22/7/2015

# Central Australian Family Violence and Sexual Assault Network Submission into the Domestic and Family Violence Act Review.

## 1. A preamble to the Domestic and Family Violence Act

CAFVSAN submits that the Domestic and Family Violence Act should include a preamble that recognises domestic and family violence as a human rights and social justice issue; whilst acknowledging the gendered nature of domestic and family violence and the damage it causes to communities and children. A good example of such a preamble can be found in the Victorian Family Violence Prevention Act (2008).

## 2. More detailed definitions about the kinds of behaviour that may constitute domestic and family violence

Whilst the Domestic and Family Violence Act currently includes an outline of different kinds of abuse, it would be useful if these terms were expanded to raise awareness about the extensive range of behaviours that may constitute domestic and family violence. This could be done by including a non-exhaustive list of examples as to how abusive behaviour might occur in practical terms. In South Australia, the Intervention Orders (Prevention of Abuse) Act (2009) includes an extensive range of examples across a number of areas. One example of these practical explanations relates to the topic of 'Unreasonable and non-consensual denial of financial, social or personal autonomy'. This can be found at s8(5) of the SA legislation. It would be useful if examples were given across a range of abusive behaviours, to improve community understanding about how domestic and family violence may manifest.

## 3. Preventing direct cross examination of Applicants or protected persons by unrepresented Defendant

Under s114 of the Domestic and Family Violence Act, the court has discretion to make an order that the Defendant cannot directly cross examine a witness who is in a domestic relationship with the defendant. If such an order is made, these questions can be put to the witness by a third party authorised by the court. CAFVSAN submits that these protections are inadequate, that this should not be a discretionary matter, and there should be a clear direction through the legislation that a Defendant not be permitted to directly cross examine such witnesses. An exception may be the informed consent of the witness to this cross examination. In the event that a defendant is not represented, we submit that representation for the purpose of cross examination be provided on a duty basis, with adequate resourcing provided to enable this. This is the approach taken in Victoria. In considering such a reform in the NT, the relevant sections of the Victorian legislation are a useful reference point. These can be found in the Family Violence Protection Act (2008), 'Special rules for cross-examination of protected witnesses', s70(1).

## 4. Domestic Violence Orders

A national Domestic Violence Order registration scheme:

CAFVSAN submits that the establishment of a national Domestic Violence Order registration scheme would be a positive step, improving the safety of protected persons through providing more effective and streamlined protection to those in need, regardless of their location. We submit that once a DVO (or equivalent) becomes enforceable in one jurisdiction, it should be registered on a national database so that it can be enforceable in other jurisdictions without the administrative requirement of being registered at the request of the protected person. Many CAFVSAN members work with clients who move regularly between different locations in the NT, WA and SA. Women are often unaware that the reach of a DVO stops at the border of the jurisdiction in which it originated, unless an application has been made for interstate registration. A national registration scheme would remove this onus from protected persons, reduce confusion, and afford more cohesive protection to those that need it.

Duration of DVOs:

CAFVSAN recommends that consideration be given to advising judicial officers that the presumptive departure point for a DVO be between two and five years, rather than the current 6 months to one year; all other aspects of judicial discretion remaining the same; and that there be scope to apply for DVOs with no sunset clause. This would put the onus on the offender to contest and demonstrate a substantial change and provide incentives to address underlying behaviour. It would also protect the victim from having to repeat the process of proving their danger and the risk of re-traumatisation.

## 5. A formal domestic and family violence death review process

CAFVSAN and several of its member organisations have advocated for the establishment of a formal domestic and family violence death review process for some time. Unfortunately the NT remains

one of the few jurisdictions in Australia where such a process does not exist, despite the disproportionate levels of domestic and family violence that it hosts. A formal domestic and family violence death review process would enable systemic issues to be identified, along with gaps in service provision and barriers to accessing it. Following a review, recommendations could then be made with a view to improving responses to domestic and family violence and preventing similar fatalities from occurring.

For more detailed discussion, we have attached a copy of a 2012 article written by the Central Australian Women's Legal Service and the Top End Women's Legal Service, titled 'Reducing domestic fatalities in the NT: Why the Territory needs a formal domestic and family violence death review process.'

### 6. Information Sharing between Domestic Violence Services and the Police

CAFVSAN recommends the models of information sharing used in both Victoria and the ACT be investigated for their potential utility in the NT with a view to improving the referral of all parties to appropriate services following identification of Domestic and Family Violence.

### 7. Child Protection and the re-victimisation of women and children.

CAFVSAN raises the issue of the failures of current child protection interventions to keep children and their mothers safe. Fear of family separation and child removal has created a reluctance of family to disclose incidents where their children have witnessed or been the victim of violence. Commonly cached in terms of "violent relationships" rather than violence being perpetrated against women and children, the woman is investigated and held responsible for "failing to keep the child safe", and the victimisation of children and mothers is duplicated.

CAFVSAN recommends a move away from ideas that both parents are complicit in the damage to the child and that measures are put into the legislation that the perpetrator be investigated and removed, not the mother or the child.

CAFVSAN recommends that the Protection of Children Act, the Domestic and Family Violence Act and Family Law are pulled into alignment to better serve the safety, care and empowerment of children and mothers experiencing paternal violence.

### 8. Specialist Domestic and Family Violence court

CAFVSAN supports the recommendation for a specialist Domestic and Family Violence court so that matters of Family Law and Domestic and Family Violence are not duplicated or undermined in isolation from each other.

9. **Training for police, judicial officers and others**

CAFVSAN recommends that training on the research evidence about Domestic and Family Violence be provided to all police, judicial officers, child protection officers and agencies which provide services in the court environment.

**10. Sexual Assault issues**

Communication privilege:

CAFSVAN recommends that there be clearer articulation in the legislation of what is and is not protected communication in a confidential counselling environment where sexual abuse or sexual assault trauma is being addressed.

Medical imaging protection:

CAFSVAN recommends that there be clearer articulation in the legislation of the purpose of medical imaging of injuries (ie: not for court use, or subpoena - only for medical specialist interpretation of injury).

CAFVSAN recommends standardisation of the national age of consent.

Thank you for considering this submission,

**The Central Australian Family Violence and Sexual Assault Network**

Quorum members:

Alice Springs Women's Shelter

Central Australian Aboriginal Congress, Men's Program/Targeted Family Support Service

Central Australian Aboriginal Family Legal Unit

Central Australian Women's Legal Service

Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara Women's Council – Domestic Violence Service

Tangentyere Council, Social Services

The CAFVSAN Secretariat can be contacted at cdt@asws.org.au

# Reducing domestic fatalities in the NT:

## Why the Territory needs a formal domestic and family violence death review process

*Emily Webster, Solicitor, Central Australian Women's Legal Service,*
*Adrianne Walters, Senior Solicitor, Top End Women's Legal Service*

*IN MAY OF THIS YEAR, THE NORTHERN TERRITORY WAS SHOCKED BY THE VIOLENT DEATHS OF FOUR PEOPLE WITHIN TWO WEEKS IN ALLEGED DOMESTIC AND FAMILY VIOLENCE INCIDENTS: A WOMAN IN ALICE SPRINGS, AND TWO CHILDREN AND THEIR FATHER IN DARWIN. UNFORTUNATELY, DEATHS LINKED TO DOMESTIC VIOLENCE ARE NOT UNCOMMON IN THE NORTHERN TERRITORY. IN THE PAST TWELVE MONTHS, SIX PEOPLE HAVE DIED AS A RESULT OF ALLEGED DOMESTIC VIOLENCE INCIDENTS IN THE ALICE SPRINGS TOWNSHIP ALONE.*

Statistics show that the overwhelming majority of domestic violence victims are women. In Australia generally, it is estimated that one in three women have experienced some form of physical violence since the age of 15 and nearly one in five have experienced sexual violence.[2] These shocking statistics have driven the Federal, State and Territory Governments to commit to the National Plan to Reduce Violence against Women and their Children ('the National Plan').

This article discusses the need for, and possibilities of, a domestic violence death review process in the Northern Territory. Since 2007, domestic violence death review processes have been established in different forms in Victoria, New South Wales, Queensland, South Australia, and, most recently, Western Australia. In each of those jurisdictions, the review mechanism differs in terms of structure, procedure and scope, however; each review process has a common aim: to identify systemic and procedural issues in domestic violence responses in order to facilitate measures to reduce and prevent fatal and non-fatal domestic violence.

## Domestic violence related deaths in the Northern Territory and Australia – the numbers

In Australia generally, homicide statistics are heavily skewed towards what the National Homicide Monitoring Program (NHMP) describes as 'domestic homicides'.[3] In 2007-08, 52% of the 273 homicides in Australia were domestic.

Domestic violence related fatalities are a gendered phenomenon, with the impact being borne disproportionately by women. Whilst women make up only 41% of the total number of homicide victims, they make up the majority of victims of *domestic* homicide (60%).[4] Further, 78% of victims of *domestic* homicide were women killed by an intimate partner.[5] The victimisation of Aboriginal and Torres Strait Islander women was even greater, representing 73% of all Aboriginal and Torres Strait Islander victims of domestic homicide.[6]

The impact on children should not be forgotten. In 2007-08, 15% of domestic homicides involved a parent or step-parent killing a child.[7] 22% of young people will witness an act of physical violence against their mother or step-mother. Witnessing such violence is a recognised form of child abuse.

When looking at the Northern Territory alone, the statistics are

> *The harsh reality is that women in the Territory face a higher risk of experiencing injury or death as a result of domestic violence than their counterparts in any other State or Territory of Australia.*

disturbing. The homicide rate in the Territory is starkly higher than any other jurisdiction in Australia, with 8.2 homicides per 100,000 people, compared to the national average of 1.2 per 100,000.[8] 61% of homicides in the Northern Territory occur in a domestic context.[9] The harsh reality is that women in the Territory face a higher risk of experiencing injury or death as a result of domestic violence than their counterparts in any other State or Territory of Australia. Indeed, three major risk factors for being subjected to domestic violence in Australia are:

- **Being a woman;**
- **Being young; and**
- **Living in the Northern Territory.**[10]

For Aboriginal and Torres Strait Islander women, the risk is even greater.

Finally, the economic impact of domestic violence must be weighed into any proposed measure to reduce domestic violence. Domestic and family violence perpetrated against women costs the nation $13.6 billion each year. By 2021, the figure is likely to rise to $15.6 billion.[11]

In light of the significant human and economic costs of women's experiences of domestic violence, measures aimed at preventing and reducing such violence should be a paramount priority for the Northern Territory Government.

## What is a domestic violence death review process?

Domestic violence death review processes conduct a detailed review of deaths linked to domestic violence, aimed at identifying weaknesses and strengths in the systems and processes that are designed to respond to domestic violence.

The basic objectives of a domestic violence death review process are twofold:

1) To reduce domestic fatalities by improving the service provision and systemic responses to domestic violence; and

2) To compile and interpret accurate, detailed data concerning domestic fatalities.[12]

The four main tasks of a review process are to:

1) Identify deaths that occur in a domestic violence context for review.

2) Review individual deaths. This review encompasses not just the circumstances of the death itself, but also explores the context in which the death occurred, including the history of the violent relationship, the victim's contact with, and access to, domestic violence intervention strategies and services, and the effectiveness of those strategies and services. The review aims to identify oversights, barriers, gaps and/or failures in systems and services.

3) Conduct broader reviews of all the domestic violence related deaths that occur in a given period, and maintain statistics and data on domestic violence deaths to:

   a. Identify risk and contributory factors associated with domestic violence; and

   b. Identify trends, patterns of behaviour and systemic issues.

4) Make recommendations to Government agencies, statutory bodies, other agencies and organisations involved in domestic violence prevention, aimed at improving responses to domestic violence.[13]

The domestic violence death review process does not play a role in the criminal investigation or prosecution of the death, which means that evidence, information and data that is inadmissible in criminal proceedings can be analysed. It adopts a 'no blame, no shame' ethos; it does not seek to attribute blame to any individual involved or connected with the death. This is the role of the existing coronial and criminal processes. The focus is on analysing the systematic, organisational and procedural responses to victims and perpetrators of domestic violence. In this way, a domestic violence death review process can be seen as complementary to the traditional criminal and coronial processes.

## Why does the Northern Territory need a domestic violence death review mechanism?

Most domestic violence related deaths occur following a history of domestic violence, in which one or more agencies have had prior contact with the victim or perpetrator. For example, in 2006-07, 43% of cases of intimate partner homicide involved parties who had a prior history of domestic violence that had required some degree of police involvement.[14] As was noted in the Queensland Domestic and Family Violence Death Review Panel's Final Report:

> *"Domestic and family violence deaths are almost never without warning... When viewed as the escalation of a predictable pattern of behaviour, domestic or family homicides can be seen as largely preventable deaths."*[15]

While the Northern Territory does have a process for reviewing deaths through the coronial system, there are no specific structures in place for domestic violence related deaths to be investigated and reviewed as a subset. Further, the police and criminal justice system treats each death as an isolated incident. This is appropriate, as each death is factually and legally different and the right to a fair trial dictates that each charge against an individual be proven beyond reasonable doubt.

Viewed holistically, and in the context of other domestic violence related deaths, however, it can be seen that separate domestic violence fatalities are relevant and related; for example, different deaths may involve similar identifiable risk factors. Thus, when looked at together, systemic issues may be brought to light and gaps or barriers to service responses may be identified. Recommendations can then be made to address shortcomings in the response to domestic violence with the aim of preventing similar fatalities in the future.

The creation of a domestic violence death review process would also be consistent with the Northern Territory Government's commitment to the National Plan. In particular, it would assist the Northern Territory Government to meet the following objectives under the National Plan:

- Continuous improvement and leadership across justice systems, including "through sharing outcomes of reviews into deaths and homicides related to domestic violence";[16]
- Supporting services in the domestic violence sector to identify and deliver responses that meet the needs of victims of domestic violence and their children;[17] and
- Developing strategies to intervene early to prevent domestic violence.[18]

A domestic violence death review process is essential to the Northern Territory Government's ability to share "*outcomes of reviews into deaths and homicides related to domestic violence*". A domestic violence death review process would also provide analysis and data on domestic violence related deaths, including data on Territory-specific trends and risk factors, which the Northern Territory could use to improve justice responses, identify effective preventative strategies and provide input into national policy development in relation to domestic violence. Further, it would assist services in the Northern Territory domestic violence sector by identifying gaps, barriers or system failures, as well as successful responses and interventions.

## A case example from Queensland

The recent Findings handed down by Queensland Coroner, Mr Michael Barnes, in the Inquest into the deaths of Antony Way, Tania Simpson, Kyla Rogers and Paul Rogers highlight the positive contribution of a domestic violence death review process.[19] The case was a tragic one, in which Paul Rogers killed his former partner, Tania Simpson, and her friend, Antony Way, before abducting their daughter, Kyla Rogers, and killing both himself and Kyla. It was a case that involved a protracted history of *non-physical* domestic violence on the part of Mr. Rogers,

"*"Domestic and family violence deaths are almost never without warning...When viewed as the escalation of a predictable pattern of behaviour, domestic or family homicides can be seen as largely preventable deaths."*

**Queensland Domestic and Family Violence Death Review Panel**"

> *I am persuaded by the valuable contribution made by the [Domestic and Family Violence Death Review Unit's] analysis of these deaths and other reports that I have read that will inform future inquests that its disbanding would be a setback for community safety.*
>
> Queensland Coroner, Mr Michael Barnes

in which he utilised controlling, manipulative, dishonest and obsessive behaviours. A total of 21 people had been made aware of factors that indicated that Mr. Rogers was capable of domestic homicide; however, different factors were known by different people in different agencies, thus preventing accumulation and analysis of knowledge and the possibility of effective intervention.

Blame was not attributed to any one person or agency however; Mr. Barnes found that more could have been done to prevent the deaths from occurring. Mr. Barnes made a number of comments and recommendations about the connection between domestic violence and homicide. He noted that the deaths before him were not isolated cases in the sense that they were one of a number of deaths resulting from domestic violence in Queensland each year.

Mr. Barnes referred to the important work of the Queensland Domestic and Family Violence Death Review Unit (DFVDRU), describing it as a "*small, expert, interdisciplinary unit*"[20] focused on cases that result in death, which complemented the work of the police domestic violence units. Mr. Barnes made three recommendations that directly involved the work of the DFVDRU, the first of which was that the Queensland Government continued to fund the DFVDRU "*so that intensive, expert scrutiny of all aspects of these deaths can better inform the responses of the relevant agencies.*"[21]

Mr. Barnes' second recommendation addressed procedural issues related to the Queensland police risk assessment framework. Notably, Mr. Barnes' final recommendation was that the DFVDRU liaise with the relevant Queensland Government Department in relation to public awareness campaigns "*about the risks posed by non-violent domestic and family violence.*"[22]

It is clear that the Queensland DFVDRU had provided important investigation and analysis which informed the recommendations arising from the Inquest. In recommending that the funding for the DFVDRU be continued, Mr. Barnes specifically stated:

> *"I am persuaded by the valuable contribution made by the unit's analysis of these deaths and other reports that I have read that will inform future inquests that its disbanding would be a setback for community safety."*[23]

## A case example from South Australia

In South Australia there exists a relatively watered-down version of a domestic violence death review mechanism. A single senior research officer has been funded to review and investigate currently open coronial cases, and to research closed coronial cases, where a domestic violence context can be identified. Despite the limited nature of this domestic violence death review process, it has already played a role in indentifying issues and gaps in domestic violence service provision in high risk cases. This can be seen in the Inquest into the death of Ms Robyn Hayward, who was shot and killed by her estranged partner in the Murray Mallee region of South Australia.[24]

The Inquest revealed systems issues relating to interagency information sharing in high risk cases, processes for reporting, recording and follow-up and case management procedures. The Inquest also heard evidence about improvements in service provision that had already been enacted by local agencies following Ms Hayward's death and about a framework for managing high risk cases ('Family Safety Framework') that existed in other regions of South Australia. As a result, in May 2011, Deputy State Coroner, Mr Anthony Schapel, made a preliminary recommendation that the Family Safety Framework be implemented "at the first available opportunity" in the Murray Mallee.[25] This recommendation had been acted upon by the time the final Inquest Findings were handed down by Mr Schapel in January 2012.

These recent contributions made by domestic violence death review mechanisms in Queensland and South Australia highlight the positive outcomes that could arise from a domestic violence death review process in the Northern Territory.

## What form could a domestic violence death review process take in the Northern Territory?

Domestic violence death review processes are constituted and operated in different ways across the jurisdictions in which they operate. This gives the Northern Territory the opportunity to replicate structures and procedures that work, whilst learning lessons from difficulties faced in other jurisdictions.

## Examples from other Jurisdictions

In Victoria, Queensland, New South Wales and South Australia, the review system sits within the Office of the Coroner but takes a different form in each jurisdiction. The Victorian model, the first to be introduced in Australia, is not enshrined in legislation but rather exists in furtherance of the Coroner's legislated preventative role. In New South Wales and Queensland, the review systems are specifically legislated for. The New South Wales model consists of a permanent expert multi-disciplinary panel with representatives from both Government and non-Government agencies. In Queensland, the DFVDRU (above) is assisted by an expert advisory group. As set out above, South Australia has established a specific position, based within the Coroner's office to research and investigate domestic violence related coronial cases.

The Western Australia system, which came into existence on 1 July 2012, is unique because the Western Australian Ombudsman is given the role of reviewing domestic and family violence fatalities.

Overseas, review systems have been established in various jurisdictions in Canada, the United States, United Kingdom and New Zealand. Again, the models take many different forms, however a commonly observed structure is that of a legislated multi-agency independent taskforce, consisting of both Government and non-Government agencies and headed by a senior government official.

## Considerations for a Northern Territory domestic violence death review process

In thinking about a domestic violence death review model that may work for the Northern Territory, some key considerations are:

- ***Legislative underpinning***: enshrining the existence and operation of the review process in legislation is necessary to ensure its effective operation, particularly to guarantee its independence, confidentiality, accountability and ability to collect (and compel the release of) relevant data and information.
- ***Recommendations:*** the review system must have the power to make recommendations to any Minister, public statutory authority or entity in respect of its review. It is central to the effectiveness of the review process that those to which a recommendation is directed towards are compelled to provide a written response setting out action that has or will be taken in response to the recommendation. Transparency and accountability require that these responses be made public.
- ***Data collection and analysis:*** the review system needs to be able to collect and maintain a broad range of data and undertake analysis over an extended period to ensure the broader review of deaths as a connected group. This allows for the identification of risk factors and contributory factors; trends, patterns of behavior; and systemic procedural issues.
- ***Multidisciplinary:*** consideration should be given to ensuring the review system is genuinely multi-disciplinary and involves Government and non-government agencies, experts, and representatives from relevant communities (such as Aboriginal and Torres Strait Islander communities and refugee and migrant communities).
- ***Definitions and scope:*** consideration must be given to how the review system will identify a domestic and family violence related death. For example, the New South Wales legislation defines a 'domestic violence death' as being "the death of a person that is caused directly or indirectly by a person who was in a domestic relationship with the deceased person" and includes fatal accidents caused by domestic violence behaviour, and where domestic violence was a primary catalyst for suicide.[26] This is broader in scope than, for example, the Victorian model which has limited capacity to investigate suicides related to domestic violence. Definitions will impact on the quantity and type of deaths that can be investigated, the recommendations made and ultimately the effectiveness of the review system.
- ***Clear philosophy:*** it is important that the review system has an agreed philosophy underpinning its work. Such a philosophy could include:
    - That domestic and family violence deaths are preventable;

- An aim of social change leading to an end to domestic violence;
- A focus on systemic issues and not individual blame; and
- The perpetrator is culpable, but agencies need to be accountable.

## Conclusion

In a jurisdiction with the highest rate of homicide in the country, and unacceptable levels of domestic violence, it is time to give serious consideration to the introduction of a domestic violence death review process in the Northern Territory.

A vital first step would be to convene a working group comprised of representatives from the government and non-government agencies working within the domestic violence sector to conduct a review into models appropriate for implementation in the Northern Territory, addressing elements such as location, scope and definitions, and reporting and recommendatory roles.

The need for such a review process is undeniable. If we are serious about eradicating domestic violence, and specifically domestic fatalities, we must learn from the tragic deaths of those who die in such circumstances. We owe no less to the victims and their families than to work to prevent such deaths from occurring in the future.

**Endnotes**

1. Throughout this article, the term 'domestic violence' is used to describe both family violence and domestic violence.
2. Department of Families, Housing Community Services and Indigenous Affairs, *The National Plan to Reduce Violence Against Women and their Children 2010-2022*, Australian Government, Foreword.
3. Domestic homicides are defined as being incidents "involving the death of a family member or other person from a domestic relationship". See Marie Virueda and Jason Pain (2010), *Homicide in Australia: 2007-2008 National Homicide Monitoring Program Annual Report*, Australian Institute of Criminology, Canberra, at 7.
4. Ibid, at 19
5. Ibid.
6. Ibid, at 22.
7. Ibid, at 9.
8. No other State or Territory had a rate higher than 1.4 per 100,000. Ibid, at 7
9. Ibid.
10. Australian Bureau of Statistics (2006), *Personal Safety Survey* (reissue), Cat. No. 4906.0, Canberra; see also National Council to Reduce Violence against Women and their Children (2009), *The Cost of Violence against Women and their Children*, Department of Families, Housing, Community Services and Indigenous Affairs, Canberra, Australia, at 4..
11. Ibid.
12. Nadia David (2007), *Exploring the Use of Domestic Violence Fatality Review Teams*, Issues Paper 15, Australian Domestic & Family Violence Clearinghouse.
13. Ibid. See also Coroners Court of Victoria (2011), *Victoria's Coronial Model for Investigating Family Violence Related Death*, State of Victoria, at 10
14. Jack Dearden & Warwick Jones (2009) *Homicide in Australia: 2006-07 National Homicide Monitoring Program Annual Report*, Australian Institute of Criminology, Canberra, at 2.
15. Domestic and Family Violence Death Review Panel, *Report of the Domestic and Family Violence Death Review Panel 2010*, Department of Communities, Child Safety and Disability Services, Queensland, at 6.
16. Above, n 2, Strategy 5.2, at 27.
17. Ibid, Strategy 4.2 and 4.3, at 24-25.
18. Ibid, Strategy 6.3, at 30.
19. *Inquest into the deaths of Antony Way, Tania Simpson, Kyla Rogers and Paul Rogers*, Office of the State Coroner, (21 June 2012).
20. Ibid, at 29.
21. Ibid, at 30
22. Ibid, at 31
23. Ibid, at 30
24. *Inquest into the deaths of Robyn Eileen Hayward and Edwin Raymond Durance*, Coroners Court, South Australia (23 January 2012)
25. Ibid, at [1.3]
26. *Coroners Act 2009* (NSW), s 101C. Note that 'Domestic relationship' is defined to include relatives and extended family or kin in the case of a death of an Aboriginal person or Torres Strait Islander.