Family and Domestic Violence Fatality Review

Overview

This section sets out the work of the Office in relation to this function. Information on this work has been set out as follows:

- Background;
- The role of the Ombudsman in relation to family and domestic violence fatality reviews;
- The family and domestic violence fatality review process;
- Analysis of family and domestic violence fatality reviews;
- Patterns, trends and case studies relating to family and domestic violence fatality reviews;
- Issues identified in family and domestic violence fatality reviews;
- Recommendations;
- Timely handling of notifications and reviews;
- Major own motion investigations arising from family and domestic violence fatality reviews;
- Other mechanisms to prevent or reduce family and domestic violence fatalities; and
- Stakeholder liaison.

Background

The *National Plan to End Violence against Women and Children 2022-2032* (**the National Plan**), building on the work of the former *National Plan to Reduce Violence against Women and their Children 2010-2022* sets out actions across four domains to end violence:

1. **Prevention** – working to change the underlying social drivers of violence by addressing the attitudes and systems that drive violence against women and children to stop it before it starts.
2. **Early intervention** – identifying and supporting individuals who are at high risk of experiencing or perpetrating violence and prevent it from reoccurring.
3. **Response** – providing services and supports to address existing violence and support victim-survivors experiencing violence, such as crisis support and police

intervention, and a trauma-informed justice system that will hold people who use violence to account.

4. **Recovery and healing** – helping to reduce the risk of re-traumatisation, and supporting victim-survivors to be safe and healthy to be able to recover from trauma and the physical, mental, emotional, and economic impacts of violence.

In Western Australia, the *Annual Action Plan 2009-10*, associated with the *WA Strategic Plan for Family and Domestic Violence 2009-13*, identified a range of strategies to reduce family and domestic violence including a 'capacity to systematically review family and domestic violence deaths and improve the response system as a result' (page 2). The *Annual Action Plan 2009-10* set out 10 key actions to progress the development and implementation of the integrated response in 2009-10, including the need to '[r]esearch models of operation for family and domestic violence fatality review committees to determine an appropriate model for Western Australia' (page 2).

Following a Government working group process examining models for a family and domestic violence fatality review process, the Government requested that the Ombudsman undertake responsibility for the establishment of a family and domestic violence fatality review function.

On 1 July 2012, the Office commenced its family and domestic violence fatality review function.

In 2017, the State Government released the *Stopping Family and Domestic Violence Policy*, which set out 21 new initiatives for responding to family and domestic violence. This document superseded *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities* (**former State Strategy**) and the *Freedom from Fear Action Plan 2015*. Also in 2017, the first Minister for the Prevention of Family and Domestic Violence was appointed. In July 2020, the Department of Communities (**Communities**) released *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030* (**State Strategy**) and the associated *First Action Plan 2020-2022* (**First Action Plan**). The State Strategy's stated purpose is to 'guide a whole-of-community response to family and domestic violence in Western Australia from 2020-2030' and sets out the following guiding principles:

- People in Western Australia should be safe in their relationships and their homes;
- The safety and wellbeing of victims is the first priority;
- Children and young people exposed to domestic violence are victims;
- Perpetrators are solely responsible for their actions – victims must not be blamed;
- Women's safety is linked to gender equality;
- Everyone has a role in stopping family and domestic violence;
- Effective solutions are locally tailored, culturally safe and trauma informed;
- Men and boys are integral to the solution; and
- There is 'no wrong door approach' to service delivery.

The Ombudsman's family and domestic violence fatality reviews examine stakeholder implementation of the State Strategy, to prevent or reduce the risks associated with family and domestic violence fatalities.

It is essential to the success of the family and domestic violence fatality review role that the Office identified and engaged with a range of key stakeholders in the implementation and ongoing operation of the role. It is important that stakeholders

understand the role of the Ombudsman, and the Office understands the critical work of all key stakeholders.

Working arrangements have been established to support implementation of the role with the Western Australia Police Force (**WA Police Force**) and Communities and with other agencies, such as the Department of Justice (**DOJ**) and relevant courts.

Through regular liaison with key stakeholders, the Office gains valuable information to ensure its review processes are timely, effective and efficient.

The Office has also accepted invitations to speak at relevant seminars and events to explain its role in regard to family and domestic violence fatality reviews and since 1 July 2012, has participated as a Member of the Australian Domestic and Family Violence Death Review Network.

The Role of the Ombudsman in Relation to Family and Domestic Violence Fatality Reviews

Information regarding the use of terms

Information in relation to those fatalities that are suspected by WA Police Force to have occurred in circumstances of family and domestic violence are described in this report as family and domestic violence fatalities. For the purposes of this report the person who has died due to suspected family and domestic violence will be referred to as 'the person who died' and the person whose actions are suspected of causing the death will be referred to as the 'suspected perpetrator' or, if the person has been convicted of causing the death, 'the perpetrator'.

Additionally, following Coronial and criminal proceedings, it may be necessary to adjust relevant previously reported information if the outcome of such proceedings is that the death did not occur in the context of a family and domestic relationship.

WA Police Force informs the Office of all family and domestic violence fatalities and provides information about the circumstances of the death together with any relevant information of prior WA Police Force contact with the person who died and the suspected perpetrator. A family and domestic violence fatality involves persons apparently in a 'family relationship' as defined by section 4 of the *Restraining Orders Act 1997*.

More specifically, the relationship between the person who died and the suspected perpetrator is a relationship between two people:

(a) Who are, or were, married to each other; or

(b) Who are, or were, in a de facto relationship with each other; or

(c) Who are, or were, related to each other; or

(d) One of whom is a child who —

  (i) Ordinarily resides, or resided, with the other person; or

  (ii) Regularly resides or stays, or resided or stayed, with the other person; or

(e) One of whom is, or was, a child of whom the other person is a guardian; or

(f) Who have, or had, an intimate personal relationship, or other personal relationship, with each other; or

(g) One of whom is the former spouse or former de facto partner of the other person's current spouse or current de facto partner.

'Other personal relationship' means a personal relationship of a domestic nature in which the lives of the persons are, or were, interrelated and the actions of one person affects, or affected the other person.

'Related', in relation to a person, means a person who —

(a) Is related to that person taking into consideration the cultural, social or religious backgrounds of the 2 persons; or

(b) Is related to the person's —

(i) Spouse or former spouse; or

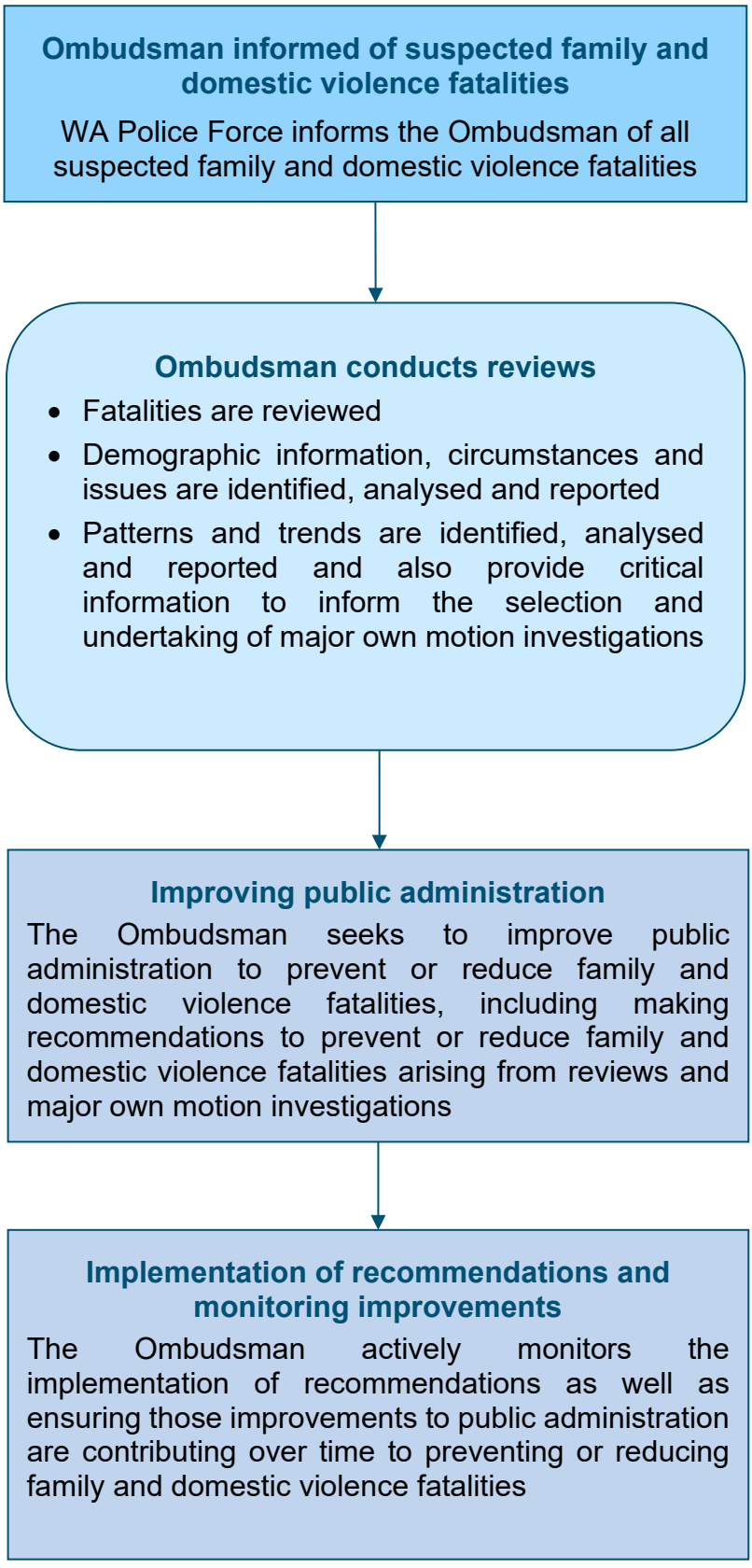
(ii) De facto partner or former de facto partner.

If the relationship meets these criteria, a review is undertaken. A review may also be undertaken where a fatality occurs in the circumstances of family and domestic violence.

The extent of a review depends on a number of factors, including the circumstances surrounding the death and the level of involvement of relevant public authorities in the life of the person who died or other relevant people in a family and domestic relationship with the person who died, including the suspected perpetrator. Confidentiality of all parties involved with the case is strictly observed.

The family and domestic violence fatality review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce family and domestic violence fatalities. The review does not set out to establish the cause of death of the person who died; this is properly the role of the Coroner. Nor does the review seek to determine whether a suspected perpetrator has committed a criminal offence; this is only a role for a relevant court.

The Family and Domestic Violence Fatality Review Process



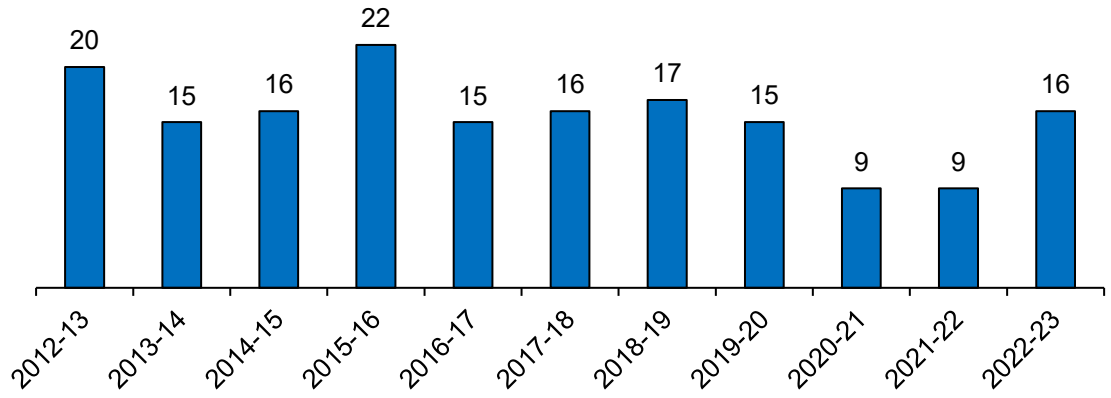
Analysis of Family and Domestic Violence Fatality Reviews

By reviewing family and domestic violence fatalities, the Ombudsman is able to identify, record and report on a range of information and analysis, including:

- The number of family and domestic violence fatality reviews;
- Demographic information identified from family and domestic violence fatality reviews;
- Circumstances in which family and domestic violence fatalities have occurred; and
- Patterns, trends and case studies relating to family and domestic violence fatality reviews.

Number of family and domestic violence fatality reviews

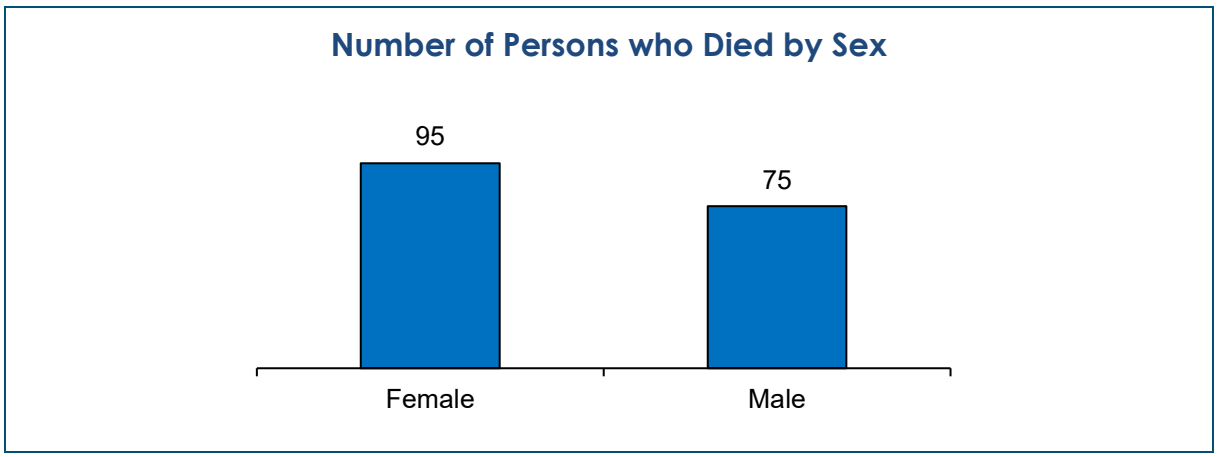
In 2022-23, the number of reviewable family and domestic violence fatalities received was 16, compared to nine in 2021-22, nine in 2020-21, 15 in 2019-20, 17 in 2018-19, 16 in 2017-18, 15 in 2016-17, 22 in 2015-16, 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

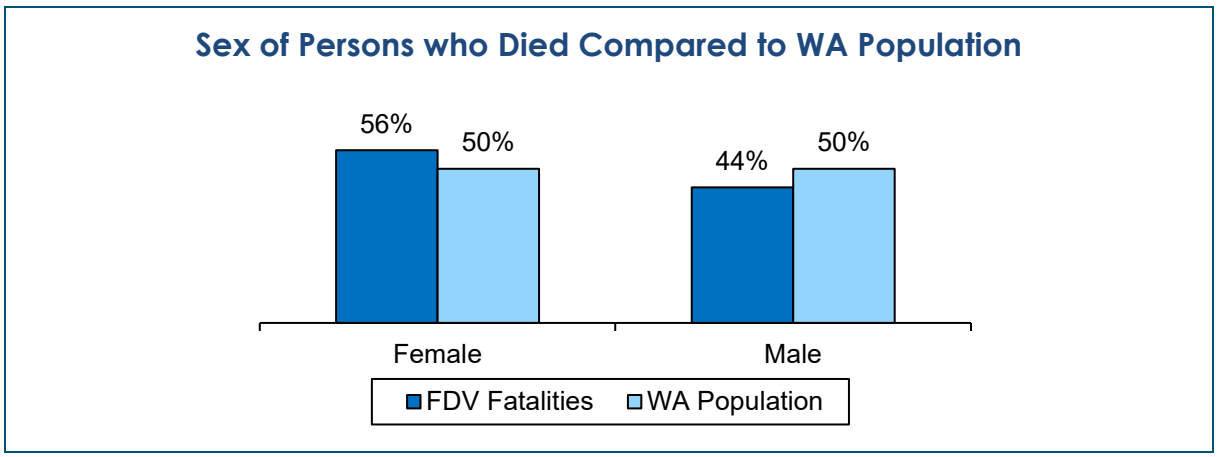


Demographic information identified from family and domestic violence fatality reviews

Information is obtained on a range of characteristics of the person who died, including sex, age group, Aboriginal status, and location of the incident in the metropolitan or regional areas.

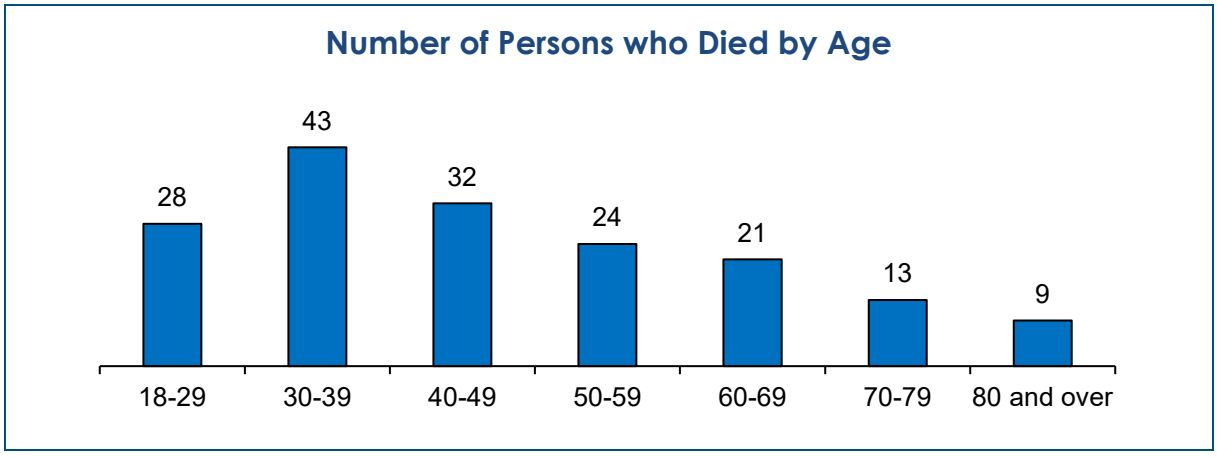
The following charts show characteristics of the persons who died for the 170 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2023. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

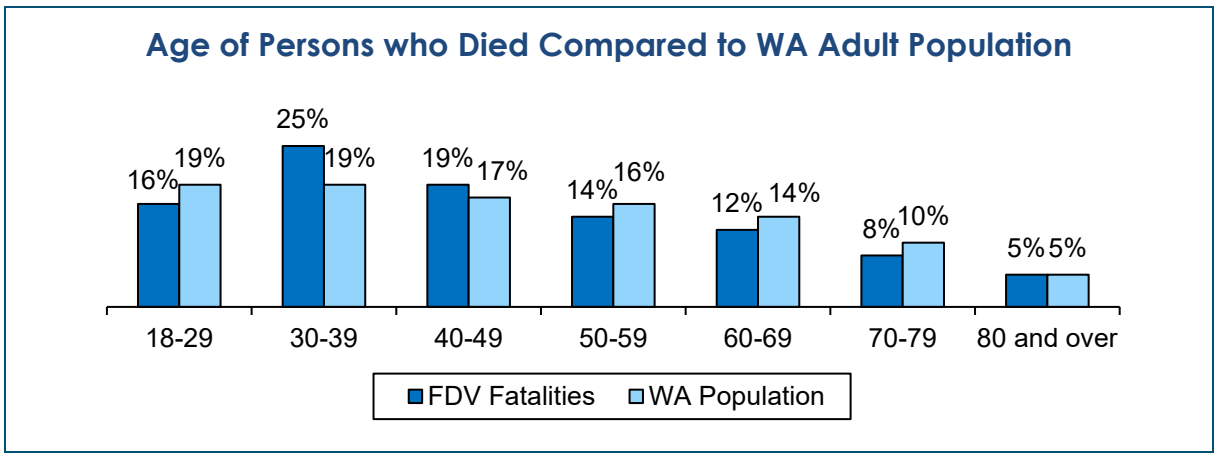




Information is collated on the sex of the deceased, and the suspected perpetrator, as identified in agency documentation provided to this Office. Compared to the Western Australian population, females who died in the 11 years from 1 July 2012 to 30 June 2023 were over-represented, with 56% of persons who died being female compared to 50% in the population.

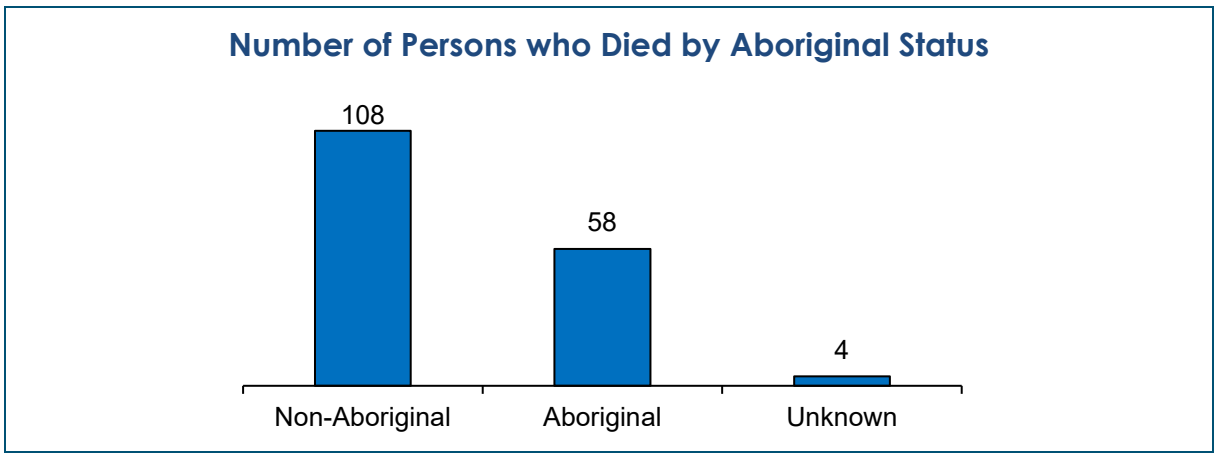
In relation to the 95 females who died, 88 involved a male suspected perpetrator. Of the 75 men who died, 14 were apparent suicides, 28 involved a female suspected perpetrator, 29 involved a male suspected perpetrator and four involved multiple suspected perpetrators of both sexes.

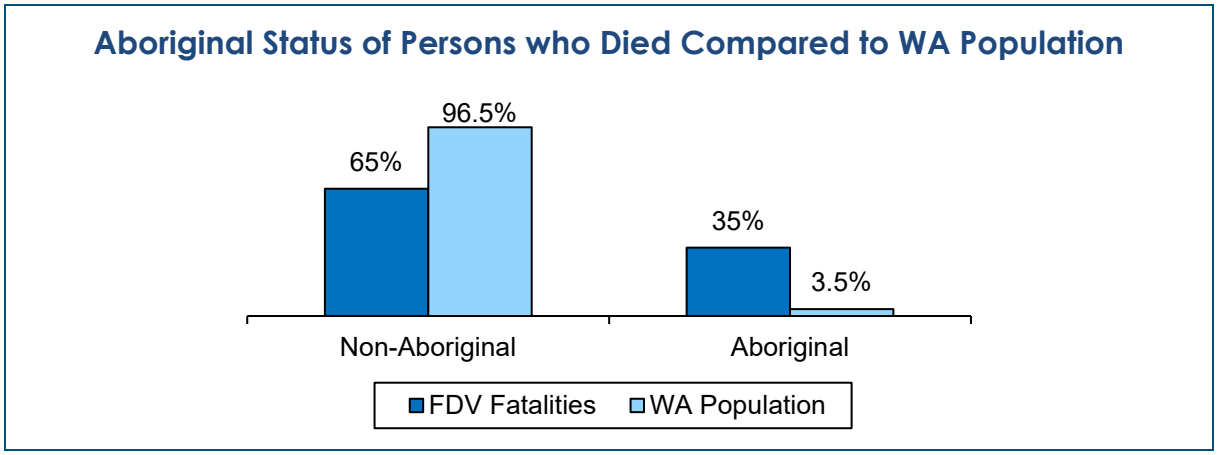




Note: Percentages may not add to 100% due to rounding.

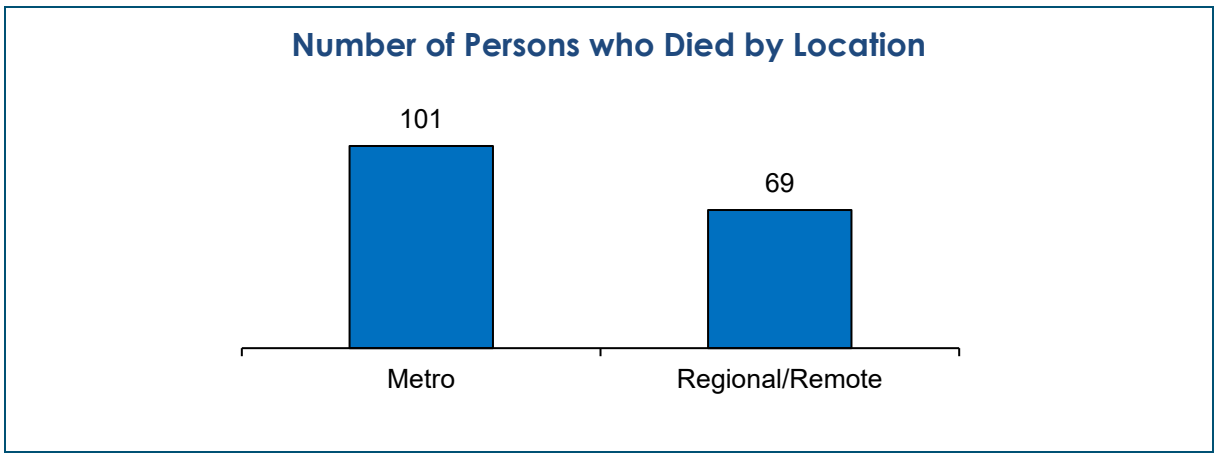
Compared to the Western Australian adult population, the age groups 30-39 and 40-49 are over-represented, with 25% of persons who died being in the 30-39 age group compared to 19% of the adult population, and 19% of persons who died being in the 40-49 age group compared to 17% of the adult population.

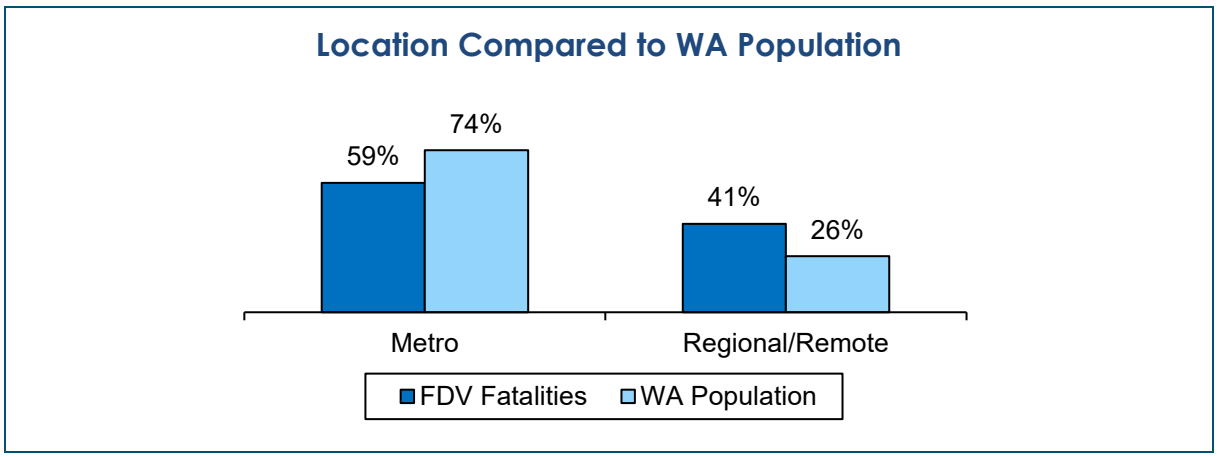




Note: In the above chart, percentages are based on those where Aboriginal status is known.

Information on Aboriginal status is collated where the deceased, and suspected perpetrator, identify as Aboriginal to agencies they have contact with, and this is recorded in the documentation provided to this Office. Compared to the Western Australian population, Aboriginal people who died were over-represented, with 35% of people who died in the 11 years from 1 July 2012 to 30 June 2023 being Aboriginal compared to 3.5% in the population. Of the 54 Aboriginal people who died, 35 were female and 23 were male.





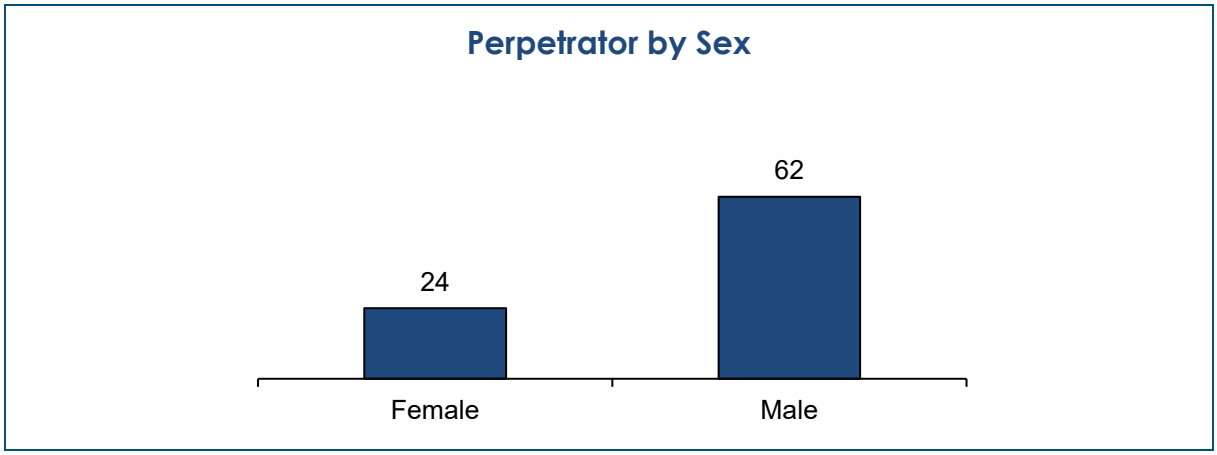
Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 41% of the people who died in the 11 years from 1 July 2012 to 30 June 2023 living in regional or remote locations, compared to 26% of the population living in those locations.

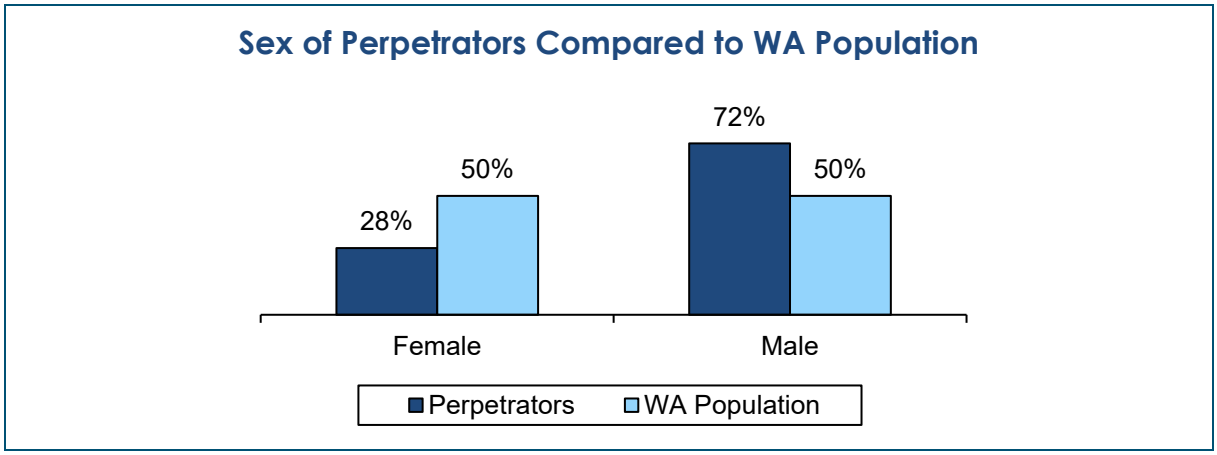
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2023 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2023.

Of the 170 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2023, coronial and criminal proceedings were finalised in relation to 86 perpetrators.

Information is obtained on a range of characteristics of the perpetrator including sex, age group and Aboriginal status. The following charts show characteristics for the 86 perpetrators where both the coronial process and the criminal proceedings have been finalised.

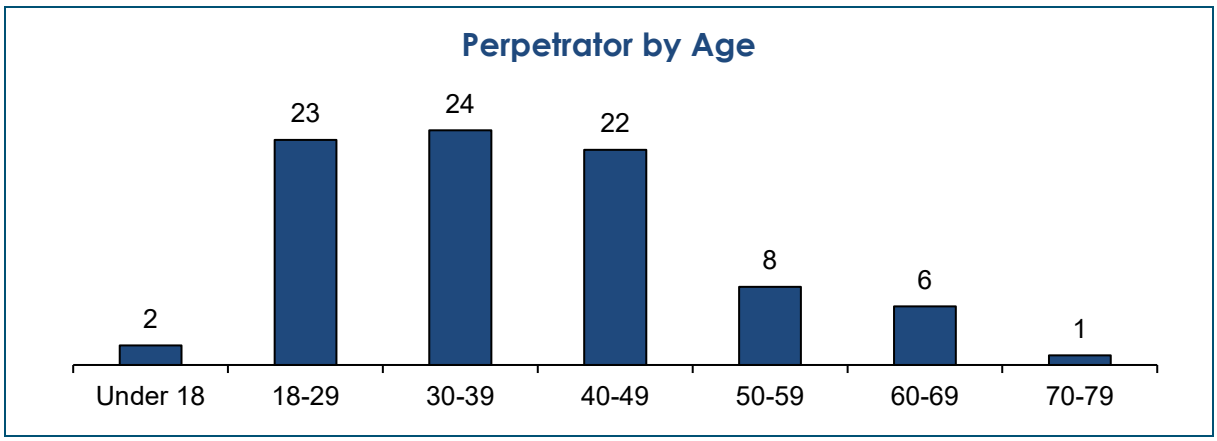


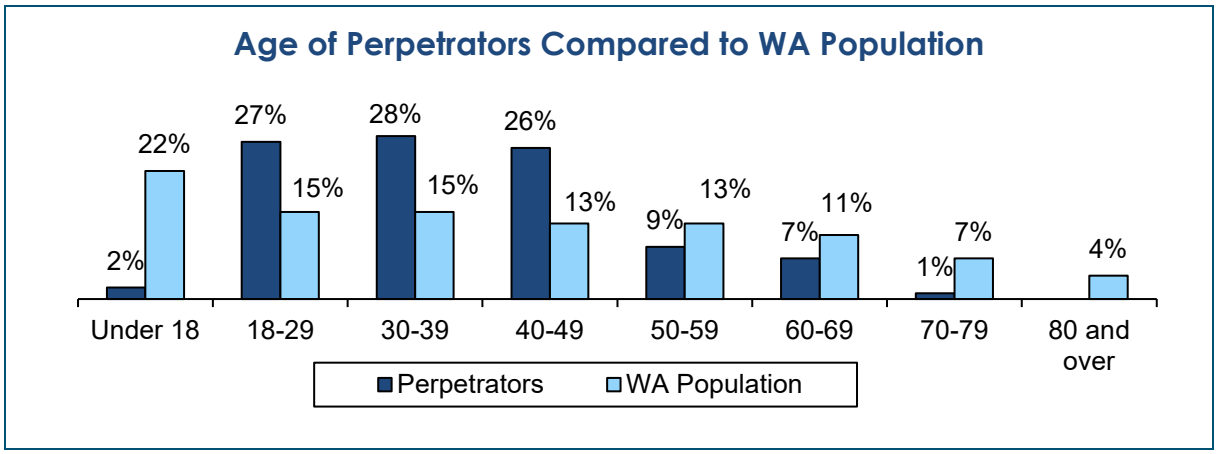


Compared to the Western Australian population, male perpetrators of fatalities in the 11 years from 1 July 2012 to 30 June 2023 were over-represented, with 72% of perpetrators being male compared to 50% in the population.

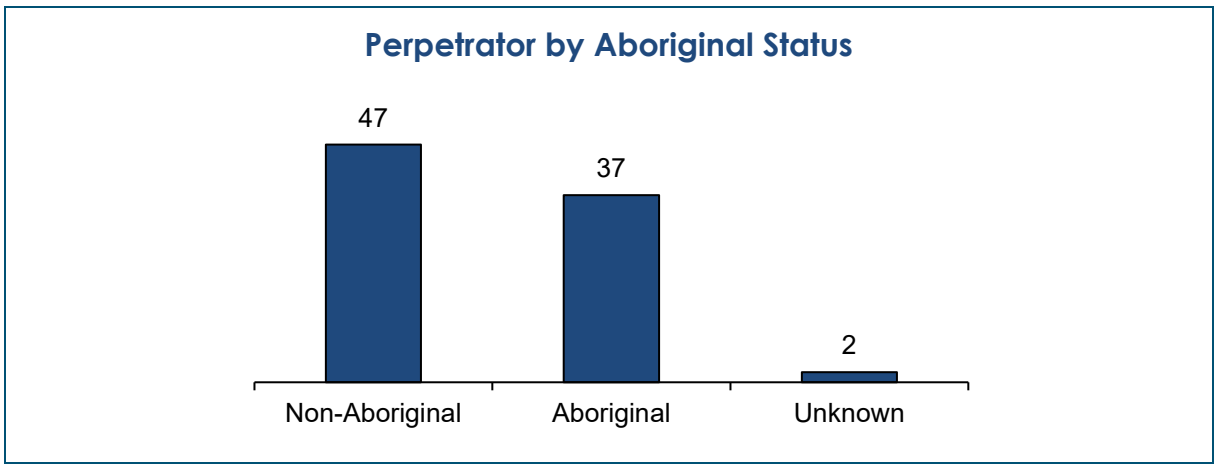
Nineteen males were convicted of manslaughter and 43 males were convicted of murder. Eleven females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death and 12 females were convicted of murder.

Of the 23 fatalities by the 24 female perpetrators, in 22 fatalities the person who died was male, and in one fatality the person who died was female. Of the 63 fatalities by the 62 male perpetrators, in 47 fatalities the person who died was female, and in 16 fatalities the person who died was male.

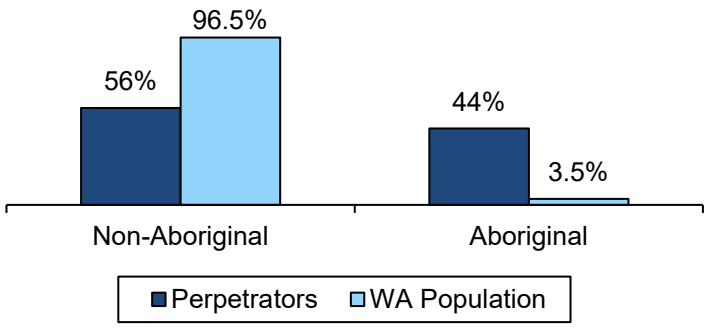




Compared to the Western Australian population, perpetrators of fatalities in the 11 years from 1 July 2012 to 30 June 2023 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 27% of perpetrators being in the 18-29 age group compared to 15% in the population, 28% of perpetrators being in the 30-39 age group compared to 15% in the population, and 26% of perpetrators being in the 40-49 age group compared to 13% in the population.



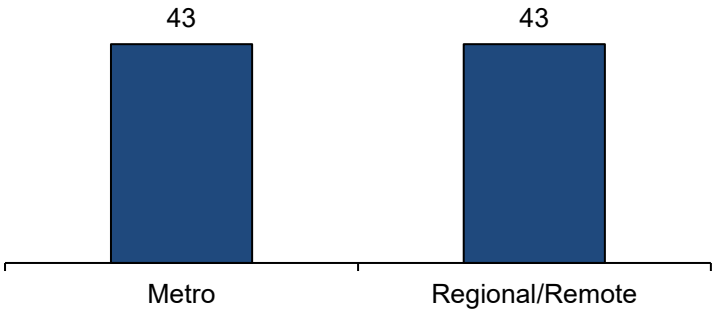
Aboriginal Status of Perpetrators Compared to WA Population



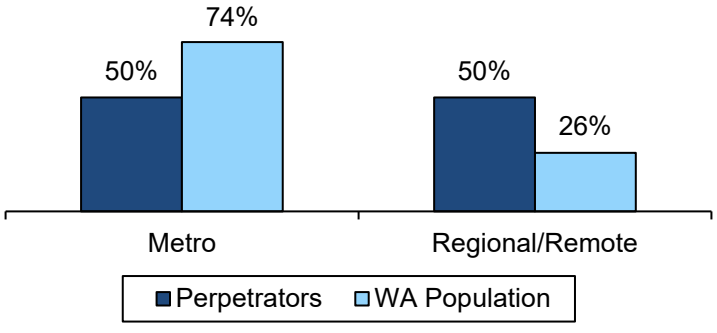
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the 11 years from 1 July 2012 to 30 June 2023 were over-represented with 44% of perpetrators (where Aboriginal status was recorded in information provided to this Office) being Aboriginal compared to 3.5% in the population.

In 35 of the 37 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location



Perpetrators by Location Compared to WA Population



Compared to the Western Australian population, of the 86 fatalities from 1 July 2012 to 30 June 2023 for which coronial and criminal proceedings were finalised, regional or remote locations were over-represented, with 50% of the fatal incidents occurring in regional or remote locations compared to 26% of the population living in those locations.

Circumstances in which family and domestic violence fatalities have occurred

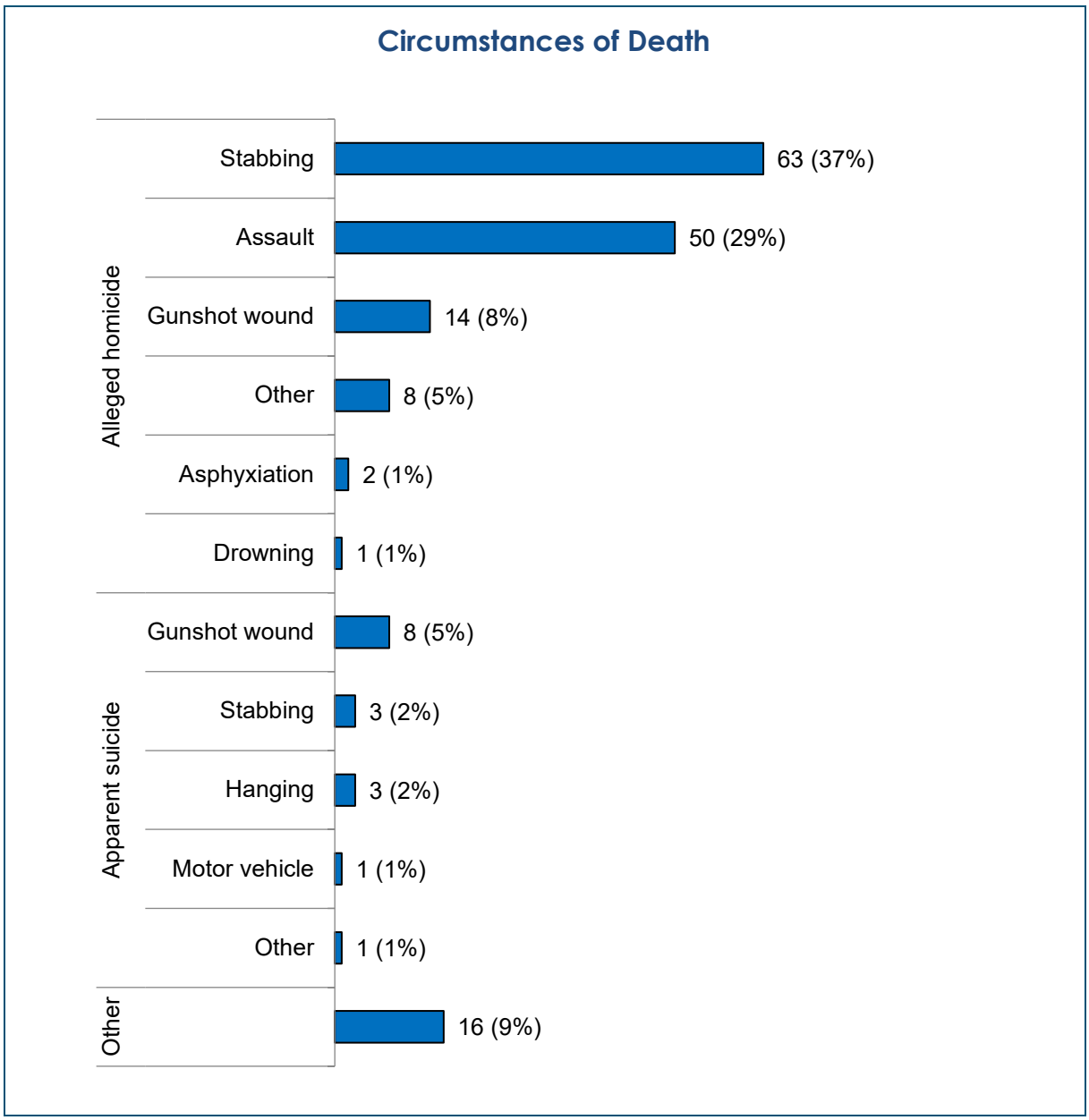
Information provided to the Office by WA Police Force about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

Family and domestic violence fatalities may occur through alleged homicide, apparent suicide or other circumstances:

- Alleged homicide includes:
  - Stabbing;
  - Physical assault;
  - Gunshot wound;
  - Asphyxiation/suffocation;
  - Drowning; and
  - Other.
- Apparent suicide includes:
  - Gunshot wound;
  - Overdose of prescription or other drugs;
  - Stabbing;
  - Motor vehicle accident;
  - Hanging;
  - Drowning; and
  - Other.
- Other circumstances includes fatalities not in the circumstances of death of either alleged homicide or apparent suicide.

The principal circumstances of death in 2022-23 were alleged homicide by physical assault and stabbing.

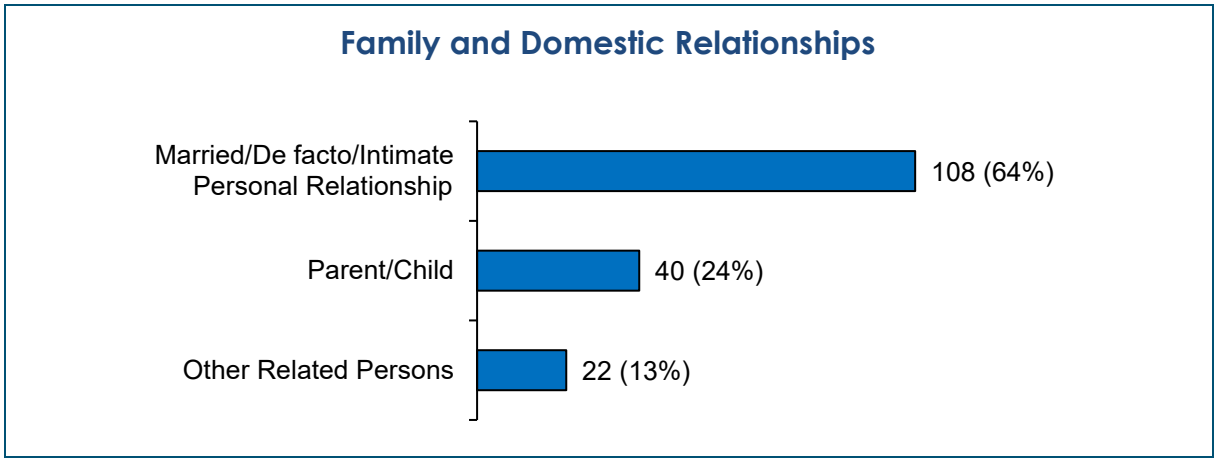
The following chart shows the circumstance of death as categorised by the Ombudsman for the 170 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2023.



Note: Percentages may not add to 100% due to rounding.

Family and domestic relationships

As shown in the following chart, married, de facto, or intimate personal relationship are the most common relationships involved in family and domestic violence fatalities.



Note: Percentages may not add to 100% due to rounding.

Of the 170 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2023:

- 108 fatalities (64%) involved a married, de facto or intimate personal relationship, of which there were 90 alleged homicides, 12 apparent suicides and six in other circumstances. The 108 fatalities included 20 deaths that occurred in 10 cases of alleged homicide/suicide and, in all 10 cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. Of the other two apparent suicides, one involved a male and one involved a female. Of the remaining 80 alleged homicides, 56 (70%) of the people who died were female and 24 (30%) were male;
- 40 fatalities (24%) involved a relationship between a parent and adult child, of which there were 28 alleged homicides, four apparent suicides and eight in other circumstances. Of the 28 alleged homicides, 11 (39%) of the people who died were female and 17 (61%) were male. Of these 28 fatalities, in 21 cases (75%) the person who died was the parent or step-parent and in seven cases (25%) the person who died was the adult child or step-child; and
- There were 22 people who died (13%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, eight (36%) were female and 14 (64%) were male.

Patterns, Trends and Case Studies Relating to Family and Domestic Violence Fatality Reviews[2]

State policy and planning to reduce family and domestic violence fatalities

The State Strategy states 'Communities is the lead agency coordinating strategy and policy direction in prevention of family and domestic violence in Western Australia'. Communities has now established, within its organisation, the Office for Prevention of Family and Domestic Violence to 'elevate the profile of family and domestic violence and provide the stewardship needed within Communities and across government to deliver improved outcomes in the areas of primary prevention, Aboriginal family safety, victim survivor safety and perpetrator accountability' (Department of Communities).

The Ombudsman's family and domestic violence fatality reviews and the Ombudsman's major own motion investigation, *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, have identified that there is scope for State Government departments and authorities to improve the ways in which they respond to family and domestic violence. In the report, the Ombudsman recommended that:

> Recommendation 1: DCPFS, as the lead agency responsible for family and domestic violence strategy planning in Western Australia, in the development of Action Plans under *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, identifies actions for achieving its agreed Primary State Outcomes, priorities among these actions, and allocation of responsibilities for these actions to specific state government departments and authorities.

[2] In this section, DCPFS refers to the (then) Department of Child Protection and Family Support (now Communities), DOTAG refers to the (then) Department of the Attorney General (now DOJ) and WAPOL refers to (then) Western Australia Police (now the Western Australia Police Force).

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that steps have been taken to give effect to the Ombudsman's recommendation. Subsequent to this recommendation, the First Action Plan, to be implemented between July 2020 and June 2022, was released with the State Strategy. This Office will continue to monitor implementation of the First Action Plan, and subsequent Action Plans, in family and domestic violence fatality reviews.

Type of relationships

The Ombudsman finalised 160 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2023.

For 101 (63%) of the finalised reviews of family and domestic violence fatalities, the fatality occurred between persons who, either at the time of death or at some earlier time, had been involved in a married, de facto or other intimate personal relationship. For the remaining 59 (37%) of the finalised family and domestic violence fatality reviews, the fatality occurred between persons where the relationship was between a parent and their adult child or persons otherwise related (such as siblings and extended family relationships).

These two groups will be referred to as 'intimate partner fatalities' and 'non-intimate partner fatalities'.

For the 160 finalised reviews, the circumstances of the fatality were as follows:

- For the 101 intimate partner fatalities, 83 were alleged homicides, 12 were apparent suicides, and six were other circumstances; and
- For the 59 non-intimate partner fatalities, 46 were alleged homicides, three were apparent suicides, and 10 were other circumstances.

Intimate partner relationships

Of the 83 intimate partner relationship fatalities involving alleged homicide:

- There were 61 fatalities where the person who died was female and the suspected perpetrator was male, 18 where the person who died was male and the suspected perpetrator was female, one where the person who died was male and the suspected perpetrator was male, and three where the person who died was male and there were multiple suspected perpetrators of both sexes;
- There were 32 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In 21 of these fatalities the person who died was female and in 11 the person who died was male;
- There were 41 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 14 at the residence of the person who died or the residence of the suspected perpetrator, eight at the residence of family or friends, and 20 at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 40 fatalities where the person who died lived in regional and remote areas, and in 30 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 59 non-intimate partner fatalities, there were 39 fatalities involving a parent and adult child and 20 fatalities where the parties were otherwise related.

Of the 46 non-intimate partner fatalities involving alleged homicide:

- There were 14 fatalities where the person who died was female and the suspected perpetrator was male, three where the person who died was female and the suspected perpetrator was female, 23 where the person who died was male and the suspected perpetrator was male, and six where the person who died was male and the suspected perpetrator was female;
- There were 13 non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 18 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 19 at the residence of the person who died or the residence of the suspected perpetrator, and nine at the residence of family or friends or in a public place; and
- There were 19 fatalities where the person who died lived in regional and remote areas.

Prior reports of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reports of alleged family and domestic violence between the parties. In 48 (58%) of the 83 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2023, alleged family and domestic violence between the parties had been reported to WA Police Force and/or to other public authorities. In 17 (37%) of the 46 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2023, alleged family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities.

Collation of data to build our understanding about communities who are over-represented in family and domestic violence

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, found that the research literature identifies that there are higher rates of family and domestic violence among certain communities in Western Australia. However, there are limitations to the supporting data, resulting in varying estimates of the numbers of people in these communities who experience family and domestic violence and a limited understanding of their experiences.

Of the 65 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, from the records available:

- Four (6%) fatalities involved a deceased person with disability;
- None of the fatalities involved a deceased person in a same-sex relationship with the suspected perpetrator;
- 37 (57%) fatalities involved a deceased Aboriginal person; and
- 35 (54%) of the people who died lived in regional/remote Western Australia.

Examination of the family and domestic violence fatality review data provides some insight into the issues relevant to these communities. However, these numbers are limited and greater insight is only possible through consideration of all reported family and domestic violence, not just where this results in a fatality. The report found that neither the former State Strategy nor the *Achievement Report to 2013* identified any actions to improve the collection of data relating to different communities experiencing higher rates of family and domestic violence, for example through the collection of cultural, demographic and socioeconomic data. In the report, the Ombudsman recommended that:

> Recommendation 2: In developing and implementing future phases of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, DCPFS collaborates with WAPOL, DOTAG and other relevant agencies to identify and incorporate actions to be taken by state government departments and authorities to collect data about communities who are overrepresented in family and domestic violence, to inform evidence-based strategies tailored to addressing family and domestic violence in these communities.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that steps have been taken, and are proposed to be taken, to give effect to this recommendation.

Subsequent to this recommendation, Action Item 4 of the First Action Plan intends to '[d]evelop a family and domestic violence dashboard that tracks and reports demand data, to support monitoring and analysis of current and emerging data trends and inform planning'. In relation to data collation about communities over-represented in family and domestic violence, and how this is used to inform evidence-based strategies tailored to addressing family and domestic violence in these communities, the Ombudsman will continue to monitor the implementation and effectiveness of the State Strategy, and First Action Plan for responding to Aboriginal family violence.

Identification of family and domestic violence incidents

Of the 65 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, WA Police Force was the agency to receive the majority of these reports. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, noted that DCPFS may become aware of family and domestic violence through a referral to DCPFS and subsequent assessment through the duty interaction process. Identification of family and domestic violence is integral to the agency being in a position to implement its family and domestic violence policy and processes to address perpetrator accountability and promote victim safety and support. However, the Ombudsman's reviews and own motion investigations continue to identify missed opportunities to identify, and respond to, family and domestic violence in interactions.

In the report, the Ombudsman made two recommendations (Recommendations 7 and 39) that WA Police Force and DCPFS ensure all reported family and domestic violence is correctly identified and recorded. *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that WA Police Force and DCPFS had proposed steps to be taken to give effect to these recommendations. The Office will continue to monitor, and report on, the steps being taken to improve identification, recording and reporting by WA Police Force and Communities of family and domestic violence.

Provision of agency support to obtain a violence restraining order

Prior to 1 July 2017 in Western Australia, a person who experienced domestic violence by another person, whether or not they were related, could apply to the Magistrates Court for a protection order being a violence restraining order. In July 2017, family violence restraining orders were introduced in Western Australia. A family violence restraining order is governed under the *Restraining Orders Act 1997* and can be used to 'restrain' a 'family member' as defined by the *Restraining Orders Act 1997*.

As identified above, WA Police Force is likely to receive the majority of reports of family and domestic violence. WA Police Force attendance at the scene affords WA Police Force with the opportunity to provide victims with information and advice about:

- What a family violence restraining order is and how it can enhance their safety;
- How to apply for a family violence restraining order; and
- What support services are available to provide further advice and assistance with obtaining a family violence restraining order, and how to access these support services.

Support to victims in reported incidences of family and domestic violence

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, examined WA Police Force's response to family and domestic violence incidents through the review of 75 Domestic Violence Incident Reports (associated with 30 fatalities). The report found that WA Police Force recorded the provision of information and advice about violence restraining orders in 19 of the 75 (25%) instances. In the report, the Ombudsman recommended that:

> Recommendation 9: WAPOL amends the *Commissioner's Operations and Procedures Manual* to require that victims of family and domestic violence are provided with verbal information and advice about violence restraining orders in all reported instances of family and domestic violence.
>
> Recommendation 10: WAPOL collaborates with DCPFS and DOTAG to develop an 'aide memoire' that sets out the key information and advice about violence restraining orders that WAPOL should provide to victims of all reported instances of family and domestic violence.
>
> Recommendation 11: WAPOL collaborates with DCPFS and DOTAG to ensure that the 'aide memoire', discussed at Recommendation 10, is developed in consultation with Aboriginal people to ensure its appropriateness for family violence incidents involving Aboriginal people.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that WA Police Force had taken steps and/or proposed steps to be taken to give effect to these recommendations. Subsequent to these recommendations, Action Item 13(d) of the First Action Plan indicates the WA Police Force intends to undertake 'comprehensive family violence training that is reported in the WA Police Force Annual Report'. In 2020, WA Police Force introduced body worn cameras for use by police and it is now mandatory for body worn cameras to be activated when attending a family and domestic violence incident. This Office is now able to access video from body worn camera to examine police responses to family and domestic violence, including the provision of information of family violence restraining orders. The Office will continue to monitor, and report on,

the provision, by WA Police Force, of information and advice regarding family violence restraining orders.

Support to obtain a violence restraining order on behalf of children

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, also examined the response by DCPFS to prior reports of family and domestic violence involving 30 children who experienced family and domestic violence associated with the 30 fatalities. The report found that DCPFS did not provide any active referrals for legal advice or help from an appropriate service to obtain a violence restraining order for any of the children involved in the 30 fatalities. In the report, the Ombudsman recommended that:

> Recommendation 44: DCPFS complies with the requirements of the *Family and Domestic Violence Practice Guidance*, in particular, that '[w]here a VRO is considered desirable or necessary but a decision is made for the Department not to apply for the order, the non-abusive adult victim should be given an active referral for legal advice and help from an appropriate service'.

Further, the report noted DCPFS's *Family and Domestic Violence Practice Guidance* also identifies that taking out a violence restraining order on behalf of a child 'can assist in the protection of that child without the need for removal (intervention action) from his or her family home', and can serve to assist adult victims of violence when it would decrease risk to the adult victim if the Department was the applicant. In the report, the Ombudsman made three recommendations relating to DCPFS's improved compliance with the provisions of its *Family and Domestic Violence Practice Guidance* in seeking violence restraining orders on behalf of children (Recommendations 45, 46 and 47), including:

> Recommendation 45: In its implementation of section 18(2) of the *Restraining Orders Act 1997*, DCPFS complies with its *Family and Domestic Violence Practice Guidance* which identifies that DCPFS officers should consider seeking a violence restraining order on behalf of a child if the violence is likely to escalate and the children are at risk of further abuse, and/or it would decrease risk to the adult victim if the Department was the applicant for the violence restraining order.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that in relation to Recommendations 44, 45, 46 and 47, DCPFS had taken steps and proposed steps to be taken to give effect to all these recommendations. The State Strategy identifies the need to '[s]upport the long-term recovery and wellbeing of children who have experienced family and domestic violence' as a Priority Action. Communities' *Casework Practice Manual 2.3.3 Family violence restraining orders* provides practice guidance for 'child protection workers about applying for a Family Violence Restraining Order (FVRO) on behalf of a child or supporting adult victims to seek FVROs that include themselves and their children'. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Support during the process of obtaining a family violence restraining order

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identified the importance of opportunities for victims to seek help and for perpetrators to be held to account throughout the process for obtaining a, then, violence restraining order, and

that these opportunities are acted upon, not just by WA Police Force but by all State Government departments and authorities. In the report the Ombudsman recommended that:

> Recommendation 14: In developing and implementing future phases of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, DCPFS specifically identifies and incorporates opportunities for state government departments and authorities to deliver information and advice about violence restraining orders, beyond the initial response by WAPOL.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps to give effect to this recommendation.

Subsequent to this recommendation, in May 2020, initiated in the context of concerns for increased family and domestic violence during COVID-19 restrictions, new laws were introduced to enable victims of family and domestic violence to apply for family violence restraining orders online through registered legal services which provide family violence assistance. Today, this action is intended to make it more convenient and less stressful for victims to obtain family violence restraining orders.

The State Strategy identifies that victims of family and domestic violence 'often need information, social support and legal advice on a range of issues such as…restraining orders. Actions under the Strategy will focus on making this available at an early stage to support people's safety and wellbeing and help them make informed choices'. Action Item 17 of the First Action Plan intends to '[e]xplore options to improve early access to legal advice for victims and perpetrators of family and domestic violence'. The outcome of Action Item 17 will be considered by this office in future family and domestic violence reviews.

Support when a family violence restraining order has not been granted

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, examined a sample of 41,229 hearings regarding violence restraining orders and identified that an application for a, then, violence restraining order was dismissed or not granted as an outcome of 6,988 hearings (17%) in the investigation period. In cases where an application for a violence restraining order has been dismissed it may still be appropriate to provide safety planning assistance. In the report, the Ombudsman recommended that:

> Recommendation 25: DOTAG, in collaboration with DCPFS, identifies and incorporates into *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, ways of ensuring that, in cases where an application for a violence restraining order has been dismissed, if appropriate, victims are provided with referrals to appropriate safety planning assistance.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DOTAG and DCPFS had proposed steps to be taken to give effect to this recommendation.

Provision of support to victims experiencing family and domestic violence

In November 2015, DCPFS launched the *Western Australia Family and Domestic Violence Common Risk Assessment and Risk Management Framework (Second edition)* (available at WA.gov.au). This across-government framework states that:

> The purpose of risk assessment is to determine the risk and safety for the adult victim and children, taking into consideration the range of victim and perpetrator risk factors that affect the likelihood and severity of future violence.
>
> Risk assessment must be undertaken when family and domestic violence has been identified…
>
> Risk assessment is conducted for a number of reasons including:
>
> - evaluating the risk of re-assault for a victim;
> - evaluating the risk of homicide;
> - informing service system and justice responses;
> - supporting women to understand their own level of risk and the risk to children and/or to validate a woman's own assessment of her level of safety; and
> - establishing a basis from which a case can be monitored.
>
> (pages 36-37)

The Ombudsman's family and domestic violence fatality reviews and the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, have noted that, where agencies become aware of family and domestic violence, they do not always undertake a comprehensive assessment of the associated risk of harm and provide support and safety planning.

In the report, the Ombudsman made eight recommendations (Recommendations 40 – 44 and 48 – 50) to public authorities that they ensure compliance with their family and domestic violence policy requirements, including assessing risk of future harm and providing support to address the impact of experiencing family and domestic violence.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to all these recommendations. Subsequent to these recommendations, Action Item 12 of the First Action Plan intends to update the *Common Risk Assessment and Risk Management Framework* to '[s]trengthen approaches to risk management and information sharing'. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 48 (58%) of the 83 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2023, prior family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities. The Ombudsman's reviews identify where perpetrators have a history of reported violence, with one or more partners, and examines steps taken to hold perpetrators to account for their actions and support them to cease their violent behaviours.

The Ombudsman's reviews have noted that victims and perpetrators of family and domestic violence may be under the age of 18 years. Youth intimate partner violence may require a different response to adult intimate partner violence, particularly to address perpetrator behaviours.

Case Study

Responding to youth intimate partner violence

In reviewing a family and domestic violence fatality involving youth intimate partner violence, the Ombudsman has identified the need for WA Police Force to amend practice, so that such matters are not closed without proceeding to a Family Violence Incident Report and referral to the Family and Domestic Violence Response Team, to enable the provision of support to the youth perpetrator and/or youth victim. The Ombudsman made the following recommendation:

> That the WA Police Force provides this office with the amended version of its *Family Violence Procedural Guidelines* once finalised, confirming that all FDV incidents involving children will require submission of a *Family Violence Incident Report* and cannot be closed at computer aided dispatch.

Fatalities with no prior reported family and domestic violence

Based on the information available to the Office, in 35 (42%) of the 83 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2023, the fatal incident was the only family and domestic violence between the parties that had been reported to WA Police Force and/or other public authorities. It is important to note, however, research indicating under-reporting of family and domestic violence. The Australian Bureau of Statistics' *Personal Safety Survey 2016* (www.abs.gov.au) collected information about help seeking behaviours, noting that:

- In the most recent incident of physical assault by a male, women were most likely to be physically assaulted by a male that they knew (92% or 977,600).

And

- Two-thirds of men and women who experienced physical assault by a male did not report the most recent incident to police (69% or 908,100 for men and 69% or 734,500 for women).

The Ombudsman's reviews provide information on family and domestic violence fatalities where there is no previous reported history of family and domestic violence, including cases where information becomes available after the death to confirm a history of unreported family and domestic violence, drug or alcohol use, or mental health issues that may be relevant to the circumstances of the fatality.

The Ombudsman will continue to collate information on family and domestic violence fatalities where there is no reported history of family and domestic violence, to identify patterns and trends and consider improvements that may increase reporting of family and domestic violence and access to supports.

Family violence involving Aboriginal people

Of the 160 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2023, Aboriginal Western Australians were over-represented, with 53 (33%) persons who died being Aboriginal. In all but six cases, the suspected perpetrator was also Aboriginal. There were 41 of these 53 fatalities where the person who died lived in a regional or remote area of Western Australia, of which 31 were intimate partner fatalities.

The Ombudsman's family and domestic violence fatality reviews and the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities,* November 2015, identify the over-representation of Aboriginal people in family and domestic violence fatalities. This is consistent with the research literature that Aboriginal people are 'more likely to be victims of violence than any other section of Australian society' (Cripps, K and Davis, M, *Communities working to reduce Indigenous family violence*, Brief 12, Indigenous Justice Clearinghouse, New South Wales, June 2012, p. 1) and that Aboriginal people experience family and domestic violence at 'significantly higher rates than other Australians' (Aboriginal and Torres Strait Islander Social Justice Commissioner, *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities – Key Issues, An overview paper of research and findings by the Human Rights and Equal Opportunity Commission, 2001 – 2006*, Human Rights and Equal Opportunity Commission, June 2006, p. 6).

Contextual factors for family violence involving Aboriginal people

As discussed in the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities,* November 2015, the research literature suggests that there are a number of contextual factors contributing to the prevalence and seriousness of family violence in Aboriginal communities and that:

> …violence against women within the Indigenous Australian communities need[s] to be understood within the specific historical and cultural context of colonisation and systemic disadvantage. Any discussion of violence in contemporary Indigenous communities must be located within this historical context. Similarly, any discussion of "causes" of violence within the community must recognise and reflect the impact of colonialism and the indelible impact of violence perpetrated by white colonialists against Indigenous peoples
>
> … A meta-evaluation of literature … identified many "causes" of family violence in Indigenous Australian communities, including historical factors such as: collective dispossession; the loss of land and traditional culture; the fragmentation of kinship systems and Aboriginal law; poverty and unemployment; structural racism; drug and alcohol misuse; institutionalisation; and the decline of traditional Aboriginal men's role and status – while "powerless" in relation to mainstream society, Indigenous men may seek compensation by exerting power over women and children...
>
> (Blagg, H, Bluett-Boyd, N, and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 3).

The report notes that, in addition to the challenges faced by all victims in reporting family and domestic violence, the research literature identifies additional disincentives to reporting family and domestic violence faced by Aboriginal people:

> Indigenous women continuously balance off the desire to stop the violence by reporting to the police with the potential consequences for themselves and other family members that may result from approaching the police; often concluding that the negatives outweigh the positives. Synthesizing the literature on the topic reveals a number of consistent themes, including: a reluctance to report because of fear of the police, the perpetrator and perpetrator's kin; fear of "payback" by the offender's family if he is jailed; concerns the offender might become "a death in custody"; a cultural reluctance to become involved with non-Indigenous justice systems, particularly a system viewed as an instrument of dispossession by many people in the Indigenous community; a degree of normalisation of violence in some families and a degree of fatalism about change; the impact of "lateral violence" … which makes victims subject to intimidation and community denunciation for reporting offenders, in Indigenous communities; negative experiences of contact with the police when previously attempting to report violence (such as being arrested on outstanding warrants); fears that their children will be removed if they are seen as being part of an abusive house-hold; lack of transport on rural and remote communities; and a general lack of culturally secure services.
>
> (Blagg, H, Bluett-Boyd, N and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 13).

More recently, the ANROWS (Australian National Research Organisation for Women's Safety) Horizons Research Report entitled *Innovative Models in addressing violence against Indigenous women: Final report* (January 2018, available at www.anrows.org.au) informs:

> This research report undertakes a critical inquiry into responses to family violence in a number of remote communities from the perspective of Aboriginal people who either work within the family violence space or have had experience of family violence. It explicitly foregrounds Indigenous knowledge of family violence, arguing that Indigenous knowledge departs from what we call in this report "mainstream knowledge" in a number of critical respects. The report is based on qualitative research in three sites in Australia: Fitzroy Crossing (Western Australia), Darwin (Northern Territory), and Cherbourg (Queensland). It supports the creation of a network of regionally based Indigenous family violence strategies owned and managed by Indigenous people and linked to initiatives around alcohol reduction, intergenerational trauma, social and emotional wellbeing, and alternatives to custody. The key theme running through our consultations was that innovative practice must be embedded in Aboriginal law and culture. This recommendation runs counter to accepted wisdom regarding intervention in family and domestic violence, which tends to assume that gender trumps other differences, and that violence against women results from similar forms of oppression, linked to gender inequalities and patriarchal forms of power. While not disputing the role of gender and coercion in underpinning much violence against Indigenous women, we, nonetheless, claim that a distinctively Indigenous approach to family violence necessitates exploring causal factors that reflect specifically Indigenous experiences of colonisation and its aftermath. (page 9)

The Ombudsman's reviews and report have Identified that Aboriginal victims want the violence to end, but not necessarily always through the use of family violence restraining orders. The Ombudsman's reviews have also examined agency action to facilitate co-design of locally based solutions to promote Aboriginal family and community safety. In 2020-21, the Ombudsman has made four recommendations that seek to support community led solutions. The implementation of these recommendations is reported later in this section.

A separate strategy to prevent and reduce Aboriginal family violence

In examining the family and domestic violence fatalities involving Aboriginal people, the research literature and stakeholder perspectives, the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identified a gap in that there is no strategy solely aimed at addressing family violence experienced by Aboriginal people and in Aboriginal communities.

The findings of the report strongly support the development of a separate strategy that is specifically tailored to preventing and reducing Aboriginal family violence. This can be summarised as three key points.

Firstly, the findings set out in Chapters 4 and 5 of the report identify that Aboriginal people are over-represented, both as victims of family and domestic violence and victims of fatalities arising from this violence.

Secondly, the research literature, discussed in Chapter 6 of the report suggests a distinctive '…nature, history and context of family violence in Aboriginal and Torres Strait Islander communities' (National Aboriginal and Torres Strait Islander Women's Alliance, *Submission to the Finance and Public Administration Committee Inquiry into Domestic Violence in Australia*, National Aboriginal and Torres Strait Islander Women's Alliance, New South Wales, 31 July 2014, p. 5). The research literature further suggests that combating violence is likely to require approaches that are informed by and respond to this experience of family violence.

Thirdly, the findings set out in the report demonstrate how the unique factors associated with Aboriginal family violence have resulted in important aspects of the use of violence restraining orders by Aboriginal people which are different from those of non-Aboriginal people.

The report also identified that development of the strategy must include and encourage the involvement of Aboriginal people in a full and active way, at each stage and level of the development of the strategy, and be comprehensively informed by Aboriginal culture. Doing so would mean that an Aboriginal family violence strategy would be developed with, and by, Aboriginal people. In the report, the Ombudsman recommended that:

> Recommendation 4: DCPFS, as the lead agency responsible for family and domestic violence strategic planning in Western Australia, develops a strategy that is specifically tailored to preventing and reducing Aboriginal family violence, and is linked to, consistent with, and supported by *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*.
>
> Recommendation 6: In developing a strategy tailored to preventing and reducing Aboriginal family violence, referred to at Recommendation 4, DCPFS actively invites and encourages the involvement of Aboriginal people in a full and active way at each stage and level of the process, and be comprehensively informed by Aboriginal culture.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to these recommendations. In December 2022, seven years after the Ombudsman recommendation, Communities launched the *Aboriginal Family Safety Strategy 2022-2032*. This Office will continue to monitor the finalisation and implementation of the *Aboriginal Family Safety Strategy 2022-2032*.

Case Study

Ensuring culturally safe and responsive practice

In reviewing a youth intimate partner fatality, where the families were known to Communities, the Ombudsman has identified the importance of culturally safe and responsive practice. The Ombudsman made the following recommendation:

> That the Department of Communities undertakes immediate and ongoing action to provide culturally safe and responsive practice in the context of Child Safety Investigatio''s and Intensive Family Support, and associated statutory obligations, with Aboriginal children and families, across the State, while the long-term work of the *Aboriginal Cultural Capability Reform Program* is progressed. Communities will provide a report to the Ombudsman, within three months of the finalisation of this review, on the progress of the immediate and ongoing actions that are being implemented.

Limited use of violence restraining orders

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identified that while Aboriginal people are significantly over-represented as victims of family and domestic violence, they are less likely than non-Aboriginal people to seek a violence restraining order. The report examined the research literature and views of stakeholders on the possible reasons for this lower use of violence restraining orders by Aboriginal people, identifying that the process for obtaining a violence restraining order is not necessarily always culturally appropriate for Aboriginal victims and that Aboriginal people in regional and remote locations face additional logistical and structural barriers in the process of obtaining a violence restraining order.

In the report, the Ombudsman recommended that:

> Recommendation 23: DOTAG, in collaboration with key stakeholders, considers opportunities to address the cultural, logistical and structural barriers to Aboriginal victims seeking a violence restraining order, and ensures that Aboriginal people are involved in a full and active way at each stage and level of this process, and that this process is comprehensively informed by Aboriginal culture.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DOTAG had taken steps and proposed steps to be taken to give effect to this recommendation. Subsequent to this recommendation, Action Item 25 of the First Action Plan intends to '[d]evelop a Department of Justice Aboriginal Family Safety Strategy'. More recently, in December 2022, the Department of Justice informed this office that work has commenced to develop this *Aboriginal Family Safety Strategy*. The Office will continue to monitor, and report on, the steps being taken to implement this action item.

The November 2015 report noted that data examined by the Office concerning the use of police orders and violence restraining orders by Aboriginal people in Western Australia indicates that Aboriginal victims are more likely to be protected by a police order than a violence restraining order. This data is consistent with information examined in the Ombudsman's reviews of family and domestic violence fatalities involving Aboriginal people. In the report, the Ombudsman recommended that:

> Recommendation 16: DCPFS considers the findings of the Ombudsman's investigation regarding the link between the use of police orders and violence restraining orders by Aboriginal people in developing and implementing the Aboriginal family violence strategy referred to in Recommendation 4.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to this recommendation.

The findings from the Ombudsman's family and domestic violence fatality reviews and the own motion investigations will contribute to the development of Action Item 25 of the First Action Plan, and the Office will continue to monitor, and report on, the steps being taken to implement Recommendation 16 from the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015.

Strategies to recognise and address the co-occurrence of alcohol consumption and Aboriginal family violence

The Ombudsman's reviews of the family and domestic violence fatalities of Aboriginal people and prior reported family violence between the parties, identify a high co-occurrence of alcohol consumption and family violence. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, examined the research literature on the relationship between alcohol use and family and domestic violence and found that the research literature regularly identifies alcohol as 'a significant risk factor' associated with intimate partner and family violence in Aboriginal communities (Mitchell, L, *Domestic violence in Australia – an overview of the issues*, Parliament of Australia, 2011, Canberra, accessed 16 October 2014, pp. 6-7). As with family and domestic violence in non-Aboriginal communities, the research literature suggests that 'while alcohol consumption [is] a common contributing factor … it should be viewed as an important situational factor that exacerbates the seriousness of conflict, rather than a cause of violence' (Buzawa, E, Buzawa, C and Stark, E, *Responding to Domestic Violence*, Sage Publications, 4th Edition, 2012, Los Angeles, p. 99; Morgan, A. and McAtamney, A. 'Key issues in alcohol-related violence,' *Australian Institute of Criminology*, Canberra, 2009, viewed 27 March 2015, p. 3).

In the report, the Ombudsman recommended that:

> Recommendation 5: DCPFS, in developing the Aboriginal family violence strategy referred to at Recommendation 4, incorporates strategies that recognise and address the co-occurrence of alcohol use and Aboriginal family violence.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to this recommendation. The *Aboriginal*

Family Safety Strategy 2022-2032, launched by Communities in December 2022, identifies 'the need to respond to the different drivers of violence experienced by Aboriginal people, which may include poor or inadequate housing, barriers to accessing services, high rates of imprisonment, unemployment and alcohol and other substance use'. It is anticipated that further information on addressing these drivers will be available when an associated action plan is released.

Strategies to address the over-representation of family violence involving Aboriginal people in regional WA

Of the 53 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2023 involving Aboriginal people, 41 (77%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Nineteen (36%) of the Aboriginal people who died lived in the Kimberley region, which is home to 1.3% of all people and 16% of Aboriginal people in the Western Australian population.

As outlined above, *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to Recommendations 4 and 6 of the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015. These recommendations related to DCPFS developing 'a strategy that is specifically tailored to preventing and reducing Aboriginal family violence' that would encompass all regions of Western Australia and would ensure actively inviting and encouraging 'the involvement of Aboriginal people in a full and active way at each stage and level of the process' and being 'comprehensively informed by Aboriginal culture'. Subsequent to these recommendations, Item 5 of the First Action Plan intends to '[c]o-design the Aboriginal Family Safety Strategy with Aboriginal people and communities'. The *Aboriginal Family Safety Strategy 2022-2032* was launched by Communities in December 2022 and associated action plans are yet to be released, The Ombudsman's reviews have also examined agency action to facilitate co-design of locally based solutions to promote Aboriginal family and community safety. In 2020-21, the Ombudsman made four recommendations that seek to support community led solutions. The implementation of these recommendations is reported later in this section.

Factors co-occurring with family and domestic violence

Where family and domestic violence co-occurs with alcohol use, drug use and/or mental health issues, a collaborative, across service approach is needed. Treatment services may not always identify the risk of family and domestic violence and provide an appropriate response.

Co-occurrence with alcohol and other drug use

Consistent with the research literature relating to the co-occurrence between alcohol consumption and/or drug use and incidents of family and domestic violence (as outlined in the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015), the State Strategy notes that:

> Other intersecting factors, such as mental ill health and problematic use of alcohol and other drugs, can compound the severity and consequences of family and domestic violence. Mental ill health and the use of alcohol and other drugs do not cause family and domestic violence, but their contribution to the frequency and severity of violence and abuse means consideration of these factors is critical in the responses developed under this Strategy.

On the information available, relating to the 129 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2023, the Office's reviews identify where alcohol use and/or drug use are factors associated with the fatality, and where there may be a history of alcohol use and/or drug use.

	ALCOHOL USE		DRUG USE	
	Associated with fatal event	Prior history	Associated with fatal event	Prior history
Person who died only	4	6	6	10
Suspected perpetrator only	11	18	19	24
Both person who died and suspected perpetrator	40	48	15	26
Total	**55**	**72**	**40**	**60**

Stakeholders have suggested to the Ombudsman that programs and services for victims and perpetrators of violence in Western Australia, including family and domestic violence, do not address its co-occurrence with alcohol and other drug abuse. Specifically, this means that programs and services addressing family and domestic violence:

- May deny victims or perpetrators access to their services, particularly if they are under the influence of alcohol and other drugs; and
- Frequently do not address victims' or perpetrators' alcohol and other drug abuse issues.

Conversely, stakeholders have suggested programs and services which focus on alcohol and other drug use generally do not necessarily:

- Address perpetrators' violent behaviour; or
- Respond to the needs of victims resulting from their experience of family and domestic violence.

The Office will monitor the effectiveness of the State Strategy to reduce family and domestic violence, in responding to family and domestic violence and co-occurrence with alcohol and drugs.

Co-occurrence of mental health issues

As noted in the previous section, the State Strategy recognises that 'mental ill health…can compound the severity and consequences of family and domestic violence'.

The Ombudsman's reviews have examined steps taken by mental health service providers to assess patient risk of violence and to develop relevant safety planning where appropriate. The Office will continue to monitor action taken by mental health service providers to reduce the risk of family and domestic violence fatalities.

Issues Identified in Family and Domestic Violence Fatality Reviews

The following are the types of issues identified when undertaking family and domestic violence fatality reviews.

It is important to note that:

- Issues are not identified in every family and domestic violence fatality review; and
- When an issue has been identified, it does not necessarily mean that the issue is related to the death.

- Not providing culturally safe and responsive practice when working with Aboriginal families.
- Not using interpreters where appropriate.
- Not complying with agency policy and practices in responding to family and domestic violence, and limited effective governance to ensure compliance.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities for body worn camera activation while investigating reported incidents of FDV.
- Not adequately investigating offences in the context of family and domestic violence.
- Missed opportunities to address family and domestic violence victim safety.
- Missed opportunity to respond to youth intimate partner family and domestic violence.
- Missed opportunity to assess risk of harm and develop strategies to reduce or prevent family and domestic violence in the context of mental health issues and/or drug and alcohol use.
- Not undertaking sufficient family, intra-agency, inter-agency and Aboriginal Community Controlled Organisation communication to enable effective case management and collaborative responses.
- Not adequately meeting policy and procedures of the Family and Domestic Violence Response Team, including instigation of multi-agency case management meetings.
- Inaccurate recordkeeping.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following six recommendations were made by the Ombudsman in 2022-23 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. That the WA Police Force provides this office with the amended version of its *Family Violence Procedural Guidelines* once finalised, confirming that all family and domestic violence incidents involving children will require submission of a *Family Violence Incident Report* and cannot be closed at computer aided dispatch.

2. The WA Police Force accept that family and domestic violence and Aboriginal Family Violence is a crime of violence predominantly perpetrated by men (including young men) against predominantly women (including young women), that no culture accepts this violence and that it is condemned by all cultures, and that the role of the WA Police Force, as first responders, is always to protect primary and secondary victims (i.e. children of primary victims) from violence, using every legal means possible. WA Police Force will continue to ensure that its recruitment, training and standards monitoring reflect this fact.

3. That Communities undertakes an audit of the provision of case practice guidance, including supervision and consultation to the Regional Child Safety Team and Regional Intensive Family Support team, with the outcome of this audit, and all relevant documentation, to be provided to the Ombudsman within six months of the completion of this family and domestic violence fatality review.

   The audit should:
   a. Identify any barriers and contextual factors to the provision of case practice guidance, including supervision and consultation in the Regional District in accordance with Communities' standards and practice requirements in all the circumstances; and
   b. Evaluate the quality and quantity of case practice guidance, including supervision and consultation delivered in the Regional District from 1 January 2022 to 30 June 2022.

4. That Communities undertakes immediate and ongoing action to provide culturally safe and responsive practice in the context of Child Safety Investigation's and Intensive Family Support, and associated statutory obligations, with Aboriginal children and families, across the State, while the long-term work of the Aboriginal Cultural Capability Reform Program is progressed. Communities will provide a report to the Ombudsman, within three months of the finalisation of this review, on the progress of the immediate and ongoing actions that are being implemented.

5. WA Country Health Service provides this office with an update, within six months of the finalisation of this review, on the progress of the 'audit' referred to in the WACHS Cultural Governance Framework, relating to current tools used to assess Aboriginal patient's 'physical, spiritual, social and emotional wellbeing', with respect to alleged FDV, mental health issues, adolescent substance use and child protection risk, across hospital and community health services, to confirm

these tools are culturally valid, and that associated pathways for risk identified by these tools are culturally responsive and effective.

6. That the Department of Education reports back to the Ombudsman, six months following finalisation of this review, outlining its consideration of whether further action is required to:
   a. provide support to school aged children who are pregnant and/or parenting; and
   b. promote school aged pregnant and/or parenting students' engagement in education, in accordance with Part 2, Divisions 1 and 3 of the School Education Act 1999.

   This consideration includes, but is not limited to:
   (i) minimum standards of practice.
   (ii) current guidance to schools and regions (including Participation Teams).
   (iii) culturally informed responsive practice for Aboriginal and Torres Strait Islander students, and Culturally and Linguistically Diverse students.

   to optimise education achievement and outcomes.

The Ombudsman's *Annual Report 2023-24* will report on the steps taken to give effect to the one recommendation made about ways to prevent or reduce family and domestic violence fatalities in 2021-22. The Ombudsman's *Annual Report 2024-25* will report on the steps taken to give effect to the six recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2022-23.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2020-21

The Ombudsman made eight recommendations about ways to prevent or reduce family and domestic violence fatalities in 2020-21. The Office has requested that the relevant public authorities notify the Ombudsman regarding:

- The steps that have been taken to give effect to the recommendations;
- The steps that are proposed to be taken to give effect to the recommendations; or
- If no such steps have been, or are proposed to be taken, the reasons therefor.

Recommendation 1: In the context of Communities' commitment to the development of Aboriginal led, co-designed, local solutions to reduce family and domestic violence and promote safety, Communities provides a report to the Ombudsman by 31 December 2020 on the progress of the engagement with the Remote community to develop strategies to promote safety for women, children, and families.

Steps taken to give effect to the recommendation

Communities provided this office with a letter dated 5 January 2021, in which Communities relevantly informed this Office that:

In recognition of the number of family violence fatalities and child deaths that have occurred in similar circumstances in the Region, Communities has been working with stakeholders to identify and address the recurrent issues…

This progress update includes an overview of the work underway...

Focus one: Safety of Aboriginal women and children in Remote community

…Communities has been working to engage and build relationships with the Remote community to facilitate discussion about family violence, and options or opportunities to improve responses and create safety. The engagement work is primarily being facilitated through three processes:

1. establishment of the Joint Response Team;
2. engagement via the Regional Coordinator and Aboriginal Practice Leader; and
3. building relationships with the Community Chairperson and Remote community Aboriginal Corporation Board.

…Communities and WA Police Force have established a Joint Response Team (JRT) in the Region…Deployment of the JRT has provided the ideal opportunity to support and facilitate discussions about community safety overall, including in relation to family violence.

The JRT visits the Remote community and communities in the Region on a fortnightly basis (each location monthly)…The JRT is working to build relationships with the community to enable discussions and planning about the safety of women and children.

…

The JRT is also routinely accompanied by the district Aboriginal Practice Leader who assists with supporting culturally informed and appropriate engagement including in relation to following cultural protocols, understanding community governance and leadership, and connecting with key community members.

…

Thus far, the regular community engagement with the Remote community via the JRT, has enabled discussion about a range of safety measures that the community wishes to implement. These measures are wide ranging and include:

- how services (including WA Police Force) interact with, and respond to episodes of family violence;
- provisions for improving community safety at night, including improved lighting and installation of CCTV cameras;
- establishing a safe house; and
- introducing controls on young people's internet access to limit access to pornography (considered by the community to be a factor contributing to sexualised behaviours).

…

Focus three: Responding to family violence

Common themes arising from the Ombudsman's review of child deaths and family violence fatalities has been:

- the suitability of mainstream interventions for addressing Aboriginal family violence, particularly for women and children in remote locations;

- lack of understanding about family violence among professionals including the dynamics of coercive control and related indicators of risk for women and children. In several cases this was demonstrated to lead to incident focused assessment of family violence and plans for safety that did not adequately address the documented risk;
- lack of information exchange, coordination or collaboration between services to reduce or manage risk; and
- gaps in service system responses to women without children who are experiencing family violence, particularly following a WA Police Force response to family violence;

Communities is leading and/or involved in a range of initiatives to address these issues and improve responses to family violence. In the Region this includes development of a regional plan for responding to family violence. The regional plan will be aligned to *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020-2030* and will set out the work across government and community sector services that will be a focus in the Region. It will be developed and managed via a working group of the District Leadership Group.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

This recommendation has been actioned

Further information on Communities' engagement with the Remote community to develop strategies to promote safety for women, children, and families is outlined in Recommendation 8 below.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 2: DOJ provides a report to the Ombudsman by 31 March 2021 on:

- **the progress of discussions with the Western Australia Police Force to promote DOJ's timely access to Family Violence Incident Reports when managing family and domestic violence offenders on Community Based Orders; and**
- **the outcomes of the process evaluation of the Domestic Violence Screening Instrument (DVSI - R) for use with family and domestic violence offenders on Community Based Orders.**

Steps taken to give effect to the recommendation

DOJ provided this office with a letter dated 15 March 2021, in which DOJ relevantly informed this Office that:

The Department of Justice (the Department) is currently collating information at the request of the WA Police Force Information Management Directorate to support an application for Department staff to access FVIR's direct from the Police Incident Management System (IMS). Once approved, select Departmental staff will have access

to WA Police Force information that will be used to inform the assessment of adult FDV offenders serving an effective sentence of six months or greater in custody, and those managed in the community on Community Based Orders. The application for the Department to access IMS is part of an in-principle agreement between both agencies to develop a two-way information exchange process specifically relating to FDV perpetrators.

The DVSI-R pilot evaluation was finalised in November 2020 and the overall findings and feedback from Adult Community Corrections (ACC) staff was positive. It was reported that the tool was easy to use and fostered a more holistic approach to the assessment and case management of FDV offenders across agencies. It was noted that the use of a more diverse collection of information sources, including access to FVIR's provided a comprehensive profile of the offender's pattern of FDV behaviours and provided a greater victim focus.

The evaluation recommended that the roll out of the DVSI-R is extended to provide a more representative sample of community based offenders to further assess the discriminative and predictive ability of the tool. In response to this, ACC officers in the regions have been trained in the use of DVSI-R and are currently cascading the training across their respective areas.

This Office requested that DOJ inform the Office of any further information on the steps taken to give effect to the recommendation. In response, DOJ provided a range of information in a letter to this Office dated 15 March 2023, containing a report prepared by DOJ.

In DOJ's report, DOJ relevantly informed this Office that:

The Department has taken steps to give effect to the recommendation.

…in July 2022, a meeting was held between the Department, WA Police Force and the Department of Communities to discuss improvements to information sharing between these agencies.

An agreement was reached to establish a multi-agency Information Sharing Project comprising of three streams: Business, Legal and Technical Advisory Groups.

The objectives of these groups are to identify:

- opportunities to improve information sharing;
- what information would be beneficial; and
- technical or legal barriers that may hinder information exchange and whether information exchange should be limited to any person of interest or only relate to family violence.

To progress work by the Advisory Groups, a detailed list has been provided of the types of WA Police Force information that if shared with the Department could improve the case management of FDV offenders subject to Court and Early Release Orders.

…

Further to the Department's March 2021 report regarding the second element of the Ombudsman recommendation: State-wide rollout of the DVSI-R was completed in late

2021 for use by the Department's ACC. The DVSI-R screening tool is fully implemented as business as usual for ACC. When combined with other risk assessment tools, the DVSI-R enhances the assessment of FDV perpetrators including the risk of harm they pose to the victim/others and guides case management practice.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 3: Communities considers if any action is required to ensure safety planning for the parents' wellbeing is undertaken to address the potential escalation of FDV risk when a child is taken into the Chief Executive Officer's care in the context of FDV, in accordance with Section 2.3.5 Safety planning for emotional abuse - FDV of the Department's Casework Practice Manual, and reports back to the Ombudsman on the outcome of this consideration by 30 April 2021.

Steps taken to give effect to the recommendation

Communities provided this office with a letter dated 11 May 2021, in which Communities relevantly informed this Office that:

> Communities acknowledges that where a child is taken into the Chief Executive Officer (CEO's) care in the context of FDV, there is the potential for an escalation of risk to the adult survivor. Communities aims to reduce this risk via operational child protection responses and systemic mechanisms such as the Family and Domestic Violence Response Teams (FDVRT).
>
> Currently, Communities is consolidating FDV operations to ensure FDV informed approaches are embedded across child protection responses. This includes initiatives to strengthen responses to families who are experiencing FDV, including parents and adult survivors who have had children brought into the CEO's care, such as:
>
> - work towards the development of an FDV Informed Approach;
> - the review of Communities practice guidance in relation to FDV with a focus on child protection guidance, in accordance with the further development of the FDV Informed Approach;
> - the review of the FDVRTs; and
> - Safety Planning Bootcamps being delivered in Districts in 2021, which have a focus on safety planning responses to FDV.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> Current Status
>
> *Signs of Safety Bootcamps*
>
> In 2021, three day Signs of Safety Bootcamps were delivered in each child protection District. The Bootcamps had a focus on safety planning where concerns include FDV.

FDV Practice Guidance

The *Emotional Abuse – FDV Assessment Toolkit* (the Toolkit), which is available on the CPM as a Related Resource, contains guidance outlining that service intervention, including WA Police Force or child protection, can result in an escalation in a perpetrator's use of violence. Further, the Toolkit contains guidance for personal safety planning, including questioning prompts to explore increased times of danger.

Office of Prevention of Family and Domestic Violence

In March 2022, a dedicated Office for Prevention of Family and Domestic Violence (OPFDV) was established in the Strategy and Partnerships division of Communities. The intent of the OPFDV is to enhance the coordination, development, and implementation of family and domestic violence strategic policy across Western Australia, with a focus on improved outcomes in primary prevention, Aboriginal family safety, victim-survivor safety and perpetrator accountability…

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 4: Communities, with input from Regional Aboriginal communities including Aboriginal Community Controlled Organisations, reviews the five Tjallara Consulting documents on the Law and Culture Community Engagement Framework to consider their value for engagement with Aboriginal communities in the Regional district to co-design strategies to promote Aboriginal family and community safety and, informs the Ombudsman on the outcome by 30 September 2021.

Steps taken to give effect to the recommendation

Communities provided this office with a letter dated 29 September 2021, in which Communities relevantly informed this Office that:

> In line with the Ombudsman of Western Australia's recommendation, Communities has reviewed and considered the value of the five Tjallara Consulting documents on the *Law and Culture Community Engagement Framework* for engagement with Aboriginal communities in the Kimberley and more broadly across Western Australia. As you might be aware in July 2021, Communities contracted Tjallara Consulting (Managing Director, Professor Victoria Hovane) to engage with key stakeholders across the State including government, Aboriginal Community Controlled Organisations (ACCOs) and the sector to consult and co-design the development of the Aboriginal Family Safety Strategy. There were obvious synergies and efficiencies to be gained from the same consultant undertaking this important work. Communities will have ongoing discussions with Tjallara Consulting around the applicability and the appropriateness of the five documents on Law and Culture Community Engagement Framework that they developed when engaging ACCOs. Tjallara Consulting is currently completing these consultations. Communities will continue to keep the Ombudsman informed of the development of the Strategy and the resources used to inform this work.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

This recommendation has been actioned.

Since this update, the Aboriginal Family Safety Strategy was finalised and released, informed by consultation with more than 1000 people.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 5: That, for the period 2020-2022 prior to the co-design of the Aboriginal Family Safety Strategy, in its development of an FDV-Informed Approach underpinned by Safe & Together principles and core components, Communities:

- **requests the Aboriginal Cultural Council, in accordance with its remit of 'offering advice from an Aboriginal perspective, ensuring policy and practice development is informed with a cultural viewpoint', provide Communities with advice about the cultural safety of the Safe & Together Model for use across the diverse population of Aboriginal people, families and communities in Western Australia, including whether further action is required to 'validate' of 'adapt' the model to ensure cultural safety; and**
- **provides this Office with a report on the advice provided by the Aboriginal Cultural Council and, if relevant, information about how Communities will address that advice.**

Steps taken to give effect to the recommendation

Following the provision of this recommendation, the Communities Aboriginal Cultural Council was discontinued. This Office met with Communities on 30 June 2021 to discuss progression of this recommendation, in the absence of the Communities' Aboriginal Cultural Council structure. Communities subsequently provided this Office with an email dated 18 August 2021, in which Communities relevantly informed this Office that consultation had occurred with Yorgum Healing Services, Wungening Aboriginal Corporation and Men's Outreach Service Aboriginal Corporation (MOSAC) in relation to the recommendation. Communities then provided this Office with a letter dated 31 August 2021, in which Communities provided a copy of the report prepared by Communities: *Further consultation with Aboriginal people on the Safe and Together principles and critical components*. The report states that:

> …all three organisations stated they find the Safe and Together principles and critical components a suitable approach for their work with Aboriginal families experiencing family and domestic violence.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> In implementing the Ombudsman's recommendation, Communities engaged with Aboriginal Community Controlled Organisations trained in Safe and Together: Yorgum Healing Services (Yorgum), Wungening Aboriginal Corporation (Wungening) and the Men's Outreach Service Aboriginal Corporation (MOSAC). The three organisations reported that they found the Safe and Together principles and critical components suitable for supporting Aboriginal people and families experiencing family and domestic

violence, in circumstances where engagement is securely underpinned by culturally-informed and trauma-informed practice.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 6: Communities reiterates to the Regional District (including the Crisis Care Unit and after hour services) the role of Communities in facilitating access for Aboriginal people to safe, short stay accommodation options.

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> Actions taken by the Regional District
>
> …The Regional District has taken steps to increase Aboriginal people's access to safe accommodation within the District…
>
> Further, the Regional District staff have a good awareness of accommodation providers…, and staff and the broader District maintain a positive relationship with all…services. The Regional District routinely refers Aboriginal people to the services and provides funding for their stays…
>
> Actions taken by SRRS
>
> Following the death…, and since SRRS commenced their statewide function, the SRRS collated information on resources across Western Australia and made them available to staff via a sharepoint site. These resources are accessible by staff to assist vulnerable people, in particular women and survivor/victims of FDV, to access safe accommodation, including after hours.
>
> Further, over 50% of staff in SRRS have completed Safe and Together training, including guidance on assessing FDV and identifying victim/survivors. Staff have an increased understanding about Communities' roles and responsibilities to support vulnerable women to access safe and supported accommodation, particularly after hours.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 7: That, by 1 November 2021, the WA Police Force provides to the Ombudsman a report co-signed by the Department of Communities and a representative of the Remote Aboriginal Community, which details:

- **the dates and outcomes of Joint Response Team (JRT) visits to the Remote Aboriginal Community;**
- **the measures identified by the community, in discussion with the JRT, to improve family and community safety in the Remote Aboriginal Community;**
- **who is responsible for the measures and the anticipated completion date; and**
- **an update on the implementation of the measures to date.**

Steps taken to give effect to the recommendation

WA Police Force provided this office with a letter dated 31 October 2021, co-signed by WA Police Force and Communities, in which this Office was relevantly informed that:

> Communities and WA Police Force acknowledges the disproportionate impact of FDV on Aboriginal women, children, families, and communities and recognises the importance of Community owned and led solutions. FDV is a very serious issue in the Region and Remote Aboriginal Community Lands, where cultural practices are strong and the need for specialist knowledge and skills are required to meet the needs of the Community.
>
> In addition to the agreed initiatives…, the Women within the Remote Aboriginal Community during a recent informal meeting raised a request for a Safe House to be built in the community. No further discussion or decision has been made regarding the request for a Safe House, as further research and consultation is required to understand the full impacts of the suggestions.
>
> As partners of the JRT both agencies remain committed to ongoing visitation and consultation with the Remote Aboriginal Community, whilst remaining flexible to ensure there is due consideration and respect for cultural traditions and events and seasonal community population. Visits to the Community will remain centred around community safety issues including child sexual abuse and family and domestic violence.

The letter dated 31 October 2021 included a report, which confirmed the dates of nine Remote Aboriginal Community visits by the JRT that occurred between August 2020 and December 2021, and actions undertaken during these community visits. The report also outlined two initiatives identified by the Remote Aboriginal Community to improve family and community safety, agreed deliverables and an update on implementation. The report was signed by two representatives of the Remote Aboriginal Community.

This Office requested that WA Police Force inform the Office of any further information on the steps taken to give effect to the recommendation. In response, WA Police Force provided a letter to this Office dated 27 March 2023, containing the following table as an attachment:

Status	Proactive and Reactive actions
Ongoing	Region Detectives Office (RDO) respond to and investigate all reported Child Abuse in the Region District: • A strong working relationship is maintained with the Department of Communities by RDO for child abuse matters and by the Region District Family Violence Team for family violence matters, with the implementation of safety and harm reduction strategies for victims/survivors a priority. • For reports of child abuse, RDO, together with WA Police Force Child Abuse Squad, Child Assessment Interview Team, and Department of Communities, assess the risk, triage and prioritise the response and implement safety strategies for any child at risk of harm. There was one reported incident in 2022. • RDO attend Community (including by air) for any urgent incidents.
Ongoing	Region Police attend Remote Aboriginal Community every three to four weeks, staying approximately three days. The last visit was on 23 February 2023, with five officers remaining in community until 27 February 2023. Officers engage the Remote Community Aboriginal Corporation Community Development Advisor (CDA), Local Aboriginal Health Clinic, the Remote Community school, families and youth and discuss issues, how to improve community family and community safety and safety strategies. Police also engage Remote Aboriginal Community members when they visit Regional town (and reside in town Camp), and Officer in Charge Region maintains regular contact with CDA. Police will attend Remote Aboriginal Community (including by air) for any urgent incidents.
Completed	In May 2022, CCTV and additional lighting were installed in the Remote Aboriginal Community.
Ongoing	RWA Regional Office seeks to increase Region FTE under the growth program to better serve the Remote Aboriginal Community. Considerations for a multi-agency facility in the Remote Aboriginal Community are ongoing. COVID caused significant disruption to the planning of this concept.
Completed	To assist officers to provide a culturally appropriate response: • Region Police have a separate induction for Remote Aboriginal Community outlining cultural issues and mixing officers to maintain continuity and build experience. • Region Detectives are all current in Cultural Awareness training and are encouraged to undertake further studies to increase knowledge and awareness of Childhood trauma. Recent achievements include officers qualified in Childhood Trauma, with one officer having achieved a Post Graduate qualification in Aboriginal Studies.

	• Remote Aboriginal Community language is part of the WA Police Force Yarning app.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 8: That Communities works with the WA Police Force (the lead agency for the JRT) to provide to the Ombudsman by 1 November 2021 a report, co-signed by a representative of the Remote Aboriginal Community, which details:

- **the dates and outcomes of JRT visits to the Remote Aboriginal Community;**
- **the measures identified by the community, in discussion with the JRT, to improve family and community safety in the Remote Aboriginal Community;**
- **who is responsible for the measures and the anticipated completion date; and**
- **an update on the implementation of the measures to date.**

Steps taken to give effect to the recommendation

WA Police Force provided this office with a letter dated 31 October 2021, co-signed by WA Police Force and Communities, in which this Office was relevantly informed that:

> Communities and WA Police Force acknowledges the disproportionate impact of FDV on Aboriginal women, children, families, and communities and recognises the importance of Community owned and led solutions. FDV is a very serious issue in the Region and Remote Aboriginal Community Lands, where cultural practices are strong and the need for specialist knowledge and skills are required to meet the needs of the Community.
>
> In addition to the agreed initiatives…, the Women within the Remote Aboriginal Community during a recent informal meeting raised a request for a Safe House to be built in the community. No further discussion or decision has been made regarding the request for a Safe House, as further research and consultation is required to understand the full impacts of the suggestions.
>
> As partners of the JRT both agencies remain committed to ongoing visitation and consultation with the Remote Aboriginal Community, whilst remaining flexible to ensure there is due consideration and respect for cultural traditions and events and seasonal community population. Visits to the Community will remain centred around community safety issues including child sexual abuse and family and domestic violence.

The letter dated 31 October 2021 included a report, which confirmed the dates of nine Remote Aboriginal Community visits by the JRT that occurred between August 2020 and December 2021, and actions undertaken during these community visits. The report also outlined two initiatives identified by the Remote Aboriginal Community to improve family and community safety, agreed deliverables and an update on implementation. The report was signed by two representatives of the Remote Aboriginal Community.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> Joint Response Team actions to achieve the Ombudsman's recommendation
>
> …WA Police Force sent a report to the Ombudsman, which is co-signed by representatives of the Remote Aboriginal Community, and details:
>
> - the dates and outcomes of the Joint Response Team (JRT) visits to the Remote Aboriginal Community between August 2020 and December 2021; and
> - two measures identified by the Remote Aboriginal Community to improve family and community safety:
>   - plans for the installation of lighting and security cameras in the Remote Aboriginal Community by the Shire, which was an approved schedule of works to be completed in the 2021-2022 financial year.
>   - plans for Communities to be responsible for the JRT delivering 'culturally appropriate Protective Behaviours resources' with the Remote Aboriginal Community, from November 2021.
>
> …the following progress has been made to achieve the two measures identified by the Remote Aboriginal Community to improve family and community safety:
>
> - lighting and security cameras have now been installed near the women's centre and can be viewed from the community office; and
> - when the JRT visited the Remote Aboriginal Community in February 2022, Protective Behaviours was delivered in the local school.
>
> …
>
> Joint Response Team – other actions
>
> Since the Progress Update provided to the Ombudsman…, the JRT attended the Remote Aboriginal Community on three occasions, from 8 to 10 November 2021, 6 to 8 December 2021 and 14 to 17 February 2022.
>
> Communities have not undertaken any further visits to the Remote Aboriginal Community since February 2022, due to:
>
> - COVID outbreaks in the community…;
> - Communities' staff illness which prevented Communities from accompanying WA Police on a visit to the community in March 2022; and
> - the Senior Child Protection Worker – FDVRT who had led the previous visits to the Community is currently acting as the Team Leader for the Goldfields District Child Safety Team. The Senior Child Protection Worker – FDVRT position has remained vacant despite ongoing attempts to recruit to the position.
>
> It was planned for the Communities' Regional Executive Director and Aboriginal Practice Leader to travel to the Community in September 2022, to further consult the Community about their needs and views. This visit did not eventuate due to cultural business being undertaken in the community at the time and the community not wanting the visit to occur.

The Regional District have held some concerns about whether the JRT visits are welcomed by the community, whether the visits are achieving the purpose of promoting women and children's safety and whether the JRT visits have the potential to increase risks for FDV survivor safety…Women have expressed that they do not want meetings happening in the community, however talked about going out bush instead. In response to this feedback, during one visit workers did meet with some elder women out bush to cook damper and roo tail and speak about what was happening in the community.

The Regional District Leadership Team, including the Aboriginal Practice Leader, have held internal discussions in relation to how the Remote Aboriginal Community's safety can be best promoted via meeting with women outside of the community. These discussions are ongoing.

…

Region FDV Plan

A working group consisting of Communities and external stakeholders are currently developing a Project Plan for the Region FDV plan, which will seek to reduce FDV across the Regional District. The Plan will outline strategies and recommendations for how FDV will be reduced, and safety increased, across the Region.

As part of the development of the plan, Communities will undertake consultations with the Remote Aboriginal Community.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

The Office will continue to monitor, and report on, the steps being taken to give effect to the recommendations including through the undertaking of reviews of family and domestic violence fatalities and in the undertaking of major own motion investigations.

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of family and domestic violence fatalities. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2022-23, timely review processes have resulted in 44% of all reviews being completed within six months and 68% of reviews completed within 12 months.

Major Own Motion Investigations Arising from Family and Domestic Violence Fatality Reviews

In addition to investigations of individual family and domestic violence fatalities, the Office identifies patterns and trends arising out of reviews to inform major own motion investigations that examine the practice of public authorities that provide services to children, their families and their communities.

Details of own motion investigations are provided in the Own Motion Investigations, Monitoring and Improvement section.

Investigation into Family and Domestic Violence and Suicide

On Thursday 20 October 2022, the Ombudsman tabled in Parliament the report of his major own motion investigation titled *Investigation into family and domestic violence and suicide*. Arising from the findings of the investigation, the Ombudsman made nine recommendations to four government agencies about ways to prevent or reduce family and domestic violence related deaths by suicide.

Further details of this report is provided in the Own Motion Investigations, Monitoring and Improvement section.

The full report, *Investigation into family and domestic violence and suicide*, is available at: www.ombudsman.wa.gov.au/Publications/Reports/FDV-Suicide-2022-Volumes-1-to-4.pdf

Monitoring recommendations from major own motion investigations

The Office actively monitors the steps taken to give effect to recommendations arising from own motion investigations, including:

- *Investigation into family and domestic violence and suicide*, which was tabled in Parliament in October 2022; and
- *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, which was tabled in Parliament in November 2015.

Details of the Office's monitoring of the steps taken to give effect to recommendations arising from own motion investigations are provided in the Own Motion Investigations, Monitoring and Improvement section.

On 19 November 2015, the Ombudsman tabled in Parliament a report entitled *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*. Recommendation 54 of the report is as follows:

> Taking into account the findings of this investigation, DCPFS:
>
> - conducts a review to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance;
> - develops an associated action plan to overcome identified barriers; and
> - provides the resulting review report and action plan to this Office within 12 months of the tabling in the Western Australian Parliament of the report of this investigation.

Section 25(4) of the *Parliamentary Commissioner Act 1971* relevantly provides as follows:

> (4) If under subsection (2) the Commissioner makes recommendations to the principal officer of an authority he may request that officer to notify him, within a specified time, of the steps that have been or are proposed to be taken to give effect to the recommendations, or, if no such steps have been, or are proposed to be taken, the reasons therefor.

On 13 October 2016, the Director General of the (then) Department for Child Protection and Family Support (**DCPFS**) provided the Ombudsman with two documents constituting DCPFS's response to Recommendation 54. These were the *Family and Domestic Violence Practice Guidance Review Report* and the *Family and Domestic Violence – Practice Guidance Implementation*.

On 10 November 2016, the Ombudsman tabled in Parliament *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, which, among other things, identified that:

> The review report and action plan have been provided to the Office within 12 months of the tabling of the FDV Investigation Report, and will be reviewed by the Office and the results of this review reported on in the Office's 2016-17 Annual Report.

In the Office's *Annual Report 2016-17*, the Office identified that (the then) DCPFS's response to Recommendation 54 had been reviewed and that the Office's analysis would be tabled separately.

The Office has now concluded its review of the (now) Department of Communities' (**Communities**) review report. The Office has considered the *Family and Domestic Violence Practice Guidance Review Report* and that Communities has conducted a project to review its family and domestic violence practice guidance. The focus of the review conducted by Communities was to identify and recommend amendments to Communities' family and domestic violence practice guidance. The review did not include any actions 'to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance'. Further, while Communities identified several issues which potentially relate to barriers to effective implementation, a range of Communities' 'proposed actions' to overcome these potential barriers were not considered to be appropriate.

Following consideration of all of the above matters, the review conducted by Communities did not constitute a review to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance. As developing an associated action plan to overcome identified barriers was contingent on conducting a review to identify those barriers, the *Family and Domestic Violence – Practice Guidance Implementation* document did not constitute an associated action plan to overcome identified barriers.

In a pleasing response to this finding, Communities indicated the following:

> Communities acknowledges this finding and confirms it is a priority for Communities to address and implement the intent of the recommendation. It was the intent of the *Family and Domestic Violence Practice Guidance Review Report* (the report) and the *Family and Domestic Violence Practice Guidance Implementation* to do so. The report did help to identify a range of issues that limit the implementation of policy and practice guidance, and Communities has undertaken numerous activities and processes to address these. These include:
>
> - new toolkits for assessment and safety planning in cases of emotional abuse - family and domestic violence, which aim to support child protection workers to form an evidence-based professional judgement, and include practice examples of how to gather information to inform assessments, analyse the information, and practice examples of safety planning;
> - mandatory training concerning family and domestic violence for new and current employees to have a focus on effectively engaging perpetrators, including assessments within the training and in the field;
> - workshops and presentations with Team Leader and Senior Practice Development Officer groups to encourage strong leadership within districts of the policy and practice guidance;

- case consultation with child protection workers to provide opportunities for staff to reflect on and plan their practice;
- a centralised intake model in July 2017, including a 'threshold tool' to provide a consistent response to child protection referrals;
- a partnership with Curtin University, the University of Melbourne and the Safe and Together Institute in order to integrate techniques in working with perpetrators into practice; and
- a practice audit is currently being undertaken to assess the implementation to date of the family and domestic violence practice guidance, and to establish a baseline from which further audits or reviews of practice can be measured. The audit examines 50 cases (three from each district) at various stages of Communities' Child Protection and Family Support division involvement, identifies areas for practice improvement and provides opportunities to work with districts to improve understanding of key issues in the intersection between child protection and family and domestic violence.

Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

In addition to reviews of individual family and domestic violence fatalities and major own motion investigations, the Office uses a range of other mechanisms to improve public administration with a view to preventing or reducing family and domestic violence fatalities. These include:

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through working with public authorities and communities where individuals may be at risk of family and domestic violence to consider safety issues and potential areas for improvement, and to highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information, where appropriate, with other accountability and oversight agencies including Ombudsmen and family and domestic violence fatality review bodies in other States to facilitate consistent approaches and shared learning;
- Engaging with other family and domestic violence fatality review bodies in Australia through membership of the Australian Domestic and Family Violence Death Review Network (**the Network**). The Network worked in partnership with the Australia's National Research Organisation for Women's Safety (**ANROWS**) to publish the *Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2010-2018, Second Edition 2022*. This collaboration is also working to develop a national dataset of the characteristics of the deaths of children by parents to inform prevention initiatives at a national level;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

Efficient and effective liaison has been established with WA Police Force to develop and support the implementation of the process to inform the Office of family and domestic violence fatalities. Regular liaison occurs at senior officer level between the Office and WA Police Force.

Key stakeholder relationships

There are a number of public authorities and other bodies that interact with or deliver services to those who are at risk of family and domestic violence or who have experienced family and domestic violence. Important stakeholders, with which the Office liaised as part of the family and domestic violence fatality review function in 2021-22, included:

- The Coroner;
- Relevant public authorities including:
  - WA Police Force;
  - The Department of Health;
  - Health Service Providers;
  - The Department of Education;
  - The Department of Justice;
  - The Department of Communities;
  - The Mental Health Commission; and
  - Other accountability and similar agencies including the Commissioner for Children and Young People;
- The Centre for Women's Safety and Wellbeing and relevant non-government organisations; and
- Research institutions including universities.

Aboriginal and regional communities

In 2016, the Ombudsman established a Principal Aboriginal Consultant position to:

- Provide high level advice, assistance and support to the Corporate Executive and to staff conducting reviews and investigations of the deaths of certain Aboriginal children and family and domestic violence fatalities in Western Australia, complaint resolution involving Aboriginal people and own motion investigations; and
- Raise awareness of and accessibility to the Ombudsman's roles and services to Aboriginal communities and support cross cultural communication between Ombudsman staff and Aboriginal people.

In 2022-23, the Ombudsman created a critical new executive position, Assistant Ombudsman Aboriginal Engagement and Collaboration, which was filled by Laurence Riley in August 2022. This is the first time in the fifty year history of the Office that an Assistant Ombudsman position, and member of Corporative Executive, has been dedicated to Aboriginal Western Australians.

Significant work was undertaken throughout 2022-23 to continue to build relationships relating to the child death review jurisdiction with Aboriginal and regional communities, for example by communicating with:

- Key public authorities that work in regional areas;
- Non-government organisations that provide key services, such as health services to Aboriginal people; and
- Aboriginal community members and leaders to increase the awareness of the child death review function and its purpose.

Additional networks and contacts have been established to support effective and efficient child death reviews. This has strengthened the Office's understanding and knowledge of the issues faced by Aboriginal and regional communities that impact on child and family wellbeing and service delivery in diverse and regional communities.