Coroners Court of Victoria

Royal Commission into Family Violence

Response to Issues Paper

Date	26 May 2015
Agency	Coroners Court of Victoria
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Question One: Are there other goals the Royal Commission should consider?

Coroners Court of Victoria's Response to Question One

The Royal Commission could consider the inclusion of a goal relating to reporting suspected or confirmed incidents of family violence to an authority empowered, equipped and required to respond. Specifically for non-emergencies, as 000 already exists to respond to these incidents.

Under-reporting of family violence is recognised and efforts have been expended across the service system to encourage reporting by persons exposed to family violence. Coronial investigations of family violence homicides have also identified that third parties and professionals are often aware of the occurrence of family violence, however for various reasons have not notified any authority. This finding is replicated amongst those exposed to family violence who subsequently die from suicide, with almost 85% of these women having discussed their exposure to violence with either professionals or family and friends. These themes were reported in the Coroners Court of Victoria's (CCOV's) Victorian Systemic Review of Family Violence Deaths (VSRFVD) First Report[1] published in 2012.

Reporting of child abuse by mandated professionals was the subject of a recommendation made to the then Department of Education and Early Childhood Development (DEECD) by the then State Coroner Judge Jennifer Coate[2]. Judge Coate's recommendations are reproduced below and the finding is available on the CCOV's website.

Recommendation 1.

That the Department of Education and Early Childhood Development complete and introduce an ongoing evaluation of its mandatory reporting training provided to teachers, in order to monitor its efficacy in achieving its stated aims.

Recommendation 2.

That the Department of Education and Early Childhood Development ensure that its ongoing professional development obligations to its teachers address the identified barriers to reporting of child abuse.

Recommendation 3.

That the Department of Education and Early Childhood Development (DEECD) accept and implement Recommendation 10 of the Protecting Victoria's Vulnerable Children Inquiry' contained in Chapter 7: Preventing Child Abuse and Neglect. Specifically, the DEECD develop a wide ranging education and information campaign for parents and care-givers of all school aged children on the prevention of child sexual abuse.

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1 Walsh, C., McIntyre, S-J., Brodie, L., Bugeja, L. & Hauge, S. 2012, *Victorian Systemic Review of Family Violence Deaths – First Report*, Coroners Court of Victoria, Melbourne, Victoria.

2 Court Reference Number 20081484.

Third-party reporting of family violence was the subject of some commentary by State Coroner Judge Coate in her October 2011 finding into the death of Lynette Kent[3].

32. The investigation into the circumstances in which Lyn's death occurred revealed that despite a number of people suggesting to her that she seek the assistance of the police in respect to her exposure to family violence, she did not pursue this option. Lyn had stated on several occasions that she thought she could handle Peter and that going to the police would only make things worse for her. The investigation also revealed that Lyn did not make contact with any primary domestic violence crisis service in the state. The investigation did not reveal any evidence that Peter had sought the assistance of any agency or service to assist him.

More recently, third-party reporting of family violence was the subject of a recommendation made to Victoria Police and Crime Stoppers by State Coroner Judge Ian Gray in January 2015. Judge Gray's comments and recommendations are reproduced below and the finding is available on the CCOV's website[4]. The response to Judge Gray's recommendation will be provided upon receipt.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

25. Members of a victim's social network can play a significant role in addressing violence and abuse. Oftentimes, friends, family members and work colleagues are the first to know or suspect that violence is occurring. Their actions, both big and small, can make a meaningful difference toward helping victims increase their safety and address a problematic relationship. In order for this to occur, it is necessary for the community to have a sound understanding about the range of behaviours that comprise family violence, and the options available to assist those at risk. In addition, it is important that messages emphasising that family violence is a crime and not condoned in the community continue to be expressed.

26. In a large number of family violence homicides reviewed as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD), there was evidence that family members, friends, neighbours and/or co-workers were aware or suspected that violence was occurring in the relationship. It has also been identified that these 'third parties' do not feel equipped to assist or are concerned that becoming involved may make the situation more dangerous for the victim or themselves.

27. To address this, various violence prevention initiatives have been implemented, ranging from increased community awareness to legislative provisions such as the Northern Territory's mandatory reporting of domestic violence laws. In Victoria, responses to this issue have also included a community education component, such as the Commonwealth Government's 1800 RESPECT telephone counselling initiative. These initiatives have featured strategies to develop a shared understanding of family violence, promote community resources and services and encourage attitudinal and behavioural change.

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3 Court Reference Number 20095426. Available from: http://www.coronerscourt.vic.gov.au/home/coroners+written+findings/findings+-+524609+lynette+ann+kent

4 Court Reference Number 20102064. Available from: http://www.coronerscourt.vic.gov.au/home/coroners+written+findings/findings+-+206410+nicole+joy+millar

28. *However, the circumstances surrounding Ms Millar's death and many others indicate that families, friends, colleagues and neighbours need an effective mechanism to bring suspected family violence to the attention of an authority empowered and equipped to respond in a timely manner. Noting that Crime Stoppers is a recognised brand and has accountability mechanisms, I consider that it has the potential to fill the gap between public awareness campaigns and emergency services with respect to family violence.*

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation connected with the death:

29. *Crime Stoppers has developed the Say Something campaign, which urges young people who witness acts of violence to be brave and look out for their friends by reporting incidents of violence confidentially. A website and iPhone app are available to help empower young people to report crime easily and online without identifying themselves. I therefore recommend that Victoria Police, together with Crime Stoppers, conduct a trial extending the Say Something campaign to family violence.*

The Royal Commission could also consider an examination of specific aspects of reporting family violence, specifically: parties; requirements; thresholds; mechanisms; entities; and responses.

Reporting parties includes the spectrum of people to whom evidence of family violence may be disclosed, witnessed or suspected. Specifically:

- the person(s) exposed to family violence
- professional persons[5]
- non-professional persons[6]

The other aspect of reporting parties that should be considered is age. Exposure to and information about incidents of family violence is not limited to adults, and reporting of family violence by persons less than 18 years requires additional and specialised consideration.

Reporting requirements have been the topic of much debate in both the areas of policymaking and research. The only evaluation of mandatory reporting requirements for family violence in an Australian setting was unable to draw definitive conclusions about its impact[7]. Given the paucity of evidence on the effectiveness of mandatory reporting requirements, consideration should be limited to voluntary reporting.

Reporting thresholds have been outlined in legislation in both Victoria (mandatory reporting of child abuse) and other Australian jurisdictions (mandatory reporting of domestic violence in the Northern Territory). This is an important consideration as it has implications for response capacity. Drawing from exiting threshold statements in these legislative and other tools may assist to develop clear criteria.

Reporting mechanisms could comprise face-to-face, via telephone or electronic (email or web-based form). Each has strengths and limitations that would have been considered and

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5 This includes health and medical, legal and community welfare professionals.

6 This includes family members, friends, neighbours, work colleagues or others in a person's social network. Also referred to as 'third parties'.

7 KMPG. 2012, 'Evaluation of the impact of mandatory reporting of domestic and family violence.' *Northern Territory Department of Children and Families.*

accounted for in other public and professional reporting processes, which could be drawn from. Key considerations would include: literacy; cultural and linguistic diversity; age; and anonymity.

Ideally the reporting entity should already exist, have the mandate, work force and processes in place to receive, assess and respond to reports of family violence. If some or all of this is not already in place, other public reporting processes such as mandatory reporting of child abuse could be applied.

The final and key aspect is the reporting entity's response to a report of family violence. Again existing investigative processes could be applied or expanded.

Question Two: The Royal Commission wants to hear about the extent to which recent reforms and developments have improved responses to family violence, and where they need to be expanded or altered.

Question Three: Which of the reforms to the family violence system introduced in the last ten years do you consider most effective? Why? How could they be improved?

Coroners Court of Victoria's Response to Questions Two and Three

The focus of coronial investigations of family violence homicide is typically on a single incident or occasionally an issue relevant to two or more incidents. The Coroner is also required to focus on death, although it is acknowledged that family violence can result in a range of adverse health outcomes.

While the factors identified across the Victorian population of family violence homicides are in the process of being systematically recorded for analysis, the focus of the CCOV's research activity has been on optimising the death review process and the presence, nature and contribution of risk factors. Once complete, this will enable greater ability to empirically examine the impact of reforms for the purposes of identifying remaining gaps that may be the subject of future recommendations by Coroners. At the present time, the CCOV's response would not be evidence-based and therefore unable to appropriately inform the recommendations of the Royal Commission.

Question Four: If you or your organisation have been involved in programs, campaigns or initiatives about family violence for the general community, tell us what these involved and how they have been evaluated.

Coroners Court of Victoria's Response to Question Four

Each year in Victoria, approximately 40 per cent of all deaths attributed to homicide occur between parties in an intimate or familial relationship (~25 deaths per year). Many of these deaths occur in the context of family violence and are therefore considered preventable.

The Victorian Systemic Review of Family Violence Deaths (VSRFVD) was established in 2009 to assist with the coronial investigation into these incidents. The VSRFVD conducts in-depth reviews of these complex deaths to contribute to strengthening the response to family violence across the state. The main vehicle for these advances is via Coroners' powers to make recommendations on public health and safety.

The VSRFVD has five main objectives, which are to:

- examine the context in which family violence deaths occur;
- identify risk and contributory factors associated with family violence;

- identify trends or patterns in family violence-related deaths;
- consider current systemic responses to family violence; and
- provide an evidence base for coroners to support the formulation of prevention focussed recommendations aimed at reducing non-fatal and fatal forms of family violence.

The VSRFVD does not further the criminal investigation into the death, nor does it seek to attribute blame to any action or inaction on the part of individuals that may have been connected to the death. Rather, the VSRFVD seeks to improve the understanding of the human and systemic factors specific to a death to identify opportunities to improve systems, policies and service responses for both victims and perpetrators of family violence. In doing this, the following principles are adopted:

- the VSRFVD is conducted in an objective and impartial manner;
- the VSRFVD is undertaken in a considerate and sensitive way that respects the lives lost due to family violence; and
- efforts are expended to engage with stakeholders, experts and the wider community for the purpose of informing the VSRFVD and connecting it to relevant family violence initiatives in Victoria.

The scope of the VSRFVD is limited to reportable deaths as defined by the *Coroners Act 2008 (Vic)* where:

- the death resulted from the actions or inactions of another person
- the deceased and the offender were or had previously been:
    - in an intimate or familial relationship as defined by the *Family Violence Protection Act 2008 (Vic)* or
    - family like relationship, in particular kinship relationship as defined by the Victorian Indigenous Family Violence Taskforce (2003) (Note: these are referred to as **family homicides**)
- the death occurred in the context of family violence as defined by the *Family Violence Protection Act 2008 (Vic)* (Note: these are referred to as **family violence homicides**).

Deaths that meet the above criteria are subject to a specialist review and further investigation, which culminates in the provision of advice to the Coroner on:

- the inclusion criteria for the VSRFVD.
- the relevant historical facts.
- summary of the circumstance of the deaths.
- outcome of the forensic medical and scientific investigation.
- review of presence of risk factors (individual, relationship etc.).
- examination of contact with the service system (justice, health, community, child protection etc.).
- opportunities for prevention intervention.

Expert advice and consultative support is provided to the VSRFVD by a Reference Group. The VSRFVD Reference Group assists in the identification of system wide issues pertaining to family violence, as well as advising on policy and program developments occurring at a local, state and national level. The wealth of collective knowledge and experience held within the

Reference Group is a significant resource to the VSRFVD. The VSRFVD Reference Group meets face-to-face annually, however ad hoc consultations with individual or groups of members is also undertaken as required.

The Reference Group is comprised of members from both government and non-government organisations, including: Koori family violence services; legal services; police; the Magistrates' Court; culturally and linguistically diverse services; disability, health and welfare organisations; academics and policy analysts.

Provided there is no conflict of interest, the VSRFVD works closely with Victoria Police throughout all stages of the coronial investigation, particularly their coronial, family violence and homicide specialists. This specialist advice contributes to Coroners decisions about an inquest, their findings, comments and recommendations. This process enhances our understanding of the distribution and determinants of family violence deaths and contributes to the formulation of evidence-based and feasible recommendations.

A program and impact evaluation of the VSRFVD in meeting its objectives and contributing to the prevention of family violence to date has not been conducted.

The CCOV has also recently examined the presence and contribution of family violence amongst persons who died from suicide using the Victoria Suicide Register (VSR)[8]. The results show that about a quarter of the 550 suicide deaths annually from 2009-12 were women; almost 35% had a reported history of family violence, that is around 50 deaths a year[9]. In addition, a large number of men who died from suicide in Victoria over the same period had a history of family violence. Men were more likely to be perpetrators of violence, a history of which was present in approximately 110 deaths annually. Research into the factors associated with these suicides is continuing, but there is a clear opportunity for primary prevention of deaths related to family violence. A better understanding of the precipitants of violent behaviour and investigating solutions and better access to appropriate services might mitigate this risk. This is an opportunity to prevent both the suicides and homicides associated with family violence, potentially representing over 150 Victorian lives saved annually.

A systematic literature review of interpersonal violence (incorporating family violence) as a contributor to suicide is underway by the CCOV. Ongoing research support would allow the CCOV to better utilise the potential for the VSR to contribute to a reduction in deaths related to family violence.

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[8] The Victorian Suicide Register (VSR) is an initiative of the Coroners Court of Victoria which contains coded and free text information on suspected suicides in Victoria. The VSR comprises 161 data fields across 13 screens on information such as: socio-demographic characteristics; location information; presence and nature of physical and mental illness; situational and interpersonal stressors; service contact; evidence of intent; forensic toxicological results; suicide method. Case identification and population of a minimum set of data fields has been completed for the period 2000 to present. Coding is complete for the full data set for the period 2009-2012 and 2013 is currently underway.

[9] MacIsaac M et al. *The contribution of interpersonal violence to death from suicide amongst Victorian women: a systematic review.* Unpublished manuscript.

Question Five: If you or your organisation have been involved in observing or assessing programs, campaigns or initiatives of this kind, we are interested in your conclusions about their effectiveness in reducing and preventing family violence.

Coroners Court of Victoria's Response to Question Five

For all family homicides, the CCOV seeks to identify whether the parties involved had contact with any service, particularly in the twelve months proximate to death. If identified, the adequacy of the service provision is assessed against policy / guidelines in place at the time. Information is also sought about what, if any, changes to the service or the policy / guidelines have been made since the death occurred. Such an examination rarely involves specific programs, campaigns or initiatives and therefore the CCOV does not have evidence of value to the Royal Commission on this question.

Question Six: What circumstances, conditions, situations or events, within relationships, families, institutions and whole communities, are associated with the occurrence or persistence of family violence?

Coroners Court of Victoria's Response to Question Six

There is a body of scientific research that has examined individual, environmental and systemic factors that increase the risk of violence occurring between persons in an intimate or familial relationship. There are a number of methodological problems within this body of research, which present difficulties in synthesising the findings and in turn their application to the Australian / Victorian setting. These include: variations in the definitions of violence; inclusion of relationships; populations examined; availability of data; sample sizes; use of comparison groups; and measures of association.

Definitions of the behaviours that constitute family violence and the relationships considered intimate or familial vary considerably across the literature. This makes it difficult to compare the results of studies over time and across jurisdictions. The nature of traditional research outputs often does not afford researchers the space for detailed definitions. To overcome this, the World Health Organization's (WHO's) definitions of violence and relationships could be adopted or used as a basis to develop internationally agreed definitions of these two important measures.

Despite these limitations, common co-occurring factors have been identified and found to be present and contributory during coronial investigations of family homicides in Victoria and other Australian States and Territories. These include: a history of family violence; relationship separation; threats of harm; alcohol misuse; and the presence of a mental illness. In addition, factors associated with the increased vulnerability of victims, such as having a disability or cultural and linguistic diversity has also been observed. A comprehensive list of factors specific to offenders, victims, children and intimate partners is contained in South Australia's Family Safety Framework's Domestic Violence Risk Assessment Form[10].

In addition to these individual and relationship factors, other factors that contribute to the occurrence and persistence of family violence include: barriers for victims disclosing family violence; a lack of community understanding and recognition of family violence; and sub-optimal interaction with the health and justice system.

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[10] http://officeforwomen.sa.gov.au/womens-policy/womens-safety/family-safety-framework

Question Seven: What circumstances and conditions are associated with the reduced occurrence of family violence?

Coroners Court of Victoria's Response to Question Seven

As per the CCOV's response to question six, there is some scientific research that has examined protective factors that decrease the risk of violence occurring between persons in an intimate or familial relationship. The applicability of interventions that have been evaluated and shown to be effective could be considered for implementation in the Australian setting.

In the future, the CCOV may be in a position to contribute to the formulation and / or evaluation of family violence interventions using the detailed information contained in the coronial record. It is widely acknowledged that coronial information is one of the richest sources of data available to examine public health problems. The Coroners Prevention Unit (CPU)[11] has developed a sophisticated surveillance system for recording all deaths reported to the CCOV and classifying the cause and manner of death in accordance with internationally agreed mortality classification systems at multiple stages of the investigation. For some types of death, such as suicide[12], the CPU has been funded from external sources to enhance these surveillance systems to also record information on the presence, nature, contribution and source of information on risk factors. The CPU routinely performs analyses (both quantitative and qualitative) using data from these surveillance systems and, in combination with a policy analysis and stakeholder consultation, provides advice to Coroners on prevention-focussed recommendations. On occasion, this method has been applied to assist other prevention-focused inquires[13].

Given that the necessary focus of the CCOV's family violence resources has been on assisting the Coroner with their investigation, the development of an enhanced surveillance system for family violence homicide has not progressed to the same extent as the VSR. At present the information gathering is complete for: the identification of suspected family violence homicide incidents; the parties involved and their relationship; and socio-demographic characteristics of the parties involved. This allows for the generation of basic descriptive statistics on the frequency and nature of family homicide in Victoria. Significant work remains to complete the extraction of information about the known and emerging risk factors recorded in the coronial record and determined by the criminal and / or coronial investigations to have contributed to the death. This intelligence and linkages with other sources of data across the health, legal, community welfare and specialist family violence services is crucial to developing evidence-based and feasible interventions applicable to the Victorian setting.

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[11] The Coroners Prevention Unit comprises a multi-disciplinary team of investigators that support coroners to fulfil their prevention mandate. The CPU assists coroners to identify opportunities for and strengthen public health and safety via the formulation of evidence-based and feasible recommendations.

[12] The Victorian Suicide Register (VSR) is an initiative of the Coroners Court of Victoria which contains coded and free text information on suspected suicides in Victoria. The VSR comprises 161 data fields across 13 screens on information such as: socio-demographic characteristics; location information; presence and nature of physical and mental illness; situational and interpersonal stressors; service contact; evidence of intent; forensic toxicological results; suicide method. Case identification and population of a minimum set of data fields has been completed for the period 2000 to present. Coding is complete for the full data set for the period 2009-2012 and 2013 is currently underway.

[13] See Volume 2, Appendix 10 (pp787-799) in Parliament Victoria. 2014. Inquiry into the supply and use of methamphetamine in Victoria. Law Reform, Drugs and Crime Prevention Committee.

Question Eight: Tell us about any gaps or deficiencies in current responses to family violence, including legal responses. Tell us about what improvements you would make to overcome these gaps and deficiencies, or otherwise improve current responses.

Coroners Court of Victoria's Response to Question Eight

One of the main objectives of the CCOV's VSRFVD is to identify common elements among family violence homicides, which includes the identification of areas of system deficiency. Key themes identified during coronial investigations on the issue of responses to family violence were reported in the CCOV's Victorian Systemic Review of Family Violence Deaths First Report[14]. This information is summarised below.

Barriers to disclosing family violence

Evidence provided to the CCOV for the investigation of family violence homicides has shown that persons exposed to family violence have denied or minimised their exposure when questioned by family, friends and service providers. It appeared that victims held a range of concerns that prevented a full disclosure being made. This included factors connected to their cultural background which made it difficult to speak openly about abuse occurring at home. Concerns were also expressed about the possibility of exacerbating the situation or uncertainty as to how services would respond appeared to be most salient. In these situations, the difficulty victims' faced in discussing their exposure to violence had the effect of curtailing intervention efforts, including not holding the perpetrator accountable for their behaviour.

A number of incidents involved the deceased or offender having had contact with a range of service providers within a six month period prior to the fatal event. This indicates that system contact with those most at risk does occur, although barriers may remain in connection to the identification, disclosure and reporting of family violence in these settings.

Key providers have made considerable progress utilising standardised risk assessment tools to identify and assess violence. This includes measures in place among organisations most likely to have contact with victims at high risk times. There appears to be a need for this work to be extended to and co-ordinated across other contact points within the service system, particularly across a range of health care settings.

Community understanding and recognition of family violence

In a number of deaths, there was evidence that third parties (such as friends, family members or neighbours) held important information about the victim's exposure to family violence and/or sexual assault. This had come about through direct observation; disclosures made by the victim; overhearing threats made by the perpetrator; or witnessing the victim with significant injuries shortly before their death. These included incidents where perpetrators made clear threats to others regarding their intentions to harm the victim and an incident where a friend of the victim had observed them to be seriously injured and in the presence of the perpetrator just hours before they died.

A number of individuals known to the victim appeared to have wanted to offer further assistance and support, but did not due to a range of reasons. These included fear of the perpetrator; lack of recognition of the signs of escalating violence; lack of awareness as to the range of legal and community services that could provide assistance; a reluctance to get involved in family disputes; and hesitation about contacting police or other services. Witness

14 Walsh, C., McIntyre, S-J., Brodie, L., Bugeja, L. & Hauge, S. 2012, Victorian Systemic Review of Family Violence Deaths – First Report, Coroners Court of Victoria, Melbourne, Victoria.

statements also revealed that individuals were not always clear about the range of behaviours that comprised family violence, particularly in connection to non-physical forms of abuse (e.g. emotional abuse, financial abuse, coercion / control of movements or liberty).

There appears to be a continuing need to increase community awareness about the nature and dynamics of family violence, with the intention that those who come into contact with both victims and perpetrators are better able to recognise and respond to this continuum of behaviours. Consideration could be given to promoting the 'safe actions' community members can take in order to assist a victim exposed to violence. This might include increased awareness/availability of helpline services for advice, education around safely initiating conversations with victims; increasing the visibility of family violence and related community support services; and most importantly, highlighting the role of police in respect to both proactive and crisis responses.

Contact with health services

Persons exposed to violence are likely to present in a range of health care settings, including general practice, community health centres, hospital emergency departments and private clinical practices. While an immediate disclosure regarding exposure to violence may not always be made, if correctly identified, interventions to improve health outcomes and increase safety can be introduced[15]. To this end, it is generally agreed that the key elements for providing effective assistance to victims within health care settings involve: violence identification, risk assessment, validation, patient education, information about resources and options, safety planning, documentation and follow-up[16].

Among the deaths investigated by the CCOV involving intimate partner violence, contact with a health care practitioner was often identified. Although ending with a fatality, pro-active approaches to providing assistance for some victims were identified. For example, in one situation, the victim of family violence attended a hospital emergency department to seek treatment for her injuries following a physical assault by her male partner. On this occasion her facial injuries were correctly attributed to partner violence, and the attending medical officer discussed the serious nature of her situation. Further, the strong possibility of her ongoing exposure to violence was raised and a basic safety plan implemented. Plans for her to spend the night away from her partner were also discussed, and referral information was given. This was a positive example of an appropriate response provided to a victim in a hospital setting.

Coronial investigations have also revealed various examples in which the family violence support given to victims in health care settings could have been improved. Issues that have been identified included: a lack of recognition of victim exposure to violence; a limited understanding of the nature and dynamics of violence; limited awareness of the risk and contributory factors associated with this problem; a lack of follow-up once family violence had been disclosed; and a lack of ongoing support and/or referral to specialist services.

Consideration of these incidents indicates that opportunities to strengthen the response to family violence in health care settings exist. Areas that might be considered include: increased education for health care providers about the nature and dynamics of family violence; education about risk indicators and markers of intimate partner abuse (including awareness of high risk times for escalating violence such as separation and the ante/post-natal period); greater promotion of referral information regarding family violence services

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15 Campbell, J.C. 2002, 'Health consequences of intimate partner violence,' *Lancet*, vol. 359, pp. 1331 – 1336.

16 Falsetti, S. 2007, 'Screening and responding to family and intimate partner violence in the primary care setting,' *Primary Care: Clinics in Office Practice,* vol. 34, no. 3, pp. 641 – 657.

and community organisations; and greater promotion of key publications currently available to assist primary health care providers in this area.

Contact with the justice system

The justice system is a cornerstone in the response to family violence, with police, legal services, corrections and the courts playing a pivotal role for increasing victim safety and ensuring perpetrator accountability. In addition, the justice system contributes to the prevention of violence through a range of strategies to halt emerging violent behaviours and address the attitudes that support them. For this reason, the justice system has been a site of considerable reform over the past decade.

As might be expected, the coronial investigations of family violence homicide have revealed that many parties involved in fatal family violence incidents had previous contact with the justice system. Many had contact with the police, courts and / or community corrections within six months of the fatal event. In addition, in some incidents, the perpetrator of family violence had a current family violence intervention order against them at the time of the fatal event. There was evidence of perpetrators breaching the conditions of the order in close proximity to orders having been made, as well as further violence occurring that was not reported to police. While family violence intervention orders are an integral part to improving victim safety, for a proportion of cases, it is evident that an intervention order does not result in an end to violence. As demonstrated here, this can be to the extent that a fatal outcome occurs.

Police play a crucial role in providing both immediate intervention and long-term protection to victims of family violence. Coronial investigations have revealed several positive examples in this area. There have been situations in which police recognised the nature and dynamics of family violence; provided an immediate response; pursued both civil and criminal options for dealing with the perpetrators; ensured follow up contact and support was provided to victims; and made referrals to both specialist family violence and sexual assault services.

Despite this, the police response to family violence is an area that has received attention in some investigations. These have highlighted the importance of members adhering to procedural expectations set by the organisation; the importance of maintaining effective communication channels with other key organisations; and the sources during the initial stages of any investigation. These areas were reflected in the coroners' recommendations for the associated investigations.

Not all victims of family violence seek intervention through the courts. However, when contact does occur, the approach to victim safety and perpetrator accountability needs to be consistent and reliable. Many parties involved in family violence homicides had contact with the courts in the months preceding a fatal incident. In one case, information presented at the coronial inquest revealed demand pressures experienced by the Magistrates' Court, and the implications this has for service delivery, were issues relevant to victim's safety[17]. Further, it was noted that while additional support services designed to assist victims and perpetrators of family violence are available in some court locations, these are not universally available. Regional variations of this kind have the potential to create imbalances across the legal system in its response to family violence and inconsistencies for victims seeking justice and protection.

Prior contact with various justice agencies is frequently identified in fatal family violence incidents. What has been emphasised in the scientific research literature is the need for

[17] Court Reference Number 20080359.

continued efforts to ensure that a coordinated and integrated response takes place across police, the courts and corrections.

The role of health and legal services in the identification of and response to family violence was the subject of a comment in State Coroner Judge Gray's finding in to the death of MF[18].

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

35. *Given the frequency with which members of Victoria Police encounter family violence in the course of their duties, there is a need for the organisation to continually consider approaches and ways for effectively responding to this issue. The introduction of the approach described above appears to be one such example, and it would be of great benefit to determine the impact of this approach on reducing family violence via a formal program evaluation in due course.*

36. *Similarly general practice is a setting where persons experiencing physical and mental health treatment for injuries and illnesses resulting from family violence and where disclosures about exposure to family violence are frequently made. These and other health services serve as an important pathway for referral to specialist family violence support services. It is vital that general practitioners are equipped to identify symptoms of family violence, assess risk, provide advice about referrals to specialist services and in what circumstances legal intervention is required. Clinical guidelines addressing these issues has been available via the Royal Australian College of General Practitioners since 2008 and is now in it's third edition. While this work is acknowledged ongoing efforts are required to strengthen the identification and response to family violence within the health care sector.*

Lack of evidence about deaths from suicide related to family violence

Most research informing our responses to family violence has focused on victims. It is now emerging that a significant number of deaths from suicide amongst Victorian men have a history of perpetrating family violence. However, the relationship and mediating factors between these two events is not well understood. Better understanding this phenomenon, through targeted research will allow the development of appropriately focused support services and access to assistance for men in this situation. This primary prevention opportunity has been neglected in past research.

The VSR can generate crucial intelligence that can inform the identification of evidence-based prevention opportunities. It contains rich data on all Victorian suicides from 2009-12, including detailed information on family violence. The VSR is necessary for ensuring there is a better understanding of this phenomenon. It would help to overcome the current deficiencies in primary prevention of deaths related to family violence through provision of support to men at risk of using violence. The current funding for the VSR expires in October 2015.

[18] Court Reference Number 20094238.

Question Nine: Does insufficient integration and co-ordination between the various bodies who come into contact with people affected by family violence hinder the assessment of risk, or the effectiveness of (early intervention, crisis and ongoing) support provided, to people affected by family violence? If so, please provide examples.

Question Ten: What practical changes might improve integration and co-ordination? What barriers to integration and co-ordination exist?

Coroners Court of Victoria's Responses to Questions Nine and Ten

Communication between agencies has been identified in a number of family violence homicides, particularly within legal services and between legal and health services. This was particularly relevant to the death of Selina Tilley[19], which State Coroner Judge Coate made some comments about in her finding.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment(s) connected to the death of Selina Tilley:

Variation and revocation of intervention orders involving Victoria Police

1. *The material examined as part of this coronial investigation indicates that the Victoria Police member who was the original complainant to the intervention order made on 16 February 2007 did not receive notification of the application to vary the order, which subsequently occurred on 28 September 2007. Information contained in Ms Tilley's court file indicates that a fax was sent requesting she be advised, however, the reason this did not reach her is not clear. While it may not have altered the outcome of Ms Tilley's death, it is important that this oversight be documented, and for both the Magistrates' Court and Victoria Police to be diligent in ensuring adherence to the process regarding the requirements that police complainants be informed in circumstances such as these.*

Communication between organisations

2. *Ms Tilley was in contact with numerous service providers in the months preceding her death. To this end, important information was held by these organisations concerning the level of risk she faced and the likelihood of further violence occurring. Based on the information available during this investigation, it does not appear that communication between the' respective organisations took place, nor were they aware of the extent of each service's involvement with Ms Tilley. As a result, information about her situation and exposure to family violence was not accurately assessed or shared: Communication could have occurred with Ms Tilley's consent, and there is no evidence to indicate she would have objected to this. Alternatively, the Information Privacy Act 2000 (Vic) allows for disclosure of primary purpose information, particularly in situations where there are imminent and serious concerns for the life, health, safety or welfare of an individual. Had such communication transpired, a more co-ordinated approach to the provision of services might have been introduced to help improve her safety.*

This issue of integration and co-ordination is also currently the subject of an active coronial investigation by the State Coroner. The finding will be available and provided to the Royal Commission later in 2015. In the meantime, the Royal Commission could consider assessing

[19] Court Reference Number: 20084850.

the feasibility of the introduction of information sharing protocols in Victoria. The experiences of South Australia[20], New South Wales and the Northern Territory could be sought to assist with the consideration of this process. This may overcome the issue of confidentially / privacy considerations as a barrier to information sharing about persons at risk of harm.

Question Eleven: What are some of the most promising and successful ways of supporting the ongoing safety and wellbeing of people affected by violence? Are there gaps or deficiencies in our approach to supporting ongoing safety and wellbeing? How could measures to reduce the impact of family violence be improved?

Coroners Court of Victoria's Responses to Question Eleven

The most successful way of supporting the ongoing safety of people affected by family violence is to eliminate their risk of exposure. A deficiency in the current approach is that the underlying determinants of using violence have not been identified and / or translated into public health policy or violence prevention programs. Consideration should be given to addressing this intelligence gap and / or translating this into the policy framework as a priority equivalent to that of supporting victims.

While it is possible the benefits of this approach may not be realised for at best a generation, this investment in primary prevention may be what is required to achieve the desired reductions in the incidence of family violence in the future. It is also likely that reductions in adverse health outcomes in other areas of public health will be observed given the links between violence, mental illness, substance misuse and premature death.

Parallel to this, there is also a need to prioritise the identification of and responses to persons who already use violence. It is acknowledged that policy and programs already exist to hold people who use violence accountable and assist them to change their behaviour. In addition to these some form of therapeutic custody could be explored.

Question Twelve: If you, your partner or a relative have participated in a behaviour change program, tell us about the program and whether you found it effective. What aspects of the program worked best? Do you have criticisms of the program and ideas about how it should be improved?

Coroners Court of Victoria's Response to Question Twelve

This question is not relevant to the CCOV.

Question Thirteen: If you, your partner or a relative have been violent and changed their behaviour, tell us about what motivated that change. Was a particular relationship, program, process or experience (or combination of these) a key part of the change? What did you learn about what caused the violent behaviour?

Coroners Court of Victoria's Response to Question Thirteen

This question is not relevant to the CCOV.

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[20] OmbudsmanSA. 2013. Information Sharing Guidelines for promoting safety and wellbeing. Adelaide.

Question Fourteen: To what extent do current processes encourage and support people to be accountable and change their behaviour? To what extent do they fail to do so? How do we ensure that behaviour change is lasting and sustainable?

Coroners Court of Victoria's Response to Question Fourteen

This issue is currently the subject of an active coronial investigation by the State Coroner. The finding will be available and provided to the Royal Commission later in 2015[21].

Question Fifteen: If you or your organisation have offered a behaviour change program, tell us about the program, including any evaluation of its effectiveness which has been conducted.

Coroners Court of Victoria's Response to Question Fifteen

The CCOV does not offer a behaviour change program and has no information to assist the Royal Commission.

Question Sixteen: If you or your organisation have been involved in observing or assessing approaches to behaviour change, tell us about any Australian or international research which may assist the Royal Commission. In particular, what does research indicate about the relative effectiveness of early intervention in producing positive outcomes?

Coroners Court of Victoria's Response to Question Sixteen

As per response to question five.

Question Seventeen: Are there specific cultural, social, economic, geographical or other factors in particular groups and communities in Victoria which tend to make family violence more likely to occur, or to exacerbate its effects? If so, what are they?

Question Eighteen: What barriers prevent people in particular groups and communities in Victoria from engaging with or benefiting from family violence services? How can the family violence system be improved to reflect the diversity of people's experiences?

Question Nineteen: How can responses to family violence in these groups and communities be improved? What approaches have been shown to be most effective?

Coroners Court of Victoria's Response to Questions Seventeen, Eighteen and Nineteen

This issue is currently the subject of a number of active coronial investigations by the CCOV[22]. The findings will be available and provided to the Royal Commission later in 2015.

However, the intersection between cultural and linguistic diversity (CALD) and family violence has been examined previously by the CCOV. Family violence exists within, and is influenced by, religious, ethnic and cultural contexts. While it is important to avoid generalisations and stereotypes, cultural values and beliefs can have implications for the

21 Court Reference Number 20104416.

22 Court Reference Numbers: 20092344; 20100463; 20120131; 20121543-1545; 20124184.

way in which violence is experienced[23]. Further, CALD victims may also encounter greater difficulty eliciting assistance and support from mainstream service providers[24]. There are many reasons for this, including: discrimination and marginalisation; a lack of awareness about legal rights and protections; fear of jeopardising immigration status; concern about bringing dishonour to the family; fear of authority figures such as police and courts; as well as communication or language barriers[25].

A broad range of cultural groups have been represented among the fatal incidents investigated by the CCOV, and cultural and linguistic diversity has been a particularly salient feature. Here, cultural and language barriers; traditional views of marriage; social isolation and a reluctance to speak out about abuse due to the negative perceptions of others were identified as relevant factors that shaped the victims experience of violence. By way of example is Judge Gray's recent comments made in his finding into the death of Ms Marzieh Rahimi[26].

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment(s) connected with the death:

30. *With respect to Ms Rahimi's inability to make contact with police when she telephoned 000 on 1 November 2007, I reiterate the concerns raised by Her Honour Justice King and note that, currently, the 000 emergency call service does not have the facilities to translate different languages at the point of answer. If a caller to 000 is unable to speak English, their call is transferred to the capital city police in the state they are calling from, and an interpreter will then be arranged. In Ms Rahimi's case, it appears that she ended the call before this could occur.*

31. *It is also apparent that when Ms Rahimi reported the incident and nonattendance of police to Ms MacKinnon and Ms Suresh on 1 November 2007, no further action was taken in relation to the violence and threats that morning. Ms MacKinnon referred Ms Rahimi to Ms Suresh, and Ms Suresh advised her to telephone 000 if there was any further violence. Had Ms Rahimi made contact with police and reported the violence, she might have been able to take steps to maintain a safe environment for herself and her children.*

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23 Bartels, L. 2010, Emerging issues in domestic/family violence research, Research in Practice Report, No.10, Australian Institute of Criminology, Canberra, ACT.; Fawcett, J., Starr, K. & Patel, A. 2008, Now that we know: Findings from the Washington State Domestic Violence Fatality Review, Washington State Coalition Against Domestic Violence, Washington.; Bonar, M. & Roberts, D. 2006, A review of the literature relating to family and domestic violence in culturally and linguistically diverse communities in Australia, Department of Community Development, Family and Domestic Violence Unit, Western Australian Government, WA.

24 Garcia, L., Soria, C., & Hurwitz, E.L. 2007, 'Homicides and intimate partner violence : A literature review,' Trauma, Violence and Abuse, vol. 8., no. 4., pp. 370 – 383.

25 Bonar, M. & Roberts, D. 2006, A review of the literature relating to family and domestic violence in culturally and linguistically diverse communities in Australia, Department of Community Development, Family and Domestic Violence Unit, Western Australian Government, WA.

26 Court Reference Number: 20074719.

The CCOV's VSRFVD First Report also identified responsiveness to vulnerable groups as one of three focus areas for prevention, noted as follows on page 47**.**

Improved responsiveness to vulnerable groups

Many of the deaths examined in detail revealed the presence of factors that created challenges for engagement with mainstream or specialist services. These included known vulnerability indicators among both victims and perpetrators, such as belonging to a CALD community; the presence of a disability or a mental health condition; and problems with the use of alcohol and other drugs. In some instances, these factors appeared to inhibit service contact altogether, while in others, they prevented a complete picture of the underlying family violence dynamics from being obtained by the service providers. As a result, the potential for severe or fatal violence was often not identified by agencies and organisations involved with either the victim or perpetrator. A further compounding factor in these situations was the relative social isolation and/or lack of community integration among the parties involved. This meant there were fewer opportunities for informal monitoring or assistance to occur, which had the effect of exacerbating risk.

The additional needs and complex presentations among many victims and perpetrators of family violence are widely understood as challenges for the service system. The multiplicity of issues represented here across a range of incident types means that no single prevention strategy is likely to prove effective in this area. However, it reflects the need for both mainstream and specialist services to give adequate weight to the contributions of vulnerability factors (i.e. CALD background, disability, mental health issue or substance dependence) when assessing risk, undertaking safety planning or formulating intervention strategies.

Question Twenty: Are there any other suggestions you would like to make to improve policies, programs and services which currently seek to carry out the goals set out above?

Coroners Court of Victoria's Response to Question Twenty

The CCOV has a number of active coronial investigations nearing completion that may contain recommendations to improve family violence prevention. These findings will be provided to the Royal Commission upon completion.

Question Twenty-one: The Royal Commission will be considering both short term and longer term responses to family violence. Tell us about the changes which you think could produce the greatest impact in the short and longer term.

Coroners Court of Victoria's Response to Question Twenty-One

This submission has provided suggestions on a number of areas of improvement for consideration by the Royal Commission. In addition, the CCOV has a number of family violence homicide investigations underway, which may include additional recommendations. These will be provided to the Royal Commission as they are completed.

However, there two areas the CCOV would like to propose recommendations for consideration.

<u>Identification of and Improvements to Information Gathering and Sharing</u>:

Recommendation 1: Assisting persons exposed to family violence (as perpetrators and / or victims) relies on detection by appropriately skilled professionals with a mandate to respond. In conducting in-depth reviews of service contacts amongst persons involved in family violence homicides, the CCOV has identified family violence-related contacts with a number

of government and non-government entities across the legal, health and community setting. In many instances important information about the occurrence of family violence was not sought and / or shared between these entities. Had the pattern and nature of contacts amongst both parties to the homicide been available to all services involved, the level and nature of risk may have been assessed differently and points of intervention may have been more clearly identified, which may have changed the outcome. While it is acknowledged that improvements to information sharing is warranted, prior to any amendments it is important to identify the entities that capture information about family violence. It could therefore be considered that a project is conducted to:

a. identify the services that potentially record information about a persons use of and / or exposure to family violence; and

b. document:

    i. the nature of the information collected;

    ii. how the information is stored (e.g. paper-based or electronic);

    iii. policies in place that mandate information sharing;

    iv. policies in place that facilitate information sharing; and

    v. policies in place that prohibit information sharing.

This environmental scan of services that collect information about family violence may assist in the development of systems or protocols to improve end-to-end information sharing. In addition it may be possible to develop a mechanism to accumulate information about an individual's exposure to family violence to facilitate early intervention.

Prioritisation of and Sustained Focus on Primary Prevention of Family Violence:

As discussed in the CCOV's response to Question 11, eliminating family violence requires some additional understanding of the determinants of why people use violence. Specifically, the public health approach should be applied to:

- advance our understanding of the determinants of the use of violence;
- develop an evidence-based approach to responding to persons identified as at risk of violence and already using violence;
- prioritise primary prevention strategies to respond to persons identified as at risk of using violence;
- prioritise prevention strategies to respond to persons who already use violence; and
- evaluate the impact of strategies on measurable harms associated with family violence, for example deaths from homicide and suicide.

A large volume of information is generated for the Coroners' investigation into unnatural deaths, particularly deaths from homicide and suicide. In addition, a key purpose of the CCOV is to contribute to public health and safety, which is realised through their powers to make recommendations to public statutory authorities and entities (which must be responded to and made publicly available). The Coroners Prevention Unit (CPU) supports Coroners in their prevention role and comprises a multi-disciplinary team of staff trained in the areas of: medicine, nursing and health sciences (including mental health); law; science; the social sciences and research. To assist Coroners with their investigations, the CPU draws on a range of material to apply to the circumstances of the death under investigation. This includes: the scientific and grey literature; legislation, regulations, policies, codes or practice, clinical guidelines or procedures; and consultation with content area experts and

policymakers. In addition, the CPU has developed detailed surveillance systems to record standardised information in the areas of: suicide (the Victorian Suicide Register); drugs; and homicide (the Victorian Homicide Register). These surveillance systems allow for real time identification of suspected deaths, socio-demographic information, identified contributing factors and recommendations.

While these tools are primarily used to assist Coroners, there is the potential for this information and expertise to be used for the purposes of research. It could therefore be recommended that an additional resource be provided to the CCOV to expand the terms of reference of the Victorian Systemic Review of Family Violence Deaths to lead a program of collaborative prevention-orientated research. In the long term, a fuller understanding of the determinants of violent behaviour in families and its association with suicide and homicide, through a coordinated research program on the detailed data in the VSR and VHR, has the potential to prevent a large number of family violence deaths in Australia.