NSW Domestic Violence Death Review Team

This fact sheet summarises the Ask LOIS webinar on this topic, presented by Dr Lesley Laing
NSW Domestic Violence Death Review Team and Senior Lecturer, University of Sydney
on 7 November 2013. This webinar can be downloaded for free at www.asklois.org.au/webinars/past-webinars.

What is a Domestic Violence Death Review Team?

- Collaboration of government & non-government agencies
- Seeks to reduce domestic violence related homicides
- Identifies & recommends improvements to agencies
- Monitors implementation of recommendations
- Draws on emerging research to develop best practice guidelines

Your notes:

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Key Drivers in NSW

- Long campaign by NSW DV Coalition
- Political context
- Murder of Melissa Cook, Dec. 2008
- Interagency Panel
- Non-Government Chair
- Short time-frame to May 2009
- BOCSAR 5 year review
- 43% deaths not flagged as DV related on COPS
- 36% of those were intimate partners/intimate partner related
- DVDRT announced May 2010

Your notes:

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Advisory Panel – February – May 2009

- Define ‘domestic & family violence related’ homicide
- Consider the BOCSAR’s analysis of trends & patterns in DFV related homicides in NSW for 1 January 2003 - 30 June 2008
- Consider elements of an ongoing review mechanism, including –
  - The need for a legislative basis
  - The need for any amendments to privacy legislation
  - Data collection methodology
- Recommend changes to practices & procedures to reduce preventable DFV related homicides, including a model for an ongoing review mechanism

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Panel Method

• Review of research literature
• Consideration of the analysis of DV related homicides 2003-2008 conducted by BOCSAR
• Analysis of international models for DV homicide reviews
• Documentation of existing death review mechanisms in NSW
• Consultations with officers from NSW Ombudsman and Coroner
• Attempted analysis of 5 case studies of DV related homicides

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Essential Features

A DV homicide review mechanism for NSW should include a strong legislative framework incorporating:
• Protection from disclosure in legal proceedings;
• Immunity to those who disclose information;
• Exemptions from freedom of information legislation;
• The ability for the review mechanism to compel information from relevant agencies;
• Objectives that centre on a ‘no blame’ philosophy;
• A requirement that members are bound by confidentiality
• A clear notification process;
• The power to make recommendations public;
• A mechanism to ensure implementation of recommendations;
• Membership that includes all relevant government & non-government service providers
• Capacity to seek expert advice where required;
• Minimum number of required meetings per year;
• Oversight mechanisms; &
• Periodic statutory review.

Positive Outcomes

• DVDRT finally established after >10 years of advocacy
• Includes suicides & ‘accidental’ deaths in addition to homicides
• Legislative base (
Recommendations

Domestic Violence Death Review Team - Annual Reports: 2010/11; 2011/12; 2012/13 (currently being finalised)


- Quantitative and qualitative data
- Database of all 'closed external cause assault deaths homicides’ from June 2000 – current reporting year years
- Annual in depth case reviews- 12/13 report covers 1 July 2009 and 30 June 2010 (19 cases)

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