Submission

THIS SUBMISSION WAS PREPARED BY THE FEDERATION OF COMMUNITY LEGAL CENTRES (VICTORIA) INC, IN CONSULTATION WITH MEMBER CENTRES

Federation of Community Legal Centres submission to the

Royal Commission into Family Violence

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About the Federation of Community Legal Centres (Victoria) Inc

The Federation is the peak body for 50 community legal centres across Victoria. A full list of our members is available at http://www.communitylaw.org.au .

The Federation leads and supports community legal centres to pursue social equity and to challenge injustice.

The Federation:

- provides information and referrals to people seeking legal assistance
- initiates and resources law reform to develop a fairer legal system that better responds to the needs of the disadvantaged
- works to build a stronger and more effective community legal sector
- provides services and support to community legal centres
- represents community legal centres with stakeholders

The Federation assists its diverse membership to collaborate for justice. Workers and volunteers throughout Victoria come together through working groups and other networks to exchange ideas and develop strategies to improve the effectiveness of their work.

About community legal centres

Community legal centres are independent community organisations which provide free legal services to the public. Community legal centres provide free legal advice, information and representation to more than 100,000 Victorians each year.

Generalist community legal centres provide services on a range of legal issues to people in their local geographic area. There are generalist community legal centres in metropolitan Melbourne and in rural and regional Victoria.

Specialist community legal centres focus on groups of people with particular needs or specific areas of law (eg mental health, disability, consumer law, environment etc).

Community legal centres receive funds and resources from a variety of sources including state, federal and local government, philanthropic foundations, pro bono contributions and donations. Centres also harness the energy and expertise of hundreds of volunteers across Victoria.

Community legal centres provide effective and creative solutions to legal problems based on their experience within their community. It is our community relationship that distinguishes us from other legal providers and enables us to respond effectively to the needs of our communities as they arise and change.

Community legal centres integrate assistance for individual clients with community legal education, community development and law reform projects that are based on client need and that are preventative in outcome.

Community legal centres are committed to collaboration with government, legal aid, the private legal profession and community partners to ensure the best outcomes for our clients and the justice system in Australia.

Contents

List of Abbreviations

AOD	Alcohol and other drugs
AFM	Affected family member
CALD	Culturally and linguistically diverse
CBO	Community-based order
CLC	Community legal centre
COAG	Council of Australian Government
CPU	Coroners Prevention Unit
CRAF	Common Risk Assessment Framework
DHS	Department of Human Services
ECLC	Eastern Community Legal Centre
FVCD	Family Violence Court Division
FVIP	Family Violence Integration Project
FVLO	Family Violence Liaison Officer
FVPA	*Family Violence Protection Act 2008* (Vic)
FVPLS	Aboriginal Family Violence Prevention & Legal Service
FVSN	Family Violence Safety Notice
GVCLC	Goulburn Valley Community Legal Centre
HRCLS	Hume Riverina Community Legal Service
IVO	Intervention order
LCCLC	Loddon Campaspe Community Legal Centre
LSB	Legal Services Board
MBC	Men's Behaviour Change program
MOU	Memorandum of Understanding
NSW	New South Wales
SSRV	Social Security Rights Victoria
VCAT	Victorian Civil and Administrative Tribunal
VLA	Victoria Legal Aid
VLRC	Victoria Law Reform Commission
VOCAT	Victims of Crime Assistance Tribunal
VSRFVD	Victorian Systemic Review of Family Violence Deaths

Recommendations

RECOMMENDATION 1
Legal assistance for both affected family members (AFMs) and respondents in intervention order proceedings should be funded to make the process more efficient, reduce trauma and anxiety for AFMs, and increase the effectiveness of any orders made.

RECOMMENDATION 2
In its funding decisions, the Victorian Government should prioritise consistent and long-term proven models rather than short-term or one-off project funding.

RECOMMENDATION 3
In its funding decisions, wherever possible, the Victorian Government should prioritise locally-based and connected, permanent services rather than partial outreach.

RECOMMENDATION 4
Community legal centres should be funded to provide early intervention via legal assistance for family violence intervention order applications in all Magistrates' Courts (models to be determined by local circumstance and needs eg clinic, designated duty lawyer).

RECOMMENDATION 5
Community legal centres should be funded to act for AFMs in directions hearings and contested hearings in all Magistrates' Courts.

RECOMMENDATION 6
The Family Violence Court Division model should be expanded statewide, including:

- providing for an Applicant Support Worker or their equivalent for every AFM on every day in every court; a funded Family Violence Coordinator (to facilitate integration and build partnerships/collaboration), a Koori Support Worker, a Disability Support Worker and paralegal support to assist with triaging lists for both Applicant and Respondent Duty Lawyers, at every Court; and other specialist workers as required according to local need
- capacity to hear related matters within the jurisdiction of the Magistrates' Court including criminal and child protection matters
- mandated Men's Behaviour Change attendance, and
- judicial monitoring of offenders and of respondents' attendance and outcomes at Men's Behaviour Change programs.

RECOMMENDATION 7
The Victorian Government's proposed safety audit of courts should be conducted in consultation with court stakeholders and expanded to include:

- an audit of risk assessment and management processes, and
- all courts and tribunals where family violence victims/survivors may present, not only Magistrates' Courts (including the County Court, Coroners Courts and VCAT)

with the aim of embedding an expanded Common Risk Assessment Framework in the practice of all relevant courts.

RECOMMENDATION 8
Remote witness or videolink facilities should be expanded to be accessible to AFMs in all family violence courts. This should include provision of remote witness facilities for women in refuges to be able to attend court with no reference to their location.

RECOMMENDATION 9
Security for family violence hearings, waiting areas and to accompany protected persons to and from their cars when required should be consistently provided by appropriately trained personnel.

RECOMMENDATION 10
Mandated intensive and regular training, involving external service partners who participate in the integrated response, should be required for all Victorian Magistrates and Registrars in the family violence jurisdiction, including training on:

- mandatory considerations under the *Family Violence Protection Act 2008* (Vic)
- approaches to risk assessment and decision-making
- family law, and
- sensitive management of proceedings.

RECOMMENDATION 11
Judicial officers, court staff, legal representatives, police and non-legal family violence support workers should be provided with ongoing training and professional development to foster expertise and specialisation in family violence.

RECOMMENDATION 12
Magistrates and Registrars should be subject to effective complaints and accountability processes.

RECOMMENDATION 13
Recruitment and retention of specialist Magistrates, Registrars, police, lawyers, support workers in the family violence jurisdiction should be encouraged.

RECOMMENDATION 14
Magistrates should be encouraged to attend each other's courts on a regular basis to provide an informal method of peer support and to mitigate inconsistencies between Magistrates' approaches to family violence matters.

RECOMMENDATION 15
Magistrates' Courts should be funded to be able to provide separate interpreters for each party in family violence matters, with interpreters required to attend family violence training including in the Common Risk Assessment Framework.

RECOMMENDATION 16
Magistrates' Courts should be funded to book interpreters so that they can be available as long as they are required on the day of the client's hearing.

RECOMMENDATION 17
There should be regular independent auditing of interpreters who are practising in the family violence courts to monitor accuracy and impartiality.

RECOMMENDATION 18
In recognition of the need for legal aid-funded private lawyers (especially relevant to rural areas where the potential for both CLC and VLA to have a conflict may be greater), specialist family violence legal services should be funded to provide family violence training for private lawyers, including in risk assessment; and in legal issues arising from family violence such as family law, credit and debt and homelessness, so that referrals can be made to appropriate services.

RECOMMENDATION 19
The Victorian Government and the Magistrates' Court of Victoria should encourage and model best practice collaboration, including via statewide protocols and MOUs, between all family violence court

stakeholders, including police, Registrars, Applicant and Respondent Workers or equivalents, paralegals and duty lawyers.

RECOMMENDATION 20
Courts with large family violence lists should provide for staggered listings, at least for half of the list.

RECOMMENDATION 21
Where there is not a dedicated family violence list and it is feasible to do so, priority should be given for family violence matters to be heard first.

RECOMMENDATION 22
Initial applications should be taken in a private space by Registrars specifically trained in interviewing AFMs.

RECOMMENDATION 23
Family violence matters should not be adjourned to be heard concurrently with criminal matters, or until after family law proceedings, without a compelling reason.

RECOMMENDATION 24
The Magistrates' Court and Victoria Police should review the format of safety notices and intervention order application forms to facilitate collection of sufficient information to support the application.

RECOMMENDATION 25
In matters where the Department of Human Services (DHS) has an active interest and protective concerns, a representative of Child Protection should be required to attend court.

RECOMMENDATION 26
DHS should more actively engage in both the governance and service aspects of the family violence integrated response, including the provision of external and consistent family violence training for child protection workers.

RECOMMENDATION 27
Victoria Police and the Magistrates' Court of Victoria should implement an acceptable, reliable and electronic system for confirming service of family violence documents.

RECOMMENDATION 28
Policy and practice of Victoria Police should be to take action in respect of any intentional breach of an intervention order, regardless of its 'magnitude'.

RECOMMENDATION 29
Specialist training within Victoria Police should be reviewed and expanded with the aim of ensuring that police responses reflect the seriousness of family violence and are consistent across the state.

RECOMMENDATION 30
A Victoria Police, CLC and family violence services group should be established to work together to improve issues around service delays, referrals to duty lawyers for legal advice when police are the applicant, and response to breaches.

RECOMMENDATION 31
Changes should be made to tighten the 'web of accountability' around perpetrators of family violence, by:

- funding adequate mandated Men's Behaviour Change places

- providing at all courts for judicial monitoring of offenders and of respondents' attendance and outcomes at Men's Behaviour Change programs, and cross-court sharing of information
- providing at all courts for a case management approach including swift sanctions for breaches of intervention orders
- providing on-the-spot access to assessment and referral to mental health and alcohol and drug services at all courts
- expanding therapeutic programs such as the Court Integrated Services Program to include family violence respondent referrals and ensuring these programs operate with an understanding of specific factors influencing family violence offending and risk
- ensuring that community corrections sanctions have capacity to monitor family violence offenders effectively and to mandate participation in appropriate behaviour change and violence intervention programs
- mapping different points of intervention with family violence perpetrators across the different service contexts including child protection, courts, corrections, police and health services to identify effective intervention, and
- exploring whether the introduction of restorative justice options might improve perpetrator accountability and maximise victim safety and acknowledgement in certain cases.

RECOMMENDATION 32

Family violence should be embedded as a core element of the work of Corrections Victoria. Corrections agencies should have in place:

- a process for assessing all offenders for risk or history of family violence
- a range of programs and interventions for family violence offenders serving a community corrections order and prisoners serving a custodial sentence who are assessed as indicating risk of family violence offending
- ongoing training to ensure all community corrections and prison staff understand the dynamics of family violence and can identify and manage risk of family violence, and
- a range of programs, therapeutic supports and other referrals such as legal services available for women in the corrections system who are at risk of, or have experienced, family violence.

RECOMMENDATION 33

Training for Magistrates, Registrars, police and private lawyers should incorporate a gendered analysis of cross application dynamics (see Recommendations 10-11 & 18).

RECOMMENDATION 34

The *Family Violence Protection Act 2008* should be amended to require leave to be granted in order to apply for a cross application, and to require that a risk assessment be conducted before leave is granted.

RECOMMENDATION 35

The Magistrates' Court of Victoria should work with the Department of Justice to consider legislative and/or practice reform to ensure that cross applications receive additional and earlier scrutiny than other applications (for example, by requiring that cross applications cannot be made by consent; requiring specialist family violence registrars to assess the merit of the application before it is filed.

RECOMMENDATION 36

Funding should be provided for increased access to affordable family law services for family violence parties engaged in post intervention order parenting disputes, including through community legal centres.

RECOMMENDATION 37

The Victorian Government should advocate to the Commonwealth for a waiver of the divorce filing fee when it is a family violence matter.

RECOMMENDATION 38

The Federation endorses the recommendations of Women's Legal Service Victoria in their submission to the Royal Commission, and in particular the recommendations that:

- The Magistrates' Court develop a practice direction restricting parties from negotiating parenting agreements at court during intervention order hearings
- Section 68R, S & T of the *Family Law Act 1975* (Cth) be comprehensively reviewed and redrafted by the Federal Attorney General's Department
- The 21 day time limit in section 68T be removed, and
- A process be established between the Magistrates' Court and Family Court registries providing that a section 68R suspension order trigger an application for variation of a parenting agreement/order.

RECOMMENDATION 39

The Victorian Government should work with COAG to implement the National Recognition Scheme for family/domestic violence intervention orders without delay. Recognition must extend to interim orders.

RECOMMENDATION 40

The Federation strongly endorses the submission and recommendations to the Royal Commission by our member centre, Justice Connect (Homeless Law). We are also a signatory to the joint submission to the Commission from 129 organisations, on family violence, homelessness and affordable housing.

RECOMMENDATION 41

The Federation strongly endorses the submission and recommendations to the Royal Commission by our Infringements Working Group.

RECOMMENDATION 42

Research should be commissioned into why Victims of Crime Assistance Tribunal (VOCAT) applications are not pursued more often by people who have experienced family violence, with the research to be informed by a steering group of CLCs, family violence services and VOCAT staff.

RECOMMENDATION 43

Community legal centres should be funded to be able to provide a holistic service for family violence victims/survivors so that all family violence-related legal matters, including ongoing family law representation, may be addressed with continuity of assistance.

RECOMMENDATION 44

Community legal centres should not be subject to restrictions that prevent centres assisting victims of family violence based on flexible criteria that recognise financial disadvantage as well as other factors impacting a victim's access to justice.

RECOMMENDATION 45

The Victorian Government should use the Family Violence Integration Progject as a 'best practice model' to improve integration in the family violence jurisdiction across the state.

RECOMMENDATION 46

A funded Family Violence Coordinator should exist at every Court.

RECOMMENDATION 47

The Magistrates' Court of Victoria should commission regular independent research on court user experiences, particularly those of AFMs.

RECOMMENDATION 48

The Federation strongly endorses the recommendations concerning the Family Violence Risk Assessment and Risk Management Framework in the submission to the Royal Commission from our member centre, Domestic Violence Resource Centre Victoria.

RECOMMENDATION 49

The Victorian Government should establish a statutory governance framework for a coordinated, statewide, integrated family violence response that includes:

- permanent cross-ministerial governance and accountability
- resourced partnership between government, legal and community sectors, and
- shared understandings and practices across the family violence system.

Shared understandings and practices should include prioritising victim safety (including risk assessment and management), perpetrator accountability and family violence prevention.

RECOMMENDATION 50

The Victorian Government should ensure that the experience of CLCs and the full range of research issues identified by CLCs inform the development of the Family Violence Index.

RECOMMENDATION 51

The Victorian Government should commission research which tracks victims/survivors and respondent contacts with the integrated response to family violence over several years, rather than simply providing snapshot information.

RECOMMENDATION 52

The Victorian Systemic Review of Family Violence Deaths (VSRFVD) should be statutorily established according to best practice principles, with secure adequate funding and full integration into the family violence governance and service framework, including risk assessment.

RECOMMENDATION 53

Best practice principles underpinning the VSRFRD should include:

- independence, public accountability, transparency and the active participation and central involvement of advocates for women and experts in violence against women
- regular engagement with the broader family violence sector and Victorian communities, and
- regular dissemination of public education material.

RECOMMENDATION 54

The VSRFRD should provide regular public reports on systemic trends and its own activities.

RECOMMENDATION 55

The VSRFVD should include or be closely linked to a program for monitoring implementation of recommendations, including analysis and identification of key and recurring recommendations and agency responses over time.

RECOMMENDATION 56

The VSRFVD should be independently evaluated every four years.

RECOMMENDATION 57

Inquests should be mandated for all suspected family violence deaths.

RECOMMENDATION 58

In order to ensure consistent best practice in coronial investigations and inquests into family violence homicides, minimum standards, guidelines, and a practice direction should be developed.

RECOMMENDATION 59

Two specialist coroners should be appointed to conduct all family violence inquests.

RECOMMENDATION 60

The use of expert witnesses in family violence inquests should be developed as standard practice, including via establishment of an expert panel in consultation with relevant community and legal organisations.

RECOMMENDATION 61

Funding and availability of legal assistance providers must be sufficient to enable all families to obtain, without financial hardship, effective legal advice and representation for investigations and inquests, at a level that is consistent with the level of legal representation accorded to government and other institutional parties in the inquest. A specific pool of funds should be made available to enable community legal centres to provide legal representation for families at inquests.

RECOMMENDATION 62

The State Government should amend section 327 of the *Crimes Act 1958* as follows:

> Failure by a person in authority to disclose a sexual offence committed against a child under the age of 16.
>
> ...a person ~~of or over the age of 18 years (whether in Victoria or elsewhere~~) in authority in a relevant organisation who has information that leads the person to form a reasonable belief that a sexual offence has been committed in Victoria against a child under the age of 16 years by another person of or over the age of 18 years must disclose that information to a member of the police force of Victoria as soon as it is practicable to do so, unless the person has a reasonable excuse for not doing so.

RECOMMENDATION 63

The State Government repeal amendments made to the *Family Violence Protection Act 2008* with respect to finalisation conditions in interim intervention orders.

Introduction

Many community legal centres (CLCs) provide legal assistance to victims, and sometimes perpetrators, of family violence in Victoria. For the financial year 2013-14, 'family or domestic violence order' was the top legal problem type for CLC work across Victoria, comprising 15.1% of all problem types recorded on CLSIS. Five thousand, one hundred and twenty-five (5125) instances of information (about 1 in every 11 overall), and 6267 legal advices (more than 1 in 9) concerning family violence were provided. 8462 new family violence cases were opened, meaning that greater than 1 in every 3 new cases for CLC lawyers were about family violence. In the first half of 2014-15, 39% of new cases initiated by Victorian CLCs related to family violence.

Community legal centre work provides the Federation, as the peak body, with a unique understanding of the issues for victims of family violence encountering the justice system. The Federation has therefore been collaborating with various family violence services and peak bodies for many years on issues of family violence practice, policy and law reform, working with our member centres, particularly our specialist member centres Women's Legal Service Victoria, Domestic Violence Resource Centre Victoria, and Aboriginal Family Violence Prevention and Legal Service (Victoria), as well as larger generalist centres.

As a member of the first Statewide Steering Committee to Reduce Family Violence established in 2002, we worked in partnership with government and community organisations, police and courts to reform Victoria's family violence system by developing an integrated response to family violence. This work included developing the vision for family violence systems reform and implementation of a range of policy, practice and governance initiatives. We also advocated with our community partners for a review of family violence legal responses in Victoria. This led to the Victorian Law Reform Commission (VLRC) review of family violence laws, which we worked on as a member of the VLRC Advisory Committee.[1]

The Federation co-leads, with Domestic Violence Victoria, the Victorian Family Violence Justice Alliance, which began by advocating for the adoption of the recommendations made by the VLRC, many of which are now part of legislation and practice. The Federation and its members were key participants in the resulting legislative reform consultative process. In November 2007 then Attorney-General, Rob Hulls, wrote to the Federation describing the collaboration between community participants in the law reform process as 'unprecedented', and congratulating us for making 'significant' and 'valuable' contributions to the family violence law reform process.

Our work alongside government and community organisations continues to involve strategic research, policy development and law reform activities, and participation in various statewide forums of government and community stakeholders. The Federation and individual CLCs are regularly consulted by Government, opposition parties, academics and media on systemic family violence issues.

While there is much in the Victorian approach to commend to other jurisdictions, there are also valuable lessons to be learned about the day-to-day operation of the response, the importance of continuing the reform impetus, and the need to adequately fund services responding to family violence so that they are genuinely capable of keeping women and children safe, irrespective of where or who they are.

Community legal centres are in a unique position to comment on how the statewide family violence response is actually operating 'on the ground', because of the breadth of family violence work that they undertake. As we outline below, many of the core principles for an effective response to family violence are 'rules to live by' for CLCs, such as specialisation, partnerships and shared understandings, listening and learning from clients' experiences of the system, and a long term view of protection and prevention.

[1] Victorian Law Reform Commission, *Review of Family Violence Laws Report* (2006).

Our submission first outlines the role of community legal centres in the family violence response. It next addresses a range of matters associated with the family violence intervention order process, with a focus on practices, resources and personnel in Magistrates' Courts. We then consider and make recommendations to improve perpetrator accountability and the need for some improvement in the way the *Family Violence Protection Act 2008* operates in practice.

While we refer the Commission to more extensive submissions from our specialist member centres, including Youthlaw, inTouch, Social Security Rights Victoria, Seniors Rights Victoria and Justice Connect (Seniors Law), our submission raises some key legal issues related to family violence but outside the intervention order process, together with significant gaps in legal need. The submission then considers some further improvements to the family violence response, including the need for genuinely integrated services, better data, and the Victorian Systemic Review of Family Violence Deaths. Finally, we address the impact of two recent law reform initiatives.

Community legal centres' contribution to the family violence response

Legal help with intervention order matters

Currently 20 of the Federation's member centres provide specialist duty lawyer services in 29 Magistrates' Courts, in order to assist victims of family violence to obtain a family violence intervention order.

CLCs are an essential source of free legal assistance for victims/survivors of family violence, despite operating on extremely limited budgets. Victorian policy- and decision-making concerning the civil court elements of the integrated family violence response have long recognised that there is great value in having parallel duty lawyer services for the applicant/affected family member (AFM) and for the respondent.[2] Where both parties are represented, there is also a high rate of matters being resolved by consent at the first mention date, which is not only a safer outcome for the AFM, but also reduces pressure on the courts and is more cost efficient for the system as a whole.

While many CLCs will assist respondents as well as applicants, generally, unless there is a conflict of interest, CLCs will overall mainly assist applicants, with Victoria Legal Aid (VLA) mainly assisting respondents.

Example

A CLC assisted the applicant. Victoria Legal Aid assisted the respondent. The applicant alleged she had been the victim of controlling behaviour over many years, including being forced to have sex during her marriage. Consent orders without admissions were negotiated, including for the respondent to leave the home.

The *Family Violence Protection Act 2008* (Vic) (FVPA) provided many valuable new protections for victims of family violence, but also increased the need for applicants to have access to legal advice so that they could be aware of, and be able to make use of, the expanded legal protections offered by the legislation. For example, without legal advice an applicant may be unaware of the provisions in relation to residential tenancies, meaning, for instance, that if they are renting, they may apply to have the lease changed. The applicant may also be unaware that in appropriate matters they can apply for an interim victims of crime order for funds to change locks.

[2] The applicant for the intervention order may not necessarily be the affected family member (AFM). For example, police may apply for the order on the victim's behalf.

Victims of family violence may also be unaware of the expanded definition of family violence in Victorian legislation. For example, they may not know that family violence also includes where children hear or witness the behaviour. It is vital that victims also have access to legal advice about the family law implications of their situation.

Specialist and holistic services

Specialist duty lawyer and other assistance for victims/survivors of family violence in intervention order matters is an essential part of CLCs' contribution to the crisis response. In addition to the 20 CLCs that provide help at court, 15 other CLCs provide assistance to family violence victims/survivors in many related areas of law, including family law, fines, debts, housing/homelessness and compensation for victims of crime. The community legal sector has an established tradition in which generalist centres often refer or receive expert input from specialist CLCs, which in family violence work means that it is more likely that a client can have many of their legal needs met via one service contact.

> *The way our specialist service has been set up — no wrong door —is really useful for clients. We're generous with our time and not strict—so they can come back and be linked with several other services for other related legal problems. That takes a considerable amount of investment, and we draw on the expertise of others.*

> *The specialisation and cultural safety of the service makes us unique. We can offer a holistic service for the duration of the matter, including non-legal support. The availability of dedicated services for Aboriginal and Torres Strait Islander victims/survivors through Aboriginal Family Violence Prevention and Legal Service Victoria has resulted in their growing engagement with the legal system and a greater willingness to seek protection through legal options.*

> *The results we get with women at risk of or experiencing homelessness are because we assign lawyers to particular individuals and work with them until the issues are resolved. And the lawyers work alongside a social worker who may stay involved for even longer. You need someone to step our clients through the process.*

> *We can put things in place to sort out all of the issues. Family violence work is such a huge proportion of what CLCs do —it is a speciality area for CLC staff.*

> *Because we don't do criminal law, we don't focus through that lens. So we have more of a focus on the unique nature of family violence and recognise that it's not just another area of law.*

Many of our member centres are also co-located or partnered with other specialist services, and continue to work to build common understandings and practices, such as the achievements of Inner Melbourne Community Legal's Acting on the Warning Signs project.[3] Some CLCs have developed specific projects to foster integration with other legal and non-legal services, such as Eastern Community Legal Centre's Family Violence Integration Project.[4] Others, like Brimbank Melton Community Legal Centre's work with maternal and child health nurses, Hume Riverina Community Legal Service's Holistic Outreach and Legal Assistance pilot, and Eastern Community Legal Centre's Mothers and Babies Engaging and Living Safely project [5] use the sector's strength in community legal education and development to build linkages so that women and children can be supported earlier and more effectively.

[3] We refer the Commission to of Inner Melbourne Community Legal's submission for further detail.

[4] We refer the Commission to Eastern Community Legal Centre's submission for further detail.

[5] We refer the Commission to the submissions from Brimbank Melton Community Legal Centre, Hume Riverina Community Legal Service and Eastern Community Legal Centre for further detail.

We're here because we want to be, it's not about billing clients. There's so much less red tape. We're small, we can brief our colleagues, we've got really good connections in the community, we've been able to build trust, we're present and visible. For instance, I had a police officer call me up and refer me to a matter where a respondent was a police officer. I just couldn't imagine that happening anywhere else. So much time has gone into building the relationship so it's not us versus them. It's just a really useful partnership.

Embedded in local communities

Another strong feature of CLC family violence work is the ability of our member centres to address locally specific needs in their communities, because they are located there and have often built up relationships over many years.

> *It's better if there is a local CLC that a women can see face to face, and then that person can link the woman to local services. It's safer for women to see someone face to face than to receive phone calls or make phone calls. Also local services understand the risks of being on a regional property like distance, public transport issues and so on.*

This also means that CLCs are well placed to assist particular marginalised communities and to obtain feedback from clients about what works for them and where needs are not being adequately met. For example, Hume Riverina Community Legal Service and Murray Mallee Community Legal Service are uniquely placed to comment on cross-border family violence intervention order issues. Loddon Campaspe Community Legal Centre has recently completed a ground breaking project which sought detailed feedback from women about their experiences of the intervention process.[6] Eastern Community Legal Centre's Family Violence Integration Project has addressed many of the same themes in a metropolitan court.[7]

Understanding disadvantage

The emphasis on a more holistic approach to service provision would not be feasible without another fundamental element of community legal centre philosophy: a sophisticated understanding of structural determinants and contributors to family violence and to disadvantage more broadly. It means that approaches like Justice Connect Homeless Law's Women's Homelessness Prevention Project understand that in working effectively with clients it is essential that lawyers work alongside a social worker to ensure the most appropriate strategies to avoid a revolving door of homelessness.[8]

> *Anyone who works in a CLC is there because they care - they're not there for money or for themselves. They have empathy and compassion for clients, particularly victims/survivors of family violence. Workers are more understanding and looking out for clients' needs. It's not a business, it's about helping the vulnerable.*

Integration of direct service provision with systemic advocacy

CLCs are expected to engage in policy and law reform activities as a result of their legal assistance work—as many have done with their own submissions to the Royal Commission. This makes them experts at 'seeing the wood as well as the trees'. The Federation regularly consults and collaborates with our member centres to inform our statewide policy and law reform work with Government and other stakeholders, as we have done for this submission.

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[6] We refer the Commission to Loddon Campaspe Community Legal Centre's submission for further detail.

[7] We refer the Commission to Eastern Community Legal Centre's submission for further detail.

[8] We refer the Commission to Justice Connect Homeless Law's submission for further detail.

We really understand family violence. We breathe it and we know it and have advocated around family violence for as long as we've existed. And our systemic approach—we're committed to the prevention of family violence.

We have the ability to speak out about these issues.

Prevention

As the homelessness example above shows, there are also important early intervention and prevention elements to CLC work. For example, if a woman who is experiencing violence is able to receive help to obtain an intervention order, this not only helps her to keep safe, but also provides the message to her and the perpetrator that she has such a right.

Assistance provided by CLCs often extends far beyond the provision of legal advice, and for this reason, has further capacity to deliver preventative outcomes.

Example

A woman, the AFM in a police-initiated family violence intervention order application, sought the assistance of a CLC through the Applicants' Family Violence Duty Service at Court. Police had applied for an intervention on her behalf against her teenage child, [redacted]. [redacted] was developmentally delayed and had a series of behavioural problems which led him to act violently at times. The AFM's response to violence outbursts had been to call the police. Sometimes, neighbours or the AFM's younger child phoned the police. Due to the number of call-outs and because of concerns for the safety of the younger child, police sought an intervention order. However, the AFM wanted [redacted] to remain at home. The AFM explained to the CLC that she received no support from local agencies as [redacted] 'fell through the gap' in terms of programs delivered by services due to his age ([redacted]) and his particular disability.

The CLC facilitated a range of negotiations with local support agencies, resulting in [redacted] providing a limited undertaking and a number of supports being put in place. The police agreed to withdraw the intervention order application as they were satisfied that [redacted] would be supported and the AFM would have more appropriate supports to assist his with volatile behaviour.

The involvement of the CLC meant that family relationships were preserved, measures to prevent violent outbursts were taken, and ultimately, the AFM and her younger child felt safer, better equipped and supported to respond to the signs of escalating behaviour.

Example

Loddon Campaspe Community Legal Centre (LCCLC), describes how Family Violence Court outreach programs in the region are an essential component of any family violence prevention strategy. After the program began in December 2006 there was a noticeable increase in the region in understanding and awareness of family violence, which was further enhanced by the introduction of the *Family Violence Protection Act 2008*. When the Act was first implemented, private practitioners, police prosecutors and in some instances the Court sought the advice and opinions of LCCLC about the application of the legislation. LCCLC's educative role in the region, although now limited by lack of funding, continues to play an important part in maximising safety for victims of family violence and accountability for respondents using violence against women and children.

The Court outreach programs provide an opportunity to properly advise and educate victims of family violence about what family violence is, to de-bunk common misconceptions about what is and is not violence, such as 'he only pushes me around—he never actually hits me', and 'the police can't charge him with threatening to kill me because it's only a threat.' By informing clients about what the law recognises as family violence, CLCs contribute to the curtailing of further or escalating family violence: if victims recognise the signs of violence at an earlier point and act proactively, there may be a decrease in the incidence of the higher levels of violence—including death and serious assaults.

When victims present at Court it may be the first time they have had any access to information about family violence and the legal options available to them. Legal advice may extend to family law property issues, Victims of Crime applications, proper reporting of breaches/criminal offences and advocating for the client in instances that the Police are not adhering to the Police Family Violence Code of Practice or properly investigating criminal offences committed by the respondent/perpetrators. The Court outreach services are also an important opportunity to link clients in with appropriate non-legal family violence support services. In each outreach court location, LCCLC has a strong working relationship with the local family violence support agencies.

The Court outreach program is also an essential part of safety planning for victims of family violence: tailoring intervention orders to allow for the family members to stay in the home and the respondent to be excluded; arranging safe means of communication between the parties whilst the intervention order is in place; making appropriate referrals and conditions of intervention orders directing the respondent to attend Men's Behaviour Change programs, and so on.

Access to legal assistance and court support can be especially difficult for women living in rural/remote locations, particularly in farming communities where there nearest court can be over an hour away. LCCLC receives family violence telephone advice calls from women who are geographically isolated, where the violent respondent may be literally 'out the back paddock' when they call and where there is often more empathy from the local police station towards the perpetrator rather than focusing on the safety needs of the women and children.

The safety concerns also extend to high risk of homelessness where the woman has married into a 'family farm'—when they attempt to leave they are ostracised and are threatened that they have no claims on any of the property or assets of the relationship. If there is a successful interim intervention order that excludes the respondent from the home, there are often grave concerns around the ability of local police to respond if there are any further family violence incidents. Firearms are also of a major concern in rural remote areas.

The role of preventative strategies within these communities is therefore of utmost importance – reinforcing the intolerance of family violence, and the message that men should be taking a lead role in the 'no to violence' message within their own families, clubs and workplaces. LCCLC has played an integral role in many of these preventative strategies across the region—and is therefore engaged in much more than just a narrow 'legal response'.

For this submission, our member centres have been able to provide substantial 'on the ground' analysis and observations of how the integrated family violence response is operating across Victoria, with a particular emphasis on the justice elements.[9] They emphasise that recent reforms and developments have improved responses to family violence, and identify the changes that are proving to be the most effective. CLCs are also in a prime position to observe gaps and deficiencies in current responses, but to make suggestions for reform that emphasise that the system is not irredeemably broken but rather instead needs further investment.

[9] Unless otherwise indicated, all greyed extracts are quotes from CLC lawyers or managers.

The family violence intervention order process

Courts

The state of the courts epitomises the reality that Victoria's integrated response to family violence, and its associated resourcing and collaborative service relationships, varies in accessibility and effectiveness across Victoria. This results in a form of 'postcode justice' and a system that tends to serve better those victims who are not also socially disadvantaged in other ways (such as Aboriginal and CALD women, women with disabilities).

In 2005, $35.1 million was allocated for a new family violence system, which included the establishment of the Family Violence Court Division of the Magistrates' Court at Heidelberg and Ballarat, and the Specialist Family Violence Service at Melbourne, Frankston and Sunshine (with a circuit to Werribee). Although the original aim had been to eventually roll out the specialist model statewide, in 2015 there is now effectively a four-tier model of court operation.

The top, optimal model, the Family Violence Court Division, includes funded applicant (CLC) and respondent lawyers (VLA), specialist court-funded Applicant and Respondent Workers, dedicated prosecutors, a specialist registrar, mandated counselling for perpetrators via Men's Behaviour Change programs, and empowering of magistrates to hear related criminal, child protection and victims of crime matters, together with judicial monitoring.

The Specialist Family Violence Service operates in four courts with some of the features of the Division, including applicant and respondent lawyers, an applicant support worker, a dedicated prosecutor and specialist registrar. However, unless gazetted (Frankston only) these courts cannot mandate attendance at Men's Behaviour Change Programs and cannot hear proceedings other than intervention order proceedings.

The two lower tiers —the majority of courts — have either an ad hoc funded arrangement for Applicant and/or Respondent Workers, and, in one court (Moorabbin) mandated counselling, or simply have none of the elements of the two top tier courts.

Although the Magistrates' Court of Victoria has now committed to providing an Applicant and Respondent worker at all headquarter courts, as we detail below, the good work begun in the court system with the development of the six specialist court sites has been stalled somewhat, as courts face increasing strain due to lack of funding for infrastructure.

CLCs operate family violence duty lawyer programs across all of the four court tiers, although CLCs are not currently funded or able to provide services at every court.

Insufficient duty lawyer capacity

While the increase in demand for family violence assistance can be seen as a success of the reforms, it places a significant burden on all parts of the integrated family violence system—including community legal centres. The number of new family violence cases opened by community legal centres increased by 85% between 2008/09 and 2013/14.[10] The ongoing and substantial rise in family violence matters in courts that have established CLC duty lawyer programs, together with yawning gaps in legal need in some parts of the State, particularly the regions, are not able to be met by existing CLC service capacity.

Before 2005, Victorian community legal centres had been conducting family violence duty lawyer services at Magistrates' Courts for many years without dedicated funding or support, in order to obtain protection for victims of family violence. At that stage victims of family violence were unable to secure

[10] Community Legal Service Information System data.

free legal assistance elsewhere. When the new family violence system was established in 2005, Darebin Community Legal Centre and Central Highlands Community Legal Centre were funded to establish full-time family violence applicant duty lawyer positions servicing the Family Violence Court Division.[11] The 2005 commitment to fund a further four specialist family violence court services included funding for additional CLC lawyers to provide specialist duty lawyer assistance to victims.

In July 2007, the Victorian Government and Victoria Legal Aid provided funding to 10 CLCs across Victoria to establish 6 full-time and 4 half-time specialist family violence lawyer positions. After the *Family Violence Protection Act 2008* (Vic) was introduced, $24.1 million was allocated to the family violence system and to work associated with the law reform.

Currently our member centres that provide duty lawyer or other family violence–related legal assistance are funded in a variety of ways. Most receive core funding from the State via Victoria Legal Aid and from the Commonwealth, but this is often not sufficient to meet the increased demand, let alone identified unmet legal need. Seven CLCs rely heavily for their family violence work on a one-off, four year allocation provided under the former Attorney-General Mark Dreyfus which will end in June 2017.

Several of our member centres have developed innovative projects which have also assisted them to meet family violence legal need. Many of these projects are funded by the Legal Service Board. For example, Moonee Valley Legal Service and Flemington Kensington CLC's Safe from Harm project provides advice and casework to two housing estates.[12] InTouch Multicultural Centre Against Family Violence is funded for a pilot legal service to assist women from CALD backgrounds who experience family violence.[13] Loddon Campaspe Community Legal Centre was funded by the Legal Services Board for a dedicated family violence lawyer until June 2015 (discussed further below). Eastern Community Legal Centre used LSB funding to fund its Family Violence Integration Project (discussed further below). The challenge for CLCs is that project funding is time limited and usually does not translate into ongoing sustainable resourcing.

Perhaps most significantly, projected federal funding cuts of 29.8% will also impact on Victorian CLCs from mid- 2017. For CLCs already trying to stretch existing generalist budgets to provide adequate family violence assistance, a crisis looms.

The 2014 Productivity Commission Final Report, *Access to Justice Arrangements*, confirms that government funded legal assistance services in general generate net benefit to the community, that underfunding of legal assistance services leads to increased costs in other areas of government spending as well as in the justice system, and that Australia is one of the lower funding nations of legal assistance services on a per capita basis.[14] When this broad context is combined with the estimate that violence against women costs Victoria $3.4 billion a year, decisions to cut funds to CLCs and FVPLS programs are both inefficient from a fiscal perspective and likely to increase the risk of injury and death for victims of family violence. The Productivity Commission recommended an "interim funding injection" of $200 million/per year from the Australian, state and territory governments "having regard to the pressing nature of service gaps" including gaps in family violence assistance.

Passion and cost efficiency can only take CLC family violence assistance so far on the road to the holistic, safe ideal for vulnerable clients:

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[11] For more background on Victoria's whole-of-government family violence response, see Magistrates' Court of Victoria, Family Violence Court Division and Specialist Family Violence Service, *Induction Manual*; Leah Hickey and Erika Owens, 'The Victorian Family Violence Court Division: Successes and Challenges of an Integrated Response to Family Violence', *Just Partners Conference: Family Violence, Specialist Courts and the Idea of Integration*, 22-23 May 2008.

[12] We refer the Commission to Moonee Valley Legal Service's submission for further detail.

[13] We refer the Commission to inTouch's submission for further detail.

[14] Productivity Commission, *Access to Justice Arrangements*, Final Report, Canberra (September2014) ('FinalReport').

> *Our duty lawyer role is extremely limited. There is no capacity to assist with ongoing casework, follow up from court or to prepare for the next hearing. This creates unease for the applicant and frustration for the lawyers and the court, as it is recognised that assistance throughout the entire process would be a better legal response.*

Compromised CLC family violence duty lawyer capacity affects the operation of the courts in various ways. For example, the capacity of Aboriginal Family Violence Prevention and Legal Service Victoria (FVPLS) to provide duty lawyer services at courts across the State is restricted due to lack of resourcing. The Magistrates' Court of Victoria recognised the need for specialist family violence support services via the establishment of the 'two top tiers' of courts. The availability of FVPLS solicitors through an on-site duty lawyer service at these metropolitan courts would allow for specialist culturally responsible, immediately accessible legal advice and representation. In the country, Shepparton is an area with great unmet need which would be assisted by an office location, but the service is only able to provide advice over the phone.

In 2015 the federal government has 'rationalised' funding in the area of Indigenous services. National Aboriginal Family Violence Prevention and Legal Service was effectively de-funded under the Indigenous Advancement Strategy and, although the service has learnt current levels of funding will be maintained in immediate years, continues to have no direct allocation. There is no transparency or guarantee of funding for the program in the future. In one area serviced by FVPLS, reporting of family violence incidence has increased by 360%. FVPLS expects reporting rates and legal need associated with family violence will continue to increase in response to significant public attention on the issue.

Generalist CLCs are also sometimes are unable to meet duty list demand, or else the sheer numbers of clients impact on the depth of advice able to be provided.

> *We are funded for half days at court, but in reality duty lawyers will spend a full day at court due to the huge increase in cases. It is also important that the family violence duty lawyers get time away from court to ensure appropriate mental health maintenance and professional development.*

> *Since 2012 we have had an increase of 39% in the number of intervention order matters we have assisted with. The service has not received any increase in funding to deal with the increased demand.*

> *Our court is too busy to have only one lawyer there at any one time. But the Court has recently said there will be a fourth family violence day, which we can't provide, especially because they've also now requested that we pick up some directions hearings, which we're not funded for. We've also been piloting advice and casework elsewhere in our catchment without additional funding but so that we can assist early, long-term victims with applications (so it's quite intense) – but we won't be able to keep that up.*

> *We can't fully advise and represent everyone who needs help — we just don't have the capacity. Recently there were 40 people on the list, with one duty lawyer. We only looked after seven.*

> *We have the occasional day where we're so overloaded that we have to send another person over to the court. The Court has also put on a once-a-month extra day on Fridays. We undertook to cover this from our own resources for three months but we're not funded for it ongoing. The worst ever day we saw 18 clients. We've also had days where the lawyer has been at court until 6pm.*

We have not only seen an increase in number of incidents of family violence reported but also in the severity of violence reported, including risk of death. There is also an escalation in the number of matters which include abuse of drugs and alcohol as an aggravating factor. Matters are becoming more complex than they used to be and the circumstances of violence are more horrible than they used to be. This also makes the matter harder to resolve.

There is a lot more pressure from the bench to resolve matters quickly — they say to the duty lawyers 'go out and settle this in an hour.'

The big increase is impacting on case management and time spent with clients.

The increasing number is having a negative effect on the service provided.

Having the time available to meet even the urgent legal need is particularly pressing in rural areas, where duty lawyers may spend significant time travelling, and alternatives like telephone and skype for at least some advice are not always reliable. For example, Emma House Domestic Violence Legal Services is funded for one duty lawyer to provide a service throughout the region. This involves:

- Tuesday – Portland (once fortnightly 207km round trip): usually 10 applications
- Wednesday – Hamilton (once fortnightly – 213km round trip): usually 10 applications
- Friday – Warrnambool (weekly): varies from 20 – 45 applications per day (plus any urgent interim applications that need legal representation)

If the AFM is in a refuge, the lawyer may be required to travel to other courts to make the application in order to ensure the woman's location is not disclosed. There is no administrative support person, paralegal or any other employee of this CLC to assist the duty lawyer.

A further strain on the system is that in Emma House's 'off week' from Portland and Hamilton, people are forced to represent themselves because VLA will not assist the AFM, because they do not want to create conflicts that then mean the Respondent has no legal representation.

Hume Riverina Community Legal Service (HRCLS) provides a cross border service, with the nearest Legal Aid office and CLC 2 hours' drive away. Duty lawyer arrangements illustrate the 'cobbled together' nature of services in a region with a number of courts. HRCLS provides a duty lawyer service 1 day a week at Wodonga Magistrates' Court, fortnightly via a VLA secondee lawyer, and via a generalist outreach lawyer in the alternate week. HRCLS does not have family violence funding as such, and so is unable to service the Wangaratta Magistrates' Court which is an area of high need. Other courts in the catchment area that do not have a duty lawyer service are in Benalla and Myrtleford. HRCLS would like to be able to employ a full-time family violence lawyer to supplement the work of the duty services they provide, such as assisting with family law matters—and also to extend a duty service to the other courts in the area.

Even free legal advice on family violence is not readily available in in Benalla and Wangaratta. HRCLS attends once a fortnight in Wangaratta and once a month in Benalla. However on the few days when they can assist, there is no local free service for the other party, other than via the Women's Legal Service Victoria skype service.

Loddon Campaspe Community Legal Centre (LCCLC) was able to greatly enhance their family violence work (about half of the centre's current caseload) via a three-year Legal Services Board project grant, which enabled a dedicated family violence lawyer to attend five regional courts (duty lawyer 1 day pw at Bendigo Magistrates' Court, 1 day fortnightly at Echuca, Kyneton and Maryborough, and monthly at Swan Hill) and also to provide assistance on a case-by-case basis to Kerang and Castlemaine. Even

with this money, LCCLC was not able to meet all of the demand, and due to the project concluding on 30 June 2015, the service will have to revert to generalist lawyers for duty work, and provide duty lawyer services in only two courts, Bendigo and Echuca. The precise impact of this loss in terms of unmet legal need is uncertain, but it could equate to up to half of the present duty lawyer caseload not being able to be assisted.

Goulburn Valley Community Legal Centre (GVCLC) provides a duty lawyer service 1 day per week at Shepparton and Seymour Magistrates' Courts, and 1 day a fortnight at Cobram Magistrates' Court. Family violence-related legal assistance comprises a substantial proportion of GVCLC's work (more than 36%). Funding for family violence services in the Goulburn Valley needs to be seen in the context of overall underfunding for GVCLC. Simply increasing funding to cover Benalla would meet an immediate and pressing need. However, it would be better to allocate funds to enable comprehensive family violence service provision in the region, including Benalla, and enable existing GVCLC funds to be spent on other pressing needs.

Gippsland Community Legal Service is only funded to provide a duty lawyer service at the La Trobe Valley Magistrates' Court. This means that there are many other more remote courts that do not provide duty lawyer representation, such as Bairnsdale, Wonthaggi, Korumburra and Sale Magistrates' Courts. This significantly disadvantages those who live in rural areas who have matters listed at these courts.

CLCs that provide family violence duty lawyer services would welcome being also able to provide representation at directions hearings and contests, as well as assisting AFMs with initial intervention order applications.

On matters where there is no contest or where they are resolved by consent, AFM applicants have genuine access to the Court at no cost to them. However, if the matter is contested, they will probably have restricted access to the Court due to strict legal aid guidelines which many people do not meet even though they still cannot afford to pay for private help. Even if they are eligible for legal aid, it is not available for directions hearings. The Court might make a section 72 order which requires legal aid to be provided so that the respondent cannot directly cross-examine the AFM, but if so, funding for representation is limited to the cross-examination.[15]

> *At the same time those Applicants who the Police choose to appear for have full support and representation the whole way through the process — so it's a two-tier system.*

As CLC family violence lawyers engage with an increasingly complex family violence system, more time is also required to commit to various network and prevention initiatives, without commensurate funding increases. The importance of community legal education and early intervention has not been reflected in recent funding decisions.

RECOMMENDATION 1

Legal assistance for both AFMs and respondents in intervention order proceedings should be funded to make the process more efficient, reduce trauma and anxiety for AFMs, and increase the effectiveness of any orders made.

[15] Section 72 of the *Family Violence Protection Act 2008* (Vic) provides that if the AFM (the protected witness) is legally unrepresented, the court must order Victoria Legal Aid to provide legal representation for the protected witness for purpose of cross-examination by the respondent's legal representative unless the protected witness objects. Section 71 of the Act provides that if the respondent does not obtain legal representation for the cross-examination of a protected witness after being given a reasonable opportunity to do so, the court must order Victoria Legal Aid to offer the respondent legal representation for that purpose (subject to standard legal aid conditions).

RECOMMENDATION 2
In its funding decisions, the Victorian Government should prioritise consistent and long-term proven models rather than short-term or one-off project funding.

RECOMMENDATION 3
In its funding decisions, wherever possible, the Victorian Government should prioritise locally-based and connected, permanent services rather than partial outreach.

RECOMMENDATION 4
Community legal centres should be funded to provide early intervention via legal assistance for family violence intervention order applications in all Magistrates' Courts (models to be determined by local circumstance and needs eg clinic, designated duty lawyer).

RECOMMENDATION 5
Community legal centres should be funded to act for AFMs in directions hearings and contested hearings in all Magistrates' Courts.

Variable availability of non-legal supports at court
Courts vary considerably in terms of what non-legal supports are provided for AFMs and Respondents. It is not unusual for even some larger courts not to have a Respondent Worker (eg Geelong, Sunshine, Ringwood Magistrates' Courts).

> *Certain services, including family violence court support services and culturally specific services, are only accessible on particular days.*

> *There are no non-legal supports at our small rural courts save for court support who make the AFMs a cup of tea and help with babies when victims need to give evidence in support of their application.*

There is a distinct lack of respondent support services. In police applications, it is common for police to informally require that the respondent engage in counselling before the police will remove certain conditions of an intervention order. Long adjournments and further adjournments are often required to allow enough time for this to happen.

Even some larger courts like Bendigo currently do not provide support or referral information for respondents. Where there is officially an Applicant Worker, arrangements are often cobbled together from a mix of funding and pro bono sources, which can mean there is not always a worker consistently on site. This state of affairs should change to some extent in 12 months' time with the anticipated rollout of applicant and respondent workers to headquarter courts.

Department of Human Services workers are a striking absence from family violence courts (discussed further under *Children*):

> *There are lots of child protection matters on police days and they take a very long time to get back about what is and what isn't safe. We can only contact them via phone through the police. This causes delays in orders, for parents seeing their children etcetera. For the number of child protection matters it would be easier to have a worker present and it would definitely be more efficient.*

Other services that may be able to assist with related support such as mental health and alcohol and drug issues are often absent from the court model.

At some courts, external service provision is able to add value to court-funded client support. For example, AFVPLS provides paralegal support so that this assists both the client and the lawyer. In Wodonga, an unfunded pilot project by the Centre Against Violence has begun to coordinate different services to be present on the family violence day, but it is a slow process due to its voluntary nature.

RECOMMENDATION 6

The Family Violence Court Division model should be expanded statewide, including:

- providing for an Applicant Support Worker or their equivalent for every AFM on every day in every court; a funded Family Violence Coordinator (to facilitate integration and build partnerships/collaboration), a Koori Support Worker, a Disability Support Worker and paralegal support to assist with triaging lists for both Applicant and Respondent Duty Lawyers, at every Court; and other specialist workers as required according to local need
- capacity to hear related matters within the jurisdiction of the Magistrates' Court including criminal and child protection matters
- mandated Men's Behaviour Change attendance, and
- judicial monitoring of offenders and of respondents' attendance and outcomes at Men's Behaviour Change programs.

Safety and risk management at court

There is, again, enormous variation in the extent to which courts are able to provide safety for AFMs and adequate space for all parties. For example, most courts have only one entry or exit. Courts sometimes do the best they can with old or inadequate buildings, by separating applicants and respondents on two floors. However, often interview rooms and waiting areas are located in such a way that AFMs and respondents are likely to cross paths.

> *I have had respondents burst into my office before quite angry and police won't be anywhere around because the Family Violence Liaison Officer also often assists court with the lists due to their being under-resourced. So is quite dangerous. Often my clients will say 'he's already approached me at court.'*

> *There are just not enough seats generally, and no secure space for the AFMs. There is a very small room that a particularly vulnerable AFM may be able to get to. Sometimes we might use the secure witness room.*

> *There have been a number of incidents of eyeballing in the foyer, a few where security has been called and a few where respondents have been arrested for approaching or harassing.*

Ringwood Magistrates' Court offers the only optimal service, with a designated Protected Persons space. Interviews are conducted in the space and protected persons are able to stay in there the entire time they are at court, unless they are required to give evidence. Ballarat and Heidelberg Magistrates' Courts—Family Violence Court Division courts—have a layout which allows for a separate dedicated courtroom and separate waiting areas for applicants and respondents.

Quite a few courts appear to have remote witness or at least on-site video link facilities, but it is unclear how often these are used. In addition, the 2015/16 State Budget included $14.7 million to improve technology in the Magistrates' Court including the expansion to the video conference network. In most courts there is no safe room.

Mildura Court has adequate space available subject to the designation of an area dedicated to Applicants. Swan Hill has very limited space for interviewing clients and no room for any dedicated space for vulnerable Applicants. Robinvale is chronically lacking in any space other than the courtroom, a small foyer/office area and one small interview room mostly occupied by the Police and also competed

for by the general duty lawyer, the family violence duty lawyer, and the Aboriginal legal service. Otherwise the only place to interview clients is the open grass area outside the Court.

> *It's terrible—crowded and the AFM and respondent must sit across the hall from each other.*

> *There is no such thing as risk management. If requested, police may be free to walk someone to their car.*

Portland Magistrates' Court is an old bluestone building (with a heritage overlay) consisting of one courtroom and one interview room which is shared with the VLA duty lawyer. Police, Corrections, Child Protection and family violence professionals are required to discuss matters in the corridor, which is one metre by five metres in area—or outside. There is no safe space, remote witness facility or videolink available for the protection of victims. There is one entry point through a single door where victims pass perpetrators.

In Hamilton Magistrates' Court (heritage overlay) there is a foyer area about one meter by four meters in area or an outdoor veranda area for victims to meet with the duty lawyer. There is no safe place for victims to wait without being in full view and hearing of perpetrators. There is a videolink facility.

In Portland and Hamilton court catchments, the CLC endeavours to contact all AFM applicants prior to their court date to establish whether or not they need to attend in person. The magistrates accept that there are occasions where the CLC relies on police statements or informants to avoid the AFM/applicant having to risk interactions with the perpetrator. However, private practitioners and the VLA manager are not supportive of this practice and have indicated they believe that the AFM or applicant should be present at all hearings regardless of safety issues.

A further problem is that if police are not applying on their behalf, AFMs are then in an unsafe tiny space in Portland and Hamilton, and if they are unrepresented, having to deal directly with the respondent's lawyer or the respondent himself if he is unrepresented.

There is a reasonably new facility in Warrnambool Magistrates' Court, and the Registrar and staff have tried to reduce the risk of harm to victims when they are required to attend court. Access is always available to the remote witness facility, and so a safe exit from court and police security is available whenever it is requested. The main issue in this court is that AFMs are directed to the end of the court which is completely visible to all those coming in, or standing outside smoking or talking. The glass is clear and they are effectively sitting in a fishbowl.

The new courtroom in Bendigo is so far at least used only for criminal matters. It has security but not for family violence. There are no confidential interview rooms at Echuca, Kyneton, Castlemaine and Kerang Magistrates' Courts, and on occasion staff have used their cars. Kyneton, Kerang, Castlemaine and Maryborough Magistrates' Courts have no waiting areas at all. People use the park or squeeze into the court house on rainy days. There is no disability access at Maryborough.

Goulburn Valley CLC provides a duty lawyer service at courts like Seymour or Cobram Magistrates' Courts where victims and perpetrators might be forced to sit or stand in the same space while waiting. There are no safe rooms other than at Shepparton Magistrates' Court, where the Court Network room has glass panels. At Cobram interviews are generally conducted on park benches opposite the Court with no security at all. There is no disability access at Cobram.

Risk to AFMs and others in court spaces can be high and obvious, but there is generally no real management framework in Victorian courts:

We have to walk people out sometimes. The foyer's really tiny so people often loiter around outside. Sometimes we bring people into the staff area.

There have been cases where things go on out front of court building, but security at the door don't do anything as it isn't their job. The car park is at the back of the court, out of sight of security. Asking lawyers to walk them to the car is putting lawyers at risk also. The Court just tells you to contact the police, but police have no one there to do it as they have reduced their hours.

Our clients report that they are frightened, forced to walk out of secure and safe areas into court, and give evidence before busy courtrooms.

No security at all! A respondent smashed a window and was arrested in front of us once.

If we can we'll get the AFMs to sit in the police station next door but the main counter is unmanned.
No screening either. Like a little country court.

All the matters lumped in on the one day and everyone is sitting in the one courtroom listening to everyone else's matters.

Serious incidents occur in the court surroundings with some regularity. Lower order harassment and intimidation is commonplace eg respondents, their friends and relations eyeball applicants and make threats and harassing comments. It can also be difficult and unsafe for women when leaving the court complex. They could be threatened or harassed and followed as they return to their car. It is sometimes possible to make arrangements for women to be escorted to their cars but these arrangements are ad hoc at best. The level of training and competence in security services is variable. The most highly skilled Protective Services Officers display a nuanced understanding of violence and how to diffuse and prevent it.

Police provide security and the Magistrate will call them when needed. On criminal days there is sometimes a desk with scan machines by hand, but there's no screening process on family violence day, which is concerning in the country because there is more access to firearms.

Although there are security guards at the front, court doesn't finish until late and there is no one to escort parties to all-day car park which is a long way away from the court. This is a safety risk for lawyers and AFMs alike who both have to make their way to their cars, often in the dark.

RECOMMENDATION 7

The Victorian Government's proposed safety audit of courts should be conducted in consultation with court stakeholders and expanded to include:

- an audit of risk assessment and management processes, and
- all courts and tribunals where family violence victims/survivors may present, not only Magistrates' Courts (including the County Court, Coroners Courts and VCAT)

with the aim of embedding an expanded Common Risk Assessment Framework in the practice of all relevant courts.

RECOMMENDATION 8

Remote witness or videolink facilities should be expanded to be accessible to AFMs in all family violence courts. This should include provision of remote witness facilities for women in refuges to be able to attend court with no reference to their location.

RECOMMENDATION 9

Security for family violence hearings, waiting areas and to accompany protected persons to and from their cars when required should be consistently provided by appropriately trained personnel.

Magistrates

Our consultations with specialist family violence lawyers were clear that there is inconsistency in: magistrate decision making; magistrates' attitude to and understanding of the dynamics of family violence and the potential for respondents to abuse the court process; cultural sensitivity; and knowledge of the *Family Violence Protection Act 2008* (FVPA), including its relationship to family law.

> *The demeanour of presiding magistrates significantly affects the experience of clients in the court, no matter the outcome of their case. The best magistrates put the parties at ease and demonstrate to the respondent community expectations about violence in a strong and respectful manner.*

Historically there have been instances where magistrates were unreasonably intimidating and distressing for both parties. Today there are far fewer examples of this behaviour, but inappropriate behaviour by magistrates remains difficult to address. Clients are too distressed to focus on the outcome of their matters to make formal complaints. Lawyers may also be reluctant to pursue such complains because they are repeat players in the system.

> *There is currently a different approach to orders and the giving of evidence, depending on the magistrate on the day. There's a lack of accountability by perpetrators, and non enforcement of or low penalties given for breaches. One applicant said that she would not have applied had she known what it would be like giving evidence before the magistrate.*

> *We had one matter where the respondent was unrepresented and started talking about belongings in the garage. He had already been three times with police to retrieve the property but in court he was permitted to change the whole focus away from safety of our client to the stuff he had in the shed. Another magistrate threatened a client with not making an order unless she agreed to family law arrangements, then stood the matter down to negotiate. In a third matter, a respondent when with a previous partner had been caught in the roof space with knife and ties, and cut his throat in front of police. He now has a new partner who gave evidence and minimised his behaviour saying she hadn't had problems. There were two children. He was allowed to contact her daily to speak with the children. You can train magistrates but if they aren't motivated to understand what is going on and the control dynamics you will never get good results.*

> *One magistrate said 'a threat to kill is just something you do over the dinner table.' The same magistrate ordered all witness statements to be provided in two weeks before the contest, otherwise the matter would be dismissed. The AFM wouldn't get a legal aid lawyer that far in advance so she was required to do a lot of work. We are now helping her with the witness statements even though this is not what we are not usually funded to do.*

Magistrates are appropriate in the way they speak to victims and work with respondents to resolve matters as swiftly as possible. They also accept that there are occasions where police or informant statements are relied on to avoid the AFM having to risk interactions with a perpetrator.

We have less to complain about now, but some magistrates are insisting that conflicts of interest don't exist.

Example
An unrepresented respondent succeeded in significantly protracting negotiations by being obstructive and unreasonable about how to access his property that was on the site that the AFM wished him to be excluded from as a condition of the intervention order. The CLC duty lawyer finally achieved agreement and went into Court, only to find that the Magistrate wouldn't accept consent order because one of the proposed conditions was about property. Instead the Magistrate insisted the respondent could simply go there to collect the property with a mutually agreed on associate, despite the expressed fear of the AFM of him and his associates. The respondent had dragged the process of collection out on numerous occasions, giving various reasons why he had to take so long each time and could not finalise dates and times. The property was clearly being used as part of his intimidation and harassment of the AFM. After being at court since 11am, the AFM was still in the CLC's office at 5pm, crying, and had to be assisted to make a safety plan.

Example
A magistrate refused to make an exclusion order because the respondent had a child, applying the provisions of the FVPA to conclude that making the child homeless was not what Parliament would have intended.

The family law provisions in the FVPA are underutilised by many magistrates, either because they are not confident about how they interleave with the *Family Law Act 1975* or because of time pressures.

I think they just veer away. They look at you like you're from outer space. Clients appearing for themselves walk away without those orders being made. You can't always rely on magistrates knowing exactly what to do.

At least one CLC suggests that there is a similar underuse of s 71 and s 72 (FVPA) orders (requiring legal aid to be provided for cross examination in a contest).

CLC duty lawyers also acknowledge the pressures on magistrates placed by burgeoning demand:

They're quite good on the whole but then something happens and it's just really inconsistent. I wonder if it's because they have matter after matter and little support, and there's a huge emphasis on efficiency.

Our magistrate has a clear commitment to family violence and probably works harder than any other magistrate in the area. But does hold things up for the duty lawyer in getting matters through because they are very considered and read all documents, not just submissions.

We all agree that magistrates need more time, but the reality is that's not going to change.

Ongoing specialisation and substantial and regular training of magistrates is therefore essential - and efficacious:

> *Our magistrates are now very good. They seem to be trained up on family violence and recognise the emotional and psychological abuse more than in the past. We are particularly pleased at the number of orders that have been granted for longer than 12 months where there is merit to do so. A number of indefinite orders have been granted recently.*

> *The recent training provided by Domestic Violence Resource Centre Victoria has had our magistrates specifically quoting it, and they are now much better. There was even a recent matter where the magistrate ordered protection beyond what the lawyers had agreed on.*

RECOMMENDATION 10
Mandated intensive and regular training, involving external service partners who participate in the integrated response, should be required for all Victorian Magistrates and Registrars in the family violence jurisdiction, including training on:

- mandatory considerations under the *Family Violence Protection Act 2008* (Vic)
- approaches to risk assessment and decision-making
- family law, and
- sensitive management of proceedings.

RECOMMENDATION 11
Judicial officers, court staff, legal representatives, police and non-legal family violence support workers should be provided with ongoing training and professional development to foster expertise and specialisation in family violence.

RECOMMENDATION 12
Magistrates and Registrars should be subject to effective complaints and accountability processes.

RECOMMENDATION 13
Recruitment and retention of specialist Magistrates, Registrars, police, lawyers, support workers in the family violence jurisdiction should be encouraged.

RECOMMENDATION 14
Magistrates should be encouraged to attend each other's courts on a regular basis to provide an informal method of peer support and to mitigate inconsistencies between Magistrates' approaches to family violence matters.

Interpreters
It is difficult to get interpreters for all the languages needed in some courts, and particularly for courts outside Melbourne:

> *We have problems with availability and willingness to travel to remote areas. On the day they never get there even if there is one booked. Generally you do the best you can. We occasionally use the Translating and Interpreting Service (by telephone). If that is not possible generally you are dealing with family members that can assist the client in understanding the matter which is not feasible. There are times where the interpreter is organised through the court and they still simply don't turn up.*[16]

[16] Rural barrister.

Some courts only book interpreters for a half day, usually from the beginning of the day until 1pm. If negotiations are delayed with the respondent, interpreters will often not be able to extend their time. This can lead to pressure to make hasty decisions in order to push matters through by lunch time or adjourn the matter.

Interpreters do not always adhere to appropriate professional standards, and It is unclear without independent verification how accurately and impartially interpreters are communicating information and instructions between lawyer and client.

Courts are only funded to provide one interpreter if both parties speak the same language, which results in at least a perception of bias and enhanced vulnerability for clients.

RECOMMENDATION 15
Magistrates' Courts should be funded to be able to provide separate interpreters for each party in family violence matters, with interpreters required to attend family violence training including in the Common Risk Assessment Framework.

RECOMMENDATION 16
Magistrates' Courts should be funded to book interpreters so that they can be available as long as they are required on the day of the client's hearing.

RECOMMENDATION 17
There should be regular independent auditing of interpreters who are practising in the family violence courts to monitor accuracy and impartiality.

Working with others at court
Overall, CLC duty lawyers have a good relationship with registry staff, particularly specialist family violence registrars and in courts where there is less turnover and therefore greater consistency in approach.

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In general, CLC duty lawyers have a positive working relationship with their Victoria Legal Aid counterparts and appreciate that they are working under the same stringent conditions. Indeed, CLC family violence duty lawyers acknowledge that sometimes VLA's general duty lawyers are operating under even more demanding conditions as they are also acting in criminal matters and seeing respondents in police applications. However, community lawyers reported some variability in VLA lawyers' understanding of the legislation and the dynamics of family violence, and at times a tendency to adversarialism, which was thought to be related to the criminal law background of many generalist duty lawyers.

RECOMMENDATION 11

Judicial officers, court staff, legal representatives, police and non-legal family violence support workers should be provided with ongoing training and professional development to foster expertise and specialisation in family violence.

CLC experiences of private lawyers are more variable around the State. In some rural areas, private lawyers are essential because of the high potential for both the CLC and VLA to have a conflict of interest, or because there is not sufficient coverage from other sources.

For example, in Mildura, there is no VLA duty lawyer. The duty lawyer scheme is run by the local private practitioners with funding from VLA, and there is a good relationship with Murray Mallee CLS. Swan Hill has no VLA office but has visiting VLA duty lawyers on circuit from Bendigo. If the visiting service is withdrawn, there are now no private solicitors in Swan Hill who are prepared to do legal aid work in family violence, which might be due to new VLA panel requirements.

Some CLCs have good and strong relationships with private lawyers, but many others have concerns:

> *It is rare that the other party is privately represented. But when they are, negotiation is more difficult. It seems to be about showing the client they are getting their money's worth.*

> *We have a great relationship but they are also there for one case, whereas we're trying to juggle eight, and they expect you to be ready when they are.*

> *There was one who would dismiss text messages, just completely disregarded information that I had. They often just want to speak about the property. There are all kinds of tactics that are played usually, such as refusing to speak with her while running up the bill all morning.*

> *We often have problems with private lawyers approaching our clients while they are waiting, threatening to bring up mental health issues.*

> *They like to show that they are earning their money. They will try to push family law stuff, push it to a contest. They see it as a fight, as opposed to the CLC view of getting the best safety outcome.*

> *There are two extremes when it comes to private lawyers. Some can be worse than VLA in that they can be totally unwilling to negotiate and may even refuse to take an offer back to their client. Or they will be there with you all day showing the client that they are putting in the hours and negotiating.*

Concern about inappropriate use of cross applications (see below) relates mostly to respondents who are represented privately.

> *Neither private lawyers nor VLA duty lawyers like the fact that applicants do not always come to court due to the safety risk. They think AFMs should be present whether there is a risk or not.*

> *There aren't that many that understand the Act (FVPA). It's disappointing that having a family law understanding doesn't mean an understanding of family violence. Their discretion and confidentiality also needs work.*

Failure to attend directions hearings because they don't get paid under the grant scheme leaves us to do the work for them.

RECOMMENDATION 18

In recognition of the need for legal aid-funded private lawyers (especially relevant to rural areas where the potential for both CLC and VLA to have a conflict may be greater), specialist family violence legal services should be funded to provide family violence training for private lawyers, including in risk assessment; and in legal issues arising from family violence such as family law, credit and debt and homelessness, so that referrals can be made to appropriate services.

RECOMMENDATION 19

The Victorian Government and the Magistrates' Court of Victoria should encourage and model best practice collaboration, including via statewide protocols and MOUs, between all family violence court stakeholders, including police, Registrars, Applicant and Respondent Workers or equivalents, paralegals and duty lawyers.

RECOMMENDATION 5

CLCs should be funded to act for AFMs in directions hearings and contested hearings in all Magistrates' courts.

Other court practices and procedures

Courts tend not to have staggered listings, meaning that clients arrive at 9.30am and may not have their matter heard until 3pm. In addition, smaller courts may not prioritise family violence matters, meaning that there may be a considerable wait with attendant stress and safety concerns.

I waited until 3:00pm to have my first matter heard yesterday. There were mothers with babies in prams who were there all day with the respondents. There are no baby changing facilities. Mothers were breastfeeding in the waiting room.

RECOMMENDATION 20

Courts with large family violence lists should provide for staggered listings, at least for half of the list.

RECOMMENDATION 21

Where there is not a dedicated family violence list and it is feasible to do so, priority should be given for family violence matters to be heard first.

In some courts, applicants are being interviewed for initial intervention order applications over the counter in the public reception area. Clients have felt uncomfortable and exposed discussing private information in this environment.

RECOMMENDATION 22

Initial applications should be taken in a private space by registrars specifically trained in interviewing AFMs.

In at least one court there can be a delay of concurrent criminal proceedings where the respondent seeks to have the intervention order matter adjourned to the same date as the criminal proceeding. The respondent's rationale is to prevent any incriminating evidence being exposed before the criminal matter proceeds. However it can take months for criminal charges to be heard. The interests of timely resolution of the application and the need for protection of the applicant are of prime importance and should not have to wait until finalisation of the criminal charges.

RECOMMENDATION 23
Family violence matters should not be adjourned to be heard concurrently with criminal matters, or until after family law proceedings, without a compelling reason.

Further and better particulars are being ordered more frequently, and so are required to be supplied by the duty lawyer service. It is more appropriate that these documents be drafted by the lawyer or service that will represent the client at the contested hearing. Because there are very few other options for most applicants, at least one CLC has taken on this role, which has significantly increased the already heavy workload of the service.

Improvements in drafting the initial application could also reduce the need for further and better particulars. The application form is complex, and applicants are generally not able to obtain assistance or advice beforehand, so they do not know what to focus on or what is relevant, and may omit important information.

RECOMMENDATION 4
Community legal centres should be funded to provide early intervention via legal assistance for family violence intervention order applications in all Magistrates' Courts (models to be determined by local circumstance and needs eg clinic, designated duty lawyer).

RECOMMENDATION 24
The Magistrates' Court and Victoria Police should review the format of safety notices and intervention order application forms to facilitate collection of sufficient information to support the application.

Children
How matters are approached and resolved in relation to the safety of children can be problematic in some courts. Magistrates vary in terms of the extent to which they will turn their minds to the question of whether children should be listed on the mother's intervention order, although best practice is to include children as a matter of course, with appropriate tailoring if there are safe contact arrangements ordered by the Family Court.

> *Often in relation to police applications and if she doesn't get legal advice, she agrees to contact, so the child is taken off the (interim) order. Then we have to apply to vary the order without police support of any kind, usually. Then they don't resolve so it's off to a contest.*

A related and vexed issue concerns child protection, which can be a two-edged sword for mothers experiencing violence from their partner. FVPLS advocates to protect the cultural interests of children and to ensure that Aboriginal and Torres Strait Islander family members can have meaningful input into decisions around a child's placement and cultural care. Given the significance of family violence as a factor in child protection interventions, and the overrepresentation of Aboriginal and Torres Strait Islander children in the child protection system, this places a significant burden on women and the service.

Other CLCs are frustrated by the lack of child protection workers at court, and what appears to be a common practice of the Department of Human Services requiring the mother experiencing family violence to demonstrate that she is a protective parent by obtaining a family violence intervention order that includes the child—and yet providing no support for her to do so:

> *DHS confuses them and sends them to court without paperwork. They may not even want an order but DHS has threatened them— it's really hard to advise then. You're having to make these epic decisions in a short space of time with-*

out Child Protection's involvement. I've had no involvement with them ever and it's not because I don't want to, they're a really hard agency to work with.

Delays in completing risk assessments for the children's safety and lack of communication means that matters are unable to be finalised on their listing date. There are rarely Child Protection workers at court and access to them via telephone is difficult and very time consuming. This can be very stressful for clients.

DHS should adopt CRAF compulsorily when dealing with children at risk of family violence. When DHS assess one parent as protective but the other is not, DHS should support the protective parent, including in court proceedings, to manage the risk posed by the other, 'non-protective' parent.

It's very difficult to satisfy the Court that child protection is an issue. Those mothers are often the least articulate. DHS should provide letters to tender, or assist women to apply.

We don't see DHS helping women to get an intervention order very often. They tell women to go and do it themselves! Then we advise them about whether they should. We're not able to provide as much help as we'd like, because we're already turning people away.

RECOMMENDATION 25
In matters where DHS has an active interest and protective concerns, a representative of Child Protection should be required to attend court.

RECOMMENDATION 26
DHS should more actively engage in both the governance and service aspects of the family violence integrated response, including the provision of external and consistent family violence training for child protection workers.

Police

Police at family violence courts
The introduction of Family Violence Liaison Officers (FVLOs) at family violence courts, although not universally available across the State, has greatly improved relationships between CLC duty lawyers and police.

It's great having a go-to person. It's a name to give the clients. They are very helpful and good to have.

As with many relationships at court, a combination of specialisation and longevity in the FVLO job is the most effective, but not always the case in practice.

The same can be said for police prosecutors, who act in court to seek an application for an intervention order to protect the AFM. It is important to understand that because the police prosecutor is the applicant in the matter, he or she does not legally represent the AFM, unlike a CLC duty lawyer. There is considerable variation across courts as to whether AFMs in police applications are referred to duty lawyers for legal assistance when they require it, and how that need is assessed. Legal help may be

particularly crucial if police are applying for an order or conditions which the AFM does not want,[17] especially if there are also family law implications.

> *AFMs are not always referred for legal help when they should be. And police may be reluctant to assist further down the track eg if there's an application by the respondent to revoke.*

> *At our court we assist with all the police matters. It's taken a while to get there—the police will come straight into my office when we're ready to chat to them. Clients feel really supported doing it that way.*

> *We do not often get referrals from the police to give advice to the AFM. Often the AFM is not aware that she can still seek legal advice.*

> *Referrals don't happen as much as we would like, but we're working on it.*

> *Police don't really refer AFMs to us here. The attitude is they don't need to get legal advice. We need to build that relationship with police though we have a great relationship with the police prosecutors.*

> *It depends on the individual you have in the role—it's really only when the client insists.*

CLCs may also be limited in their current capacity to provide advice to AFMs in these circumstances if police applications have their own separate listing day, as it means another day at court for the duty lawyer service. Similarly, if there is a large mixed list, the CLC could be forced by time constraints to prioritise AFMs who are making their own applications.

Police service of applications and orders

There are safety issues for AFMs when orders have not been able to be served on respondents, because interim orders are then not enforceable. CLCs recognise that sometimes in these situations delay is unavoidable, especially in rural or cross-border contexts where it may be hard to locate the respondent. Police are also under-resourced for this task in some regions.

> *Duty lawyers regularly see clients at Court where the intervention order application has not been served on the respondent and so the matter cannot proceed on that day. Not having been notified about the lack of service, applicants take time off work and arrange for childcare. They overcome their anxiety about an unknown legal process and their fear of confronting the respondent and attend Court only to find the matter is adjourned to another date when they will have to go through the same process again. Also, without direct notification from police when service is made, clients are uncertain about when they can rely on the application's interim protection. Failure to serve can happen multiple times which causes delays in the process, wasting both the client's and the court's time. It leaves applicants vulnerable without protection of an interim order.*

Some failures to serve seem to be more about lost paperwork and other police inefficiency.

[17] Police are empowered to apply for an order in these contexts if they believe it is necessary to protect the AFM.

Case study

[redacted]had made an application to extend a no contact intervention order against her ex-partner [redacted] against a background of a long history of physical, verbal and emotional abuse, including threats to kill. The first mention was adjourned for lack of service. Four weeks later, at the second mention,[redacted] did not attend Court and [redacted]was told the matter would be adjourned again because the Court had no record of [redacted] being served. [redacted] called the informant's station and although he was not on duty, his colleague confirmed service was recorded on the police data base as having been made. However the physical paper copy of the police certificate of service, required by the Court to proceed, could not be located. The station does not keep copies of certificates of service and so the Magistrate adjourned [redacted]application for another 6 weeks, when she will again have to take a day off work to attend the Court.

They could phone or drive past or go to his work –these options aren't being used. One respondent lives at the end of the street where the police station is and he still hasn't been served.

RECOMMENDATION 27

Victoria Police and the Magistrates' Court of Victoria should implement an acceptable, reliable and electronic system for confirming service of family violence documents.

Policing family violence more broadly

There have been substantial improvements in policing of family violence in recent years. Nevertheless, attitudes and practices around the State are inconsistent. Despite the stipulations of the Police Code of Practice, the single largest category of complaint from CLC lawyers about police treatment of family violence victims concerns police response to complaints of family violence, including breaches of intervention orders.

The value of an intervention order is only as good as the protected person's willingness to report breaches and the police's capacity and willingness to enforce the order.

A client went to report an assault to police who responded by saying 'he only hit you in the head this time, that's not too bad is it?' Another police officer said to an AFM 'taking action may make him more angry'. We've also heard of a situation where threatening to slice someone's throat was not enough—police wanted dates, times and 'means to giving effect to a threat'.

A massive shift needs to take place— implementation of referral protocols and asking about an individual's Aboriginal or Torres Strait islander status so they can be referred to culturally safe services.

It's one of the major issues. A lot revolves around section 92, with respondents writing narratives to clients that are not relevant to children, just guilt tripping. Every time their phone beeps the client's heart sinks and police are just not understanding how orders work. So much of my time is spent chasing up police, probably one of the most time-consuming aspects of the job. It gets cast as 'just a minor breach' but there will often be a series of them. Respondents are always testing the boundaries.

Our clients make regular complaints to the duty lawyer about police not prosecuting breaches—particularly electronic communication breaches. This can lead to clients ceasing to report incidents when the violence may be more serious in the future.

'Technical breaches' don't exist!

Case study

[redacted] was physically assaulted and stalked by her ex-boyfriend about 12 years ago. This happened over a two year period in a regional area in Victoria. She had an intervention order in place but her boyfriend breached those conditions many times.

He would arrive at her house with a cricket bat and smash her windows and locks and break down her doors, destroy her property and cut off her phone line. He threatened to kill her ex-husband in front of her children (who were living at another address) if she didn't come out of the house when he came around.

At first she went to the police in the small town where she lived and reported what had happened. The police did not investigate the complaints and encouraged her to leave town as they said that she was responsible for their high workload. Police who did try to help were transferred. After the threat to kill her ex-husband, she again went to the police station, fearing that her ex-boyfriend would carry out the threat. The Senior Sergeant indicated to the other staff that he thought [redacted] was crazy. She was told to wait. Sometime after that her ex-boyfriend arrived at the police station. The Senior Sergeant ordered her to leave the station. Her ex-boyfriend pulled her arm while the Senior Sergeant escorted her out of the station. She has been unable to disclose to anyone what happened to her that night. She experienced post-traumatic stress disorder, depression and anxiety for the last ten years and now says that if something bad was to happen to her, the police would be the last people she would call for help.

Her ex-boyfriend has a violent criminal history and his level of the violent offending has escalated considerably over the past ten years.

This year her health improved and she lodged a complaint with IBAC. She then also approached the Federation of Community Legal Centres for a referral for legal advice. As she lives in regional Victoria it is difficult for her to access help as the few community legal centres that give advice because they require clients to live or work in their catchment areas and don't usually give phone advice.

[redacted] is now on a 5 week waiting list for legal advice at a community legal centre. In the meantime, IBAC has contacted her requesting further information from her within the next 14 days. There are real concerns for her physical and mental health while she unable to access a lawyer to discuss her complaint. The Federation is not a legal practice but is attempting to give her procedural information and support while she is on the waiting list.

We have a really good relationship with the Family Violence Unit at one of the stations, but we're still working on another one.

One-man stations can be a nightmare. For example, they try to mediate or 'keep an eye on things', rather than charging with a breach. Or they have the view that 'if you won't show me your injuries I can't do anything about it.'

We have good relationships with family violence unit police, but there have been changes locally in the last month so new contacts are being organised. It is often the police 'on the beat' who may not react to family violence issues as well.

Once again, specialisation and perhaps particular personalities and local leadership result in better and more consistent practice.

Police in our area have a regular presence, and there is a dedicated family violence unit overseeing family violence matters, and regional family violence advisors. This is improving the policing of family violence.

Responses depend on whether you're dealing with a uniform or a family violence unit member.

Members of Morwell Family Violence Unit have informed Gippsland Community Legal Service that it is their policy to refuse to accept undertakings from adult respondents in police intervention order applications. This demonstrates police taking family violence matters seriously.

There has been a huge improvement in the area—police in the court are excellent and push hard on behalf of victims and don't easily back down. But there are still inconsistent and even inappropriate responses by some police officers in the IVO process. This sometimes demonstrates a lack of understanding of the dynamics of family violence on the part of some police, particularly in circumstances of self defence. And despite the training they receive there are still inconsistencies in risk assessment conducted by the police.

Case study

[redacted] was the subject of a police application, which had removed her from her home. She had spent the night on a friend's couch. Her two small children had remained at the home with her partner. [redacted] was undergoing medical treatment for a life threatening condition and was stressed when she met with a CLC lawyer. She seemed slow in taking in advice. She indicated that she had told police that she was the real victim and that there had been frequent violence in the past. She had obtained intervention orders against her partner before. There was a history of heavy drug use. The police made no attempts to ascertain the true situation at the incident, relying on the partner's blood nose as evidence. They were insistent that their guidelines required them to take action.

Police responses can also be inconsistent in terms of whether police will make the application on behalf of the AFM or if they will refer her to court to make it herself.

If you could say with certainty, this is what's going to happen and tell them what to do eg go and report to the police. I feel sometimes I'm chasing my tail and there's resistance at every point. Clients are quite happy to do it themselves and so it would be nice to be able to refer with confidence to the police—and more efficient for my time.

RECOMMENDATION 28

Policy and practice of Victoria Police should be to take action in respect of any intentional breach of an intervention order, regardless of its 'magnitude'.

RECOMMENDATION 29

Specialist training within Victoria Police should be reviewed and expanded with the aim of ensuring that police responses reflect the seriousness of family violence and are consistent across the state.

RECOMMENDATION 30

A Victoria Police, CLC and family violence services group should be established to work together to improve issues around service delays, referrals to duty lawyers for legal advice when police are the applicant, and response to breaches.

Accountability for perpetrators

Perpetrator accountability should be a cornerstone of the justice system's response to family violence, across the intervention order system and criminal justice responses. In the intervention order system perpetrator accountability should underpin the conditions of an intervention order, but also be actioned through on-the-spot referral to services at court that can address both a perpetrator's violent behaviour and various possible contributors to it. Ideally, magistrates are empowered to mandate Men's Behaviour Change program attendance and link the respondent to a court-funded Respondent Worker, who can also ensure the provision of assistance for alcohol and drug issues or assist him to find housing if he has been excluded from the home.

In a system designed to maximise perpetrator accountability, that same magistrate can also hear related criminal matters such as breach of an intervention order, and judicially monitor both the impact of the MBC program and any penalty such as a community corrections order.

In practice, however, while the power of magistrates to mandate MBC attendance when making an intervention order has recently at least begun to be extended outside the FVCD, a significant limiting factor is the lack of availability of MBC places. Waiting lists can be anywhere from six months to two years, with some programs having closed their books. Even otherwise well-resourced courts may only be able to mandate MBC participation if the respondent is from a specified postcode area. Respondents from a CALD background and other respondents with specific needs may not be able to access a program at all.

As outlined above (*Variable availability of non-legal supports at court*), even where places are available in the area within a realistic time frame, the court may not have a respondent worker to 'oil the wheels' of referrals for magistrates.

Alternative justice options to increase perpetrator accountability

For many people, holding perpetrators to account through the justice system can be interpreted as ensuring that perpetrators are adequately punished and, in particular, are sanctioned with long custodial sentences.

Certainly, the criminal justice response to perpetrators of family violence must be consistent and clear that family violence is a serious crime and will be dealt with as such. It has taken decades of work by family violence victims, services and advocates to change the traditional treatment of family violence as "just a domestic" and of violence against a family member as less serious than other forms of violence. This context can lead to caution about exploring alternative justice approaches for family violence offending.

Therapeutic justice responses such as the Courts Integrated Services Program that aim to tackle the factors that contribute to an individual's offending are already acknowledged as highly effective. These must be central to the justice response to family violence and should be expanded and applied to family violence offenders. Custodial sanctions in their current form are unlikely to increase safety in the long term in light of the evidence that prison is, in itself, criminogenic.

Restorative justice options have not been trialled in the context of family violence in Victoria. However, restorative justice options may have potential—in certain cases—to provide victims of family violence with something the current system rarely offers, a sense of having been heard and understood and that the perpetrator has acknowledged the harm caused.[18]

[18] Loddon Campaspe Community Legal Centre, *Will Somebody Listen to Me? Insight, actions and hope for women experiencing family violence in regional Victoria* , 2015

RECOMMENDATION 31

Changes should be made to tighten the 'web of accountability' around perpetrators of family violence, by:

- funding adequate mandated Men's Behaviour Change places
- providing at all courts for judicial monitoring of offenders and of respondents' attendance and outcomes at Men's Behaviour Change programs, and cross-court sharing of information
- providing at all courts for a case management approach including swift sanctions for breaches of intervention orders
- providing on-the-spot access to assessment and referral to mental health and alcohol and drug services at all courts
- expanding therapeutic programs such as the Court Integrated Services Program to include family violence respondent referrals and ensuring these programs operate with an understanding of specific factors influencing family violence offending and risk
- ensuring that community corrections sanctions have capacity to monitor family violence offenders effectively and to mandate participation in appropriate behaviour change and violence intervention programs
- mapping different points of intervention with family violence perpetrators across the different service contexts including child protection, courts, corrections, police and health services to identify effective intervention, and
- exploring whether the introduction of restorative justice options might improve perpetrator accountability and maximise victim safety and acknowledgement in certain cases.

Improving corrections interventions in family violence offending

Improving police and court responses to criminal acts of family violence is vital. However, the impact of the justice response to family violence will remain limited if penalties applied to those convicted of family violence offences are not effective. Penalties must hold perpetrators to account for their behaviour, and seek to change the behaviour and prevent future violence as much as is possible.

Arguably, Victoria's corrections agencies have been slower to understand and respond to family violence as a core aspect of their work when compared with many other parts of government. Less than four years ago, one report identified serious deficiencies in Corrections Victoria's approach to family violence, concluding that, "formal capture of family violence details is not currently undertaken by Corrections Victoria and it is necessary that specialist family violence assessment measures and management approaches be adopted."[19] The report also found that, "Corrections Victoria staff members require enhanced understanding of the dynamics of family violence through educational training and supervision".

While Corrections Victoria has subsequently introduced family violence training for some staff and has commenced some programs designed to tackle the specific characteristics of family violence offending, it is important that:

- courts are confident that, if a Community Corrections Order is imposed in respect of family violence offending, appropriate family violence intervention and Men's Behaviour Change programs will be available for the offender and corrections staff responsible for supervising the offender will be trained to identify and manage changes in risk of violence
- specific family violence programs and other interventions are available in the prison system for offenders who receive a custodial sentence
- Corrections Victoria has the capacity to assess all offenders for risk of family violence offending, regardless of whether an offender's contact with the corrections system is directly related to a family violence offence, and is able to provide appropriate programs for all offenders

[19] Prof James Ogloff and the Office of Correctional Services Review, September 2011, *Review of Parolee Offending By Way of Murder*, 7. Retrieved from http://assets.justice.vic.gov.au/corrections/resources/051c107d-da39-44af-abf9-b19f4ed28695/reviewofparoleereoffendingbywayofmurder.pdf on 17 June 2015.

- all Community Corrections staff, including those working with other categories of offenders, are trained to identify and manage risk of family violence
- the risk of family violence offending is considered and mitigated in pre-release planning and transition support, and
- Corrections Victoria considers other opportunities to play a preventative role in relation to family violence, for example through education programs in the men's prison system.

Similarly, a high proportion of women with whom Corrections Victoria has contact are likely to have had past or recent experience as victims of family violence. For many, their experience is causally connected to their offending.

For women prisoners, Corrections Victoria should have routine assessments in place for all women entering the corrections system so that Corrections Victoria can:

- identify any history or risk of family violence, and
- connect a prisoner or offender with relevant therapeutic supports as well as legal and other services.

RECOMMENDATION 32

Family violence should be embedded as a core element of the work of Corrections Victoria. Corrections agencies should have in place:

- a process for assessing all offenders for risk or history of family violence
- a range of programs and interventions for family violence offenders serving a community corrections order and prisoners serving a custodial sentence who are assessed as indicating risk of family violence offending
- ongoing training to ensure all community corrections and prison staff understand the dynamics of family violence and can identify and manage risk of family violence, and
- a range of programs, therapeutic supports and other referrals such as legal services available for women in the corrections system who are at risk of, or have experienced, family violence.

Issues with the *Family Violence Protection Act 2008*

The FVPA is widely regarded as a best practice model in terms of the legal protections offered and its purpose, which is to prevent and reduce family violence, prioritise the safety of victims, and hold perpetrators accountable for their use of violence.[20] Seven years on provides opportunity to reflect on how the legislation is working in practice.

Cross applications

The Victorian Law Reform Commission concluded in 2006 that cross applications are often made to intimidate women and continue the abuse, and may be consented to by the woman simply to ensure that she gets her own order.[21] As the VLRC emphasised, cross applications may sometimes be appropriate: in situations where there is genuinely family violence perpetrated by both parties, or where it is actually the victim who has to make the cross application against the perpetrator who 'got in first' with a groundless application.[22] The VLRC confined its recommendations to a requirement that there be sufficient grounds established by a magistrate before a mutual order can be made.[23]

However, cross applications continue to be a vexed issue.

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[20] *Family Violence Protection Act 2008* (Vic) s 1; Australian Law Reform Commission and NSW Law Reform Commission, *Family Violence–A National Legal Response*, ALRC Report 114, NSWLRC Report 128 (2010), 201-3.

[21] Victorian Law Reform Commission, *Review of Family Violence Laws Report* (2006), 279-84.

[22] Victorian Law Reform Commission, *Review of Family Violence Laws Report* (2006), 283.

[23] Victorian Law Reform Commission, *Review of Family Violence Laws Report* (2006), 284.

There is an increasing number of respondents making cross applications against a protected person at court on the day of the hearing. This can be extremely distressing for the protected person to then have to defend an application which is often brought with little merit. It is often suggested to the ADM that they consent to mutual orders despite the implications in the family law jurisdiction.

Our client had been a victim of family violence for many years and then fought back. So she was excluded from house and seeing the children. SO when she went back to the house she was charged with breaches. She couldn't get legal aid for the criminal matter because it wasn't deemed to be serious enough, and because she had breached the intervention order she couldn't be assisted for family law. So our CLC helped with her plea, and got her contact with her children so she could rebuild the relationship. She still had to relocate and had trouble finding secure housing, so she ended up falling off the rails for other reasons.

Magistrates will try to convince the AFM to consent to mutual orders. It also sends the wrong message—makes it seem as though the applications are equal in merit when often they are not.

Case study

[redacted], who was pregnant at the time, had taken out an intervention order against her ex-partner, [redacted], after he punched her in the stomach. [redacted] however made a cross application and on legal advice [redacted] consented without admission. [redacted] was subsequently jailed after numerous breaches, and on release, he commenced family law proceedings for contact orders in respect of their young child. He mentioned to [redacted] that he had withdrawn his intervention order against her. Not long after, he called [redacted] and threatened suicide. As a result of the number of calls made by her at this point to put him in contact with a crisis telephone line, thinking his life was at risk, [redacted] was charged with committing a breach of the intervention order, which she had believed was no longer in existence. On advice provided by her private lawyer that she would be dealt with leniently by the court and that it would not affect her family law grant of aid, [redacted] pleaded guilty. However VLA immediately cancelled the grant. [redacted] was left to navigate the Family Court system on her own while [redacted] had legal representation.

Private lawyers often try to bring them as a strategy. It acts as a disincentive for the woman who is genuinely needing protection. Lawyers can be adversarial or collaborative—and they are more of the former.

Despite the Police Code of Practice for the Investigation of Family Violence stating 'only one primary aggressor should be identified. Do not make cross applications for intervention orders',[24] some CLCs have to assist victims of family violence who are listed as a respondent in a Family Violence Safety Notice, and are then the focus of police efforts to obtain a limited intervention order.

Case study

[redacted] was a young mother who had been a victim of family violence by her partner, [redacted], for several years. They had a young child who was less than a year old. [redacted] and her partner lived with her in-laws, who witnessed the violence perpetrated against her by their son on a regular basis. [redacted] was too frightened to contact the police or to seek supports as her partner monitored her every move. He threatened that he would make sure that she would never get to see her child if she left him. One

[24] Victoria Police, Code of Practice for the Investigation of Family Violence (3rd Edition, 2014), 17 http://www.police.vic.gov.au/content.asp?Document_ID=43361

night, there was yet another violent incident where her partner charged at her and in protecting herself, [redacted] held up her hands which had a glass in one of them. When [redacted] charged at her, he broke the glass in [redacted]'s hands and suffered a few minor cuts. The neighbours called the police.

When the police arrived, [redacted] claimed that it was actually [redacted] who was the perpetrator of violence. He showed them cuts on his hands which were caused by the shattered glass. [redacted]'s parents corroborated [redacted]'s story. [redacted] was overwhelmed with shock and also felt unable to speak fully about what had happened. After the police interviewed [redacted] separately (where she was able to tell her full story)- the police claimed that as [redacted] had cuts on his arms they issued a safety notice against [redacted].

[redacted] was unable to see her young child due to the fact that there was a safety notice issued against her. As she was unable to return to the home (and hence, [redacted]) she was however able to contact the local family violence service who assisted her to attend at court. [redacted] was forcibly unable to see her young child (who she was still nursing) for three days. [redacted] made an application for an IVO against [redacted], but the local court refused to hear the application claiming that [redacted] had made it in retaliation for the FVSN against her.

Both the FVSN and [redacted]'s application was then transferred and listed in another Magistrates' Court. The CLC duty lawyer negotiated with the police to inform the police that [redacted] was actually the victim, not perpetrator of violence in this matter. [redacted] refused to allow the police to withdraw the FVSN and claimed that [redacted] would be too frightened to appear for an interim application against him. [redacted] also refused VLA to represent him (where he was the respondent to [redacted]'s application), saying that he wanted to represent himself to 'see if [redacted] could face him'. With the assistance of the CLC duty lawyer representing [redacted], [redacted] courageously gave evidence in court against [redacted], whilst [redacted] was at the Bar Table. The Magistrate ordered that [redacted] have an interim order protecting her and the child. The police application proceeded only with a limited order against [redacted].

Case study

At first mention, [redacted] attended court alone and could see [redacted] talking to his lawyer in the waiting area and smirking at her. [redacted]'s lawyer advised the court that he would be making a cross application. DHS had made a notification but they did not attend and had not made it clear to [redacted] what their position was. [redacted] indicated that he wished to contest the matter. It was adjourned to directions with a full interim order and with s92 conditions relating to arrangements for contact with their daughter. [redacted] was represented again at the directions hearing and his lawyer provided [redacted] with a draft parenting plan. [redacted] was at this stage heavily pregnant and feeling very pressured by the process. She was concerned about DHS and the welfare of her children. She reluctantly agreed to an interim parenting plan providing for supervised contact.

We oppose cross applications where appropriate which means we then delay a resolution, increase court time and then have further time taken up to run the contested hearing.

The way that cross applications are currently dealt with can lead to ridiculous situations. We have had matters where the police act for a woman on an application against her partner but will not act for her on the cross application bought by that same partner. This has led to the duty lawyer acting for the partner as Respondent on the original application and as Applicant on the cross application. We have then been asked to appear for the woman as Respondent to the cross application because the police will not act for her. Effectively you have two parties and three legal representatives, two of whom must co-operate to run different sides of the same argument.

RECOMMENDATION 33
Training for Magistrates, Registrars, police and private lawyers should incorporate a gendered analysis of cross application dynamics (see Recommendations 10-11 & 18).

With the vast increase in demand on courts, it may also be appropriate to consider an earlier mechanism for scrutinising those applications that ultimately would not result in a mutual order.

RECOMMENDATION 34
The *Family Violence Protection Act 2008* should be amended to require leave to be granted in order to apply for a cross application, and for a risk assessment to be conducted before any leave is granted.

RECOMMENDATION 35
The Magistrates' Court of Victoria work with the Department of Justice to consider legislative and/or practice reform to ensure that cross applications receive additional and earlier scrutiny than other applications (for example, by requiring that cross applications cannot be made by consent; requiring specialist family violence registrars to assess the merit of the application before it is filed.

Family law
Given the often complex family law issues that can arise out of intervention order proceedings, it is essential for victims to have access to legal advice and representation at their first mention date, through duty lawyer services. The family law assistance may be offered by the CLC providing the duty lawyer service or via other local CLCs (see also Other family violence-related legal issues and gaps in legal need).

Example
The applicant and respondent had recently separated and had in place an informal arrangement concerning shared care of the children. The applicant alleged that at changeovers the respondent had made threats and physical contact and that the children witnessed these incidents. Despite this, the applicant had not sought to include her children on the intervention order.

Example
The applicant stated that she was fearful that the respondent (her ex-partner) might 'abduct' their child. There was no parenting plan in place and the applicant had not sought family law advice.

Example
The applicant was caring for the child of her ex-partner. The ex-partner had a Family Court order but in relation to the child's mother, not the applicant. The applicant had not previously accessed any family law advice.

Difficulties for both AFMs and duty lawyers arise from the fact that there are two separate legal systems that do not always interleave in a consistent manner. As previously discussed, the complexities can be compounded when magistrates and police are not confident or informed about the interrelationship in family violence matters. For example, some magistrates expect duty lawyers to negotiate a parenting plan at court. This is inappropriate for AFMs in crisis, and it takes time away from other matters.

Case study
At first mention, [redacted] attended court alone and could see [redacted] talking to his lawyer in the waiting

area and smirking at her. [redacted]s lawyer advised the court that he would be making a cross application. DHS had made a notification but they did not attend and had not made it clear to [redacted] what their position was. [redacted] indicated that he wished to contest the matter. It was adjourned to directions with a full interim order and with s92 conditions relating to arrangements for contact with their daughter. [redacted] was represented again at the directions hearing and his lawyer provided [redacted] with a draft parenting plan. [redacted] was at this stage heavily pregnant and feeling very pressured by the process. She was concerned about DHS and the welfare of her children. She reluctantly agreed to an interim parenting plan providing for supervised contact.

Even if the property is only a car, Police won't deal with it—they refer to family law. He'd done it to inconvenience her because the FVPA does include a car as personal property.

CLCs are assisting a growing number of women who have debts in joint names, or only in their name due to the controlling and financially abusive aspects of the relationship.

There's no legal aid funding to try to help sort that out. We try to sort that out when we can but we're turning people away in that category in a growing number.

Case study

[redacted] separated from [redacted] after a 5-year marriage, and sought a divorce. She could not afford the $265 filing fee. [redacted] took out a family violence order against [redacted] for her protection. She had entered the relationship with a substantial amount of savings, furniture, a caravan and a car. [redacted] came into the relationship with two caravans and a debt of more than $54,000.

During the relationship, [redacted] had to pay off [redacted]'s debt and a $11,000 property settlement to his ex-wife. She also took care of [redacted]s four children when they stayed periodically.. After the separation, [redacted] had the full-time care of [redacted]'s [redacted] year-old from his previous marriage. [redacted] came out of the property settlement with a split of [redacted]'s Superannuation to the amount of $11,000. There were no other assets as [redacted] had gone bankrupt.

[redacted] was diagnosed with breast cancer and was undergoing surgery, chemotherapy and radiation treatment when she came to the CLC for help. She also had other health issues that prevented her from working full time. Even for a Commonwealth card holder, cancer treatments have significant co-payments.

[redacted] sought a divorce but was unable to file, and took two years to save up the $265. [redacted] was solely supported by a disability support pension and unable to work. She had previously taken out a Centrelink loan and is paying it off. The CLC phoned many services and charities to see if they were able to assist, without any luck.

[redacted] thus could not marry her new partner as planned. She also had to endure an additional burden of an unwanted legal status for another 12 months at an already difficult time in her life.

The introduction of exclusion orders into Victorian family violence legislation has proven invaluable in securing the safety of victims by removing the perpetrator from the home. However, the problem is the competing interests of the *Family Law Act*. The FVPA allows magistrates' courts to suspend current

family law orders subject to a 21-day time period.[25] This is not long enough to get an emergency application before the federal circuit court.

RECOMMENDATION 36
Funding should be provided for increased access to affordable family law services for family violence parties engaged in post intervention order parenting disputes, including through community legal centres.

RECOMMENDATION 37
The Victorian Government should advocate to the Commonwealth for a waiver of the divorce filing fee when it is a family violence matter.

RECOMMENDATION 38
The Federation endorses the recommendations of Women's Legal Service Victoria in their submission to the Royal Commission, and in particular the recommendations that:

- The Magistrates' Court develop a practice direction restricting parties from negotiating parenting agreements at court during intervention order hearings
- Section 68R, S & T of the *Family Law Act 1975* (Cth) be comprehensively reviewed and redrafted by the Federal Attorney General's Department
- The 21 day time limit in section 68T be removed, and
- A process be established between the Magistrates' Court and Family Court registries providing that a section 68R suspension order trigger an application for variation of a parenting agreement/order.

Interstate orders

Example
[redacted] had an interim order that was issued by a magistrate in New South Wales. The matter was due to come before the Local Court for hearing but the magistrate was sick and all matters were adjourned for one month with her interim order continuing. The Respondent was ostensibly complying with the interim order in NSW but would follow her across the border to Victoria and stake out and stalk her at places she frequented.

[redacted] was not able to register the NSW order in Victoria because it did not 'substantially correspond to a final order' as required in the definition of a 'corresponding interstate order' in section 3 of the *Family Violence Protection Act* 2008. The NSW Police did not consider that they could breach the Respondent for the stalking behaviour in Victoria because it did not constitute a breach of the interim NSW Order.

[redacted] has now made an application for a family violence intervention order in a Victorian Magistrates' Court in respect of the stalking behaviour occurring in Victoria, so that she will be covered in both States. If the Respondent contests that application, the matters will be adjourned to a directions hearing to appoint a hearing date.

[redacted] is represented by Police in NSW through to and including the final hearing. In Victoria she has commenced the application herself, and a CLC has appeared for her on the initial interim application. The magistrate was not prepared to grant the interim order because (in direct contrast to the NSW Police) he felt that as the Applicant and the Respondent lived in NSW the Applicant should be covered by the extra-territorial nature of the NSW order so as to allow the NSW Police to breach the Respondent under the NSW interim Order, for behavior in Victoria.

[25] *Family Law Act 1975* (Cth), ss 68R, 68S, 68T.

The CLC appeared again for [redacted] on the first return date when it was adjourned to allow service on the Respondent. The CLC will appear on the next occasion, but if it is contested [redacted] will have to represent herself or pay a private lawyer to appear. Hopefully before then she will have obtained a final order in NSW which can then be registered in Victoria without the need for a second contested hearing.

RECOMMENDATION 39
The Victorian Government should work with COAG to implement the National Recognition Scheme for family/domestic violence intervention orders without delay. Recognition must extend to interim orders.

Other family violence-related legal issues and gaps in legal need

Best practice legal assistance for victims of family violence involves providing a holistic response, where the same lawyer or legal service can provide help with the range of legal issues arising from the experience of abuse. In addition to assistance with intervention order proceedings, this might include assistance with child contact and residence issues, tenancy issues, working to establish the extent of assets and debt in a situation of economic abuse, property matters where there are limited assets or the settlement requires resolution of debts, infringements or victims of crime compensation applications.

A holistic response means that a victim does not need to repeat her story again and again to multiple lawyers, compounding the feeling that she alone is responsible for holding the perpetrator to account and resolving the issues arising from her experience of abuse. A holistic legal response to victims also increases the prospect that lawyers providing assistance will be trained in and understand the dynamics of family violence, reducing the risk of an inappropriate response.

Currently CLCs that provide duty lawyer services also assist victims/survivors with family violence-related legal matters outside their days at court. These CLCs aim to assist victims of family violence with as many legal, and often non-legal, issues as possible and many have practice expertise in the range of legal issues referred to above. However, this assistance is often limited due to capacity constraints.

> *All of our family violence funding goes to providing the duty lawyer service. It is stretched to encompass the expanding needs of family violence clients.*

Family law
All generalist CLCs and some specialist CLCs provide advice and assistance in family law, with a smaller number of CLCs such as Women's legal Service Victoria and Peninsula Community Legal Centre providing casework assistance in family law matters. Provision of ongoing representation in family law is extremely resource intensive and most CLCs are not able to undertake a significant volume of family law casework. For people who meet the strict legal aid means test, assistance with children's issues is generally provided by Victoria Legal Aid lawyers or by the private profession through grants of legal aid.

Victoria Legal Aid has recently reviewed the provision of family law services and, in that review, recognised the value of early intervention and continuity of service for particularly vulnerable clients including victims of family violence. In our submission to that review we suggested there is value in funding CLCs to undertake more family law work, particularly with victims of family violence given specialist CLC lawyers already have initial contact with victims through the intervention order process.

Case study

[redacted] separated from her husband after a 3-year relationship. She has three children from a previous relationship. The husband had been physically violent on a weekly basis, made threats to kill, withdrew money from her bank account, was emotionally abusive (accusing her of cheating on him), and smashed her laptop. He also took her car keys from time to time preventing her from leaving the home.

[redacted] went to police with allegations of rape and criminal damage and was granted an intervention order. The intervention order required the husband to leave the home, but the home was a rental property through Defence Housing who gave [redacted] notice to vacate the home so that the husband could move back in.

[redacted] had not been told by the Police about the women's refuge, and because she felt she had nowhere else to go, she applied for the intervention order to be varied to remove the condition that prevented her and the husband from living in the same home. She then resumed living in the same home as the husband. She also withdrew her complaint against the husband which meant that the Police were unable to proceed with criminal charges.

There was further violence and further threatening behaviour, so a further intervention order was taken out the following year by police. At that time, the police did advise her about the women's refuge, so she was able to move out. Before moving out, [redacted] had been operating a hairdressing salon from the home and the husband had trashed it, causing damage amounting to $12,000. He also approached male clients and asked them to leave, and made threats to [redacted]'s safety.

No property compensation order was sought for the property damage as part of the intervention order process initiated by Police. Police failed to advise [redacted] at any time about VOCAT.

Subsequently, [redacted] approached a CLC for advice about the property damage and divorce. In relation to the divorce, legal aid was not available even though divorce was imperative in this situation. It was difficult for [redacted] to do the divorce application herself, as her husband subsequently moved interstate to an unknown location and avoided proceedings, not disclosing his address. The divorce was able to proceed because the CLC made contact with the husband via email and although he refused to disclose an address, his comments in an email to the CLC indicated that he was aware of the proceedings, so the Court dispensed with service. This process would have been far more difficult had [redacted] been required to self-represent.

The CLC also assisted with court documents so that [redacted] could seek a property settlement from her husband by applying to the Federal Circuit Court.

[redacted] represented herself in Court and successfully obtained a superannuation split, because the husband failed to attend court on numerous occasions. However, the husband has now lodged an appeal so [redacted] will now have further court events to go through. She will not be eligible for legal aid and the CLC can only help with advice and court documents, as it has no capacity to represent Adele in court.

When [redacted] came to the CLC, she was advised of her VOCAT rights, but she was advised by a local solicitor that because she had withdrawn the police complaint, there would be difficulties. She was out of time to proceed with a VOCAT application (most significant incidents were in 2012). She may have still attempted a VOCAT application if there was not the risk that her ex-husband would be invited to participate in proceedings given the lack of police prosecution.

Housing and homelessness

RECOMMENDATION 40

The Federation strongly endorses the submission and recommendations to the Royal Commission by our member centre, Justice Connect (Homeless Law). We are also a signatory to the joint submission to the Commission from 129 organisations, on family violence, homelessness and affordable housing.

Infringements

Many CLCs assist with family violence-related infringement issues, but the capacity to do so is constrained by family violence not being recognised as a special circumstance in the *Infringements Act 2006*, and, for vehicle-related fines, the lack of clear policy for family violence victims required to nominate the perpetrator as the driver.

RECOMMENDATION 41

The Federation strongly endorses the submission and recommendations to the Royal Commission by our Infringements Working Group.

Victims of crime applications

CLCs recognise the importance of being able to assist victims of family violence to apply for victims of crime compensation and other assistance, and the fact that VOCAT is generally underutilised in family violence matters. However, there are capacity constraints for the majority of services.

> *We will take them up if they are an exceptional case because we feel we can understand the sensitive nature of it. Victims have come to you for family violence court and have a rapport with you and wouldn't feel comfortable going to another lawyer.*

> *We only do a trickle—mostly more serious matters or where clients want security matters. It became not worth it in terms of time management when amounts were decreased some years ago.*

> *We used to, when we had a lot more capacity. We cut down because private lawyers did it and we had a good contact to refer clients to—but they've now left, and private lawyers are not getting paid enough. It's a discussion we're going to have to have.*

> *We don't assist but would like to change that. There used to be private lawyers but there are only a few left that will. It's underutilised, definitely. We'd like to improve in-house too.*

RECOMMENDATION 42

Research should be commissioned into why Victims of Crime Assistance Tribunal (VOCAT) applications are not pursued more often by people who have experienced family violence, with the research to be informed by a steering group of CLCs, family violence services and VOCAT staff.

Proposed restrictions to CLC funding and services

Unfortunately, as indicated above, the ideal of providing holistic service is undercut by fiscal realities, and this is further threatened by proposed changes in Commonwealth funding to CLCs.

The May 2015 Federal Budget disclosed that the Federal Government proposes to cut funding to Victorian CLCs by almost 30% in July 2017.

In addition to funding cuts, the Commonwealth is negotiating a new funding agreement for legal assistance funding with states and territories. These proposals include various changes to CLC funding

arrangements that threaten some of the holistic services CLCs currently provide to victims of family violence. In the draft funding agreement, the Commonwealth is proposing to require CLCs to target services to people experiencing financial disadvantage. CLCs have historically provided services to people whose access to justice is impacted by various forms of disadvantage and vulnerability, including but not limited to financial disadvantage.

For many services provided to victims of family violence, including duty lawyer services, assistance to understand the extent of assets and debts in a situation of economic abuse, or general advice on navigating the justice system, CLCs do not currently apply a strict means test. For other forms of assistance CLCs can provide a vital safety net for victims who do not meet the very strict legal aid means test but are far from being able to afford a private lawyer. We have raised concerns that the Commonwealth's proposed approach, essentially the imposition of a de facto means test, will further limit the services available for victims of family violence. While we acknowledge legal assistance resources are limited, it is unacceptable that victims of family violence should have to navigate the justice system and face their perpetrator unassisted, or that they should be forced into massive debt simply to resolve the issues arising from their abuse.

A means test is likely to mean that people who own their own home are not eligible—and yet this is more than 30% of our FV clients (who usually co-own with the perpetrator). I've had a spike in matters with AFMs who work full time and have properties and really severe family violence experience.

A means test would be terrible. It is an area where it really cuts through all financial strata and you see people who may look like they have means on paper but cannot access those means. And it is important that there be a universal service everyone can access. With something like family violence people are so disenfranchised.

We generally try to assist clients who cannot get legal aid, and a similar legal aid type test would prevent this happening.

Our clients have fled violence with very little and usually have no access to bank accounts or assets.

A means test doesn't take into account the dynamics of family violence.

RECOMMENDATION 43

Community legal centres should be funded to be able to provide a holistic service for family violence victims/survivors so that all family violence-related legal matters, including ongoing family law representation, may be addressed with continuity of assistance.

RECOMMENDATION 5

Community legal centres should be funded to act for AFMs in directions hearings and contested hearings in all Magistrates' courts.

RECOMMENDATION 4

Community legal centres should be funded to provide early intervention via legal assistance for family violence intervention order applications in all Magistrates' Courts (models to be determined by local circumstance and needs eg clinic, designated duty lawyer).

RECOMMENDATION 2

In its funding decisions, the Victorian Government should prioritise consistent and long-term proven models rather than short-term or one-off project funding.

RECOMMENDATION 3
In its funding decisions, wherever possible, the Victorian Government should prioritise locally-based and connected, permanent services rather than partial outreach.

RECOMMENDATION 44
Community legal centres should not be subject to restrictions that prevent centres assisting victims of family violence based on flexible criteria that recognise financial disadvantage as well as other factors impacting a victim's access to justice.

Further improvements to policies, programs and services

Genuine integration is yet to be achieved
While there have been significant advances in law reform and the courts' response to family violence in the last few years, Victoria's justice system is at a crucial stage in terms of moving towards genuinely joined up services. Clearly, adequate and sustainable funding is urgently needed to address the aspects of the court system discussed above. But a recurring theme is also the sheer variability of practices, personnel and consequently, outcomes, in intervention order matters and other family violence-related legal issues.

The need to consult with 35 of our member CLCs around the state to produce this submission epitomises the patchwork nature of the present family violence 'integrated' response. Our present system produces more than postcode justice—the shaping of victim protection and perpetrator accountability by geographical location and specific social demographics of AFMs and respondents. It is also profoundly dependent on relationships and even individual personalities of the different workers staffing services. And as one of our CLC's noted about their own local context:

> *Different courts in our region have different Magistrates and different court clerks and so we have several sets of different relationships.*

Our member centres stress how critical it is that they are able to provide a truly holistic service, in courts that are consistent in their practices and understandings.

> *Otherwise it's confusing for us, confusing for clients, confusing for respondents.*

It is therefore important for governments to understand that genuinely effective responses to domestic violence do not simply require injections of funds. As outlined above, even though Victoria is in many ways an example of best practice in its family violence response, there are still many gaps and inconsistencies in the family violence system that endanger women and children and can even result in deaths. Major contributing factors include:

- The diverse range of family violence crisis agencies, other support services, justice and police responses do not always communicate effectively with each other.
- Government departments do not always collaborate or communicate with each other or with community services. 'Silos' still exist, such as that between family violence and child protection agencies, policies and practices.
- Standards of practice and shared understandings about family violence do not always exist or are not adhered to, with unclear lines of accountability.

What is required is core consistency and best procedures and practice, adapted for locally specific conditions but independent of who comes to occupy a particular role.

One of the impacts of the growing impost on the family violence system has been some falling away of early attempts to foster collaborative practices. For example, in some parts of Victoria, the practice of

meeting before court in the morning has become less attractive as the court struggles to deal with enormous listings. But we need more rather than less cross-service meetings in order to cope with the pressure on the family violence system.

The Federation asked our member CLCs with family violence duty lawyer services: 'What works well in your court, and why?' An overwhelming number of responses referred to relationships and interactions with other staff from various services and roles.

> *We have an excellent team, from the magistrate, police, court staff, practitioners and down to court-support-cuppa-tea people… everyone works well together and has the skill to analyse a matter quickly and know when to fight and when to resolve.*

Eastern Community Legal Centre's (ECLC) Family Violence Integration Project (FVIP) was a partnership that worked with the Ringwood Magistrates' Court, Victoria Police, Eastern Domestic Violence Service, Victoria Legal Aid Ringwood, EACH Eastern Victims Assistance and Counselling Program and Court Network to improve the experience for intervention order applicants. The FVIP led to:

- the establishment of the Protected Persons Space (a separate waiting area for applicants);
- morning coordination meetings on family violence court days (to identify high risk cases and responses);
- increased information available to Court users and for service providers;
- regular training opportunities for community agency workers about Court and the intervention order process;
- a Koori Court Support Worker role; and
- significant improvement in victim/survivor experiences of court.

The FVIP demonstrated a need to improve the coordinated legal response and expand partnerships; and the necessity of prioritising integration across all levels of the family violence system in order to ensure safety and accountability.

That systemic advocacy has largely ended now that the project, together with funding for an Integration Coordinator, has concluded.

RECOMMENDATION 45
The Victorian Government should use the Family Violence Integration project as a 'best practice model' to improve integration in the family violence jurisdiction across the state.

RECOMMENDATION 46
A funded Family Violence Coordinator should exist at every Court.

RECOMMENDATION 47
The Magistrates' Court of Victoria should commission regular independent research on court user experiences, particularly those of AFMs.

Risk assessment and management
A related and crucial element of genuine integration is implementation of system-wide processes for risk identification and achieving safety. While there has been much work undertaken to embed common risk assessment and management across the family violence system, there remains a significant challenge, especially within criminal justice systems, to establish risk and safety awareness across the broad range of professionals who routinely come into contact with women and children experiencing, or men using, family violence.

For this task it is impossible to overstate the critical role of gender-based, specialist services for women and children victims of family violence. Comprehensive specialist risk assessment and coordinated risk management must be the umbrella under which client outcomes are measured.

RECOMMENDATION 48

The Federation strongly endorses the recommendations concerning the Family Violence Risk Assessment and Risk Management Framework in the submission to the Royal Commission of our member centre, Domestic Violence Resource Centre Victoria.

Governance

Effective family violence system responses require effective governance, policy arrangements and legislation to provide an effective 'authorising environment'. When the Victorian integrated family violence system began, it was predicated on leadership and whole of government and cross-sectoral integrated responses involving government and the community sector. The reform was facilitated by a number of high-level governance mechanisms, bringing five Ministers and their respective Departments together to work within a single policy framework. Multi-ministerial responsibility provides a holistic approach to addressing the issue and encourages mutual accountability. Within this model Victoria benefited from high-level leadership and the weight this carries in driving reform.

Given the broad range of agencies and sectors involved in responding to and preventing family violence, an 'anti-siloed', whole of government approach to governance is essential. This requires genuine partnerships comprised of government and non-government members across sectors and departments, including in co-designing reforms that are discussed and implemented in a publicly transparent manner. From the top down, there must be strong leadership and multi-ministerial responsibility on this issue, including sending an inspirational message to the community that male leaders are prepared to put men's violence towards women and girls at the forefront of public policy. It would demonstrate that violence is not only a women's issue, but also a crisis that affects all Victorians and which requires a well-resourced and concerted effort in order to be effectively addressed.

As recommended by the Australian and New South Wales Law Reform Commissions, a common interpretive framework is the essential underpinning for every successful strategy within a whole of government, anti-silo, coordinated response. For example, in order for any integrated system to respond effectively and consistently to victims and perpetrators of family violence, there must be appropriate understandings, language, standards, training, practices, guidelines, protocols and accountability mechanisms right across community services, including community legal services, government services, the police, the courts and prisons.

This anti-silo strategy must be backed up not only by work to maintain existing hard-built linkages, but also by a push for better integration more broadly, so that, for example, appropriate support services and peak bodies such as mental health, drug and alcohol services, health practitioners and criminal prosecutors are better linked in to the whole of government response.

What this means in practice is that all professionals in this system need to work together in partnership, in networks and within governance committees to continually focus on improving responses for women and children experiencing family violence, at individual and systemic levels. Over the past decade in Victoria, this has included cross-sector sharing of information about risk to clients (with attendant clear guidelines about when this is appropriate); attending cross-sector court user meetings at Magistrates' Courts to examine issues in client risk management; committing to participate actively in cross-sector high risk management panels; co-case management and consultations between domestic violence and legal workers focused on the safety needs of clients.

RECOMMENDATION 49

The Victorian Government should establish a statutory governance framework for a coordinated, statewide, integrated family violence response that includes:

- permanent cross-ministerial governance and accountability
- resourced partnership between government, legal and community sectors, and
- shared understandings and practices across the family violence system.

Shared understandings and practices should include prioritising victim safety (including risk assessment and management), perpetrator accountability and family violence prevention.

Data

In order to assess the efficacy of the system and to improve strategies, accurate, timely and thorough data collection and independent evaluation are essential. However, data related to specific justice and legal assistance aspects of the family violence system is often not available or even not collected, making it hard to assess 'what works'.

Even basic questions relevant to legal assistance are unable to be answered at present. For example, there is no easy way to find out how many AFMs and respondents are legally represented, let alone the impact this might have on various outcomes.

> *I tried to get data from the Magistrates' Court and couldn't. I had to count through our lists. 1440 matters and I've had to do our own stats manually! It would be nice if we could get easy access.*

CLCs have a host of research questions relevant to the effectiveness of their work with victims/survivors. For example:

- Analysis of multiple legal needs and history of family violence for women who are homeless or at risk of homelessness, including the long-term impact of homelessness, and a cost analysis of early intervention.
- Data about the experience of women after they have obtained an intervention order, in relation to the outcomes of their other legal issues.
- Data about whether the outcome for the woman is better or worse depending on whether have to self- apply at court or if police apply.
- Data to identify why police will/won't assist AFMs.
- Research examining why people consent to orders or withdraw their application, and the impact on withdrawal of AFMs not being able to get funding for directions hearings
- Research specifically analysing the barriers to women leaving the violent relationship. What could be improved in the legal system to reduce the number of unsuccessful attempts?

Perhaps most importantly, it would be invaluable not to simply have access to a snapshot picture of CLC legal assistance in family violence, but to be able to gain a sense of how victims/survivors and perpetrators track over time, and the associated interventions that might make the most difference to safety and accountability.

RECOMMENDATION 50

The Victorian Government should ensure that the experience of CLCs and the full range of research issues identified by CLCs inform the development of the Family Violence Index.

RECOMMENDATION 51

The Victorian Government should commission research which tracks victims/survivors and respondent contacts with the integrated response to family violence over several years, rather than simply providing snapshot information.

Victorian Systemic Review of Family Violence Deaths

Around 40 per cent of Victorian homicide incidents involve intimate partners or other family members. Many of these deaths occur in a context of family violence, and feature a clearly documented pattern of abusive behaviour. Close examination of these incidents can reveal important information about the circumstances and conditions under which these deaths occur. This analysis can assist in the identification and development of strategies aimed at reducing the prevalence of both fatal and non-fatal forms of family violence.

The Federation advocated for many years for a family violence death review in Victoria, including as a member of the Statewide Steering Committee to Reduce Family Violence, which in 2006 prioritised the establishment of a Family Violence Death Review Committee. We also actively campaigned for the Victorian Law Reform Commission Review of Family Violence Laws, and engaged in the subsequent submission process that resulted in Recommendation 153 of the 2006 Final Report, that a family violence death review be established.

The Victorian Systemic Review of Family Violence Deaths (VSRFVD) commenced operation in 2009. Positioned within the Coroners Prevention Unit, the VSRFVD has five main aims:

- 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 focused recommendations aimed at reducing non-fatal and fatal forms of family violence.[26]

Each family violence death is investigated by a coroner, which may lead to an inquest. The Coroners Court integrates legal and medical death investigation and takes a broad public health approach.[27] Coroners are required to discover the truth about a death, whether it was avoidable and if so, how the system failed and how future such deaths might be prevented.

Consistent with the role of the coronial jurisdiction generally, the VSRFVD was tasked with considering whether there are any identifiable gaps or areas of improvement in the operation of Victoria's public health and safety systems and family violence service systems or systems of administration of justice. The Coroner may then comment or recommend how such deaths can be prevented in the future.

The VSRFVD is accordingly an important element of Victoria's integrated service response to family violence. The Federation and several of our specialist CLCs have been members of the VSRFVD Reference Group since its inception, including working closely with the Coroner and the Coroner's Prevention Unit to develop the methodology, scope and direction of the VSRFVD.

Effectiveness of the VSRFVD

There has been no formal evaluation of the VSRFVD, but the Federation believes that our significant involvement can provide useful reflections for the Commission.[28]

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[26] http://www.coronerscourt.vic.gov.au/home/coronial+investigation+process/family+violence+investigations/

[27] James Reason, 'Human Error: Models and Management' (2000) 320 *British Medical Journal* 768; Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: Do They Lead to Positive Public Health Outcomes?' (2003) 10 *Journal of Law and Medicine* 399; Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13 *Journal of Law and Medicine* 173.

[28] The following may provide useful background: David, Nadia (Prosecutor, NSW Police), *Exploring the use of DV Fatality Review Teams* ADFVC Issues Paper October 2007; Ontario Domestic Violence Death Review Committee Reports http://www.crvawc.ca/section-research/domestic_death_review_committee.html; *Report of the Domestic Violence Homicide Advisory Panel* NSW 2009 [see especially pp 62-7]; Taylor, Betty for DV Death Review Action Group, *'Dying to be Heard': Domestic and Family Violence Death Reviews Discussion Paper* 2008.

The establishment of the VSRFVD as the first Australian review of family/domestic violence deaths was regarded as a model by other states and territories. By encouraging other jurisdictions to develop similar strategies to prevent family violence, Victoria played a key role in beginning to 'join up' justice for Australian women and children experiencing violence. This is consistent with the recommendations of Time for Action, the Plan developed by the National Council to Reduce Violence against Women and their Children (2009), which proposed establishing and building upon homicide fatality review processes across Australia, because this would enhance our understanding of the primary risk factors leading to those deaths, improve system and service responses, and inform policy designed to reduce rates of domestic-related homicide.29 The National Plan to Reduce Violence against Women and their Children subsequently listed as one of the four high-level indicators of change that will be used to show progress, 'reduced deaths related to domestic violence and sexual assault'.[30]

Lack of funding

However, it is our view that over the last few years the potential of the VSRFVD has not been realised, and that its contribution to the integrated family violence system has stalled somewhat. Much of this decline can be attributed to a lack of resourcing. Since July 2010 the VSRFVD has not had its own allocated funding, until this year's State Budget when the Victorian Government committed to re-funding it.[31]

The lack of designated funding directly impacted on the key role of the Coroners Prevention Unit (CPU). The CPU was established in 2008 in order to strengthen the prevention role of coroners by supporting them to make practically implementable recommendations that would ultimately reduce the number of avoidable deaths, including family violence homicides.[32] However, the 2013 restructure of the Coroners Court included restructuring of the CPU, which resulted in a significant reduction of specialist family violence staffing. There is now no separate intentional deaths team, which previously included 2.5 positions for the VSRFVD. Where previously a specialist family violence case investigator worked with coroners and stakeholders, this role has been reduced to a fraction of the role of the Manager of the CPU. The Coroners Court also continues to be significantly under-resourced.

As a key member of the VSRFVD Reference Group, we continue to observe the effects of reduction in staff and associated resources. For example, when there was a full-time specialist family violence case investigator, the Federation was regularly contacted for input and discussion of possible relevant factors and issues in preliminary reviews of particular deaths, and to inform related research conducted by the CPU. The Reference Group also met quarterly. Since the Coroners Court restructure such contact has been rare, and the Reference Group has met twice since December 2013.

It is also clear that the valuable function of the VSRFVD in identifying systemic causes and possible solutions to family violence homicides has been compromised by the decline in funding and support structure. In 2012 the VSRFVD produced its first public research report, based on an analysis of deaths over 2000-2010, and of 28 case reviews completed by the VSRFVD team for metropolitan and regional coroners.[33] This report showed that Victoria has many of the statistical patterns and trends identified by overseas family violence death reviews and research. The deaths examined had many of the known risk and contributory factors associated with escalating and severe violence. These includ-

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[29] National Council to Reduce Violence against Women and their Children, *Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009–2021* (March 2009), Recommendation 4.3.2 . See also Betty Taylor for the Domestic Violence Death Review Action Group, *Dying to be Heard: Domestic and Family Violence Death Reviews Discussion Paper* (2008), 11.

[30] Commonwealth of Australia, National Plan to Reduce Violence again Women and their Children 2010-2022 13.

[31] Victorian Government. *Service Delivery 2015-16*. Budget Paper no.3 2015, 5-7.

[32] Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4035 (Rob Hulls, Attorney-General); Coroners Court of Victoria Annual Report 2010-2011, 34.

[33] C Walsh, S-J McIntyre, L Brodie, L Bugeja & S Hauge, Coroners Court of Victoria, Victorian Systemic Review of Family Violence Deaths - First Report (2012) http://www.coronerscourt.vic.gov.au/home/investigations/family+violence+investigations/

ed a history of family violence; relationship separation; threats of harm; alcohol and drug misuse; and the presence of a mental illness.

This type of report has clear implications for intervention and prevention initiatives in the broader Victorian family violence response. For example, in at least 79 of the homicide incidents (29%) either the offender or the deceased had contact with the health care system six months before the death. In 61 of the incidents there was evidence of both mental illness and contact with the health system. Among the case reviews involving intimate partner violence, contact with a health care practitioner was often found. The First Report therefore identified the need for increased efforts to strengthen the identification and response to family violence within the health care sector.[34]

However, the necessary linkages to governance structures, such as the former Violence Against Women and Children Forum established under the previous Liberal Government, do not appear to have been made. Active and regular engagement by the CPU, alongside the Reference Group, in various statewide and specialist family violence forums is essential for continuing to strengthen the integrated model.

The Federation, together with some of our member centres and external partners, attend family violence inquests when possible as part of endeavouring to enhance our ongoing provision of feedback to the CPU on key broad issues. We have been struck by how useful family violence death investigation and review is for our ongoing work in implementing and adhering to the Common Risk Assessment Framework applying across all services assisting women and children experiencing or at risk of family violence. In turn, we have been able to feed our knowledge of risk factors and best practice risk management into the work of the VSRFVD. This nexus is vital, not only for death prevention but also for the prevention of family violence in general.

There have been no further research reports produced by the VSRFVD. 2014 was a particularly concerning year for Victorian communities due to several highly publicised family violence homicides, including two that occurred in a public space. This was a missed opportunity for the VSRFVD to take a prominent role in informing the public about the risk factors for family violence killings and to actively link in with various community and government entities in order to improve intervention and prevention.

In late 2013, in recognition of the limitations of what could be achieved by a fiscally constrained CPU and Coroners Court, the State Coroner proposed a series of panels that would meet more regularly than the existing Reference Group to discuss matters around family violence death investigations. The panels were envisaged as providing greater capacity for representatives from the family violence sector to contribute and participate in coronial family violence case reviews.

The Federation and other members of the VSRFVD Reference Group expressed our support for our greater involvement in the death review process, but emphasised that without providing our organisations with funding for this, and ensuring that the CPU has genuine capacity to support the Review, this strategy will not be effective. As far as we are aware, the panel process has not yet commenced.

Investigation of deaths

Some of the significant limitations of the current model and operation of the VSRFVD are related to its being embedded in the broader coronial system. Bereaved families and advocates have raised concerns about inconsistency and lack of public transparency and accountability with respect to the investigation of deaths. The Victorian Parliament Law Reform Committee *Coroners Act 1985 Final Report* (2006) found that there were 'problems with the way in which police carry out coronial investi-

[34] C Walsh, S-J McIntyre, L Brodie, L Bugeja & S Hauge, Coroners Court of Victoria, *Victorian Systemic Review of Family Violence Deaths—First Report* (2012), 44-48.

gations'.[35] Such problems included unacceptable delays and a perceived conflict of interest when police investigate deaths in which other police officers are involved.[36] This continues in 2015.

There is also a lack of clarity about why some family violence deaths proceed to a full and lengthy inquest while others do not, and the scope of review of those deaths that are not inquested. For example, many of the approximately 17 homicides committed by parolees and those on community based orders were family violence homicides or otherwise committed by men with long and often continuing histories of family violence and/or other history of intense and prolonged violence against women.[37] Most of these deaths have proceeded only to chambers findings. Only one of these homicides proceeded to an inquest—a death where the FV issues although significant were less acute and systemic then other parolee and CBO homicides.[38]

In Victoria it is also standard practice to defer the coronial investigation until after any criminal process has concluded, and then, only possibly, investigate in depth from within the coronial jurisdiction. For this reason, full Victorian family violence inquests tend to be skewed towards those deaths where the perpetrator also died.[39]

It is important to ensure that all family violence deaths are thoroughly investigated. Discovering what led to a person's death is vitally important for their family, who often say they would get some comfort from sparing others the same fate.

Experience of families and the Wanting Justice Project

The coronial process can be an exceptionally difficult and traumatic experience for bereaved families. They can endure long delays between the death and any inquest, and between the inquest and when findings are released. Although the Federation is not a legal service, families regularly contact us as well as individual community legal centres because they cannot find an affordable lawyer, or feel they have been on a referral 'merry-go-round' without obtaining effective legal assistance. Their contact with us it is often at the last minute and because they feel they have 'reached the end of the line' in trying to access legal help and information. They are often confused and frustrated about aspects of the investigation or inquest process, and often only find out about their rights to participate when it is too late to try to exercise them meaningfully.[40] It is very rare for families in such circumstances to receive legal aid, even for legal advice.

Our attendance at inquests and other contact with bereaved families has impressed upon us the need to improve support for such families. In July 2015, the Federation will embark on a new project, 'Wanting justice: Helping families through the coronial process after a family violence death'. Funded by the Legal Services Board, the project will address a significant area of unmet legal need by developing a sustainable model to help families bereaved by family violence-related deaths to access legal and other assistance throughout the coronial process. The project aims to build legal assistance capacity and develop improved access to information and referrals.

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[35] Victorian Parliament Law Reform Committee, *Coroners Act 1985 Final Report* (2006), 199.

[36] Victorian Parliament Law Reform Committee, *Coroners Act 1985 Final Report* (2006), 199-204.

[37] See eg: Tracey Greenbury (Parolee homicide) http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/vic/VSC/2010/10.html?stem=0&synonyms=0&query=title(Robinson%20)&nocontext=1; Douglas Phillips (parolee homicide) http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/vic/VSC/2010/359.html?stem=0&synonyms=0&query=title(Phillips%20)&nocontext=1; Jayde Bounds (CBO homicide) http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/vic/VSC/2010/202.html?stem=0&synonyms=0&query=title(Middendorp%20)&nocontext=1.

[38] Inquest into the Death of Margaret Burton http://www.coronerscourt.vic.gov.au/home/investigations/family+violence+investigations/

[39] See http://www.coronerscourt.vic.gov.au/home/coronial+investigation+process/family+violence+investigations/

[40] Federation of Community Legal Centres Victoria (2013), *Saving Lives by Joining Up Justice: Why Australia Needs Coronial Reform* and *How to Achieve It*, attached as Appendix and at http://www.fclc.org.au/cb_pages/federation_reports.php#Coronial.

Implications for prevention

Best practice preventative coronial systems aim not only to assist the bereaved family but also to contribute to a broader systemic picture of risks and a framework of prevention.[41] Inquests usually involve close examination of the actions of government, community and private service providers. In most cases, these agencies' interests are legally represented at inquests, and families' are not.[42] Expert witnesses are also rarely called in family violence inquests. This means that opportunities to assist the Coroner to explore further systemic matters and lessons for prevention may be lost.

Inquests may not result in coronial recommendations when in families' and advocates' view these could have been made. In some inquests this is also due to the narrow scope of police and/or coronial investigation. The powers of coroners were broadened under the *Coroners Act 2008* (Vic), allowing coroners to make prevention-focused recommendations on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[43] Nevertheless, some coroners will not make any recommendations concerning relevant services unless they find that the service has clearly caused the death.

It therefore follows that many coroners do not implicate a service's processes or actions, even as suitable considerations for the development of prevention strategies to avoid similar deaths in the future. The Victorian Parliament Law Reform Committee's 2006 comment remains salient:

> 'Given that recommendations are viewed as one of the most relevant and powerful aspects of a coroner's findings with respect to achieving public good, it is surprising how infrequently they are made'.[44]

Where coroners do make recommendations, in some cases they are insufficiently specific to produce meaningful change to service policy and practice.[45]

Even where appropriate and targeted coronial recommendations have been made in inquests into family violence deaths, it is often unclear how, or sometimes if, the service responded to the coronial recommendation, and what action, if any, has subsequently been pursued. This is particularly the case for inquests before 1 November 2009, because responses to coronial recommendations were not then mandatory, and were not required to be published on the Coroners Court of Victoria website.[46]

Even since the 2009 reform, it remains the case that after a public statutory authority or entity has responded to a coronial recommendation, there is no established mechanism to monitor any subsequent implementation.[47] This gap is against recommended best practice in family/domestic violence

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[41] David Wexler, 'Therapeutic Jurisprudence: An Overview' (2000) 17(1) *Thomas M Cooley Law Review* 125; Michael King, 'Therapeutic Jurisprudence in Australia: New Directions in Courts, Legal Practice, Research and Legal Education' (2006) 15 *Journal of Judicial Administration* 129.

[42] Coronial Council of Victoria Annual Report 2012-13, 11; Federation of Community Legal Centres Victoria (2013), Saving Lives by Joining Up Justice: Why Australia Needs Coronial Reform and How to Achieve It (Appendix).

[43] *Coroners Act 2008* (Vic) s 72(2). See also Preamble, s 1(c), s 8(f), s 93(2), s 110(2)(b); *Thales Australia Limited v The Coroners Court of Victoria & Anor* [2011] VSC 133 (11 April 2011) paras 68-76; Victorian Parliament Law Reform Committee, *Coroners Act 1985 Final Report* (2006), 360-70.

[44] Victorian Parliament Law Reform Committee, *Coroners Act 1985 Final Report* (2006), 379; and see further 379-81.

[45] Victorian Parliament Law Reform Committee, *Coroners Act 1985 Final Report* (2006), 330-31; Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4.

[46] Cf *Coroners Act* 2008 (Vic) s 119 and Sch 1 cl 7. See also Victorian Parliament Law Reform Committee, *Coroners Act 1985 Final Report* (2006), 331-7, 372-5, 386-410.

[47] Victorian Parliament Law Reform Committee, *Coroners Act 1985 Final Report* (2006), 403-5; Australian Inquest Alliance, *Saving* Lives *by Joining Up Justice* (2013), 31-4, attached separately.

death reviews.[48] Implementation is the crucial aspect of systemic investigation and recommendations, as experience in the broader coronial jurisdiction shows.[49]

Resource implications have limited our ability to pursue the outcome of those publicly available family violence inquest recommendations and responses, but we refer the Commission to the published family violence investigation findings and responses on the Coroners Court website.[50] For an account of many of the broader systemic issues, we also refer the Commission to our appended blog on the inquest into the death of Luke Batty (Peninsula Community Legal Centre acted as solicitor on the record for Luke's mother Rosie during the inquest).

Responding to risk

The Federation is aware of at least one instance of a non-family violence death inquest in which safety risks of a participating party were raised with the Court and no safety risk assessment of that party was carried out. Unfortunately, we are unable to share this case study with the Commission because of confidentiality. However, their experience highlights the urgent need for the Coroners Court to apply appropriate assessment and management practices when parties, witnesses or observers to an inquest may be at risk of family violence.

It is imperative that the Coroners Court develops clear guidelines on how to respond to family violence risk that witnesses and or interested parties may be exposed to during an inquest and particularly in giving evidence. It is critical that the Coroners Court is responsive to safety concerns raised by participating witnesses and interested parties so that witnesses and interested parties can participate in the coronial processes safely. The First Report of the VSRFVD acknowledges the importance of the Courts and justice system in increasing victim safety and mitigating the risk of family violence and the need for a coordinated and integrated response across the justice system. One way of addressing this would to have specialist family violence workers in the Coroners court and to provide training to Coroners and coronial support staff about family violence risk assessment. The introduction of a family violence risk assessment practice guidelines would also assist and should be considered.

The Federation continues to be a strong supporter of an effective family violence death review. We would be pleased to provide the Commission with further information on any of the issues discussed above.

RECOMMENDATION 52

The VSRFVD should be statutorily established according to best practice principles, with secure adequate funding and full integration into the family violence governance and service framework, including risk assessment.

RECOMMENDATION 53

Best practice principles underpinning the VSRFVD should include:

- independence, public accountability, transparency and the active participation and central involvement of advocates for women and experts in violence against women
- regular engagement with the broader family violence sector and Victorian communities, and
- regular dissemination of public education material.

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[48] See eg Report of the Domestic Violence Homicide Advisory Panel NSW 2009 p 64 (emphasis added): 'The implementation by agencies of recommendations and the evaluation of agencies' progress in implementing these recommendations would be the responsibility of the Coroner, who could report back to the Parliament through an Annual Report'. See also Margaret Hobart, Washington State Coalition Against Domestic Violence, *Advocates and Fatality Reviews* 2004, 21(emphasis added):

> 'In order to make lasting contributions, fatality reviews should result in concrete changes in policy, practice, protocols and forms. This means that *the process itself should include mechanisms for creating change and following through on recommendations*.'

[49] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4.

[50] http://www.coronerscourt.vic.gov.au/home/coronial+investigation+process/family+violence+investigations/

RECOMMENDATION 54
The VSRFVD should provide regular public reports on systemic trends and its own activities.

RECOMMENDATION 55
The VSRFVD should include or be closely linked to a program for monitoring implementation of recommendations, including analysis and identification of key and recurring recommendations and agency responses over time.

RECOMMENDATION 56
The VSRFVD should be independently evaluated every four years.

RECOMMENDATION 57
Inquests should be mandated for all suspected family violence deaths.

RECOMMENDATION 58
In order to ensure consistent best practice in coronial investigations and inquests into family violence homicides, minimum standards, guidelines, and a practice direction should be developed.

RECOMMENDATION 59
Two specialist coroners should be appointed to conduct all family violence inquests.

RECOMMENDATION 60
The use of expert witnesses in family violence inquests should be developed as standard practice, including via establishment of an expert panel in consultation with relevant community and legal organisations.

RECOMMENDATION 61
Funding and availability of legal assistance providers must be sufficient to enable all families to obtain, without financial hardship, effective legal advice and representation for investigations and inquests, at a level that is consistent with the level of legal representation accorded to government and other institutional parties in the inquest. A specific pool of funds should be made available to enable community legal centres to provide legal representation for families at inquests.

‘Fail to disclose’ legislation

The Federation joined with 11 family violence and sexual assault advocacy organisations in opposing the Crimes Amendment (Protection of Children) Bill 2014, which proposed making it a criminal offence for people to fail to disclose child sexual abuse to police. We said that such an offence could inadvertently cause more harm to children suffering sexual abuse, and was potentially detrimental to women experiencing family violence.

We argued that Clause 4 of the Bill exceeded the scope of the report of the Cummins Inquiry on child protection, which recommended that laws be restricted to persons of authority within institutions, and the terms of reference of the Betrayal of Trust report.

We were also concerned that a proposed defence in the Bill was inadequate to recognise the impact of family violence on women's capacity to safely disclose, and that similar laws in other countries have been used almost exclusively against women who are themselves victims. We advocated that the better public policy approach was to create a narrow criminal offence that did not also capture vulnerable victims, and so should be limited to a failure to disclose by a person in authority within a relevant organisation.

In our view, the focus should be on providing more resources and training so that non-abusing parents and other people can be supported to safely disclose to police, confident that the child will then receive justice and help.

The present Victorian Government shared our concerns about the Bill when in Opposition, but the Bill is now law. For more detail, see the separately attached Appendices 3A and 3B.

RECOMMENDATION 62

The State Government amend section 327 of the *Crimes Act 1958* as follows:

> Failure by a person in authority to disclose a sexual offence committed against a child under the age of 16.
>
> ...a person ~~of or over the age of 18 years (whether in Victoria or elsewhere)~~ in authority in a relevant organisation who has information that leads the person to form a reasonable belief that a sexual offence has been committed in Victoria against a child under the age of 16 years by another person of or over the age of 18 years must disclose that information to a member of the police force of Victoria as soon as it is practicable to do so, unless the person has a reasonable excuse for not doing so.

Finalisation conditions

In August 2014 the seven member organisations of the No More Deaths campaign, including the Federation, wrote to the Attorney-General, Robert Clark, to express concerns about a proposal in the Family Violence Protection Amendment Bill 2014 to introduce 'finalisation conditions'. This meant that subject to certain requirements, including the victim consenting, a temporary intervention order would become final if the perpetrator of the violence does not object. At present, victims must return to court to obtain a more tailored final intervention order, at which stage they and the respondent are able to access legal advice. If a final order is made, magistrates are able to hold perpetrators to account in open court.

Various community organisations including the Federation, Women's Legal Service Victoria, Domestic Violence Resource Centre Victoria, Aboriginal Family Violence Prevention Legal Service, and inTouch Multicultural Centre Against Family Violence had previously made a joint submission to the Department of Justice strongly opposing a proposal similar to that in the 2014 Bill. As a result, the 2014 proposed legislation was a substantially modified form of what had originally been proposed.

We argued that the rise in family violence matters indicates that the statewide response to family violence which began 11 years ago is actually working. Now is therefore the time to resource the courts to build on this success. It is important that we strengthen our risk assessment and safety planning for women, and tighten the web of accountability for perpetrators.

Campaign representatives then met with the Attorney-General's office and the Department of Justice. As a result of our advocacy, the Government made substantial amendments before the legislation was passed. These changes included stronger safeguards related to when finalisation conditions might be used, and a commitment to evaluating the impact of such conditions on women and children's safety and perpetrator accountability.

Finalisation conditions have not yet commenced in Victorian law. Many agencies are concerned that if the finalisation conditions do come into effect, more perpetrators may never attend court, thereby potentially reducing intervention orders to being on a par with traffic tickets. This is likely to have repercussions for women's safety, as well as being unlikely to save time and costs across the family violence system, due to likely complaints from respondents further down the track about lack of procedural fairness, and the need for people to come to court at a later stage because they have not

been able to access the services, such as duty lawyers, that would be there if they had attended in the first place.

As the peak body for community legal centres, we are also concerned that if finalisation conditions come into practice, the role of the courts as a cornerstone of the Victorian family violence response could be undermined, as judicial oversight is reduced.

For more detail, see the separately attached Appendices 4A and 4B.

RECOMMENDATION 63

The State Government repeal amendments made to the *Family Violence Protection Act 2008* with respect to finalisation conditions in interim orders.

Appendices

(Attached separately)

Appendix 1
Australian Inquest Alliance, *Saving Lives by Joining Up Justice* (2013). Also available at http://www.fclc.org.au/cb_pages/currentprojects.php.

Appendix 2
Luke Batty inquest blog (to be supplied separately). Also available at https://communitylawblog.wordpress.com/category/luke-batty-inquest/

Appendix 3A
Joint Submission to the Victorian Government in response to the Discussion Paper on Proposed 'Failure to Protect' Laws (7 September 2011)

Appendix 3B
Joint letter to Attorney-General re Crimes Amendment (Protection of Children) Bill 2014 (2 April 2014)

Appendix 4A
NGO alliance response to Department of Justice re Proposal to Streamline the Family Violence Intervention Order system (September 2013)

Appendix 4B
No More Deaths Campaign letter to Attorney-General re Family Violence Protection Amendment Bill 2014 (15 September 2014)

Appendix 1

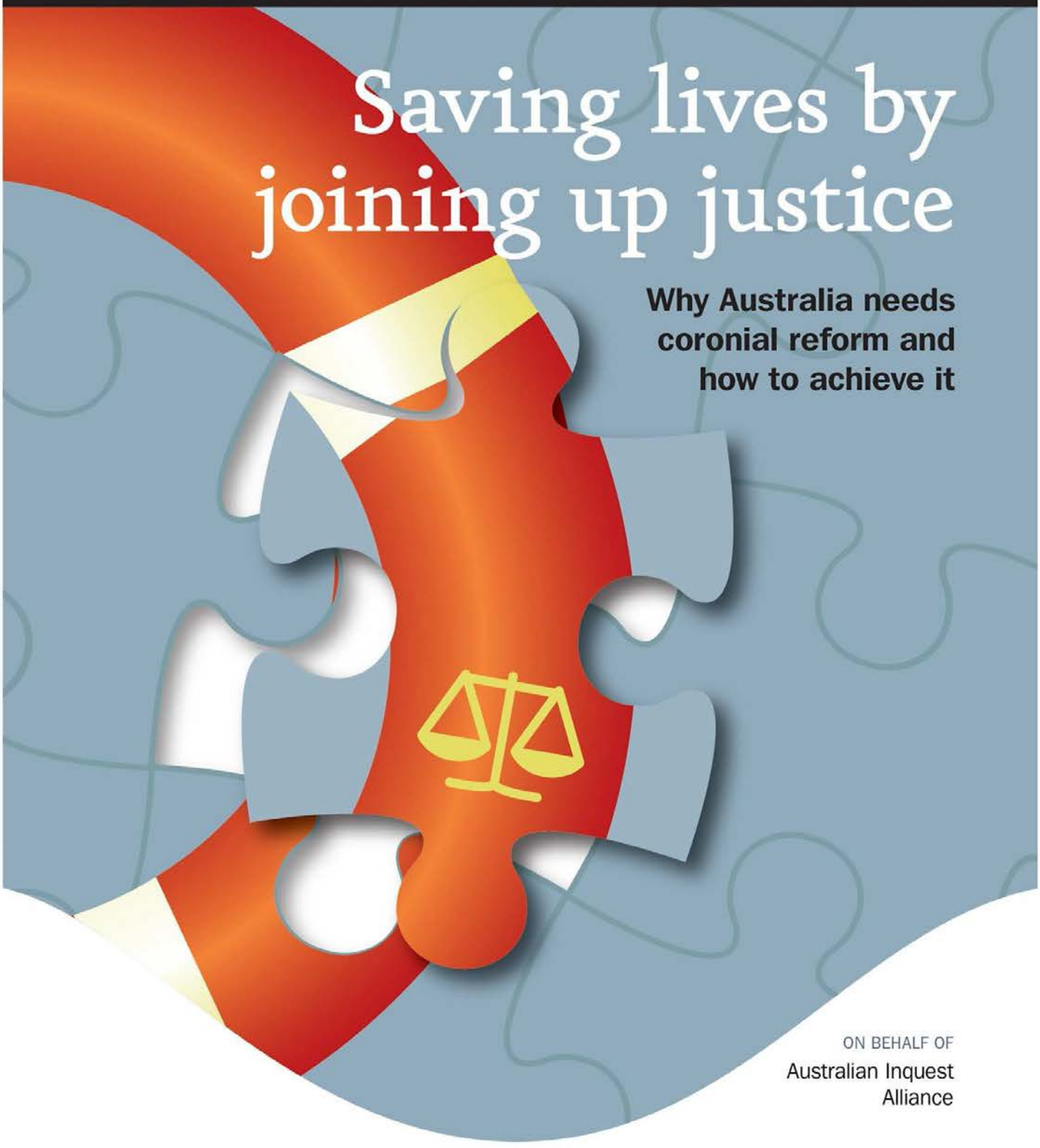
Federation of
Community Legal Centres
VICTORIA

Issues Paper

March 2013

Saving lives by joining up justice

Why Australia needs coronial reform and how to achieve it



ON BEHALF OF
Australian Inquest
Alliance

Contents

About the Federation of Community Legal Centres (Victoria) Inc

The Federation is the peak body for Victoria's 51 community legal centres (CLCs). The Federation leads and supports CLCs to make justice accessible for all.

The Federation:

- provides information and referrals to people seeking legal assistance;
- conducts law reform and policy work to improve the justice system;
- works to build a stronger and more effective community legal sector;
- provides services and support to CLCs; and
- represents CLCs with stakeholders.

The Federation assists its membership to collaborate for justice. CLC workers come together through working groups and other networks to exchange ideas and improve CLC services. The Federation regularly works in partnership with government, legal aid, the private legal profession and community partners.

About community legal centres

Community legal centres are independent, community organisations that provide free legal services to the public. CLCs provide free legal advice, information and representation to more than 100,000 Victorians each year.

Generalist CLCs provide services on a range of legal issues to people in their local geographic area. There are generalist community legal centres in metropolitan Melbourne and in rural and regional Victoria. Specialist CLCs focus on groups of people with special needs or particular areas of law such as mental health, tenancy, consumer law and the environment.

CLCs receive funds and resources from a range of sources including state, federal and local government, philanthropic foundations, pro bono contributions and donations. Centres also harness the energy and expertise of over a thousand volunteers across Victoria.

CLCs provide effective and innovative solutions to legal problems based on their experience within their community. It is CLCs' community relationship that distinguishes them from other legal providers and enables them to respond effectively to the needs of our communities as they arise and change.

CLCs integrate legal assistance for individual clients with community legal education, community development and law reform projects that are based on client need and that are preventative in outcome. CLCs are committed to collaboration with government, legal aid, the private legal profession and community partners to ensure the best outcomes for our clients and the justice system in Australia.

Acknowledgments

Research, writing and editing of this Issues Paper was undertaken by:

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Laura Wilson (FCLC Student researcher)

The Alliance also expresses its grateful thanks to various family members, advocates, and staff of Coroners Courts and legal aid/pro bono bodies for responding to requests for information or comment.

For more information about the Australian Coronial Reform Project and to join the Australian Inquest Alliance, contact:

Dr Chris Atmore
Senior Policy Adviser
Federation of Community Legal Centres (Vic) Inc
[redacted]

Legal Services BOARD
Funded through the Legal Services Board Grants Program

Executive Summary

> 'Put yourself into the situation of a family that has just lost someone. Why put ourselves through this anyway?...[I]t is a hardship reading through every detail in a coronial inquest, but if at the end of the day you know that, "Such-and-such happened, that is why your son is dead", then all right. I knew three and a half years ago that the death should have been avoidable. There was no need for anyone to plough through 11 days of evidence for that. But if something else comes out of it, if systems can change, then yes, it is worth doing.'[1]

The Australian Inquest Alliance has developed the Australian Coronial Reform Project, which has two main aims: reform of Australia's coronial system, and establishment of a National Inquest Clearing House.

We need coronial reform across Australia so that all states and territories have independent and effective coronial systems that learn from past deaths in order to prevent future avoidable deaths. System responses must also effectively address social justice issues if they arise from particular deaths. Coronial reform should include consistent best practice support and sensitively facilitated participation of families in investigations, inquests and all other aspects of the required systemic response. We also need to establish a National Inquest Clearing House to facilitate effective coronial systems and enhance the participation of families.

The Project seeks to advance these goals via discussion with key stakeholders in the coronial system: bereaved families and friends, advocates, researchers, and other supporters.

In **Part 1** of the Paper, we outline why national coronial reform is needed. The coronial system has a distinctive place in Australian legal practice. Coroners investigate certain types of deaths, such as those that are sudden, unexpected or violent. In some cases, the coroner also presides over an inquest, which is a court hearing that is usually public. Coroners are required to discover the truth about a death — generally, who the deceased was, how they died, and the circumstances of their death. This process means investigating not only the immediate but also the underlying causes of death.

Coronial investigations and inquests are formally inquisitorial (truth-seeking) rather than adversarial (against someone), and are not bound by the rules of evidence and procedure in other courts. Instead, coroners take a broad public health approach, which means that in a best practice investigation the focus is on drawing any relevant systemic lessons from the death in order to try to prevent, or at least minimise the chances of, similar deaths occurring in the future. Systemic issues can arise from contexts as diverse as those involving faulty products, medically related deaths, industrial accidents, the treatment of persons in custody and care, or the way that governments respond to family violence. Coronial investigations therefore often also have social justice implications. Families seeking some comfort from investigations and inquests, along with advocates working to oppose systemic injustices, expect comprehensive coronial findings and appropriately targeted recommendations as the key to preventing similar deaths in the future.

Each Australian state and territory has its own coronial legislation, court and office support. As a result, the official procedures for inquiring into a death, following up on any systemic issues, and providing information to families and the general public can differ between jurisdictions. When it comes to providing publicly accessible, clear and thorough information about the outcomes of coronial investigations and inquests, there is also considerable variation across states and territories. In some

[1] Mrs M. Kaufmann, mother of Mark who was fatally shot by police, *Minutes of Evidence*, 22 August 2005, 68–9, Law Reform Committee, Parliament of Victoria, *Inquiry into the Review of the Coroners Act 1985* <http://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/coroners_act/transcripts/22-08-2005_Kaufmanns_and_Springvale_Monash_Legal.pdf>.

jurisdictions, information is simply not available. Under-resourcing of Coroners Courts and Offices also hampers their ability to provide public information and to cooperate with external researchers and advocates. While the National Coronial Information System is a very valuable tool, it is only automatically accessible to coroners, and other potential users must seek approval to use it and in most cases pay a significant fee.

Nevertheless, in all state and territory jurisdictions, procedures and standards for coronial investigations and inquests are required to adhere to Australia's international treaty obligations to respect, protect and fulfil the human right to life. Best practice approaches to inquests that have been developed in the last few decades therefore focus on the goals of truth, fairness, accountability, healing and an increased emphasis on prevention. Best practice consequently also requires independent inquiry into system failure and identification of any institutional responsibility and systemic issues to be backed up by appropriately directed practical recommendations to prevent future deaths.

In reality, however, many families who have lost loved ones experience the coronial process and its aftermath as traumatic, mystifying, frustrating and disempowering. The human rights standard that coronial investigations be independent is also not usually adhered to when police are potentially implicated in a death. Another common source of anguish for family members concerns the considerable time that can elapse between when a death is first discovered and when coroner's findings are made. Delays of up to five years are not uncommon, and in 2011–12, no state or territory reached the national standard for acceptable backlog of cases. Many other difficulties experienced by families are due to a general failure across jurisdictions to fully implement into practice the right of families to participate in coronial processes concerning their loved ones.

The content of coronial recommendations and their potential influence on death prevention are of particular concern to family members and advocates. Although there have been recent reforms in several states and territories, the emphasis on prevention and on the role of coronial recommendations varies considerably. Coroners also often have little assistance to help them formulate their findings and recommendations.

Families and advocates also need to know what responses have been made by government departments and other agencies to coronial recommendations addressed to them, together with information about how recommendations are being implemented, and how implementation will be monitored to ensure that avoidable deaths are prevented in the future. However, most states and territories do not legally require responses to all coronial recommendations in their jurisdiction, meaning that particular recommendations may never be followed up, and can even be lost. In most jurisdictions it is also difficult to find public information about whether recommendations are responded to, and in what manner.

Due to a lack of monitoring and little in the way of collection of information about implementation, it is difficult to assess the impact of coronial recommendations upon the prevention of deaths in Australia, either generally or in relation to any particular kind of death. Jurisdictions that mandate responses to recommendations are likely to have a better rate of implementation. However, in general, implementation of recommendations is an ad hoc process. Whether or not particular recommendations are implemented is influenced by the way in which recommendations are framed and targeted by coroners, whether implementation accords with government policies and priorities, and whether a proactive system for review of recommendations exists within the targeted organisation. Other relevant factors include media, family, community and advocacy group pressure.

Coroners may therefore make potentially life-saving recommendations, only for them never to be responded to or implemented, with no follow-up and no public awareness of what has happened. Within any particular jurisdiction, even where recommendations are implemented, this may not happen in time to prevent other similar deaths. The present patchwork system also means that even though

coroners may be sharing information across Australia, government and other agencies in one jurisdiction are unlikely to learn effectively and in a timely way from a death, or even a pattern of deaths, in another jurisdiction. This is evident even in contexts where there are clear national ramifications, such as deaths in custody. For this reason, the Royal Commission into Aboriginal Deaths in Custody recommended reform of the state and territory coronial systems. However, over 20 years later, none of the Royal Commission's recommendations have been implemented in a systematic, nationwide manner.

The piecemeal approach to death prevention means that there are other striking examples where lessons have failed to be learned across and even within jurisdictions, resulting in more avoidable deaths. The systemic failure that led to the death is often perpetuated due to an inability of governments and other entities to respond effectively. One tragic illustration is the example of blind cord deaths, where infants are accidentally strangled or hanged due to becoming entangled in a blind or curtain cord. Despite the risks having been raised by coroners and researchers for many years, infants have continued to die, and even now it is unclear whether all states and territories have implemented ongoing community campaigns and strategies to render safe those blinds and curtains that are already installed. Blind cord deaths therefore starkly demonstrate the lack of clear recommendation and implementation pathways across states and territories, together with, in most jurisdictions, few if any mechanisms to monitor the progress of recommendations, and consequently little in the way of public accountability.

This Paper therefore makes recommendations aimed at 'joining up' independent and effective coronial systems across Australian jurisdictions, in order to enhance death prevention via learning from past deaths. While there are some limited opportunities to contribute to joining up justice at the state and territory level, State, Territory and Commonwealth Governments are increasingly recognising that in order to more effectively and consistently address many legal and social issues in Australia, a federally coordinated, cross-border approach of some kind is needed. We discuss the examples of national initiatives to better prevent and respond to violence against women and children, the coronial recommendations and Federal Government response concerning the death of Dianne Brimble, and proposals to centrally record coronial recommendations and share information across states and territories concerning family/domestic violence homicides.

Greater emphasis on prevention must be accompanied by best practice support and sensitively facilitated participation of families in investigations, inquests and all other aspects of the required systemic response. **Part 2** of the Paper discusses how families need legal representation and other support in order to be able to exercise their human rights to fully participate in the inquest. However, legal assistance is often not affordable, and appropriate support is not always available. Within the limits of accessible public information, we paint a picture of the legal assistance currently available for families, and describe the role of various public legal service providers. The reality for many families is that they may not even be aware that they have the right to a lawyer, let alone be able to obtain legal help throughout the process. We therefore make recommendations that aim to ensure equity in legal assistance for families in the inquest process and coronial-related matters.

Public interest organisations also play an important role in supporting and advocating on behalf of families, or raising prevention issues as interveners, yet their involvement is often limited by lack of resources. The Paper therefore goes on to outline why a new national non-government organisation — a National Inquest Clearing House (NICH) — is needed to consolidate and share the knowledge and understanding gained by legal assistance providers over many years. In playing this 'joining up' role, the NICH will both enhance inquest representation for families and community organisations, and improve the coronial process by consolidating and sharing knowledge in order to focus on prevention of avoidable deaths.

We hope that stakeholders will work with us in developing and advocating for the directions and strategies we should use to support 'joined up' independent and effective coronial systems across

Australian jurisdictions — systems which facilitate learning from past deaths in order to prevent future avoidable deaths, and which provide enhanced support for families at all stages of the coronial process.

Recommendations

1. All State and Territory governments should act to adopt core best practice and guarantee that the preservation of life is central to their coronial systems, by introducing, as appropriate to the jurisdiction, prevention and reporting amendments to their coronial legislation.

These amendments should include or have the effect of:

- a preamble that expresses the role of the coronial system as involving the independent investigation of deaths, for the purpose of finding the causes of those deaths and to contribute to the prevention of avoidable deaths and the promotion of public health and safety and the administration of justice, across Australia;
- purpose and objects provisions that include the prevention of avoidable deaths through the findings of the investigation, and the making of findings, comments and recommendations, by coroners;
- a provision empowering coroners to make comments and recommendations on any matter connected with a death investigated at an inquest, including public health or safety and the administration of justice; and
- a provision empowering coroners to make recommendations to any Minister, public statutory authority or entity.

2. The Commonwealth Government should work with State and Territory governments to achieve a uniform national coronial public reporting and review scheme for coronial findings and recommendations which:

- guarantees that all coronial recommendations will be considered and meaningfully responded to by the government agencies or entities to whom they are directed (updates on progress towards implementation should be provided by the relevant agency or entity where the initial response was only a holding response);
- provides ready public access to all coronial findings, recommendations, responses and updates;
- records and makes publicly available (including via a Coroners Annual Report to the relevant State or Territory Parliament and on the Internet) whether or not coronial recommendations have been implemented by responsible government agencies or entities;
- enables evaluation of the impact of coronial recommendations upon the prevention of deaths;
- adheres to timeliness at every step of the recommendations process; and
- provides feedback to families (including a copy of recommendations and responses to families, other parties and legal representatives) at every step of the recommendations process.

3. As an important element of Recommendation 2, State and Territory Governments should:

- appoint coronial liaison officers to enable public sector agencies to respond to coronial recommendations in a timely and appropriate manner; and
- allocate, for each jurisdiction, the responsibility for monitoring the implementation of coronial recommendations to an independent statutory body adequately resourced for the task and with powers to alert government and public about any key implementation issues.

4. The Commonwealth Government should work with State and Territory governments to enable each jurisdiction to effectively recognise the international human rights obligation to respect, protect and fulfil the right to life by introducing, as appropriate, amendments to their coronial legislation so that coronial investigation is independent, appropriately and adequately resourced, and considers systemic issues.

In particular, in investigations into deaths in police custody or in the course of police operations, the agency conducting the primary investigation at the direction of the Coroner must have practical, institutional and hierarchical independence from the police.

5. Primary and secondary coronial legislation in the various jurisdictions should be amended or introduced in recognition of the principle that participation of families in the inquest process is a fundamental component of Australia's international human rights obligations.

Specifically, reforms must enable families and friends of the deceased to experience the coronial process in as sensitive, timely and fully informed a manner as possible, regardless of the circumstances of the death.

These reforms must include:

- provision of proper and timely notification of family members and proactive provision of accessible, timely and explanatory information, at every stage of investigation and inquest processes. This should include as comprehensive as possible access to police and coronial documents, and accessible material on families' legal rights;
- no unreasonable delays in investigations and inquests;
- resolution of any cultural or spiritual conflicts raised by the coronial process;
- recognition of the need to have Aboriginal and Torres Strait Islander legal and health services and communities involved in the coronial process; and
- provision of quality, accessible, and culturally and spiritually appropriate support and counselling services for families.

6. All States and Territories should establish or continue funding for their own Coroners Prevention Unit similar to the current Victorian model, including funding to facilitate an effective role for the Unit in the reforms in Recommendations 1 – 5.

7. State and Territory Governments should adequately fund their Coroners Courts with the aim of reducing delays in inquests, investigations and the delivery of findings, in order to at least conform to current national standards.

8. The remaining recommendations of the National Report of the Royal Commission into Aboriginal Deaths in Custody (1991) must be implemented.

9. As a fundamental component of Australia's international human rights obligations under the right to life, funding and availability of legal assistance providers must be sufficient to enable all families to obtain, without financial hardship, effective legal advice and representation for investigations and inquests, at a level that is consistent with the level of legal representation accorded to government and other institutional parties in the inquest. A specific pool of funds should be made available to enable community legal centres to provide legal representation for families at inquests.

10. Legal assistance services must be sufficient to enable all advocacy organisations with a sufficient interest to intervene in inquests, as a fundamental component of Australia's international human rights obligations under the right to life.

11. An independent National Inquest Clearing House, along the lines of INQUEST (UK), should be established and adequately funded.

Introduction

The Australian Inquest Alliance

In March 2010, the Federation of Community Legal Centres convened the first meeting of the Australian Inquest Alliance (the Alliance). Community legal centres have a long history of supporting and representing in coronial inquests families and friends of those who have died, and of advocating for legal and social change so that future deaths can be prevented.

The Alliance consists of a growing number of organisations and individuals across state and territory borders, including community legal centres, Aboriginal and Torres Strait Islander Legal Services (ATSILS), advocates for imprisoned women and men, academic researchers and policy/law reform advocates. Our members include:
Aboriginal Legal Rights Movement of South Australia;
Aboriginal Legal Service (NSW/ACT) Limited;
Aboriginal & Torres Strait Islander Legal Service (Qld) Ltd;
Aboriginal Legal Service of WA (Inc);
Community Legal Centres NSW Inc;
Deaths in Custody Watch Committee WA;
Federation of Community Legal Centres Victoria;
Flemington & Kensington Community Legal Centre Inc;
Human Rights Law Centre Ltd;
Indigenous Social Justice Association Inc;
North Australian Aboriginal Justice Agency;
Prisoners' Legal Service Inc;
Public Interest Advocacy Centre;
Queensland Association of Independent Legal Services Inc;
Sisters Inside Inc;
Victorian Aboriginal Legal Service Co-operative Limited;
Villamanta Disability Rights Legal Service Inc;
Ray Watterson, Adjunct Professor of Law, La Trobe University.

The Alliance has a significant depth of advocacy, research and social policy experience and expertise gained over many years. This knowledge encompasses coronial investigations, inquests, human rights and broader coronial frameworks across jurisdictional boundaries. We recognise the key influence played by systemic inequality in many preventable deaths.

As a priority, the Alliance is committed to addressing the shamefully high number of deaths of Aboriginal and Torres Strait Islander peoples, particularly deaths in custody and, for women especially, deaths from family violence. Despite overwhelming evidence and practical recommendations on what is required, provided by investigations such as the Royal Commission into Aboriginal Deaths in Custody, these deaths continue. This fact profoundly illustrates the present systemic failure to redress the ongoing impact of colonialism, racism, misogyny and economic and cultural dispossession on Australia's first peoples.

We also recognise that effective systemic responses to preventable deaths require an understanding of other forms of structural inequality and disadvantage that contribute to a disproportionate number of deaths, including deaths of: people in police custody and prison; people with mental illness; women killed by male partners; migrants from CALD communities; asylum seekers and refugees; young people; and people with disabilities.

The Alliance welcomes new members.

The Australian Coronial Reform Project

As an integral part of our focus on systemic change, the Alliance has developed the Australian Coronial Reform Project. The Project aims for reform of coronial systems across Australia, so that social justice may be effectively pursued for those who have died in circumstances where the death may have been prevented. This must be accompanied by best practice support and sensitively facilitated participation of families in investigations, inquests and all other aspects of the required systemic response.

The Project seeks to advance these goals via discussion with key stakeholders in the coronial system: bereaved families and friends,[2] advocates, researchers, and other supporters of an independent and effective coronial system that is sensitive to the bereaved and learns from past deaths in order to prevent future avoidable deaths.

In **Part 1** of the Paper, we outline why national coronial reform is needed. We examine current Australian coronial systems and show that while there have been recent reforms in various jurisdictions, the emphasis on prevention and on the role of recommendations varies considerably. It is even difficult to assess and compare processes in different states and territories, due to the lack of consistent publicly accessible information on inquests, recommendations, and responses by relevant agencies. Most states and territories also do not legally require responses to all coronial recommendations in their jurisdiction, meaning that particular recommendations may never be followed up, and can even be lost.

The piecemeal approach to death prevention means that there are striking examples where lessons have failed to be learned across and even within jurisdictions, resulting in more avoidable deaths. We therefore make recommendations aimed at 'joining up' independent and effective coronial systems across Australian jurisdictions, in order to enhance death prevention via learning from past deaths.

Greater emphasis on prevention must be accompanied by best practice support and sensitively facilitated participation of families in investigations, inquests and all other aspects of the required systemic response. **Part 2** of the Paper discusses how families need legal representation and other support in order to be able to exercise their human rights to fully participate in the inquest, and yet legal assistance is often not affordable, and appropriate support is not always available. Public interest organisations play an important role in supporting and advocating on behalf of families, or raising prevention issues as interveners, but their involvement is often limited by lack of resources. We therefore make recommendations that aim to ensure equity in legal assistance for families in the inquest process and coronial-related matters.

We also outline why a new national non-government organisation — a National Inquest Clearing House (NICH) — is needed to consolidate and share the knowledge and understanding gained by legal assistance providers over many years, and how in playing this role the NICH will enhance inquest representation for families and community organisations, and improve the coronial process.

Note

Some of the weaknesses in the current coronial system discussed in this report mean that relevant data is either difficult to obtain or simply not collected. Accordingly, our analysis has been limited to the best available information.

[2] This Paper uses 'family' as a shorthand for those who may have been close to the deceased and wish to find out the truth on their behalf. A significant caveat is that in some deaths, such as those of people who were mentally ill or deemed to be so, or in some family violence deaths, the family may have been in conflict with the person who died, or the deceased person may have been socially isolated. In these contexts it is especially important that an appropriate person or organisation is able to ask questions on behalf of the deceased person and represent their interests.

Part 1 Why we need national coronial reform

The coronial system

The coronial system has a distinctive place in Australian legal practice. Coroners investigate certain types of deaths, such as those that are sudden, unexpected or violent. In some cases, the coroner also presides over a court hearing, usually public, called an inquest. Coroners are required to discover the truth about a death — generally, who the deceased was, how they died, and the circumstances of their death. This process means investigating not only the immediate but also the underlying causes of death.[3]

Coronial investigations and inquests are formally inquisitorial rather than adversarial, and are not bound by the rules of evidence and procedure in other courts. Instead, the coronial jurisdiction takes a broad public health approach, which means that the focus of the investigation is on drawing any relevant systemic lessons from the death in order to try to prevent, or at least minimise the chances of, similar deaths occurring in the future.[4]

Systemic issues can arise from contexts as diverse as those involving faulty products, medically related deaths, industrial accidents, the treatment of persons in custody and care, or the way that the government responds to family violence. Coronial investigations therefore often have social justice implications.

Each state and territory has its own coronial legislation, court and office support. This means that the official procedures for inquiring into a death, following up on any systemic issues, and providing information to families and the general public can vary between jurisdictions.

When is there a coronial investigation?

All jurisdictions except the Australian Capital Territory define 'reportable deaths'.[5] This category includes any death that is, or is suspected of being, violent or unnatural, occurring under anaesthetic, or occurring while the deceased was in care or custody. Many jurisdictions also require investigation of: deaths in suspicious or unusual circumstances; sudden deaths of unknown cause; those resulting from an accident or injury; where death was not the expected medical outcome; where there is no death certificate; or where the identity of the deceased is not known.[6]

As a general rule, Australian coroners must investigate reportable deaths, or any death when directed to investigate (usually by the State Coroner, Chief Magistrate or relevant Minister),[7] unless that death

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[3] Graeme Johnstone, 'An Avenue for Death and Injury Prevention' in Hugh Selby (ed), *The Aftermath of Death* (1992) 140, 145.

[4] Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4034 (Rob Hulls, Attorney-General).

[5] *Coroners Act 2009* (NSW) ss 6(1), 23–24; *Coroners Act 1993* (NT) s 12(1); *Coroners Act 2003* (Qld) s 8(3); *Coroners Act 2003* (SA) s 3; *Coroners Act 1995* (Tas) s 3; *Coroners Act 2008* (Vic) s 4; *Coroners Act 1996* (WA) s 3.

[6] *Coroners Act 1997* (ACT) ss 13(1), 14(2); *Coroners Act 2009* (NSW) ss 6(1), 23–24; *Coroners Act 1993* (NT) ss 12(1), 12(1A); *Coroners Act 2003* (Qld) ss 8–10, 10AA; *Coroners Act 2003* (SA) s 3; *Coroners Act 1995* (Tas) s 3; *Coroners Act 2008* (Vic) s 4; *Coroners Act 1996* (WA) s 3. Victoria also requires investigation of reviewable deaths, which are where a child dies and they are the second or subsequent child of the deceased child's parent to have died, and they did not spend their entire lives in hospital: *Coroners Act 2008* (Vic) s 5.

[7] Victorian coroners must also investigate fires if requested to do so by the Country Fire Authority or Metropolitan Fire and Emergency Services Board, unless the coroner determines that it is not in the public interest: *Coroners Act 2008* (Vic) s 30. Similar provisions apply in New South Wales, in the Australian Capital Territory where they also refer to disasters, in Tasmania where they also refer to explosions, and in the Northern Territory only in relation to disasters: *Coroners Act 1997* (ACT) ss 18(1), 19; *Coroners Act 2009* (NSW) s 32; *Coroners Act 1993* (NT) s 29; *Coroners Act 1995* (Tas) s 40(2).

has been, is being, or is intended to be, investigated in another jurisdiction.[8] Coroners also have some discretion to investigate other categories of deaths.[9]

When is there an inquest?

An investigation need not necessarily proceed to an inquest. However, generally inquests are mandatory where the person was in custody, and in various jurisdictions are also required when the person was in care or where homicide is suspected.[10] Inquests are also mandatory in some jurisdictions for other types of reportable deaths, such as drowning or as the result of medical procedures;[11] or where the identity of the deceased is unknown.[12] As with investigations, a coroner must not hold an inquest if he or she does not have jurisdiction to do so.

Other than the contexts where inquests are required, coroners often have discretion to decide whether to hold an inquest. Where coronial discretion is expressly provided for, the relevant legislation usually does not give specific guidance, but instead enables coroners to make their own judgment if they believe an inquest is unnecessary, or if it is deemed desirable in the interests of justice.[13] The current Review of Coronial Practice undertaken by the Law Reform Commission of Western Australia has found that 'the primary catalyst to a decision to hold an inquest in a particular case [is] family pressure'.[14]

The WA Law Reform Commission believes that the Queensland approach provides more useful guidance to coroners as to when they may use their discretionary power.[15] In Queensland, the coroner

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[8] Coroners must not investigate or continue investigations in other specified circumstances. For example, in Tasmania, if a coroner suspects the body in a reported death may be Aboriginal remains, he or she must refer the matter to an approved Aboriginal organisation, which must then investigate: *Coroners Act 1995* (Tas) s 23. A coroner who has begun investigating must cease in certain circumstances, including, in Queensland, if the investigation shows that the body is Indigenous burial remains: *Coroners Act 2003* (Qld) s 12(2).

[9] For example, in NSW and Victoria a coroner may investigate a death that occurred less than 100 years before it was reported: *Coroners Act 2009* (NSW) s 19; *Coroners Act 2008* (Vic) ss 14(1), 15(c) (in Victoria, if the death appears to have been a reportable death occurring less than 50 years before being reported, investigation is mandatory). Victorian coroners may also investigate deaths reported by a member of the immediate family if the deceased person was discharged from an approved mental health service within 3 months immediately before the person's death: *Coroners Act 2008* (Vic) ss 12(2), 14(2). Coroners also have discretion to investigate fires in some circumstances; and also in NSW and Tasmania, explosions: *Coroners Act 1997* (ACT) s 18(2); *Coroners Act 2009* (NSW) s 31; *Coroners Act 1995* (Tas) s 43(2); *Coroners Act 2008* (Vic) s 31. In the Northern Territory, in addition to deaths, coroners may investigate disasters: *Coroners Act 1993* (NT) s 30.

[10] *Coroners Act 1997* (ACT) ss 13(1)(a), (k); *Coroners Act 2009* (NSW) ss 27(1)(a)–(b) (includes deaths as a result of police operations); *Coroners Act 1993* (NT) s 15(1) (includes deaths in care); *Coroners Act 2003* (Qld) s 27 (includes deaths in care and deaths related to police operations); *Coroners Act 2003* (SA) s 21(1)(a); *Coroners Act 1995* (Tas) s 24(1) (includes deaths in care, deaths while attempting to escape from custody or care, and deaths in the process of attempts to detain the deceased person); *Coroners Act 2008* (Vic) ss 52(2)(a)–(b) (includes deaths in care); *Coroners Act 1996* (WA) s 22(1) (includes deaths in care).

[11] *Coroners Act 1997* (ACT) ss 13(1)(b), (e).

[12] *Coroners Act 1993* (NT) s 15(1)(c); *Coroners Act 1995* (Tas) s 24(1)(c); *Coroners Act 2008* (Vic) s 52(2)(c). In South Australia, in some circumstances the Coroner's Court must also hold an inquest into a fire or accident that causes injury to person or property, and into any other event if required under other legislation: *Coroners Act 2003* (SA) s 21(1).

[13] *Coroners Act 2009* (NSW) s 25(3); *Coroners Act 1993* (NT) s 15(2); *Coroners Act 2003* (Qld) s 28; *Coroners Act 1996* (WA) s 22(2). In South Australia, the Coroner's Court must hold an inquest into any reportable death or disappearance if the State Coroner considers it necessary or desirable to do so: *Coroners Act 2003* (SA) s 21(1)(b). In Victoria, a coroner may hold an inquest into any death he or she is investigating: *Coroners Act 2008* (Vic) s 52(1). The Tasmanian Coroners Act does not expressly provide for coronial discretion as to whether to hold an inquest. The ACT Coroners Act provides for some coronial discretion to hold a hearing as part of an inquest or inquiry, and for the Chief Coroner to hold a fresh inquest or inquiry: *Coroners Act 1997* (ACT) ss 34A, 68(2).

[14] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 134.

[15] *Review of Coronial Practice in Western Australia Discussion Paper*, 134; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 85–6.

investigating a reportable death may hold an inquest if satisfied that it is in the public interest. In determining whether it is in the public interest, the coroner may consider:

(a) the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future; and

(b) any guidelines issued by the State Coroner about the issues that may be relevant for deciding whether to hold an inquest for particular types of deaths.[16]

In all jurisdictions except South Australia, any person can also apply for an inquest to be held, although some jurisdictions require the person to have a 'sufficient interest'.[17] In some contexts, the person applies directly to the Chief or State Coroner who may then arrange for an inquest.[18] If the application is refused, the person can usually apply or appeal to a higher authority (the Chief or State Coroner, Minister, District or Supreme Court) for an inquest to be held.[19]

In some jurisdictions, a person seeking an inquest may apply directly to the District or Supreme Court for an order that an inquest be held.[20] In still other cases, authorities such as the relevant Minister can direct that an inquest be held without another person needing to request it,[21] or can make an application themselves to the Supreme Court.[22] The District or Supreme Court may generally only order an inquest where satisfied that it is in the interests of justice or the public interest.[23]

Human rights, coronial investigations and inquests

Procedures and standards for coronial investigations and inquests are required to adhere to Australia's international treaty obligations to respect, protect and fulfil the human right to life.[24] In addition, Victoria and the Australian Capital Territory are directly obligated to honour the right to life via their respective charters of human rights.[25] With respect to coronial investigations, the right to life has been interpreted as encompassing the following minimum requirements:

- the investigation must be independent;
- the investigation must be effective;
- the investigation must be reasonably prompt;
- there must be a sufficient element of public scrutiny;
- the next of kin must be involved to an appropriate extent; and

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[16] *Coroners Act 2003* (Qld) s 28. See also Queensland State Coroner's Guidelines (December 2003), [8.1] <http://www.courts.qld.gov.au/__data/assets/pdf_file/0004/84919/state-coroners-guidelines.pdf>.

[17] *Coroners Act 1997* (ACT) s 64(2)(b); *Coroners Act 1995* (Tas) s 27(1). Tasmania also permits senior next of kin to apply for an inquest to be held, or for an inquest not to be held where a workplace death is concerned: *Coroners Act 1995* (Tas) ss 26(2), 26A(2). Persons may also apply for an inquest into a fire in Tasmania and Victoria: *Coroners Act 1995* (Tas) s 44; *Coroners Act 2008* (Vic) s 53(2).

[18] *Coroners Act 1997* (ACT) s 64; *Coroners Act 2003* (Qld) s 30; *Coroners Act 1995* (Tas) s 27; *Coroners Act 2008* (Vic) s 52(5); *Coroners Act 1996* (WA) s 24.

[19] *Coroners Act 1997* (ACT) ss 91–92; *Coroners Act 2003* (Qld) ss 27(1)(c)–(d), 30; *Coroners Act 1995* (Tas) ss 26–27; *Coroners Act 2008* (Vic) s 82; *Coroners Act 1996* (WA) s 24.

[20] *Coroners Act 2009* (NSW) ss 84–85; *Coroners Act 1993* (NT) s 16.

[21] *Coroners Act 2009* (NSW) s 28; *Coroners Act 2003* (Qld) ss 27(1)(b)–(c); *Coroners Act 2003* (SA) s 21(1)(b); *Coroners Act 1996* (WA) s 22(1)(d); *Coroners Act 1995* (Tas) ss 24(1)(g)–(h). In Tasmania, the Chief Magistrate may also hold an inquest into a death if he or she considers it desirable to do so: *Coroners Act 1995* (Tas) s 24(2). In South Australia the Attorney-General can direct a coroner to hold an inquest into a fire or or accident that causes injury to person or property: *Coroners Act 2003* (SA) s 21(1)(b)(iv).

[22] *Coroners Act 1997* (ACT) ss 92–93; *Coroners Act 2009* (NSW) ss 84–85.

[23] *Coroners Act 1997* (ACT) ss 91–93; *Coroners Act 2009* (NSW) ss 84–85; *Coroners Act 2003* (Qld) s 30(8); *Coroners Act 1995* (Tas) ss 26(3), 27(4); *Coroners Act 1996* (WA) s 24(3).

[24] Australia is a signatory to the *International Covenant on Civil and Political Rights* (opened for signature 16 December 1966, 999 UNTS 171, entered into force 23 March 1976). Article 6 outlines the right to life.

[25] *Charter of Rights and Responsibilities Act 2006* (Vic) s 9; *Human Rights Act 2004* (ACT) s 9.

- the State must act of its own motion and cannot leave it to the next of kin to conduct any part of the investigation.[26]

Coronial comments, recommendations and implications for prevention

As the result of his or her investigation, the coroner must determine, if possible: the identity of the deceased, the cause of death, and, usually, the circumstances in which the death occurred.[27] These determinations are usually known as 'findings'.[28]

The coroner generally also has discretion to comment on any matter connected with the death, including public health and safety or the administration of justice.[29] In all Australian jurisdictions, coroners are also empowered to make recommendations aimed at avoiding preventable deaths.[30] In terms of prevention of similar deaths in the future, while comments by coroners are important for governments, media and the general public, any coronial recommendations that are made are the key outcome of the investigation. Several states and territories expressly frame the power of coroners to make comments and recommendations in terms of the prevention of future deaths.[31]

This more recent increased focus on prevention serves several purposes. Emphasising the preventative role of coroners and inquests helps to meet Australia's obligations concerning the right to life, by requiring independent inquiry into system failure and identification of institutional responsibility to be backed up by appropriately directed practical recommendations to prevent future deaths.[32] This ap-

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[26] *Jordan v United Kingdom* (2001) 37 EHRR 54, [105]–[109]; *R v Secretary of State for the Home Department; Ex parte Amin* [2003] UKHL 51 [18]–[23] (Lord Bingham); *R (Middleton) v West Somerset Coroner* [2004] AC 182, [3], [47]; *R on the Application of D v Secretary of State for the Home Department* [2006] All ER 946, [9(iii)]; Jonathon Hunyor, 'Human Rights in Coronial Inquests' (2008) 12 (6) *Australian Indigenous Law Review* 4, 64.

[27] *Coroners Act 1997* (ACT) s 52(1); *Coroners Act 2009* (NSW) ss 3(c), 81(1); *Coroners Act 1993* (NT) s 34(1)(a); *Coroners Act 2003* (Qld) s 45(2); *Coroners Act 1995* (Tas) s 28(1); *Coroners Act 2008* (Vic) s 67; *Coroners Act 1996* (WA) s 25(1). In South Australia, the Coroner's Court must attempt to find the cause and circumstances of the death: *Coroner's Act 2003* (SA) s 25(1). In Tasmania, the coroner must also attempt to find the identity of any person who contributed to the cause of death: *Coroners Act 1995* (Tas) s 28(1).

[28] In New South Wales, if the investigation includes an inquest, a jury may be appointed, in which case the jury delivers a verdict rather than findings: *Coroners Act 2009* (NSW) ss 48, 81. In the Northern Territory, Tasmania, Victoria and Western Australia, coroners are expressly empowered to make findings if an inquest is not held, but in Victoria are not required to make a finding as to circumstances of death: *Coroners Act 1993* (NT) ss 3, 11, 34(1)(a), 35; *Coroners Act 1995* (Tas) s 28; *Coroners Act 2008* (Vic) s 67(2); *Coroners Act 1996* (WA) s 25(1). Comparable provisions with respect to findings in fire investigations (generally, findings on cause, origins and circumstances) are *Coroners Act 1997* (ACT) s 52(2); *Coroners Act 2009* (NSW) ss 3(d), 81(2); *Coroners Act 1993* (NT) s 34(1)(b); *Coroners Act 1995* (Tas) s 45(1); *Coroners Act 2008* (Vic) s 68.

[29] *Coroners Act 1997* (ACT) s 52(4); *Coroners Act 1993* (NT) s 34(2); *Coroners Act 2003* (Qld) s 46(1); *Coroners Act 1995* (Tas) s 28(3); *Coroners Act 2008* (Vic) s 67(3); *Coroners Act 1996* (WA) s 25(2). South Australian legislation does not expressly provide such a broad discretion for comments, as it requires coroners to set out in their findings the cause and circumstances of the death (*Coroner's Act 2003* (SA) s 25(1)); however, South Australian coronial jurisdiction is interpreted broadly: *WRB Transport v Chivell* [1998] SASC 7002 (23 December 1998) [21] (Lander J).

[30] *Coroners Act 1997* (ACT) s 57; *Coroners Act 2009* (NSW) s 82(1); *Coroners Act 1993* (NT) s 26(2); *Coroners Act 2003* (Qld) ss 46–47, sch 2; *Coroners Act 1995* (Tas) s 28(2); *Coroners Act 2008* (Vic) ss 1(c), 72(2). In Western Australia, only the State Coroner has this express power, although in practice all WA coroners may make recommendations: *Coroners Act 1996* (WA) s 27(3); Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 103. In South Australia, the coronial power to make recommendations is limited to recommendations that might, in the opinion of the Court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest: *Coroners Act 2003* (SA) s 25(2).

[31] *Coroners Act 1993* (NT) s 26(2); *Coroners Act 2003* (Qld) s 46(1)(c); *Coroner's Act 2003* (SA) s 25(2); *Coroners Act 1995* (Tas) 28(2); *Coroners Act 2008* (Vic) s 1(c).

[32] *R v Secretary of State for the Home Department; Ex parte Amin* [2003] UKHL 51 [58]–[62] (Lord Hope); Jonathon Hunyor, 'Human Rights in Coronial Inquests' (2008) 12 (6) *Australian Indigenous Law Review* 4, 64. Some Australian coroners have expressly agreed that the right to life requires States to adopt positive measures to prevent future avoidable deaths; see eg, Magistrate Jacqueline Milledge, The 'Brimble' Recommendations, 3 December 2010, 2 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Brimblerecs2.pdf/$file/Brimblerecs2.pdf>.

proach means that coronial investigations, and particularly coronial recommendations, play a crucial part in producing long-term solutions to any systemic problems at the heart of the death.[33]

The preventative aspect of investigations and inquests is also consistent with their therapeutic jurisprudence approach, in which the aim is to help with the healing process for the family and others involved in the inquest, together with the broader community and society.[34] The linked goals of prevention and healing are also associated with other issues in the public interest, such as truth, accountability and fairness.

Because systemic issues can arise from diverse contexts and there are often social justice implications, the content of coronial recommendations and their potential influence on death prevention are of particular concern to family members and advocates.

Coroners try to draw any systemic lessons from deaths in order to prevent future avoidable deaths. Often there are social justice implications to a coronial investigation. This makes coronial recommendations especially important for families and advocates.

Experiences of families

Despite the therapeutic ideal, many families and communities experience the coronial process and its aftermath as neither fair nor healing. Exacerbation of the family's trauma often begins with lack of access to free legal representation (see **Part 2**). Families commonly experience additional suffering and frustration during the investigation and, if it takes place, the inquest. For example, the human rights standard that coronial investigations should be independent means that police should not investigate deaths that may have been caused or contributed to by police. Nevertheless, police investigating police is standard practice in Australian jurisdictions.[35]

The human rights standard that coronial investigations be independent is not usually adhered to when police are implicated in a death.

Delays

Another common source of anguish for family members concerns the considerable time that can elapse between when a death is first discovered and when coroner's findings are made. Delays can begin with forensic medical examinations and then continue at the police investigation stage.[36] A Law Reform Commission of Western Australia study showed that between 2004 and 2010, the average time for a death in prison to reach inquest actually increased by 10 months, to 31 months. This was despite the fact that almost all of the 2010 cases were deaths from natural causes, whereas most of

[33] David Ranson, 'The Role of the Pathologist' in Hugh Selby (ed), *The Aftermath of Death* (1992) 80, 120–21; *Royal Commission into Aboriginal Deaths in Custody* ('RCIADIC') *National Report Vol 1* (1991), [4.7.4]; Graeme Johnstone, 'An Avenue for Death and Injury Prevention' in Hugh Selby (ed), *The Aftermath of Death* (1992) 140; James Reason, 'Human Error: Models and Management' (2000) 320 *British Medical Journal* 768.

[34] David Wexler, 'Therapeutic Jurisprudence: An Overview' (2000) 17(1) *Thomas M Cooley Law Review* 125; Michael King, 'Therapeutic Jurisprudence in Australia: New Directions in Courts, Legal Practice, Research and Legal Education' (2006) 15 *Journal of Judicial Administration* 129.

[35] See eg Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 93–6; Federation of Community Legal Centres, Human Rights Law Centre, Darebin Community Legal Centre and Flemington Kensington Community Legal Centre, *Effective Transparent Accountable: An independent system to investigate police-related deaths in Victoria* (June 2011) <http://www.fclc.org.au/cb_pages/federation_reports.php#Policeaccountability>.

[36] See eg Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 47.

the 2004 deaths were suicide deaths, where one might expect police investigations to be more complex.[37]

The Commission commented that if the time taken to get to inquest is any more than 12–18 months,

> 'the circumstances of the death become historical and recommendations to prevent the occurrence of future deaths in similar circumstances are less meaningful. A number of respondents to the Commission's public survey who had been involved as witnesses in prison deaths also commented that the significant delays in the coronial process meant that it was difficult to recall events accurately and this made the experience of giving evidence very stressful.'[38]

Where a person has been charged with an offence or is believed by the coroner to have committed an offence in respect of a death, generally Australian jurisdictions require that any inquest into the death not commence or be adjourned until after the conclusion of criminal proceedings.[39] This can contribute considerable delay in a significant number of investigations and inquests. For example, the 2010–11 Victorian Coroners Court Annual Report notes that as of 30 June 2011, 606 cases were currently the subject of police criminal investigations or other court proceedings.[40]

If the death proceeds to inquest, more time is needed to prepare the inquest brief. The inquest itself can take anywhere from one day to many weeks. This depends not only on whether anyone is charged with an offence which would halt the inquest at least temporarily, but also on the complexity of the issues, the nature and number of the 'parties',[41] and the potential for other legal proceedings to follow the inquest.

There is then often another period of time before the coroner's findings are released. If the parties make written submissions, this last period may be extended because lawyers require transcripts of the inquest proceedings, and this can take a significant time. As an example, a review by the Victorian Coroners Court over March–June 2011 found that the average time to receive a transcript of inquest proceedings was 89 days.[42] The Court's 2010–11 Annual Report noted:

> 'Delays in receiving transcripts of court hearings from the Victorian Government Recording Services (VGRS) has been identified as a serious impediment to the court's ongoing efforts to reduce waiting periods between the last day of an inquest and the handing down of the coroner's finding.'[43]

A long inquest hearing can also add substantially to the time taken, as it not only requires more transcription and more time to prepare submissions, but resource limitations may mean that there are gaps between sitting dates.

One way to measure overall delay in the coronial system is via measures of backlog. Some degree of backlog is not surprising because unlike other courts, the date of lodgement of the case is the time of notification of the death before any investigation is undertaken for a report to the Coroner.[44] However, the number of cases pending that are more than 12 months old is considered to be a key backlog

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[37] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 91.

[38] *Review of Coronial Practice in Western Australia Discussion Paper*, 91.

[39] *Coroners Act 1997* (ACT) s 58; *Coroners Act 2009* (NSW) ss 78–79; *Coroners Act 2003* (Qld) s 29; *Coroners Act 2003* (SA) s 21(2); *Coroners Act 1995* (Tas) s 25; *Coroners Act 1996* (WA) s 53.

[40] *Coroners Court of Victoria 2010–2011 Annual Report*, 47.

[41] As discussed in Part 2, technically there are no parties to an inquest, but the term tends to be used in a more general sense.

[42] *Coroners Court of Victoria 2010–2011 Annual Report*, 40.

[43] *Coroners Court of Victoria 2010–2011 Annual Report*, 40.

[44] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 38–9.

indicator, and national standards require that any coronial jurisdiction should have no more than 10% of such cases.[45]

At 30 June 2012, no state or territory reached the national standard, with the lowest rate being 12.4% in New South Wales, and the highest being Victoria with 41.3%.[46] National standards also set a benchmark that there should be no pending cases more than 24 months old.[47] All jurisdictions failed to reach this mark, with the worst performers being Victoria at 24.3% and the Northern Territory at 18.4%.[48]

It is also important to remember that in a significant number of cases, the delay will be considerably longer than the benchmark time length. For example, 198 of the cases in the Law Reform Commission of Western Australia study were more than three years old,[49] and for South Australian inquests where findings were delivered in 2011–12, the time elapsed since the date of death ranged from 14 months to over seven years.[50] Cases where the time elapsed between date of death and inquest findings is around eight years are not unknown.

Another measure of likely delays is the case clearance indicator, which is calculated by dividing the number of finalised cases by the number of new cases lodged in the same period.[51] The clearance indicator gives an idea of whether Coroners Courts are likely to manage to 'keep on top of' their work-load if their resources are not also increased. For example, if the indicator is under 100% it means that the court finalised fewer cases than were lodged and so the pending caseload has increased.[52] For the year ending 30 June 2012, Victoria (98.4%), Tasmania (96.7%) and the Northern Territory (93.4%) all had increased pending caseloads.[53]

In 2011 no state or territory reached the national standard for acceptable backlog of cases. It can take five years before a reported death results in coronial findings, and sometimes up to eight years.

Often the reasons for substantial delays do not seem justified to families, who may not only be extremely emotionally distressed but can sometimes also experience financial hardship if, for example, the coroner's finding is required by a life insurance company or for payment of superannuation.[54]

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[45] Productivity Commission, *Report on Government Services 2013*, 7.30.

[46] *Report on Government Services 2013*, 7.37.

[47] *Report on Government Services 2013*, 7.30.

[48] *Report on Government Services 2013*, 7.37.

[49] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 39.

[50] *Annual Report of the State Coroner Financial Year 2011–2012*, 23–24 <http://www.courts.sa.gov.au/OurCourts/CoronersCourt/Pages/Annual-Reports.aspx>.

[51] Productivity Commission, *Report on Government Services 2013*, 7.40.

[52] *Report on Government Services 2013*, 7.40; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 38.

[53] *Report on Government Services 2013*, 7.42.

[54] For example, the Law Reform Commission of Western Australia found that because insurances often require formal certification of cause of death, a small number of family members reported not being able to finalise the deceased's affairs until the inquest findings were made, which might be some years after the death. Accordingly, the Commission has recommended that the Office of the WA State Coroner consider reviving its practice of providing interim coronial determinations to the Registrar of Births Deaths and Marriages in order to enable the issuing of a death certificate at the earliest opportunity (Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 60–62; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 41–2).

Other difficulties experienced by families

Family suffering is exacerbated if there is no clear information or regular follow-ups with the family by coronial or other official personnel.[55] Other common difficulties for families have been documented in the Victorian Parliament Law Reform Inquiry into the Coroners Act 1985 (Vic) and the current Review of Coronial Practice in Western Australia, and continue to varying degrees in all Australian jurisdictions:

- lack of clarity about the roles, functions and process of the Coroner and other personnel in the investigation or inquest;
- communication from the Coroner's Office being too formal and not sensitive enough;
- lack of adequate support services;
- not knowing what to expect from the inquest proceedings;
- lack of knowledge of legal rights, including the right to representation;
- failure of coronial systems to adequately accommodate cultural and spiritual considerations, including Aboriginal and Torres Strait Islander understandings of who is next of kin;
- the carrying out of autopsies when there were no suspicious circumstances;
- families not being able to view and touch the body of the deceased person while it is in the coroner's jurisdiction;
- inadequate case investigation caused by a lack of thoroughness in collecting witness statements or by inexperienced coroner's assistants, particularly in the context of medical investigations; and
- the inability of some families to have a case investigated adequately or at all by the coroner, in circumstances where the families had unanswered questions about the cause of death or felt that certain parties should be made accountable for the death.[56]

These kinds of issues are underpinned by a general failure across jurisdictions to fully implement into practice the right of families to participate in coronial processes concerning their loved ones.

There is a general failure to fully implement the right of families to participate in coronial processes concerning their loved ones.

Families can also be disappointed with the manner in and degree to which any goal of prevention translates into practice. Families look for coronial outcomes that might give some positive meaning to the aftermath of the death. Families, their communities and advocates, along with others more broadly concerned with the relationship between preventable deaths and social justice issues, therefore need a coronial system that consistently produces findings and recommendations that are comprehensive, as timely as possible, and appropriately targeted to specific entities, such as government departments, Ministers, and private and government corporations. For a coronial system to achieve genuine prevention, these entities must respond in a manner that addresses the issues at the heart of the death, so that similar deaths do not occur in the future.

It is therefore not sufficient to simply inform families, advocates and the general public that moves will be made to achieve a preventative outcome, and yet not specify what these moves will be. Families, and Australian communities more broadly, need to see the preventative system actually working, and so must be kept informed about what recommendations have been made, how those recommendations are being implemented, and how such implementation will be monitored so that preventable deaths are eliminated, or at least reduced in number.

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[55] Law Reform Committee, Parliament of Victoria, *Coroners Act 1985 Final Report* (2006), 428–9; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 187–93.

[56] *Coroners Act 1985 Final Report*, 428–30; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 55–7; *Review of Coronial Practice in Western Australia Discussion Paper*, 181–93. See also Shannon Chapman, 'The Coroner's Exercise of Discretion: Are Guidelines Needed?' (2008) 12 (6) *Australian Indigenous Law Review* 103.

In order to begin to address these issues in detail, we first need to consider a more fundamental difficulty — the variation in, and sometimes sheer lack of, thorough, clear and publicly accessible information about the outcomes of coronial investigations (including inquests) across Australia.

Families and Australian communities need to see the preventative system actually working, and so must be kept informed about what recommendations have been made, how those recommendations are being implemented, and how implementation will be monitored.

Information about coronial findings

Let us assume that a member of the public wants to find out basic statistics concerning coronial findings for the different Australian jurisdictions. He or she might first wish to know the number of deaths reported to coroners, and the number of investigations completed which did or did not lead to an inquest.

Annual Reports/Reviews

Coroners Courts or Coroner's Offices generally provide some statistics on coroners' activities in their Annual Report or Review, or as a contribution to another entity's Annual Report. The relevant documents are usually available on the Internet, but can be hard to locate if the searcher is not already aware of which entity conventionally takes responsibility. It can be especially difficult to find information when the data is only a part of another Annual Report. The amount and type of publicly available information also varies considerably.

The most recent data, as available on the Internet, is summarised in **Table 1**. Figures for the Northern Territory were unavailable from the Internet at the time of publication.[57]

[57] The *Northern Territory Department of Justice Annual Report 2011–2012* does not report on the number of inquests, and there is no separate coroners annual report.

Table 1 Reported deaths, investigations without inquest, and inquests

Jurisdiction	Reporting period	Number of deaths reported	Number of death investigations without inquest	Number of in-quests[58]	Source
Australian Capital Territory	2010–11[59]	317	unknown[60]	20	*Annual Report of the Chief Coroner to the Attorney-General Pursuant to s 102 of the* Coroner's Act 1997 *2010–11*, 15
New South Wales	2011	5694	unknown	290	Attorney General's Department, *Local Court of New South Wales Annual Review* (2011), 20[61]
Queensland	2011–12	4461	4690	81	Office of the State Coroner, *Annual Report 2011–2012*, 45[62]
South Australia	2011–12	2088	unknown	45	*Annual Report of the State Coroner Financial Year 2011–2012*, 18, 23–24[63]
Tasmania	2011–12	478	462[64]	9	*Magistrates Court Annual Report 2011–2012*, 49[65]
Victoria	2010–11	4857	5050[66]	142[67]	*Coroners Court of Victoria 2010–2011 Annual Report*, 48[68]
Western Australia	2011–12	2679	2094	98	Office of the State Coroner, *Annual Report 2011–2012*, 11[69]

It might also be important to know the frequency of different types of deaths in the various states and territories, such as the number of deaths in custody or deaths in care. Most jurisdictions that are statutorily required to report this type of information do so in the relevant Annual Report. For example,

[58] Figures in this column, other than for Victoria, represent the number of inquest hearings completed in the relevant time period, irrespective of whether findings have been delivered. However, time elapses between a death being reported and the conclusion of an investigation, even if it does not result in an inquest, and especially if it does lead to inquest. This means that in any jurisdiction it is likely that many of the deaths investigated are not a subset of the reported deaths for that year but instead are deaths reported in earlier years. The figures are therefore only for approximate cross-jurisdictional comparison purposes.

[59] Updated information is unavailable for the ACT, because there is no coronial data published in the relevant Annual Report, from the Justice and Community Safety Directorate <http://www.justice.act.gov.au/page/view/197>.

[60] The ACT Annual Report does not disaggregate death investigations and fire investigations. As there were considerably more fire matters than deaths reported in 2010–11, it is not possible to estimate how many of the investigations that did not proceed to inquest were deaths.

[61] <http://www.localcourt.lawlink.nsw.gov.au/agdbasev7wr/_assets/localcourts/m401551l3/annual%20review%202011.pdf>.

[62] <http://www.courts.qld.gov.au/about/publications#Office%20of%20the%20State%20Coroner%20Annual%20Reports>.

[63] <http://www.courts.sa.gov.au/OurCourts/CoronersCourt/Pages/Annual-Reports.aspx>.

[64] This is only an approximate figure, because it is for number of cases closed.

[65] <http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0011/192449/2010-2011_Annual_Report_.pdf>.

[66] This figure is for the number of findings without inquest, and hence cannot be directly compared to other jurisdictions' figures for completed investigations without inquest.

[67] This figure is for the number of findings with inquest, and hence cannot be directly compared to other jurisdictions' figures for completed inquests, as there may be a delay before findings are delivered. The figure also excludes inquests into fires (= 2).

[68] <http://www.coronerscourt.vic.gov.au/resources/5/2/5200ff00495ac07a86a3d647b5aa48fe/4635+coroners+annual+report+2010-2011+web+v2.pdf>.

[69] <http://www.coronerscourt.wa.gov.au/_files/Coroners_Court_Annual_report_12.pdf>.

New South Wales reports the number of deaths of children in care and disability deaths,[70] and the number of deaths in custody or during or as a result of a police operation, including the number of deaths of Aboriginal persons. New South Wales also produces a separate more detailed report on deaths in custody[71] and an annual report on domestic violence deaths.[72] Queensland and Western Australia summarise their coronial investigations into all deaths in custody. For more detail on the information required to be reported, see **Appendix 1**.

Various jurisdictions comment on notable inquests and patterns of deaths, but other than in relation to deaths in custody and care, domestic violence deaths in New South Wales, and, in some jurisdictions, reporting on responses to coronial recommendations (see pp 29–31), there is not necessarily any statutory obligation to do so.

The extent of other coronial information provided in Annual Reports varies, depending on the particular Coroners Court or Coroner's Office. The Western Australia *Office of the State Coroner Annual Report 2011–2012* includes brief summaries of a number of inquest findings,[73] and both the *Coroners Court of Victoria Annual Report 2010–2011* and the *Queensland Office of the State Coroner Annual Report 2011–2012* include an overview of investigations or inquests of significant public interest.[74] The *Coroners Court of Victoria Annual Report* also includes developments in public health and safety as the result of coronial investigations.[75] South Australia publishes a brief case review summary of domestic violence deaths in its *Annual Report of the State Coroner 2011–2012*,[76] and Victoria has recently published a separate report on its Systemic Review of Family Violence Deaths.[77] For more detail on family/domestic violence death reviews, see *Proposals to centrally record coronial recommendations* (p 45). Most jurisdictions also provide information about their clearance rates of coronial cases.

Coroners websites

If a member of the public wishes to access particular coronial findings and recommendations, many can now be obtained via the relevant Coroners Court or Coroner's Office website.[78] The exception ap-

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[70] 'Disability deaths' broadly refer to deaths of people receiving residential care or services within the meaning of the *Disability Services Act 1993* (NSW).

[71] <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/DICReport2010Part1.pdf/$file/DICReport2010Part1.pdf>. The latest report available online is for 2010.

[72] NSW Domestic Violence Death Review Team, *Annual Report 2011–2012* <http://www.coroners.lawlink.nsw.gov.au/agdbasev7wr/_assets/coroners/m401601l5/dvdrt_annual_report_final_october_2012x.pdf>.

[73] *Office of the State Coroner Annual Report 2011*–2012 <http://www.coronerscourt.wa.gov.au/_files/Coroners_Court_Annual_report_12.pdf>.

[74] *Coroners Court of Victoria 2010–2011 Annual Report*, 19–23 <http://www.coronerscourt.vic.gov.au/resources/bff76d3b-fed7-4f5f-91b2-528cd624ef5b/4635%2bcoroners%2bannual%2breport%2b2010-2011%2bweb%2bv2.pdf>; Office of the State Coroner, *Annual Report 2011–2012*, 31–44 <http://www.courts.qld.gov.au/about/publications#Office%20of%20the%20State%20Coroner%20Annual%20Reports>.

[75] *Coroners Court of Victoria 2010–2011 Annual Report*, 24–6 <http://www.coronerscourt.vic.gov.au/resources/bff76d3b-fed7-4f5f-91b2-528cd624ef5b/4635%2bcoroners%2bannual%2breport%2b2010-2011%2bweb%2bv2.pdf>.

[76] *Annual Report of the State Coroner 2011–2012*, 12 <http://www.courts.sa.gov.au/OurCourts/CoronersCourt/Pages/Annual-Reports.aspx>.

[77] *Victorian Systemic Review of Family Violence Deaths—First Report* <http://www.coronerscourt.vic.gov.au/find/publications/victorian+systemic+review+of+family+violence+deaths+_+first+report>.

[78] <http://www.courts.act.gov.au/magistrates/page/view/597/title/selected-findings>;
<http://www.coroners.lawlink.nsw.gov.au/coroners/findings.html.c=y>;
<http://www.nt.gov.au/justice/courtsupp/coroner/inquestlist.shtml>;
<http://www.courts.qld.gov.au/courts/coroners-court/findings>;
<http://www.courts.sa.gov.au/CoronersFindings/Pages/All-Findings.aspx>;
<http://www.magistratescourt.tas.gov.au/decisions/coronial_numeric_index>;

pears to be Western Australia, with only one finding, from 2012 in relation to the Christmas Island Tragedy, published on the Internet.[79] The WA Coroner's Court website advises: 'Coroner's inquest findings are available on the date of delivery of the finding or later by request in writing to the Office of the State Coroner.'[80]

No coroners website provides automatic public access to all coronial findings for the jurisdiction, because coroners have some discretion to withhold findings to protect privacy or recognise suppression orders.[81] In addition, even a more comprehensive public database of findings such as Victoria's has few findings before the new legislation commenced in 2009.

Coroners websites also vary in terms of the amount and level of information available to the general public. Northern Territory, Tasmanian, Victorian and Western Australian coroners are expressly empowered to make findings when an investigation does not proceed to inquest, but only Tasmania and Victoria include these findings along with inquest findings on their respective websites.[82] The Queensland, South Australian and Victorian findings databases are searchable to some extent, and the Queensland site also includes judicial decisions relevant to coronial issues.

There is considerable variation across and even within jurisdictions in terms of how findings are set out and written.[83] It is also very difficult to find out information on whether in a specific inquest the family was legally represented, and whether advocacy organisations have been involved in particular inquests in other capacities. These problems are addressed in **Part 2**.

There are other significant limitations to most of the publicly available information. While all published findings include any coronial recommendations made, only Victoria, New South Wales, South Australia and Western Australia publish responses to recommendations. Victoria is the only jurisdiction that publishes responses as a matter of course on its coroners website alongside the relevant findings. The issue of responses to recommendations is discussed further below.

States and territories vary considerably in terms of how much clear information about the outcomes of coronial investigations and inquests is publicly accessible.

Coroners Courts/Offices

For advocates and researchers trying to prevent future deaths by learning from patterns of death via accessing findings and recommendations for all similar deaths, the information sought is often not

<http://www.coronerscourt.vic.gov.au/home/case+findings/>.

[79] <http://www.coronerscourt.wa.gov.au/I/inquest_findings.aspx?uid=9349-4756-3915-2531>. WA does publish inquest findings concerning hospital and healthcare deaths, via the Office of Safety and Quality in the Department of Health <http://www.safetyandquality.health.wa.gov.au/mortality/inquest_finding.cfm>.

[80] <http://www.coronerscourt.wa.gov.au/I/inquest_findings.aspx?uid=9349-4756-3915-2531>. The rationale for not publishing findings was given by the Parliamentary Secretary representing the Attorney General: 'The Coroner's Court used to publish findings on the website. However, this facility was suspended following complaints from families. In summary, families were concerned that details of the death of their loved ones were publicly available and open to voyeurism. . .The provision of anonymised findings is no guarantee that the deceased will not be identified. Almost every death has its own unique set of circumstances from which it is relatively easy to identify the deceased. Findings are made publicly available following the inquest and, to facilitate bone fide requests thereafter, the Coroner's Court will make them available by application via its website' (Western Australia, *Parliamentary Debates*, Legislative Council, 29 June 2010, 4719 (Helen Morton)).

[81] See eg *Coroners Act 2008* (Vic) s 73(1).

[82] The fact that findings without an inquest do not appear on a website may also be a function of them being rarely, if ever, made in this context. Public data is not available to clarify this issue.

[83] See also Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 20.

publicly accessible via the Internet. Coroners Courts or Coroners Offices are then the logical place to inquire about this data.

As the Law Reform Commission of Western Australia notes:

> 'If the coroner is to effectively discharge a death prevention role then it is clear that there needs to be a high degree of cooperation between the Office of the State Coroner and legitimate researchers and special interest advocacy groups within the community and government.'[84]

However, Coroners Courts/Offices vary in terms of the level of resourcing that they have to enable them to provide such information. For example, 'there appears to be very little direct information sharing' between the WA Office of the State Coroner and groups seeking coronial data.[85] This appears due to the lack of capacity of staff to be able to deal with internal work, let alone external requests.[86]

In contrast, the Victorian Coroners Court is supported by the Coroners Prevention Unit (CPU), which provides coroners with research and analysis to support the coronial recommendation function, as well as responding to external requests for data and research. However, even in this better resourced coronial jurisdiction, the prioritised needs of coroners combined with limited capacity mean that external requests may not be able to be actioned by the CPU. Public interest advocacy groups also appear less likely than government departments to be able to quickly obtain the data they seek.

For example, as an important part of ongoing policy work on police accountability and independent systems of investigation in policing-related deaths, the Federation of Community Legal Centres is seeking copies of all recommendations in Victorian inquests related to such deaths, including recommendations made before 2009. Despite the fact that coronial recommendations made from 2009 onward concerning police-related deaths are publicly available on the Victorian Coroners Court website,[87] the Federation must apply via the Department of Justice Ethics Committee for access to the pre-2009 recommendations. If the application is successful, it is also unlikely that findings and recommendations made before 2000 will be made available, because cases before that time are not part of the electronic system, and there is no paper index. A very time-consuming manual review of all deaths, involving a recall of all of those files, would be required to identify those cases where a relevant recommendation was made.

'If the coroner is to effectively discharge a death prevention role then it is clear that there needs to be a high degree of cooperation between the Office of the State Coroner and legitimate researchers and special interest advocacy groups within the community and government.'
Law Reform Commission of Western Australia

Under-resourcing of Coroners Courts/Offices hampers their ability to provide public information and to cooperate with external researchers and advocates.

National Coronial Information System

There are other potential sources of information that have the added advantage of recording inquest data across state and territory boundaries. The National Coronial Information System (NCIS), an initiative of the Australasian Coroners Society, is a national database for all coronial matters. The NCIS is

[84] *Review of Coronial Practice in Western Australia Discussion Paper*, 163.

[85] *Review of Coronial Practice in Western Australia Discussion Paper*, 163.

[86] *Review of Coronial Practice in Western Australia Discussion Paper*, 163–4. The Commission has accordingly recommended that a prevention team be established within the Office of the State Coroner (Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 102).

[87] See eg <http://www.coronerscourt.vic.gov.au/home/case+findings/coroners2+-+554208+tyler+cassidy>.

based at the Victorian Institute of Forensic Medicine and managed by the Victorian Department of Justice. It is advertised as containing case detail information about every death reported to an Australian coroner since July 2000, or January 2001 for Queensland.[88] The NCIS is a very valuable tool and a significant step forward in the prevention of untimely death. Its primary role is to assist coroners by providing them with the ability to review similar previous coronial cases.

NCIS data, including the full text of coronial findings and recommendations, is not publicly available. However, the public can access a publication, *Fatal Facts*, which identifies and summarises all coronial recommendations that have been uploaded to the NCIS over the relevant period, although with a significant delay between the time that recommendations are made and when they appear in summary.[89] Each edition also provides in-depth case studies on a featured topic, such as deaths in custody.

Individuals or organisations other than coroners may apply as a 'third party' for direct access to the NCIS. A third party is an Australian individual or organisation with a bona fide role or interest in public health and safety or with a statutorily mandated statistical role. This includes Commonwealth, State and Territory government departments and agencies, university research centres, and other research or non-profit organisations with a role or interest in public health and safety.[90]

If a researcher or an organisation seeks access to information such as the full text of coronial findings and recommendations, they must therefore make an application to the NCIS, which is then subject to approval by the NCIS Research Committee and the Victorian Department of Justice Research Ethics Committee.[91] The application process takes at least two months and a fee of between $1000 and $17000 is payable.[92]

It appears that few public legal service providers acting for families seek access to NCIS data to assist in the preparation of their evidence and submissions at inquests. However, from time to time, lawyers representing government agencies and corporations whose actions are to be called into question at an inquest apparently obtain NCIS data in preparation.

Entities who are not deemed to be third parties, such as media and private organisations, may apply for access to de-identified data, for which they must pay a fee. The NCIS team can be engaged to conduct a search of the NCIS to retrieve data as agreed between the team and the applicant. The charge for this service is at the hourly rate of $165 (GST-inclusive), which covers the time taken for the research officer to perform the search and collate the results. The information provided to the applicant can range from basic statistical data to the provision of detailed reports that include additional analysis and commentary.[93]

However, access may be denied. For example, in July 2009, amidst controversy about attacks on Indian students, investigative reporters from the *Sydney Morning Herald* were reportedly denied access to NCIS data in their attempt to determine the number of deaths of overseas students in Australia reported to coroners between November 2007 and 2008.[94]

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[88] <http://www.ncis.org.au/>.

[89] <http://www.ncis.org.au/web_pages/fatal_facts.htm>. For example, the 2012 edition summarises 2009 recommendations <http://www.ncis.org.au/web_pages/Fatal%20Facts_Edition%2022.pdf>.

[90] <http://www.ncis.org.au/web_pages/NCIS%20Information%20Sheet_2012.pdf>.

[91] <http://www.ncis.org.au/web_pages/NCIS%20Information%20Sheet_2012.pdf>. Some applications for access to Western Australian data also require approval from the Western Australia Coronial Ethics Committee.

[92] Non-profit organisations and community groups would probably pay $1000, as the fee is based on an assessment of organisation size, regularity of use and capacity to pay: Jessica Pearse, Manager NCIS, email (23 May 2011), cited in Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 162 n 10.

[93] <http://www.ncis.org.au/web_pages/how_to_apply_for_access.htm>.

[94] 'Student Death Toll Set to Rise', *Sydney Morning Herald*, 1 July 2009.

45 searches for external parties were performed in 2010–11.[95] Most searches were undertaken on behalf of government (including local government) and statutory agencies, with eight performed for universities and six for health bodies.[96] Four suicide prevention organisations, three media, three community organisations and one private citizen had searches performed.[97]

The National Coronial Information System is a very valuable tool, but is only automatically accessible to coroners. Other potential users must seek approval to use it and usually pay a significant fee.

Aiming for prevention — coronial recommendations

Families seeking some comfort from the inquest, along with advocates working to oppose systemic injustices, look to coronial recommendations as the key to preventing similar deaths in the future. However, it is important to note that cases investigated by coroners do not always result in findings, and only a small minority of cases produce recommendations.[98] Even more significantly, states and territories vary not only in the way that coroners write their findings, but also according to how often coronial recommendations are made,[99] and in the scope of such recommendations.

Some of this may be due to the fact that jurisdictions still differ in the extent to which their legislation underpinning coronial practice has an express commitment to prevention. For example, while various parts of the *Coroners Act 2008* (Vic) and the *Coroners Act 2003* (Qld) directly address prevention, including in the Preamble and Purposes (Victoria) and the Objects (Queensland), the *Coroners Act 2006* (WA) does not expressly refer to any object or purpose of prevention, and the *Coroners Act 2003* (SA) refers to prevention only once, in the provision concerning the recommendation power of coroners.[100] For a detailed comparison of the various jurisdictions, see **Appendix 1**.

The scope and frequency of recommendations are also clearly influenced by the extent of coroners' powers to make recommendations. For example, in South Australia, the recommendation power is quite narrow, relating to the cause or circumstances of the death rather than also including events that occurred immediately after the death, or encompassing issues not similar to the event that was the subject of the inquest.[101] This narrow power means that, for example, in the inquest into the death of an Aboriginal prisoner in an overcrowded doubled-up cell with another prisoner who had an infectious disease, the South Australian State Coroner, although empowered to make broad comments, was unable to make any recommendations about the health risks of overcrowding, because the pris-

[95] *NCIS Annual Report 2010–11*, 10 <http://www.ncis.org.au/web_pages/Annual%20Report%202011_FINAL%20for%20web.pdf>.

[96] *NCIS Annual Report 2010–11*, 29 <http://www.ncis.org.au/web_pages/Annual%20Report%202011_FINAL%20for%20web.pdf>.

[97] *NCIS Annual Report 2010–11*, 29 <http://www.ncis.org.au/web_pages/Annual%20Report%202011_FINAL%20for%20web.pdf>.

[98] Of the 4158 cases closed by Australian coroners between 1 June 2009 and 30 September 2009, 3358 resulted in findings, and 51 of these produced recommendations (*NCIS Fatal Facts* Edition 22 (May 2012), 1 <http://www.ncis.org.au/web_pages/Fatal%20Facts_Edition%2022.pdf>).

[99] Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13(2) *Journal of Law and Medicine* 173, 175; Ian Freckelton and David Ranson, 'The Evolving Institution of Coroner' in Ian Freckelton and Kerry Petersen (eds), *Disputes and Dilemmas in Health Law* (2006) 296, 309; Lyndal Bugeja, Joseph Ibrahim, Joan Ozanne-Smith, Lisa Brodie and Roderick McClure, 'Application of a Public Health Framework to Examine the Characteristics of Coroners' Recommendations for Injury Prevention' *Inj Prev* published online December 26, 2011 doi: 10.1136/injuryprev-2011-040146, downloaded from injuryprevention.bmj.com 27 December 2011.

[100] *Coroners Act 2003* (SA) s 25(2).

[101] *Coroners Act 2003* (SA) s 25(2); Christopher Charles, 'The *Coroners Act 2003* (SA) and the Partial Implementation of RCIADIC: Consequences for Prison Reform' (2008) 12 (6) *Australian Indigenous Law Review* 75, 77–80.

oner died of a drug overdose.[102] Despite the 1991 recommendation of the Royal Commission into Aboriginal Deaths in Custody, the scope of South Australian coroners' recommendation powers remains unchanged.[103]

Another factor that may affect whether recommendations are made in a particular inquest is that although coroners are independent judicial officers with the power to obtain documents and answers to questions about a death from governments, corporations and individuals,[104] coroner's offices are usually under-resourced, with little assistance provided to help them compile their findings and recommendations.[105] The only study to date of the implementation of coronial recommendations in all Australian jurisdictions, published in 2008 in the *Australian Indigenous Law Review* (the AILR study),[106] found that factors influencing whether a recommendation was implemented included:

- the manner in which a recommendation was formulated or expressed by a coroner;
- the manner in which a recommendation was distributed or communicated by a coroner;
- whether prior coronial recommendations arising from similar deaths were drawn to the attention of the relevant authorities; and
- the feasibility of a recommendation.[107]

The degree of emphasis on prevention and on the role of recommendations varies considerably among states and territories. Coroners also often have little assistance to help them formulate their findings and recommendations.

Many coroners require training in order for their recommendations to be at least potentially effective.[108] It is still possible to find examples of coronial recommendations that are not directed to a particular entity or do not target the appropriate agency, and therefore will not receive a response. In a review of coronial recommendations from inquests performed in 2007, the Law Reform Commission of Western Australia found that

> 'recommendations directed to private entities or vaguely directed to "the government" received poor or no responses. Recommendations that were broad in nature or not targeted to specific actions tended to receive platitudinous responses with little likelihood of implementation.'[109]

The AILR study also found that there were

> 'recurring instances where coronial recommendations had not been communicated or had been miscommunicated, or were lost within bureaucratic processes.'[110]

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[102] State Coroner Wayne Chivell, Findings of the Inquest into the Death of Marshall Freeland Carter, 16 June 2000 [8.23]; Christopher Charles, 'The *Coroners Act 2003* (SA)', 78–9.

[103] Recommendation 13: That a Coroner inquiring into a death in custody be required to make findings as to the matter which the Coroner is required to investigate and to make such recommendations as are deemed appropriate, with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate (Royal Commission Into Aboriginal Deaths In Custody *National Report Vol 1* (1991) [4.74]).

[104] *Coroners Act 1997* (ACT) ss 43–45, 66–67; *Coroners Act 2009* (NSW) s 53, Part 6.3; *Coroners Act 1993* (NT) ss 19, 41; *Coroners Act 2003* (Qld) ss 13, 37; *Coroners Act 2003* (SA) ss 22–23; *Coroners Act 1995* (Tas) s 53; *Coroners Act 2008* (Vic) ss 42, 55; *Coroners Act 1996* (WA) ss 33, 46.

[105] See eg references to understaffing and under-funding in Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 24; *Coroners Court of Victoria 2010–2011 Annual Report*, 15, 42–4.

[106] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4. The study tracked the response of government agencies to 484 coroners' recommendations in 185 inquests around Australia, mostly in 2004.

[107] Watterson, Brown and McKenzie, 12.

[108] See eg Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 51.

[109] *Review of Coronial Practice in Western Australia Background Paper*, 21–2.

[110] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 5.

> 'Recommendations directed to private entities or vaguely directed to "the government" received poor or no responses. Recommendations that were broad in nature or not targeted to specific actions tended to receive platitudinous responses with little likelihood of implementation.'
> Law Reform Commission of Western Australia

> 'There were recurring instances where coronial recommendations had not been communicated or had been miscommunicated, or were lost within bureaucratic processes.'
> AILR study

Responses to coronial recommendations

As evident from the AILR study, even where comprehensive and appropriately targeted recommendations are made, in most jurisdictions there is no guarantee that governments and other entities will respond to them. Only four of the eight jurisdictions statutorily mandate responses to coronial recommendations, with only the Northern Territory and Victoria legally requiring responses to all coronial recommendations.[111] The Australian Capital Territory and South Australia mandate responses only in relation to deaths in custody.[112]

In June 2009 the New South Wales Premier issued a memorandum to Ministers and government agencies, indicating that they should respond to coronial recommendations within six months of receiving them, outline any action being taken to implement the recommendation, and give any reasons if it is not proposed to implement a recommendation.[113] Ministers and agencies are also encouraged to provide updates to the Attorney General on any further action taken to implement recommendations following their initial advice.[114]

The Premier's memorandum instructs that if the proposed Government response to a coronial recommendation involves significant change to Government policy, impacts on more than one portfolio, or has budgetary implications, a Minister should bring forward a Cabinet Minute.[115] Unfortunately, the new Guidelines are not enshrined in the *Coroners Act 2009* (NSW), and therefore may be subject to policy change.

How can the general public find out whether responses have been made?

The Australian Capital Territory, the Northern Territory, South Australia and Victoria all legally require some form of public reporting of mandatory responses to coronial recommendations.

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[111] In the Northern Territory, a written response is required within 3 months from the Chief Executive Officer of the relevant NT Agency or the Commissioner of Police, to the NT Attorney-General, with the response including a statement of the action that the Agency or the Police Force is taking, has taken or will take: *Coroners Act 1993* (NT) ss 46A, 46B. In Victoria, a written response is required within 3 months from the relevant public statutory authority or entity, to the coroner, with the response specifying a statement of action (if any) that has, is or will be taken: *Coroners Act 2008* (Vic) ss 72(3)–(4). For more detail, see **Appendix 1**.

[112] In the ACT, the custodial agency in whose custody the death happened must give a written response within 3 months to the Minister responsible, including a statement of any action that has been or is being taken: *Coroners Act 1997* (ACT) s 76. In South Australia, the Minister responsible must within 6 months and 8 sitting days give details to each House of Parliament of any action taken or proposed to be taken: *Coroners Act 2003* (SA) s 25(5).

[113] <http://www.dpc.nsw.gov.au/announcements/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations>.

[114] <http://www.dpc.nsw.gov.au/announcements/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations>.

[115] <http://www.dpc.nsw.gov.au/announcements/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations>.

In the ACT, which only mandates responses concerning deaths in custody, the coroner, along with providing copies of findings concerning a death in custody to the immediate family and any witnesses,[116] must report the findings and provide a copy of the response to the Australian Institute of Criminology.[117] If the deceased was an Aboriginal person or Torres Strait Islander, the coroner must also report the findings and provide a copy of the response to an appropriate local Aboriginal legal service, and to any other person whom the coroner considers appropriate.[118] The Chief Coroner is also required to give details of responses to recommendations and any related correspondence in his or her annual report to the Attorney-General, for presentation to the ACT Legislative Assembly.[119]

In the Northern Territory, the Attorney-General must report on the coroner's report and recommendations and the response to them, and lay the report before the Northern Territory Legislative Assembly.[120] The Attorney-General may also give a copy of the report to the coroner, who may give it to the senior next of kin, a witness or any other party with sufficient interest in the inquest or investigation.[121] It is impossible to find any details concerning responses on the Internet.

In South Australia, which only mandates responses concerning deaths in custody, the responsible Minister must report to each South Australian House of Parliament giving details of any action taken or proposed to be taken in response to coronial recommendations.[122] While this report must also be forwarded to the State Coroner,[123] and findings and recommendations must be given to persons with sufficient interest, including those who appeared personally or were legally represented at the inquest,[124] families do not receive copies of responses to recommendations as of right. However, the State Coroner's Annual Report lists responses to recommendations concerning deaths in custody.[125]

Victoria requires responses to coronial recommendations to be published on the Internet,[126] and copies to be provided to any person with a sufficient interest.[127] As previously noted, the *Coroners Court of Victoria Annual Report 2010–2011* also includes discussion of selected responses in its summary of developments in public health and safety.[128] The First Report from the Victorian Systemic Review of Family Violence Deaths also summarises responses to coronial recommendations in a selection of closed investigations.[129]

The NSW Premier's memorandum indicates that the Attorney General will maintain a record of all coronial recommendations made, together with the responses received from relevant Ministers and NSW

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[116] *Coroners Act 1997* (ACT) s 75(2). For any other type of death, the coroner must provide a copy of the findings to the immediate family if they request it: *Coroners Act 1997* (ACT) s 54(1).

[117] *Coroners Act 1997* (ACT) ss 75(1)(c), 76(4).

[118] *Coroners Act 1997* (ACT) ss 75(1)(d)–(e).

[119] *Coroners Act 1997* (ACT) s 102(2)(d). See <http://www.courts.act.gov.au/magistrates/page/view/3411/title/annual-reports>.

[120] *Coroners Act 1993* (NT) s 46B(3).

[121] *Coroners Act 1993* (NT) s 46B(4).

[122] *Coroners Act 2003* (SA) s 25(5)(a).

[123] *Coroners Act 2003* (SA) s 25(5)(b).

[124] *Coroners Act 2003* (SA) s 25(4)(b).

[125] *Annual Report of the State Coroner Financial Year 2011–2012*, 34–45 <http://www.courts.sa.gov.au/OurCourts/CoronersCourt/Pages/Annual-Reports.aspx>.

[126] *Coroners Act 2008* (Vic) s 72(5)(a).

[127] *Coroners Act 2008* (Vic) s 72(5)(b).

[128] *Coroners Court of Victoria 2010–2011 Annual Report*, 24–6 < http://www.coronerscourt.vic.gov.au/resources/bff76d3b-fed7-4f5f-91b2-528cd624ef5b/4635%2bcoroners%2bannual%2breport%2b2010-2011%2bweb%2bv2.pdf>.

[129] *Victorian Systemic Review of Family Violence Deaths — First Report*, 59–68 <http://www.coronerscourt.vic.gov.au/find/publications/victorian+systemic+review+of+family+violence+deaths+_+first+report>.

government agencies.[130] In June and December each year, the NSW Attorney General publishes on the Internet detailed summary tables of findings, coronial recommendations and responses received.[131]

Queensland, Western Australia and Tasmania do not require responses to coronial recommendations concerning any type of death.[132] Following the Queensland Ombudsman's Coronial Recommendations Project in 2006,[133] a report outlining government responses to coronial recommendations is tabled annually in the Queensland Parliament and published on the Internet. The latest report concerns responses to recommendations made in 2011.[134] The most recent Annual Report from the Western Australia Office of the State Coroner includes responses to coronial recommendations together with summaries of findings.[135]

For Tasmania, a member of the general public seeking information on responses must usually try to find information via documents provided to the Attorney-General, or tabled in Parliament, or in an Annual Report, or provided on a coroners website at the coroner's discretion (for more detail, see **Appendix 1**). At present, none of these routes are likely to provide access.

The NCIS is working with each Coronial Office to develop the best process to allow access to NCIS in order to track the progress of agency responses to coronial recommendations.[136] It appears that this function will be limited to those jurisdictions that mandate responses, and as with other NCIS services, will only be available to registered users.

Even where comprehensive and appropriately targeted recommendations are made, in most jurisdictions there is no guarantee that governments and other entities will even respond to them. In most states and territories it is also difficult to find public information about responses to recommendations.

Implementation of responses to coronial recommendations

There has been scarce systematic research tracking the pathways of coronial recommendations from agency response to implementation and potential impact on preventable deaths.[137] The paucity of research is at least in part due to the continuing lack in most jurisdictions of easily accessible information about what recommendations are made, whether they are responded to, and in what manner.

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[130] <http://www.dpc.nsw.gov.au/announcements/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations>.

[131] < http://www.lsb.lawlink.nsw.gov.au/lsb/coronialrecommendations.html>.

[132] With the exception of the WA Department of Health, by virtue of internal policy in Information Circular IC0008/07 (cited in Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 170 n31). Summaries of inquest findings, recommendations and responses concerning hospital and healthcare deaths are published by the Office of Safety and Quality in the Department of Health. See eg <http://www.health.wa.gov.au/CircularsNew/attachments/553.pdf>.

[133] Queensland Ombudsman, *The Coronial Recommendations Project: An investigation into the administrative practice of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations* (December 2006). The Project also proposed that responses to coronial recommendations be made mandatory (at xiv, 31).

[134] <http://www.justice.qld.gov.au/__data/assets/pdf_file/0013/171022/qld-govt-response-to-coronial-recommendations-2011.pdf>.

[135] Office of the State Coroner, *Annual Report 2011–2012* <http://www.coronerscourt.wa.gov.au/_files/Coroners_Court_Annual_report_12.pdf>.

[136] *NCIS News* Edition 9, Winter 2011, 3–4 <http://www.ncis.org.au/web_pages/NCIS%20News%20-%20Edition%209%20(July%2011).pdf>.

[137] Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: Do They Lead to Positive Public Health Outcomes?' (2005) 10(4) *Journal of Law and Medicine* 399; Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13(2) *Journal of Law and Medicine* 173, 175; Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 4.

The NCIS does not hold systematic data about the implementation of coronial recommendations. Coupled with the limitations of publicly available investigation and inquest data, this means that it is very difficult for researchers, let alone the general public, to assess the impact of coronial recommendations upon the prevention of deaths in Australia, either generally or in relation to any particular kind of death.

The one study that has examined implementation of coronial recommendations in all Australian jurisdictions, the AILR study, was undertaken before the changes in New South Wales and Victoria made responses to coronial recommendations mandatory. It found that in New South Wales, the areas of health, housing, energy, fair trading and police had 'significant problems with government organisations responding to coronial recommendations.'[138] The Northern Territory — the only jurisdiction at that time with mandatory responses for all deaths — was the exception, in that there appeared to be no matters in which coronial recommendations were not communicated to the relevant government agency or were lost or neglected within a government agency. The AILR study therefore concluded that jurisdictions that mandate responses to recommendations are likely to have a better rate of implementation.[139]

Whether or not entities are compelled to respond in a particular jurisdiction, the pathway from recommendation to response and implementation of possible prevention strategies is not a smooth one. Integrity of the pathway depends first upon the quality of response and then on whether there is any monitoring or follow-up if a response is unsatisfactory.

For example, the Victorian Guidelines for Responding to Coroners' Recommendations state that the response to the relevant recommendation may fall within one of five categories, including 'the coroner's recommendation is under consideration'.[140] There is no legislative requirement to follow up on this type of 'holding' response, and it is unclear whether staff capacity would allow this to be undertaken as standard practice.

As another illustration, the New South Wales Premier's memorandum encourages Ministers and agencies to provide updates to the Attorney General on any further action taken to implement recommendations following their initial advice.[141] However, it is not clear that any follow up is likely to occur if the Minister's or agency's response is to state that they have referred the issue to another entity or — again, a 'holding' response — that implementation is simply 'progressing'. A perusal of tables of responses also shows that the 'Future — Next response' row of the table is often blank.[142]

It is very difficult to assess the impact of coronial recommendations upon the prevention of deaths in Australia.

A further issue on the path from response to potential implementation concerns whether there is any monitoring to ensure that agencies put their stated strategies into practice. The question of whether there is any entity that actually takes responsibility for monitoring of implementation is a vexed one, even in those jurisdictions that mandate responses to coronial recommendations. In theory, the best approach involves a prevention team supporting the Coroners Court/Office 'in publishing, monitoring and evaluating responses to and implementation of coronial recommendations'.[143] Hence for exam-

[138] Watterson, Brown and McKenzie, 13.

[139] Watterson, Brown and McKenzie, 12.

[140] The Guidelines are not available as a separate entity on the Coroners Court of Victoria website, but are listed as part of Telstra Corporation Ltd, Response – Finding without Inquest into the Death of Andrew Campbell, 1 July 2010.

[141] <http://www.dpc.nsw.gov.au/announcements/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations>.

[142] <http://www.lsb.lawlink.nsw.gov.au/lsb/coronialrecommendations.html>.

[143] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 164.

ple, the current Review of Coronial Practice in Western Australia takes Victoria as a model for improving WA approaches to coronial recommendations and death prevention.[144] In practice, however, much hinges on the interpretation of 'monitoring' and 'evaluating' the responses and implementation.

For example, the recent Victorian changes include as a function of the Coroners Prevention Unit (CPU), monitoring and collecting information on the response to and implementation of recommendations.[145] The Coroners Court of Victoria website also states that one of the central goals of the CPU is to increase the uptake and implementation rate of coronial recommendations, and that the CPU may contribute at any stage of the coronial process, including after recommendations have been made, 'by monitoring and collecting information on the response to and implementation of coronial recommendations'.[146]

The CPU is not a statutory body and so there is no legislative guidance concerning its role, but the Second Reading Speech for the Coroners Bill 2008 includes:

> '. . .there was a need to strengthen the prevention role of the coroner. . .The bill addresses this issue and is supported by the establishment of the first coroner's prevention unit, which will assist the coroner in relation to the formulation of appropriate prevention recommendations as well as help monitor and evaluate the effectiveness of those recommendations.'[147]

In practice, however, Victorian follow-up with respect to most recommendations consists of collecting responses and publishing them on the Internet. There does not usually appear to be capacity to follow up, as standard operating procedure, on insufficiently detailed responses or to monitor whether a response is put into practice, let alone to monitor how that subsequent implementation might be contributing to death prevention.

The AILR study, albeit undertaken before developments such as the establishment of Victoria's CPU, found that fewer than half of coroners' suggestions to prevent future deaths were implemented by governments across Australia, with the proportion in each jurisdiction of coronial recommendations that were implemented ranging from 27 per cent (Victoria) to 65–70 per cent (Northern Territory and ACT).[148] While responses from Commonwealth agencies to coronial recommendations (for example, concerning deaths in immigration detention) were not examined in the study, anecdotal evidence suggests that this implementation rate is also low.

The AILR study concluded that implementation of recommendations is an ad hoc process, with the chances of implementation of particular recommendations improved by factors such as media pressure, advocacy group intervention, and family and community action.[149]

Since the AILR study was published, it does not appear that the state of affairs concerning implementation has changed significantly. For example, the Report by the Standing Committee on Environment and Public Affairs of the WA Inquiry into the Transportation of Detained Persons noted in July 2011:

> 'A number of stakeholders advised the Committee that there had been a lack of transparency surrounding the practical implementation of the Coroner's recommendations. For example, [the Deaths in Custody Watch Committee] expressed the view that there is "scant information available publicly" from the Government regarding action taken to implement the Coroner's

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[144] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 105–7.

[145] 'Coroners Prevention Unit', 2 <http://www.coronerscourt.vic.gov.au/home/investigations/brochure+-+coroners+prevention+unit>.

[146] Coroners Prevention Unit <http://www.coronerscourt.vic.gov.au/home/investigations/whos+involved/coroners+prevention+unit/>.

[147] Victoria, *Parliamentary Debates*, Legislative Assembly, 13 November 2008, 5029 (Justin Madden).

[148] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 4.

[149] Watterson, Brown and McKenzie, 19.

> recommendations [concerning the death of Mr Ward] other than the Government's Response to the Recommendations made by the State Coroner following the investigation into the death of Mr Ward (September 2009), which is often superficial and lacks clear timelines for implementation.'[150]

The Committee went on:

> 'The Committee is dismayed about the lack of transparency regarding the implementation of the Coroner's recommendations in the case of Mr Ward. Government departments did not proactively communicate with family, stakeholders and the public regarding the progress of action to implement the Coroner's recommendations. Given the tragic nature of Mr Ward's death, a Parliamentary inquiry, questions in Parliament and stakeholders chasing up Ministers and Government departments should not be required to obtain this information.'[151]

Whether recommendations get implemented is generally an ad hoc process.

As discussed above, the way in which coroners frame and target their recommendations also influences whether a recommendation is likely to be implemented. Other significant factors found by the AILR study include:

- whether implementation accords with government policies and priorities; and
- whether a proactive system for review of recommendations exists within the targeted organisation.[152]

Coroners may therefore make potentially life-saving recommendations, only for them never to be responded to or implemented, with no follow-up and no public awareness of what has happened. The examples above demonstrate a need not only for mandatory responses, but also for coroners to be provided with the power to comment on the adequacy and timeliness of responses, and to be assisted by a well-resourced prevention unit to obtain progress reports on implementation of recommendations.

Coroners may make potentially life-saving recommendations, only for them never to be responded to or implemented, with no follow-up and no public awareness of what has happened.

Implications for prevention

As the AILR study found, within any particular jurisdiction, recommendations may never be implemented. Even if recommendations receive a response and are ultimately implemented, current approaches mean that this may not happen in time to prevent other similar deaths. The present patchwork system also means that even though coroners may be sharing information across Australia via the NCIS, government and other agencies in one jurisdiction are unlikely to learn effectively and in a timely way from a death, or even a pattern of deaths, in another jurisdiction.

Recommendations may not be implemented in time to prevent other similar deaths — or may never be implemented.

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[150] Legislative Council Standing Committee on Environment and Public Affairs, Parliament of Western Australia, *Inquiry into the Transportation of Detained Persons: The Implementation of the Coroner's Recommendations in Relation to the Death of Mr Ward and Related Matters* (July 2011), 43 [2.169].

[151] Legislative Council Standing Committee on Environment and Public Affairs, Parliament of Western Australia, *Inquiry into the Transportation of Detained Persons: The Implementation of the Coroner's Recommendations in Relation to the Death of Mr Ward and Related Matters* (July 2011), 43–4 [2.173].

[152] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 12.

Failure to bridge the gap between coronial recommendations and implementation, and to apply the lessons from recommendations concerning earlier deaths to similar subsequent situations, is evident even in contexts where there are clear national ramifications or where a national body is implicated in the recommendations.

Government and other agencies in one jurisdiction are unlikely to learn effectively and in a timely way from a death in another jurisdiction.

This failure is best illustrated by the fate of many of the recommendations of the Royal Commission into Aboriginal Deaths in Custody.

Royal Commission into Aboriginal Deaths in Custody

The Royal Commission into Aboriginal Deaths in Custody was established in 1987 to address concerns about the high numbers of Aboriginal and Torres Strait Islander people dying in prisons, police custody, and juvenile detention institutions. The Royal Commission's 1991 *National Report* concluded that the high death rate was due to the gross over-representation of Aboriginal and Torres Strait Islander people in custody.[153] The Royal Commission therefore examined the underlying reasons for this, including profound social, economic and cultural disadvantage.

As part of its investigation, the Royal Commission observed that there was a

> 'pervasive and troubling failure of the coronial structure in every state and territory to supply the critical analysis needed to uncover the reasons for Aboriginal deaths in custody.'[154]

This was coupled with a failure of the coronial system as a whole to help prevent Aboriginal and Torres Strait Islander deaths.[155]

The *National Report* offered practical suggestions to reduce the risk of Aboriginal and Torres Strait Islander incarceration and deaths in custody. 34 of the 339 recommendations concerned reform of the state and territory coronial systems. In essence, they urged that the coronial system be strengthened so that coroners could be empowered to effectively address systemic prevention.[156]

This Paper has already discussed the failure in South Australia to implement the Commission's recommendation to broaden coroners' powers to make recommendations. Recommendation 13 addressed this issue:

> <u>Recommendation 13</u>
> That a Coroner inquiring into a death in custody be required to make findings as to the matters which the Coroner is required to investigate and to make such recommendations as are deemed appropriate with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate.[157]

Five of the Royal Commission's recommendations also specifically concerned the need for mandatory responses to coronial recommendations:

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[153] Royal Commission Into Aboriginal Deaths In Custody *National Report Vol 1* (1991) (RCIADIC National Report).

[154] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 6.

[155] Watterson, Brown and McKenzie, 6.

[156] Watterson, Brown and McKenzie, 6.

[157] RCIADIC National Report, 172.

Recommendation 14

That copies of the findings and recommendations of the Coroner be provided by the Coroners Office to all parties who appeared at the inquest, to the Attorney-General or Minister of Justice of the State or Territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate.[158]

Recommendation 15

That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person.[159]

Recommendation 16

That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the Coroner at the inquest, to the Coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations.[160]

Recommendation 17

That the State Coroner be required to report annually in writing to the Attorney-General or Minister for Justice (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations made by Coroners pursuant to the terms of Recommendation 13 above and as to the responses to such findings and recommendations provided pursuant to the terms of Recommendation 16 above.[161]

Recommendation 18

That the State Coroner, in reporting to the Attorney-General or Minister for Justice, be empowered to make such recommendations as the State Coroner deems fit with respect to the prevention of deaths in custody.[162]

It is important to stress the Royal Commission's view that in some situations there might be 'substantial reasons' for an agency or department not to adopt the coroner's recommendations.[163] The *National Report* explained:

> 'It is not a question of compelling the government or public authorities to act on recommendations, but rather to ensure that they have received proper consideration.'[164]

While a number of the Royal Commission reforms have now been implemented, many have not. In relation to the coronial recommendation issues, the Commonwealth Government and all State and Territory governments supported Recommendations 14, 15, 17 and 18. Recommendation 16, essentially dealing with keeping the inquest parties 'in the loop' in relation to responses, and with coronial

[158] RCIADIC National Report, 172.
[159] RCIADIC National Report, 172.
[160] RCIADIC National Report, 173.
[161] RCIADIC National Report, 173.
[162] RCIADIC National Report, 173.
[163] RCIADIC National Report, [4.5.97]. For example, if the recommendation is not feasible in the circumstances or if the recommended changes have already been made.
[164] RCIADIC National Report, [4.5.97].

follow-up of responses, was not endorsed by South Australia, Tasmania or the Northern Territory.[165] Over 20 years later, none of these recommendations have been implemented in a systematic, nationwide manner.

In 2009, the Western Australian State Coroner, Alastair Hope, handing down his findings and recommendations in the inquest into the death of Western Australian Aboriginal Elder, Mr Ward, supported the continuing relevance of the Royal Commission's recommendations and drew upon them to underpin his view of best practice coronial investigation and death prevention.[166] Mr Hope said that in his view the correct approach to coronial inquiry was described by the AILR study (discussed above), which he quoted at length:

> 'The Royal Commission recommended an expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.'[167]

The remaining Royal Commission recommendations, particularly those concerned with coronial recommendations, need to be implemented, with one significant qualification: they should apply to all deaths where coronial recommendations are made, not only to deaths in custody. This extension is important, first, because Aboriginal and Torres Strait Islander deaths do not only occur in custody. For example, Aboriginal and Torres Strait Islander peoples are also over-represented in other deaths, such as deaths in care and after release from custody and care, and family violence deaths.[168] Second, encompassing all deaths where there has been an inquest and recommendations is in the interests of harmonising effective death prevention across Australia.

The Royal Commission into Aboriginal Deaths in Custody recommended reform of state and territory coronial systems. Over 20 years later, none of these recommendations have been implemented in a systematic, nationwide manner.

The need for joined up justice

The systemic failure that led to the death is therefore often perpetuated due to a second tier of systemic failure — an inability of governments and other entities to respond effectively. In these contexts, coronial recommendations concerning earlier deaths might have saved later lives if they had been implemented.

This second systemic failure is most clearly illustrated by those deaths that form a repeating pattern irrespective of state and territory boundaries, such as deaths associated with the transportation of detained persons, the presence of hanging points in prisons, police shootings, or institutional failure to effectively intervene in family violence.

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[165] For more detail, see Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 22.

[166] State Coroner of Western Australia, Findings and Recommendations of the Inquest into the Death of Mr Ward, 12 June 2009.

[167] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 6, quoted in Findings and Recommendations of the Inquest into the Death of Mr Ward, 12 June 2009, 116–17.

[168] See also Law Reform Committee, Parliament of Victoria, *Coroners Act 1985 Final Report* (2006), 407.

For example, Northern Territory Coroner Greg Cavanagh observed in relation to the petrol sniffing deaths of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby that 'the problems leading to the deaths are manifest, well known and well researched,'[169] and he referred to his own earlier findings, those of other coroners and various government inquiries.[170] Coroner Cavanagh continued:

> 'Sadly, as was revealed at this Inquest, witnesses (especially Aboriginal women) are getting tired of co-operating with inquiries about the problem including coronial Inquests with no result.'[171]

Mr Cavanagh's remarks demonstrate how

> 'some coroners are frustrated with what they identify as a relatively internal coronial dialogue about remedial action that finds little external traction. Coroner Cavanagh's [2005] findings illustrate that coroners are well aware of the issues facing Indigenous communities through both their own repeated investigations into preventable deaths and the investigations and insights of other coroners. That is, they are developing individual and collective expertise with respect to these deaths. And, in each instance, in investigating deaths, holding inquests and making findings, those coroners draw on the expertise and experience of witnesses. This is a devastating amount of expertise to be stockpiling without consequence throughout Australian States and Territories.'[172]

To highlight in detail the present piecemeal approach to death prevention where lessons have often failed to be learned both within and across state and territory jurisdictions, we turn to a different but equally tragic pattern, of child deaths due to accidental strangulation or hanging by blind or curtain cords.

Blind cord deaths perhaps best illustrate why reform of the broader system that analyses and responds to deaths is necessary. The blind cord cases clearly show the gaps in the system that can perpetuate the pattern of deaths when responses to coronial recommendations are not only not mandatory, but also are not part of a coordinated nationwide response.

Blind cord deaths — examples of double system failure

On 28 July 2004, the Victorian State Coroner, Graeme Johnstone, brought down his findings in relation to Infant M,[173] who died in November 2003 when his neck became entangled in a looped blind cord. Mr Johnstone commented:

> 'Safer design options would help to prevent future deaths of young children from blind and curtain cords. Had safe design solutions been implemented many years ago when these types of "accidental" deaths began to occur, it is likely that the death of [Infant M] would have been prevented. It should be noted that there are numerous examples of deaths in other areas of coronial investigation where historical approaches to manufacturing common products have not, in the past, taken account of information in coroner's files to learn lessons about potential improvements in safe design.
>
> Accidental child strangulations or hangings with blind and curtain cords are not unusual and have been happening for many years. Last year, prior to the death of [Infant M] an issue of concern was raised by a researcher. . .following a search of the NCIS. On receipt of the notice

[169] *Inquest into the Deaths of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby* [2005] NTMC 034, [14].

[170] *Inquest into the Deaths of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby* [2005] NTMC 034, [10]–[14], [38]–[39], [42]–[46], [60]–[66].

[171] *Inquest into the Deaths of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby* [2005] NTMC 034, [30].

[172] Rebecca Scott Bray, '"Why This Law?" Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention' (2008) 12 (6) *Australian Indigenous Law Review* 27, 36.

[173] Where findings are not publicly available, infants who have died are referred to by their first initial, and the findings are referenced in the main text only.

advising of the issue of concern all State and Chief Coroners and the Victorian Attorney General were advised in early August 2003. [The researcher] also provided some information on developments with countermeasures and this information was given to the relevant authorities.'

Mr Johnstone examined similar deaths in some other Australian and overseas jurisdictions, and adopted the recommendations delivered on 19 December 2003 by Coroner Helen Wood in a Tasmanian inquest concerning the death of Infant Z in September 2002 in almost identical circumstances:

- a public education program should be implemented which highlights the risk and informs the community about methods to address the hazard;
- an effective approach should be adopted to render safe blinds and curtains which are already installed; and
- a mandatory safety standard should be implemented [in Victoria] with regard to the sale/supply of window coverings with new cords to address the risk of infant strangulation.

On 1 March 2007, 13-month-old Nicholas Esposito died in South Australia as a result of hanging.[174] As with similar deaths, the Deputy State Coroner, Anthony Schapel, said there was absolutely no suggestion that any neglect was involved in Nicholas' care, and concluded that his death was an accident. The post-mortem report from forensic pathologist Professor Roger Byard said that hanging from cords is a recognised risk when cots are placed next to blinds. In his findings, Mr Schapel noted that Professor Byard had also given evidence at a previous South Australian inquest into the death of 15-month-old Brayden Alsford in November 1999 by hanging involving a blind cord.[175]

As a result of Brayden's death in 1999, the then South Australian State Coroner, Wayne Chivell, had called for a public warning to be given to the parents of young children about the risks involved in allowing them to have access to ropes or cords which are long enough to go around the child's neck. He said that parents should ensure that curtain cords are kept out of the reach of small children and that they should be provided with advice and assistance about how to avoid these risks.

In Nicholas Esposito's inquest more than eight years later, Mr Schapel said that child blind cord deaths were preventable. However he pointed out that over 2000–2008 there had been eight coronial reports from other States or Territories of infant blind cord deaths. Two of these deaths were those of Infant Z (Tasmania) and Infant M (Victoria) described above. Mr Schapel noted that these two deaths were the subject of coronial findings and recommendations that were in the public domain and were very similar to those made in the present inquest into the death of Nicholas Esposito.

Mr Schapel also found that while the ACT, New South Wales, Queensland, Tasmania and Western Australia now had blind cord regulations in place, South Australia and Victoria did not. The difference between Tasmania and Victoria in relation to the legislation, despite two very similar deaths, appears largely due to the media coverage in Tasmania as a result of the activism of the mother of the child who died there.[176] Victoria introduced mandatory safety standards for internal window coverings on 30 December 2008.[177]

Mr Schapel noted in Nicholas Esposito's inquest that product safety regulators across Australia were undergoing a process of harmonising all applicable legislation, which had been agreed to by all State, Territory and Commonwealth Ministers and would include safety standards and bans. Mr Schapel's findings stated that the nationwide system was expected to be in place by mid 2009. Mandatory na-

[174] Deputy State Coroner Anthony Schapel, Findings into the Death of Nicholas Esposito, 15 December 2008.

[175] State Coroner Wayne Chivell, Findings into the Death of Brayden John Alsford, 20 October 2000.

[176] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 17–18. See also the discussion in *Implementation of responses to coronial recommendations* (p 31).

[177] Consumer Affairs Victoria, Response — Finding without Inquest into the Death of Lachlan McCann, 21 February 2011.

tional safety standards were in fact not put into place until 30 December 2010.[178] The nationwide regulatory mechanisms also apply only to new curtains and blinds.[179]

By October 2010 there had been six more blind cord deaths since Nicholas Esposito's inquest in 2008.[180] For example, in Victoria, two-year-old Lachlan McCann died on 6 August 2009 from strangulation after Lachlan and his brother removed the safety covers from the blind cord.[181] Two-year-old Rosie Smith died on 30 September 2009 from strangulation involving a blind cord pre-dating the Victorian safety standards.[182] Coroner Parkinson therefore recommended that Consumer Affairs Victoria (CAV) undertake continuing public safety campaigns, which appears to have been implemented by CAV after commencing their initial campaign following the deaths of Lachlan and Rosie.[183]

Nevertheless, it is unclear whether all states and territories have now implemented ongoing community campaigns and the other approach recommended by the Victorian State Coroner in 2004 — rendering safe those blinds and curtains that are already installed.

The blind cord deaths starkly demonstrate the lack of clear recommendation and implementation pathways across states and territories, together with, in most jurisdictions, few if any mechanisms to monitor the progress of recommendations, and consequently little in the way of public accountability. This situation creates a serious obstacle to consistent best practice in inquests, to attempts at systematic research, and ultimately to more effective death prevention across Australia.

Blind cord cases show the gaps in the system that can perpetuate the pattern of deaths when responses to coronial recommendations are not only not mandatory, but also are not part of a coordinated nationwide response.

The piecemeal approach to recommendations is also at odds with Australia's obligations, across state and territory boundaries, to respect, protect and fulfil the human right to life. Simply put, if states and territories do not develop an effective response system and become able to learn from each other when similar deaths occur in different jurisdictions — whether those deaths occur in prison transport, are due to avoidable accidents, or take place in any other preventable context — people will continue to die unnecessarily.

If states and territories do not develop an effective response system and become able to learn from each other when similar deaths occur in different jurisdictions, people will continue to die unnecessarily.

Beginning to join up justice

Progressive reform of coronial systems has taken place in recent years in Australia. Reforms implemented in Queensland (2003), the Northern Territory (2004), Victoria (2008), New South Wales (2009) and the ACT (2011) have included a greater statutory focus on death prevention. However, as this Paper has discussed, significant changes are still required in all jurisdictions.

As suggested by the Northern Territory example from the AILR study discussed above, mandatory responses would improve both the communication and implementation of coronial recommendations. The six jurisdictions that have yet to do so must statutorily mandate responses to all coronial recom-

[178] Coroner Kim Parkinson, Finding without Inquest into the Death of Lachlan McCann, 29 October 2010.
[179] Coroner Kim Parkinson, Finding without Inquest into the Death of Lachlan McCann, 29 October 2010.
[180] Coroner Kim Parkinson, Finding without Inquest into the Death of Lachlan McCann, 29 October 2010.
[181] Coroner Kim Parkinson, Finding without Inquest into the Death of Lachlan McCann, 29 October 2010.
[182] Coroner Kim Parkinson, Finding without Inquest into the Death of Rosalind Smith, 29 October 2009.
[183] Consumer Affairs Victoria, Response — Finding without Inquest into the Death of Lachlan McCann, 21 February 2011.

mendations, and all states and territories need an effective system for monitoring recommendations, responses and appropriate implementation. Government agencies and other relevant entities must be encouraged to develop their own internal systems for dealing with recommendations, with clear lines of responsibility.

Mandatory responses would improve both the communication and implementation of coronial recommendations.

Other necessary reforms include: making findings and responses to recommendations easily accessible to the public; improving the experiences of families via, for example, specifying the factors that coroners must consider when performing their role;[184] and broadening the categories of deaths that must be reported. The whole process would also function more effectively if coroners had access to more systematic training and resources to assist them with the formulation and distribution of recommendations,[185] supported by system-wide data and research able to be easily accessed across jurisdictions.

All states and territories need an effective system for monitoring recommendations, responses and implementation.

State and territory initiatives

At the individual state and territory level at present, there are some limited opportunities to contribute to joining up justice. There are no current reviews or reforms planned in the Northern Territory, South Australia or Tasmania, and as discussed above, Victoria, New South Wales and the ACT have recently reviewed their coronial legislation. However, in July 2011 in Western Australia, the Report by the Standing Committee on Environment and Public Affairs of the Inquiry into the Transportation of Detained Persons recommended that

> 'Government departments and agencies establish processes to appropriately inform family, stakeholders and the public of the progress of Government action taken to implement coronial recommendations on a regular basis.'[186]

The Committee also noted that submitters to the Inquiry had expressed strong support for mandating responses to coronial recommendations in Western Australia,[187] and the Committee recommended this course of action.[188] The Committee noted that submitters

> 'urged the Committee to recommend that this reform be implemented as a matter of urgency and not delayed until the Law Reform Commission of Western Australia reports on their reference.'[189]

The recent review of coronial practice in Western Australia has also recommended the mandating of responses, following strong support in submissions.[190]

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[184] See eg *Coroners Act* 2008 (Vic) s 8. For a broader discussion of the relevant Victorian provisions addressing family issues, see Ian Freckelton, 'Opening a New Page', *Law Institute Journal* June (2009) 29.

[185] See eg Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 51.

[186] Legislative Council Standing Committee on Environment and Public Affairs, Parliament of Western Australia, *Inquiry into the Transportation of Detained Persons: The Implementation of the Coroner's Recommendations in Relation to the Death of Mr Ward and Related Matters* (July 2011), 44 (Recommendation 9).

[187] *Inquiry into the Transportation of Detained Persons*, 65 [4.10].

[188] *Inquiry into the Transportation of Detained Persons*, 67 (Recommendation 16).

[189] *Inquiry into the Transportation of Detained* Persons, 65 [4.10].

[190] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 107 (Recommendation 87).

The Queensland Ombudsman's Coronial Recommendations Project contained a number of recommendations to improve the responses to coronial recommendations, including mandating responses.[191] With respect to improving and monitoring implementation of responses, the Ombudsman recommended that public sector agencies should appoint coronial liaison officers, whose responsibilities should include:

- liaising with the State Coroner and staff;
- responding to any recommendations made; and
- maintaining a suitable coronial database within the agency.[192]

Coronial liaison officers might help to avoid some of the difficulties along the recommendations–response pathway, where recommendations do not reach the appropriate people responsible in a timely manner. Appointment of officers would also improve the efficiency of any necessary follow-up where no response has been received or the response requires clarification.

The Queensland Project also addressed the issue of monitoring the implementation of coronial recommendations, by recommending that the Ombudsman undertake this role.[193] However, the Project Report notes that this was not supported by the Queensland Director-General of the Department of Justice, or by the Attorney-General, and that there are different views among commentators as to who should undertake monitoring.[194]

Nevertheless, the Project identified the key issue that at present there is no entity with the responsibility and resources to follow up on what happens once agencies have responded to recommendations, and that it is therefore necessary for the various jurisdictions to allocate this essential role to a body that, if it is not able not enforce implementation, at least can bring the issue to government and public notice.

A federal approach — the example of violence against women and children

Increasingly, there is more recognition from State, Territory and Commonwealth Governments that many legal and social issues in Australia require a federally coordinated, cross-border approach of some kind, so that they can be more effectively and consistently addressed.

Recent illustrations pertinent to coronial reform concern violence against women and children. For example, the then Commonwealth Attorney-General, Robert McClelland, in support of the Law and Justice (Cross Border and Other Amendments) Bill 2009, noted with respect to the Bill:

> 'The scheme responds to community concerns, including from the NPY Women's Council, that justice services are being hampered by state boundaries. In particular, there is concern that state boundaries are enabling perpetrators of violence against women and children to evade police and the justice system. . .The flexible arrangements established under the scheme will assist police, magistrates and other officials to deal with the high levels of family violence, sexual abuse and substance misuse in the remote regions more effectively.'[195]

As another example, the National Council to Reduce Violence Against Women and their Children stated in their *Background Paper to Time for Action*:

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[191] Queensland Ombudsman, *Report of the Queensland Ombudsman: The Coronial Recommendations Project* (2006). The strategy of mandating responses was supported by the State Coroner (at xiv, 31).

[192] *Coronial Recommendations Project*, 33 (Recommendation 1).

[193] *Coronial Recommendations Project*, 38 (Recommendation 3).

[194] *Coronial Recommendations Project*, 36–8.

[195] Commonwealth, *Parliamentary Debates*, House of Representatives, 25 May 2009, 4181 (Robert McClelland, Attorney-General). The *Law and Justice (Cross Border and Other Amendments) Act 2009* commenced on 7 September 2009.

> '[T]he analysis reveals many similarities between jurisdictions in the way they respond to violence against women and their children. This suggests that there is considerable scope for greater cooperation and collaboration between the Commonwealth, states and territories in developing a unified, national approach to one of Australia's most pressing social issues.'[196]

The resulting Federal Government's National Plan to Reduce Violence Against Women and their Children 2010–2022 (National Plan), together with the Australian Law Reform Commission and NSW Law Reform Commission, *Family Violence — A National Legal Response Final Report* (October 2010), both identified the need for harmonisation and collaboration across jurisdictions, so that women's right to be free from violence can be effectively realised.[197]

In response, in 2011, the Standing Committee of Attorneys-General (SCAG — since 17 September 2011, the Standing Council on Law and Justice (SCLJ)) noted that Ministers had agreed to a national domestic and family violence order (DVO) scheme involving:

> '(a) States and Territories introducing model provisions that provide automatic recognition across jurisdictional borders of court issued DVOs;
> (b) subject to Police Ministers' agreement, the establishment and funding of a national DVO information-sharing capability using CrimTrac's National Police Reference System.'[198]

SCAG also noted that Ministers had agreed to develop a national response to the Australian and NSW Law Reform Commissions' Final Report on family violence.[199]

Federal, State and Territory governments have now committed to start developing a National Data Collection and Reporting Framework on domestic violence and sexual assault.[200] They also agreed to work towards the development of a National Centre of Excellence to enhance the evidence base.[201] The Select Council on Women's Issues noted:

> 'The National Plan acknowledges that no government or group can address this problem alone. A unified approach to engagement is critical if we are to make real progress. Therefore, the National Plan is underpinned by the belief that involving all governments and the wider community is pivotal to reducing violence in the short and longer terms. Since many of the actions in the Time for Action report relate to state and territory responsibilities, the Commonwealth and state and territory governments have worked in partnership to develop the National Plan and build on the comprehensive work already being undertaken by all governments.'[202]

Impetus from other cross-jurisdictional issues

As we have discussed in this Paper, deaths in preventable circumstances also repeat across state and territory boundaries. Some individual deaths or joint inquests also raise complex cross-jurisdictional issues, and therefore particularly emphasise the need for joined up approaches similar to the Law and Justice (Cross Border and Other Amendments) Bill 2009 discussed above. For example, many of the

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[196] National Council to Reduce Violence Against Women and their Children, *Background Paper to Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009–2021* (March 2009), 7.

[197] The National Plan includes various initiatives to try to produce more effective and 'wrap around' service provision, such as a national domestic violence and sexual assault telephone and online crisis service.

[198] SCAG Communiqué, 4 & 5 March 2011, 3 <http://www.sclj.gov.au/agdbasev7wr/sclj/documents/pdf/scag_communique_4-5_march_2011_final.pdf>.

[199] SCAG Communiqué, 21 & 22 July 2011, 2 <http://www.sclj.gov.au/agdbasev7wr/sclj/documents/pdf/scag_communique_21-22_july_2011_final.pdf>. The SCLJ *Annual Report 2011–12* (at 4) notes that Ministers agreed to a national response in 2012–13 <http://www.sclj.gov.au/agdbasev7wr/sclj/documents/pdf/sclj%20annual%20report%202011-12.pdf>.

[200] Council of Australian Governments Select Council on Women's Issues, *National Implementation Plan 1st Action Plan 2010–2013 Building a Strong Foundation* (September 2012), 'Building the Evidence Base: New Ways of Working Together.'

[201] *National Implementation Plan 1st Action Plan 2010–2013*, 'Building the Evidence Base'. The Centre begins operations this year <http://awava.org.au/2013/02/16/weekly-round-up-15-february/>.

[202] *National Implementation Plan 1st Action Plan 2010–2013*, 'Background' (no page numbers).

recommendations from the former New South Wales Senior Deputy State Coroner, Magistrate Jacqueline Milledge, concerning the death of Dianne Brimble on a P&O Cruise Ship, were addressed to the Australian Federal Government.[203]

The recommendations included that the Australian Federal Government establish a special Parliamentary Committee which should have special regard to:

- cross jurisdictional issues that face the States, Territories and the Commonwealth; and
- the overlap of the various Coronial Jurisdictions with power to investigate the 'cause and manner' of death (even extending beyond the limits set by the Crimes at Sea Act) and those of the many State, Territory and Federal Police Forces and other investigative bodies.[204]

The Law Reform Commission of Western Australia has recently addressed similar themes, noting that in 2007, in the context of discussions on cross-border disaster inquests, the Standing Committee of Attorneys-General agreed to implement a model provision so that coroners may provide assistance to, or request assistance from, coroners in another Australian jurisdiction.[205] To date, only Queensland and New South Wales have implemented the provision.

In response to Magistrate Milledge's recommendations, the Federal Government agreed to refer some of these issues to the House Standing Committee on Social Policy and Legal Affairs (the Committee) for consideration.[206] While the Government believes that the inquest report did not identify any specific deficiencies in existing protocols and arrangements for determining cross-jurisdictional issues in response to the incident, and that accordingly the current arrangements are appropriate, 'there is value in the Committee considering whether these arrangements can be improved.'[207]

Magistrate Milledge had also commented:

> 'In recent years there have been a number of deaths reported to the New South Wales State Coroner under the provisions of Section 13C (now Section 18 new Act). The 2000 and 2002 Bali Bombing victims, the Tsunami Victims 2004, the murder of the "Balibo Five" journalists, the shooting of Private Jake Kovco and many others. Investigating the death of Dianne Brimble and the resulting inquest was resource poor but complex and challenging for the limits of the State jurisdiction. There is a real and pressing need for these "mega" inquests to be undertaken by a Federal Coroner who would have the investigative and administrative resources that are lacking at State level.'[208]

Magistrate Milledge accordingly recommended that the Commonwealth Attorney General establish a federal coronial jurisdiction, and that a Federal Court judge should be appointed as the Federal Coroner.[209]

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[203] Magistrate Jacqueline Milledge, The 'Brimble' Recommendations, 3 December 2010 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Brimblerecs2.pdf/$file/Brimblerecs2.pdf>.

[204] Magistrate Jacqueline Milledge, The 'Brimble' Recommendations, 3 December 2010, 3 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Brimblerecs2.pdf/$file/Brimblerecs2.pdf>.

[205] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 103.

[206] Government Response to the Recommendations of the NSW Coroner Following the Inquest Into the Death of Ms Dianne Brimble, 22 June 2012, 5–6 <http://www.ag.gov.au/Organisationalstructure/Pages/21-June-2012---Government-Response-to-the-recommendations-of-the-NSW-Coroner-following-the-inquest-into-the-death-of-Ms-Dia.aspx>.

[207] Government Response to the Recommendations of the NSW Coroner Following the Inquest Into the Death of Ms Dianne Brimble, 22 June 2012, 5 <http://www.ag.gov.au/Organisationalstructure/Pages/21-June-2012---Government-Response-to-the-recommendations-of-the-NSW-Coroner-following-the-inquest-into-the-death-of-Ms-Dia.aspx>.

[208] Magistrate Jacqueline Milledge, The 'Brimble' Recommendations, 3 December 2010, 4 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Brimblerecs2.pdf/$file/Brimblerecs2.pdf>.

[209] Magistrate Jacqueline Milledge, The 'Brimble' Recommendations, 3 December 2010, 4 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Brimblerecs2.pdf/$file/Brimblerecs2.pdf>.

The Federal Government rejected this recommendation, because it considered that

> 'there is not a demonstrated need for a federal coronial jurisdiction at this time, due to the collaborative arrangements currently in place to facilitate a cross-jurisdictional approach. There is no evidence of a gap in the current coronial system in Australia. Collaboration amongst State and Territory coroners is well developed. For example, coroners regularly meet to discuss issues of a cross-jurisdictional nature and have an established practice of regular liaison and cooperation on operational issues. State and Territory coroners have collaborated in the past in conducting inquests, such as following the Bali Bombings.'[210]

However, the Federal Government responded that it will give consideration to establishing a federal coronial jurisdiction if a need is identified.[211] As this Paper has demonstrated, there are gaps in the current coronial system. Even apart from the issue of the effectiveness of cross-jurisdictional collaboration, examples such as infant blind cord deaths and widespread failures to implement, or monitor the impact of, many coronial recommendations, emphasise the need for a federal role in 'joining up justice'.

Examples like infant blind cord deaths and widespread failures to implement, or monitor the impact of, many coronial recommendations, emphasise the need for a federal role in 'joining up justice'.

Proposals to centrally record coronial recommendations

An effective, coordinated national preventative response to repeating patterns of deaths must include a central database of coronial recommendations that is easily accessed by coroners, researchers and the general public, irrespective of their particular state or territory location. There has been some government recognition of the need for this approach, via national efforts to prevent violence against women and children.

In 2009, *Time for Action*, the Plan developed by the National Council to Reduce Violence against Women and their Children, suggested establishing and building upon domestic/family homicide fatality review processes across Australia, because this would enhance our understanding of the primary risk factors leading to those deaths, improve system and service responses, and inform policy designed to reduce rates of domestic-related homicide.[212] Recommendation 4.3.2 listed for urgent implementation:

> Establish or build on emerging 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. As part of this process ensure all information is, or recommendations are, centrally recorded and available for information exchange.[213]

The Australian Government's response to *Time for Action* in April 2009 stated:

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[210] Government Response to the Recommendations of the NSW Coroner Following the Inquest Into the Death of Ms Dianne Brimble, 22 June 2012, 12 <http://www.ag.gov.au/Organisationalstructure/Pages/21-June-2012---Government-Response-to-the-recommendations-of-the-NSW-Coroner-following-the-inquest-into-the-death-of-Ms-Dia.aspx>.

[211] Government Response to the Recommendations of the NSW Coroner Following the Inquest Into the Death of Ms Dianne Brimble, 22 June 2012, 12 <http://www.ag.gov.au/Organisationalstructure/Pages/21-June-2012---Government-Response-to-the-recommendations-of-the-NSW-Coroner-following-the-inquest-into-the-death-of-Ms-Dia.aspx>.

[212] National Council to Reduce Violence against Women and their Children, *Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009–2021* (March 2009), 115.

[213] *Time for Action*, 120.

> 'Starting in 2009 the Government will. . .work with the States and Territories through the Standing Committee of Attorneys-General to. . .improve the uptake of relevant coronial recommendations.'[214]

> '[T]he Government, through the Standing Committee of Attorneys-General. . .Will work with the States and Territories to assess the impact of strategies to encourage responsiveness to Coroners' recommendations including on domestic violence related deaths.'[215]

The resulting Commonwealth National Plan to Reduce Violence Against Women and Their Children refers to, as one of the four high-level indicators of change that will be used to show progress, 'reduced deaths related to domestic violence and sexual assault'.[216] Strategy 5.2, 'Strengthen leadership across justice systems', includes

> 'Drive continuous improvement through sharing outcomes of reviews into deaths and homicides related to domestic violence.'[217]

The NSW *Report of the Domestic Violence Homicide Advisory Panel* (2009), which led to the establishment of the New South Wales Domestic Violence Death Review Team, proposed that a best practice model of data collection for such a review would include improving and strengthening the information currently captured by NCIS.[218]

While the NSW Domestic Violence Death Review is the only one of its type established by statute and therefore to expressly provide in legislation for prevention strategies,[219] several Australian States now have family/domestic violence death reviews, with New South Wales, Victoria, Queensland and South Australia reviews being hosted or convened by the State Coroner or supported by the State Coroner's Office. The various death reviews also share information via a national network. However, as this Paper has outlined, there is still no central publicly accessible repository of coronial recommendations.

With respect to preventable deaths more broadly, in 2008, the then Federal Minister for Home Affairs, the Honourable Bob Debus, expressed his hope that coronial recommendations and the prevention of avoidable deaths would be added to the SCAG agenda.[220] In 2010, the Federal Attorney-General, Robert McClelland, responded to a petition concerning the death of Mr Ward.[221] The petition asked the Commonwealth Government to lead the State and Territory Governments to enact reforms that create obligations on governments to respond to coronial recommendations. Mr McClelland stated:

> 'Through the Standing Committee of Attorneys-General, I have encouraged my State and Territory counterparts to take steps to monitor the progress of initiatives to promote responsiveness to coronial recommendations. The National Coroners Information Service is currently exploring options to record responses to coronial recommendations on the NCIS system. The outcomes of that work will be reported back to SCAG.'[222]

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[214] Commonwealth of Australia, *The National Plan to Reduce Violence against Women: Immediate Government Actions* (April 2009), 5.

[215] *Immediate Government Actions*, 12. The NSW *Report of the Domestic Violence Homicide Advisory Panel* (2009, 76) also notes that 'The Commonwealth Government, through [SCAG], has committed to working with the States and Territories to conduct a thorough review of current procedures to monitor the consideration, implementation and reporting of coronial recommendations in order to identify best practice approaches with respect to domestic violence homicides.'

[216] Commonwealth of Australia, *National Plan to Reduce Violence again Women and their Children 2010–2022*, 13.

[217] *National Plan*, 31.

[218] *Report of the Domestic Violence Homicide Advisory Panel* (NSW 2009), 47.

[219] *Coroners Act 2009* (NSW) Chapter 9A. See **Appendix 1** of this Paper.

[220] Hon Bob Debus, 'Foreword' (2008) 12 (6) *Australian Indigenous Law Review* 4, 1.

[221] State Coroner of Western Australia, Findings and Recommendations of the Inquest into the Death of Mr Ward, 12 June 2009. The petition was dated 19 November 2009.

[222] Commonwealth, *Parliamentary Debates*, House of Representatives, 24 May 2010, 3777 (Robert McClelland, Attorney-General).

As outlined earlier in this Paper, a process is being developed so that users can use the NCIS to track the progress of agency responses to coronial recommendations, but probably only in those jurisdictions where responses are mandatory. The issue of responsiveness to coronial recommendations appears to have been the subject of consideration by SCAG.[223] A 2009 document setting out legislation and administrative requirements in each Australian jurisdiction to respond to coronial recommendations is provided on the SCAG website,[224] but no further information concerning the work of SCAG or SCLJ on coronial recommendations is publicly available. The Report of the Standing Committee on Environment and Public Affairs of the Inquiry into the Transportation of Detained Persons states:

> 'The Committee understands that the Standing Committee of Attorneys General was of the view that a legislated approach to responding to coronial recommendations was not warranted or necessary.'[225]

An effective, coordinated national preventative response must include a central database of coronial recommendations that is easily accessed by coroners, researchers and the general public, irrespective of their particular state or territory location.

We need national leadership to achieve a prevention-focused coronial process, through co-operative federalism initiatives, that includes a national, publicly accessible system to report whether or not coronial recommendations have been implemented by responsible government agencies. Ian Freckelton's comment in the *Journal of Law of Medicine* in 2010 remains salient:

> 'For the present, the various jurisdictions in Australia continue to adjust their legislation in a disuniform way, albeit increasingly with similar objectives motivating the changes. It is to be hoped that before too much further time passes the Standing Committee of Attorneys-General will move toward nationally consistent coronial legislation in Australia.'[226]

We need national leadership, including a national, publicly accessible system to report whether or not coronial recommendations have been implemented by responsible government agencies.

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[223] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 171.

[224] Summary requirements August 2009 <http://www.scag.gov.au/lawlink/SCAG/ll_scag.nsf/pages/scag_coronialrecommendations>.

[225] The Report footnotes Submission No 31 from Department of the Attorney General, 28 May 2010, p5 (Legislative Council Standing Committee on Environment and Public Affairs, Parliament of Western Australia, Inquiry into the Transportation of Detained Persons: The Implementation of the Coroner's Recommendations in Relation to the Death of Mr Ward and Related Matters (July 2011), 64 [4.7] fn 296).

[226] Ian Freckelton, 'Anglo-Australian Coronial Law Reform: The Widening Gap' (2010) 17 *Journal of Law and Medicine* 471, 479–80.

Recommendations (Part 1)

1. All State and Territory governments should act to adopt core best practice and guarantee that the preservation of life is central to their coronial systems, by introducing, as appropriate to the jurisdiction, prevention and reporting amendments to their coronial legislation.

These amendments should include or have the effect of:

- a preamble that expresses the role of the coronial system as involving the independent investigation of deaths, for the purpose of finding the causes of those deaths and to contribute to the prevention of avoidable deaths and the promotion of public health and safety and the administration of justice, across Australia;
- purpose and objects provisions that include the prevention of avoidable deaths through the findings of the investigation, and the making of findings, comments and recommendations, by coroners;
- a provision empowering coroners to make comments and recommendations on any matter connected with a death investigated at an inquest, including public health or safety and the administration of justice; and
- a provision empowering coroners to make recommendations to any Minister, public statutory authority or entity.

2. The Commonwealth Government should work with State and Territory governments to achieve a uniform national coronial public reporting and review scheme for coronial findings and recommendations which:

- guarantees that all coronial recommendations will be considered and meaningfully responded to by the government agencies or entities to whom they are directed (updates on progress towards implementation should be provided by the relevant agency or entity where the initial response was only a holding response);
- provides ready public access to all coronial findings, recommendations, responses and updates;
- records and makes publicly available (including via a Coroners Annual Report to the relevant State or Territory Parliament and on the Internet) whether or not coronial recommendations have been implemented by responsible government agencies or entities;
- enables evaluation of the impact of coronial recommendations upon the prevention of deaths;
- adheres to timeliness at every step of the recommendations process; and
- provides feedback to families (including a copy of recommendations and responses to families, other parties and legal representatives) at every step of the recommendations process.

3. As an important element of Recommendation 2, State and Territory Governments should:

- appoint coronial liaison officers to enable public sector agencies to respond to coronial recommendations in a timely and appropriate manner; and
- allocate, for each jurisdiction, the responsibility for monitoring the implementation of coronial recommendations to an independent statutory body adequately resourced for the task and with powers to alert government and public about any key implementation issues.

4. The Commonwealth Government should work with State and Territory governments to enable each jurisdiction to effectively recognise the international human rights obligation to respect, protect and fulfil the right to life by introducing, as appropriate, amendments to their coronial legislation so that coronial investigation is independent, appropriately and adequately resourced, and considers systemic issues.

In particular, in investigations into deaths in police custody or in the course of police operations, the agency conducting the primary investigation at the direction of the Coroner must have practical, institutional and hierarchical independence from the police.

5. Primary and secondary coronial legislation in the various jurisdictions should be amended or introduced in recognition of the principle that participation of families in the inquest process is a fundamental component of Australia's international human rights obligations.

Specifically, reforms must enable families and friends of the deceased to experience the coronial process in as sensitive, timely and fully informed a manner as possible, regardless of the circumstances of the death.

These reforms must include:

- provision of proper and timely notification of family members and proactive provision of accessible, timely and explanatory information, at every stage of investigation and inquest processes. This should include as comprehensive as possible access to police and coronial documents, and accessible material on families' legal rights;
- no unreasonable delays in investigations and inquests;
- resolution of any cultural or spiritual conflicts raised by the coronial process;
- recognition of the need to have Aboriginal and Torres Strait Islander legal and health services and communities involved in the coronial process; and
- provision of quality, accessible, and culturally and spiritually appropriate support and counselling services for families.

6. All States and Territories should establish or continue funding for their own Coroners Prevention Unit similar to the current Victorian model, including funding to facilitate an effective role for the Unit in the reforms in Recommendations 1–5.

7. State and Territory Governments should adequately fund their Coroners Courts with the aim of reducing delays in inquests, investigations and the delivery of findings, in order to at least conform to current national standards.

8. The remaining recommendations of the National Report of the Royal Commission into Aboriginal Deaths in Custody (1991) must be implemented.

Part 2 Why we need a National Inquest Clearing House

Overview

Discovering the truth of a person's death is vitally important for the family, friends and community of the deceased. The families of those whose lives are cut short by avoidable death want to spare others the same fate.

Modern coroners are expected to recognise these needs and to respond thoughtfully and compassionately to families and communities. As best practice, all Australian coronial jurisdictions should provide for the full and effective participation of families and advocates throughout the investigative and inquest processes.

In reality, however, the coronial process can be an exceptionally difficult and complicated experience, particularly for bereaved families. As **Part 1** discussed, families can endure long delays between the death and any inquest, and again between the inquest and when findings are released. Further, even if recommendations are made, in most jurisdictions they can disappear into the ether with no flow-on to accountable implementation.

Inquests also often take place in the public spotlight where the interests of government and other agencies are under scrutiny. Inevitably, these interests are legally represented at inquests. In contrast, families often lack legal representation and other support. It is therefore not uncommon for families to remain mystified about aspects of the investigation or inquest process, or to find out about their rights to participate when it is too late to try to exercise them meaningfully. Broader prevention issues may also go unaddressed or under-emphasised without the input of other advocates to assist the coroner.

This second part of the Paper first discusses the avenues for legal assistance that may be available for families involved in a coronial investigation or inquest. The reality for many families is that they may not even be aware that they have the right to a lawyer, let alone be able to obtain legal help throughout the process. We then outline the important role of public interest organisations in inquests. This suggests that a National Inquest Clearing House (NICH) is needed to enable the provision of adequate legal assistance funding for families, and so that public interest interveners can be represented at inquests as appropriate. The NICH will consolidate and share knowledge and understanding in order to achieve the best prevention-based outcomes from the coronial process.

Discovering the truth of a person's death is vitally important for the family, friends and community.

All Australian coronial jurisdictions should provide for the full and effective participation of families and advocates throughout the investigative and inquest processes.

Legal assistance for families in the coronial process

When might families need legal assistance?

As **Part 1** of this Paper discusses, there are many contexts in which a person dies where there must be a coronial investigation, and perhaps also an inquest. Families can find it helpful, even in the early stages following the death, to get legal advice about what to expect from the process, or in some cases so that they can be assisted to request an investigation and/or an inquest. However, families are most likely to confront the question of whether to get legal help when a decision has been made to

hold an inquest. An inquest is a formal court hearing, and the legislation of each state and territory provides certain individuals and groups with an opportunity to appear at an inquest.

Who has the right to appear in an inquest?

A 'party' with a 'sufficient interest' may apply for leave to appear or to be represented.[227] These are usually the deceased's family members, parties about whom adverse allegations may be made, and public interest groups.[228]

Some jurisdictions do not define what constitutes a 'sufficient interest' or provide any guidance as to how a coroner will interpret the requirement.[229] The right to appear at an inquest is 'generally liberally interpreted'[230] but highly discretionary,[231] meaning that whether specific persons are found to qualify as having a sufficient interest will vary according to the particular coroner and inquest.[232]

Why might families wish to be legally represented at an inquest?

Due to the fact that, unlike many other legal proceedings, inquests are formally inquisitorial rather than adversarial, strictly speaking there are no parties.[233] Nevertheless, many families find inquest proceedings highly formal and intimidating, especially when there are issues involving government departments or corporations, whose interests are often advanced in an adversarial manner via legal representation.[234] The legal issues can also be very complex and time-consuming, and the whole process may be the subject of intense media interest.[235] Unrepresented families tend to rely on the Counsel assisting the Coroner or the police informant for legal information, which raises conflicts of interest.[236]

For these reasons, 'a right to appear in the complex hearings that are the modern coronial process without the related [realised] right to representation is virtually meaningless.'[237] In order to realise

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[227] *Coroners Act 1997* (ACT) s 42; *Coroners Act 2009* (NSW) s 57(1); *Coroners Act 1993* (NT) s 40(3); *Coroners Act 2003* (Qld) s 36(1)(c); *Coroners Act 2003* (SA) s 20(1)(b); *Coroners Act 1995* (Tas) s 52(4); *Coroners Act 2008* (Vic) ss 56, 66(3) (s 56(b) further requires that it must be 'appropriate' for the interested party to appear); *Coroners Act 1996* (WA) s 44(1).

[228] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 588.

[229] Exceptions include *Coroners Act 2009* (NSW) s 57(3), which presumes family members are interested parties unless there is exceptional evidence to the contrary. Reg 17 of the Coroner's Regulations 1997 (WA) provides an exhaustive list of 'interested persons', including spouse, de facto partner, child, parent or other personal representative, or next of kin under the Act; however this list is not conclusive: *Coroners Act 1996* (WA) s 44(3). *Coroners Act 2003* (Qld) s 36(1)(c) provides three examples of an interested party, including a family member, and the Queensland State Coroners Guidelines state that 'parties who will have sufficient interest include the family and any other individual or organisation which might be the subject of adverse findings or comment during the course of the inquest. Employers, treating doctors, supervisors, professional accreditation bodies, government welfare agencies and regulatory agencies are examples of parties that may not be directly implicated in the death but who may have sufficient interest to be given leave to appear', 8.9 <http://www.courts.qld.gov.au/__data/assets/pdf_file/0004/84919/m-osc-state-coroners-guidelines.pdf>. *Coroners Act 1993* (NT) s 46B(4)(c) implies that senior next of kin or their representative will have a sufficient interest.

[230] Ian Freckelton, 'Inquest Law' in Hugh Selby (ed), *The Inquest Handbook* (1998) 1, 9.

[231] Freckelton, 'Inquest Law', 10.

[232] Freckelton, 'Inquest Law', 10. There are certainly suggestions that not all potential public interest interveners (see **Public interest organisations** p 67) obtain leave. For example, the *Report on the Coroners Act 1985* (Law Reform Committee, Parliament of Victoria (2006), 4) recommended that the coroner be required to apply a public interest test 'which would allow a broader range of participants than is currently the case.'

[233] Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006), 566.

[234] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 588–9; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 146–9.

[235] Gibson, 589.

[236] Gibson, 590.

[237] Gibson, 590.

these interrelated rights, the family must therefore obtain legal representation. However the first barrier many families face is in becoming aware that they even have the right to a lawyer.

Families might want legal advice about what to expect from the coronial process. Inquest proceedings can be intimidating, complex and time-consuming, with intense media scrutiny.

If families rely on the coroner's assistant or police informant for legal information, there can be conflicts of interest.

How do families know that they have a right to a lawyer?

Because the issue of legal representation generally arises when an investigation or inquest is planned, families tend to rely on the information that is provided to them about the coronial process by the relevant Coroners Court. While many Coroners Court websites and other public information may acknowledge the right to a lawyer, it is not always framed in clear and encouraging language.

For example, the ACT Coroner's Court website states under the heading 'Legal representation':

> 'A person summoned to give evidence at a hearing, or a person with sufficient interest in the subject matter of the inquest or inquiry, may be given leave by the Coroner to appear in person at the hearing or to be represented by a lawyer.'[238]

Some families may not understand that the category of 'person with sufficient interest', and perhaps the 'person summoned to give evidence' category, apply to them.

The Northern Territory Coroners Office website describes 'What Happens at an Inquest?'

> 'An inquest is a formal court hearing.
> Witnesses at an inquest are usually asked questions by a Counsel assisting the Coroner. This is a legal practitioner experienced in coronial matters.
> People with an interest in the circumstances of a death may, at the Coroner's discretion, ask questions of a witness or a lawyer may ask questions on their behalf.
> Family members may raise issues with a Counsel assisting the Coroner who can then ask questions relevant to those issues, if appropriate.
> Family members may also raise issues in a letter addressed to the Coroner, preferably before the inquest, so the Coroner is aware of their concerns.'[239]

The brochure, *The NSW Coroners Court — A guide to services*, responds to the question 'Do I have to be represented by a solicitor at the inquest?' with:

> 'This is not usually necessary, but some people choose to have a lawyer. If you wish, the legal officer assisting the Coroner can help you by asking questions on your behalf.'[240]

The website of the Magistrates Court of Tasmania simply states:

> 'If you consider you need legal advice or indeed legal aid you should consult the telephone directory for assistance.'[241]

The website then provides the telephone numbers of the Law Society of Tasmania, Aboriginal Legal Aid and the Legal Aid Commission.

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[238] <http://www.courts.act.gov.au/magistrates/courts/coroners_court>.

[239] <http://www.nt.gov.au/justice/courtsupp/coroner/inquests.shtml>.

[240] *The NSW Coroners Court — A guide to services*, 10 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Coroner'sCourtBrochure20100101.pdf/$file/Coroner'sCourtBrochure20100101.pdf>.

[241] <http://www.magistratescourt.tas.gov.au/divisions/coronial/coronial_procedures>.

In contrast, the Queensland Coroners Court website takes a more helpful approach, answering 'Does the family need to be legally represented?' with:

> 'Anyone with a sufficient interest (including family members) can apply to the coroner to participate in the inquest. This means you can be given permission to ask questions of witnesses and make submissions at the inquest. Parties can act for themselves or they can be legally represented.
>
> Family members may choose to be legally represented and may wish to discuss this with the lawyer or police officer assisting the coroner at the inquest (called counsel assisting). The counsel assisting is an independent person who ensures that all relevant information is presented to the coroner. Counsel assisting does not act for the family but they will be able to explain the process and the issues to be explored during the inquest.'[242]

Families may not be aware that they even have the right to a lawyer, let alone how to find one.

How do families obtain a lawyer?

If a family knows they have the right to a lawyer and are determined to seek legal representation, they may still not be aware of how to obtain it. Some jurisdictions will refer parties to, or give them the contact details of, a relevant body such as the Law Institute of Victoria, the New South Wales Law Society, Legal Aid Queensland or the National Association of Community Legal Centres, who will then refer them to an appropriate legal practitioner for legal advice and/or representation at the inquest. In other jurisdictions, such as the ACT and the Northern Territory, it appears that at least from what is available on the Internet, the family has to rely on being given contact details if they request them, or perhaps on being supplied with written information that is not on the coroners website.

The next hurdle for many families is then the question of cost. Because the coronial jurisdiction is formally non-adversarial, costs are not usually awarded in inquests. This means that unlike in many other civil matters, families cannot use an inquest to prove that particular entities were implicated in the death, and then seek payment from them toward their legal fees. Family members seeking legal assistance must therefore either try to fund legal representation themselves or attempt to get help in some other way.

Privately funded legal assistance

Paying for a private lawyer is expensive. It is not unusual for legal fees in an inquest to total $40 000, once several hearing days and the services of a barrister and solicitor are included. When it is considered that often the circumstances in which people die involve social disadvantage, private legal representation is simply out of reach for most families. For example, the Commonwealth Government's Review of the Commonwealth Community Legal Services Program noted that 82% of community legal sector clients earned less than $26,000 per annum.[243] In other cases, family members go into serious debt in order to try to get justice for their loved one.

Legal Aid

Parties unable to fund private representation can apply for legal assistance from their state or territory Legal Aid service. Legal aid commissions are state and territory statutory agencies that typically have a

[242] Office of the State Coroner Queensland, What to expect at an inquest – A guide for family and friends <http://www.courts.qld.gov.au/__data/assets/pdf_file/0008/92870/m-osc-fs-what-to-expect-at-an-inquest.pdf>.

[243] Review of the Commonwealth Community Legal Services Program (March 2008) <http://www.ag.gov.au/www/agd/agd.nsf/Page/RWP6DE98B3437EEB6FDCA25742D007B0738>.

central head office and regional offices. If legal aid is granted, a family could be assisted by a lawyer employed by the relevant Legal Aid Commission, or by a private lawyer who receives legal aid funding for the work.

The conditions under which legal aid will be provided for representation vary across jurisdictions, but all states and territories except Western Australia grant legal aid if representation at an inquest is considered to be in the public interest.[244] The conditions under which legal aid assistance may be granted for an inquest are summarised in **Table 2**.

[244] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 598.

Table 2 Conditions for granting legal aid for inquests

Jurisdiction	**Conditions under which legal aid assistance will be granted for inquest** (yellowed entries = additional considerations[245])	Source
Australian Capital Territory	• Where the inquest involves issues of substantial public interest. • Not if total cost likely to exceed $20 000, unless exceptional circumstances. • 'Substantial public interest' is determined 'on a case by case basis. . .in inquests that involve exposure to criminal prosecution for serious offences, involve disadvantaged people or highlight an issue that impacts on the community, we would be likely to grant legal assistance to an applicant who otherwise meets our financial criteria.'[246]	Legal Aid ACT, Legal Assistance Guidelines (October 2012) <http://www.legalaidact.org.au/pdf/la_act_guidelines_oct_2012.pdf>
New South Wales	• Where representation at the inquest is a preliminary step to civil proceedings for which aid is available; or • where the public interest would be advanced by representing the applicant. Regard will be had to: • whether applicant has reasonable prospects of being granted leave to appear at the inquest; • applicant's relationship to the deceased; • likelihood of deceased's family's interests being represented at inquest if legal aid not granted. • Where death occurs in police custody, prison, psychiatric hospital, child care centre, juvenile justice centre or community welfare centre, questions of public interest will generally be considered to have arisen.	Legal Aid New South Wales, Policies <http://www.legalaid.nsw.gov.au/for-lawyers/policyonline/policies/6.-civil-law-matters-when-legal-aid-is-available/6.12.-coronial-inquests-into-deaths>
Northern Territory	• Where it is considered that the applicant's claim for damages will be significantly advanced if representation is made available for coronial proceedings; or • where in the opinion of the Director there are strong reasons based on the public interest for providing representation to ensure a full airing of the facts; or • where there is a reasonable likelihood that the applicant will be charged with a criminal offence as a result of the inquest.	Northern Territory Legal Aid Commission, Guidelines <http://www.ntlac.nt.gov.au/left_menucontent/guidelines/Chapter05Guidelines.pdf>

[245] Adapted from Gibson, 595–7 (Table 1).

[246] Email from ACT Legal Aid Office to Frances Gibson, 25 May 2007, quoted in Gibson, 597.

Queensland	• Where the applicant has in some way been involved in the death or deaths and may be criminally charged; or • there is a substantial public interest element; or • the applicant for aid is a relative of an Aboriginal or Torres Strait Islander who died in custody. • Legal aid should be considered where the result of the inquest may affect the applicant's prospects of success in a potentially substantial civil claim. • Substantial public interest element = case will have a direct/indirect benefit on other claims in Qld and involves multiple claimants who reside in Qld.	Legal Aid Queensland, Grants Handbook <https://elo.legalaid.qld.gov.au/grantshandbook/default.asp>
South Australia	There is no reference to inquests. Generally, where there is a public interest.	Legal Services Commission of South Australia, Eligibility for Legal Aid <http://www.lsc.sa.gov.au/cb_pages/practitioners_eligibility.php#guidelines>
Tasmania	• Normally, only if there is a possibility that the applicant will be charged with a serious offence in relation to the death; or • in the opinion of the Director there are strong reasons based on the public interest for providing representation to ensure a full airing of the facts.	Legal Aid Commission of Tasmania, Inquest <http://www.legalaid.tas.gov.au/Guidelines/3%20Matter%20Type/3B%20State/Civil/Guideline%2020%20Inquest.htm>
Victoria	• If it is reasonably likely that the applicant will be charged with a serious offence eg murder, manslaughter or culpable driving; or • it is in the public interest that the person be legally represented.	Victoria Legal Aid, VLA Handbook for lawyers, Guideline 4 — coronial inquests <http://www.legalaid.vic.gov.au/handbook/205.htm>
Western Australia	• Where as a result of the inquest there is a realistic risk that serious criminal charges may arise against the applicant; or • where the outcome of the inquest can reasonably be seen to be likely to have a significant impact on civil proceedings involving the applicant; and • as a result of such representation, there is a real likelihood of some substantial benefit accruing to the applicant.	Legal Aid Western Australia, Chapter 6B State Eligibility Guidelines, Manual of Legal Aid <http://www.legalaid.wa.gov.au/InformationForLawyers/Documents/chapter_6b_July_06.pdf>

Legal Aid New South Wales differs from its state and territory counterparts in that it has a dedicated statewide specialist service, the Coronial Inquest Unit (CIU). The CIU provides free legal advice, assistance and representation to people at inquests where the matter involves some public interest.[247]

[247] The CIU website defines 'public interest' as 'something of serious concern common to the public at large or a significant section of the public, such as a disadvantaged or marginalised group', and gives as some examples of inquests likely to involve

Usually, legal aid is provided by the CIU to a family member or next of kin to the deceased person. In exceptional circumstances, aid might be granted to someone other than a family member. Legal advice may be provided to a 'person of interest' (a person who might face criminal charges as a result of the death), but representation is usually not available to such people.[248]

Whether family members can receive legal aid for help at an inquest is not only dependent on the particular conditions of the jurisdiction. Their case must also be deemed to have merit, and perhaps most importantly, the applicants must satisfy a means test. Due to funding shortages, means eligibility for legal representation is limited mainly to people with very low incomes and low assets.[249]

Aboriginal and Torres Strait Islander Legal Services (ATSILS)

Aboriginal or Torres Strait Islander families can seek representation from Aboriginal and Torres Strait Islander legal services, which are independent, non-profit bodies. The legal service then either seeks a grant of legal aid or applies to the Commonwealth Attorney-General's Department for special test case funding. Aboriginal and Torres Strait Islander legal services are provided in accordance with priorities laid down in the Commonwealth Attorney-General's service delivery directions for the delivery of legal assistance to Indigenous Australians.[250]

The service delivery directions stipulate that a priority client includes a family member of a person who died in custody, and who is seeking representation at an inquiry into the death, unless other appropriate assistance is readily available for that person.[251] As the Law Reform Commission of Western Australia observed in 2011:

> '[R]ecommendation 23 of the Royal Commission into Aboriginal Deaths in Custody, which states that the family of the deceased be entitled to government-funded legal representation for deaths in custody inquests does not appear to have been legislatively implemented, either in Western Australia or elsewhere.'[252]

A priority client is also defined as an eligible client who 'faces a real risk to his or her physical, cultural or personal well-being',[253] or who 'would be significantly disadvantaged were assistance not provided'.[254] This means that it is possible for family members to obtain legal representation for an inquest other than a death in custody, such as an inquest concerning a death in psychiatric care. However, this is far from automatic, and Aboriginal and Torres Strait Islander people often do not get legal assistance for inquests where the death did not occur in custody.[255]

The ability of ATSILS to represent families in inquests is also restricted due to funding shortages and the time-consuming and labour-intensive nature of such work:

> 'There's such urgent need for other legal work, so the inquest would need to be extremely significant, because we only have one civil law solicitor and he does everything. So he has to

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a public interest, a death in custody, a death of a child in care, a death in a psychiatric hospital and a death involving a matter of public safety. <http://www.legalaid.nsw.gov.au/what-we-do/civil-law/coronial-inquest-matters>. See also **Table 2** above.

248 <http://www.legalaid.nsw.gov.au/what-we-do/civil-law/coronial-inquest-matters>.

249 Community Law Australia, *Unaffordable and Out of Reach: The Problem of Access to the Australian Legal System*, 9-10 <http://www.communitylawaustralia.org.au/wp-content/uploads/2012/07/CLA_Report_Final.pdf>.

250 Australian Government Attorney-General's Department, *Service Delivery Directions for the Delivery of Legal Assistance to Indigenous Australians Indigenous Legal Assistance and Policy Reform Program*, effective from July 2011.

251 Australian Government Attorney-General's Department, *Service Delivery Directions*, 4.5c, 7.

252 Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 147, citing Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 600.

253 Australian Government Attorney-General's Department, *Service Delivery Directions for the Delivery of Legal Assistance to Indigenous Australians Indigenous Legal Assistance and Policy Reform Program*, 4.5b, 7.

254 Australian Government Attorney-General's Department, *Service Delivery Directions*, 4.5d, 7.

255 Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 599.

make really hard choices. It's a capacity issue because it's one man – the capacity's not there.' (ATSILS worker)

The following examples obtained in 2011–12 illustrate the kinds of legal assistance ATSILS provide to families in inquests and coronial investigations.

- ATSILS (Qld) Ltd has assisted approximately 40 families in relation to reportable deaths, and has appeared or briefed (usually in-house) counsel in 15 inquests, since 2008. 10 inquests have concerned deaths in custody, and two were about deaths in care. Other than one Deaths in Custody Officer position, the service is not funded for coronial-related work.
- Since 2007, the North Australian Aboriginal Justice Agency (NAAJA) has assisted about 40 people with inquiries relating to coronial matters, and has appeared for families in approximately eight inquests. NAAJA has also appeared in the Supreme Court in two matters in which the family objected to an autopsy being conducted, and has assisted families in three other cases to make representations to the Coroner objecting to an autopsy.
- Since 2009, Victorian Aboriginal Legal Service Co-operative Limited (VALS) has represented families in two inquests concerning deaths in care, acted for the family in a further four reportable deaths, and provided advice in other situations.

Community legal centres (CLCs)

Families and groups can receive advice and sometimes representation from community legal centres, which are independent non-profit organisations largely funded by State/Territory and Federal Governments to provide legal assistance at no cost to the public. CLCs aim to represent the family and to also address systemic issues that may be raised during the inquest. CLCs have a long history of advising and representing families, as well as of acting for public interest organisations, and acting as public interest interveners themselves (see **Public interest organisations** p 67).

As one lawyer explains:

'The scope of the investigation would have been more narrow without the help of our community legal service. Because it was about prison issues and we had been involved with prison issues for quite some time, there was already knowledge of a whole lot of systemic problems, so that informed what went into the preparation. And it was really important because it is about making change and making sure that the same problems don't happen again, and so looking broadly at all of the issues was really important from our perspective because we had a strong background in the systemic issues. Whereas private practitioners who don't have that systemic background in the prison system perhaps wouldn't have gone to some of the places that we were able to go to or had knowledge of.' (Community lawyer)

Some examples where CLCs have legally assisted families in inquests are:

- Inquest representation by Redfern Legal Centre (NSW), for the daughter of Sallie-Anne Huckstepp, in the coronial inquiry into her death (1987);
- Inquest representation by Redfern Legal Centre (NSW), for the brothers and sisters of David Gundy, shot by police in his home (1989);
- Appearance by Queensland Advocacy Inc in an inquest into the death of a person with an intellectual disability in supported accommodation (1998);
- Appearance of University of Newcastle Legal Centre (NSW) for the family of Roni Levi at the inquest into his shooting by police on Bondi Beach (1998);
- Inquest representation by Brimbank Melton Community Legal Centre (Victoria), for the wife and children of a prisoner, Garry Whyte, shot dead by a prison guard (2004);[256]
- Inquest representation by Public Interest Advocacy Centre (NSW) for the mother of Scott Simpson, who committed suicide while in custody as a forensic patient (2006);

[256] Above examples from Gibson, 599.

- Inquest representation by Fitzroy Legal Service (Victoria) for the daughter of Ian Westcott, who died from an asthma attack in prison when the alert button failed to work (2009); and
- Inquest representation by Public Interest Advocacy Centre (NSW) for the sisters and brother of Mark Holcroft, who suffered a heart attack in a prison van and was not able to attract guards' attention (2011).

> 'It is about making change and making sure that the same problems don't happen again, and so looking broadly at all of the issues was really important from our perspective because we had a strong background in the systemic issues.'
> Community lawyer

A significant limitation on inquest work by CLCs is the resource-intensive nature of the process, which can continue for years and is work which may fall outside the core and already under-funded activities of the centre undertaking it.[257] CLCs may still be committed to such work because the death has significant social justice implications, and the alternative could be that no one would assist the family because they do not qualify for legal aid.

As two inquest advocates explain:

> 'CLCs have a different approach to work on inquests. They work on the whole case with the family of the deceased involved. As a result the CLC lawyers are stretched and exhausted by the time it comes to writing the submissions and there is little money to pay legal counsel to do this. There is a heavy amount of research involved in this work. The real cost of the work would be huge.' (Community legal worker)

> 'At the centre that I was at I was the only lawyer, so basically we had to get money to employ somebody to do my job in that period of time and because it went on for quite a long period of time that was quite a lot of resources needed. It put a lot of strain on a small centre and it put a lot of strain on the other staff — it's huge administrative demands that it places on the centre. So it was great to get the philanthropic funding and that really helped, but in terms of comparing all the hours that we all put in and the strain that it put on the centre it was really not much.' (Community lawyer)

Because community legal centres also often do not receive funding to represent individuals and groups at inquests, they may rely on their volunteers to support the family, and may also work to locate other solicitors together with barristers who will provide further pro bono assistance in the inquest:

> 'We ended up getting philanthropic funding to be able to run the case and we did get some money, I believe, for counselling, and we did arrange some volunteers to be support people during the hearing as well because we were having to handle all aspects of running the case as well trying to be lawyers. So in trying to fulfil that role, I think we had a number of volunteers for the support of clients during the hearing which was really important.' (Community lawyer)

Pro bono assistance

There are various state and territory pro bono schemes that coordinate pro bono assistance for individuals seeking legal representation for coronial proceedings. These schemes refer potential clients to, among others, the relevant bar associations that may then arrange free private legal assistance or legal help at reduced rates, for family members.

[257] Community Law Australia, *Unaffordable and Out of Reach: The Problem of Access to the Australian Legal System* 9–10 <www.communitylawaustralia.org.au/wp-content/uploads/2012/07/CLA_Report_Final.pdf>.

How often are families represented and who appears for them?

Overview

It is not possible to quickly ascertain how many people are represented at inquests across Australia, or, when they are represented, what proportion of that representation is publicly funded.[258] To obtain this information, each inquest file would need to be viewed. As one Coroners Court official explained, this is a very time consuming and onerous task, and one that many officers of Coroners Courts may not be enthusiastic to undertake upon request.[259]

The following outline of inquest representation in the various states and territories is the result of intensive Internet research and personal email and telephone inquiries to a wide range of legal service providers in early 2012. Even so, the information is often simply not collected or not ascertainable from the category of data. For example, law societies are the most likely source of data on referrals to privately funded lawyers, but they rarely keep inquest-related statistics. Legal Aid Commissions do not always record data to that level of specificity, or may not make it publicly available. It is difficult to obtain national and state/territory figures on inquest assistance provided by ATSILS, and the national Community Legal Service Information System (CLSIS) does not separately record legal assistance for inquests provided by community legal centres. In many contexts, despite several inquiries and being referred on to other staff or other organisations, ultimately service providers were unable to assist.

Figures for each state and territory may also include some duplicate inquiries/referrals. For example, a person may contact a law society, then be referred to a Legal Aid office and have their application denied and so then seek pro bono assistance. As an approximate indicator of the low level of legal representation, the most recent figure for the number of inquests is also documented where available (from **Table 1** above).

Australian Capital Territory
The Pro Bono Clearinghouse only considered one application over 2010–11 with respect to a coronial inquiry.[260] No other data is available. There were 20 inquests in 2010–11.

New South Wales
The NSW Law Society was unable to provide any coronial data.

Over 2009–11, the Coronial Inquest Unit in Legal Aid NSW provided either representation at inquests or substantive submissions to the coroner in support of an inquest being held, in about 25 matters per year. Another 25 coronial matters per year entailed advice or other forms of minor assistance to family members and others.[261]

Legal Aid NSW also referred four inquiries to the NSW Public Interest Law Clearinghouse. Barristers will often do pro bono inquest work.[262]

The figures can be roughly compared to the 290 inquests in 2011.

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[258] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 594. The NCIS does not collect this data.

[259] Communication from Michell Heidtmann, ACT Coroners Court, to Courtney Guilliatt, 18 May 2009.

[260] Communication from Debbie Sims, Executive Secretary, ACT Law Society, to Beth King, 24 February 2012.

[261] Communication from William de Mars, Solicitor Advocate, Coronial Inquest Unit, Legal Aid Commission NSW, to Chris Atmore, 17 September 2012.

[262] Communication from Katrina Ironside, Principal Solicitor/Coordinator, PILCH NSW, to Beth King, 13 February 2012.

Northern Territory

The Northern Territory Law Society does not have a formal referral service and does not keep a list of inquiries, but only provides a list of Northern Territory law firms for callers.[263]

Northern Territory Legal Aid received two applications for coronial-related legal aid in 2010–11, and approved one of them. In 2009–10, six applications were received and six approved. Over 2008–11, NT Legal Aid provided an average of 19 legal advices and one duty lawyer assistance per year concerning coronial matters.[264]

Queensland

The Queensland Law Society does not keep statistics on coronial-related legal inquiries and referrals, but anecdotally, inquiries are very rare.[265]

Legal Aid Queensland declined to respond to inquiries.[266] In the absence of more recent available data, Frances Gibson's research on legal aid for inquests, published in 2008, gives some sense of the scope of under-representation: in 2005–6 there were 22 new approved applications for aid in Queensland inquests.[267]

Queensland Public Interest Law Clearinghouse records its information on CLSIS, so as noted above, inquest data is not available. Anecdotally, over the five years to 2011 there would have been no more than six coronial-related inquiries. Two of these were referred for pro bono help and the remainder to Legal Aid Queensland.[268]

The figures can be roughly compared to the 81 inquests in 2011–12.

South Australia

The Law Society of South Australia does not collect coronial-related data.

In 2010–11, the Legal Services Commission of South Australia provided 12 telephone advices concerning inquest matters, eight of which concerned deaths in custody. The Commission provided 10 advice interviews concerning inquest matters, one of which concerned a death in custody. A grant of legal aid, necessary if more substantial assistance is required, is not normally provided for coronial matters, and the last such legal aid application received, which was refused on guidelines, was in May 2009.[269]

JusticeNet SA, which coordinates pro bono assistance, had three inquiries from 2009 to early 2012, but does not record the areas of law precisely, so this could be an under-estimate. At the time of our query, two of the inquiries were in process, and in the third, a request for legal representation, was declined on the basis that there was insufficient evidence for the argument that authorities had acted improperly.[270]

The figures can be roughly compared to the 45 inquests in 2011–12.

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[263] Communication from Danielle Sawyer, Licensing Officer, NT Law Society, to Beth King, 13 February 2012.

[264] Communication from Fiona Hussin, Coordinator, Policy & Projects, NT Legal Aid Commission, to Beth King, 13 February 2012.

[265] Communication from Vicky Moore, Call Centre Operator, Queensland Law Society, to Beth King, 13 February 2012.

[266] 'LAQ would prefer not to participate in this project at this time. We do not currently have any serious issues with the Queensland Coroners' legislation' (Email from Mary Burgess, Director, Strategic Policy and Communication, Legal Aid Queensland, to Beth King, 16 February 2012).

[267] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 596.

[268] Communication from Tony Woodyatt, Queensland PILCH, to Beth King, 13 February 2012.

[269] Communication from George Hatzirodos, Team Leader, Community Education, Legal Services Commission SA, to Sharee Macfarlane, 20 April 2012.

[270] Communication from Louise, Administration Assistant, JusticeNet SA, to Beth King, 13 February 2012.

Tasmania

No recent data is available. Frances Gibson's 2007 research notes that legal aid for inquests had not been granted in Tasmania for five years, although there had been two inquests funded prior to that.[271]

The figures can be roughly compared to the 9 inquests in 2011–12.

Victoria

In 2011, there were 10 referrals from the Law Institute concerning legal assistance related to inquests.[272]

During the 2010–11 financial year, Victoria Legal Aid provided grants of aid for legal assistance, including representation, in 13 inquest matters, with two refusals.[273]

In 2010–11 PILCH (VIC), which also administers the Law Institute of Victoria Legal Assistance Scheme and the Victorian Bar Pro Bono Scheme, received a total of 17 coronial inquiries.[274] Since July 2010, PILCH (VIC) has referred nine matters for legal assistance.[275]

The figures can be roughly compared to the 142 findings with inquest in 2010–11.

Western Australia

None of the legal assistance providers in Western Australia record specific data concerning requests and referrals for legal assistance relating to coronial inquiries or inquests. Research undertaken for the current Western Australian Review of Coronial Practice found that in 2009, of 33 inquests, 21 had counsel.[276] Most of the lawyers appearing did so for nurses, doctors and police officers called as witnesses, with families being legally represented in only six inquests.[277]

As the WA Law Reform Commission notes, given the absence of public interest criteria for legal aid funding for inquests in Western Australia, families will rarely, if ever, receive legal aid for representation.[278] Accordingly, the Commission has recommended that the Western Australian government fund Legal Aid WA, the Aboriginal Legal Service of Western Australia and community legal centres to provide legal representation and assistance to families for the purposes of an inquest where such representation is in the public interest.[279]

Implications for families

As discussed above, many families who have lost a loved one do not obtain effective, adequately funded legal representation. At a time when they are struggling to comprehend the death, they are also encountering a world of legal jargon and processes that is unfamiliar to most people.

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[271] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 596.

[272] Communication from Susan Woodman, General Manager, Membership and Marketing, Law Institute of Victoria Legal Referral Service, to Beth King, 16 February 2012.

[273] Communication from Chris Ermacora, Business Information Coordinator, Victoria Legal Aid, to Chris Atmore, 7 February 2012. The 13 successful applicants included both family members and persons potentially facing criminal charges.

[274] Information supplied by PILCH (VIC).

[275] Reasons for rejection of inquiries included, in order of frequency: client withdrew application; no merit; did not meet means test; no legal issue; not the relevant jurisdiction; legal aid available (information supplied by PILCH (VIC)).

[276] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 36.

[277] *Review of Coronial Practice in Western Australia Background Paper*, 36.

[278] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 147.

[279] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 93.

One family, whose father and husband was killed in a car accident, were concerned about inconsistencies in the police investigation, and so wrote to the Coroner seeking an inquest.

> 'It took a year to get a (one-day) inquest, which I had to lobby for. Information was only given to me in dribs and drabs. I only got photos of the scene after several visits to the Coroners Office. No one told me what I was actually entitled to have.'

The family was not legally represented at the ensuing inquest.

> 'With hindsight, we would have got a lawyer, but we just thought "It's only an inquest." We were in close contact with coronial staff but no one really said you should get a solicitor and that if it didn't go our way you have to appeal it at the Supreme Court. At no point were we told that you only get one shot. We were probably a bit naïve as to what an inquest was, it being our first inquest.'

Many families who have lost a loved one do not obtain effective, adequately funded legal representation.

The lack of legal representation was a particularly critical issue because, as with a significant number of inquests, the family wanted to ask questions about the actions of police, and Counsel assisting the Coroner is most usually a police officer.

> 'We don't want sympathy – that's not what you want when you're wanting justice. We just want something to happen. . .I just wanted some justice, some form of comfort for us. I want someone independent to investigate the police. I just want my mother to have some peace, and know that his death was taken seriously.'

'Information was only given to me in dribs and drabs. . . No one told me what I was actually entitled to have.'
Family member

'We were probably a bit naïve as to what an inquest was, it being our first inquest.'
Family member

'I want someone independent to investigate the police.'
Family member

'We don't want sympathy – that's not what you want when you're wanting justice. We just want something to happen.'
Family member

A second experience also began with seeking an inquest.

> 'Because I did not have faith in the thoroughness of the police investigation, I gathered a lot of the evidence myself, and my solicitor also obtained documents under freedom of information law. This cost me just under $70,000. It cost me another $3000 to get legal help to apply for the inquest. I travelled from overseas to the directions hearing,[280] and it also cost me $1100 for a Barrister to represent me. He didn't fight very hard for all information to be revealed and wanted at least $7500 for the Inquest. As I could only spend one hour with him prior to the inquest starting, I decided to represent myself — I could then ask questions that would be on record. When you add my flights and accommodation costs, telephone calls, taxi fares, registered mail and so on, not to mention the fees of my independent expert, it amounts to well over $100,000.'

[280] A directions hearing is a preliminary hearing of the matter before the inquest date is set.

At the inquest where this parent represented herself, there were 10 barristers representing the other parties, including two senior counsel.

> ‘When you add my flights and accommodation costs, telephone calls, taxi fares, registered mail and so on, not to mention the fees of my independent expert, it amounts to well over $100,000.’
> Family member

> At the inquest where one parent represented herself, there were 10 barristers representing the other parties, including two senior counsel.

A third example, of a rural parent whose child was a victim of domestic homicide, demonstrates a lack of clear information and sometimes misinformation about the available options, along with gaps in legal referral pathways.

‘I got a letter from the Coroners Court and I also got pamphlets for counselling but I can’t remember getting any information about being able to get a lawyer. I spoke to the detective and he said there was no need to get one, but I had lost confidence in the police by then as I felt like nothing they told me had been right. It just didn’t feel like he was on my side. Because I was seeing a community support agency in the country for the victims compensation, they sent me to a local lawyer. Apparently he does all their stuff, but I don’t think he had very much experience with what happened with my child. The work he did was about sorting out the financial affairs like super and so on. That cost over $2000. I kept asking would he come to the court and give evidence but he said there wouldn’t be an inquest. I think he probably got told that by the detective.

Then we were told there was going to be an inquest and the directions hearing was coming up over the summer. I googled some lawyers on the Internet — there’s a site where you pay $80 to contact a lawyer by sending an email with a brief description of what you want. A lot had gone on holidays, but one rang me back and said she would represent us at the directions hearing. When we went there with her, the detective was a bit put out. I didn’t know how much it was going to cost until they told me after the directions hearing that it was over $4000. I had no idea it was going to cost that much.

The inquest was set for four days, so I contacted Legal Aid but they said because I was already in the system with the community support agency I should go back to them. The country office of the agency just told me there were no funds available and sent me to the city office who said I was entitled to legal representation but sent me back to the country office. They said we’d had the maximum because we got victims compensation divided among the different members of the family. The private lawyer that we’d had at the directions hearing said she’d approach Legal Aid for us but she never did.

We got a quote from her for the inquest which was $9000 a day, so almost $40 000. We couldn’t afford that. No one talked about trying to get pro bono help. The only time I even heard those words “pro bono” was on *Boston Legal*! You just don’t know. God forbid if it happened to me again — I’d be a lot more experienced. No one tells you anything. You’ve got to find out as you’re going along. You’re not even on the same planet at the start. That’s something that really needs to be addressed.’

> ‘I googled some lawyers on the Internet. . .I didn’t know how much it was going to cost until they told me after the directions hearing that it was over $4000. I had no idea it was going to cost that much.’
> Family member

> 'The country office of the agency just told me there were no funds available and sent me to the city office who said I was entitled to legal representation but sent me back to the country office. . . The private lawyer that we'd had at the directions hearing said she'd approach Legal Aid for us but she never did.'
> Family member

> 'We got a quote from her for the inquest which was $9000 a day, so almost $40 000. We couldn't afford that. No one talked about trying to get pro bono help. The only time I even heard those words "pro bono" was on *Boston Legal*!'
> Family member

> 'No one tells you anything. You've got to find out as you're going along. You're not even on the same planet at the start. That's something that really needs to be addressed.'
> Family member

A fourth situation is described by a worker who provided some assistance to 'X', the parent of a man who was pursued and later fatally shot by police in a public place. The worker explains how financial barriers to obtaining legal representation can compromise the family's legal rights. The example also clearly documents the stress and problems families continue to experience in accessing both inquest briefs and legal representation before an inquest hearing date is set.

'Because X's son was killed by police, an inquest is mandatory. In 2011, three years after the death, a coroner set a date for a directions hearing. X approached us about four weeks before the directions hearing after being referred by a suburban law firm. X sought advice from us on how to go about getting legal aid in order to be represented at this hearing.

My observation was that X was almost completely overwhelmed and intimidated by the complexity of the investigation and coronial processes and was extremely anxious about the prospect of attending the direction hearing without any support. A complicating factor was that the Coroners Court had denied X access to the full brief of evidence, advising X that the unreleased parts could only given to X's lawyer.

As an interim measure I drafted a formal request for the inquest brief, advising the court of the Catch 22 situation X was in: the court wouldn't release the brief until X had retained a lawyer, but the pro bono lawyer scheme and Legal Aid wanted access to the brief in order to determine the merits of the application.

In response, the Coroner advised that they would not release the brief before the directions hearing and that the Coroner would provide the reasons at the hearing. This left us unable to fully prepare for the directions hearing at which X would potentially face complex legal argument with lawyers for the Commissioner for Police around the scope of the inquest, as well as needing to respond to arguments invoking public immunity grounds to resist disclosure of some of the brief.

Legal aid was refused two weeks before the directions hearing but we managed to obtain a pro bono law firm and barrister to represent X at that hearing. Because we were able to access pro bono lawyers for X, the Coroner released the brief to the legal team with non-disclosure undertakings. The Coroner noted the importance of legal representation in this case and emphasised the complexity of the issues involved in this inquest.

Following the directions hearing, our client appealed the decision to refuse legal aid. Legal aid was then granted, but for only two days of the inquest. To date, there have been four separate direction hearings and 10 inquest hearing days, with 4 more days to follow.

> Fatal police shootings and their investigation are always matters of public interest. In this case, the circumstances of the death of X's son raise serious concerns about the safety of members of the public, who as innocent bystanders may be exposed to serious danger or death through what may be described as an unplanned, uncoordinated and uncontained police shoot-out. It is therefore a real concern that it was not possible to obtain a full grant of legal aid to effectively represent the family throughout the entire inquest.'

'Legal aid was refused two weeks before the directions hearing but we managed to obtain a pro bono law firm and barrister. . .Following the directions hearing, our client appealed the decision to refuse legal aid. Legal aid was then granted, but for only two days of the inquest. To date, there have been four separate direction hearings and 10 inquest hearing days, with 4 more days to follow.'
Community lawyer

The worker's comments above highlight a common issue facing families wishing to be legally represented through a grant of legal aid. Legal aid rates are below market rates, so some private lawyers avoid legally aided work. The longer the inquest, the less likely it is that a private lawyer will be willing to take on the work. If the family can't afford legal representation, or access it through legal aid, community legal centres or Aboriginal and Torres Strait Islander Legal Services, the only other option is to seek pro bono help:

> 'If it hadn't been for my wonderful kind-hearted lawyers, who are working on my behalf on a pro bono basis, I don't know where I'd be. . .In the event I might have had to represent myself, I resigned myself to reading the brief. I read 187 pages of the 481-page brief and the memory still lingers. No mother should have to read so many accounts of her son's last half hour on Earth.
>
> I strongly believe however that everyone has the right to be heard and represented especially in situations like this where a coronial inquest is mandatory. . .The coronial process has been longer and more difficult than I could ever have imagined. I hate to think what it would have been like to go through this process alone. Had I not been represented I truly believe that I would not have uncovered the answers to many of my questions.'[281]

However, again, the longer the inquest, the less likely that any solicitor and barrister will be able to give unpaid time. Families are therefore often left to fend for themselves in complex and traumatic inquests. In contrast, many other interested parties, such as government departments, retain senior counsel, and in complex and lengthy inquests an entire legal team, throughout the process.

'If it hadn't been for my wonderful kind-hearted lawyers, who are working on my behalf on a pro bono basis, I don't know where I'd be. . . Had I not been represented I truly believe that I would not have uncovered the answers to many of my questions.'
Bobbi, mother of Samir Ograzden

One family advocate estimates that with respect to legal representation, families are outspent by other parties at a rate of 20 to 1. Another community advocate talks about the frustration of

> 'being there and seeing the masses of resources of all the powers that be, compared to our own. . .At the time it is not so much of an issue because you just get so focused on what you're doing and what you need to achieve — but you notice when one of the big law firms have their clerk wheel their trolleys into court every day with all these beautifully prepared documents that the lawyers haven't put their hands on and we were doing it all ourselves and trying to transport and cart things. And that sort of stuff, which at the time you don't think about. . .it's just really

[281] Bobbi, mother of Samir Ograzden who was shot by police, quoted in Adrian Lowe, 'Mother slams lack of help in son's coronial inquest', 19 March 2012 <http://www.theage.com.au/victoria/mother-slams-lack-of-help-in-sons-coronial-inquest-20120318-1vdld.html>.

exhausting and it all seems a little bit unfair — you think about it later and about the fact that it's unfair and that it shouldn't be the case. Why should the family of the person that's died, and the legal team, have to be in that position, while everybody else representing people who have some responsibility for what happened be massively well-resourced — it makes no sense, no sense whatsoever!' (Community lawyer)

Whether families will have to pay for legal help depends on the particular state or territory, and especially on whether the case is deemed to have merit, and on the means of the family. Due to funding shortages, legal aid is limited mainly to people with very low incomes and low assets. Families might get help from Aboriginal and Torres Strait Islander legal services or community legal centres, but both these are under-funded and may not have capacity. Pro bono help is sometimes provided, but many families who have lost a loved one do not obtain effective, adequately funded legal representation, and end up either without a lawyer or having to pay at least $40 000.

'Why should the family of the person that's died, and the legal team, have to be in that position, while everybody else representing people who have some responsibility for what happened be massively well-resourced?'
Community lawyer

Public interest organisations

Public interest organisations will generally seek to become involved in an inquest as public interest interveners, meaning that the organisation has interests that are different from those of the existing parties.[282] 'Public interest' is most commonly understood as referring to matters with systemic implications that 'affect the general community or a group in the community, especially those that involve significant harm' and which adversely affect 'disadvantaged sectors of the community'.[283]

The Coroners Court will grant leave for the organisation to intervene if it deems the organisation to have some qualification or expertise to put forward the public interest.[284] Via tendering evidence and making submissions, and perhaps, in some inquests, examining witnesses, public interest interveners will seek to raise matters harming the community or affecting a disadvantaged group, in such a way that the outcome of the proceeding will have a positive impact on those matters.[285]

Just as for the data on legal representation at inquests, it is difficult to assess the extent and range of public interveners in inquests in Australia. The Australian Human Rights Commission (formerly the Human Rights and Equal Opportunity Commission) has intervened in a number of inquests in different jurisdictions, including Aboriginal deaths in custody, deaths of asylum seekers, and petrol sniffing deaths.[286]

[282] George Williams, 'The Amicus Curiae and Intervener in the High Court of Australia: A Comparative Analysis' (2000) 28 *Federal Law Review* 365, 368.

[283] Public Interest Advocacy Centre (PIAC) in Penny Martin, 'Defining and Refining the Concept of Practising in "the Public Interest"' (2003) 28(1) *Alternative Law Journal* 3, 4. 'Disadvantage' has been defined as 'social and economic problems arising out of a differential and unequal distribution of opportunities and entitlements in society' (Rajeev Dhavan, 'Whose Law? Whose Interest?' in Jeremy Cooper and Rajeev Dhavan (ed), *Public Interest Law* (1986) 17, 21).

[284] Julie O'Brien, 'Intervention Powers of the Human Rights Commission' (2006) February *Law Society Journal* 39.

[285] See eg *Australian Conservation Foundation Inc v Commonwealth* (1980) 146 CLR 493; *Onus v Alcoa of Australia Ltd* (1981) 149 CLR 27.

[286] Submission to Court as Intervener and Amicus Curiae <http://www.humanrights.gov.au/legal/submissions_court/index.html>.

Other public interest interveners in inquests have included the Public Advocate, Aboriginal and Torres Strait Islander legal services (ATSILS), Aboriginal Justice Advisory Committees and community legal centres (CLCs).

Examples of community legal centre public interest intervention in inquests include:

- Flemington/Kensington Legal Service (Victoria) in a series of inquests into fatal shootings by police in the 1980s;
- Villamanta Legal Service (Victoria) at inquest into the deaths in Kew cottages of people with intellectual disabilities (1996);
- Tenants Union Victoria and PILCH Homeless Persons Legal Clinic at inquest into the deaths of Christopher Giorgi and Leigh Sinclair in a rooming house fire (2008–9);
- Mental Health Legal Centre (Victoria) at inquest into the death of James Bloomfield, a man with a mental illness who died of severe burns after police sprayed him with capsicum spray (2009–10); and
- Human Rights Law Centre at inquest into the death of 15-year-old Tyler Cassidy, who was fatally shot by police (2010–11).

Victoria Legal Aid also intervened in the Tyler Cassidy inquest.

Public interest interveners play an important role in inquests by raising matters of social justice, and through indirectly assisting the coroner to examine all of the relevant systemic issues and to make appropriate recommendations aimed at long-range prevention. Interveners are probably particularly important where the family is not legally represented, as at least they may be able to make submissions and perhaps examine witnesses about issues that the family would like to see investigated. As with the situation of ATSILS and CLCs providing legal representation to families, however, many of the organisations likely to be the most useful to the inquest process are those organisations that operate on scarce resources and therefore may not be in a position to intervene.

Public interest organisations are important in inquests because they draw attention to systemic issues that often involve questions of social justice. They can be especially important when the family is not legally represented. However, these organisations often have scarce resources and therefore may not be able to intervene.

A National Inquest Clearing House

As detailed above, CLCs, ATSILS, Legal Aid Commissions and other public legal assistance providers support, represent and otherwise help families through the inquest process. In addition, public interest organisations, often also CLCs or affiliated with ATSILS or the family's community, play a significant role in the prevention function of inquests. This work has continued for many years, and yet the knowledge and understanding gained by individual providers through countless individual inquests has not been effectively consolidated and shared among public legal assistance providers throughout Australia.

A new national non-government organisation, a National Inquest Clearing House (NICH),[287] founded by a coalition of public legal assistance providers and allied organisations, is needed to fulfil this role. The NICH would be committed to securing, in the public interest, the best outcomes from the coronial process for families, via access to specialist knowledge, expert opinion and other resources necessary to monitor and report on coronial processes and their outcomes.

[287] The acronym 'NICH' has been chosen because of its affiliation with the word 'niche', meaning a gap that is filled in a specialist manner. 'Niche' also evokes a place of support and safety.

The NICH would enhance inquest representation for families and community organisations, and improve the coronial process by:

- providing a specialist legal advice, referral and support service for families and community groups entering the coronial process;
- maintaining a register of legal practitioners willing and able to undertake casework for, and experts willing to assist, these parties;
- acting as a forum for the exchange of information and experience;
- undertaking specialist coronial advocacy and support training, and professional development programs;
- providing access to a 'bank' of standard operating procedures, policies, protocols and MOUs, together with legislation and case law from all jurisdictions;
- undertaking research and resource support for public legal assistance providers, including community legal centres, Aboriginal and Torres Strait Islander Legal Services and Legal Aid Commissions;
- facilitating access to coronial recommendations from all jurisdictions;
- monitoring and analysing coronial findings and recommendations and their implementation, in the interests of family and community wellbeing, public health and safety and the administration of justice;
- conducting community legal education; and
- developing policy proposals and engaging in law reform.

In many ways the roles proposed for the NICH are similar to those of the United Kingdom non-government organisation, INQUEST (see **Appendix 2**). Like INQUEST, the NICH would assist the development of expertise in the coronial jurisdiction, and provide greater capacity for policy development and systemic reform, together with media campaigns and community education. The two main anticipated differences are that the NICH would respond to all preventable deaths;[288] and at this stage at least it is not envisaged that the NICH would itself undertake casework. The policy and law reform work of the NICH would include advocating for the provision of adequate legal assistance funding so that all families could obtain legal representation for coronial investigations and inquests without financial hardship, and so that public interest interveners could be represented at inquests as appropriate.

A National Inquest Clearing House is needed to enhance inquest representation for families and public interest organisations, and to improve the coronial process by consolidating and sharing knowledge for the prevention of avoidable deaths.

[288] INQUEST's main focus is on deaths in custody.

Recommendations (Part 2)

9. As a fundamental component of Australia's international human rights obligations under the right to life, funding and availability of legal assistance providers must be sufficient to enable all families to obtain, without financial hardship, effective legal advice and representation for investigations and inquests, at a level that is consistent with the level of legal representation accorded to government and other institutional parties in the inquest. A specific pool of funds should be made available to enable community legal centres to provide legal representation for families at inquests.

10. Legal assistance services must be sufficient to enable all advocacy organisations with a sufficient interest to intervene in inquests, as a fundamental component of Australia's international human rights obligations under the right to life.

11. An independent National Inquest Clearing House, along the lines of INQUEST (UK), should be established and adequately funded.

Appendix 1 Provisions in State/Territory legislation relevant to death prevention and system accountability (as at 28 February 2013)

Legislation	Heading	Provision
Coroners Act 1997 (ACT)	Objects of Act	s 3BA(1)(d) [The main objects of this Act are to— [...]] allow a coroner, based on the coroner's findings in an inquest or inquiry, to make recommendations about the following: (i) the prevention of deaths; (ii) the promotion of general public health and safety including occupational health and safety; (iii) the administration of justice; (iv) the need for a matter to be investigated or reviewed by an entity. s 3BA(2)(c) [As far as practicable, the objects of this Act must be carried out in a way that— [...]] promotes the development of a systematic and comprehensive public record of findings made by a coroner and any associated recommendations made by the coroner; and s 3BA(2)(d) increases public awareness of a coroner's findings about— (i) violent or unusual deaths; and (ii) serious risks to public health and safety; and (iii) ways to protect public health and safety by reducing the risk of death, fire or disaster
	Coroner's findings	s 52(4) The coroner, in the coroner's findings— (a) must— (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and (ii) if a matter of public safety is found to arise—comment on the matter; and (b) may comment on any matter about the administration of justice connected with the inquest or inquiry.
	Report after inquest or inquiry	s 57(3) A report by a coroner to the Attorney-General— (a) must be in writing; and (b) must set out the coroner's findings about any serious risks to public safety that were revealed in the inquest or inquiry to which the report relates; and (c) may make recommendations about matters of public safety if the recommendations— (i) relate to the coroner's findings about a cause of death, fire or disaster; and (ii) would, in the coroner's opinion, improve public safety. s 57(4) If the Attorney-General receives a report under this section, the Attorney-General must— (a) present the report to the Legislative Assembly within 6 months after the day the Attorney-General receives the report; and (b) present a statement of the Executive's response to the report on the same day the report is presented to the Legislative Assembly.
	Findings about quality of care, treatment and supervision	s 74 The coroner holding an inquest into a death in custody must include in a record of the proceedings of the inquest findings about the quality of care, treatment and supervision of the deceased that, in

		the opinion of the coroner, contributed to the cause of death.
	Copies of reports of findings	s 75(1) After the coroner has completed an inquest into a death in custody, the coroner must, in writing, report the findings to— (a) the Attorney-General; and (b) the custodial agency in whose custody the death happened and to the Minister responsible for that agency; and (c) the Australian Institute of Criminology; and (d) if the deceased was an Aboriginal person or Torres Strait Islander—an appropriate local Aboriginal legal service; and (e) any other person whom the coroner considers appropriate. s 75(2) The coroner must make available a copy of a report of the findings into a death in custody to— (a) a member of the immediate family of the deceased or a representative of that member; and (b) a witness who appeared at an inquest into the death.
	Response to reports	s 76(1) The custodial agency to which a report is given under section 75 must, not later than 3 months after the date of receipt of the report, give to the Minister responsible for the custodial agency a written response to the findings contained in the report. s 76(2) A written response under subsection (1) must include a statement of the action (if any) that has been, or is being, taken in relation to any aspect of the findings contained in the report. s 76(3) The Minister to whom a copy of a response is given under subsection (2) must give a copy of the response to the coroner in relation to whose findings the report relates. s 76(4) The coroner must give a copy of the response to each person or agency to whom a copy of the report was given under section 75.
	Annual report of court	s 102(1) The Chief Coroner must give a report relating to the activities of the court during each financial year to the Attorney-General for presentation to the Legislative Assembly. s 102(2) The report must include particulars of— (a) reports prepared by coroners into deaths in custody and findings contained in those reports; and […] (c) recommendations made under section 57 (3); and (d) responses of agencies under section 76, including correspondence about the responses. s 102(3) The Chief Coroner must give the report to the Attorney-General as soon as practicable after the end of the financial year and, in any event, within 6 months after the end of the financial year. [s 102(4)-(7) = conditions for an extension of time] s 102(8) The Attorney-General must present a copy of a report under this section to the Legislative Assembly within 6 sitting days after the day the Attorney-General receives the report.

Coroners Act 2009 (NSW)	Objects of Act	s 3(e) to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies)
	State Coroner to inform Ombudsman about certain child or disability deaths	s 36(1) The State Coroner is to provide the Ombudsman, in accordance with subsection (2), with all relevant material held by the State Coroner relating to: (a) any death or suspected death of a person in any of the circumstances referred to in section 24 (1) [specified children and disabled persons], or (b) any death of a person who is less than 18 years old in the circumstances referred to in section 23 (d) [in or temporarily absent from a detention centre, correctional centre or lock-up]. s 36(2) The relevant material referred to in subsection (1) is to be provided as soon as practicable after: (b) if an inquest is held—the conclusion or suspension of the inquest.
	State Coroner to report on deaths in custody	s 37(1) The State Coroner is to make a written report to the Minister containing a summary of the details of the deaths or suspected deaths that: (a) the State Coroner has been informed about under section 35 or 38 [reportable deaths or suspected reportable deaths], and (b) appear to the State Coroner to involve the death or suspected death of a person in circumstances referred to in section 23 [deaths in custody or as a result of police operations]. s 37(2) A report under subsection (1) is to be made for the period of 12 months commencing on 1 January of each year. A report is to be made within 2 months after the end of the period to which it relates. s 37(3) The Minister is to cause a copy of the report made to the Minister under subsection (1) to be tabled in each House of Parliament within 21 days after the report is made. s 37(4) If a House of Parliament is not sitting when the Minister seeks to cause a copy of the report to be tabled before it, the Minister is to cause a copy of the report to be presented to the Clerk of that House of Parliament. s 37(5) A copy of the report presented to the Clerk of a House of Parliament under this section: (a) is, on presentation and for all purposes, taken to have been laid before the House, and (b) may be printed by authority of the Clerk of the House, and (c) if so printed, is taken to be a document published by or under the authority of the House, and (d) is to be recorded: (i) in the case of the Legislative Council—in the Minutes of the Proceedings of the Legislative Council, and (ii) in the case of the Legislative Assembly—in the Votes and Proceedings of the Legislative Assembly, on the first sitting day of the House after receipt of the copy of the report by the Clerk.

	Coroner or jury may make recommendations	s 82(1) A coroner (whether or not there is a jury) or a jury may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned. s 82(2) Without limiting subsection (1), the following are matters that can be the subject of a recommendation: (a) public health and safety, (b) that a matter be investigated or reviewed by a specified person or body. s 82(4) The coroner is to ensure that a copy of a record that includes recommendations made under this section is provided, as soon as is reasonably practicable, to: (a) the State Coroner (unless the coroner is the State Coroner), and (b) any person or body to which a recommendation included in the record is directed, and (c) the Minister, and (d) any other Minister (if any) that administers legislation, or who is responsible for the person or body, to which a recommendation in the record relates.
	Domestic Violence Death Review Team	Chapter 9A
	Object of Chapter	s 101A The object of this Chapter is, through the constitution of the Domestic Violence Death Review Team, to provide for the investigation of the causes of domestic violence deaths in New South Wales, so as to: (a) reduce the incidence of domestic violence deaths, and (b) facilitate improvements in systems and services.
	Members of Team	s 101E(1) The Team is to consist of the Convenor of the Team and other persons appointed by the Minister. s 101E(2) The Minister is to appoint as Convenor of the Team the State Coroner, a Deputy State Coroner or a former State Coroner or Deputy State Coroner.
	Functions of Team	s 101F The Team has the following functions: (a) to review closed cases of domestic violence deaths occurring in New South Wales, (b) to analyse data to identify patterns and trends relating to such deaths, (c) to make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths, (d) to establish and maintain a database (in accordance with the regulations) about such deaths, (e) to undertake, alone or with others, research that aims to help prevent or reduce the likelihood of such deaths.
	Matters to be considered in reviews	s 101G(1) In carrying out a review of closed cases of domestic violence deaths, the Team is to consider the following matters: (a) the events leading up to the death of the de-

		ceased persons, (b) any interaction with, and the effectiveness of, any support or other services provided for, or available to, victims and perpetrators of domestic violence, (c) the general availability of any such services, (d) any failures in systems or services that may have contributed to, or failed to prevent, the domestic violence deaths. s 101G(2) This section does not limit the matters that the Team may consider or examine in any review of closed cases of domestic violence deaths.
	Reports	s 101J(1) The Team must prepare, within the period of 4 months after 30 June in each year, and furnish to the Presiding Officer of each House of Parliament, a report on domestic violence deaths reviewed in the previous year. s 101J(2) Without limiting subsection (1), the report may include the following: (a) identification of systemic and procedural failures that may contribute to domestic violence deaths, (b) recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths, (c) details of the extent to which its previous recommendations have been accepted.
	Reporting to Parliament	s 101K(1) A copy of a report furnished to the Presiding Officer of a House of Parliament under this Part must be laid before that House on the next sitting day of that House after it is received by the Presiding Officer. s 101K(2) The Team may include in a report a recommendation that the report be made public forthwith. s 101K(3) If a report includes a recommendation that a report be made public forthwith, a Presiding Officer of a House of Parliament may make it public whether or not that House is in session and whether or not the report has been laid before that House.
Coroners Act 1993 (NT)	Report on additional matters by coroner	s 26(2) A coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant.
	Coroner to send report etc. to Attorney-General	s 27 The coroner must cause a copy of each report and recommendation made under section 26 to be sent without delay to the Attorney-General.
	Coroner's findings and comments	s 34(2) A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated.
	Coroner's reports	s 35(2) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner. s 35(2) A coroner may make recommendations to the Attorney-General on a matter, including public health

		or safety or the administration of justice connected with a death or disaster investigated by the coroner.
	Reports etc. under section 27 or 35 to be forwarded to Agencies etc.	s 46A(1) If the Attorney-General receives a report or recommendation from a coroner under section 27 or 35 that contains comment relating to an Agency or the Police Force of the Northern Territory, the Attorney-General must, without delay, give a copy of the report or recommendation to the Chief Executive Officer of the Agency or the Commissioner of Police, as the case requires. s 46A(2) If the Attorney-General receives a report or recommendation from a coroner under section 27 or 35 that contains comment relating to a Commonwealth department or agency, the Attorney-General, must without delay, give a copy of the report or recommendation to the Commonwealth Minister responsible for the administration of the department or agency.
	Response to reports	s 46B (1) If a Chief Executive Officer or the Commissioner of Police receives a copy of a report or recommendation under section 46A(1), the Chief Executive Officer or Commissioner must, within 3 months after receiving the report or recommendation, give to the Attorney-General a written response to the findings in the report or to the recommendation. s 46B(2) The response of the Chief Executive Officer or the Commissioner of Police is to include a statement of the action that the Agency or the Police Force is taking, has taken or will take with respect to the coroner's report or recommendation. s 46B(3) On receiving the response of the Chief Executive Officer or the Commissioner of Police, the Attorney-General: (a) must, without delay, report on the coroner's report or recommendation and the response to the coroner's report or recommendation; and (b) may give a copy of his or her report to the coroner; and (c) must lay a copy of his or her report before the Legislative Assembly within 3 sitting days after completing the report. s 46B(4) The coroner may give a copy of the Attorney-General's report to: (a) the senior next of kin of a deceased person mentioned in the report (or a representative of the senior next of kin); and (b) a witness who appeared at the inquest the subject of the report; and (c) any other person who the coroner considers has sufficient interest in the inquest or investigation the subject of the report.
Coroners Act 2003(Qld)	Object of Act	s 3(d) to help to prevent deaths from similar causes happening in the future by allowing coroners at inquests to comment on matters connected with deaths, including matters related to – (i) public health or safety; or (ii) the administration of justice.
	When inquest may be held	s 28(2)(a) In deciding whether it is in the public interest to hold an inquest, the coroner may consider—

		(a) the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future.
	Coroner's Comments	s 46(1) A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to— (a) public health or safety; or (b) the administration of justice; or (c) ways to prevent deaths from happening in similar circumstances in the future. s 46(2) [The coroner must give a written copy of the comments to...] (d) if a government entity deals with the matters to which the comment relates— (i) the Attorney-General; and (ii) the Minister administering the entity; and (iii) the chief executive officer of the entity; and (e) if the comments relate to the death of a child—the children's commissioner.
	Coroner's comments and findings for particular deaths	s 47(1) This section applies to the findings, and any comments, of a coroner made in relation to the investigation of a death in care, death in custody or death that happened in the course of or as a result of police operations. s 47(2) The coroner must give a written copy of the findings and comments to— (a) the Attorney-General; and (b) the appropriate chief executive; and (c) the appropriate Minister.
	Annual report	s 77(1) As soon as practicable after the end of each financial year, the State Coroner must give the Attorney-General a report for the year on the operation of this Act. s 77(2) The report must also contain— (a) the State Coroner's guidelines that were operative in the year; and (b) a summary of the investigation, including the inquest, into each death in custody; and[...] s 77(3) The report may also contain a summary of any other investigation that the State Coroner considers should be brought to the Minister's attention. s 77(4) The Attorney-General must table a copy of the report in the Legislative Assembly within 14 sitting days after receiving the report.
Coroners Act 2003 (SA)	Findings on inquests	s 25(1) The Coroner's Court must, as soon as practicable after the completion of an inquest, give its findings in writing setting out as far as has been ascertained the cause and circumstances of the event that was the subject of the inquest. s 25(2) The Court may add to its findings any recommendation that might, in the opinion of the Court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest. s 25(4) The Court must, as soon as practicable after the completion of the inquest, forward a copy of its

		findings and any recommendations— (a) to the Attorney-General; and (b) in the case of an inquest into a death in custody— (i) if the Court has added to its findings a recommendation directed to a Minister or other agency or instrumentality of the Crown— to each such Minister, agency or instrumentality of the Crown; and (ii) to each person who appeared personally or by counsel at the inquest; and (iii) to any other person who, in the opinion of the Court, has a sufficient interest in the matter. s 25(5) The Minister or the Minister responsible for the agency or other instrumentality of the Crown must, within 8 sitting days of the expiration of 6 months after receiving a copy of the findings and recommendations under subsection (4)(b)(i)— (a) cause a report to be laid before each House of Parliament giving details of any action taken or proposed to be taken in consequence of those recommendations; and (b) forward a copy of the report to the State Coroner.
	Annual report	s 39(1) The State Coroner must, on or before 31 October in each year, make a report to the Attorney-General on the administration of the Coroner's Court and the provision of coronial services under this Act during the previous financial year. s 39(2) The report must include all recommendations made by the Coroner's Court under section 25 during that financial year. s 39(3) The Attorney-General must, within 12 sitting days after receiving a report under this section, cause copies of the report to be laid before both Houses of Parliament.
Coroners Act 1995 (Tas)	Findings, &c., of coroner investigating a death	s 28(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate. s 28(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice. s 28(5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care.
	Reports on deaths	s 30(1) A coroner may report to the Attorney-General on a death which the coroner investigated. s 30(2) A coroner may make recommendations to the Attorney-General on any matter connected with a death which the coroner investigated, including public health or safety or the administration of justice.

	Annual report	s 69(1) The Chief Magistrate must, on or before 30 November in each year, prepare and submit to the Attorney-General a report in relation to the operation of this Act during the financial year ending on the preceding 30 June. s 69(2) The report – (a) must include details of deaths of persons held in custody and findings and recommendations made by coroners; and (b) may include any other matter that the Chief Magistrate considers appropriate. s 69(3) The Attorney-General must cause a copy of the report to be laid on the table of each House of Parliament within 10 sitting days after receiving the report.
Coroners Act 2008 (Vic)	Preamble	The coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of deaths and fires for the purpose of finding the causes of those deaths and fires and to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice.
	Purposes	s 1(c) [The purposes of this Act are] to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners.
	Factors to consider for the purposes of this Act	s 8(f) the desirability of promoting public health and safety and the administration of justice.
	Findings of coroner investigating a death	s 67(3) A coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.
	Reports and recommendations	s 72(1) A coroner may report to the Attorney-General on a death or fire which the coroner has investigated. s 72(2) A coroner may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death or fire which the coroner has investigated, including recommendations relating to public health and safety or the administration of justice. s 72(3) If a public statutory authority or entity receives recommendations made by the coroner under subsection (2), the public statutory authority or entity must provide a written response, not later than 3 months after the date of receipt of the recommendations, in accordance with subsection (4). s 72(4) A written response to the coroner by a public statutory authority or entity must specify a statement of action (if any) that has, is or will be taken in relation to the recommendations made by the coroner. s 72(5) The coroner must— (a) publish the response of a public authority or entity on the Internet; and

		(b) provide a copy of the response to any person— (i) who has advised the principal registrar that they have an interest in the subject of the recommendations; and (ii) who the principal registrar considers to have a sufficient interest in the subject of the recommendations.
	Publication of findings and reports	s 73 (1) Unless otherwise ordered by a coroner, the findings, comments and recommendations made following an inquest must be published on the Internet in accordance with the rules.
	Assignment of magistrates and acting magistrates to be coroners	s 93(2) In assigning a magistrate or acting magistrate to be a coroner for the Coroners Court, the State Coroner and Chief Magistrate must have regard to the experience and knowledge of the magistrate or acting magistrate in relation to coronial investigations, investigations into deaths and fires and the identification of preventative measures following such investigations.
	Annual report	s 102(1) As soon as practicable in each year but not later than 31 October, the State Coroner must submit to the Attorney-General a report containing— (a) a review of the operation of the Coroners Court during the 12 months ending on the preceding 30 June; and (b) any other matters that are prescribed by the regulations. s 102(2) The Attorney-General must cause each annual report submitted to him or her under this section to be laid before each House of Parliament within 7 sitting days after receiving it.
	Function of the [Coronial] Council	s 110(1) The function of the Council is to provide advice, and make recommendations, to the Attorney-General either— (a) of its own motion; or (b) at the request of the Attorney-General. s 110(2) Advice and recommendations prepared under subsection (1) must be in respect of— (a) issues of importance to the coronial system in Victoria; (b) matters relating to the preventative role played by the Coroners Court; (c) the way in which the coronial system engages with families and respects the cultural diversity of families; (d) any other matters relating to the coronial system that are referred to the Council by the Attorney-General.
	Annual report [of the Coronial Council]	s 113(1) As soon as practicable each year but not later than 31 October, the Council must submit to the Attorney-General a report— a) of its operations for the year ending on 30 June that year; and (b) that includes any prescribed matter. s 113(2) The Attorney-General must cause each annual report submitted to him or her under this section to be presented to each House of Parliament within 7 sitting days of that House after receiving it.

Coroners Act 1996 (WA)	Functions of State Coroner	s 8(d) The functions of the State Coroner are to ensure that an inquest is held whenever there is a duty to do so under this Act or whenever it is desirable that an inquest be held.
	Findings and comments of coroner	s 25(2) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice. s 25(3) Where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care.
	Reports	s 27(1) The State Coroner must report annually to the Attorney General on the deaths which have been investigated in each year, including a specific report on the death of each person held in care. s 27(2) The Attorney General is to cause a report submitted under subsection (1) to be laid before each House of Parliament within 12 sitting days of such House after its receipt by him or her. s 27(3) The State Coroner may make recommendations to the Attorney General on any matter connected with a death which a coroner investigated, including public health or safety, the death of a person held in care or the administration of justice. s 27(4) Where a recommendation made under subsection (3) regarding a death of a person held in care is relevant to the operation of an agency, the State Coroner must inform that agency in writing of the recommendation.

Appendix 2 The model of INQUEST (UK)

Context

The national coronial jurisdiction in the United Kingdom is the responsibility of the Ministry of Justice. Although the system is local, with coroners overseeing 127 distinct jurisdictions, the Chief Coroner monitors coronial standards nationally. INQUEST is an independent specialist organisation that provides free and confidential services to bereaved families in England and Wales.[289]

Casework

Inquests into deaths in custody

The bulk of INQUEST's operations are casework, with priority given to deaths in custody, including prison or police custody and psychiatric or immigration detention. INQUEST provides a dedicated caseworker to each family as well as legal representation via a solicitor or barrister from their INQUEST lawyers group, which is a collection of legal practitioners who are willing to offer their legal services via INQUEST. INQUEST will also work with the client's existing practitioner and attend legal meetings with the client if the client has already sought legal advice, and assist families to access funding for legal representation if needed.

General advice

INQUEST also offers a general advice and information service to any bereaved person seeking help in relation to an inquest. They operate a unique telephone-based service providing free support, advice and information about the inquest process, and help callers contact more specialist services if necessary. In addition, INQUEST provides the *Inquest Handbook,* downloadable at no cost from their website.[290] It contains an overview of the UK coronial system and procedures, and a comprehensive list of professional and voluntary organisations that bereaved individuals can contact for specialist advice.

Policy and parliamentary work

INQUEST's casework informs its research, parliamentary and policy work. INQUEST campaigns for change to prevent future deaths and increase accountability, and to remedy deficiencies in the current system from the perspective of the bereaved. It focuses dually on reform of the inquest system and reduction in deaths in custody. This work includes submitting evidence to Parliament and European human rights committees, publishing a wide range of resources including press releases and narratives of bereaved families and their experience with the coronial investigation and inquest, and working with prisons and non-government organisations to raise concerns.

Education and training

Membership of the INQUEST Lawyer's Group promotes the circulation of knowledge and expertise among members. Regular meetings led by leaders in the field act as a forum for exchange of information and experience, and training courses have been provided for practitioners on current issues in inquest law. Members also receive a subscription to the Inquest Law Magazine, published three times

[289] Information in this Appendix was obtained from <http://www.inquest.org.uk>.
[290] INQUEST, *Inquest Handbook* (2011) <http://www.handbook.inquest.org.uk>.

a year, and have access to an email group in which ideas and questions are discussed and information on developments in inquest law is exchanged.

Public monitoring and support for bereaved families

INQUEST monitors the number of deaths in custody as well as the number of unlawful killing verdicts delivered at inquests. It also supports family campaigns that are independently run by individuals and groups and which aim to raise media awareness for their concerns. INQUEST also organises support groups for bereaved families, and can refer to pathologists if an independent post-mortem is required.

Funding and resources

A non-government organisation, INQUEST is funded by donations and grants. Funds are received from purchases of publications, subscription to the *Inquest Law* magazine, membership of the INQUEST Lawyers Group, and donations. Support of professionals and leaders in the field provides the organisation with credibility and expertise.

Appendix 2

Luke Batty Inquest, Day One

Posted on **October 20, 2014**

This blog comments generally on key systemic issues as they emerge during the current inquest into the death of Luke Batty. It is not an exhaustive account of the inquest evidence. It aims to set each day's public proceedings in the broader context of family violence and family violence homicides, with links to selected media analysis. The inquest continues.

This is part one of a series on the Luke Batty inquest by Dr Chris Atmore, Senior Policy Adviser, Federation of Community Legal Centres.

The inquest into the death of 11-year-old Luke Batty begins. The key events of 12 February 2014 are now well known: Luke's father Greg Anderson killed him at cricket practice when Anderson was with Luke in the nets. Anderson was then shot by police and later died. There had been a long history of violence by Anderson towards Luke's mother, Rosie. Luke witnessed much of this violence, and was therefore under Victorian law also a victim of Anderson's family violence. At the time of his death Luke was protected under a Family Violence Intervention Order (FVIO) together with Rosie.

Scope of the inquest

In an inquest, a Coroner must find the causes and circumstances of the death. The inquest must also consider issues of public health and safety and the administration of justice arising directly from Luke's death, particularly whether his death could have been prevented.

An inquest examines the system and tries to make it accountable by looking at where there may have been systemic failure. If there was failure, the inquest considers how that might be addressed to prevent future deaths in similar circumstances. A key question in Luke's death:

What could have been done to prevent Luke being alone with Anderson that night?

In addition to Rosie Batty, the parties to the inquest are the Chief Commissioner of Police representing various police officers, and the Department of Human Services (Child Protection). The inquest's broad scope is the last 18 months of Luke's life, with a focus on:

- What DHS and Victoria Police knew or should have known of Luke being at risk of violence by Anderson;
- What DHS and Victoria Police did or should have done in relation to that risk of violence;
- What systems, policies, protocols, procedures and training were in place?
- What reviews have been done since Luke's death, what was the outcome, and what in the systems, policies etc has changed, if anything?

Rosie will also be asked what she knew of Luke being at risk of violence by Anderson and what she did in relation to those risks.

The Coroner is particularly interested to hear evidence about how the risk to Rosie and Luke from Anderson was investigated, assessed and managed, and whether and how important information was shared. The inquest will also examine the family violence intervention order system as it was experienced by Rosie, and Anderson's compliance with the process. Another key issue is the fact that at the time of Luke's death, there were 11 outstanding criminal charges (7 for family violence offences) against Anderson and four unexecuted warrants for his arrest in addition to an ongoing FVIO on which Luke and Rosie were protected persons.

Family violence homicides

We know all too well that the killing of Luke was not an isolated event. According to the First Report from the Victorian Systemic Review of Family Violence Deaths (VSRFVD), over 2000–2011 there were an average of 27 family violence-related deaths each year – about 40 per cent of all homicides.

Almost half of these were intimate partner killings, and about one third parent-child (parents killing children, or the reverse).

The Coroners Court 2013–14 Annual Report tells us that there were at least 14 family homicides in the first half of 2014. five of these were intimate partner deaths, and six parent-child. Over 2009–14, most of the parents who killed their children were fathers.

Coroners have been making recommendations in family violence-related inquests with the support of the VSRFVD, since 2011. It is striking how often the same kinds of system failings are identified. For example, the need for:

- Police to enhance familiarity and compliance with Code of Practice (Inquest into the Death of Hayley [full name suppressed] 2011; Inquest into the Death of James Thomas Smith 2011)
- Agencies to collaborate more closely and share information more effectively – for example, police and DHS (Hayley 2011)
- Mapping of service provision and capacity – for example, DHS (Hayley 2011)
- Better training of DHS and police re child abuse signs (Hayley 2011)
- More intensive support at court for victims, consistent across all family violence courts (Smith 2011)
- Better coordination of different police databases so that police can access all relevant information (Inquest into the Death of the Osbornes 2012).

Navigating the family violence maze

Rosie's evidence about the myriad processes and structures she had to try to access and understand illustrates the byzantine journey victims of family violence often have to undertake. They must deal with the Magistrates' Court to get an intervention order – frequently on multiple occasions if the perpetrator of the violence fails to appear, or contests the matter, or applies for a variation, or his subsequent violent behaviour means that the victim has to try to obtain more strict conditions to protect herself and any children. If the perpetrator breaches the order, as Anderson did several times, the victim may have to go back to the Magistrates' Court again, as a witness in a criminal hearing.

If there are children, the Family Court system also becomes involved. There is a complex and often confusing relationship between the Magistrates' Court – a State court – and the Family Court, which is a federal court. This is frustrating and exhausting for an already traumatised victim, especially because in family law matters women are often not eligible for legal aid and so may not have a lawyer to speak for them inFamily Court.

If, as is often the case, there is no continuous support from any professional, a woman may lack crucial information or be misinformed. She is in effect trying to act as her own case manager – to understand and navigate the differences between the various legal forums. In the midst of all this, she may also be regularly trying to alert police and other services to the safety and support needs of herself and her child.

Child Protection may also be notified – by the mother herself or by an agency like the police that is legally required to do so if it is suspected that a child may be at risk of harm. The difficulty for a woman experiencing family violence from the child's father is that the onus is then placed on her as the 'protective parent', at a time when she is also doing all that she can to cope with the father's violence. She needs extensive resources and support, not only to protect her child but also to keep herself safe.

Mothers who suffer family violence tend to be held to a higher parenting standard than fathers, even when those fathers are violent. At the same time, society drums into women that children need their fathers, even if they are violent to the mother.

Despite reforms, both family and child protection law continue to be shaped by these conflicting gendered norms. A perpetrator of violence, already using controlling and manipulative tactics against the mother, may routinely exploit this tension. He will then contest attempts by the mother – fearful for the child's safety, or at the very least concerned about the impact of the violence against her on the child's wellbeing – to prevent or reduce his contact with the child.

Rosie's evidence today shows how much we put on abused women to wrangle the system by themselves. She made a very telling comment this afternoon, 'You need someone to go with you on that journey'. But there wasn't anybody else making sure that all the different points in the system were talking to each other, and keeping her in the loop, and doing risk assessments. Rosie's experience was that it was just her.

Related media

Luke Batty: Victoria inquiry opens into killing by father, *BBC News Australia*

Luke Batty inquest: Coroner expected to investigate what authorities could have done differently, *ABC News Online*

Luke Batty inquest begins with hopes for reforms to tackle domestic violence, *Guardian Australia*

Luke Batty inquest hears father sought to get son alone before murder,*Guardian Australia*

Luke Batty's mother wanted boy to have a 'normal' relationship with his father, *Guardian Australia*

To arrange an interview with Dr Chris Atmore, please contact

Darren Lewin-Hill on [redacted]

Luke Batty Inquest, Day Two

Posted on **October 21, 2014**

This is part two of a series by Dr Chris Atmore on the Luke Batty inquest.

Onus on the victim

Where does the accountability lie for family violence? Victoria's family violence intervention order system was radically reformed in 2008, in an attempt to lift at least some of the burden from victims. In theory and in law, accountability now comes to rest on the perpetrator, together with the justice system that is required to protect victims, hold violent men responsible for their actions, and prevent future violence.

Yet we know that Greg Anderson, Luke Batty's father, was almost never held to account. Across the state, violent men continue to fail to appear in intervention order matters and to fail to answer criminal charges. Instead they resist the victim's attempts to protect herself by applying for variations of her orders or themselves applying for orders against her. Procedural fairness means that the victim may experience more delays as a result, and have to come back to court yet again.

Best practice that does exist in small pockets of Victoria uses Respondent Workers to assist perpetrators of violence to link with appropriate services that address their violence and focus on related concerns that facilitate or exacerbate their behaviour, such as drug and alcohol use or mental health issues. But most respondents do not receive or take up these referrals, often due to demand far outstripping resourcing. The perpetrator is a kind of absent presence in the whole process.

Today we heard audio recordings of three intervention order proceedings Rosie Batty experienced, with Anderson almost entirely failing to appear. Assessment of risk to the woman and child are built in to Victoria's family

violence intervention legislation, and therefore are meant to inform court deliberations. For example, if a Magistrate becomes aware that the violent father is using child contact arrangements to manipulate the mother, this is a 'red flag' for risk, and should inform judicial decision-making. If this red flag is combined with other well-known risk indicators such as recent separation, threats to kill with a weapon and suicide threats, a Magistrate may conclude that the risk to the child is so great that contact with the father should cease.

In the first proceeding, Rosie got this outcome. Victims can feel vast relief when they receive a sympathetic hearing and the Magistrate then makes an order with strict conditions that are mindful of the safety of the woman and her child. Some of that relief is because someone else, with the power to do so, is taking the responsibility for standing up to the perpetrator. However, the FVIO was not served by police on Anderson for five weeks – leaving Rosie and Luke wholly unprotected by a FVIO.

For the same reason – taking some of the burden away from victims – after some deliberation, family violence advocates joined with police in agreeing that the 2008 family violence law reforms should include the power for police to apply for an intervention order even if the woman does not consent.

And yet it's the victim who is left to try to get the order enforced if the perpetrator breaches it. She has to rely on prompt response by police, not only to protect her and her child, but to apprehend the perpetrator and ensure he gets to court where he can be held accountable. But if the system falls down, that extra burden on the victim is for nothing. We heard an example today when Rosie contacted police to say that Anderson had come to see Luke at a Scouts meeting, which she understood to be in breach of the limited contact he was permitted. They said the wording of the order was ambiguous – and that Rosie should go back to court and get it clarified.

These days the police make about 70 per cent of all family violence intervention order applications. This means that they apply for the order on behalf of the victim. Women in Rosie's position are often not made aware that although the matter is taken over at court by the Police Prosecutor, that person is not the woman's lawyer. In contrast, if the woman herself applies for the order and she does not already have a private lawyer, there is a good chance these days that she will see a duty lawyer at court who can advise and appear for her at the early stage of the process. These duty lawyers are from community legal centres or Victoria Legal Aid.

The fact that police are now more often acting in intervention order

matters is an improvement that has come about in the last decade and reflects sustained work by Victoria Police to enhance their role in keeping women safe. But ideally, a woman whose application is being taken by police should also be referred to the duty lawyer in case there are legal issues that need to be canvassed. In practice though, caseload pressures on the courts and varying degrees of relationship building between police and duty lawyers means this does not always happen. The problem then is that if a woman in Rosie's situation is told to come back to court – perhaps numerous times – she might be completely reliant on police personnel – who cannot give her legal advice, thereby limiting how they can help her navigate the legal system – and may not even be the same officers throughout all of the different matters.

Rosie also appeared before several different magistrates in the course of her arduous journey to try to get legal protection for herself and Luke. Like other personnel in the family violence system, magistrates vary in their manner, approach to, and sometimes understanding of the risks. There are few options for a victim who is traumatised by how her matter is treated by a court. There are limited grounds on which she can appeal, within the broad limits of judicial discretion, and if she can get legal help. But there is no effective avenue for complaints about insensitivity or much other magistrate behaviour that nevertheless perpetuates the victim's sense of powerlessness and fear.

If the perpetrator is difficult to locate, the victim also needs to be confident that rigorous and consistent practices are in place to find him. Prior to the inquest, Victoria Police acknowledged unacceptable delays in the warrant system and that their main database (LEAP) could not be relied upon to always deliver timely information when police conduct searches.

In a complex system that consists of disparate elements and practices, it is essential for a victim that all personnel have common understandings, and can easily share information with each other and with her, so that they can operate in a 'joined up' manner. It is critical for all of the various components to 'say no' on behalf of the woman, and then back it up in a consistent way. If this does not happen, the same elements of the system must be able to be publicly held to account.

Shouldering the burdens of risk and accountability

There were so many points in the system where Rosie was expected to blow the whistle on Anderson, deal with her concerns for Luke, navigate the court system, and interact with police and child protection. And on so many of those occasions, Rosie's experience was that she wasn't assisted or kept informed. To ask questions now about what she knew and what she did concerning Luke's risk from his father feels outrageous in those circumstances – because a lot of the time she didn't know, she

wasn't informed, and she did so much, often to no avail.

We need to think about how we can get evidence from bereaved family members differently, so that how they are expected to tell us what happened doesn't perpetuate the abuse of the original processes. Could an inquest live up to its therapeutic promise and actually become more like a mini-truth-and-reconciliation inquiry involving all the parties?

We have occasional glimpses of what that might be like. Rosie's friends in court wearing yellow for Luke. A beautiful photograph of Luke on the railing of the witness box. A police officer covering his face as Rosie talks about system failure. A child protection solicitor in tears as Rosie's raw anguish is exposed. But the process needs more built-in compassion, and less lawyerly 'objectivity' as the only response to the bereaved person reacting to yet another upsetting request to go to a painful place. Sometimes that's as simple as Rosie said today, 'You need a sympathetic person'.

Many in the courtroom really felt for Rosie towards the end of today. It's impossible to imagine what it would be like to be in her shoes, but we're getting some inkling. As she said, 'I don't want anyone else to be where I am right now, in the Coroner's Court giving evidence about my son being killed'. It's our obligation to take that seriously, to try to imagine and understand, and all work to make sure that those same gaps don't open up again.

We haven't heard evidence from the other parties yet. It's extremely critical that DHS and the police meet the level of Rosie's resilience, generosity and honesty, and ask themselves hard and uncomfortable questions about what could have been done differently, and provide full and frank answers. Experience of past inquests when the actions of agencies are implicated is that despite the formally inquisitorial nature of the process, their legal counsel may look for ways to say either 'we didn't know enough to have done anything differently' or 'it wasn't up to us to do it'.

Counsel assisting the Coroner has already said that the role of a Coroner is not to find fault or apportion blame. What is appropriate is system accountability. If as a community we need to ask some questions that make us all feel a little bit guilty and implicated, that's our small loss. It's what we owe Luke and Rosie and all the future Lukes and Rosies there will otherwise continue to be.

Related media

Luke Batty inquest: Police told Rosie Batty they could not protect her from violent former partner, *ABC News Online*

Rosie batty hits back at questions about her actions before son Luke's murder, *Guardian Australia*

To arrange an interview with Dr Chris Atmore, please contact Darren Lewin-Hill on [redacted]

Luke Batty Inquest, Day Three

Posted on **October 22, 2014**

This is part three of a series by Dr Chris Atmore on the Luke Batty inquest.

Rosie is still in the witness box. We expect so much of women in her place. It is astounding that she is still capable of providing coherent responses. Even though the inquest is largely concentrating on the past 18 months, it must be an enormous task to try to remember all the times she's had contact with different authorities, especially because so often those contacts were traumatic and frustrating.

Juggling the system

And yet today is a day of profound insights about a victim's experience of our justice system, and her survival of that process. A striking theme is what a good mother Rosie was to Luke, and what difficult choices she had to make as part of that parenting. As any parent knows, sometimes the decisions you make are not black and white, because there are so many things to think about in terms of what the child's best interests are, let alone Rosie's own interests as a victim of violence.

So Rosie is trying to parent Luke at the same time as having to fight to say 'you've got to arrest Anderson', and she's not getting any financial support – having to do all that herself. And it becomes so fragmented, so the urgency dissipates as far as the system is concerned. There are so many court hearings and charges, and then because of all the adjournments, things ebb away again – momentum gets lost, and when

they return to it weeks later, there might be different people involved, so that when Rosie rings the police she might not get the same person.

What also really leapt out today was Rosie's evidence that 'Luke was like me, he knew how to manage Greg'. It is essential that we recognise the dynamics of long-term abuse, and the risk that we perpetuate that process via the ways we expect victims to engage with the justice system, including the coronial process.

We heard yesterday about the onus on the victim and the need for the justice system to lift that burden. Today Rosie told the Court that she felt it was great that various organisations contacted her after she was assaulted by Anderson in 2012. 'You didn't have to go looking for them, they came to you.'

Rosie's evidence today also showed how important it is that all the agencies involved appreciate that if so much expectation is placed on the victim to contact them and protect herself and her child, there is a high attendant danger. Family violence services know that perpetrator violence escalates when his control is challenged. Rosie contacted DHS in desperation because she couldn't afford to go to the Family Court to try to get a no contact order, and a lawyer she ran into at court when she was unrepresented suggested that DHS could take out a child protection order to achieve the same result.

The upshot of the contact with DHS was that Rosie signed an undertaking that she would protect Luke from Anderson, including keeping Luke within her line of sight when he was at sports with Greg. After Rosie notified Child Protection, she recounted, 'There's an underlying fear because you're finally making a stand and you don't know what's going to happen next'.

Helping Rosie with risk – problems with bail

Again, as we heard in the first two days, information that would have helped Rosie to assess risk was not shared with her. For example, experienced perpetrators can exploit the current bail system. If they fail to report as part of their bail requirements and a warrant is issued for their arrest, the bail conditions lapse.

This is important because bail conditions can function instead of an intervention order to protect the victim, by including conditions such as requiring the person charged to stay away from the area where the victim lives. Police may prefer bail over an intervention order because if bail conditions are breached the person goes straight back before court, unlike with an intervention order where defendants have to be processed at the police station and charged first.

The problem then becomes that if the bail conditions lapse and there is no intervention order in place, the perpetrator can go back to the area without breaking the law. The only way to provide any accountability is for police to execute the warrant, which means they must find the perpetrator. Even if they do, they may not be able to charge him for what would have been breaches of conditions, but only for failure to report.

Rosie wasn't told when Anderson failed to report and was unaware that the bail conditions were therefore no longer relevant. This was critical after Rosie got her intervention order prohibiting Anderson from having contact with Luke, because Anderson failed to report for bail and so was not served with the order. This meant that he could continue to have contact with Luke without committing an offence. Police inability to locate Anderson meant he was not served for five weeks.

Police risk assessment

Gaps in risk assessment procedures were identified when Rosie finally left the witness box and police evidence began this afternoon. The Court heard that Greg Anderson was very difficult to deal with and aggressive, and at definite risk of 'going postal'. When Chelsea Police went to serve an interim FVIO on Anderson, they took four officers.

Senior Constable Kate Anderson, who apprehended Anderson after a complaint from Rosie and was the informant at several key points in the intervention order process, described family violence as being 40 per cent of her job. However, in her general training she had never been told that a perpetrator suicide threat is a red flag for harm to others, and there is no police training in how to weight the various factors in deciding whether future family violence is likely.

If different police have been involved in various matters with the same perpetrator and victim, they don't put their heads together to compare notes – instead each officer fills out their own key police risk assessment document, the L17. They can refer to LEAP to find earlier L17s concerning the same people.

But it takes some time for an L17 to be entered on to the LEAP system so that other police can access it. For example, in January 2014 police served a Personal Safety Intervention Order on Anderson following his threat to decapitate his housemate. At this time there were multiple warrants and charges against Anderson related to the family violence, and yet these police did not find any outstanding matters on LEAP. This meant that there was a missed opportunity for police to serve outstanding warrants on Anderson – they didn't all know of each others' matters involving Anderson. And in Rosie's case there were other gaps in LEAP information about risk that apparently were not on the original L17 form –

possibly because LEAP entry and filling out the L17 are the responsibilities of different people.

Related media

Luke Batty inquest: Rosie Batty defends her actions leading up to son's death, ABC Radio Current Affairs, *The World Today*

Luke Batty inquest: Rosie batty says she was traumatised by Victoria's court system, *ABC News Online*

Luke Batty death: Police shortfalls may have hindered father's arrest,*Guardian Australia*

To arrange an interview with Dr Chris Atmore, please contact Darren Lewin-Hill on [redacted]

Luke Batty Inquest, Day Four

Posted on **October 23, 2014**

This is part four of a series by Dr Chris Atmore on the Luke Batty inquest.

Legal help for bereaved family members

Rosie seeks me out to give the Federation some reflection on her experience in the witness box. 'I've just realised,' she says, 'what it would have been like if I hadn't had a legal team. Originally I didn't even think I needed to go to Luke's inquest – I couldn't see the point and didn't know what it was for. Now I realise that I would have spent the last three days going through what I've gone through and there would have been no-one there to represent me. I can't imagine what that would have been like!'

Most bereaved family members don't get legal representation in inquests, and often not even legal advice. In contrast, even though an inquest is meant to provide an opportunity for the system to be held up to the light, and for parties to put their own individual or agency needs second in the interests of the greater good and of preventing further deaths down the track, more often there is defensiveness. The agencies and government departments appear with their senior counsel and their legal teams and people like Rosie often have nobody. At best, as in Rosie's case, they are lucky to have pro bono and community legal centre help and some legal aid funding to slightly compensate those volunteers.

The Federation is starting a new Legal Services Board-funded project next year, to build capacity to help more family members bereaved by family violence homicide go through the coronial process. The Coronial Council also recently wrote to the Attorney-General recommending that in situations similar to Rosie's, the Coroner should have legislative discretion to require that legal representation be provided to the family member.

More problems with bail

Today the Court viewed a DVD of a police interview with Anderson following his arrest for threatening to kill Rosie and cut off her foot. The highly controlling and aggressive appearance of Anderson was reinforced by evidence from the arresting officer, Senior Constable Paul Topham, that within two seconds of talking with Anderson he decided to oppose bail. Senior Constable Topham described Anderson as having no regard for authority whatsoever. However he received bail, with one of the conditions being that he reside in a Salvation Army motel that was only available for three days.

From the evidence today, it appears to be difficult to provide sufficient corroborating evidence to oppose a bail application, and if the police informant is on leave by the time of the bail hearing, their view is not necessarily sought. Relevant emails to the informant while they are on leave seem unlikely to make their way to the person taking over the matter in their absence.

More problems in locating the perpetrator emerged, with evidence given that it is common for people to be bailed to a non-specific address, such as 'Mornington'. Police seem to rely on LEAP, the White Pages (when Anderson was living in his car most of the time) and talking with other police informants.

More problems with warrants

Senior Constable Topham emailed Detective Andrew Cocking, who was seeking to execute a warrant on Anderson in relation to child pornography charges, and suggested that he could do this by attending Malvern Police Station because Anderson signed on for bail there every Monday. The email warned that Anderson 'probably will be quite dangerous'.

A major flaw in the warrant system at that time was that police had 28 days to execute the warrant before it was filed onto LEAP, meaning that other officers would not be aware of any outstanding warrant until this was done. This has since been rectified so that the delay is now two days.

Could Anderson control his violence?

A question that emerged very soon after Luke's death was whether Anderson had a mental illness, and if so, how that related to his violent behaviour. Evidence was heard today that a psychiatric assessment after he was arrested for an assault against Rosie found no evidence of mental illness. Other evidence, however, including Rosie's, referred to religious delusions and erratic and irrational behaviour.

Most people with mental illness are not violent, and most family violence perpetrators do not have a significant mental illness. The question of whether an official diagnosis at one point in time conclusively shows that a person is not mentally ill is a vexed one. However, Senior Constable Topham, who arrested Anderson following his threat to cut off Rosie's foot and make her suffer, related yesterday that Anderson 'could turn it on and turn it off' and was 'very much in control of the situation'. Senior Constable Topham illustrated his assertion by describing an incident where Anderson was warned that the officer might have to deploy capsicum spray if he continued his behaviour. Anderson desisted.

One of the key characteristics of perpetrators of family violence is that generally their violence is targeted to specific victims. Violent men often terrorise their families with impunity because to the outside world they can appear congenial and even charming. Indeed, the cycle of violence, well known to family violence specialists, can mean that perpetrators can turn this charm onto their own family members – until their control is threatened. It may be how such a man enters his victim's life in the first place, and is the reason why the murder of intimate partners is often symbolised by campaigners using red roses.

Another indicator of Anderson's generally rational and calculating behaviour was his ability to play the system in relation to not reporting for bail. He may or may not have been mentally ill, but in relation to Rosie and Luke, witnesses suggest Anderson knew what he was doing. A question remains as to whether a public hospital might also consider using family violence risk assessment when a mental state examination is requested by police.

Police risk assessment and risk management, again

More gaps in information provided about risk to victims were revealed. Anderson was charged with child pornography offences in January 2013, but Rosie did not find out until six months later when Anderson's lawyer disclosed this to the court during her intervention order hearing. Senior Constable Paul Topham said today that he thought privacy legislation prohibited disclosure to Rosie earlier that year, even though children at the football Anderson attended were considered to be at risk.

Risk assessment in the Victorian family violence integrated response is the subject of detailed and specific training via the Common Risk Assessment Framework, and is regarded as an interactive process of weighing risk factors, listening to the victim and using professional judgment. Yet evidence over the last two days suggests that it is regarded by some police as more a combination of a gut feeling about what is commonsense that is developed on the job, and tick-a-box form filling via the L17. This evidence suggests the need for further training on

the Common Risk Assessment Framework.

Related media

Luke Batty inquiry: Police ‘worked hard’ to stop killer, *BBC News Australia*

Luke Batty inquest: Police officer ‘astounded’ Greg Anderson granted bail before killing, *ABC News Online*

Rosie batty storms out of her murdered son’s inquest, almost in tears,*Guardian Australia*

To arrange an interview with Dr Chris Atmore, please contact Darren Lewin-Hill on [redacted]

Luke Batty Inquest, Day Five

Posted on **October 24, 2014**

This is part five of a series by Dr Chris Atmore on the Luke Batty inquest.

Police risk assessment and management, again

Today we heard how in January 2013, Anderson was arrested and bailed for the child pornography offences he was alleged to have committed in November 2012.

Detective Andrew Cocking had a warrant for Anderson's arrest on these charges and engaged in a series of communications with Rosie about Anderson's possible whereabouts, beginning in May 2013. Like Senior Constable Paul Topham, Detective Cocking never told Rosie the nature of the charges Anderson was facing, because he believed it would do more harm than good and that privacy legislation most likely prevented him from doing so. It was in July 2013 that Rosie made a compromise agreement for Anderson to resume contact, in public, with Luke. When pressed by Rosie's Senior Counsel that knowledge of the child pornography charges may well have informed how Rosie navigated the contact arrangements, Detective Cocking conceded that this was not how he had been trained.

A factor in Detective Cocking's decision-making about the risk to Luke was that the charges related to images of girls rather than boys, and his conclusion that therefore Luke couldn't be a target. This suggests the need for better training in social science evidence that some child sexual abusers are not gender-specific in their choice of victim.

Rosie's Senior Counsel advanced the view that the risk to Anderson's reputation if the charges were not ultimately proven appears to have carried more weight in the ultimate decision not to tell Rosie. And yet by February 2014 the South Melbourne Police were sufficiently concerned

about the risk resulting from the charges that they described Anderson as a ‘known sex offender’ and advised officers to ensure that he wasn’t loitering around public areas with large numbers of (gender not specified) children. In cross-examination, Rosie’s Senior Counsel pointed out the irony that by this time, Anderson was regularly in the company of large numbers of children via his Court-permitted contact with Luke at sports – which Rosie had eventually agreed to after her own assessment of the risk, unaware of the child pornography charges.

Where are the clear police risk assessment processes in this context? If the pornographic images had been of boys, would this have tipped the balance in favour of disclosure to Rosie, and if so, how?

By coincidence, in early February 2014 Anderson phoned Rosie and disclosed his current address. Rosie immediately contacted Detective Cocking but said she had concerns for her safety if Anderson learned she was the one who had provided the information. Police response to this was to hold off on arresting Anderson.

In an echo of earlier police advice to Rosie that if Anderson was determined to breach the order they could not protect her and so she should consider moving back to the UK, police concluded that the risk to Rosie was more important that arresting Anderson – which was of ‘no real perceived urgency’. Detective Cocking told the court that his concern was that Anderson would be filled with anger when he got out (of remand). As Rosie’s Senior Counsel asked, isn’t this always a risk?

And so police management of the risk to Rosie took the same appeasement approach that Rosie, Luke and countless other victims of family violence use to try to stay alive – they tried not to make Anderson angry. To repeat Rosie’s words on Day Three, ‘Luke was like me, he knew how to manage Greg’.

As Detective Cocking acknowledged, things might have been different if he had known about the Personal Safety Intervention Order matter, as the finger would then be pointed away from Rosie. Instead, police failed to execute the warrants, rather than, for example, as with risk management by family violence services, formulating a safety plan for Rosie and Luke. This left Anderson, less than a week later, free to attend Luke’s cricket practice on the night of 12 February.

More glitches in the warrant process

Earlier in the week we heard about how on several occasions the burden was placed on Rosie to alert police if Anderson appeared, so that they could execute their various warrants and arrest him. Today we heard more about a failure to arrest him on 8 May 2013 at the local football oval,

despite Rosie ringing 000 as instructed, at elevated risk to her – and despite Detective Cocking agreeing that it would have been quite reasonable to just have police sitting outside the oval and waiting to apprehend Anderson when he eventually appeared to see Luke.

On that night, Rosie was informed by police that they couldn't make the arrest because the warrants hadn't arrived. But today, the Court was told that police don't have to actually see the warrant to act – they just have to have a reasonable belief that it exists.

Rosie reported Anderson's presence again a few days later, but this time police were unable to attend as they were 'attending an urgent matter'. After a series of failures to appear in court on various matters, Anderson was finally arrested in late May, remanded, bailed two weeks later, and then failed to appear at the committal hearing in January 2014.

More bail flaws

Even if police have continuity in informants attending the bail hearing, and are fully in the loop in relation to each other's matters so that all relevant risk factors are raised at the hearing, witnesses have given evidence that they believe it is unlikely that Anderson would have been denied bail at the various points in time identified.

Today Police Prosecutor Darren Cathie, who applied for Rosie's 'no contact' intervention order against Anderson, expressed his regret that in his view 2004 reforms to the Bail Act have weakened the chances of remanding defendants like Anderson.

Regardless of views on bail reform, it is apparent that within the statewide family violence integrated response developed over the last decade, the family violence risk assessment matrix does not extend to the bail process. If risks pertaining to family violence were thoroughly embedded in judicial decision-making about bail, would it be possible to better protect victims, and without unacceptably compromising the rights of those traditionally disadvantaged by the law placing significant weight on their past failure to answer bail?

Related media

'No real perceived urgency' to arrest Luke Batty's father before killing, detective tells inquest, *The Age*

Luke batty's father not arrested to protect ex-partner, police tell inquest,*Guardian Australia*

Luke batty inquest: Police detail difficulties in keeping Greg Anderson in

custody, *ABC News Online*

To arrange an interview with Dr Chris Atmore, please contact Darren Lewin-Hill on [redacted]

Luke Batty Inquest, Day Six

Posted on **October 28, 2014**

This is part six of a series by Dr Chris Atmore on the Luke Batty inquest.

A system approach to death prevention

The strength of our modern coronial system lies is the way it is underpinned by a system approach to death prevention. Many of the concepts and theories of this approach are informed by lessons in the medical realm. The practice of different personnel checking the same details with the patient multiple times before surgery, in order to try to avoid the 'removal of the wrong leg' scenario, is one illustration.

James Reason, writing in the *British Medical Journal* in 2000, talks about the system approach as being one that concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effects.

It is for the Coroner to decide which, if any, of those conditions, errors and effects that are found to exist, together with their interrelationships, are significant in the circumstances of the death, and whether recommendations should be made that flow from this and might strengthen death prevention.

Last week the Court heard evidence about three key intervention order hearings for Rosie Batty, in April, July and September 2013. Today was an opportunity to further consider how the issues and potential risks to Rosie and Luke tracked through the process of those three hearings.

Tracking through the three intervention order hearings

The April proceeding resulted in a Family Violence Intervention Order that included a condition that Greg Anderson have no contact with his son Luke. Magistrate Goldsbrough made the no contact condition after hearing evidence from Rosie. This included the fact that Anderson held a knife when in his car with Luke and said words to the effect of 'it could end with this'.

In early July, Anderson applied for a variation to that order that sought to have Luke removed from its protection, or failing that, to allow Anderson to resume contact with him. As with the April hearing, Rosie was not represented by a lawyer, and the Police Prosecutor – now Senior Constable Ross Treverton – responded to Anderson.

If a party to an intervention order wishes to vary it, they are usually required to apply for leave to do so and must demonstrate that there are new circumstances. We heard in the audio recording of the proceedings last week, and in evidence from SC Treverton today, that Magistrate Goldsbrough, who was not the Magistrate who granted the leave to Anderson, could not see any new circumstances and therefore allowed only an interim variation on 22 July and adjourned the final hearing to a contest in September (the third key hearing). That hearing was ultimately presided over by the Magistrate who granted leave to Anderson for the variation application.

Information-sharing and decision-making

Today's evidence also raised questions about continuity of information and decision-making when a number of different personnel are involved in intervention order matters concerning the same victim and perpetrator, and in a pressure cooker environment where they are dealing with up to 55 applications a day. For example, it appears that a police prosecutor may not necessarily get the full picture of the issues and risks addressed by the previous prosecutor. We heard that police prosecutors do not receive formal family violence risk assessment training, and that they do not conduct a formal risk assessment using the police form central to this process, the L17. If, like Rosie, the victim does not have a lawyer, that person cannot provide the continuity either.

We also heard that if the child pornography charges against Anderson had not been disclosed to the Magistrate by Anderson's lawyer, neither the Magistrate, the police prosecutor nor Rosie would have found out about the charges at that July hearing. Police prosecutors do not automatically have access to the LEAP database where the child porn charges would have been recorded.

The child porn charges played an important role in decision making on 22 July. Rosie's Senior Counsel explained today that Rosie had come to the hearing not opposed to Anderson having contact with Luke in public at sports. But once she learned about the child pornography charges, Rosie was only prepared for Anderson to have telephone contact with Luke. However, as we heard last week, the Magistrate considered the risk to Luke posed by the child pornography charges and therefore viewed telephone contact as more problematic than Anderson having contact with Luke at the sporting oval, because the oval was a public area and there would be other adults present. This was the interim order made.

Ambiguities and transcribing errors in intervention orders

We also heard about the possibility of ambiguity and errors in wording of orders not being picked up before they are served on the respondent. After the July interim order, Rosie became concerned that Anderson was attending Scouts at night to see Luke, which she regarded as unsafe and of a different order to the public, daytime sports events that she eventually agreed to in July. When she tried to report the Scouts attendance as a breach of the order, police told her that the wording of the order was ambiguous.

Senior Constable Treverton explained today that there may have also been an error in the bench clerk typing up the order from the combination of the Magistrate ticking the conditions on her decision sheet and adding written and oral changes. He told the Court that Magistrate Goldsbrough had orally indicated that the order should only allow contact between Anderson and Luke on the weekends. However, the typed order also provided for potential weekday contact. As Magistrates don't see the order again once it has been typed, there is no opportunity for correction. Luke was killed when Anderson attended cricket practice on a weeknight.

The third hearing

The third hearing on 9 September was important for Rosie, not only because it was her chance to contest Anderson's application for Luke to be removed from the order, but also because she sought to clarify the wording and make sure that Anderson was not permitted to attend Scouts. Because the July order was temporary, it was also an opportunity to contest Anderson's fallback position, contact with Luke at sports. But by the time of this third hearing with a different magistrate and a third police prosecutor, Anderson had decided that he no longer wanted to contest the issue of whether Luke should remain on the order. He attended court only briefly and then left after an outburst.

The Police Prosecutor, Senior Constable Diana Davidson, told the court that although there was 'not a lot' on the file she had been given, she

conducted research, including checking LEAP (to which she did have access). She therefore knew about the child pornography, breach and threat to kill charges, and about the knife threat involving Luke. However, SC Davidson did not have access to information from the two previous prosecutors about how matters were discussed in the earlier hearings, and this was not available on LEAP because prosecutors do not enter information on that database.

SC Davidson did not consider at that time that the no contact order should be revived, because, she said, Rosie did not ask for that and only wanted the Scouts issue clarified. Questioned further on this by Counsel assisting the Coroner, SC Davidson said that had Rosie asked and said that she wanted to go back to the no contact condition, SC Davidson would have put that to the Magistrate.

As discussed on Day Two, Rosie had no legal representation in court on 9 September. She became upset and left during proceedings, because she felt that there was no one to help her and she had to keep coming back to court due to Anderson being able to challenge at any time, including what she thought was the final order made in April.

Assessing risk and the knife incident

This afternoon the inquest heard evidence from the Sexual Offences and Child Abuse Investigation Team (SOCIT) Detective Senior Constable Deborah Charteris, who together with Department of Human Services Child Protection worker Tracie Portelli, investigated the possible risk of harm to Luke after Rosie notified DHS. Ultimately DSC Charteris and Ms Portelli concluded, after DSC Charteris interviewed Luke in Rosie's presence in September 2013, that Luke did not appear to be at risk of harm from Anderson, and that Rosie was able to act as a protective parent. The investigation was closed.

The key issue beginning to be examined today was how DSC Charteris treated Rosie's report of the knife incident in the car involving Anderson and Luke. Rosie had said that Luke told her privately that Anderson included Luke in his threat to kill, but in front of DSC Charteris and Ms Portelli, Luke 'shot me down' and said that Anderson had not aimed the threat at Luke, only himself.

DSC Charteris gave evidence that as a member of the SOCIT Team, her focus was on whether Anderson had committed the criminal offence of making a threat to kill Luke. She told the Court that she believed Luke when he told her that he had been frightened by his friends' discussion of a horror film, and that was why he was fearful that his father might kill him following the knife incident. She said Luke also said the incident had happened in November 2012 and therefore she felt a sense of relief as it

had happened some months before.

DSC Charteris also said that Rosie told her Anderson would never harm Luke, and that when DSC Charteris interviewed him, Luke had said he wasn't frightened. DSC Charteris was aware of Anderson's assault on and threat to kill Rosie in January 2013, but said that there had not been any violence toward Rosie since then. She was also aware of a knife threat Anderson made to Luke's football coach, but she was unable to contact him despite numerous attempts.

Related media

Luke Batty inquest: Police prosecutor tells of moment 'alarm bells went off', *Guardian Australia*

Detective who closed file on Luke Batty's father apologises to Rosie Batty in court, *The Age*

To arrange an interview with Dr Chris Atmore, please contact Darren Lewin-Hill on [redacted]

Luke Batty Inquest, Day Seven

Posted on **October 29, 2014**

This is part seven of a series by Dr Chris Atmore on the Luke Batty inquest.

The system approach again

As the inquest reaches Day Seven, it is worth returning again to the system approach. Of course we know that people sometimes commit wilful acts or behave in grossly negligent ways. However, James Reasonstresses the importance of focusing less on the individual origins of error and much more on the system context of those acts or omissions. One of the advantages of this stance is that it helps us identify the recurrent patterns in avoidable deaths. Reason points out that if the approach used doesn't seek out and remove the properties within the system at large that lead to or increase the possibility of a death, we won't enhance safety.

The status of Luke's description of the knife incident

Cross-examination of DSC Charteris began today. Rosie's Senior Counsel identified two contradictory statements from Luke: that he thought Anderson was going to kill him, and so Luke was fearful for himself; and that he thought Anderson was going to kill only himself, and so Luke was not in fear for himself.

At the heart of the questioning of DSC Charteris was the issue of how to interpret Luke's responses in her interview with him, and therefore how Rosie's reporting of the knife incident – which she had done not only to DHS but also (and unknown to DSC Charteris) previously to her GP, Luke's school and Police Prosecutor Cathie at the April intervention order

hearing – sat with DSC Charteris' understanding of Luke's account.

In support of her final conclusion that future violence by Anderson toward Luke was unlikely, DSC Charteris said that she would have expected Rosie to raise the issue again after Luke denied it. DSC Charteris was unaware that Rosie had given evidence about the knife incident to Magistrate Goldsbrough in April, and that this had been critical to the no contact family violence intervention order being made. DSC Charteris was also unaware that Luke had previously expressed a fear that Anderson might go to jail because of hurting somebody.

In exploring these issues, the inquest ventured onto the border of the complex territory and vexed legal history of children's accounts of traumatic events. We know that eliciting these narratives from children requires specialist training.

Risk assessment, again

DSC Charteris agreed with Rosie's Senior Counsel that Anderson's behaviour and words during the knife incident indicated the possibility of self-harm. However, she was not sure why that risk to Anderson would in itself be an indicator of risk to Rosie, despite the risk of perpetrator self-harm being a red flag for family violence in both the Common Risk Assessment Framework and the police L17 form. DSC Charteris also did not believe that there was a clear enough inference from Anderson's behaviour that Luke was at risk of emotional harm. She told the Court that SOCIT detectives do not receive specific risk assessment training or training about filicide, and that she herself (an officer of 40 years' experience) had undertaken one online training course in family violence, in 2013.

Is it relevant that DSC Charteris interviewed Luke as a potential witness to a criminal offence, when risk assessment is a different process? In the end, DSC Charteris believed Luke over Rosie. Rosie's Senior Counsel suggested that a further inconsistency was that there was more than one account from Luke of how Anderson's behaviour in the car made him feel. From the evidence heard today, it appears that DSC Charteris chose the narrative that Luke was not in fear.

Related media

Closure of Luke Batty file justified, police tell inquest, *The Age*

To arrange an interview with Dr Chris Atmore, please contact Darren Lewin-Hill on [redacted]

Luke Batty Inquest, Day Eight

Posted on **October 30, 2014**

This is part eight of a series by Dr Chris Atmore on the Luke Batty inquest.

Child Protection worker Tracie Portelli was cross-examined today. The Court heard last week on Day Three that following contact with Child Protection, Rosie signed an undertaking to protect Luke from Anderson, because Child Protection deemed her a protective parent. This afternoon Rosie's Senior Counsel suggested to Ms Portelli that the undertaking and the FVIO, with its limited and public contact between Anderson and Luke, were inconsistent: how could Rosie protect Luke if, for example, Anderson suddenly took him away, without putting herself at risk, which the intervention order was designed to prevent?

Ms Portelli agreed that for Rosie to have to choose between her safety and her son's safety was 'conflictual'. Like DSC Charteris on Day Seven, Ms Portelli was unaware of Rosie's disclosures about the knife threat to Luke's school, her GP and Police Prosecutor Cathie. But unlike DSC Charteris, Ms Portelli did form the view that Anderson had made a threat to harm Luke, and that Luke was frightened by that threat, but that he was able to rationalise it by attributing his fear to friends' discussion of a horror movie. Nevertheless, Ms Portelli told the Court that in her view this meant that Luke was at risk of being harmed emotionally.

Although she was aware of processes required to be undertaken and various risk factors to be taken into account in any assessment by DHS Child Protection workers, like DSC Charteris yesterday, Ms Portelli told

the Court she was not aware that suicidal ideation is a risk factor for escalation of the perpetrator's violent behaviour. She had not received any training or done any of her own reading on filicide. Ms Portelli also gave evidence that she had not had any training about how to weigh up the different risk factors, and had not received any risk assessments concerning Anderson's violence to Rosie and Luke from any other personnel.

It was acknowledged by Ms Portelli in cross examination that if the mother is a protective parent and she and the child are separated from the perpetrator, this does not necessarily equate to safety for them both. And yet the outcome for Rosie and Luke was an undertaking by Rosie to DHS, together with an FVIO that was effectively watered down from the April order where the knife threat was accepted as evidence – and so allowed public contact between Anderson and Luke at sports. The undertaking and FVIO were left to do the work of ensuring that no harm came to Luke. Accordingly, today's evidence raised many questions about the relationship of the family violence and child protection systems, and the onus on Rosie and Luke to provide impetus for protective responses.

Thinking about Swiss cheese

The inquest adjourns now until early December. In reflecting on what we have heard and what is ahead, it is interesting to think about James Reason's Swiss cheese model of system accidents (or we might want to call them 'failures'). If each slice of cheese is a defensive layer that the system has put in place to avoid preventable deaths, then because the cheese is Swiss, the slices have holes in them. Reason argues that holes can come about through either active failures – unsafe acts committed by people in direct contact with the victim – or latent conditions – the 'resident pathogens' in the system that can produce unsafe acts – for example, due to understaffing – and that create longstanding weaknesses in the system – for example, unworkable procedures.

Reason says that unlike the cheese, in life the holes are more dynamic and can open, shut and shift location. The presence of holes in any one slice does not usually cause a fatal outcome because the slices are all in a row and the holes are in different places. But if they do line up momentarily, hazards are brought into damaging contact with victims.

It's hard to predict active failures. Reason compares them to mosquitoes that can be swatted but just keep coming. But the latent conditions are the swamps where the mosquitoes breed. And we can drain the swamps.

Related media

More could have been done to keep Luke Batty safe, child protection worker tells inquest, *The Herald Sun*

Luke Batty feared his father would kill him, inquest into his death hears,*ABC News Online*

Rosie Batty's voice, *The Saturday Paper*

Luke Batty Inquest, Day Nine

Posted on **December 1, 2014**

This is part nine of a series by Dr Chris Atmore on the Luke Batty inquest.

The inquest into Luke Batty's death resumed today. For an overview of the key issues so far, see the previous eight days of this blog or the summary in *Croakey*.

Tensions between victim safety and perpetrator accountability

In the first week of the inquest, the Court heard about problems in the warrant system and with the main police database, LEAP (Days Two,Four and Five), and how these contributed to police inability to find and arrest Gregory Anderson. Detective Acting Sergeant Andrew Cocking gave evidence that he received information from Rosie Batty about Anderson's current address a week before Luke was killed (Day Five), but held off on executing various warrants for Anderson's arrest because Rosie had asked him not to let Anderson know that the information had come from her.

DAS Cocking was recalled as a witness today, and was asked by Counsel assisting the Coroner how he assessed the competing considerations of the need to arrest Anderson and Rosie's concern. DAS Cocking gave evidence that he weighed up consideration of Rosie's physical safety if he arrested Anderson immediately, against his view that executing the warrant was a low priority because the matters for which Anderson was sought were unlikely to result in his being remanded in

custody, and that the family violence matters were ‘relatively stale’ in terms of the time that had elapsed since the incidents, their having occurred in January and May 2013. He therefore concluded that on balance the immediate public risk did not justify an immediate attempt to arrest Anderson on the basis of Rosie’s information.

DAS Cocking said that he had also considered engineering contact between Anderson and the police in another manner that would not implicate Rosie – for example, door knocking in the area – but that logistics, costs and manpower mitigated against this. On cross-examination by Rosie’s legal counsel, DAS Cocking agreed that the day that four police officers served Anderson with a Personal Safety Intervention Order (PSIO) for his threat against his housemate – 27 January 2014 – would have been a perfect opportunity to also arrest him on the outstanding criminal matters. However, DAS Cocking didn’t know about the PSIO at the time, and those police didn’t know about DAS Cocking’s outstanding warrants.

As Rosie’s legal counsel pointed out, if individual police don’t become aware of additional acts of violence known to other officers, this lengthens the time before the perpetrator might be held to account, and thereby contributes to the ‘stale’ quality of the family violence incidents. Yet more time gets spun out when the perpetrator, as with Anderson, also fails to appear in court.

The decision-making process that might be engaged in in this kind of context raises a potential logical tension between victim safety and perpetrator accountability. This tension is not inevitable, but rather results from a system that has neither ‘joined up’ responses nor an embedded understanding of the dynamics of family violence.

On the one hand, a decision is made not to act on a victim’s information because of the assessed risk to her from the perpetrator. But on the other hand, this decision is supported by an assessment that the family violence the perpetrator has committed is ‘stale’ and therefore there is no urgency to arrest.

It is difficult not to conclude again (see Day Five) that such an approach is about managing the perpetrator’s violence rather than holding him accountable – in much the same way as many women learn to anticipate what point is next in the cycle of violence and do their best to ‘manage’ potential flashpoints.

As the Coroner, Judge Gray, commented, if Anderson had been arrested, accountability could have been enhanced via tightened bail conditions, providing ‘an opportunity to do something more than had been done in

this man's case'.

Bail and family violence

We heard early in the inquest about the issues that can arise if police wish to oppose bail when perpetrators of family violence are arrested (DaysFour and Five). Today another of the police prosecutors involved in bail hearings for Anderson, Leading Senior Constable Brownyn Martin, was cross-examined, focusing on the hearing of 11 June 2013.

This was the third in a series considering whether Anderson should get bail while charged with the child pornography and family violence offences. We heard audio recordings of the three hearings, including that by 11 June Anderson had been on remand for 11 days having dismissed his lawyer and failing to make arguments as to why he should be bailed.

LSC Martin explained that prosecutors rely on the mention coordinator, who negotiates with the defence and then directs the prosecutor as to whether bail should be opposed. The mention coordinator on that day, Sergeant Stephen Neville, also gave evidence about the process involved.

Again it seems that there is significant risk that the way the system operates will result in a series of failures to 'join the dots'. If the offences charged indicate that bailing the defendant might place others at risk, the usual approach is for the prosecutor to alert the Magistrate that the defendant is in a 'show cause' situation. This means that rather than the presumption being that the defendant will receive bail, the onus is then on the defendant to show why they should receive bail.

But the Magistrate was not alerted. It was also assumed by both LSC Martin and Sergeant Neville that the previous bail hearing, on 6 June, had addressed the formal requirements and therefore that the live issue on 11 June was the question of whether Anderson had an address to be bailed to. In fact, there had been no formal bail application before 11 June.

Once again, it appears that the presence of different personnel at different stages combined with fallible data collection and communication methods to contribute to the case not being identified as a 'show cause' situation. LSC Martin gave evidence that successive prosecutors share information about the same case via notes on the brief. However, criminal matters and family violence intervention order matters are not kept together on file, so for example, Sgt Neville was not aware of the no-contact order against Anderson made by Magistrate Goldsbrough on 24 April and the evidence from Rosie that Anderson had made the knife threat in Luke's presence.

DSC Cathie, Police Prosecutor in the 24 April hearing, had emailed

various police about his concerns and view that bail should be opposed – but Sgt Neville was unaware of this and had had no contact with other officers who as a result of their dealings with Anderson had serious concerns about the risk he posed.

Sgt Neville gave evidence that as mention coordinator he might deal with 150 briefs and up to 15 bail hearings in a day, meaning a very short time for each negotiation and no time to read the whole brief but instead a reliance on the cover sheet. He considered the fact that Anderson had been in custody for some time and now had an address, and believed that there were no strong evidence-based objections to bail.

Sgt Neville therefore directed LSC Martin not to oppose bail on 11 June.

Operationally, the onus seems to be on diligent prosecutors and police officers to make sometimes considerable efforts to join the various dots in an overloaded system.

But perhaps more significant is the question of whether the bail process sufficiently incorporates family violence risk assessment and management throughout the process. Would it work differently for perpetrator accountability if all personnel involved viewed the process through a family violence lens, not only with regard to whether bail should be opposed or granted, but even if bail was granted, what conditions should be attached in order to effectively monitor the perpetrator and keep victims safe?

Related media

Luke batty inquest: Police lawyers 'deeply troubled' by hearing timeline,*ABC News Online*

Sergeant says it was appropriate for Luke Batty's father to be out on bail,*Guardian Australia*

Luke batty inquest: on the need for a systems approach to protect women and children, *Croakey*

To arrange an interview with Dr Chris Atmore, please contact Darren Lewin-Hill on [redacted]

Luke Batty Inquest, Day Ten

Posted on **December 2, 2014**

This is part ten of a series by Dr Chris Atmore on the Luke Batty inquest.

The inquest heard today from a range of services that assisted Rosie and Luke, via a GP, an art therapist, a family violence service worker, a victims of crime counselling service, and a family violence applicant support worker.

Missing red flags for filicide

Child protection systems have had a vexed history when it comes to effectively responding to the risks to children posed by family violence when their mother is also a victim, and supporting them both in that context. As we saw on Days Seven and Eight, one problem is the child protection focus on whether the mother is sufficiently protective of the child from the father's potential or actual violence. Related to this approach, as Social Work Professor Cathy Humphreys describes it, the invisibility of the actual perpetrator of the violence 'casts a long shadow over the child protection response'. Paradoxically, 'the impact of the perpetrator is ever-present but frequently not addressed' – echoing Anderson's 'absent presence' in the evidence from Day Two, and indeed, from most days of the inquest. Professor Humphreys and many other analysts of system responses to violence against women and children therefore argue that family violence cannot simply be grafted on to the child protection system without making major changes to policy and practice.

Family violence (commonly known earlier in Victoria as domestic violence) services developed along a separate path to statutory child protection, via voluntary and feminist efforts. They have a more consistent track record of understanding that children are directly impacted by family violence against their mother. As one illustration, such services were instrumental in 2008 Victorian law reform that defined children witnessing family violence as itself a form of family violence against children. Family violence organisations also recognise that children's safety and well being isclosely tied to that of their mothers.

Even so, the key family violence risk assessment tool is designed to assess risk to women, not also to children. With respect to court resources for victims, we heard today from Frankston Magistrates' Court Family Violence Applicant Support Worker (FVASW) Christine Allen, that the FVASW Intake and Risk Assessment Form is not a form about children's safety. Family violence services may also not be funded to conduct detailed risk assessment of children. Good Shepherd Service Manager Jade Blakkarly told Rosie's Counsel in cross-examination that children affected by family violence who are not in a refuge do not receive case management.

These gaps in the understandings and tools needed to assess risk to children – in both child protection and family violence systems, if to varying degrees – extends even to assessing the risk of filicide in a family violence or parental separation context. Even specialists in protecting children may not receive training on filicide, as we heard on Days Sevenand Eight. Professionals who are not experts in either family violence or child protection but who nevertheless come into contact with abused women and children may have training or some awareness of family violence and child abuse, but as the Court was told today by Rosie's GP, Dr Lisa Farlow, this does not necessarily extend to knowledge of what might constitute red flags for filicide.

When art meets law

Kate Perry was Luke's creative arts therapist for four sessions, after Rosie became concerned that he was having problems at school and said he sometimes felt suicidal. Ms Perry gave evidence today that she assessed Luke as experiencing long-term trauma and difficulty in trusting people after years of witnessing the violence against Rosie from his father. Ms Perry showed the Court pictures of various artworks that Luke had made as part of his therapy, and gave her interpretation of them.

Ms Perry stated that it was typical of older children to engage openly in the first session and then pull back from disclosure for the next few, and so more time was needed for effective therapy. She had prepared an application to the Victims of Crime Assistance Tribunal for 40 sessions

with Luke, the longest number of sessions she had ever asked for, because she believed that with the 'push/pull' of demands on him as he was about to enter adolescence, Luke needed an ongoing therapeutic relationship.

Ms Perry identified a painting of a tree which she had done, and where Luke had added a door with a person's face in the doorway, as symbolic of Luke's feeling unseen in the midst of the violence from Anderson and its repercussions. Luke had also sculpted a snowman, which she said expressed his efforts to appear 'OK' but also hinted at deep feelings underneath.

Having Luke's art in court provided another glimpse of a more therapeutic impulse in the inquest process (see Day Two). The disjunction was brought home in cross-examination, when Ms Perry endeavoured to explain her methods of working with traumatised women and children. She stated that it was important to work with the child, and rather than probing in the early sessions, to instead try to be fully present with them – to listen from your heart. In response to questioning from Senior Counsel for the Department of Human Services, Ms Perry summed up her approach as 'touchy feely'.

It was a striking moment of dissonance, in which the more intuitive and emotionally centred techniques of therapy met the interrogative objectivity of law, with no clear sense of common ground for at least some of those listening. Ms Perry's explanation also resonated with the evidence from Days Six and Seven, which included the only other account of a professional listening to Luke's narrative of events. SOCIT detective DSC Charteris interviewed Luke once in September 2013 and concluded that Luke was not in fear of Anderson as a result of the knife incident. And yet less than a month before, in her penultimate session with Luke, Ms Perry had characterised him as not only deeply traumatised but as unsettled and reluctant to talk.

Silo: a system, process, department, etc. that operates in isolation from others ('What is the metaphoric meaning of silo?') The silos within and between family violence and child protection responses exemplify the latent conditions that contribute to system failure (see Day Eight). The resulting gaps in data, training, and assessment of risk combine with a lack of shared understandings and information, and are exacerbated by discontinuities of personnel and overburdened processes for which there is never enough time or resources.

One example of this is, ironically, the different ways in which at least some aspects of the family violence system use the Common Risk Assessment Framework. We heard today from both Ms Blakkarly and Ms Allen about

the importance of treating risk assessment as an ongoing process, and that the L17 (see Day Three) in their view is only the starting point for police risk assessment, especially because circumstances can change dramatically and quickly. But police evidence on Day Four suggested that at least some officers regard the L17 as more of a one-off tick-a-box exercise than an ongoing process.

To suggest that all parts of a genuinely integrated system must of necessity talk with one another seems so deceptively simple. Several witnesses today said that they would have found it helpful to have been contacted by child protection and various community agencies involved with Rosie and Luke, and would welcome the opportunity to participate in a family violence multi-agency panel. As Ms Blakkarly said in evidence today, there is still too much reliance on individual relationships rather than being able to depend on a consistent systemic approach. But to what extent is this possible when agencies, departments and services appear set up to defend their turf from one another, including via contests in the inquest itself (Day Eleven, to come)?

For media inquiries, please contact Darren Lewin-Hill on [redacted]

Luke Batty inquest, Day Eleven, Part One

Posted on **December 3, 2014**

This is the first post of part eleven of a series by Dr Chris Atmore on the Luke Batty inquest.

Suppression orders and sticking plasters

This morning Rosie's legal team and media lawyers argued, against the Commission for Children and Young People and the Department of Human Services, that the Commission's report of its inquiry into the death of Luke Batty should be at least partly available for direct use in examination of remaining witnesses and for the public to be able to access via media reports.

The parties to the inquest and the Coroner, Judge Gray, already had access to the report, but it was not part of the inquest brief, and Judge Gray had directed before the inquest began that the report should not be referred to in the inquest, pending any future arguments to the contrary. Ultimately Judge Gray ruled that this direction should remain, and he also suppressed the whole report for five years.

Judge Gray said that he made his decision after balancing the various competing public interests involved. He acknowledged that public confidence was not likely to be served by secrecy, but reasoned that this concern was outweighed by the need not to compromise or undermine the Commission's work in promoting continuous improvement and innovation in policies and practices relating to the safety and wellbeing of children and young persons.

The Coroner accepted the arguments of the Commission and DHS that

even the limited parts of the report sought to be made public would enable identification of individuals, and that as a result child protection workers and other professionals might refuse to participate in future inquiries, or at least be more guarded.

We must respect that ruling. However, the fate of the report does raise questions about the role and place of the Commission's inquiries into child deaths. While the Commission's report will inform the Coroner's thinking, Victorians will need to take on trust the internal workings of the Commission in following up on its own findings. It is hard to hold an entity accountable when you don't know what the basis for that accountability actually is.

The Commission for Children and Young People was established in 2012 after the report of the Protecting Victoria's Vulnerable Children Inquiry (commonly known as the Cummins Inquiry) reinforced various stakeholder concerns that the then two-stage approach of the Child Safety Commissioner and the Victorian Child Death Review Committee was not independent of Government and was also unnecessarily complex and time consuming.

Independence is typically identified as a key feature of best death prevention practice for child death review processes.

Another essential and related characteristic is the mechanism of a public reporting process. In 2010, various Monash University and University of Tasmania academics argued in the UNSW Law Journal that public reporting contributes to a review body's independence, because 'where findings and recommendations are made public, governments will be more accountable to act on the issues identified'.

The UNSW Law Journal article therefore recommended that the reporting of child death review recommendations 'should always be made public, rather than merely reported internally within the government agencies'.

The article was written before Victoria acquired the independent Commission for Children and Young People. But in the light of the suppression of the Commission's entire report – argued by DHS, and not disputed by other parties, to be a generic rather than exceptional outcome for Victorian inquiries into child deaths – perhaps we should still heed the academics' warning that without such essential features as public reporting, we risk child death reviews amounting 'at best to a series of post hoc sticking plasters to soothe political sores'.

Related media

Luke Batty report must be suppressed for five years, coroner

rules,*Guardian Australia*

Child Commissioner report into Luke Batty murder to stay secret, *Herald Sun*

Luke Batty inquest: Victorian coroner blocks release of report into 11-year-old's death, *ABC News Online*

Luke Batty's mother Rosie urges overhaul to prevent children's deaths,*The Age*

Police chief says Luke Batty's father 'should have been in jail', *The Age*

Media inquiries should be directed to Darren Lewin-Hill on [redacted]

Luke Batty Inquest, Day Eleven, Part Two

Posted on **December 3, 2014**

This is the second post of part eleven of a series by Dr Chris Atmore on the Luke Batty inquest.

Child protection, family violence and risk

This afternoon we heard evidence from Beth Allen, Assistant Director, Child Protection Unit, Statutory and Forensic Services Design Branch of the Department of Human Services. Together with the impact of the suppression order of the morning, it was difficult for many in the courtroom to piece together the systemic issues, because it had been agreed yesterday that due to time constraints, Ms Allen's lengthy written witness statements would not be read out and instead proceedings would begin with cross-examination. This also posed difficulties for media reporting, because even though statements are generally tendered as exhibits and hence may be made available to journalists who request them, this can take several days.

Accordingly, this entry departs from previous posts in providing more of an account of the evidence as well as offering some analysis via an interview with an experienced family violence worker not involved in the inquest proceedings.

Rosie's Senior Counsel, Rachel Doyle, began by asking Ms Allen about what it meant for Rosie to have been assessed by child protection as a protective parent. Ms Allen confirmed that a parent must be both willing and able to prioritise the child's safety needs. She confirmed that a parent might be willing but unable, due to factors such as the violence of the other parent; and that assessment of protectiveness must be weighed against the risks posed by the other parent. She said it was ideal for child protection to engage with and assess the perpetrator, but that this is not

always possible, as with Greg Anderson.

Ms Allen agreed with a statement of the Principal Practitioner of the Children Youth and Families Division of DHS, Robyn Miller, that child protection could have engaged more effectively with the police to try to locate Anderson. Ms Allen was asked: if child protection had information that an intervention order was likely to be contravened, what could they do to assist the mother? Ms Allen replied that child protection could go to court to give evidence, including saying that they had reached the view that it was not in the child's interests to have contact with the father. Later in cross-examination, Ms Allen agreed that there was room for improvement in child protection workers actually doing this, but that they also needed to be mindful of resources in the context of increasing numbers of family violence intervention order matters and other commitments.

Ms Allen also agreed with previous statements by child protection worker Tracie Portelli (Day Eight) and Ms Miller that requiring Rosie to sign the undertaking to DHS that she would protect Luke by keeping him in her line of sight (Day Three) was, with hindsight, not appropriate, because abiding by it might actually put her in harm's way, counter to the purpose of the intervention order in protecting Rosie and Luke from Anderson. When asked by Ms Doyle whether it might not have been instead appropriate to ask *Anderson* to sign an undertaking, Ms Allen's response was that DHS would not seek an undertaking from someone who would have little regard for it; whereas Rosie had insight into the issues, was generally compliant and would be committed to the undertaking. DHS also cannot compel someone to submit to a mental health assessment without a protection order.

The other barriers here to making Anderson more accountable included the priority in child protection processes to identify any protective parent – meaning that in this case, the threshold for DHS being able to compel Anderson in any way was not reached. The only other accountability route under this framework would be for Rosie to take the matter to the Family Court. With regard to that scenario, as with family violence intervention order matters in the Magistrates' Court, Ms Allen thought that there would have been merit in considering cessation of Anderson's contact with Luke, had all the information been known to one or more parties at particular points in time (Magistrate Goldsbrough had made such an order in April 2013 – see Day Six).

Ms Doyle reminded the Court that Ms Portelli had not received any L17s from police, nor risk assessments from family violence services engaged with Rosie, and asked Ms Allen whether that would have assisted. While Ms Allen did not necessarily agree that risk assessment tools or checklists

needed to be shared, she did emphasise how important it is that all the relevant agencies collaborate, and that this could have been enhanced in Luke's case by pursuing case conferencing. While at present two Risk Assessment and Management Panels (RAMPs) offer that approach, Ms Allen did not think that Rosie and Luke would have met the 'significant risk' criteria for referral to a RAMP.

Ms Allen was questioned at some length about the status and use of the Common Risk Assessment Framework (CRAF, and see also Day Seven) in child protection work. Unlike its core application by specialist family violence services, and despite child protection being named in that framework as one of the key professional groups who should use Practice Guide 2: Preliminary Risk Assessment, use of the family violence-focused CRAF by child protection workers is discretionary. It sits alongside the Best Interests Case Practice Model, which is the generic tool, published in 2012, that guides child protection assessment.

Asked by Ms Doyle whether it would make sense if child protection workers were to apply the CRAF as standard practice in order to be consistent with other parts of the family violence system (including the police, who are supposed to undertake risk assessment via the L17 that lists risk factors from the CRAF – see Day Three), Ms Allen saw some merit in having a common language. But her view was that 'each part of the system has its own mandate' and that the CRAF is limited in not being informed by evidence in terms of being able to identify the risk of filicide or serious harm, and not directing workers how to respond to risk.

Since the development of the Best Interests Case Practice Model, there have been a number of other specialist practice guides produced by child protection, including – this year – Working with Families where an Adult is Violent. Ms Allen confirmed that this document was the first produced as part of a suite of specialist resource guides designed to sit alongside the core Best Practice Model.

In the absence of access to Ms Allen's written statements, I searched the DHS website to find the various potentially relevant documents. It is difficult to get a sense of exactly how child protection workers would have used the multiple and often lengthy documents to assess risk, apart from the (optional) CRAF, at the time that Ms Portelli saw Luke. There is no aide memoire for family violence risk in the core 2012 Best Practice Model.

However, the subsequent specialist and supplementary guide, Working with Families where an Adult is Violent, published this year, includes the following risk behaviors (p85):

- history of previous violence (including breaches of intervention orders)
- use of and access to weapons
- history of severe violence with a partner or children
- suicidal threats or behaviors
- threats to kill, injure or punish her, the children or others
- partner's report of history of violence and fear of further violence
- partner reports severe and irrational jealousy
- severe and persistent stalking
- situations where the perpetrator fears losing the partner and/or child
- recent instability especially unemployment or financial stress

This guide goes on to note that 'in many cases of filicide there are indicators of risk that were not understood or were overlooked' (p86), including:

- dismissing breaches of intervention orders as minor
- escalation in the man's fears of losing the woman or the child
- undiagnosed mental health problems
- evidence of obsessive jealousy many months or years after separation

The conclusion: 'In the light of emerging evidence about filicide, child protection practice in relation to family violence needs to consider the multiple risks to children including the risk of intentional child killing, even where the child may not previously have been a direct victim of the violence' (p86).

We do not yet know how child protection operations in the context of risks to children in family violence situations are practically informed by this guide. The following quotes and themes are taken from an interview I conducted with a family violence worker highly experienced in use of the CRAF, who does not wish to be identified.

At least until very recently, this worker believes there has been 'a resistance from child protection to engaging with a shared understanding of the dynamics of family violence in the way the family violence sector sees it, and instead hanging onto a deeply embedded culture of holding women responsible for taking protective action, and failing to engage the perpetrator to assess risk to children'.

'Why the resistance of working as part of an integrated response to family violence, when child abuse occurs so often in a family violence context? So why would you not just add to what you do instead of assuming you already know it all? It's about enhancing professional judgment, not a substitute for or alternative to it.'

‘More than 6000 people have done CRAF training since 2008, but involvement of child protection practitioners until recently has been limited. Levels of participation seemed to depend on individual practitioners and whether there was strong local or regional leadership. And yet you would expect more child protection workers keen to embrace training and a tool that could help inform their professional judgment, complementary to their Best Interests Model.’

The worker pointed out that it is only since Luke’s death that a practice guide that explicitly names the family violence risk factors was introduced (Working with Families where an Adult is Violent, discussed above). It is notable that even in the production of this guide, there was very limited consultation with the family violence sector.

‘Certainly the CRAF is not the “perfect” framework. It needs to be reviewed and expanded to include information and advice about assessing risks to children, and more guidance regarding risk management. But even with that rider, it is a framework that helps a professional to make a more informed and structured professional judgment. Once you’ve done the training you can never “un-know” the risk factors – it becomes the lens through which you hear or see a woman’s story. And that level of literacy around risk factors and the risk assessment process can be shared, and you can at least have a conversation with similarly trained workers from other agencies based on that shared understanding.’

Related media

Luke Batty report must be suppressed for five years, coroner rules,*Guardian Australia*

Child safety commissioner report into the lead-up to Luke Batty’s murder suppressed, *The Age*

Child commissioner report into Luke batty murder to stay secret, *Herald Sun*

Child protection report into Luke Batty suppressed by coroner, *The Australian*

Media inquiries should be directed to Darren Lewin-Hill on [redacted]

Luke Batty Inquest, Day Twelve

Posted on **December 4, 2014**

This part twelve of a series by Dr Chris Atmore on the Luke Batty inquest.

Victoria Police Assistant Commissioner for the South Metro Region, Luke Cornelius, gave evidence today. This was followed by a personal statement from Rosie Batty, and her photographic tribute to Luke.

As the inquest draws to a close, many of its themes are crystallising around the following two statements.

The first, from Assistant Commissioner Cornelius: 'Anderson was at the lower end of risk for us'.

The second, from Rosie: 'I handled it myself till it got too bad. But he wasn't bad enough'.

Can we reconcile these two statements, against the final outcome for Luke, in such a way that we can prevent harm to present-day and future Lukes and Rosies by accurately assessing and managing the risk posed by violent men like Greg Anderson? Would it have been possible to look at Anderson differently through a police lens?

To answer those questions requires tracking back through earlier days in the inquest and considering identified glitches and points of difference

among the different witnesses. These concern the police risk assessment form, the L17; bail; the police database, LEAP; and other information sharing.

The L17

The first issue to consider is whether the L17, or at least the way it may be used by police, needs improvement (see Days Three and Four). AC Cornelius stated that the L17 reflects the preliminary assessment component of the Common Risk Assessment Framework (CRAF, pp 65–78). He said that although police are expected not to approach the L17 as just a tick-a-box exercise, 'automaton policing' is a risk, with the form potentially being seen as an end in itself.

AC Cornelius gave evidence that the business of frontline police is to provide protection and safety at first instance, in response to a crisis or incident, with a more considered response to risk coming later. In his view, risk assessment and management for all relevant agencies should not be one-size-fits-all – that would be 'pie-in-the-sky'. Instead, he said, the longer term process of providing safety into the future requires collaborative work with specialist family violence services and other partners – a theme to which we return below.

AC Cornelius offered the view that frontline police are not social workers. They are there to keep people safe and to identify breaches of the criminal law. But at the same time, police probably could not stop a man from killing family members 'if he has murder in his heart'. Such a scenario probably cannot be predicted, he suggested, because filicides comprise such a small proportion of homicides and there are so many unknown factors.

Rosie's Senior Counsel, Rachel Doyle, used various means in cross-examination to ascertain how Anderson might have been identified by police as of significant risk to Rosie and Luke, so that the various ensuing justice outcomes might have been different. She suggested to AC Cornelius that the L17 only offers the option of ticking 'likely' or 'unlikely' in terms of future family violence, with no ranking of risk factors. Why not low, medium or high, or developing an actuarial tool for police to use to assess risk, as reviews have suggested? This took AC Cornelius back to the problem that 'you don't want [frontline police] wandering around with a clipboard ticking boxes'. He said they are expected to exercise professional judgment, which then triggers an appropriate referral to allow more nuanced assessment.

The difficulty for a layperson in understanding this process of using the L17 is that the aspect of the CRAF on which it is based combines three elements to determine the level of risk: the victim's own assessment of

her level of risk; evidence-based risk factors; and the practitioner's professional judgment. But without the first two elements, what is 'professional judgment'? Or in other words, how do police know what risk is in a family violence context?

AC Cornelius gave evidence that police are considering the future format of the L17 due to the 'sheer volume' of L17s and the fact that they contain 'a significant amount of white noise', meaning that officers need further guidance on how to rank level of risk so that they can prioritise particular victims and perpetrators.

Bail

Another marker that might contribute to a global picture of risk assessment is recidivism. If Anderson had been identified as a recidivist, AC Cornelius said that there would be an offender management plan and that there might be bail conditions and opportunities for referral to services such as a men's behavior change program, together with judicial monitoring. Although Anderson would not have fitted the recidivist definition (at least three family violence attendances in 12 months) he 'would have attracted our interest'.

Evidence earlier in the inquest was that various police prosecutors opposed bail for Anderson but were, mainly justifiably it seems, not confident of success (see Days Three, Four and Five). Asked by Ms Doyle if subsequent revision of the bail and remand form in October 2014 was in response to Luke's death, AC Cornelius responded that it was due to a number of factors, including the quality of summaries provided by informants to prosecutors (see problems with continuity when there were different prosecutors in Anderson's bail matters – Days Three, Four andFive). He agreed that there was a public policy justification in reversing the onus where the charge is a family violence offence, so that the accused would have to 'show cause' as to why they should receive bail, rather than bail being presumed unless prosecutors could prove otherwise.

With regard to the likelihood that an accused like Anderson would receive bail, Ms Doyle suggested that it was an irony that Anderson's charges were regarded as 'stale' and hence lower-priority by the bail mention coordinator, Sergeant Neville (Day Nine). She said that the 'staleness' was partly due to Anderson's failure to appear in court and therefore more time elapsing between the offences charged and the point at which the level of risk he posed was considered in the bail matters. AC Cornelius agreed it was 'an example of the system being gamed'.

LEAP

Might it have been possible for LEAP to provide sufficient information to trigger alarm bells about Anderson? AC Cornelius acknowledged the problems previously identified on Days Two, Three and Four, and stated that police officers would need to access many LEAP screens to appreciate an offender's full history. LEAP is not a comprehensive system, and often won't have information about victims. It was designed in 1993 to focus on persons of interest (for example, suspects). There is no way to instantly get a holistic picture, and frontline police have very limited time.

AC Cornelius said that given there are so many different pathways into the legal system, it would be very difficult to create and support an information system that would cover them all, as well as serving different purposes for different agencies, and so ultimately this wouldn't enhance policing or the interests of victims. He suggested that the data integration really has to come from a collaborative approach – you would need to pull individual records and then share them via collaboration with partner agencies such as the Department of Human Services. But there are similar problems with the DHS system, because that, too, is designed for that particular entity's statutory function, and so may not contain information on persons of interest.

Other information sharing

Earlier, the inquest identified various problems with the warrants system, meaning that opportunities to apprehend or serve Anderson were missed (Days Two to Five). AC Cornelius confirmed today that the key reason for this – delays in logging warrants onto LEAP – has now been rectified, and that the longest time that can now elapse between an informant obtaining a warrant and it being made available to other officers via LEAP is 48 hours.

AC Cornelius was also questioned about whether police had acted appropriately in not informing Rosie about the child pornography charges. As with the L17, and the evidence of SOCIT detective Deborah Charteris concerning her interview with Luke (see Day Seven), the primary focus of police decision-making is the relevance of the issue to law enforcement. AC Cornelius therefore concluded that because the child pornography charges were of a comparatively low order, disclosure to Rosie was not highly relevant and therefore would not have served the purpose of law enforcement. Nevertheless, he conceded that such disclosure might have changed Rosie's attitude to Anderson's access to and contact with Luke.

AC Cornelius was asked about the Personal Safety Intervention Order against Anderson in order to protect his housemate in January 2014; and specifically, the failure of that information to be shared among different police (see Day Three). AC Cornelius responded that it highlights 'a

disconnect' in the police operating system, and that management of the offender and support for the victim need to be joined up.

Collaboration

After considering frontline police use of the L17 and problems with LEAP, a striking theme that emerges is the need for police to collaborate and share understandings with specialist family violence agencies. This need for collaboration was emphasised by AC Cornelius, who referred to recent police reviews, including a governance review due to report next year, aimed at enhancing police engagement with various services.

It is important to contrast this with Rosie's statement today that it has stood out clearly for her who has family violence expertise and who does not. She gave the example of using the 'staleness' of charges against Anderson as a predictor of the future safety of herself and Luke. Rosie emphasised the fact that family violence services well know – that without serious intervention, violence never stops. Instances of violence can be years apart, and their temporary absence is no guarantee of future safety. In other words, family violence services understand risk assessment and management.

While AC Cornelius referred to the need to formalise arrangements with key partner agencies, including protocols and clear delineation between roles, it is perhaps significant that the only agencies singled out for mention here were DHS and the Department of Health. Rosie expressed the hope that services such as police and DHS consider engaging with family violence services and expertise, and her disappointment that 'I see very little of that' and that 'family violence expertise is devalued' (for a different inter-agency model, see, for example, New Zealand's Evaluation of the Family Violence Interagency Response System Summary Report).

Without organisations being open to reflection and change we will never improve. – Rosie Batty

In her personal statement, Rosie pointed out that the one person who knew and understood the risk she and Luke faced, and responded to this by making a no-contact order against Anderson, was Magistrate Goldsbrough (see Day Six). What made the difference there, and why did that Magistrate consider that Anderson might be a man with murder in his heart, and try to prevent it?

It seems fitting to end today's reflections with an extract from a letter which Rosie read to the court, from the mother of one of the boys in Luke's class at school. She wrote: 'There will always be a loss in the lives of those who knew and cared for Luke, but if the young people can turn this tragedy into wisdom, then the world will be a better place'.

The mother then enclosed a speech Luke's classmate wrote for the final assembly. This is an extract:

This year, the Grade 6 group experienced a true tragedy with the loss of our friend, Luke. But we learnt that instead of collapsing in our sadness, we could turn our wounds into wisdom. Wise people learn from tragedy, they learn from experiences and they learn to improve their behaviours from the observations of things happening around them. . .I hope that I continue to gain wisdom, by listening and learning from everyone and everything around me. I may never be completely wise, but then if I was, how would I continue to learn?

Related media

Luke Batty inquest hears police cannot stop men intent on murdering their children, *Guardian Australia*

Luke batty inquest: Senior Victoria Police officer apologises to Rosie Batty, *ABC News Online*

Police powerless to stop Luke Batty's death, inquest told, *The Age*

Rosie batty tells inquest into her son's murder she blames no-one,*Guardian Australia*

Luke Batty's inquest told his dad was 'mad not bad' and couldn't be stopped, *Herald Sun*

Luke Batty murder inquiry closes, *BBC News Australia*

Media inquiries should be directed to Darren Lewin-Hill on [redacted]

Appendix 3A

SUBMISSION TO THE VICTORIAN GOVERNMENT IN RESPONSE TO THE DISCUSSION PAPER ON PROPOSED 'FAILURE TO PROTECT' LAWS

1. BACKGROUND

This joint submission is made by community agencies and peak bodies working in the family violence, child and family welfare and community legal sectors: Women's Legal Service Victoria, Federation of Community Legal Centres, No To Violence, Domestic Violence Resource Centre Victoria, Women with Disabilities Victoria and Domestic Violence Victoria (collectively, the partner organisations). The submission represents the well considered view of the partner organisations, who individually and collectively have significant experience and expertise in the area of family violence and child and family welfare. We have spoken to our respective member agencies and wider networks and understand that our views are widely shared by those who work in the community sector.

About the partner organisations supporting this submission:

Women's Legal Service Victoria (WLSV) has been providing free legal advice, information, representation and legal education to women for over 30 years. WLSV is the only specialist legal service in Victoria for women experiencing relationship breakdown and violence. A significant proportion of our clients have experienced family violence during a relationship, at separation, and after a relationship has ended. We are committed to improving access to justice for women and protecting the rights of those women who are least able to protect themselves.

Federation of Community Legal Centres Victoria (The Federation) is the peak body for 49 Victorian Community Legal Centres (CLCs). CLCs are independent community organisations that provide free legal advice, information, assistance, representation and community legal education to more than 100,000 Victorians each year. CLC work against family violence includes the provision of duty lawyer services in Magistrates Courts for victims of family violence. The Federation also conducts strategic research, casework, policy development and social and law reform activities.

No To Violence (NTV), the Male Family Violence Prevention Association, is the Victorian statewide peak body of organisations and individuals working with men to end their violence and abuse against family members. No To Violence developed from the integration in 1998 of the Victorian Network for the Prevention of Male Family Violence and the Men's Referral Service. NTV members come from a wide range of professional and community backgrounds and work in a range of settings including government, community based settings as well as private practice. Activities of members include providing male family violence men's behaviour change programs, counselling services to men and their families, as well as educational activities within the broader community directed at preventing male family violence. In working to prevent male family violence, NTV resources service providers through training and professional development services, service and educational resources, research and policy development and sector advocacy. NTV also provides a statewide male family violence telephone counselling, information and referral service – the Men's Referral Service. The Men's Referral Service operates as the central point of contact for men in Victoria who are making their first moves towards taking responsibility for their violent and abusive behaviour. The service also receives calls from women seeking assistance on behalf of their partners, male family members or friends, as well as from agencies seeking assistance for their male clients.

Domestic Violence Resource Centre Victoria (DVRCV) aims to prevent family violence and promote respectful relationships. DVRC works to achieve this through strategies which:

- support workforce development in the community sector around family violence;
- improve the quality of services to victims of violence;
- inform and support those affected by this violence;
- inform public policy, research and law reform; and
- raise community awareness and promote community responsibility for violence prevention.

Women with Disabilities Victoria (WDV) is an organisation made up of women with disabilities who support women with disabilities to achieve their rights in Victoria. Members and staff represent the diversity of women with disabilities, and supports women with disabilities to achieve their rights through community education, peer support, research and systemic advocacy. The organisation speaks for the human rights of women with disabilities on many of Victoria's key violence prevention and violence response committees.

Domestic Violence Victoria (DV Vic) is the peak body for over fifty family / domestic violence services in Victoria that provide support to women and children to live free from violence. With the central tenet of DV Vic being the safety and best interests of women and children, DV Vic provides leadership to change and enhance systems that prevent and respond to family / domestic violence.

2. INTRODUCTION AND SUMMARY OF PROPOSALS AND KEY CONCERNS

In its discussion paper on proposed 'failure to protect' laws, the Government has asked organisations to consider the construction of proposed offences relating to child abuse and child death and to provide any comments that may inform the development of the proposed offences (paragraph 1 of the discussion paper). 'Failure to protect' – or similar – regimes are in place in a number of other jurisdictions, including South Australia, Northern Territory, the UK and various states in the US. 'Failure to protect' laws typically create a positive obligation for adults who have custody or care of a child, or live in the same household as a child, to take action if they know or believe the child is being abused. The laws create a specific offence that can be used where a child has died due to abuse or has suffered significant harm, and an adult is aware of the abuse and its seriousness, and fails to take action.

The partner organisations agree that rates of child abuse are unacceptably high in Victoria and that more needs to be done to protect vulnerable children. However, the introduction of the proposed laws is strongly opposed. The proposed laws will not protect children from violence and abuse.

This submission addresses certain critical issues raised in the discussion paper, the key areas of concern for the partner organisations and outlines the partner organisations' proposals in response to the proposed laws. The fact that a part of the discussion paper has not been discussed should not be taken as an indication of either support or opposition to any particular issue.

Given the importance of the issues raised by the proposed laws, the partner organisations also note that they are concerned at the extremely short time period (3 weeks) which has been allowed for written submissions in response to the Government's discussion paper.

Summary of proposals and key concerns:

The partner organisations strongly oppose the creation of 'failure to protect' offences. The proposed laws should not be enacted.

- **KEY CONCERN 1: Premature**
  A coordinated approach to child protection reforms is essential. Any decision about enacting the proposed 'failure to protect' laws should await the outcome of the Government's 'Protecting Victoria's Vulnerable Children Inquiry'.

- **KEY CONCERN 2: No justification / Too broad**
  New 'failure to protect' laws will not provide any additional protection for children from violence and abuse. There is no evidence to suggest that 'failure to protect' laws are necessary or will lead to increased reporting of abuse. The partner organisations recommend that prior to further considering the introduction of the proposed laws the Government should undertake a review of child death and serious harm cases in Victoria in order to establish whether 'failure to protect' laws would have been appropriate in any of those circumstances. If changes are

desirable to meet the shortcomings exposed in those cases, it is likely that far narrower legislative intervention would suffice. Absent such a review, there is currently no evidence that the proposed laws are necessary.

- **KEY CONCERN 3: Unintended consequences**
  Any major changes in this complex field should satisfy the criteria "first, do no harm". 'Failure to protect' laws have the potential to unintentionally cause more harm to children, for instance by working contrary to best practice to support and work with protective parents, inadvertently resulting in increased 'revenge killings' (where a father kills the child to punish the mother and the mother is incarcerated for 'failure to protect'), or the mother is incarcerated for 'failure to protect', leaving the child in the care of the perpetrator or the State.
- **KEY CONCERN 4: Too simplistic / Misconceived**
  'Failure to protect' laws do not adequately recognise the dynamics and complexities of family violence and are detrimental to women and their children experiencing family violence. In particular, the legislation fails to take account of the powerful barriers to a woman leaving an abusive relationship or reporting that abuse.
- **KEY CONCERN 5: Discrimination**
  'Failure to protect' laws will have a disproportionate and discriminatory impact on women who are themselves the victims of family violence. The discriminatory effect of the proposed laws is likely to be exacerbated by well-established gender stereotyping and bias. It will be further heightened for women with disabilities, Indigenous women and women from culturally and linguistically diverse (CALD) communities, who face additional barriers to reporting.
- **KEY CONCERN 6: Incorrect allocation of responsibility**
  'Failure to protect' laws will have a negative impact on recent family violence reforms, and their particular emphasis on ensuring that the perpetrator, not the victim, bears the responsibility for violence. Importantly, they are inconsistent with Victoria Police's Code of Practice for the Investigation of Family Violence. Legislation needs to be directed at the offender, not the victim.

In order to protect children, the focus should instead be on greater investment in the services, systems and networks that support and work with protective parents. These must be significantly resourced and strengthened in order to ensure vulnerable women and children are properly protected when they are at risk.

If the Government determines to proceed with introducing legislation concerning a 'failure to protect' offence, the partner organisations expect that the Government would give significant consideration to the formulation of any offence in order to address the key concerns outlined in this submission and minimise the adverse impact of such legislation. Any such laws would need to recognise the dynamics of family violence and only apply in limited circumstances to afford sufficient protection for those in family violence situations to avoid prosecution. The laws would also need to be accompanied with adequate training about the social context of family violence for those involved in the legal process. These matters are addressed in an addendum to this submission.

3. KEY CONCERN 1: A coordinated approach to child protection reforms is essential. Any decision about enacting the proposed 'failure to protect' laws should await the outcome of the Government's 'Protecting Victoria's Vulnerable Children Inquiry'.

The need for a co-ordinated approach to dealing with child protection issues in Victoria is well recognised. The scope and focus of the Government's current 'Protecting Victoria's Vulnerable Children Inquiry' (PVVC inquiry) are a recognition of the need for a coordinated approach to this complex issue. As set out on the Government's website,[1] the PVVC inquiry will investigate systemic problems in Victoria's child protection system and make recommendations to strengthen and improve the protection and support of vulnerable young Victorians. In addition, the PVVC inquiry panel will inform the Victorian Government about how to reduce child abuse and strengthen the protection of Victorian children who are at risk of, or have experienced, neglect and/or abuse. Further, it will consider the effectiveness of existing systems and processes, and enhancements in systems and services to protect Victoria's children.

The partner organisations welcome this important inquiry but note that the PVVC inquiry panel is not due to report until 4 November 2011. The PVVC inquiry will clearly provide information of significant relevance to the Government's decision in relation to the proposed 'failure to protect' laws. Accordingly, the partner organisations believe that the Government's request for submissions on the proposed legislation is premature, given the inquiry panel is not due to report until early November 2011, and that any decision about enacting the proposed 'failure to protect' laws should await the outcome of the PVVC inquiry.

Proposal:

At a minimum, any decision on enacting the proposed 'failure to protect' laws should await the outcome of the Government's "Protecting Victoria's Vulnerable Children Inquiry" to facilitate a coordinated response to child protection reforms.

4. KEY CONCERN 2: New 'failure to protect' laws will not provide any additional protection for children from violence and abuse. There is no evidence to suggest that 'failure to protect' laws are necessary or will lead to increased reporting of abuse.

There is no evidence which demonstrates the need for the proposed 'failure to protect' laws.

Neither the discussion paper, nor other public statements by the Victorian Government in relation to the proposed laws, provide any examples or evidence of where 'failure to protect' legislation might help to protect vulnerable children or have been appropriate in any recent cases of child

[1] www.childprotectioninquiry.vic.gov.au.

death or serious harm in Victoria. The partner organisations note that the introduction of a 'failure to protect' regime has never been recommended by the Victorian Child Death Review Committee.[2]

Moreover, as identified in the discussion paper, Victoria has an existing 'failure to protect' offence under s 493 of the *Children, Youth and Families Act 2005* (CYFA). This offence applies where a person who has a duty of care in respect of a child has intentionally failed to take action that has resulted or appears likely to result in significant harm. The provision requires consultation with the Secretary of the Department of Human Services (DHS) before a decision is made to prosecute.[3] When it was introduced, the requirement to consult was described as *"an inbuilt safeguard, and encouragement to the development of family support services."*[4] We believe that this is a sound prerequisite so that the focus is ultimately on the protection of children.

In the period from July 2000 to June 2010, according to Victoria Police's Law Enforcement Assistance Program database, 17 'offences' or incidents were 'recorded' against this 'fail to act' provision (between 0-4 incidents each year), although these incidents did not result in prosecutions. As at 1 July 2010 neither the Magistrate's Court nor the Children's Court of Victoria had dealt with offences of child abuse under s 493 *CYFA*.[5] Rather, the courts have acknowledged that the circumstances giving rise to any possible charge are more likely to be dealt with by referral to the child protection agency rather than prosecution, with the emphasis being on the future safety of the child.[6] The limited recording of incidents under the Victorian provision highlight the lack of any evidence supporting the need for 'failure to protect' laws.

In addition to the Victorian legislation, the partner organisations have reviewed 'failure to protect' laws in a number of jurisdictions in considering their response to the discussion paper. If these laws were having their desired effect, one would expect there to be increased reporting of abuse. Yet in South Australia and the UK, two jurisdictions with these laws in place, there is limited or no evidence to suggest that 'failure to protect' laws led to increased reporting of abuse.

In the UK, a 'failure to protect' offence came into force on 21 March 2005. Statistics published by the Office for National Statistics indicate that, in England, the trend in the number of referrals to children's social care services has declined since the introduction of the offence.[7]

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[2] www.ocsc.vic.gov.au.

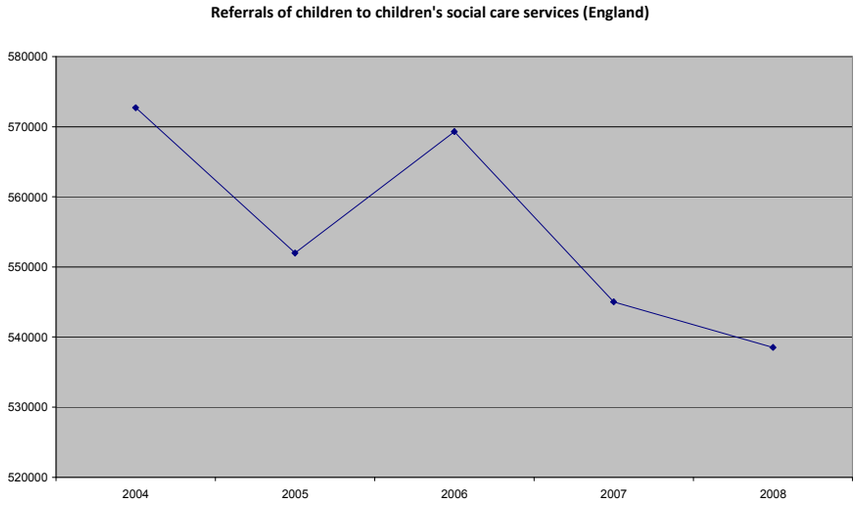
[3] This requirement to consult was introduced in 1978 to a precursor to this offence (section 81 of the *Social Welfare Act 1970* (Vic)) following extensive community consultation. The level of community consultation undertaken on this bill was described at the time as unprecedented in the field of social welfare: Victoria, *Parliamentary Debates*, Legislative Assembly, 16 November 1978, 5913 (Thomas William Roper).

[4] Victoria, *Parliamentary Debates*, Legislative Assembly, 16 November 1978, 5911 (Brian James Dixon, Minister for Social Welfare).

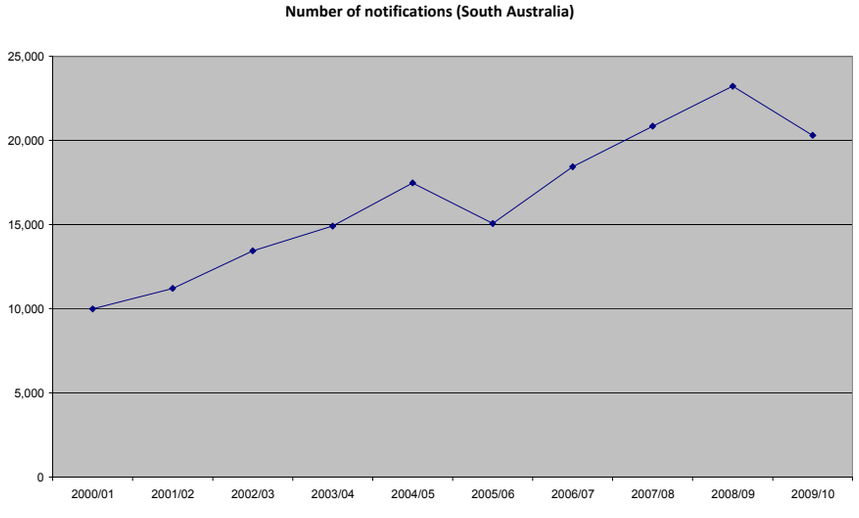
[5] ALRC and NSW Law Reform Commission, *Family Violence – A National Legal Response: Final Report*, October 2010, 941.

[6] Ibid, 941.

[7] "DCSF: Referrals, assessment and children and young people who are the subject of a child protection plan, England - Year ending 31 March 2009" obtained from www.statistics.gov.uk.



In South Australia, a similar offence came into force on 7 April 2005. Although the number of notifications have increased in South Australia, this is the continuation of a trend that began prior to the introduction of the offence.[8] Indeed, the first year the offence was in place saw a drop in levels of notifications.



In the absence of any evidence that 'failure to protect' laws lead to increased reporting of abuse or better outcomes for children, the partner organisations strongly oppose the introduction of the proposed laws. At a minimum, if the Government plans to proceed with introducing the proposed laws, the partner organisations believe that evidence of the need for such laws should be publicly demonstrated.

[8] Australian Institute of Health and Welfare, "Child protection Australia 2009–10", accessed at www.aihw.gov.au.

To the extent that it is shown that there are any loopholes in the existing law, it is highly likely that those can be met by far narrower legislation which would not be discriminatory and potentially counter productive.

Proposals:

The proposed laws should not be enacted.

Prior to further considering the introduction of the proposed laws, the Government should undertake a review of cases of child deaths and serious harm to a child in order to establish whether 'failure to protect' laws would have been appropriate in any of those cases.

5. KEY CONCERN 3: 'Failure to protect' laws have the potential to unintentionally cause more harm to children.

The partner organisations have serious concerns that 'failure to protect' laws have the potential to unintentionally, but in fact, cause more harm to children in a number of respects.

First, there has been continual acknowledgment in recent years that 'best practice' in child protection requires strengthening the mother-child relationship and that working with non-abusive parents to support these relationships enhances the safety of vulnerable children.[9] Experts in the study of family violence believe the positive relationship between the child and the non-abusive parent improves the child's well-being.[10] This relationship allows the child to share a bond with someone who recognises and understands the child's pain and is "*a source of security and thus is essential to recovery.*"[11] The proposed laws are inconsistent with this 'best practice'. In order to protect children, the Government ought to focus on greater investment in the services, systems and networks that support and work with protective parents. An appropriate focus would be to encourage therapeutic counselling for the family, and not to discourage parents from seeking help.

Second, if a mother is convicted and incarcerated for failing to protect a child there is a real likelihood that the child is then left in the care of the State, or absurdly, the perpetrator (for example see *Campbell v State* cited below (page 2) where the mother was convicted of a felony for failing to protect while the father was only guilty of a misdemeanor for inflicting third degree burns on his four year old daughter). It is difficult to understand how the removal of children already traumatised by violence from the care of the non-abusive parent can be construed as being in the child's interests in any way.

[9] See, for example, A Elliot and C Carnes, "Reactions of non-offending parents to the sexual abuse of their child: A review of the literature", 6 *Child Maltreatment* (2001), 4314–4331.
[10] BM Ewen, "Failure to Protect Laws: Protecting Children or Punishing Mothers?", 3 *Journal of Forensic Nursing* 2 (2007), 85, citing Weithorn (2001).
[11] Ibid, 85 citing Bancroft (2004).

Third, there is a real danger that 'failure to protect' laws may inadvertently result in increased 'revenge killings' where a father kills a child to punish the mother as seen in recent high-profile Victorian cases (eg. Robert Farquharson, Arthur Freeman). Not only will a 'revenge killer' be able to rob a mother of her child but with a 'failure to protect' offence in place he may also be able to expose her to imprisonment for not stopping him.

Given these concerns, the partner organisations strongly oppose the introduction of the proposed 'failure to protect' laws.

Proposals:

The proposed laws should not be enacted.

In order to protect children, the focus should instead be on greater investment in the services, systems and networks that support and work with protective parents. These must be significantly resourced and strengthened in order to ensure vulnerable women and children are properly protected when they are at risk.

6. KEY CONCERN 4: 'Failure to protect' laws do not adequately recognise the dynamics and complexities of family violence and are detrimental to women and their children experiencing family violence.

The partner organisations submit that the absence of evidence that 'failure to protect' laws increase reporting of child abuse, and hence, provide any additional protection for children, is fundamentally linked to the dynamics of family violence. Paragraphs 72 and 73 of the discussion paper raise the issue of family violence in the context of 'failure to protect' laws. The focus of these paragraphs is whether the proposed legislation should take instances of family violence into account. The partner organisations strongly believe that an informed understanding of the dynamics of family violence necessitates the conclusion that the proposed laws impose unrealistic expectations on victims of family violence.

6.1. Co-occurrence of child abuse with family violence

Research clearly demonstrates the co-occurrence of child abuse with family violence and the impact of violence on the developmental needs and safety of children and young people.[12] In Victoria, family violence is a factor in over half of substantiated child protection cases.[13] Of the 16 child death cases reviewed in the 2010 Annual Report of Inquiries into the Deaths of Children known to Child Protection, family violence was a factor in 10 cases (62%). In more than 35% of "family violence

[12] S Holt et al, "The impact of exposure to domestic violence on children and young people: A review of the literature", Child Abuse and Neglect 32 (2008) 797–810).
[13] See www.health.vic.gov.au/childrenatrisk/parents.htm.

incidents" recorded by police in each of the years 1999/00 to 2007/08, at least one child was present.[14]

Other Australian statistics also clearly point to the co-occurrence of child abuse with family violence. In its report, 'Australian Statistics on Domestic Violence', the Australian Domestic and Family Violence Clearinghouse commented that "*it is estimated that in 30% to 60% of families where domestic violence is a factor, child abuse is also occurring*."[15] In NSW, the Child Death Review Team (2001) found that in 18 out of the 19 cases reviewed where the death occurred as a result of physical abuse and neglect, there was a background of domestic violence (2000-2001).[16]

Accordingly, it is highly likely there will be a history of family violence in the vast majority of cases where charges under 'failure to protect' laws may be contemplated by authorities. Specifically, where children are abused it is very likely that there will also be violence against the mother.[17] As the Victorian *Family Violence Protection Act 2008* states in its preamble, "*while anyone can be a victim or perpetrator of family violence, family violence is predominantly committed by men against women, children and other vulnerable persons*".

The partner organisations have grave concerns that the proposed laws mean that a woman suffering family violence is more likely to be in a position where they, as the non-abusive parent, can be accused of failing to protect their children.

6.2. Proposed 'reasonable steps' demonstrate a miscomprehension of the dynamics of family violence

Paragraph 60 of the discussion paper notes that a key element of 'failure to protect' offences is that they require adults to take reasonable steps to protect a child. Paragraph 62 suggests that there are a number of different steps an adult could take in response to a risk that a child would be killed, injured or sexually abused. These include intervening to prevent the abuse, removing the child from the abusive environment and reporting the abuse to the relevant authorities.

In situations where the non-abusive parent is also a victim of family violence – which is highly likely to be the case in the majority of situations given the co-occurrence of child abuse with family violence – these supposed 'reasonable' steps demonstrate a significant misunderstanding of the nature of family violence and impose unrealistic expectations on women who are experiencing family violence. Family violence undermines the mother's parenting ability, reduces her confidence, her capacity and her judgment. For a mother experiencing family violence, the partner organisations have serious concerns about what would be seen as a 'failure to protect' in those circumstances: If she has not been able to separate from the perpetrator, is this 'failure to protect'? If she has not reported the abuse, is this 'failure to protect'?

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[14] Department of Justice Victoria, *Victorian Family Violence Database Volume 4 Nine year trend analysis* (1999-2008). The figure ranges, to almost 50% for the years 2003/04 and 2004/05.
[15] "Australian Domestic and Family Violence Clearing House Topic Paper", *Australian Statistics on Domestic Violence* (2003), 7.
[16] Ibid, 8.
[17] C Grealy et al, *Practice guidelines: women and children's family violence counselling and support program*, Department of Human Services, Victoria (2008).

6.2.1.Barriers to leaving

The proposed laws create an expectation that a woman should leave a violent relationship in order to protect her children. However, the barriers to leaving are both complex and very real. Escaping the perpetrator's control can be extremely difficult. For many victims leaving a situation of family violence is often a staggered approach and victims may attempt to leave multiple times before they are successful.[18]

Paradoxically, victims often feel safer staying in the relationship than leaving. These intuitions are confirmed by statistics: the most extreme form of family violence, homicide, occurs more often when a victim has already left the abusive relationship.[19] The Victorian Government's 'Family Violence Risk Assessment and Risk Management Framework' acknowledges that separation is a high risk period for victims of family violence.[20] A study by Humphreys and Thiara observed that domestic violence and child abuse escalate at the point of separation and beyond.[21] A UK study of cases reported to child protection from incidents of domestic violence showed that the majority (54% of 251 cases) of reports occurred where the couple had already separated.[22] Leaving prematurely and without a plan or support increases the risk of stalking, injury and homicide and therefore further endangers both the non-abusive parent and the child.[23]

Apart from fearing retribution, further barriers to leaving include a victim's access to finances. Lack of affordable and available housing and refuge places means many women have nowhere else to go. Significant disruption to work, education and children's schooling further exacerbates the difficulties of leaving violent relationships and opportunities to establish lives post violence.[24] Further, many victims are unaware of their legal options.[25] Any adverse experiences with police and the Courts can significantly hinder this process.[26]

The partner organisations have grave concerns that 'failure to protect' laws place expectations on women to separate where there is family violence or other issues of child abuse without acknowledging that this may be a highly dangerous move and not provide greater safety for either children or women.

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[18] Victorian Law Reform Commission, *Review of Family Violence Laws* (2006), 34.
[19] Ibid, 32.
[20] Department for Victorian Communities, *Family violence risk assessment and risk management framework* (2007), 55.
[21] C Humphreys and RK Thiara "Neither justice nor protection: Women's Experiences of Post-separation Violence", 25 *Journal of Social Welfare and Family Law* 4 (2003), 195–214.
[22] N Stanley, et al "Children's experiences of domestic violence: developing an integrated response from police and child protection services", 26 *Journal of Interpersonal Violence* (2011), 2372–2382.
[23] BM Ewen, above n 10, citing Kopels and Sheridan (2002).
[24] VLRC report above n 18, 34.
[25] Ibid, 34.
[26] Ibid, 65.

6.2.2.Barriers to reporting

The partner organisations are also concerned that the proposed laws also create a belief that it is reasonable to expect the non-abusive parent to report child abuse. In circumstances of family violence there are many real barriers to reporting abuse. These include a fear of retribution, not only towards themselves but also towards their children; a fear that violence will escalate and that, by reporting they may risk the lives of their children. In interviews victims consistently state that they fear for the safety of their children.[27] The victim may also be so disempowered by the experience of family violence that they feel helpless and powerless to act. The reluctance to contact authorities arises because perpetrators of family violence create environments of power and control over their victims through systematic disempowerment.[28] Anecdotally, women also report their fear that they will lose custody of their children if they attempt to report an offending partner. Most importantly, reporting the abuse often forces a woman to leave the relationship prematurely which poses all the barriers discussed above.

Barriers to reporting are particularly significant in the case of mothers with cognitive disabilities, who are already subject to surveillance of their parenting abilities. Reporting abuse puts the word of the reporter against the word of the abuser. Research indicates that women with cognitive disabilities are not likely to be believed when pitted against the word of an offender who presents as 'rational' and 'reasonable'.[29] The barriers to reporting are similarly high for Aboriginal and culturally and linguistically diverse (CALD) mothers, who often have good reason to be mistrustful of authorities and can have quite limited understandings of Australian law.

Women are also often coerced and convinced by their (former) partner that violence experienced by children is the woman's fault, and are blamed for it. Women are often so confused about their experiences of violence from a (former) partner that they are sometimes unsure about who is ultimately responsible for the violence towards children. A common example recited by men is that if their female partner was 'a better parent' or 'better at maintaining the household' then the man wouldn't have to resort to the use of violence.

The prospect of police involvement, self incrimination and fear of heavy penalties for one or more of the household is likely to create a further barrier to reporting abuse rather than encouraging reporting. In addition, given family violence and child abuse tend to occur repeatedly over long stretches of time, family members may fear that they will be criticised or prosecuted for reporting abuse too late, and hence not report at all. This will undo extensive work that has taken place in Victoria to encourage parents to seek help for children who are being abused.

[27] See excerpts of interviews with victims, ibid, 17, 22.
[28] Ibid, 7.
[29] A Gray, S Forell and S Clarke, "Cognitive impairment, legal need and access to justice", *Justice Issues* 10 (10 March 2009), Law and Justice Foundation of New South Wales.

6.3. The proposed laws may result in convictions for victims of family violence

The partner organisations are concerned that the proposed laws will see victims of family violence convicted of offences. Case law in other jurisdictions in which 'failure to protect' laws have been enacted reflects that the laws do not adequately recognise the dynamics of family violence. This can result in mothers being convicted of an offence even where they were not in a position to protect a child, or are not even present when the abuse takes place. This is highlighted in the following cases:

CASE STUDY 1: *Campbell v State* (2000)(Wyoming)[30]

In this case, Casey Campbell, the mother of a four year old girl was convicted of felony child endangerment in March 2000 and sentenced to prison. She had been at work and not in a position to prevent the abuse when her partner, Floid Boyer, severely burnt her daughter causing second and third degree burns over eighteen percent of her body.

When Campbell returned from work, she saw that her daughter was injured, however she did not immediately seek medical attention for the child as she was afraid of her partner. Campbell testified that she had been abused by Boyer since she was 16, and that he had previously violently assaulted her with knives and guns. Campbell, on appeal, contended that her years of abuse established evidence of her belief of an imminent danger of death or great bodily harm if she refused Boyer's demands to spend the evening with him, instead of taking her daughter to the hospital. Campbell sought medical attention for the child 8 hours later.

Campbell's appeal was refused and her sentence was affirmed. Boyer, however, was only convicted for a misdemeanor.

CASE STUDY 2: *State v Williams* (1983) (New Mexico)

In *State v. Williams*,[31] a New Mexico court convicted Jeanette Williams of child abuse for failing to protect her four-year-old daughter from her husband's abuse.

On appeal, Williams argued that, because she was 5 months pregnant at the time, beaten herself by her husband and threatened by him, she could do nothing to prevent the beating.

The Appellate Court, however, affirmed the conviction and found that given the finding of repeated beatings, a reasonable inference could be drawn that the defendant's failure to remove her child from the situation, or failure to seek help at the time of the incident was a proximate cause of the child's injuries.

CASE STUDY 3: *State v Mott* (1997) (Arizona)

In this case, Kay Mott, who experienced domestic violence, was charged with murder and child abuse for the death of her child from injuries inflicted by her boyfriend.

On appeal by the State of Arizona, the Arizona Supreme Court held that expert witness testimony related to 'battered woman's syndrome' offered by Ms Mott in the first instance was unable to be admitted. The expert witness testimony concluded that Ms Mott was a battered woman and that being a battered woman was relevant to her ability to protect her children. According to the doctor, and as set out in the Arizona Supreme Court judgment, a battered woman forms a "traumatic bond" to her batterer. She does not feel that she can escape her environment; she is hopeless and depressed. Furthermore, the battered woman cannot sense danger or protect others from danger. She is inclined to believe what the batterer tells her and will lie to protect him.

[30] 999 P.2d 649 (2000 WY 48).
[31] 670 P.2d 122 (NM Ct App 1983).

The expert testimony was rejected by the Court on the basis that the Arizona legislature did not accept the use of psychological testimony to challenge the *mens rea* element of a crime.

Ms Mott was sentenced to 35 years imprisonment without possibility of parole.

CASE STUDY 4: *Salma Begum* 2005 (UK)[32]

Salma had been married to her husband, Sitab Ullah, for around 2 years when he became addicted to heroin and crack cocaine. His personality changed and he became violent towards Salma and delusional.

Ullah also became violent towards the couple's young baby, Samira, who had been born 2 months premature on 19 July 2004, but had been discharged from hospital 2 weeks later. He became convinced that the baby was possessed by spirits and began to physically assault her, at first by flicking the soles of her feet to 'hurt the thing inside her' and complaining that the baby was being fed too much and becoming greedy because 'he thought the thing inside her wanted to be fed all the time'.

The assaults culminated when Ullah shook the baby so hard that she sustained a fatal brain injury and died on 16 October 2004. Ullah was found guilty of murder and Salma Begum the mother who had been subject to violence herself, pleaded guilty to child cruelty and neglect.

Given 'failure to protect' laws can be detrimental to women and their children experiencing family violence, the partner organisations strongly oppose the introduction of the proposed laws.

Proposals:

The proposed laws should not be enacted.

In order to protect children, the focus should instead be on greater investment in the services, systems and networks that support and work with protective parents. These must be significantly resourced and strengthened in order to ensure vulnerable women and children are properly protected when they are at risk.

7. KEY CONCERN 5: 'Failure to protect' laws will have a disproportionate and discriminatory impact on women who are themselves the victims of family violence. The discriminatory effect of the proposed laws will be further exacerbated for women with disabilities, Indigenous women and women from CALD communities, who face additional barriers to reporting.

7.1. Failure to protect laws are almost exclusively used against women

As the discussion above indicates, analysis and consideration of 'failure to protect' regimes in other jurisdictions shows that the laws are almost exclusively used against women who are themselves the victims of family violence. Charges against men are rare. Fugate refers to a statement by a US

[32] See BBC News Online, "*Baby killed for being 'possessed'*" 21 December 2005 accessed at news.bbc.co.uk/2/hi/uk_news/england/london/4547544.stm.

advocate which neatly summarises this issue: *"In the 16 years I've worked in the courts, I have never seen a father charged with failure to protect when the mom is the abuser. Yet in virtually every case where dad is the abuser, we charge Mom with failure to protect."* [33]

Fugate also notes that *"While it is true that more women have custody of their children and thus are more likely to have the duty to protect their children, this fact alone does not explain the discrepancy adequately. The overwhelming prevalence of female defendants can be explained best by the higher expectations that women face in the realm of parenting and child law."*[34]

The above comments demonstrate that the proposed 'failure to protect' law will have a disproportionate and discriminatory impact on women, particularly those experiencing family violence, and does not provide opportunities for men to take responsibility for their violent and abusive behaviour, or for them to be supported through a process of behavioural change. It is true that more often, women have custody of their children rather than men. The Australian Bureau of Statistics , with regard to living arrangements in separated families, stated that "*in April 1997, there were 978,000 Australian children who were living with one natural parent and who had a natural parent living elsewhere. The vast majority (88%) lived with their natural mother in either one parent families (68%) or in step or blended families (20%).*"[35] Nevertheless, the discriminatory impact on women is unjustified and wrongful. In addition to the reality that non-abusing parent is likely to also be the victim of violence – given the co-occurrence of family violence with child abuse – stereotyping and gender bias contribute to and exacerbate this discriminatory outcome:

- Women face greater scrutiny of their parenting efforts than men due to stereotyping. There is a well-documented history of the gender bias of laws and the court system where violence against women is involved. A 1989 report on gender bias commissioned by the Massachusetts Supreme Judicial Court,[36] found that when fathers contest custody, mothers are held to a different and higher standard than fathers. The report notes that: *"Even when the conduct of both parties is considered, it is often evaluated according to different standards. Women are often measured against the standard of ideal motherhood, while fathers are measured against a different and lower standard"*[37]. The report also refers to the testimony of Sheera Strick of Greater Boston Legal Services in which it was stated: *"The courts, as in the rest of society, expect far more from women as caretakers than men. Any shortcomings the woman has, whether directly relating to her parenting or not, are closely scrutinised. Whereas, if a father does anything by way of caring for his children, this is an indication of his devotion and commitment."* This bias can have a much greater impact on women subject to domestic violence. According to family service officers: *"The court treats a woman much more severely than a father if she leaves her family and then*

[33] GL Lecklitner et al, "Promoting safety for abused children and battered mothers: Miami Dade County's Model Dependency Court Intervention Programme", 4 *Child Maltreatment* 175 (1999), 176 , quoted in JA Fugate, "Who's failing whom? A critical look at failure to protect laws", 76 *New York University Law Review* 272 (2001), 274.
[34] Ibid, 274.
[35] Australian Bureau of Statistics, "Living arrangements: Caring for children after parents separate", 4102.0 Australian Social Trends (1999).
[36] "*Gender Bias Study of the Court System in Massachusetts*", 24 *New England Law Review* (spring 1990), 745.
[37] Ibid, 60.

returns. She will have a big fight on her hands in order to get any visitation rights. On the other hand, if the father leaves and returns, the judge will ask him what visitation rights does he want".[38]

- Gender bias and stereotyping also appear to be prevalent in 'failure to protect' cases in other jurisdictions. For example, in the case of *Campbell,* referred to above, it appears that the prosecution suggested that Campbell herself should have been seriously injured before she allowed her child to sustain harm. It was stated in the prosecution's closing submissions, "*She got slapped, but where are her broken bones? Where are her burns?*"[39] This approach was also reflected in the case of *Tenn. Dep't of Human Services v Tate* (1995) in which it was stated that: "*the court finds that even animals protect their young… Now, [the defendant] may have well been afraid of her husband. There were times when he was gone and even if she was afraid if she had the natural maternal instinct that any mother should have, that maternal instinct should have overcome her fear if she is to be a fit mother and she failed to do that."*[40]

7.2. Greater discrimination for women with disabilities, Indigenous women and women from CALD communities.

The discriminatory effect of the proposed laws is likely to be further exacerbated for women with disabilities, Indigenous women and women from CALD communities, who face additional barriers to reporting.

The 'Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities' reported that "*the statistics paint a frightening picture of what could only be termed an 'epidemic' of family violence and child abuse in Aboriginal Communities*".[41] Despite the supported assumption that sexual violence in Indigenous communities occurs at rates that far exceed those for non-Indigenous Australians,[42] very few victims report the issue to police or seek assistance. Some of the reasons why Indigenous women continue not to report sexual assault include intimidation by authority figures and white people in general; closeness of communities leading to fear of reprisals and shame; the relationship of the survivor to the perpetrator; unfamiliarity with the legal process; and a fear that the perpetrator will be sent to prison.[43]

If abuse is reported, in addition to the many barriers women often faced in terms of giving their evidence in court, it has been commented that Aboriginal women would further suffer the discriminatory practices of a criminal justice system that was racist; often ignorant of Indigenous

[38] Ibid, 62.
[39] JA Fugate, "Who's failing whom?", above n 33.
[40] Tenn Ct App (31 March 1995).
[41] Gordon et al, "Putting the Picture Together, Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities", Department of Premier and Cabinet , Western Australia (2002), as quoted in M Keel, *Family violence and sexual assault in Indigenous Communities' Australian Centre for the Study of Sexual Assault*, Briefing No 4, September 2004.
[42] D Lievore, *Non Reporting and Hidden Recording of Sexual Assault : An International Review*, Australian Institute of Criminology, Canberra, as quoted by M Keel, ibid, 2.
[43] M Keel, ibid, 7.

culture; and disproportionately questioned their credibility, their alcohol and drug use, and their sexual behaviour.[44]

Similar issues affect women with disabilities due a lack of independence, learned helplessness, isolation and lack of access to information. This is especially the case where the victim's abuser is also the carer.[45] A study of parents with a disability in New South Wales child protection matters has shown that a disproportionate number of parents with a disability — particularly those with an intellectual and psychiatric disability — were appearing in child protection proceedings. It found that 7.1 per cent of all care proceedings in the NSW Children's Court involved a parent with an intellectual disability. In the majority of these cases the child was put into the custody of another adult or made a ward of the state.[46]

Proposals:

The proposed laws should not be enacted.

In order to protect children, the focus should instead be on greater investment in the services, systems and networks that support and work with protective parents. These must be significantly resourced and strengthened in order to ensure vulnerable women and children are properly protected when they are at risk.

8. KEY CONCERN 6: 'Failure to protect' laws will have a negative impact on recent family violence reforms, and their particular emphasis on ensuring that the perpetrator, not the victim, bears the responsibility for violence. In particular, they are inconsistent with Victoria Police's Family Violence Code. Legislation needs to be directed at the offender, not the victim.

Recent policy advancements including the creation of Victoria Police's 'Code of Practice for the Investigation of Family Violence'[47] (Victoria Police's Family Violence Code), the enactment of the *Family Violence Protection Act 2008* (Vic) (FVPA) and use of intervention orders, as well as the 'Women's Safety Strategy: A Policy Framework' have been important in ensuring that the perpetrator, not the victim, bears the responsibility for violence. 'Failure to protect' laws are fundamentally flawed as they shift blame to the victim (for failing to leave) rather than the perpetrator.[48] Rather than supporting a woman experiencing family violence, 'failure to protect' laws criminalise the conduct of non-abusive parents. Legislation needs to be directed at the offender, not the victim.

[44] Department for Women in New South Wales, "Heroines of Fortitude: The Experiences of Women in Court as Victims of Sexual Assault", NSW Government (1996).
[45] "Domestic violence and women with disabilities", Better Health Channel, accessed at www.betterhealth.vic.gov.au.
[46] A Gray et al, *Cognitive impairment*, above n 29, 4.
[47] Victoria Police, *Code of Practice for the Investigation of Family Violence*, 2nd edition (10 December 2010).
[48] BM Ewen, above n 10, citing Magen (1999).

An example of the negative impact that 'failure to protect' laws will have on recent family violence reforms relates to the way in which police will be expected to respond to family violence and child protection incidents. The focus of 'failure to protect' laws on the non-abusive parent is inconsistent with the approach adopted in Victoria Police's Family Violence Code and undermine the code's attempt to create a culture of understanding of family violence within the police force. Victoria Police's Family Violence Code recognises the dynamics of family violence, including the barriers to leaving, that leaving is often a staggered process and the need to support children by supporting the non-abusive parent through:

- a requirement to act on *any* incident of family violence reported to them regardless of who made the report and how it was made.[49] This requirement recognises that leaving a situation of family violence may require a victim to make multiple attempts;
- collecting forensic evidence, rather than relying on victim statements so they may proceed with convictions even if the victim withdraws her complaint;[50]
- acknowledging that the first contact a person has with police can influence their experiences and impressions of the justice system and their future decisions;[51]
- adopting a 'pro-arrest' policy for instigators of family violence;[52] and
- stating that consent is not a defence to breaching an intervention order and acknowledging that the victim cannot be charged for aiding and abetting the breach of an intervention order.[53]

Asking police to prosecute a non-abusive parent for failing to report or leave significantly undermines the Code's attempt to foster a culture of understanding within the police force and appropriate reaction to domestic violence by police officers. It is deeply concerning that the proposed legislation threatens to undermine recent family violence reforms.

Proposal:

The proposed laws should not be enacted.

In order to protect children, the focus should instead be on greater investment in the services, systems and networks that support and work with protective parents. These must be significantly resourced and strengthened in order to ensure vulnerable women and children are properly protected when they are at risk.

[49] Victoria Police, *Code of Practice*, above n 47, 8.
[50] Ibid, 25.
[51] Ibid, 9.
[52] Ibid, 23.
[53] Ibid, 28, referring to *Family Violence Protection Act 2008* (Vic), s 125.

9. CONCLUSION

Given the concerns outlined above, the partner organisations strongly oppose the creation of a 'failure to protect' offence. We have spoken to our respective member agencies and wider networks and understand that our views are widely shared by those who work in the community sector.

The partner organisations repeat the recommendation above that prior to further considering the introduction of these laws, the Victorian Government should undertake a review of cases of child deaths and serious harm to a child in order to establish whether 'failure to protect' laws would have been appropriate in any of those cases. Absent such a review, there is currently no evidence that the proposed laws are necessary. Moreover, given the key concerns raised in this submission, the partner organisations submit that there are compelling reasons why the proposed laws should not be enacted.

However, if the Government determines to proceed with introducing legislation concerning a 'failure to protect' offence, the partner organisations expect that the Government would give significant consideration to the formulation of any offence in order to address the key concerns outlined in this submission and minimise the adverse impact of such legislation. Our preliminary views on these issues are outlined in an addendum to this submission.

10. CONTACT

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11. ADDENDUM TO SUBMISSION OF THE PARTNER ORGANISATIONS IN THE EVENT THE GOVERNMENT DECIDES TO PROCEED WITH THE INTRODUCTION OF 'FAILURE TO PROTECT' LAWS

As outlined in this submission, the partner organisations strongly oppose the creation of a 'failure to protect' offence.

If the Government determines to proceed with introducing legislation concerning a 'failure to protect' offence, the partner organisations expect that the Government would give significant consideration to the formulation of any offence in order to address the key concerns outlined in this submission and minimise the adverse impact of such legislation.

Our preliminary views on these issues are set out in this addendum. **Any such laws would need to recognise the dynamics of family violence and only apply in limited circumstances to afford sufficient protection for those in family violence situations to avoid prosecution.** Those limited circumstances are as follows:

- The 'failure to protect' offence should only apply to circumstances of child death;
- The 'failure to protect' offence should only apply where it is not possible to identify any person responsible for the death;
- The 'failure to protect' offence should not apply to an older sibling of the child, who is also likely to have been the victim of violence and abuse by the perpetrator;
- The prosecution should bear the onus of proving that the accused failed to protect the child from homicide (rather than the accused having to prove in a defence that they took reasonable steps);
- The concept of 'reasonable steps' needs to be clarified;
- The 'failure to protect' offence should have in-built defences, including that the accused was a victim of family violence; and
- The 'failure to protect' offence should have a requirement for consultation with the Secretary of the Department of Human Services before a prosecution can be initiated.

The laws would also need to be accompanied with adequate training about the social context of family violence for those involved in the legal process.

Each of these is discussed in further detail below.

11.1. Failure to protect' laws should only apply to circumstances of child death

If these laws are progressed, they should be limited to circumstances where a child has died.

It would be inappropriate for such an offence to apply to circumstances of sexual abuse. There is strong evidence that in most cases the non-abusing parent is unaware of the occurrence of abuse until it is disclosed by the child.[54] While the abuse may look obvious from the outside, it is often not discernible within the family unit, as perpetrator's purposefully groom their families to hide their abuse.[55] There is a strong risk that these laws will discourage children from disclosing abuse. Once it becomes known that the non-abusing parent could face prosecution for 'failure to protect', the child will be under intense pressure to retract statements. Further, as mentioned above, there is a real possibility of the non-abusive parent being removed from the family, leaving the child in the care of the State, or in the care of the perpetrator (if not convicted for the main offence). An offence of 'failure to protect' in relation to sexual abuse would undo significant work over recent years to support the non-abusing parent.

It is also inappropriate for these laws to apply to circumstances of 'serious injury'. As these laws place a positive obligation to act, they also expect a lay person to be able to determine the legal concept of what constitutes 'serious' injury. Further, the expectation that a person will know whether or not another person's conduct will result in 'serious injury' is highly onerous on the non-abusive parent.

11.2. The offence of 'failure to protect' should only apply where it is not possible to identify any person responsible for the death

The partner organisations submit that the scope of the proposed legislation should be limited only to circumstances where it is not possible to identify any person as being responsible for a child's death. The discussion paper clearly states that this is the issue the Government is attempting to address with this legislation. Limiting the scope in this way significantly reduces the potential for the unintended consequences outlined in section 5 of this submission.

11.3. The 'failure to protect' offence should not apply to an older sibling of the child, who is also likely to have been the victim of violence and abuse by the perpetrator

The partner organisations are concerned that older siblings of a deceased child may be exposed to a 'failure to protect' charge, if the class of persons to whom the proposed legislation applies is drafted broadly. An older sibling is likely to also be the victim of violence and abuse by the perpetrator. It is inappropriate that they might be exposed to a charge under the legislation. Any offence should make clear that the legislation does not apply to older siblings.

11.4. The prosecution should bear the onus of proving that the accused failed to protect the child from homicide (rather than the accused having to prove in defence that they took reasonable steps)

The partner organisations strongly submit that the onus would need to be on the prosecution to prove that the accused failed to protect the child from homicide (rather than the accused having to

[54] C Humphreys, "Child Sexual Assault Disclosure: Mothers in Crisis", PHD thesis (1991).
[55] Ibid.

prove in defence that they took reasonable steps). This safeguard acknowledges the reality of family violence and that it is common for victims of family violence (and therefore potential defendants) to be unaware of their legal options and have difficulties accessing legal resources.[56]

11.5. The concept of 'reasonable steps' needs to be clarified

The partner organisations have serious concerns about the actions a mother would be required to take before it could be said that she has protected her child. As outlined in section 6 above, the suggested 'reasonable steps' in paragraphs 60 – 62 of the discussion paper are irreconcilable with an in-depth understanding of the dynamics of family violence and the barriers to leaving and reporting. In circumstances of family violence it is not reasonable to simplistically expect the non-abusive parent to report the abuse or leave a violent relationship. Further, outside of the suggested 'reasonable steps' noted in the discussion paper, the concept of reasonable steps raises more questions than it answers. For example, if a mother has allowed the child to spend time with the father in compliance with Family Court Orders, despite her concerns that the child is at risk, would this be considered a failure to protect? Similarly, if a mother has reported abuse and DHS has not responded, has she 'failed to protect' the child? Appropriate clarity is needed within the legislation.

11.6. The 'failure to protect' offence would need to have in-built defences, including that the accused was a victim of family violence.

There should be various defences available to the charge, including an express legislative family violence defence.

'Failure to protect' laws in other jurisdictions contain as an element of the offence a consideration of the defendant's circumstances. Importantly, in South Australia the circumstances are considered subjectively rather than objectively.[57] The United Kingdom requires the prosecution to prove that "*the defendant failed to take such steps as he could reasonably have been expected to take to protect the victim from the risk*". A full understanding of the defendant's circumstances, including fear of retaliation, will define the reasonable steps in that scenario. The Northern Territory equivalent also includes an express defence of 'reasonable excuse', which is defined as including a reasonable belief of a threat to safety if a report is made.[58]

The partner organisations believe that any 'failure to protect' legislation in Victoria would need to go further. We believe that expressly providing a defence of victimisation from family violence would be necessary due to a well-documented history of gender bias of laws where violence against women is implicated, and the subsequent continued excusing of men's violence. This trend continues, despite legislative good intentions. By way of comparison, reviews of Victorian defensive

[56] VLRC report above n 18, 34.
[57] See section 14 *Criminal Law Consolidation Act 1935* (SA) under which a defendant can put the prosecution to proof on all elements of the offence, such as: whether the defendant had assumed responsibility for the victim (eg. siblings, family friends); whether the defendant took steps he or she could reasonably be expected to have taken in the circumstances; whether the defendant's conduct was so serious that a criminal penalty is warranted.
[58] Section 124A *Domestic and Family Violence Act 2007* (NT).

homicide laws have identified the need to tackle gender bias within criminal law and respond to concerns about inadequacies in the legal system's treatment of domestic homicides that occur in the context of family violence.[59] As with defensive homicide, we are concerned that any 'failure to protect' laws do not add to the injustices for women experiencing family violence. We, therefore, advocate that a strong 'safety net' would need to be introduced alongside any legislation which includes an express legislative family violence defence.

An express legislative family violence defence would need to include factors along the following lines:

- A family violence defence should apply where the accused believes that he or she needed to defend or prevent harm to themselves or another person, or the accused was under duress due to family violence.
- The defence should apply even if the harm or threat of harm is not immediate.
- Family violence should be defined broadly to include physical, sexual, and psychological abuse. The definition of family violence under s 9AH (4)-(5) of the *Crimes Act 1958* (Vic) could be adopted.
- Relevant evidence supporting the defence should also reflect the special family violence evidentiary provisions which s 9AH of the *Crimes Act 1958* (Vic) currently recognises in the context of homicide, namely:
    - the history of the relationship between the accused and the family member who is alleged to have used family violence against them or another family member;
    - the psychological effect of violence on people who are or have been in a relationship affected by family violence;
    - social or economic factors that impact on people who are or have been in a relationship affected by family violence;
    - the cumulative effect of the violence on the accused or another family member;
    - social, cultural or economic factors that impact on the accused or another family member affected by the family violence; and
    - the general nature and dynamics of relationships affected by family violence, including the possible consequences of the separation of the accused from the family violence perpetrator.[60]

[59] See Department of Justice Victoria, "Review of the offence of defensive homicide: Discussion paper", August 2010, 21; Victorian Law Reform Commission, *Defences to Homicide: Final Report* (2004).
[60] *Crimes Act 1958* (Vic) s 9AH. Inserted by *Crimes (Homicide) Act 2005* (Vic) which came into force on 23 November 2005.

11.7. The 'failure to protect' laws would need to include a requirement for consultation with the Secretary of the Department of Human Services before a prosecution can be initiated

Section 493 of the CYFA contains a necessary safeguard which requires police to consult with the Secretary of DHS prior to bringing proceedings. The partner organisations submit that this safeguard would need to be similarly applied to the proposed legislation if it is introduced. This safeguard would ensure that each case would be considered by someone with experience and understanding of the dynamics of family violence and the focus of any legislation would remain on preventing harm to children, rather than being purely punitive in nature.

11.8. Any introduction of 'failure to protect' laws would need to be accompanied by adequate training of those involved in the legal process

This express legislative safety net for victims of family violence would need to be supported by associated ongoing and comprehensive training of judges, the OPP, legal professionals and police, using information about the social context of family violence via such sources as the 'Family Violence Benchbook'[61] and the experience of advocates for women victims/survivors. This is necessary in order to provide the basis for developing a shared understanding across the continuum of responses in the justice system to family violence, including child homicide cases where family violence against the mother is involved. Training is also needed to ensure judicial expertise on the gendered realities of family violence and avoid judicial misunderstandings of the dynamics of family violence which has occurred in other jurisdictions, as adequately demonstrated in the case studies discussed above.

Protocols around handling family violence issues within the criminal courts would also need to be developed. There is a related need for more cooperation between law enforcement, the legal sector and family violence agencies, in recognition of the need for consistency in dealing with the continuum of family violence in various aspects of the civil and criminal justice process.

If 'failure to protect' legislation is introduced in the absence of such infrastructure, the justice system will fail to protect women and children by failing to recognise the complex impacts of family violence, legitimising abusers' perspectives of violence and blaming the victim. This process "*often leads to the further victimisation of those who look to the justice system for protection, and has been referred to as 'the cultural facilitation of violence'*".[62] It is directly contrary the Government's stated desire to reduce violence against vulnerable members of Victorian communities.

Proposals:

The proposed laws should not be enacted.

[61] Judicial College of Victoria (2010), accessed at www.justice.vic.gov.au/emanuals/FamilyViolenceBBWeb/default.htm.

[62] R Busch, "Don't Throw Bouquets at Me…(Judges) Will Say We're In Love: An analysis of New Zealand Judges' Attitudes Towards Domestic Violence", in J Stubbs (ed.), *Women, Male Violence and the Law*, (1994) 104–146, 105.

If the proposed laws are enacted, the laws would need to recognise the dynamics of family violence and only apply in limited circumstances to afford sufficient protection for those in family violence situations to avoid prosecution.

The laws would need to be accompanied with adequate training about the social context of family violence for those involved in the legal process.

Appendix 3B


The Honourable Robert Clark MP
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cc
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2 April 2014

Dear Attorney-General

Crimes Amendment (Protection of Children) Bill 2014

We are writing as a group of non-governmental organisations including peak bodies and statewide organisations that work in the area of family violence.

Our letter concerns the Crimes Amendment (Protection of Children) Bill 2014 ('the Bill'), introduced into Parliament on 26 March 2014, as part of the Government's response to the recommendations of the Parliament of Victoria Family and Development Committee Inquiry into the Handling of Child Abuse by Religious and Other Non-Government Organisations (the *Betrayal of Trust* Report).

We strongly support the vast majority of the Report's recommendations to strengthen the accountability of institutions for child abuse, and accordingly we welcome Clause 3 of the Bill which criminalises a failure by a person in authority to protect a child from a sexual offence.

However, we urge you to amend Clause 4 of the Bill. Clause 4 introduces a new criminal offence:

> *Failure to disclose a sexual offence committed against a child under the age of 16*.
>
> *...a person of or over the age of 18 years (whether in Victoria or elsewhere) who has information that leads the person to form a reasonable belief that a sexual offence has been committed in Victoria against a child under the age of 16 years by another person of or over the age of 18 years must disclose that information to a member of the police force of Victoria as soon as it is practicable to do so, unless the person has a reasonable excuse for not doing so.*

The offence is similar to a proposal from the Victorian Government in November 2010 to introduce a 'failure to protect' law which was intended to criminalise the behaviour of non-offending family members in child abuse cases. Many of our organisations jointly responded to the Department of Justice *Discussion Paper – 'Failure to Protect Laws'* in September 2011, and also wrote to you on 24 May 2012, and on 18 December 2013 following the release of the *Betrayal of Trust* recommendations, outlining why we oppose such a measure.

We do not support the introduction of Clause 4 in its present form, because we believe that it may inadvertently cause more harm to children suffering sexual abuse, and is potentially detrimental to women experiencing family violence.

The offence may cause more harm to children

In helping children to recover from abuse, it is widely accepted best practice that services should be resourced to work to support the non-abusing parent and assist them to enhance their child's safety. However, if the mother is incarcerated for 'failure to disclose' the abuse (see discussion below), the child may instead be left in the care of the State, or even in some instances with the perpetrator of the abuse.

In 2012, the report of the Protecting Victoria's Vulnerable Children Inquiry (the Cummins Report) found that the then proposed 'failure to protect' law could undermine the growing recognition of the complex dynamics of family violence and could be inconsistent with the recent reforms to the family violence system. Importantly, the Cummins Report suggested

that reforms addressing offender accountability 'may be waylaid by placing responsibility for abusive behavior on a non-abusive parent.'[1]

The Inquiry identified a range of risks and adverse consequences that could arise if such legislation was introduced. In particular, the Cummins Report expressed serious concerns that the law 'might have a dampening effect on help-seeking behaviour and the reporting of abuse'.[2]

It is therefore likely that Clause 4 will actually deter the reporting of abuse to child protection authorities, and so have the unintended consequences of driving the issue of child sexual abuse further underground and placing children at greater risk.

The offence will capture mothers who are victims of family violence

In its current form, the offence is so broad that it criminalises the behaviour of any person in the community who has a belief that a sexual offence has been committed against a child. In the context of a family violence situation, a mother who is a victim of family violence may be charged with this offence, on the basis that she knew of the sexual abuse and failed to disclose the information to police as soon as practicable.

Research clearly demonstrates the co-occurrence of child abuse with family violence. In Victoria, family violence is a factor in over half of substantiated child protection cases. Of the 15 child death cases reviewed in the 2013 Annual Report of Inquiries into the Deaths of Children known to Child Protection, family violence was a factor in 12 cases (80%). Given the co-occurrence of family violence and child abuse, there is therefore a high likelihood that the offence will capture mothers who are themselves victims.

Failure to protect laws do not adequately recognise the dynamics and complexities of family violence. In particular, they fail to take account of the powerful barriers to a woman leaving an abusive relationship or reporting the abuse against her and her children, including a fear of retribution.[3] There is evidence that women face greater scrutiny and higher expectations of their parenting than men.[4] The discriminatory impact is likely to be greater for women with disabilities, Aboriginal women and women from CALD communities, as they face additional barriers to disclosing abuse.

The Bill provides a defence if a person fears on 'reasonable grounds' for the safety of any person and the failure to disclose the information to police is a 'reasonable response' in the circumstances. However, this defence will not be adequate to protect vulnerable mothers, particularly given the requirement of 'reasonableness' in relation to their fear and response.

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[1] Report of the Protecting Victoria's Vulnerable Children Inquiry, 360.
[2] Ibid.
[3] Evan Stark, *Coercive Control: How Men Entrap Women in Personal Life* (Oxford University Press, New York, 2007).
[4] Jeanne Fugate, 'Who's Failing Whom? A Critical Look at Failure to Protect Laws' (2001) 76 *New York University Law Review* 272; Jonathan Herring, 'Familial Homicide, Failure to Protect and Domestic Violence: Who's the Victim?' [2007] *Criminal Law Review* 923; Julia Tolmie, 'Criminalising Failure to Protect' (2011) *New Zealand Law Journal* December 375.

'Reasonableness' is likely to be interpreted in a way that imposes unrealistic or unsafe expectations on such women.

Case law in other jurisdictions shows that failure to protect laws do not adequately recognise the dynamics of family violence, and are almost exclusively used against women who are themselves victims.[5] Although the following United States case studies concern failure to protect laws with a broader scope than envisaged by Clause 4, we believe that similar dynamics are likely to result in Victoria if the Bill is enacted in its current form.

> CASE STUDY 1: *Campbell v State* (2000) (Wyoming)
>
> Casey Campbell, the mother of a four-year-old girl, was convicted of felony child endangerment in March 2000 and sentenced to prison. She had been at work and not in a position to prevent the abuse when her partner, Floid Boyer, severely burnt her daughter causing second and third degree burns over eighteen percent of her body.
>
> When Campbell returned from work, she saw that her daughter was injured, but she did not immediately seek medical attention for the child as she was afraid of her partner. Campbell testified that she had been abused by Boyer since she was 16, and that he had previously violently assaulted her with knives and guns. Campbell, on appeal, contended that her years of abuse established evidence of her belief of an imminent danger of death or great bodily harm if she refused Boyer's demands to spend the evening with him, instead of taking her daughter to the hospital. Campbell sought medical attention for the child 8 hours later. Campbell's appeal was refused and her sentence was affirmed. Boyer, however, was only convicted for a misdemeanour.
>
> CASE STUDY 2: *State v Williams* (1983) (New Mexico)
>
> A New Mexico court convicted Jeanette Williams of child abuse for failing to protect her four-year-old daughter from her husband's abuse.
>
> On appeal, Williams argued that because she was 5 months pregnant at the time, beaten by her husband and threatened by him, she could do nothing to prevent the beating of her daughter. The Appellate Court, however, affirmed the conviction and found that given the finding of repeated beatings, a reasonable inference could be drawn that the defendant's failure to remove her child from the situation, or failure to seek help at the time of the incident, was a proximate cause of the child's injuries.

While it is possible to argue that the cases above might meet the 'reasonableness' test for the defence under Clause 4 of the Bill, there are other family violence situations where the perpetrator's tactics of entrapment are more multi-faceted and subtle. It then becomes harder to explain to a court how her partner's coercive controlling tactics undermine a mother's parenting capacity, and her sense of confidence, capacity and judgment, to such an extent that even when he is not threatening her and has not used overt tactics of violence against her recently, she is still far too constrained to be able to report the abuse of her child.

By creating the willingness to prosecute non-offending parents, this provision will undermine the strong work of the Victorian government in holding family violence perpetrators accountable for the considerable harm they cause to children and women. Such work requires child protection, family services and other practitioners to make perpetrators more visible in their casework, and to emphasise community-based, civil and criminal justice system approaches that hold them accountable for their use of sexual and other forms of violence. It will create an extremely confusing message to practitioners, community services and the community, if the Victorian government fosters the willingness to prosecute family violence victims at the same time as attempting to increase its focus on perpetrators.

[5] Ibid.

By creating a broad 'catch all' criminal offence that may result in charging a vulnerable victim, Clause 4 also places the onus on those victims to raise a defence in a criminal prosecution. This approach is again inconsistent with the emphasis of Victoria's family violence reforms on ensuring that the perpetrator, not the victim, bears the responsibility for the violence.

Amendments to the offence

We believe that the better public policy approach is to create a narrow criminal offence that does not also capture vulnerable victims. The offence should be limited to a failure to disclose by a person in authority within a relevant organisation as defined in the Bill (see Clause 3). This would be consistent with Recommendation 47 of the Cummins Inquiry. Amending Clause 4 to specify that, as with Clause 3, the offence is intended to target only organisations and those in positions of authority within them, would also be consistent with the Terms of Reference of the *Betrayal of Trust* Inquiry.

Clause 4 could be redrafted as follows:

> *Failure by a person in authority to disclose a sexual offence committed against a child under the age of 16.*
>
> *...a person ~~of or over the age of 18 years (whether in Victoria or elsewhere~~) in authority in a relevant organisation who has information that leads the person to form a reasonable belief that a sexual offence has been committed in Victoria against a child under the age of 16 years by another person of or over the age of 18 years must disclose that information to a member of the police force of Victoria as soon as it is practicable to do so, unless the person has a reasonable excuse for not doing so.*

We seek a meeting with you at the earliest opportunity to discuss these issues further.

Yours sincerely

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Federation of Community Legal Centres (Vic)
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Appendix 4A

NGO alliance response to Department of Justice re the proposal to streamline the Family Violence Intervention Order system

September 2013

Signatories to this joint submission are:

- **Federation of Community Legal Centres**
- **Domestic Violence Resource Centre**
- **Women's Legal Service Victoria**
- **Domestic Violence Victoria**
- **No To Violence**
- **Women with Disabilities Victoria**
- **Aboriginal Family Violence Legal and Prevention Service**
- **In Touch Multicultural Centre against Family Violence**
- **Council to Homeless Persons**

Context

In considering the Department of Justice proposal to streamline the Family Violence Intervention Order system, our organisations were concerned to examine the proposal in light of the history of family violence systems reform over the past 11 years, and the current context in Victoria.

Victoria has undergone system-wide reform of responses to family violence in that time, and the *Family Violence Protection Act 2008* was introduced as a central element of that integrated approach. This legislation was developed after extensive consultation through the Victorian Law Reform Commission with sector agencies, government and the Statewide Steering Committee to Reduce Family Violence. Since it was enacted, the Act has been regarded as leading the nation in terms of the legal protections offered and its purpose, which is to prevent and reduce family violence, prioritise the safety of victims, and hold perpetrators accountable for their use of violence.

An important element of the reforms is implementation of system-wide processes for risk identification and achieving safety. While there has been much work undertaken to embed common risk assessment and management across the family violence system, there remains a significant challenge, especially within the criminal justice system, to establish risk and safety awareness across the broad range of professionals who routinely come into contact with women and children experiencing, or men using, family violence.

We acknowledge that the huge increase in reporting of family violence in Victoria over the past five years has led to a corresponding blowout in demand for services across the board, including within Magistrates' Courts with applications for family violence intervention orders. The likelihood of this rise in demand was identified early in the process of reform of the family violence system. In fact, it was anticipated by those agencies dealing most closely with family violence cases that such an increase in reporting rates would be a natural consequence of systems improvements and an indication of greater victim confidence in the State's capacity to respond to the rates of family violence in our communities.

Victoria's Action Plan to Address Violence against Women & Children, released in October 2012, recognises the work that has been done to date in reforming Victoria's response system, and details the Coalition Government's 'commit[ment] to preventing violence happening, holding perpetrators to account for their actions and making sure we are supporting those women and children who experience violence'. [1]

Rise in demand is a game changing opportunity

Rather than see the rise in demand as a problem to be managed by taking shortcuts, we believe it offers a valuable opportunity to review what is working, where the gaps are, and to identify ways that we might tighten the 'web of accountability' around perpetrators of family violence. The Department's proposal fails to do this.

[1] *Victoria's Action Plan to Address Violence against Women & Children*, Victorian Government, Melbourne, October 2012.

We believe that the proposal will undermine the safety of victims and weaken the accountability of perpetrators. We are also concerned that this proposal to 'streamline' the intervention order system is happening at the same time as the Department is engaged, via the Violence against Women and Children Forum, in a conversation with key stakeholders in the family violence field about measures to improve accountability of perpetrators. We support many of the points outlined in No To Violence's submission on this second and related issue, and we believe that the two feedback processes are at odds with one another.

Consultation Process

Since 2012, members of the Department of Justice Family Violence Stakeholder Advisory Group have been participating in strategic discussion about how to address the significant increase in demand on the court system. Concerns about introducing measures to dampen demand that could compromise victim safety and perpetrator accountability have been raised at various junctures. The signatories to this submission believe that the current set of proposed changes does not reflect the advice provided by members of the Stakeholder Advisory Group over the past 12 months.

Last week non-government members of the Stakeholder Advisory Group were, without prior notice, given eight days to consult with our respective constituencies and provide written feedback to the Department on the current set of proposed changes. While we appreciate the tight internal timeframes within Government, this consultation period is manifestly inadequate to enable the family violence sector to consider the possible implications of these changes. Being part of an integrated system means that where efficiencies are made in one part of the system this will have bearing on other parts of the system – and so changes to court processes will invariably impact on other stakeholders in the integrated system. We raise concerns later in this submission about the potential unresourced impost on community–based agencies of applicants and respondents having less contact with court-based services. It is critical that planning for such changes to the system occurs with the participation of all relevant stakeholders, and with sufficient time to consider the potential system-wide implications.

Proposal to expedite matters in the court system – self-executing interim orders and determination of FVIO applications on the papers

We and many other stakeholders did not support a previous proposal for self-executing interim orders that was canvassed at the Department of Justice Family Violence Stakeholders meeting in October 2012. Many of our comments below also apply to the proposal to determine some family violence intervention order applications on the papers.

Victim safety and perpetrator accountability

As we communicated in October 2012, we are extremely concerned that if self-executing orders are introduced, opportunities to enhance consistency, monitor compliance, and ensure the undertaking of sound risk assessment and risk management processes, will be missed. Under the current system, affected family members (AFMs) generally obtain interim family violence intervention orders

without accessing legal advice/advocacy. The applicant or AFM (if Police are the applicant) returns to court to obtain a final intervention order, at which stage the AFM and respondent are able to access legal advice via the duty lawyer system.

A general lack of availability of legal assistance at the interim stage and the urgent nature of the matter means that all important long-term conditions and mandatory considerations are not necessarily addressed in the interim order, but instead end up being more fully tailored for victim safety and perpetrator accountability when the final order is made.

When the matter returns for a mention hearing, aspects of the context will often have changed and the victim has had more time to consider her needs. Once a victim has obtained legal advice, lawyers can communicate to the court any risks and raise any mandatory considerations under the Act. This may mean that, for example, children are added to the order, the respondent is excluded from the home, the interrelationship with *Family Law Act* orders is considered and safe arrangements are made for the victim and perpetrator to retrieve property.

Magistrates' best practice at the final stage also entails holding the perpetrator to account in open court, explaining the nature and impact of family violence and warning of penalties for breaches. The opportunity to hear consistent messages directly from the Magistrate about the seriousness of the respondent's use of violence, and the scope and detail of the order, can have a significant impact on both the AFM and the respondent. We know that many respondents, as well as AFMs, have trouble understanding the conditions of an Intervention Orders for a range of reasons. At this time, those Magistrates' Courts with court- or otherwise-funded additional services, such as Applicant Support and Respondent Workers, can link in both parties with appropriate assistance, such as housing support and referrals to Men's Behaviour Change programs; and where appropriate, make perpetrator attendance and compliance a condition of the order. The role of the Magistrate in imparting consistent and definitive messages about the unacceptability of family violence to both parties should not be underestimated.

A respondent who receives a notice of an interim order or application and ignores it, or decides not to challenge it, is far less likely to take the order seriously. Indeed, the option for respondents of cutting out court altogether, as would be the case with an application on the papers or a self-executing interim order where the respondent did not attend court for the interim hearing, sends the message that family violence is more akin to a parking ticket. It is also possible that receiving written notification and not understanding the process could place respondents at risk of committing further violence out of resentment towards the AFM.

Other differences between interim and final orders

It is also unclear from the proposal how a self-executing process will be able to take into account the fact that there is a different test for an interim order compared to a final order.

Impact on opportunities to negotiate final orders by consent

One of the present boosts to court efficiency is the proportion of final orders that can be negotiated by consent without admissions, due to both parties having access at court to legal advice at mention hearings and directions hearing.

We are concerned that if a final order is made and the respondent has not had the opportunity to attend court, the respondent is more likely to apply for a re-hearing. Ultimately, this may lead to an increased work load for the court in determining re-hearing applications and having the matter re-heard in the family violence list.

It is important to note that the process of applying for a re-hearing and the re-hearing itself will operate to prolong the difficulty and trauma for victims in obtaining protection in the family violence jurisdiction. This is counter-productive to the intent of these amendments.

Judicial discretion

The proposal suggests retaining judicial discretion in deciding which orders should become self-executing.

We do not believe that this would be an effective safety net, because Magistrates vary in terms of their awareness and application of risk assessment and risk management understandings, particularly if they do not have the benefit of considering legal advocates' arguments. Workload demands will add to this in influencing many Magistrates to make an interim order self-executing. For example, while in theory the proposal suggests that if a Magistrate decides that a counselling order is appropriate he or she can direct that a matter return to Court for final determination, in practice this relies on the Magistrate identifying the need and appropriateness of a counselling order at the interim stage. As outlined above, an interim hearing is less likely to provide all the evidence and considerations for this decision to be made.

We also believe that it poses challenges for Magistrates in that a final order is, effectively, determined on the limited evidence that may be available at the time an interim is made. Given the urgency of applications and interim order hearings, the decision-making process may be limited by the evidence available at the time.

For applications where no interim has been made, a determination on the papers will be based solely on the initial application made to the court. The quality of the information in these applications vary significantly. The information in the applications may not capture the whole story of family violence. It may be the case that victims do not understand the different ways in which they have experienced family violence until they speak to a duty lawyer who can assist them in identifying what acts in their personal circumstances fall within the definition of family violence. This can then be presented to the court. The minimal evidence available to Magistrates may result in a minimal number of orders being made.

The function of the courts in the integrated response

The proposal significantly unravels a key element in the integrated response, which took many years and substantial stakeholder consultation to develop. The fact that at present a significant number of family violence respondents do not attend court should not be used to justify a model in which, in effect, the courts partly resile from their role of providing judicial oversight. This approach would not be acceptable in relation to other issues that cause trauma and death, such as drink driving. As previously noted, promotion of accountability of perpetrators for their actions is a fundamental

purpose of the *Family Violence Protection Act*, and non-attendance should and can be addressed, via for example, increased issue of warrants for respondent attendance under s 50(1)(d) of the Act.

One of the reform areas that is particularly hard won in relation to family violence concerns the relationship between state-based Magistrates' Courts and the *Family Law Act*. In a child contact case where a woman is trying to protect her children from their violent father, a final family violence intervention order carries more persuasive force than an interim family violence order. It is difficult to see how an interim order that has self-executed, with interim orders subject to a different test than for granting a final order, will carry the same weight with Family Court judges, further undermining the authority that state-issued Family Violence Intervention Orders carry in the Family Court

Impact on access to justice and legal services for the disadvantaged

Pursuing the above analogy with parking tickets, legal services and financial counsellors are well aware of clients who never open their infringement notices or who are illiterate or cannot understand English well. This may lead to further reliance on family members to translate an order, including using the AFM or child as interpreter, which clearly carries significant risk. Appearance in court at proceedings for a final family violence intervention order at least offers an opportunity for lawyers, magistrates and interpreters to explain the process to respondents and applicants who may be Aboriginal, from a CALD background or have a cognitive disability.

The proposal is silent on the practicalities of how and where AFMs and respondents will access legal advice in order (for the AFM) to ensure that the order sought is the safest and most appropriate and to respond to any challenge by the respondent, and (for the respondent) to decide whether and how to challenge the application or self-executing interim order.

Given that community legal services would still be providing duty lawyer assistance for those matters that Magistrates deem should not entail self-executing orders, together with variation and revocation matters, it appears that any ostensible 'gain' in reducing court demand will be shifted as a burden to legal services, without commensurate funding.

Addressing demand

We have outlined our arguments about why we do not think that the self-executing orders proposal will deliver more *effective* responses for AFMs. We are also not convinced that the proposal will necessarily deliver more *efficient* responses. In terms of overall system efficiency, the costs of unaddressed family violence to Victorian society are now well known. However, even at the level of court demand, the efficiency benefits of the proposal are exaggerated.

For example, we discuss above the possibility that where an interim order is challenged it will more likely result in a contest than consent without admissions. It also seems likely that self-executing orders and determination of applications on the papers will result in more work for Court Registries. Respondents who fail to challenge may end up more often than now applying for revocation or variations, and may have legitimate arguments concerning the procedural fairness of decisions made on the papers or by notice.

Identifying the Primary Aggressor

It is not uncommon to hear cases of orders made against women who are in fact victims of family violence themselves. Accusing a victim of using violence is a common perpetrator tactic, and Police either erroneously identifying victims as perpetrators or taking out orders against both parties is a practice that persists across the state (particularly in rural and regional areas). We are concerned that the proposal to expedite the application process and the chance that there may not be further judicial investigation could facilitate perpetrators using this intimidation tactic against their family member. The implications for the victim are significant, especially where such orders might be used as evidence in Family Law matters.

Proposal to expand the Family Violence Safety Notice system

Reducing court demand

We fail to see how empowering Police to issue Family Violence Safety Notices (FVSNs) at any time and extending the period of FVSN validity past 120 hours will significantly reduce court demand. It is only recently (4 February 2013) that the period of validity for FVSNs was extended from 72 to 120 hours, with even this extension not supported by most family violence stakeholders in 2011 consultations.

Access to legal assistance and other services

The argument that extension of the time period past 5 days will allow respondents and AFMs to prepare and access legal advice and support services is also unconvincing. At present, Police at different Magistrates' Courts and individual Police personnel vary in terms of how regularly and in what manner they inform respondents and AFMs of their right to legal advice. In some courts and with some Police personnel this system of referral works well, but this is also because the AFM or respondent is at court and can access the legal or other service on the spot.

As with the self-executing orders proposal discussed above, if the period of a safety notice is extended and therefore the matter is listed at a later date, it is likely that services will see more AFMs and respondents out of court, but then will need to see them again at court as circumstances and the Police case may have changed, therefore adding to those services' workload without additional resources.

Use of FVSNs 24/7

The proposal's argument that allowing FVSNs to be issued 24/7 'would give police the full suite of options' is not consistent with Victoria's integrated response to family violence. As with self-executing orders, the key contribution of the courts to ensuring victim safety and perpetrator accountability would be reduced if Police can choose to issue a FVSN at any time instead of going through the courts. If this were to be combined with an even greater period for FVSNs, we would have grave concerns about the expansion of extra-judicial power, particularly given the nature of conditions that can be attached to a safety notice.

One of the core rationales for introducing FVSNs was a cited inability of the Magistrates' Court After Hours Service to process Complaints & Warrants (as they were then called) in a timely manner. Because the FVSN system was initially a pilot subject to sunsetting, it was evaluated in 2010.[2] While the Evaluation found that the pilot was meeting its objectives to a reasonable extent, it concluded that a number of further actions were required. These actions centred on improving the use of FVSNs as an *after hours* response, particularly with regard to the safety of AFMs.

The Evaluation was limited to some extent by the available data on which to base its conclusions, and so, for example, did not make a full comparison between the effectiveness of Application & Warrants and FVSNs, and contained only incomplete analysis of differing patterns of police action in different regions (eg some regions tend not to prefer to use FVSNs as much as others). Nevertheless, there was never any suggestion that the use of FVSNs should be expanded to during court hours. The Justice Legislation (Family Violence and Other Matters) Bill 2012, amending the *Family Violence Protection Act* to increase the FVSN period from 72 to 120 hours, also emphasised that the purpose was to enhance access to protection for victims of family violence and their children outside of court hours.[3]

As the Statement of Compatibility for the Bill outlined in its conclusion that the associated restrictions on human rights were justified:

> 'Any limitations on freedom of movement and protection of families and children are for the important purpose of ensuring the safety of the protected person. They are both rational and proportionate, noting that police may only issue an FVSN after hours in circumstances that require an urgent response. Further, FVSNs only operate for a limited duration and are subject to the supervision of the courts.'[4]

Alternative solutions

Rather than ostensibly providing the Police with more time to prepare, we believe that what is needed is Police training in relation to the quality of Family Violence Safety Notices and with regard to preparation for the final determination hearing. Police could also help to address the issue of some respondents failing to attend court by proceeding more often via Application & Warrant.

If the proposal is implemented

We reiterate our strong opposition to both arms of the proposal. Nevertheless, should the proposal be implemented, the following strategies will be essential:

1. The *Family Violence Protection Act* should include mandatory considerations with a focus on risk assessment and management, in order to guide Magistrates as to whether or not an order should be made self-executing.

[2] *Family Violence Safety Notice Evaluation Final Report*, Thomson Goodall Associates (August 2010).
[3] Justice Legislation (Family Violence and Other Matters) Bill 2012 Second Reading Speech, Victoria, *Parliamentary Debates*, Legislative Assembly, 15 November 2012 (Robert Clark, Attorney-General) 5077.
[4] Statement of Compatibility, Victoria, *Parliamentary Debates*, Legislative Assembly, 15 November 2012 (Robert Clark, Attorney-General) 5074-5.

2. Where due to expiry of the time period, a Family Violence Safety Notice has resulted in an interim family violence intervention order, the Police application for a final order must be heard by a Magistrate.

3. Funding should be substantially increased to community legal services and family violence services in order to address anticipated increased out-of-court demand for assistance from AFMs and respondents.

4. Self-executing orders must only be served personally.

5. Failure of respondents to appear at court must be addressed eg by Police proceeding more often by Application & Warrant, and Magistrates and appropriate Registrars issuing more warrants under s 50(1)(d) of the *Family Violence Protection Act*.

6. Inconsistent rates of Police referring parties for legal advice at court must be addressed via the development of protocols between Police, legal services and Courts.

7. If family violence intervention order applications are determined on the papers, Magistrates' Courts must ensure that the AFM is aware of the process and why they are not required to come to court.

8. If a final order is made on the papers or as the result of a self-executing interim order, there must be personal service on the AFM as well as the respondent, so that the victim is aware that the matter has resolved.

9. Legislation implementing the proposal must include an appropriate sunset clause, and be subject to an adequately funded, independent, detailed evaluation.

Appendix 4B