CONSULTATION

BACKGROUND

The ACT Government is committed to introducing a family violence death review (**FVDR**) scheme for the ACT. The aim of an FVDR scheme is to analyse information relating to specific family violence deaths and make recommendations for system-wide improvements to services to help prevent similar deaths occurring in the future.

Domestic and family violence claims the lives of more than 100 people in Australia every year and causes enduring damage to individuals and society. Violence against women and their children costs Australia $22 billion each year.[1] This figure is spread across our society and economy, and includes health costs, pain and suffering, loss of productivity due to absences from work, and law enforcement and court system costs.

Family violence deaths are not isolated incidents. Trends in these deaths and in service responses can be used to inform decision-makers about where to target resources. They also show where changes to policy, law or practices are required or have had an impact.

The first and only ACT Family Violence Death Review was published in May 2016.[2] It summarised key issues and themes from an analysis of 14 deaths which occurred in a family violence context in the ACT between 1 June 2000 and 30 June 2012. The ACT Family Violence Death Review provided 28 recommendations for action. These included the recommendation that the ACT establish a legislative mechanism for future death reviews to be undertaken, including the power to consider deaths such as suicides of both family violence victims and perpetrators and the accidental deaths of family violence victims.

In 2016, the Government published the ACT Government Response to Family Violence which included a commitment to legislate for a future FVDR and provide powers for those undertaking such a review.

FAMILY VIOLENCE DEATH REVIEW IN AUSTRALIA

The functions of FVDR teams are to:

- identify family violence deaths
- maintain a database on family violence deaths
- conduct in-depth case reviews of individual deaths

[1] KPMG, 2016, The Cost of Violence against Women and their Children in Australia, Department of Social Services, Australian Government: https://www.dss.gov.au/sites/default/files/documents/08_2016/the_cost_of_violence_against_women_and_their_children_in_australia_-_final_report_may_2016.pdf (accessed 22 January 2018).

[2] Domestic Violence Prevention Council, 2016, Findings and Recommendations from the Review of Domestic and Family Violence Deaths in the Australian Capital Territory, Public Report: http://www.cmd.act.gov.au/__data/assets/pdf_file/0003/864714/DVPC-Review-of-Domestic-and-Family-Violence-Deaths.pdf (accessed 13 November 2018).

- obtain information from agencies
- develop and monitor recommendations for systemic change
- conduct research on family violence issues, and
- prepare reports on key cases and findings.

All jurisdictions, except Tasmania and the ACT, have an FVDR function. There is no one-size-fits-all model for death review, and Australian FVDR teams vary in their structure, mandate, resources and history. A table comparing the FVDR schemes of each jurisdiction is at Attachment A.

The Australian Domestic and Family Violence Death Review Network (the National Network) brings together representatives from all Australian FVDR teams and aims to establish national consistency for case identification, data collection and reporting in order to investigate cross-jurisdictional system failures and improve strategies for community safety at the federal level. The National Network has developed a set of protocols and guiding principles which underpin effective functioning of the FVDR process. A summary of the guiding principles is at Attachment B.

PROPOSED MODELS

The Justice and Community Safety Directorate (JACS) has developed two draft models for an ACT FVDR scheme, and a proposed framework for information sharing between family violence-related entities and those responsible for FVDR. The models were developed based on analysis of models in other jurisdictions and the National Network's guiding principles for FVDR. In particular, JACS has focused on the importance of timely information sharing, independence in conducting reviews and reporting, national consistency, and privacy protections for individuals and families involved in reviews.

The draft models focus on the structural components of FVDR, including:

- composition and functions of an FVDR team
- location of an FVDR team, timing of data collection and information sharing, types of cases and deaths reviewed, use of a database and case reviews, and
- requirements for reporting and confidentiality.

The draft models are similar across a number of components. A key difference in the models is the timing of data collection and sharing, which has implications for access to information and the process and timing of case reviews. The two draft models are set out in detail, including a comparative analysis of models, at Attachment C.

Establishing a clear legislative framework for information sharing between family violence entities will be key for an effective FVDR process. The proposed information sharing framework is provided at Attachment D.

Possible intersections between an FVDR process and the ACT Children and Young People Death Review Committee will be explored as part of implementation following consideration of feedback from this current consultation process.

CONSULTATION

JACS is seeking feedback on the two draft models and information sharing framework from the community, family violence organisations, and other interested stakeholders.

SEND US YOUR FEEDBACK

Please send your feedback to:

Email: JACSLPP@act.gov.au

Post: Family Violence Death Review Draft Models – Submissions
Legislation, Policy and Programs
Justice and Community Safety Directorate
ACT Government
GPO Box 158
Canberra ACT 2601

Submissions must be received by close of business on **31 January 2019**. All submissions and comments will be treated as public, and may be published, unless the author indicates that it is to be treated as confidential. All requests for submission to be treated confidentially will be respected and dealt with in accordance with any applicable laws, including freedom of information legislation.

ATTACHMENTS

Attachment A	Jurisdictional comparison of FVDR in Australia
Attachment B	National guiding principles for FVDR
Attachment C	Draft FVDR models
Attachment D	Proposed information sharing framework

Family Violence Death Review (FVDR) Draft Models for the ACT

ATTACHMENT A: Jurisdictional comparison of family violence death review in Australia[3]

	NSW	QLD	VIC	SA	WA	NT
Structure and function of death review teams						
Death review team	Secretariat and the Domestic Violence Death Review Team (**DVDRT**).	The Domestic and Family Violence Death Review Unit (**the Unit**); and the Domestic and Family Violence Death Review and Advisory Board (**the Advisory Board**).	The Victorian Systemic Review of Domestic Violence Deaths (**VSRFVD**) (supported by a Reference Group).	The Senior Research Officer (Domestic Violence) (**SRO**).	The family and domestic violence fatality review team.	Research Officer (Family Violence)
Statutory basis for death review team	The DVDRT is established under section 101D of the *Coroners Act 2009* (NSW).	The Unit is not established under the *Coroners Act 2003* (Qld), but operates within the Coroner's office. The Advisory Board is established under section 91C of the *Coroners Act 2003* (Qld).	The VSRFVD is established under section 102U of the *Coroners Act 2008* (Vic).	The function is not established under the *Coroners Act 2003* (SA), but is carried out under the Coroner's mandate.	This function is carried out under the WA Ombudsman's mandate under the *Parliamentary Commissioner Act 1971* (WA) and *Royal Commissioners Act 1968* (WA).	The function is not established under the *Coroners Act 1993* (NT), but is carried out under the Coroner's mandate.
Body under which the death review team sits	The DVDRT is an agency within the NSW Department of Justice.	The Unit sits within the Coroners Court. The Advisory Board is an independent body.	The VSRFVD sits within the Coroner's Court.	The SRO is funded through the Office for Women and is part of the Coronial	The Office of the Ombudsman.	The Research Officer (Family Violence) sits within the Coroner's Office.

[3] Tasmania and the ACT do not have family violence death review functions. Most of the information provided in this document was obtained from: the Australian Human Rights Commission Report 'A National System for Domestic and Family Violence Death Review', December 2016. Online at https://www.humanrights.gov.au/sites/default/files/document/publication/AHRC_2016_12_19_Expanding_DV_Death_Review.pdf; and 'Australian Domestic and Family Violence Death Review Network 2018 Data Report', May 2018: Online at http://apo.org.au/system/files/174811/apo-nid174811-789371.pdf

	NSW	QLD	VIC	SA	WA	NT
				investigation team in the Coroners Court.		
Staffing model	Secretariat: 1 Manager and 1 Research Analyst. DVDRT consists of between 15 and 19 members.	The Unit consists of 1 full time Manager; 1 Principal Researcher and Coordinator; 2 Advisors; 2 Administrative Staff. The Advisory Board has a chairperson and at least 11 other persons appointed by the Minister.	1 part-time Manager; 1 full-time Project Officer; 1 part-time Solicitor; and 2 part-time investigators.	1 full-time SRO, supported by the Office for Women and the Coroner's Court.	1 Assistant Ombudsman; 1 Director; 1 Principal Aboriginal Liaison Officer; and Investigating Officers.	1 full-time Research Officer (Family Violence).
Support from experts in domestic violence and policy	DVDRT membership includes Commissioner of Victims' Rights, non-government service providers, an Aboriginal or Torres Strait Islander person, DV experts, police, and representatives from Government departments in policy, health, education, community services, justice.	Membership of the Advisory Board: • reflects diversity of the community • includes government and non-government representatives, and • includes members with relevant experience, knowledge or skills.	The VSRFVD is supported by a reference group, consisting of members from Koori family violence services, legal services, police, the Magistrates' Court, culturally and linguistically diverse services, disability, health and welfare organisations, academics and policy analysts.	The SRO, through membership of relevant government committees, is able to access expert advice from relevant government agencies and through reporting arrangements to the Chief Executives Group of the South Australian Office for Women.	The Ombudsman's Advisory Panel provides independent advice on: issues and trends relating to the death review function; professional practice relating to DV impacted persons; and issues that impact on relevant public authorities.	Information n/a
Core functions of death review team	Secretariat: • assists Coroners in reviewing coronial cases to help Coroners understand DV issues, and • prepares case review reports for the DVDRT,	The Unit assists Coroners in understanding the context and circumstances of individual DV deaths; • maintains a dataset of DV homicides and suicides;	The VSRFVD has five main aims: • examine the context in which family violence-related deaths occur • identify risk and contributory factors	Core functions of the SRO are to: • identify DV deaths; • assist investigations of system responses and interagency approaches related to DV deaths;	The Ombudsman's functions in relation to DV death review are to: • review circumstances in which and why DV deaths occur;	Research Officer (Family Violence): • assists open coronial investigations of DV deaths by examining the context in which DV

	NSW	QLD	VIC	SA	WA	NT
	which include victim/perpetrator profiles, event chronologies, relationship history, details of the death, any criminal justice outcomes, and service contact and response history. DVDRT: • reviews closed cases of DV deaths • analyses data to identify patterns and trends relating to DV deaths • makes recommendations to government/nongovernment agencies and community to reduce or prevent the likelihood of DV deaths • establishes and maintain a database about DV deaths, and • undertakes research to reduce or prevent DV deaths.	• identifies systemic shortcomings and informs development of recommendations; and • provides a secretariat function to DFVDRAB. The Advisory Board: • researches trends and risk factors relating to DV deaths; • identifies key learnings of good practice in prevention and reduction of DV deaths; and • makes recommendations to Minister for implementation by government/ nongovernment agencies.	associated with family violence • identify trends or patterns in family violence-related deaths • consider current systemic responses to family violence, and • provide an evidence base for coroners to support the formulation of prevention focussed recommendations aimed at reducing non-fatal and fatal forms of family violence. Reference Group: • assists in identification of system wide issues regarding family violence, and advises on policy and program developments at local, state and national level.	• advise Coroners about the DV context and issues; • have input into Coronial Inquests related to DV; • develop data collection systems to inform advice to Coronial processes, and identify improvements to DV related service environment, and • conduct retrospective research to build DV death review process evidence base.	• identify trends arising from reviews of DV deaths, and • make recommendations to public authorities about how to prevent and reduce DV deaths.	deaths occurred and the adequacy of system responses to DV to inform coronial findings and recommendations, and • maintains an evidence base to identify patterns and trends from reviews of DV deaths.
Identification and review of domestic violence deaths						
Types of cases reviewed	Closed coronial and criminal cases. Secretariat	Open and closed coronial and criminal cases.	Open and closed coronial cases and closed criminal cases.	Open and closed coronial cases and closed criminal cases.	Open and closed coronial and criminal cases.	Open and closed coronial investigations.

	NSW	QLD	VIC	SA	WA	NT
	can review open coronial cases.					
Types of deaths reviewed	Can consider deaths as a result of homicide, homicide-suicide, suicide and accidents.	Can consider deaths as a result of homicide, homicide-suicide, bystander homicides, and perpetrator or victim suicides.	Can consider deaths as a result of homicide, homicide-suicide and suicide.	Can consider deaths as a result of homicide, homicide-suicide, suicide and intentional self-harm deaths.	Can consider deaths as a result of homicide, homicide-suicide and suicide.	Data collection is currently limited to intimate partner DV deaths, but will be extended to include other familial relationships.
Case identification and review process	<u>Case identification</u> • Secretariat examines dataset of all homicides in NSW. • Secretariat uses court and police databases and criminal or coronial briefs of evidence to identify DV deaths. • The DVDRT is also empowered to call for information from government and nongovernment agencies. • The DVDRT has access to NCIS. • Quantitative data is entered into a DV homicide dataset. <u>Case review</u> • The DVDRT conducts in-depth case reviews of individual homicides which occur over a designated period	<u>Case identification</u> • The Unit routinely monitors all reportable deaths and collates data in relation to DV homicides and suicides. • Seeks information from relevant agencies. • Coroners may also refer any death they consider relevant to the Unit for review. <u>Case review</u> • The Advisory Board conducts a preliminary review of an identified DV case. • Final review is conducted 8 – 12 months after the death to assist coroners to identify issues warranting further investigation. • For cases with a clear history of DV, final	<u>Case identification</u> • The VSRFVD examines coronial surveillance database (Vic Homicide Register) to identify DV deaths and extract data items for quantitative analysis. <u>Case review</u> • The VSRFVD conducts in-depth case reviews to inform coronial investigations about the context in which the DV deaths occurred.	<u>Case identification</u> • The SRO works as part of the Coronial investigation team to identify domestic violence deaths. <u>Case review</u> • The SRO provides interim reports and has specific input into Coronial Inquests relating to domestic violence.	<u>Case identification</u> • WA Police informs the Ombudsman of all DV deaths and provides relevant information. <u>Case review</u> • Ombudsman conducts a review, scope of which depends on a number of factors, including circumstances surrounding the death, and public authorities' level of involvement.	Information n/a

	NSW	QLD	VIC	SA	WA	NT
	considered to be sufficiently proximal to the homicides.	comprehensive review is provided to the coroner.				
Information sharing and privacy						
Information sharing framework	Provisions in the *Coroners Act 2009* (NSW) require Government Department Heads, the Commissioner of Police, medical and health practitioners and heads of relevant welfare services to give the Domestic and Family Violence Death Review Team 'full and unrestricted access to records that are under [their] control'. The DVDRT or person acting under the direction of the team is protected from liability where their act or omission was done in good faith for the purposes of executing an Act. Liability attaches instead to the Crown.	Provisions in the *Coroners Act 2003* (Qld) state that the Advisory Board has a right to all relevant information under the control of Government Department Chief Executives, the Commissioner of Police, the Queensland Family and Child Commission and relevant service providers. An entity that provides information as required by the Advisory Board cannot be civilly or criminally liable for giving the information. Similar protection is given to members and persons helping the Advisory Board perform its functions.	The VSRFVD falls within the remit of the Coroner's Court and so is able to access information through the Coronial mandate.	The SRO falls within the remit of the Coroner's Office and so is able to access information through the Coronial mandate.	Employees of the Office of the Ombudsman are able to access information through the WA Ombudsman's mandate.	The death review process falls within the remit of the Coroner's Office and so is able to access information through the Coronial mandate.
Information sources used	• Briefs of Evidence (Criminal or Coronial) • Police and Court databases • Information from government and non-government agencies • The National Coronial Information System.	• Domestic and Family Violence Death Review Unit Database (purpose built for death reviews) • Information from agencies where the deceased and/or perpetrator has had contact in relation to	• Electronic material from coroners' investigations (police reports, post-mortem reports, coroner's findings), the Victorian Homicide Register and Austlii	• The NCIS • SA Coronial Information System • Coroners Domestic Violence Information System (purpose built for death reviews)	• Any databases accessible under powers of the Ombudsman, including databases of police, Government Departments, and Courts.	• Data is gathered through the coronial investigation of a relevant reportable death, and the NT coronial database.

	NSW	QLD	VIC	SA	WA	NT
		domestic violence (i.e. police, health, social services or courts).	(for sentencing remarks).	• Homeless to Home database (housing and domestic violence service information system).		
Privacy protections (disclosure and reporting)	Under the *Coroners Act 2009* (NSW) confidentiality provisions apply to the DVDRT or any person assisting the team. Failure to comply with the requirements results in a maximum penalty of 50 penalty units and/or 12 months imprisonment. There are some exceptions where disclosure is allowed.	Under the *Coroners Act 2003* (Qld) confidentiality provisions apply to the Advisory Board and persons assisting them. Failure to comply with the requirements results in a maximum penalty of 200 penalty units. There are some exceptions where disclosure is allowed.	The VSRFVD falls within the remit of the Coroner's Court and so must adhere to privacy requirements under the Coronial mandate. Findings that the Coroner publishes online may be redacted due to families' cultural beliefs and to protect living persons.	The SRO falls within the remit of the Coroner's Court and so must adhere to privacy requirements under the Coronial mandate.	Employees of the Ombudsman must adhere to privacy requirements under the WA Ombudsman's mandate. .	All data provided to the National Network is de-identified to ensure protection of privacy of individuals involved in coronial investigations.
Reporting						
Capacity to report and make recommendations	<u>Reporting by the DVDRT</u> To NSW Parliament (not a Minister) biennially.	<u>Reporting by the Coroner</u> Unit's activities and statistics are published in the Coroner's Annual Report. Inquest summary findings are published on the courts website. Non-inquest findings are published at the Coroner's discretion. <u>Reporting by the Advisory Board</u>	<u>Reporting by the Coroner</u> The Coroners' findings with recommendations must be published on the Coroner's website. The Coroners' findings without recommendations may be reported at the individual	<u>Reporting by the Coroner</u> Findings and recommendations are released publically by the Coroner and presented in public forums and to relevant executive and staff groups. <u>Reporting by the SRO</u>	<u>Reporting by the Ombudsman</u> The Ombudsman reports annually to Parliament on death review data, and publishes public reports on major investigations.	Information n/a

	NSW	QLD	VIC	SA	WA	NT
		The *Coroners Act 2003* (Qld) requires the Advisory Board to report annually to the Minister about performance of the board's functions, including progress on previous recommendations made by the board.	discretion of the Coroner. Activities of the team are reported in the Coroner's annual report.	Findings and recommendations are reported to the Chief Executive Group.		

ATTACH MENT B: National guiding principles for family violence death review

This document summarises the 'best practice' principles developed by the Australian Domestic Violence Death Review Network (National Network). A full description of the principles is published in the report, 'A National System for Domestic and Family Violence Death Review' (see Part 4).

Principle 1: Government endorsement, reliable funding and engagement with public and private sector agencies

Secure and recurrent Government funding is required for the adequate staffing levels identified to fulfil the function of collecting, analysing and reporting on death cases over time. Adequacy of funding depends on jurisdiction size and function of the particular death review team.

Death review teams must establish standing, authority and endorsement from Government. This enables teams to work effectively and collaboratively with Government agencies and facilitates access to information from various sources.

While a statutory basis is not mandatory for the death review function, some Governments choose to establish the role through statute.

Principle 2: Appropriate powers to access information

Death review teams rely on information from various sources to conduct quantitative and qualitative reviews of deaths. Teams rely on enabling legislation that provides access to information from all agencies where the deceased and perpetrator had contact.

Principle 3: Support from experts in domestic and family violence and policy

Death review team personnel require a degree of specialist knowledge of issues pertaining to domestic violence. This expertise can be enhanced through advisory mechanisms that support death review teams and facilitate linkages between different Government agencies.

Principle 4: Capacity to make and monitor recommendations

Recommendations aim to prevent the likelihood of similar deaths occurring the future by improving legislation and policy, system and service responses, data collection and management and public awareness.

Principle 5: Powers to conduct quantitative and qualitative reviews

Qualitative case reviews are conducted to gain a detailed understanding of the circumstances surrounding family violence deaths, including events leading up to a death, relationship history of those involved, and level and adequacy of service contact. Quantitative analysis includes characteristics of victims and perpetrators, the history of violence and the history of service contact.

Principle 6: Contribution to a National Network

National uniformity in data collection and death review is important for a coherent monitoring system. The National Network has an agreed definition of domestic and family violence, consistent case identification and inclusion criteria, a National Minimum Dataset and National Data Collection Protocols.

Principle 7: Case identification and procedures and mechanisms

The National Network has developed a 'Homicide Consensus Statement' which outlines basic criteria for classifying homicides that have occurred in a family violence context.

Principle 8: Collaborative, consultative and independent

Death review team members require a detailed knowledge about the operation of a wide range of departments, services and agencies. Collaboration with government and non-government organisations is essential for teams to understand the operating contexts of agencies and to draw on the knowledge of experts in specialty areas.

Independence of Australian death review teams is generally enshrined in statute, through legislation establishing a death review function or in legislation determining the functions of coroners or the Ombudsman, under which death review teams operate.

Principle 9: National, state and territory domestic violence frameworks

Death review teams assess service responses to family violence in the context of national, state and territory policy frameworks, which set the direction of family violence services.

Principle 10: Confidentiality and privacy protections

Death review teams must operate in accordance with confidentiality and privacy provisions, in light of the wide range of information required for death review processes.

Principle 11: Overarching philosophy of death review

Death review teams operate in accordance with the philosophy that conducting death reviews can lead to the identification of opportunities to improve responses to domestic and family violence deaths and thus prevent the likelihood of similar deaths occurring in future.

ATTACHMENT C: Proposed models and comparative analysis

	Model 1 *A legislative mandate for an ongoing FVDR capability*	Model 2 *A legislative mechanism to initiate a FVDR periodically*	Comments
Structure	Death review processes are undertaken by a Senior Research Officer (**SRO**) and the Family Violence Death Review Committee (**FVDR committee**).	Same as Model 1.	Currently in Australia FVDR is undertaken by a person or team supported by an expert advisory body (South Australia, Victoria, Western Australia), or use a two-tiered system which involves a secretariat with data collection functions, and a multidisciplinary team which conducts in-depth reviews and reports (New South Wales and Queensland). In the Northern Territory, FVDR is undertaken by a Research Officer.
Roles	The SRO has an independent, full-time role involving data collection, maintenance of a database of family violence deaths and development of interim case reviews. The SRO also has a secretariat function when the FVDR committee is stood up. The FVDR committee is an independent, multidisciplinary team which undertakes a systemic review every 3-5 years (or after a certain number of deaths).	Same as Model 1, but the SRO and FVDR committee are stood up only when a systemic review is needed – i.e. every 3-5 years (or after a certain number of deaths).	The main difference between the models is that Model 1 uses a full-time resource for continuous data collection, whereas Model 2 only requires resourcing and data collection after a certain number of years or deaths.
Composition of FVDR committee	The FVDR committee consists of representatives from government and non-government entities, from areas including health, housing, police, family violence support services, courts, community services, corrections, child and youth protection, victim support, the Aboriginal	Same as Model 1.	FVDR is undertaken by people with appropriate and varied expertise and experience, who have the authority to collect, analyse and report on information relating to the death.

	or Torres Strait Islander community, legal services and academia.		
Location	The Justice and Community Safety Directorate (**JACS**) is considering the option of co-locating the SRO with the ACT Children and Young People Death Review Committee secretariat, which is an independent role that sits within the Community Services Directorate. The SRO would be independently funded. Other options may be to locate the SRO with the ACT Human Rights Commission, Coroner's Court, or within JACS.	Same as Model 1.	FVDR teams should be independent in order to objectively assess and report on gaps in family violence systems. The Children and Young People Death Review Committee has similar functions to FVDR. The committee is an independent body that is assisted by a secretariat of one person (a senior research officer), who is also independent and sits within the Community Services Directorate. Most FVDR teams in Australia sit within the coroner's court. Placement of FVD functions with the ACT Coroner's Court would still require additional resources, as coroners' information records, available resources and current practice of the Court do not support identification and investigation of all family violence deaths.
Timing of data collection and information sharing	Continuous data collection by the SRO. Relevant information sharing entities in the ACT include ACT Policing, courts, Domestic Violence Crisis Service, ACT Health Directorate, Community Services Directorate, the ACT Education Directorate and any relevant community services and agencies. A clear legislative framework will enable information sharing from relevant entities, between FVDR teams across Australia, and with the Australian Domestic and Family Violence Death Review Network (**National Network**).	Same as Model 1, but data collection is not continuous – it occurs only at the time a systemic review process is initiated (i.e. every 3-5 years or after a certain number of deaths).	FVDR teams must collect information from family violence-related entities to understand how system improvements can be achieved. Most FVDR teams in Australia obtain information through the coroner's court. There is currently no entity in the ACT that collects all the relevant information to identify and analyse all family violence deaths. Attachment D provides the proposed framework for information sharing.

Types of cases reviewed	Closed criminal cases and open and closed coronial cases.	Same as Model 1	Some FVDR teams in Australia review open coronial and criminal family violence death cases, and others review open coronial and closed criminal cases. Reviewing cases subject to current criminal proceedings risks undermining the criminal justice system, although it has the benefit of ensuring review findings and recommendations are made in a timely way.
Types of deaths reviewed	Reviews will be able to consider potential family violence-related homicides and deaths resulting from suicides of both family violence victims and perpetrators and accidental deaths of family violence victims.	Same as Model 1.	Identification of deaths will be consistent with the National Homicide Consensus Statement, developed by the National Network, which defines inclusion criteria for family violence homicide.
Database for deaths	Continuously maintained.	Updated only at the time of systemic review (i.e. every 3-5 years or after a certain number of deaths).	Development of a database is important for quantitative reviews in order to identify trends across deaths and gaps in service delivery, policies and procedures. The ACT FVDR scheme will develop a database consistent with the National Network's Data Collection Protocol, which is used to establish a National Minimum Dataset.
Case reviews (process and timing)	The SRO undertakes **interim case reviews** of individual deaths, which result in reports that may include recommendations. The FVDR committee, assisted by the SRO, undertakes **systemic reviews** every 3-5 years (or after a certain number of deaths) by decision of the Minister. The FVDR committee would meet periodically over a 6 to 12 month period.	No **interim case reviews**. **Systemic review** process is the same as Model 1, except reviews would take a longer time (i.e. 12 months) as identification, collection and analysis would occur only at the time of systemic review (as opposed to Model 1, where data would already be available at the time systemic review is initiated).	Case reviews and systemic reviews allow qualitative analysis of the circumstances surrounding a death, including events leading up to a death, relationship history of those involved, and level and adequacy of service contact. The ACT is a small jurisdiction with a population base that results in far fewer domestic violence deaths per year compared with other jurisdictions (the ACT Family Violence Death Review identified 14 deaths over a 12 year period, compared with 205 in New South Wales, 194 in Victoria and 125 in Queensland for the same time period). Timing of FVDR functions must therefore balance concerns about anonymity and de-identification of specific deaths with the need for timely reporting for effective systemic change.

			These concerns suggest that systemic reviews resulting in detailed reports and system recommendations for the ACT should only be undertaken every 3-5 years or after a certain number of deaths.
Reporting and recommendations	Interim reviews result in confidential reports that may include recommendations to the Minister and relevant entities for system improvements. The interim reports will be informed by best practice developments by the National Network. Systemic reviews result in public reports to the Minister and relevant entities, with recommendations on system wide issues. Systemic reviews are based on interim reports and other relevant information.	Same as Model 1, except without the use of interim reports.	Recommendations aim to improve or modify: • legislation and policy • system and service responses • data collection and management, and • public awareness and education campaigns.
Privacy and confidentiality	The SRO and FVDR committee will operate in accordance with confidentiality and privacy provisions.	Same as Model 1.	The ACT FVDR scheme will include legislative provisions to ensure compliance with the *Human Rights Act 2004*.

COMPARATIVE ANALYSIS

LEGISLATIVE AMENDMENT

For both models, it is proposed that legislation is amended or established to implement the FVDR committee, including its structure, functions, reporting responsibilities, information sharing powers, and privacy and confidentiality duties.

LOCATION

For both models, co-location of a SRO with the Children and Young People Death Review Committee secretariat would leverage the existing processes and experiences of the Children and Young People Death Review Committee. In addition, co-location would enable development of a consistent approach to both child and family violence death review processes so that data can be effectively shared where cases overlap.

Placement of FVDR with the ACT Coroner's Court is also an option. This would still require additional resourcing, as coroners' information records, available resources and current practice of the Court does not support identification and investigation of all family violence deaths. Placement with the Human Rights Commission or with an ACT Government agency are also options.

DATA COLLECTION AND INFORMATION SHARING

A key difference in the models is the timing of data collection. An effective FVDR process should ideally facilitate ongoing data collection and data sharing and allow timely access to information to enable the ACT to contribute to and take advantage of outcomes by the National Network. Delayed data collection only at the time of in-depth systemic reviews places significant reliance on agencies to maintain all relevant information and have it accessible at the point of a review. In these circumstances there is a high risk that key information is lost or overlooked.

Model one combines ongoing data collection with interim reporting for each death, which ensures that the data from various entities is effectively captured for future systemic case reviews and reporting. The interim reporting may also include recommendations for the Minister and relevant agencies to allow timely changes for system improvements.

Model two only allows data collection and information sharing when a death review is stood up, which results in the ACT not being able to fully make use of the National Network insights or national comparative data. For model two, reporting and recommendations are only made for in-depth systemic reviews, which means timeliness and relevance of recommendations may be an issue given systemic reviews would only be expected after a number of years.

ATTACHMENT D: Information sharing framework

INTRODUCTION

FVDR teams require appropriate powers to access information from all agencies where the deceased and the perpetrator had contact, so that effective and timely recommendations can be made for improvements to the family violence system at the local and national level. FVDR processes in Australia rely on legislation to access the information needed (see Attachment A under 'information sharing and privacy').

PROPOSED INFORMATION SHARING FRAMEWORK

It is proposed that legislation is amended or established to allow those responsible for carrying out FVDR functions (i.e. the FVDR committee) to obtain information from entities with relevant family violence information. The information sharing framework outlined below is similar to the legislative scheme that applies to information sharing with the ACT Children and Young People Death Review Committee, which is provided in Part 19A.3 of the *Children and Young People Act 2008* (ACT).

The framework would also be consistent with the *Human Rights Act 2004* (ACT), and sharing and confidentiality provisions in the *Health Records (Privacy and Access) Act 1997* (ACT) and the *Children and Young People Act 2008* (ACT).

1. Purpose of information sharing for ACT family violence death review

The information sharing framework would enable the FVDR committee to:

- identify and classify relevant cases using the National Network's Homicide Consensus Statement and the National Data Collection Protocol
- maintain a database of deaths occurring in a family violence context in the ACT
- conduct in-depth qualitative case reviews to consider the nature and history of the domestic relationship, the circumstances of the incident, prior interaction with agencies or services, potential points of intervention, and prevention strategies, and
- share data with other jurisdictions using the National Network's Data Sharing protocols.

2. What kind of information would be collected?

An ACT FVDR scheme would collect information required for development of the National Minimum Dataset and enable identification of relevant cases based on inclusion criteria stated in the Homicide Consensus Statement, including:

- homicide details (including event details, manner, location and date of death, criminal/coronial outcome, whether homicide offender was domestic violence abuser or victim (or both))
- demographic details of victim and perpetrator (including residency, age, country of birth, cultural status, occupation, disability status and immigration status)
- case characteristics (including histories of protection orders, family law proceedings, separation, financial issues, unemployment, mental health issues), and
- information regarding the relationship between the victim and offender, including length of the relationship details regarding separation, history of violence (reported and unreported), types of violence (physical, psychological, emotional, social and sexual violence), history of stalking, and criminal justice histories (including imprisonment, conviction and other offending).

In addition, in-depth qualitative case reviews would require information about victim and offender contact with the health system, justice system, social welfare services and specialist family violence services.

3. What entities would be required to provide information?

The FVDR committee would have the power to obtain information from any entity with relevant family violence information, including:

- ACT Government directorates and agencies (including ACT Corrective Services, the ACT Education Directorate, ACT Health, Housing ACT, Child and Youth Protection Services (CYPS));
- ACT Authorities (including ACT Public Trustee and Guardian; ACT Ombudsman);
- ACT law courts (including the ACT Family Court, ACT Coroners Court, ACT Supreme Court, ACT Magistrates Court);
- ACT Policing;
- community organisations and services (including Everyman Australia, Canberra Rape Crisis Centre (CRCC), Women's Centre for Health Matters, Domestic Violence Crisis Service (DVCS))
- legal services (including Women's Legal Centre, Office of ACT Director of Public Prosecutions (DPP), Legal Aid ACT, Aboriginal Legal Service ACT); and
- other relevant agencies and sources (including the Children and Young People Death Review Committee and National Coronial Information System (NCIS)).

4. How would information be shared?

Power to request information from and share information with entities

The FVDR committee would have the power to request information from a person by written notice, where the FVDR committee believes on reasonable grounds that the person can give information that the FVDR committee considers is necessary to exercise its functions. The notice would need to state how, and the time within which, the person must comply with the requirement.

Information sharing between the FVDR committee and the Children and Young People Death Review Committee would be enabled for cases being considered in connection with both committees' functions, with the aim of avoiding duplication of work. The FVDR committee would also have the power to enter into an agreement with interstate FVDR teams, and the National Network, to exchange information relevant to their function. Information sharing with the National Network would be consistent with the National Data Sharing Protocols.[4]

Timing for provision of information

Entities would be required to give information even where the death is or may be the subject of investigation by a coroner. For deaths the subject of current criminal proceedings, information would be required to be given as soon as practicable following the conclusion of legal proceedings.

Offence for failure to provide information

A person may commit an offence if the person fails to give the information to the FVDR committee as required. However, the offence would not apply if the person has a reasonable excuse for failing to give the information as required.

Confidentiality and protection of information

Confidentiality provisions would be established which prevent a person from recording or disclosing any information that was acquired by the FVDR committee, unless certain exceptions apply (e.g. where the record or disclosure is made in good faith for the purpose of exercising FVDR functions, or where information is provided to the Child and Young People Death Review Committee in connection with that Committee's function). An offence would apply where a person contravenes confidentiality requirements. Any person or entity to whom information is revealed through the applicable exceptions would be subject to the same obligations and liabilities as applies to the FDVR committee. In addition, access to a database of family violence-related deaths (developed by the FVDR committee) would be restricted. There would also be requirements to ensure that information is de-identified where appropriate.

[4] See the Australian Domestic and Family Violence Death Review Network 2018 Data Report for further information. Accessed 24 October 2018 at: https://www.whiteribbon.org.au/wp-content/uploads/2018/06/ADFVDM-Report_2018.pdf.