ADVOCATING FOR BEST PRACTICE
The New South Wales Experience
THE CAMPAIGN BEGINS….2006

MOLLY is just eight years old. Some time before 2am on a humid January night, she ran more than half a kilometre from her home in Hosking Crescent, Glenfield, past open parklands and into a darkened street nearby.

When a family friend, Wayne Smith, opened the door she screamed that her mum had told her to run, to run for her life.

Inside the fibro townhouse Molly shared with her mother, Adele Lynch, baby brother Mason and Aaron Reed - her mother's new boyfriend - a noisy and violent fight had been escalating for more than three hours.

“Too Late for Molly, but there must be answers” Sydney Morning Herald
Feb 27th 2006
10,000 POSTCARDS

How many more women will be murdered?

Women’s Safety : Not Negotiable
Domestic violence related deaths of women in NSW are preventable.

In the event of a worker's death at a building site, the site is closed off, Work Cover begins their investigation to find out:

- What happened?
- Who was there when it happened?
- Were regular risk assessments conducted?

There is a commitment to identify what gaps there are in the system and what improvements can be made for worker safety so that future similar deaths are prevented and rightly so.

We ask....
Why are the domestic violence related deaths of women in New South Wales treated differently?

SAY 'NO' TO DOMESTIC VIOLENCE
NSW DOMESTIC VIOLENCE DEATH REVIEW TEAM

- Established from recommendations of Domestic Violence Homicide Advisory Panel (2009)
- Identified functions
  - Review individual deaths
  - Identify trends and patterns
  - Establish & maintain a comprehensive data base
  - Conduct research
  - Identify best practice guidelines for agencies
  - Educate community and professionals
  - Provide a publicly available report with findings and recommendations
CORE FUNCTIONS

- Reduce the incidence of domestic violence deaths and facilitate improvements to systems and services

- Learning through understanding the contributing factors & identifying system gaps and responses
MEMBERSHIP

- Underpinned by a legislative framework
- Multi agency team 15 members in total, government representatives by Ministerial appointment
  - Police
  - Health
  - Human Services
  - Dept. Education & Training
  - Dept. Housing
  - Dept. Justice & Attorney General
  - Dept. Premier & Cabinet
  - Community Services
  - Aboriginal Affairs
  - Juvenile Justice
  - Ageing Disability & Home Care
  - 2 non government service providers
  - 2 persons deemed to hold appropriate expertise
REVIEW PROCESS

- Closed cases
- In depth review
  - Team provided with information of each case
  - Additional agencies identified
  - Requests for information made
- Risk factors of each case noted
- Systems reviewed
- Drafting of recommendations
SO FAR......

- Team has met 6 times since March 2011
  - Conducted 20 in-depth case reviews

- 2011-12 Annual Report will include case summaries and recommendations in relation to 16 identified domestic violence deaths in NSW between March 2008-June 2009
DATABASE

- Comprehensive & captures range of information from deaths occurring in NSW from 1 July 2000
  - Deceased/perpetrator demographic information
    - Employment
    - Criminal history
    - Substance abuse
    - Psychiatric history
  - Deceased/perpetrator relationship details
  - Domestic violence history – history of court orders
  - Details surrounding the killing/s
    - Manner of death
    - Weapon
    - Child witnesses
    - Location
DATABASE CON’T

- Deceased/perpetrator service contact history in 6 months and 12 months prior to the killing
  - Includes 30 different government and non-government services providers

- Risk factors identifiable between deceased/perpetrator or other related parties
  - Includes 25 specific risk factors

- 2011-2012 Annual Report will include data analysis for all homicides occurring between 1 July 200-30 June 2009
BEST PRACTICE PRINCIPLES FOR AN EFFECTIVE MODEL

• **Team Membership**
  - Multi disciplinary
  - Multi agency
  - Diverse
  - Inclusive

• **Statutory protections in place**
  - Confidentiality
  - Compulsion to provide information, files, evidence, immunity from prosecution
• Creates time line of events
  • Conveys sense of movement
  • Identifies barriers and challenges faced by victim/offender

• Accountability
  • Recommendations coupled with reporting mechanism including follow up
  • Report is publicly available
Accurate data collection
Generates research
  - Builds on learnings
  - Contributes to a growing body of evidence
Interdisciplinary dialogue
  - Development of best practice
Informs & stimulates education, community awareness initiatives
Their deaths are not unpredictable, isolated events without context or warning. Most of the victims whose murders we discuss in this report reached out for help. They planned with friends, family, and co-workers. They went to therapists, attorneys, and health care providers. They called police. They went to court. They worked with domestic violence advocates. They stayed in shelter. They struggled to be mothers and friends and students and employees and volunteers and to contribute to their communities in the face of terrible violence from someone close to them…

“Now that We Know” Recommendations from Washington State Domestic Violence Fatality Review December 2008