010 SA Government committed to employ a research officer in the Coroner's Office, in partnership with the Office for Women, to investigate domestic violence related deaths.
- 4 year appointment commenced January 2011
- Can investigate open and closed cases involving single homicide, single suicide or multiple deaths.

Scope of DV Research position

Annual Report 2010-11 p.7

- 'Identify DV Contexts, issues and service systems to investigate adequacy of system responses.
- Identify systemic issues or inter-agency approaches to assist in death prevention in DV contexts
- Provide advice to build the capacity of the Coronial Inquest to explore & inquire into system responses to DV and recommend improvements with preventative focus.
- Develop data collection systems to enable provision of advice to coronial processes and enable identification of demographic or service trends, gaps or improvements.'

National Network

- National Family Domestic Violence Death Review Network established in April 2011 with NSW, Victoria, Queensland and SA.
- Coronial jurisdictions share information, align investigation processes and collaborate on best practice.
- WA has formed a DV death review process in the Ombudsman's Office. NT has promised a DV death review.

DV Death Review Activity in SA

- Continuous process of development over time.
- 2 inquests so far where DV was a feature of the deaths.
- Deputy State Coroner issued preliminary finding & recommendation that Family Safety Framework process be implemented in Murray-Mallee Police region.
- Arose as an outcome of evidence and advice on the potential benefit of inter-agency collaboration in management of high risk DV matters (p8).

Death Review Recommendations re Firearms

- Amend Bail Act 1985 for specific domestic violence offences, timing of court appearance and firearms test & align with the new Intervention Orders Act 2009.
- SAPOL – attention to improving evidence and statement collection and investigation of access to firearms and better access to intelligence re repeat offenders.
- SAPOL & DV sector to improve surveillance and communication re breaches of bail, access to firearms and offending history.

FAMILY SAFETY FRAMEWORK

- SA government announced a state-wide roll-out of FSF in June this year following Coronial recommendations.
- Common risk assessment process across agencies.
- The Family Safety Meetings are chaired by SA Police and attended by representatives from local agencies.
- These agencies include Families SA, Housing SA, Community Corrections, Health Services, Adult Mental Health Services, Drug and Alcohol Services, Education, Women's Domestic Violence Services and Victim Support Service.

FSF Strengths

- Educates agencies in DV contexts and system processes.
- Common risk assessment avoids different agencies from assessing risk at different levels.
- Information sharing between agencies about features of the case and the people involved.
- Co-ordinated efforts of relevant agencies working with the victim/s.

FSF Critique

- Focus on victim/s not perpetrator.
- Does not curtail perpetrator behaviour.
- Victim/s can be seen as responsible for the violence against them if they are not seen as 'co-operative'.
- Can reduce victim's agency and can discount their knowledge about their circumstance.
- A matter of time before a FSF identified victim is killed as it does not control the perpetrator.

Strengths of SA DV Death Review Approach

- Positive initiative to have a DV death review process. Much better than not having anything.
- Able to scrutinise policies, departments, agencies, frameworks and processes for gaps, flaws, failures & report on open cases.
- Able to liaise with and share information with other jurisdictions.
- Coroner's office already geared to investigate deaths and coronial recommendations must generate response from government.

Limits of SA DV Death Review Approach

- Is a research position rather than a panel or board.
- Is not legislated so vulnerable to de-funding.
- Is within the coronial process rather than the wider community – thus potentially constrained by being within a government agency.
- Is not, so far, readily open to public scrutiny beyond individual coronial reports.
- Federal-state divide (universal problem)