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Abstract

In Australia, a significant proportion of homicides occur in a domestic context, many following an identifiable history of domestic violence. For this reason, many domestic violence homicides are considered to be preventable. Sector advocacy and policy reform has reframed domestic violence as a serious social issue. In keeping with international trends, domestic violence death review teams have been introduced in Australia. These review teams examine domestic violence homicides to identify systemic gaps in service responses to prevent future deaths. This article describes the operational Australian domestic violence death review teams and the Australian Domestic and Family Violence Death Review Network.

Keywords

domestic violence, death review, homicide, coroner, intimate partner

Introduction

Some of the most extreme acts of violence and abuse in society occur in a domestic context. Domestic violence consequently has a devastating impact on individuals, families, and communities. While there is no universally agreed upon definition of the

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behaviors that comprise domestic violence, in Australia it includes a spectrum of abuse—physical and nonphysical—within an intimate or family relationship (National Council To Reduce Violence Against Women and their Children, 2009a). Domestic violence behaviors include physical assault, sexual assault, threats, intimidation, psychological and emotional abuse, social isolation, and economic deprivation (National Council To Reduce Violence Against Women and their Children, 2009a). Primarily, domestic violence is predicated upon inequitable relationship dynamics in which one person exerts power and coercive control over another (National Council To Reduce Violence Against Women and their Children, 2009a).

Research indicates that approximately one in three Australian women have experienced physical violence and one in five women have experienced sexual violence since the age of 15 (Australian Bureau of Statistics, 2006). Many of these acts of violence occur in a domestic context. Surveys including the International Violence Against Women Survey reveal that in Australia, the overwhelming majority of domestic violence is perpetrated by the current or former male intimate partner of a female victim (Mouzos & Makkai, 2004).

In Australia, domestic violence is also referred to as “family violence.” This term has achieved mainstream usage in many jurisdictions as it expands the definition of domestic violence to encompass abuse within intimate relationships and both immediate and extended families (National Council To Reduce Violence Against Women and their Children, 2009a). In particular, family violence more accurately describes the relationships in Aboriginal and Torres Strait Islander communities, where kinship systems add layers of complexity to the understanding of these behaviors (Office for Women’s Policy, 2008). While this distinction is acknowledged, in keeping with the international research literature, the term domestic violence is adopted for the purpose of this article.

Domestic violence can also be fatal. The total homicide rate in Australia is 1.3 per 100,000 population, comprising approximately 250 deaths per year (Virueda & Payne, 2010). Between July 1, 2007 and June 30, 2008, over half (52%) of these homicides occurred between parties in an intimate or familial relationship, a phenomenon referred to in the literature as “domestic homicide” (Virueda & Payne, 2010). In many of these domestic homicides, the death occurred in a context where there was history of violence and abuse in the relationship. In this article, these deaths are referred to as “domestic violence homicides.”

Against this background, and in acknowledgement of the serious issue of domestic violence and domestic violence homicide, governments across Australia have actively developed and implemented a range of initiatives that seek to address and redress the causes and consequences of domestic violence. Most recently, this has included the establishment of domestic violence death review teams in several states. These review teams operate with a view to developing evidence-based intervention and prevention strategies in relation to domestic violence homicides.

This article outlines the introduction of domestic violence death review teams in Australia; current models of operation; associated legislative frameworks and governance structures; and the main outcomes and achievements to date. The establishment

and objectives of the Australian Domestic and Family Violence Death Review (ADFVDR) Network are also described.

Domestic Violence and Domestic Homicide Monitoring in Australia

Australia has a diverse cultural population. Among the 22.5 million residents, 670,000 (3.0%) people identify as Indigenous (Aboriginal and/or Torres Strait Islander) and six million (27.0%) were born overseas (Australian Bureau of Statistics, 2012a). The Australian population is concentrated on the coast, mainly within urban areas (Australian Bureau of Statistics, 2012b). Almost two thirds of Australia's residents live in the capital cities of each state and territory (Australian Bureau of Statistics, 2012b).

Australia has a written constitution and federal system of government. Under this system, powers are divided between the federal government and individual states/territories. The Australian Constitution defines the responsibilities of the federal government, which include foreign relations, trade, defense, immigration, and family law (such as matters relating to divorce and child custody). State governments make their own laws in areas not controlled by the federal government. Territories are either administered by the federal government or are granted a right of self-government, which enables them to operate in a similar manner to a state.

Legal systems in Australia operate at both a state/territory level and at a federal level. Each state and territory has its own separate and independent criminal justice system comprised of a police force, judiciary, and corrective services/prisons (Australian Institute of Criminology, 2010). In addition to this, Australia has a federal police force that investigates crimes of national significance, such as drug importation, human trafficking, terrorism, or fraud (Australian Federal Police, 2012). Matters concerning domestic violence, such as intervention orders and criminal proceedings, are the responsibility of individual states and territories.

Domestic Violence and Cultural Diversity in Australia

Domestic violence in Australia exists within all geographical, socioeconomic, age, ability, cultural, and religious cohorts. It should be noted, however, that certain groups experience domestic violence disproportionately. In particular, research indicates that Aboriginal and/or Torres Strait Islander woman are 35 times more likely to be hospitalized due to domestic violence related assault than other Australian females. Further, they are 13 times more likely to seek emergency accommodation as a result of domestic violence (Al-Yaman, Van Doeland, & Wallis, 2006). Noting that the issues affecting Aboriginal and/or Torres Strait Islander populations are extremely complex, this article does not purport to explore the issues affecting this group in detail, other than to note the need for continued and methodologically robust research in this area.

Other groups within the Australian community may experience domestic violence disproportionately and/or differently, including: women from culturally and linguistically diverse backgrounds, women with disabilities, older women, and women from

rural and remote communities (Bartels, 2010). Similarly, further research is required to better understand the experience of domestic violence for these groups.

Domestic Homicide Monitoring in Australia

The Australian Institute of Criminology's National Homicide Monitoring Program (hereafter the NHMP) reports every 2 years on the frequency and nature of homicides in Australia. The NHMP categorizes homicides on the basis of the relationship between the deceased and offender. This includes intimate partner homicide, infanticide, filicide, parricide, and siblicide. The most recent NHMP statistics indicate that more than half of all Australian homicides ($n = 134$, 52%) occurring between July 1, 2007 and June 30, 2008 were domestic homicides. Further analysis showed that of these 134 homicides, 80 (60%) were subclassified as intimate partner homicides. The second largest subcategories involved parents killing their children (15%), followed closely by children killing their parents (13%; Virueda & Payne, 2010).

An identifiable history of domestic violence is a common feature in a high proportion of domestic homicides and such domestic violence homicides comprise an important subclassification of domestic homicides. The NHMP does not report context of domestic violence between the deceased and the offender and as such, cannot present trends and patterns on this important feature at a national level. Given that domestic violence homicide is considered to be a preventable public health problem (World Health Organization, 2010), from early 2000 there was a growing call for the establishment of mechanisms to specifically monitor and address the causes and consequences of these deaths. This aligned with a broader reform agenda in relation to domestic violence responses in Australia, led by sector advocacy and political action at both a federal and state level.

Domestic Violence Reform

Significant advocacy, research, and reform over the last 10 years has successfully reframed domestic violence in Australia as a serious social issue requiring coordinated responses across all levels of government (Council of Australian Governments, 2010). The major influences and reform outcomes in Australia over the past decade are described below.

Australian Government Responses to Domestic Violence

Australia is a signatory to several important international instruments that compel or urge nation states to address issues of violence against women, including domestic violence. Among those that have directly influenced the reform agenda in Australia are: the *Convention on the Elimination of All Forms of Discrimination Against Women* (1979); *Declaration on the Elimination of Violence Against Women* (1993); the *Convention on the Rights of the Child* (1989); the *Beijing Platform for Action* (1995); and the *United Nations Millennium Goals* (2000). Adoption of the norms and

obligations outlined in these treaties and conventions has shaped responses to domestic violence in Australia.

International treaties bind Australia at a national level; however, the federal structure of government presents a unique challenge to the realization and co-ordination of these obligations and norms. In recognition of these challenges, in May 2008 the Commonwealth Government commissioned an expert advisory panel titled *The National Council to Reduce Violence against Women and their Children* (hereafter The National Council) to advise the Australian Federal Government on measures to reduce the incidence and impact of violence against women and their children. The National Council conducted extensive community consultation (National Council To Reduce Violence Against Women and their Children, 2009a), literature reviews, and data interrogation (National Council To Reduce Violence Against Women and their Children, 2009b) to inform the development of a report entitled *Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children 2010-2022* (hereafter the Time For Action report) released in March 2009 (National Council To Reduce Violence Against Women and their Children, 2009c).

Amongst other measures, this report outlined the need for the establishment of homicide/fatality review processes in all states and territories

... to review deaths that result from domestic and family violence, so as to identify factors leading to these deaths, improve system responses and respond to service gaps (National Council To Reduce Violence Against Women and their Children, 2009c, p. 11).

Following this report, in 2011, as part of a coordinated response to the *Time for Action* report, the Council of Australian Governments (COAG) released an action plan entitled *The National Plan To Reduce Violence Against Women And Their Children 2010-2022* (hereafter The National Plan) (Council of Australian Governments, 2010).

Six key outcomes are identified in The National Plan to prevent violence against women in Australia. These key outcomes are that: (a) communities are safe and free from violence, (b) relationships are respectful, (c) Indigenous communities are strengthened to better deal with family violence and sexual assault (d) services meet the needs of women and their children experiencing violence, (e) justice responses are effective, and (f) perpetrators stop their violence and are held accountable. Achieving these outcomes requires co-ordination among state, territory, and federal governments in Australia.

Significantly, The National Plan focuses attention on domestic violence homicide through Key Outcome 5—Strategy 5.2. This strategy identifies the need to “[d]rive continuous improvement through sharing outcomes of reviews into deaths and homicides related to domestic violence” and to monitor domestic violence homicides at a national level.

Furthermore, the *Time for Action* report acknowledged the complex interaction between domestic violence and child protection laws in states/ territories versus the Commonwealth Family Law legislation known as the *Family Law Act 1975* (Cth) (National Council To Reduce Violence Against Women and their Children, 2009c). Accordingly, in 2009 the Australian Law Reform Commission together with the

Table 1. Australian State and Territory Domestic Violence Legislation.

Jurisdiction	Legislation
Australian capital territory	<i>Domestic Violence and Protection Orders Act 2008</i> (ACT)
New South Wales	<i>Crimes (Domestic and Personal Violence) Act 2007</i> (NSW)
Northern territory	<i>Domestic and Family Violence Act 2007</i> (NT)
Queensland	<i>Domestic and Family Violence Protection Act 2012</i> (Qld)
South Australia	<i>Intervention Orders (Prevention of Abuse) Act 2009</i> (SA)
Tasmania	<i>Family Violence Act 2004</i> (Tas)
Victoria	<i>Family Protection Act 2008</i> (Vic)
Western Australia	<i>Restraining Orders Act 1997</i> (WA) and <i>The Criminal Code and the Bail Act 1892</i> (WA).*
	*These Acts were amended in 2004 to provide greater protection to victims of family and domestic violence. To date there is no specific legislation in WA which codifies family/ domestic violence

New South Wales Law Reform Commission (hereafter the Commissions) conducted an inquiry into family violence. Specifically, the Commissions were asked to consider the interaction of state and territory domestic violence and child protection laws with Commonwealth family laws and the impact of any inconsistencies. The Commissions were asked to consider what, if any, improvements could be made to relevant legal frameworks to protect the safety of women and children.

The report, *Family Violence—A National Legal Response* (Australian Law Reform Commission, 2010) made 187 recommendations for law reform. The work of the Commissions was one of a number of concurrent inquiries in relation to domestic violence and family law. These included reviews that examined the appropriateness of the legislation, practices, and procedures that apply in cases where domestic violence is an issue (Chisolm, 2009) and the impact of domestic violence on children and on parenting (Family Law Council-Family Violence Committee, 2009).

These reviews informed significant amendments to the *Family Law Act 1975* (Cth). The reforms included expanding the definition of domestic violence to incorporate the full spectrum of abusive behaviors and actions, removing disincentives to the disclosure of domestic violence to the court, and ensuring that the safety of children is a key priority in family law proceedings.

State/Territory Responses to Domestic Violence

In keeping with the Australian Government's responses to domestic violence at a national level, significant law reform has also occurred among Australian states and territories implementing specific civil and criminal responses to such violence. The legislation related to the governance of domestic violence within each state and territory is shown in Table 1. These reforms have enhanced police and judicial powers to respond to and protect victims of domestic violence.

Domestic Violence Sector Advocacy

The key outcomes identified in Australian Government publications and reports, which related to domestic violence reforms, strongly echoed decades of work by advocates within the domestic violence sector across Australia. Even prior to the publication of The National Plan and law reform in both state/territory and Commonwealth jurisdictions, there was extensive and ongoing lobbying from the domestic violence sector and other advocates for improved responses to domestic violence including the systematic reviews of domestic violence homicides. The public awareness and debate created by these ongoing campaigns raised the visibility of domestic violence homicides and has been a driving force behind the introduction of death review teams in New South Wales, Queensland, South Australia, and Victoria.

Domestic Violence Death Review Teams in Australia

Background

Domestic violence death review teams examine domestic violence homicides to identify systemic gaps in service responses with a view to preventing deaths from occurring in similar circumstances (Wilson & Websdale, 2006). Review teams emerged in the United States in the early 1990s, amidst a growing concern that domestic violence service agencies were failing to adequately coordinate responses to such violence or protect victims (David, 2007). Review teams seek to provide a better understanding of the roles of agencies in responding to domestic violence and identify where resources need to be focused (Watt, 2010). Furthermore, they seek to identify intervention opportunities and promote collaboration and cooperation between agencies. More recently, review teams have been established in Canada, New Zealand, and the United Kingdom.

Australian Domestic Violence Death Review Teams

The first Australian domestic violence death review team was established in Victoria in 2009 and, as of June 30, 2012, four Australian states had domestic violence death review teams in operation. Each review team was established through state-based policy or legislation. It should be noted that on July 1, 2012 the Domestic and Family Violence Fatality Review in Western Australia commenced, but since this review is only in the initial stages of establishment, it is not examined in this article.

Drawing from international experience, the primary focus of Australian review teams is the identification of gaps and opportunities for enhancement of the domestic violence service system and formulation of prevention strategies to reduce the incidence and impact of domestic violence. To achieve this, all review teams quantify the nature and frequency of domestic violence homicides through data collection, data analysis, and undertake in-depth case reviews. It should be noted that while each jurisdiction has scope to review domestic violence related suicide, the primary focus of each team is domestic violence homicide. Accordingly, domestic violence homicide review processes are the central topic of this article.

Despite the common objectives of the Australian review teams, those currently in operation vary in terms of their structure, governance, and legislative basis. Each review team is described in detail below, providing an overview of the current approaches in Australia.

Victoria

Establishment and Legislative Framework. In 2006, the Victoria Law Reform Commission (hereafter VLRC) released the *Review of Family Violence Laws* report (Victorian Law Reform Commission, 2006). The report was the result of a comprehensive examination of the justice system's response to domestic violence and made a series of recommendations for improvement. The findings of the VLRC included that a death review committee should be implemented as a mechanism for addressing domestic violence and domestic violence homicide. After considering a range of operating models, the Victorian Systemic Review of Family Violence Deaths (VSRFVD) commenced in the Coroners Court of Victoria in 2009 pursuant to the *Coroners Act 2008* (Vic).

The definition of a relevant relationship and of the behaviors and actions that comprise domestic violence are in accordance with the *Family Violence Protection Act 2008* (Vic). The VSRFVD also incorporates the definitions provided by the Victorian Indigenous Family Violence Taskforce. This definition specifically recognizes harm done to kinship networks and communities by domestic violence.

Structure. The VSRFVD is led by the State Coroner and assisted by the Coroners Prevention Unit (hereafter CPU) within the Coroners Court of Victoria. The CPU comprises a multidisciplinary team of researchers and clinicians that assist coroners with their investigation of reportable deaths to strengthen their public health and safety role.

The VSRFVD is assisted by a reference group, comprised of government and non-government representatives, including: justice agencies; domestic violence organizations; Indigenous (Koori) services; culturally and linguistically diverse services; disability, health and welfare organizations; academia and policy divisions.

Core Functions. The core functions of the VSRFVD are to conduct in-depth case reviews of domestic violence homicide and to collect and analyze related data. Specifically, the VSRFVD examines the context in which these deaths occur; identifies associated risk and contributory factors; considers current systemic responses to domestic violence; and provides an evidence base to support the formulation of prevention recommendations.

Reporting mechanisms and outcomes. Recommendations are made by coroners in the context of their findings and are publicly available. Where recommendations target public statutory authorities or entities, a written response to these recommendations, specifying what action has or will be taken, is required within 3 months.

In collaboration with the reference group, the VSRFVD has developed an investigative framework to guide the data collection and case review process. To date, more than 30 in-depth case review reports have been completed. This information has been

used to inform the coroner's investigation and the development of associated prevention recommendations. The VSRFVD has also established a homicide register, which captures information about all identified and suspected homicides occurring since the year 2000 (both domestic and nondomestic). Of these, more than 50% of completed investigations have been identified as relevant to the VSRFVD. Analysis of these deaths has enhanced understanding of the primary service contact points for both victims and perpetrators of domestic violence in Victoria.

New South Wales

Establishment and legislative framework. On July 16, 2010, following recommendations made by the Domestic Homicide Advisory Panel, the *Coroners Amendment (Domestic Violence Death Review Team) Act 2010* (NSW) commenced. This amended the *Coroners Act 2009* (NSW) by inserting Chapter 9A and thereby establishing the Domestic Violence Death Review Team (hereafter DVDRT).

Structure. The DVDRT is convened by the New South Wales State Coroner and consists of representatives from 11 key government stakeholders, including law enforcement, justice, health, and social services, and four representatives from non-government agencies. The DVDRT became operational in February 2011.

Core functions. The core legislative functions of the DVDRT are to: review and analyze individual closed cases of domestic violence deaths including domestic violence homicides, suicides, and accidents; establish and maintain a database so as to identify patterns and trends relating to such deaths; and develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths.

Reporting mechanisms and outcomes. The DVDRT reports annually to the New South Wales Parliament. Since establishment, the DVDRT has reviewed all closed homicides occurring in NSW between July 1, 2000 and June 30, 2009. To date, the Team has reviewed 763 homicides including 221 homicides that occurred in a context of domestic violence. Demographic, service contact and risk factor information has been captured for all domestic violence homicides. Additionally, the DVDRT has prepared and reported in-depth case reviews for all domestic violence homicides in New South Wales between March 2008 and June 2009 (16 cases). These reviews focus on the characteristics of individual cases including key themes, service contact points, and the adequacy of system responses. They complement data analysis to enable the formulation of targeted recommendations by the DVDRT.

To date, the DVDRT has made 14 recommendations aimed at various agencies including New South Wales Police Force, New South Wales Government, and Housing NSW. These recommendations relate to domestic violence service responses that include the reporting of and responses to domestic violence and public awareness-raising/education.

Future directions for the DVDRT include building and maintaining an increased data set of domestic violence homicides in New South Wales; conducting in-depth

studies in relation to service contact and apprehended violence orders; and further building the research literature around domestic violence related suicides.

Queensland

Establishment and legislative framework. In August 2009, the Queensland Government commissioned an expert panel to conduct a review of coronial investigations into deaths that occurred in a context of domestic violence. Based on recommendations provided by the panel, the *Report of the Domestic and Family Violence Death Review Panel* was presented to Queensland Parliament in October 2010. The Domestic and Family Violence Death Review Unit (hereafter DFVDRU) commenced operation in the Office of the State Coroner in January 2011.

Structure. The DFVDRU is a multidisciplinary review team, with a secretariat comprised of a Principal Research Officer and a Queensland Police Service officer who assists the coroner in investigations and research related to domestic violence deaths. Guidelines for the investigation of domestic and family violence related deaths are issued by the State Coroner pursuant to the *Coroners Act 2003* (Qld). The DFVDRU reviews domestic violence deaths, which are defined in the *Domestic and Family Violence Protection Act 2012* (Qld) and reviews both open coronial cases and those where criminal proceedings have been finalized. Within the operation of the DFVDRU, expert advice and consultative support is sought from independent agencies where necessary for a particular case.

Core functions. The DFVDRU provides investigative assistance and advice to coroners examining domestic or family violence related deaths and prepares reports that identify risk factors, opportunities for intervention, and initiatives designed to reduce or prevent similar deaths occurring. The DFVDRU also undertakes research and data analysis to enhance collective knowledge and policies concerning domestic violence.

Reporting mechanisms and outcomes. As of November 2012, the DFVDRU has completed 28 in-depth case reviews of domestic homicides that have occurred in Queensland since May 2011. Each case review is provided to the coroner. Where the coroner determines that an inquest is to be conducted, the DFVDRU prepares a report that forms part of the coronial brief of evidence. Where a matter goes to inquest, a coroner may make recommendations relating to public health and safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances. The reviews produced by the DFVDRU inform coronial recommendations. Where the coroner is satisfied that no inquest is to be held, the DFVDRU's case review report is used to assist with chamber findings.

In addition to assisting coroners in the course of inquests, information is captured in relation to all domestic homicides to enable data analysis and identification of trends and patterns in relation to these deaths. The data set presently captures all domestic homicides that have occurred in Queensland since January 1, 2006 ($n = 155$).

South Australia

Establishment and legislative framework. In response to election commitments made by the South Australian Government, the South Australian Office for Women (OFW) approached the Coroner's Court to undertake a partnership to research and investigate domestic violence related deaths. The position of Senior Research Officer (Domestic Violence) commenced in January 2011.

The definitions of domestic violence and relevant domestic relationships are outlined in the *Intervention Orders (Prevention of Abuse) Act 2009 (SA)*. The investigation of open coronial cases is sanctioned within the *Coroner's Act 2003 (SA)*.

Structure. The establishment of the South Australian review team was a specific initiative of the first phase of SA's *Women's Safety Strategy (2005-2010)*; (Office for Women, 2011) and is a continuing commitment under the second phase of this reform agenda, entitled *A Right to Safety (2011-2015)*; (Government of South Australia, 2011). Day-to-day management of this review team operates within the OFW in partnership with the South Australian Coroners Court. Further senior level reporting for the review team is to the Chief Executive Group, which is chaired by the South Australian Government Minister for the Status of Women. This group consists of the chief executives of government departments that work collaboratively to oversee and advance the *A Right to Safety* agenda that aims to maximize safety and reduce the prevalence of domestic violence against women and children.

Core functions. The core functions of the Senior Research Officer (Domestic Violence) are to: investigate domestic violence deaths and produce in-depth reviews that are used to inform open coronial investigations or inquests; develop data collection systems; and conduct specific retrospective research projects to identify demographic or service response trends, gaps or areas for systemic improvement.

Reporting mechanisms and outcomes. Recommendations are made by coroners in the context of coronial findings and are publically available. Further reporting mechanisms are embedded within the South Australian *A Right To Safety* reform agenda.

Outcomes to date in South Australia include the development of a draft *South Australian Coronial Domestic Violence Investigation Framework* (hereafter the Framework), which is underpinned methodologically by the application of an *Ecological Systems Approach* (Wundersitz, 2010) and the *Conceptual Framework for Family, Domestic and Sexual Violence* (Australian Bureau of Statistics, 2009). The Framework recognizes that relevant risk and other factors may be both proximal and distal to the domestic violence homicide (National Council To Reduce Violence Against Women and their Children, 2009a). The Framework is based on systematically building the information available to the coroner, across government and non-government systems, to determine if a case should proceed to an inquest.

To date, 30 deaths have been examined and reported to coroners and the data captured for future analysis. This has included both homicides and single instance suicides where there was a domestic violence context. Two coronial inquests have been

completed where the State Coroner has made recommendations for legislative and systems improvement in relation to domestic violence.

Case Review Methodology and Outcomes of Australian Domestic Violence Death Review Teams

Inclusion Criteria

While it is beyond the scope of this article to provide a detailed description of the specific case review methodology in each Australian jurisdiction, there are some key commonalities between review teams. As previously discussed, each jurisdiction undertakes surveillance of all homicides to determine whether the death can be classified as a domestic violence homicide. This classification is complex and is subject to the following considerations: the case type; the relationship between the parties; and the domestic violence context.

Case Type. Determination of case type (i.e. external cause, natural cause, unknown cause) is the first consideration for classification. For the purpose of Australian review teams, an external cause death is any death caused, directly or indirectly, by an offender through the application of assaultive force or by criminal negligence. In cases where the cause of death is unknown, the death is monitored until further information is available.

Deceased–Offender Relationship. The second consideration for classification is whether a domestic relationship exists between the deceased and the offender, which are defined by legislation. Each review team recognizes current or former intimate partners (heterosexual and homosexual), family members (adults and children), and kin, as domestic relationships.

Domestic Violence Context. Having determined that a homicide has occurred and that a domestic relationship exists between the deceased and offender (a domestic homicide), the final consideration for classification is whether the homicide occurred in a domestic violence context. Of particular interest is evidence of an identifiable history of violence between the parties. Deaths that fulfill these criteria are defined as domestic violence homicides and are subject to review by each jurisdiction.

Each jurisdiction can also review deaths where no direct domestic relationship exists between the deceased and offender but nonetheless occurs in a context of domestic violence. For example, this might include a bystander who is killed intervening in a domestic dispute.

Data Collection and Case Review Process

Victoria, South Australia, and Queensland jurisdictions review open coronial cases of domestic violence homicide and directly assist the coroner during inquests in relation

to the investigation and formulation of recommendations. These jurisdictions also review closed cases where proceedings have concluded in the coronial or criminal justice system. New South Wales reviews closed coronial and criminal cases and operates as a stand-alone agency within the NSW Department of Attorney General and Justice (Table 2).

Data collection is recognized as a core element of most death review teams in international jurisdictions and is also central to the Australian review teams. This is important not only to quantify the annual frequency of domestic violence homicides, but also to discern patterns or emerging trends among incidents, with particular reference to: risk factors, service contact, and the context surrounding the death.

Establishing case identification and data collection mechanisms has therefore been a focus for reviews in Victoria, Queensland and New South Wales, and is underway in South Australia. Each jurisdiction has developed homicide surveillance systems, which capture data about the offender(s), deceased(s), and the circumstances surrounding the homicide. The information recorded includes: demographic information; incident details; relationship history; risk-factor information; service contact and help-seeking history; and criminal justice and coronial outcomes.

Each jurisdiction conducts case reviews of domestic violence homicides. The case review seeks to understand the circumstances and landmark events relevant to both the deceased's and offender's experience of domestic violence in the lead-up to a fatal event. There is a focus on assessing the incident in the context of other similar deaths that have occurred. This allows for any commonalities that exist to be identified and for emerging issues or trends to be examined.

Recommendations

Having identified service gaps and limitations in responses to domestic violence through case review processes and data collection, teams develop recommendations for system change. In Victoria, Queensland, and South Australia the vehicle by which recommendations are delivered is via coroners' findings. In New South Wales recommendations are set out in an Annual Report that is presented to state Parliament.

Each review team has formulated prevention-focused recommendations targeted toward agencies within their respective states. Although specific to individual states, these recommendations nonetheless demonstrate a degree of commonality with respect to the type of issues that have been identified and addressed. To date, the recommendations have sought to enhance or improve: legislation; service response and operating procedures; interagency communication and collaboration; public education and awareness raising; and professional development to enhance service responses to domestic violence.

Furthermore, the recommendations made by review teams have been directed in many cases to both government and nongovernment agencies including: police, corrective services and justice departments; social housing providers; child protection and welfare services; education and health; government ministers and policy units; and nongovernment domestic violence service providers.

Table 2. Overview of Domestic Violence Death Reviews in Australia.

Jurisdiction	Establishment date	Name of review	Legislative framework	Auspice Agency/s	Review scope	Reporting mechanisms
Victoria	2009	Victorian Systemic Review of Family Violence Deaths	Operates under the legislative mandate of the <i>Coroners Act 2008</i> (Vic)	Coroners Court of Victoria (through the Coroners Prevention Unit)	Open & closed cases	<ul style="list-style-type: none"> - Provide case review reports/ advice/data to the Coroner for domestic or family violence deaths. - Recommendations via the Coroner's finding. - Annual reports tabled in NSW Parliament.
New South Wales	2010	Domestic violence death review team	<i>Coroners Act 2009</i> (NSW) [Chapter 9A]	Department of Attorney General and Justice	Closed cases	<ul style="list-style-type: none"> - Provide case review reports/ advice/data to the State or investigating coroner for findings and/or domestic or family violence related inquests. - Recommendations made via the Coroner's finding.
Queensland	2010	Domestic and Family Violence Death Review Unit	Operates under the legislative mandate of the <i>Coroner's Act 2003</i> (QLD)	Office of State Coroner	Open & closed cases	<ul style="list-style-type: none"> - Provide case review reports/ advice/data to the State or investigating coroner for findings and/or domestic or family violence related inquests. - Recommendations made via the Coroner's finding.
South Australia	2010	Domestic Violence Death Review	Operates under the legislative mandate of the <i>Coroners Act 2003</i> (SA)	Department for Communities and Social Inclusion (Office for Women) and Courts Administration Authority (SA Coroner Office)	Open & closed cases	<ul style="list-style-type: none"> - Provide case review reports/ advice/data to the coroner for findings and/or domestic or family violence related inquests. - Recommendations made via the Coroner's finding.
Western Australia	2012	Family and Domestic Violence Fatality Review	<i>Parliamentary Commissioner Act 1971</i> (WA)	Ombudsman Western Australia	Open & closed cases	<ul style="list-style-type: none"> - Direct report to the SA Government "A Right To Safety" Chief Executive Group. - Reporting obligations of the Ombudsman as per the Act.

Each review team monitors the progress and uptake of the recommendations, and in some Australian jurisdictions, legislation mandates responses by targeted agencies. This creates an additional level of accountability for both the death review process itself (to expand the evidence base and feasibility of recommendations) and the responding entity (to be seen publicly to be taking action to contribute to the prevention of domestic violence).

Set out below are two case studies which demonstrate the case review process and how this has led to the development and implementation of recommendations in those jurisdictions.

Example Case Review: New South Wales

This case involved the homicide of a 26-year-old woman by her 27-year-old boyfriend. They had commenced their relationship 4 months earlier and were temporarily living with the perpetrator's relatives. Both identified as Aboriginal. The perpetrator had numerous convictions relating to assaults on previous intimate partners and was on parole at the time of the homicide in relation to a conviction for malicious wounding of a former girlfriend at the time of the homicide.

Two weeks before the homicide, the perpetrator seriously assaulted the deceased, dragging her by the hair across the floor, hitting her across the face and head and threatening to stab her before leaving the premises. Against the wishes of the deceased, a relative of the perpetrator called the police who attended the incident and the deceased was taken to the local station. She did not wish to provide a statement, as she was concerned that the perpetrator would be returned to prison. The police officer, therefore, made an application for an interim apprehended violence order (this is similar to a restraining order and can be sought by the police or the victim of domestic violence to impose restrictions on the behavior of a perpetrator to protect a victim from harm). This order was served on the perpetrator the following morning.

On the day of the homicide, the couple had been drinking and socializing with friends. The perpetrator was very drunk and, following a violent argument with one of his friends, the couple left the group and went home. Shortly after that, the perpetrator sought assistance from a neighbor saying there was something wrong with the deceased. She was subsequently found on the lounge room floor with a single stab wound to the back.

Following a comprehensive review, a number of key issues were identified in this case, including a reluctance by the victim to engage in legal pathways, either by way of seeking police assistance or obtaining an apprehended violence order. Friends and family were aware of the prior violence involving the perpetrator against the deceased but had not taken action to intervene. The vulnerability of the deceased and perpetrator as Indigenous Australians was also identified as a key issue in this case.

Having identified these issues, the review team made recommendations to the New South Wales Police Force regarding support and referral procedures in relation to victims of domestic violence where they are reluctant to engage with police at the scene of a domestic violence incident. The team further recommended to the New South

Wales Police Force that research be commissioned in relation to the use of police-issued apprehended domestic violence orders, particularly for Indigenous victims of domestic violence. The team made this recommendation to obtain a clear understanding of police procedures and uptake of available protections for instances of domestic violence where the victim is reluctant to engage with legal pathways.

Recommendations were made to the New South Wales Government in relation to improving public education around domestic violence, specifically targeting friends and family, and commissioning research into Indigenous women's experiences of domestic violence in New South Wales.

At the time of this writing, several of these recommendations have received in principle agreement from the targeted agencies.

Example Case Review: South Australia

This case involved the homicide of a 45-year-old woman who was shot and killed by her 62-year-old estranged male intimate partner. The offender was then killed in a police siege that same day.

Up until 2 months before the fatal event, the couple had lived together on a remote property in South Australia with the deceased's elderly father. There was a history of domestic violence in the relationship, which was exacerbated by the perpetrator's alcohol abuse. Police had responded to two prior incidents at the couple's premises because of the perpetrator's threatening behavior. On both occasions he was cautioned and removed from the property. The perpetrator had previous convictions for domestic violence offences in relation to two previous intimate relationships.

Approximately 2 months before the homicide, the perpetrator assaulted the deceased with a fire poker in the presence of her father. Police responded and the perpetrator was arrested. He was described as intoxicated and belligerent and refused to answer questions. Approximately an hour and half after his arrest the perpetrator was released on police bail into the custody of a former intimate partner (against whom he had perpetrated domestic violence). His bail conditions prevented him from approaching the deceased or returning to the couple's shared property and a court date was listed for 2 months time. No intervention order was applied for by police (which is similar to a restraining order and can be sought by the police or the victim of domestic violence to impose restrictions on the behavior of a perpetrator to protect a victim from harm).

The police officer who attended the assault call-out conducted a standard domestic violence risk assessment with the deceased. The standard risk assessment form scored the deceased's risk of harm at 97 (with a score of 45 or greater considered high-risk) and accordingly, the report should have been reviewed immediately by a senior police officer. However, the report was not examined until 5 days after the fatal incident when the domestic violence officer reviewed it. Upon reviewing the report, the domestic violence officer made a number of unsuccessful attempts to contact the deceased by telephone over a number of days. Following this the domestic violence officer went on leave and there was no further follow-up.

The day after the assault, the deceased approached the local domestic violence service for support. The perpetrator's previous two partners had attended the same domestic violence service in the past due to his violence. Both had disclosed that he had ready access to a firearm. The service did not have the ability to identify a repeat perpetrator and, as such, could not identify that the perpetrator had previously been identified as owning firearms. The service referred the deceased to a women's housing authority to assist with obtaining safe housing for herself and her father. The deceased's application for housing was approved within a few days, but the keys to the safe property were not provided as the housing officer in the region was on leave. Consequently, the deceased continued to reside at the remote rural property with her father.

After her initial appointment with the domestic violence service, a caseworker from the agency contacted the deceased by telephone for follow-up. During this conversation, the caseworker was concerned that the perpetrator may have been with the deceased as she appeared guarded and hesitant to talk. Following the call, the caseworker made inquiries to another victim support service about the perpetrator's bail conditions. These were confirmed by police to the other support service and relayed to the caseworker. However, no further investigative or protective action took place. This was the last contact the woman had with a formal service provider prior to her death.

On the morning of the homicide the perpetrator left the house where he was residing with his former intimate partner armed with a firearm and attended the deceased's property. He entered the house which was occupied by the deceased and her father and shortly thereafter shot and killed the deceased. The police arrived soon after this, having been contacted by the perpetrator's former intimate partner who was concerned for the welfare of the deceased. A siege ensued between police and the perpetrator during which police fatally wounded the perpetrator.

The case review and coronial investigation revealed clear points of potential intervention, which may have altered the outcome of the events. Specifically, it was identified that there was a lack of co-ordination and case management in relation to high-risk victims in the region. As a result, it was recommended that a structured and co-ordinated service response to domestic violence be implemented. This involved expansion of a multiagency mechanism for managing high and immediate risk of harm in the state, known as the Family Safety Framework. This recommendation was immediately adopted by the relevant agencies and is currently being implemented as a statewide, structural co-ordination mechanism.

The need to strengthen police responses to domestic violence was also identified. Specifically, a more comprehensive investigation of the assault should have occurred. It was recommended that the police commissioner reinforce to all officers their obligations to investigate criminal matters promptly and according to their guidelines, including vigilant firearms checks. Similarly, recommendations were made to domestic violence services and police to establish a register of serial domestic violence perpetrators to enable cross-referencing of agency held information.

The reasons for granting the perpetrator bail were found to be inadequate. As a result, it was recommended that the legislation be amended to preclude bail being granted by any bail authority other than a court in cases of alleged domestic violence;

and that a formal *firearms* test be required at the point of bail. It was recommended that in these cases, the defendant be brought before a Magistrate to answer charges within 48 hr of the arrest. Progress has been made in response to these recommendations, with amendments to the legislation currently under review by the South Australian Attorney General's Department.

Australian Domestic and Family Violence Death Review Network

Although review teams are still in their infancy in Australia, a unique development has been the establishment of the Australian Domestic and Family Violence Death Review Network (hereafter the Network). The Network is a collaboration of all operational domestic violence death review teams in Australia and has been established with a view to facilitating the collection of data and knowledge at a national level. Furthermore, the establishment of the Network aligns with key strategies under the National Plan which recognize that sharing information and outcomes between the states and territories is essential for driving continuous improvement and informing prevention responses to domestic violence (Council of Australian Governments, 2010).

During the early stages of the Network's formation, representatives from review teams in each state communicated regularly to discuss issues connected with the implementation and operation of their team processes. Originating as a relatively informal approach for exchanging ideas, over time it was agreed that establishing a more structured mechanism for the various death review teams to interact would be beneficial.

Terms of reference were formulated and endorsed by the Network members in March 2012. These describe and formalize the Network's purpose, structure, scope, and governance, and include a documented basis for decision making (the Terms of Reference are set out in the 2011-2012 Annual Report of the NSW Domestic Violence Death Review Team; Department of Attorney General and Justice, 2012).

The Network has formulated four overarching goals. In brief, these are to: (a) improve knowledge regarding the context and circumstances in which domestic violence deaths occur; (b) identify practice and system changes that may assist in reducing these types of deaths from occurring in the future; (c) identify at a national level the context of, and risk factors associated with, domestic violence related deaths; and (d) identify, collect, analyze, and report national data on domestic violence related deaths, and align death review findings to programs at a national level.

As of June 30, 2012, the Network comprised representatives of review teams from New South Wales, Queensland, South Australia, and Victoria. Meetings are convened monthly by a rotating State Chair either via teleconference or in-person. These meetings provide an opportunity for discussion and collaboration on common areas of interest among members, and to progress work on joint projects.

In addition, the Network liaises with regional stakeholders to promote the development of a broader knowledge base around the function and contribution of review teams in general.

The Network represents a unique collaboration in death review processes. Not only does it promote the sharing of knowledge and expertise between the Australian domestic violence death review teams, it provides an unprecedented opportunity to collect and collate national domestic violence homicide data and inform future directions in public policy at a national level.

Conclusion

Domestic violence homicide is a serious issue that affects families and communities throughout the world. As a global public health problem, dedicated research attention on the causes and consequences of this form of violence is warranted (World Health Organization, 2010). Domestic violence death review teams seek to quantify incidents, identify risk and contributory factors, and formulate recommendations for local prevention and intervention strategies.

The establishment of domestic violence death review teams in Australia has been guided by the development of death review processes in other jurisdictions. In particular, review teams operating in the United States and Canada have provided an invaluable basis for informing the processes, methodology, and composition of their Australian counterparts.

Australian review teams have made considerable inroads in terms of improving the analysis and availability of information concerning domestic violence homicide in this country. Two states have released publicly available reports that include data analysis and in-depth case reviews. All review teams have contributed to prevention recommendations directed toward both government and nongovernment organizations. These have focused on improving outcomes such as service responses to domestic violence; interagency communication; training and professional development; and community education. Many recommendations made by the teams have been implemented, resulting in practice and policy change.

Whilst acknowledging the achievements that have been made, it is essential that the teams continue to evolve in order to meet the objectives of domestic violence homicide prevention. Despite differences within the methodology and processes of individual review teams, those currently established collaborate via the Network. This represents a new and exciting partnership in death review processes worldwide and one that will promote a better understanding of domestic violence dynamics, and provide a rich and comprehensive understanding of when domestic violence becomes fatal.

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Legislation

Coroners Act 2009 (NSW)

Coroners Act 2003 (Qld)

Coroners Act 2003 (SA)

Coroners Act 2008 (Vic)

Coroners Amendment (Domestic Violence Death Review Team) Act 2010 (NSW)

Domestic and Family Violence Protection Act 2012 (Qld)

Family Law Act 1975 (Cth)

Family Violence Protection Act 2008 (Vic)

Intervention Orders (Prevention of Abuse) Act 2009 (SA)

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