



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;
- Analysis of family and domestic violence fatality reviews;
- Issues identified in family and domestic violence fatality reviews;
- Recommendations;
- 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 Reduce Violence against Women and their Children 2010-2022 (the National Plan)* identifies six key national outcomes:

- Communities are safe and free from violence;
- Relationships are respectful;
- Indigenous communities are strengthened;
- Services meet the needs of women and their children experiencing violence;
- Justice responses are effective; and
- Perpetrators stop their violence and are held to account.

The National Plan is endorsed by the Council of Australian Governments and supported by the *First Action Plan 2010-2013: Building a Strong Foundation* (available at www.dss.gov.au), which established the 'groundwork for the National Plan', and the *Second Action Plan 2013-2016: Moving Ahead* (available at www.dss.gov.au) and the *Third Action Plan 2016-2019* (available at www.dss.gov.au), which build upon this work.

The *WA Strategic Plan for Family and Domestic Violence 2009-13 (WA Strategic Plan)* and *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating safer communities (the State Strategy)*, available at www.dcp.wa.gov.au, include the following principles:

1. *Family and domestic violence and abuse is a fundamental violation of human rights and will not be tolerated in any community or culture.*

2. *Preventing family and domestic violence and abuse is the responsibility of the whole community and requires a shared understanding that it must not be tolerated under any circumstance.*
3. *The safety and wellbeing of those affected by family and domestic violence and abuse will be the first priority of any response.*
4. *Victims of family and domestic violence and abuse will not be held responsible for the perpetrator's behaviour.*
5. *Perpetrators of family and domestic violence and abuse will be held accountable for their behaviour and acts that constitute a criminal offence will be dealt with accordingly.*
6. *Responses to family and domestic violence and abuse can be improved through the development of an all-inclusive approach in which responses are integrated and specifically designed to address safety and accountability.*
7. *An effective system will acknowledge that to achieve substantive equality, partnerships must be developed in consultation with specific communities of interest including people with a disability, people from diverse sexualities and/or gender, people from Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds.*
8. *Children have unique vulnerabilities in family and domestic violence situations, and all efforts must be made to protect them from short and long term harm.*

The associated *Annual Action Plan 2009-10* identified a range of strategies 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* sets 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.

It was essential to the success of the establishment 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 was important that stakeholders understood the role of the Ombudsman, and the Office was able to understand the critical work of all key stakeholders.

Working arrangements were established to support implementation of the role with Western Australia Police (**WAPOL**) and the Department for Child Protection and Family Support (**DCPFS**)² and with other agencies, such as the Department of Corrective Services (**DCS**) and the Department of the Attorney General (**DOTAG**),³ and relevant courts.

² As of 1 July 2017, DCPFS became part of the new Department of Communities.

³ As of 1 July 2017, DCS and DOTAG became part of the new Department of Justice.



The Ombudsman’s Child Death Review Advisory Panel was expanded to include the new family and domestic violence fatality review role. Through the Ombudsman’s Advisory Panel (**the Panel**), and 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, engaged with other family and domestic violence fatality review bodies in Australia and New Zealand and, since 1 July 2012, has met regularly via teleconference with 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 WAPOL 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.

WAPOL 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 WAPOL contact with the person who died and the suspected perpetrator. A family and domestic violence fatality involves persons apparently in a ‘family and domestic 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.

'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 two people; or
- (b) Is related to the person's —
 - (i) Spouse or former spouse; or
 - (ii) De facto partner or former de facto partner.

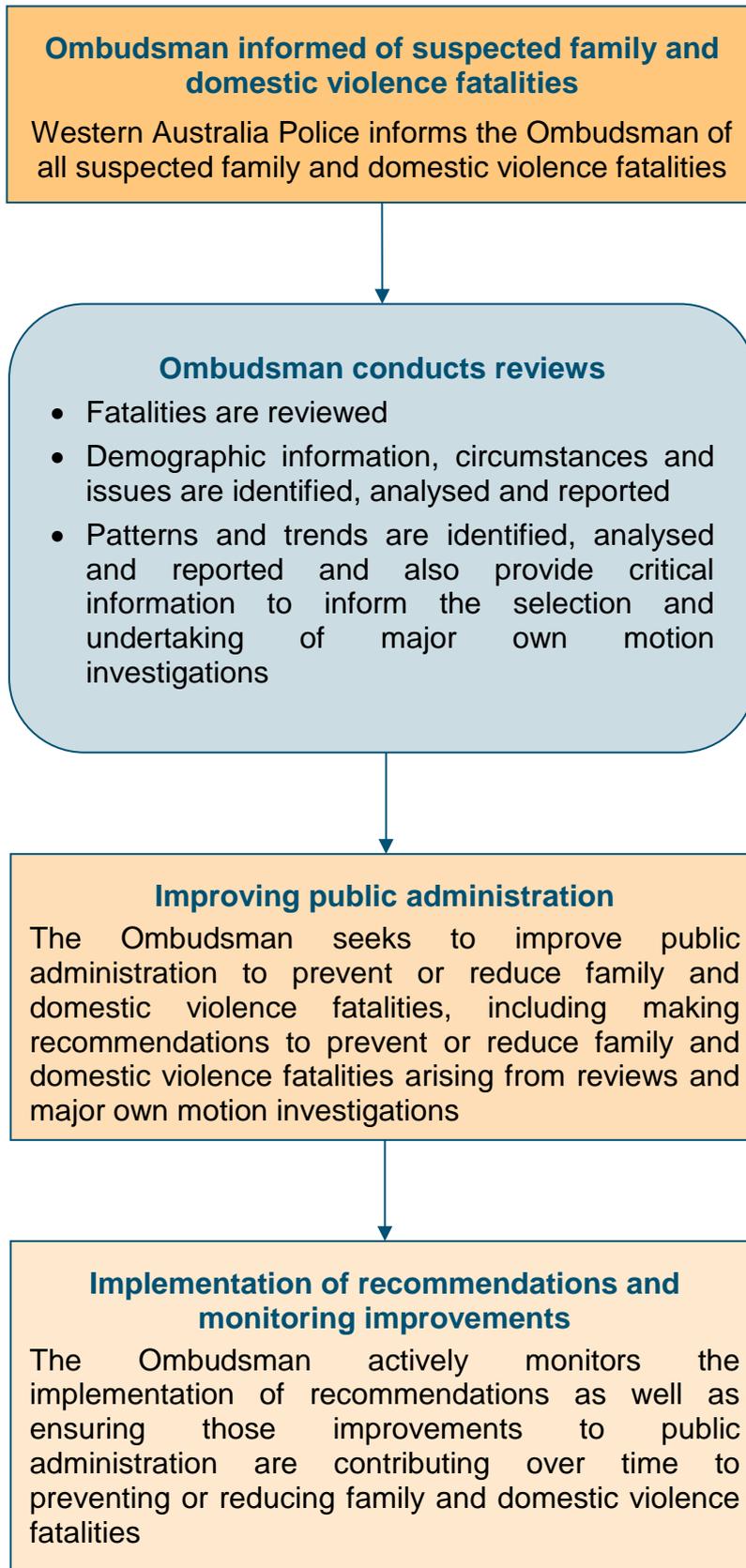
If the relationship meets these criteria, a review is undertaken.

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

Information on interpretation of data

Information in this section is derived from the 88 reviewable family and domestic violence fatalities received from 2012-13 to 2016-17. As the information in the following charts is based on five years of data, care should be undertaken in interpreting the data.

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.

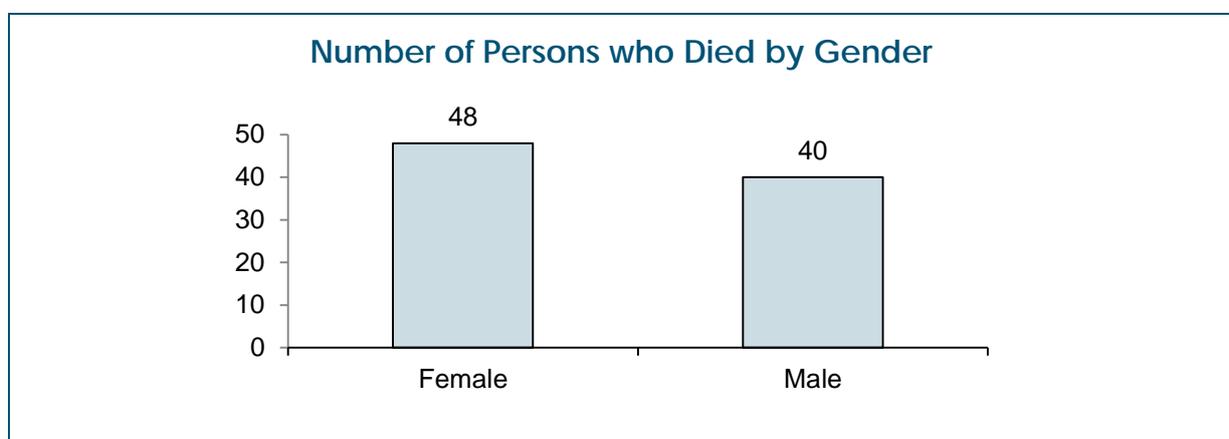
Number of family and domestic violence fatality reviews

In 2016-17, the number of reviewable family and domestic violence fatalities received was 15, compared to 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

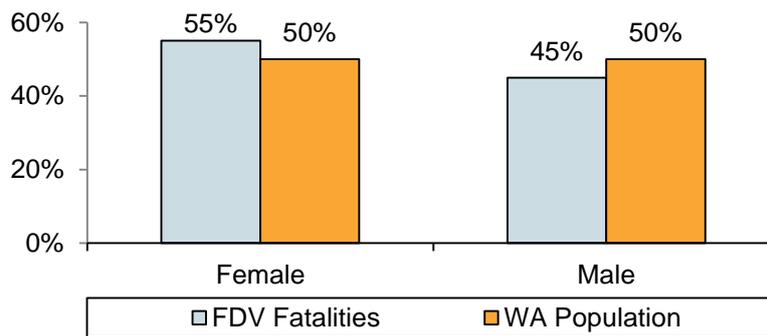
Information is obtained on a range of characteristics of the person who died, including gender, age group, Aboriginal status, and location of the incident in the metropolitan or regional areas.

The following charts show characteristics of the persons who died for the 88 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2017. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.





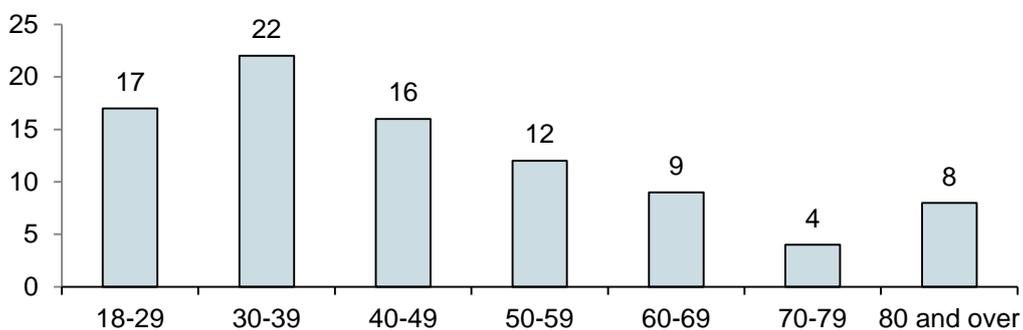
Gender of Persons who Died Compared to WA Population



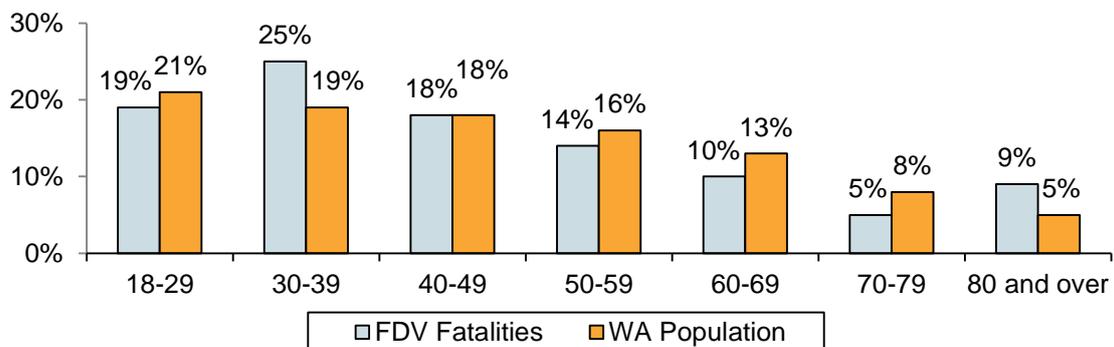
Compared to the Western Australian population, females who died in the five years from 1 July 2012 to 30 June 2017, were over-represented, with 55% of persons who died being female compared to 50% in the population.

In relation to the 48 females who died, 44 involved a male suspected perpetrator, three involved a female suspected perpetrator, and one involved multiple suspected perpetrators of both genders. Of the 40 men who died, seven were apparent suicides, 18 involved a female suspected perpetrator, 13 involved a male suspected perpetrator and two involved multiple suspected perpetrators of both genders.

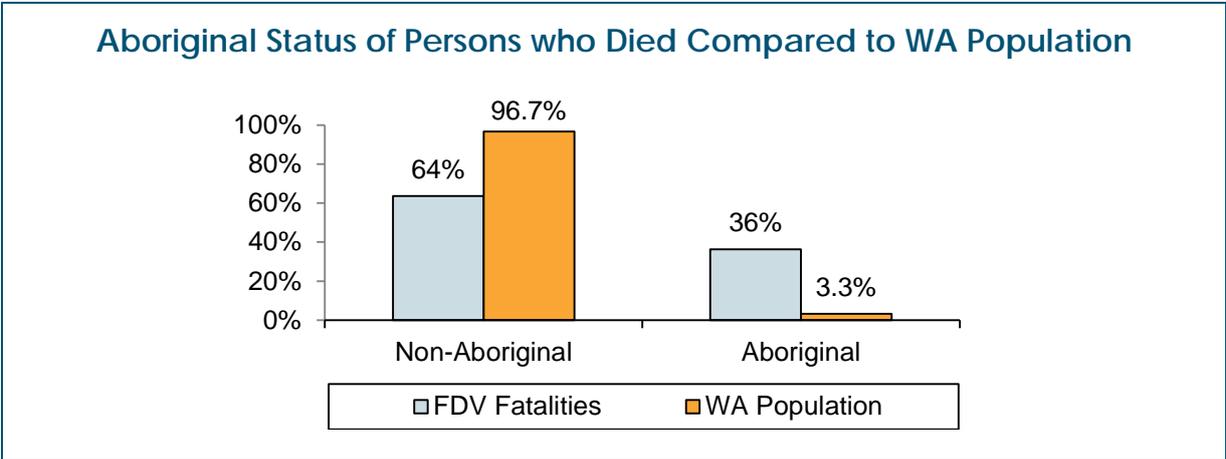
Number of Persons who Died by Age



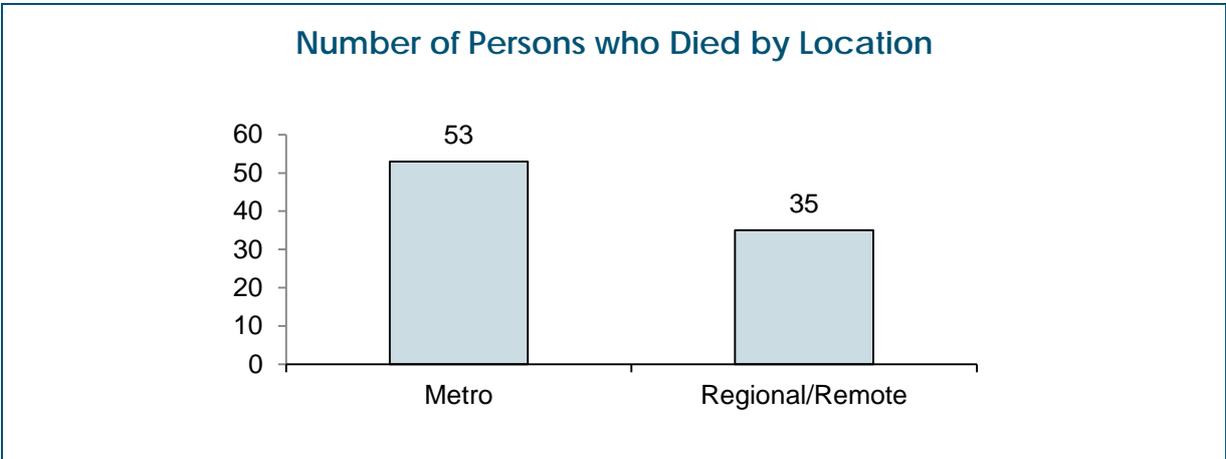
Age of Persons who Died Compared to WA Population

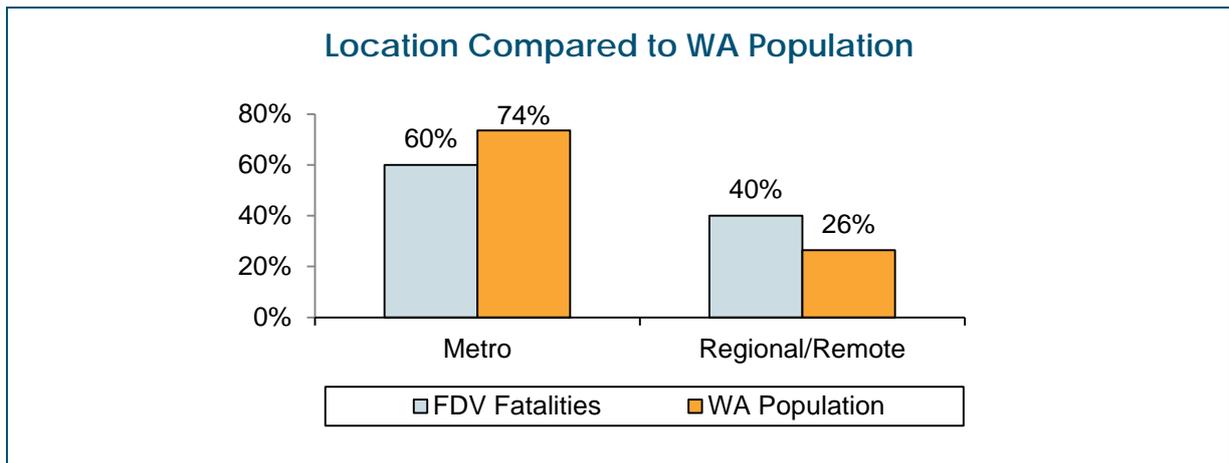


Compared to the Western Australian population, the age groups 30-39 and 80 and over are over-represented, with 25% of persons who died being in the 30-39 age group compared to 19% of the population, and nine percent of persons who died being in the 80 and over age group compared to five percent of the population.



Compared to the Western Australian population, Aboriginal people who died were over-represented, with 36% of people who died in the five years from 1 July 2012 to 30 June 2017 being Aboriginal compared to 3.3% in the population. Of the 32 Aboriginal people who died, 19 were female and 13 were male.





Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 40% of the people who died in the five years from 1 July 2012 to 30 June 2017 living in regional or remote locations, compared to 26% of the population living in those locations.

The WA Strategic Plan notes that:

While there has been debate about the reliability of research that quantifies the incidence of family and domestic violence, there is general agreement that ...

- *[A]n overwhelming majority of people who experience family and domestic violence are women, and*
- *Aboriginal women are more likely than non-Aboriginal women to be victims of family violence (page 4).*

More specifically, with respect to the impact on Aboriginal women in Western Australia, the WA Strategic Plan notes that:

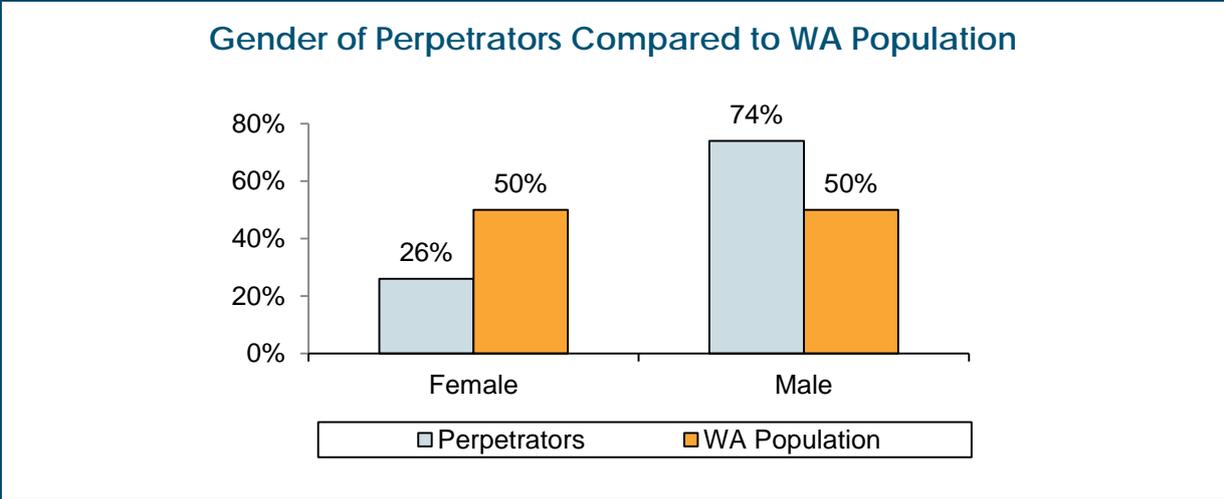
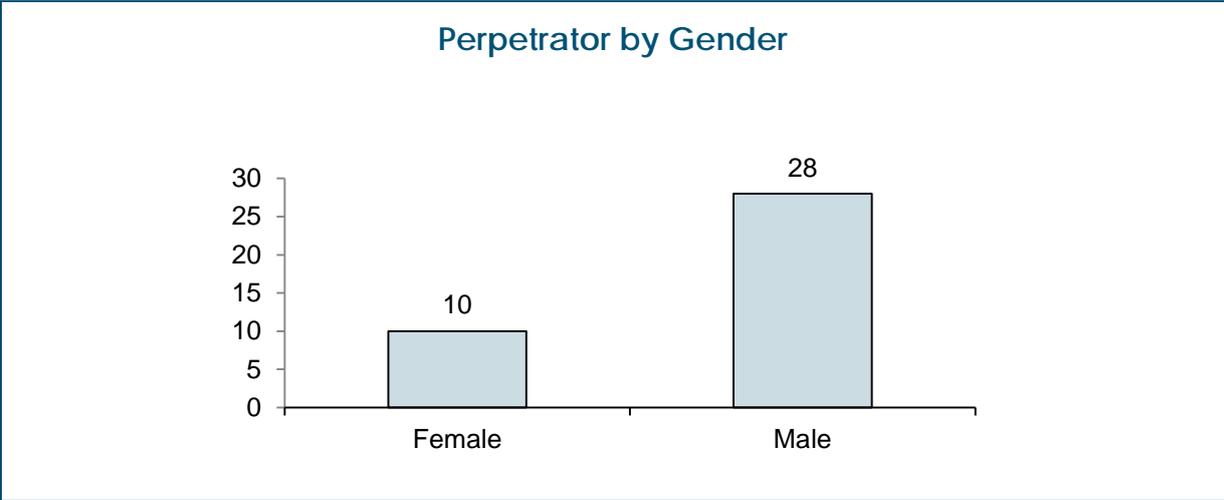
Family and domestic violence is particularly acute in Aboriginal communities. In Western Australia, it is estimated that Aboriginal women are 45 times more likely to be the victim of family violence than non-Aboriginal women, accounting for almost 50 per cent of all victims (page 4).

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 2017 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2017.

Of the 88 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2017, coronial and criminal proceedings were finalised in 38 cases.

Information is obtained on a range of characteristics of the perpetrator including gender, age group and Aboriginal status. The following charts show characteristics for the 38 perpetrators where both the coronial process and the criminal proceedings have been finalised.

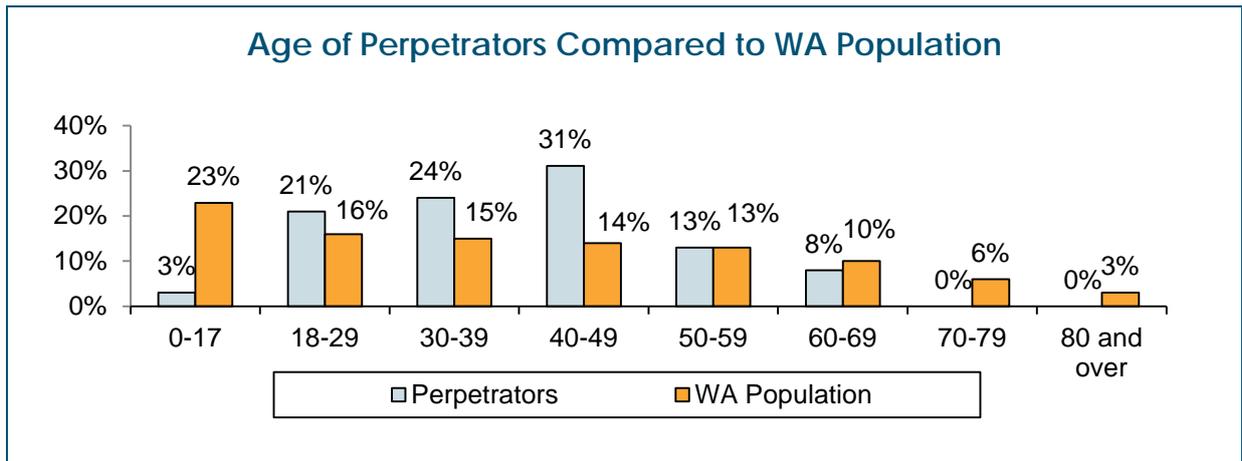
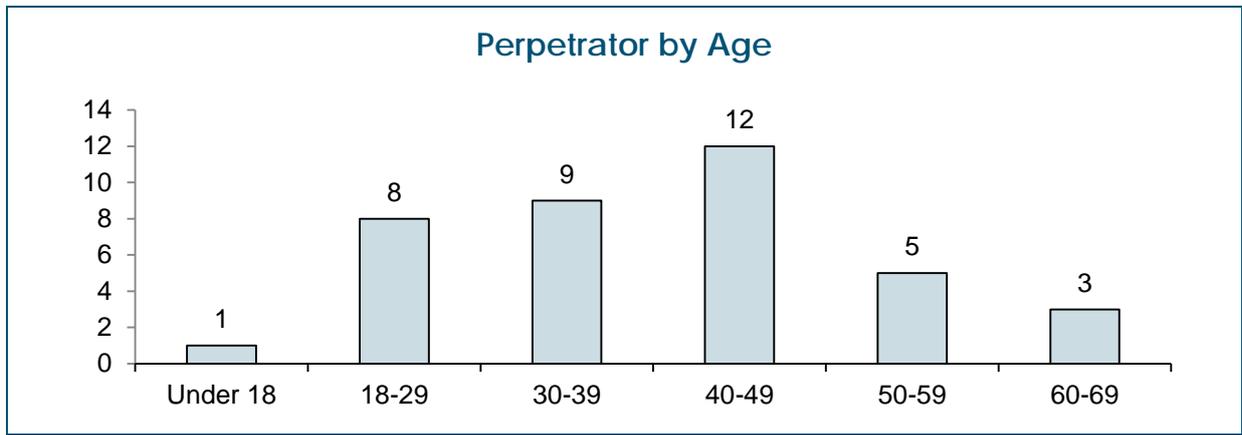


Compared to the Western Australian population, male perpetrators of fatalities in the five years from 1 July 2012 to 30 June 2017 were over-represented, with 74% of perpetrators being male compared to 50% in the population.

Nine males were convicted of manslaughter and 19 males were convicted of murder. Seven females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death and two females were convicted of murder.

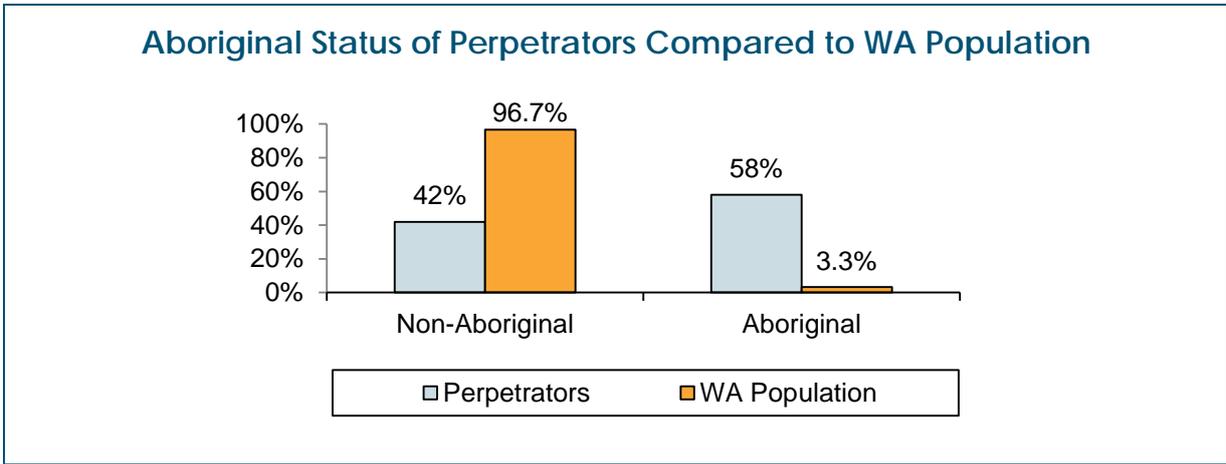
In the 10 fatalities where the perpetrator was female, the person who died was male. Of the 28 fatalities where the perpetrator was male, in 22 fatalities the person who died was female, and in six fatalities the person who died was male.





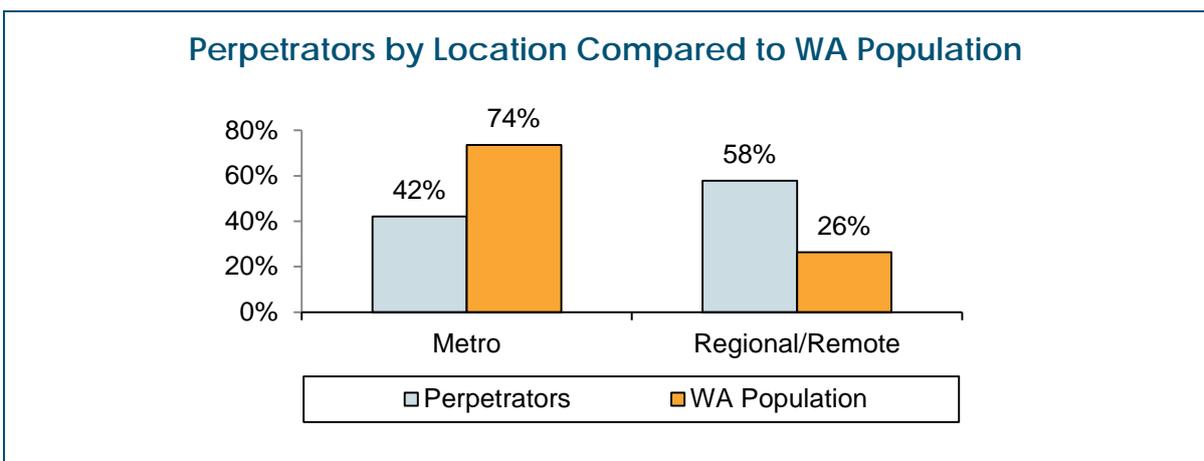
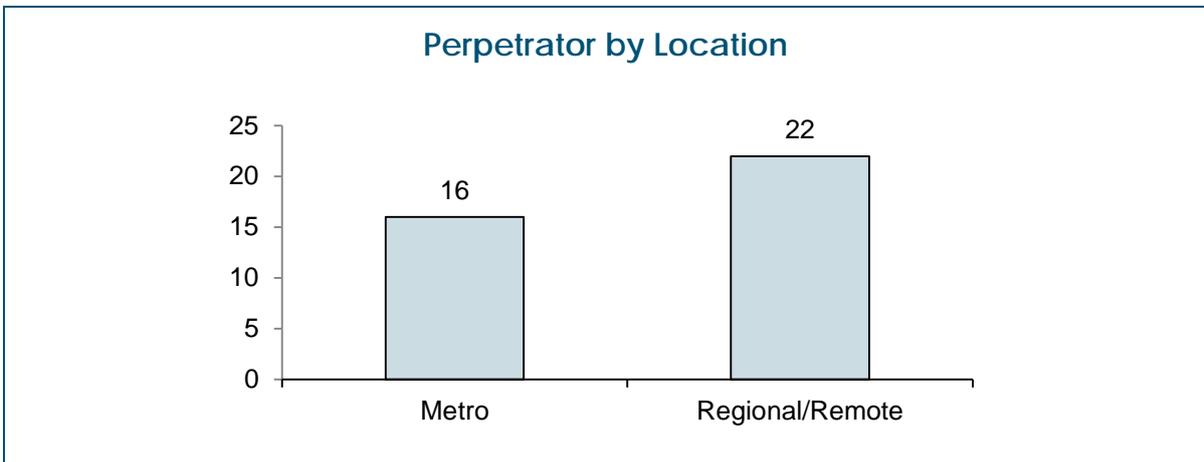
Compared to the Western Australian population, perpetrators of fatalities in the five years from 1 July 2012 to 30 June 2017 in the 40-49 age group were over-represented, with 31% of perpetrators being in the 40-49 age group compared to 14% in the population.





Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the five years from 1 July 2012 to 30 June 2017 were over-represented with 58% of perpetrators being Aboriginal compared to 3.3% in the population.

In 20 of the 22 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.



The majority of people who died lived in regional or remote areas.

Compared to the Western Australian population, the people who died in the five years from 1 July 2012 to 30 June 2017, who were living in regional or remote locations, were over-represented, with 58% of the people who died living 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 WAPOL 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.

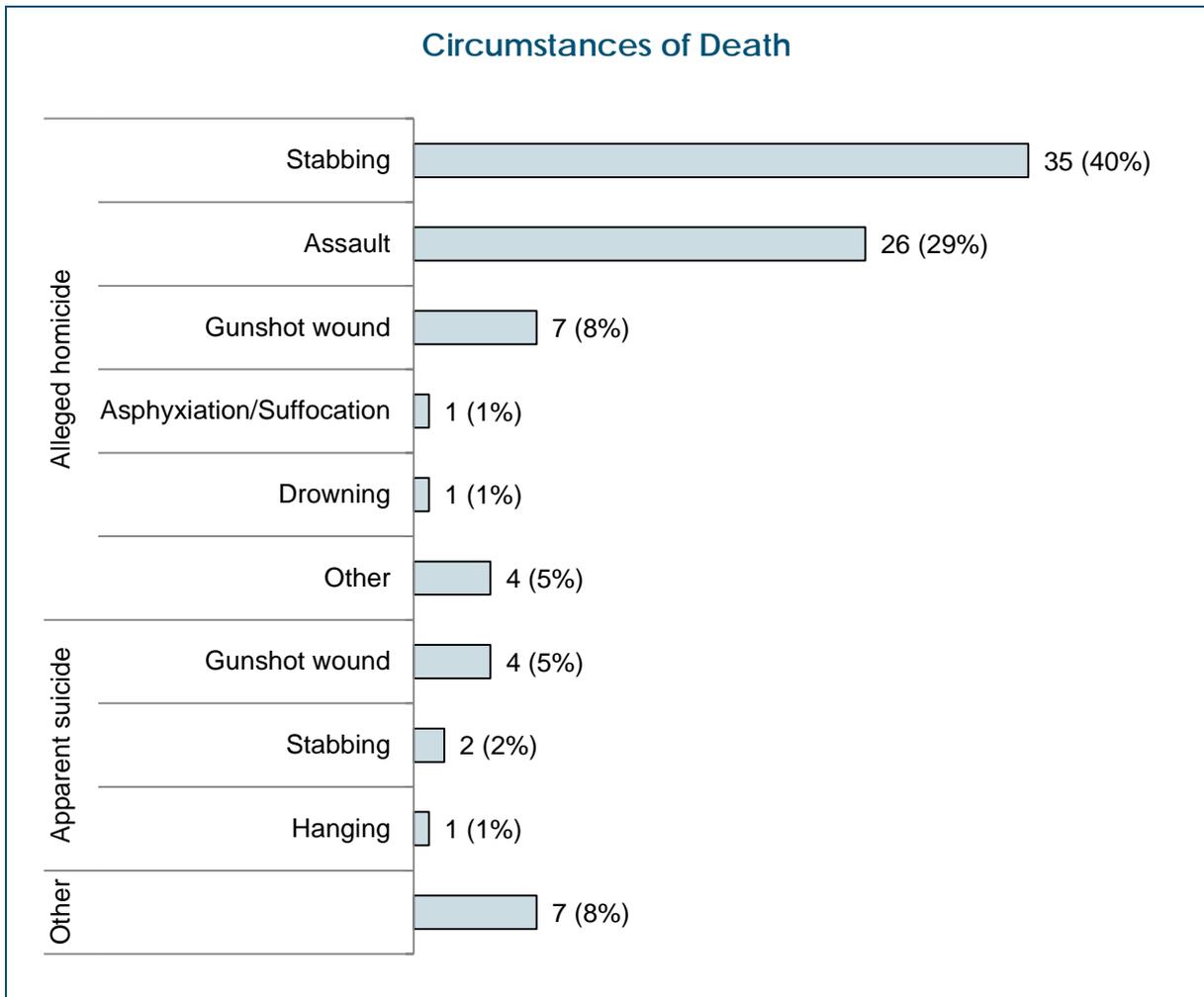
Family and domestic violence fatalities may occur through alleged homicide, apparent suicide or other circumstances:

- 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 2016-17 were alleged homicide by stabbing and physical assault.

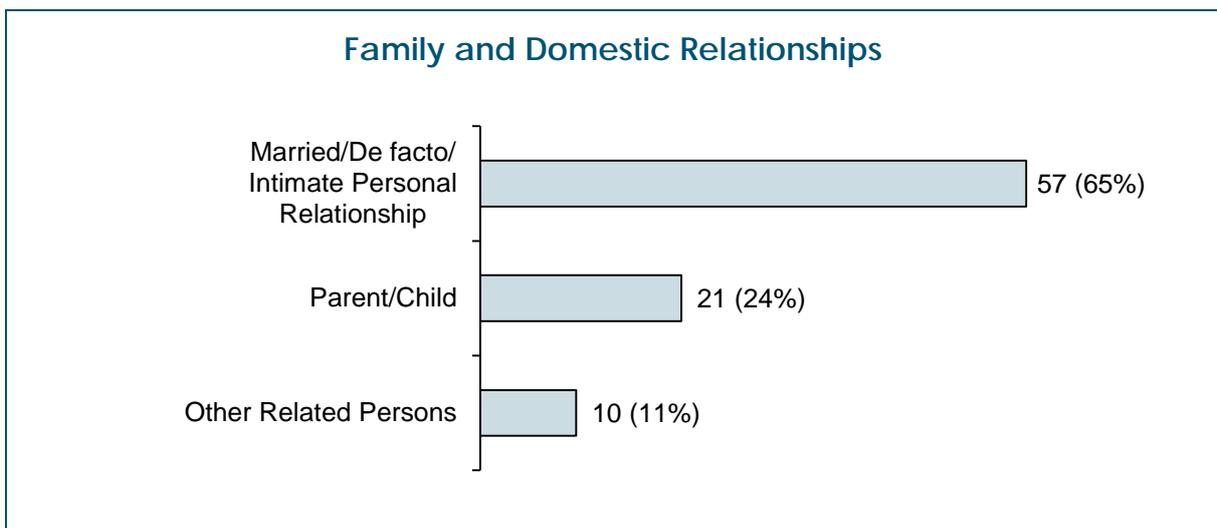
The following chart shows the circumstance of death as categorised by the Ombudsman for the 88 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2017.





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.



Of the 88 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2017:

- 57 fatalities (65%) involved a married, de facto or intimate personal relationship, of which there were 49 alleged homicides, six apparent suicides and two in other circumstances. The 57 fatalities included 10 deaths that occurred in five cases of alleged homicide/suicide and, in all five cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. The sixth apparent suicide involved a male. Of the remaining 44 alleged homicides, 30 (68%) of the people who died were female and 14 (32%) were male;
- 21 fatalities (24%) involved a relationship between a parent and adult child, of which there were 16 alleged homicides, one apparent suicide and four in other circumstances. Of the 16 alleged homicides, five (31%) of the people who died were female and 11 (69%) were male. Of these 16 fatalities, in 10 cases (63%) the person who died was the parent or step-parent and in six cases (37%) the person who died was the adult child or step-child; and
- There were 10 people who died (11%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, four (40%) were female and six (60%) were male.

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

State policy and planning to reduce family and domestic violence fatalities

The State Strategy, released in 2012, sets out the State Government's commitment to reducing family and domestic violence, identifying that it 'builds on reforms already undertaken through the [WA Strategic Plan]...' (page 3).

The DCPFS website *Family and Domestic Violence Strategic Planning* page (available at www.dcp.wa.gov.au) states DCPFS is the lead agency responsible for family and domestic violence strategic planning in Western Australia. This includes development, implementation and monitoring of the State Strategy and contribution to the National Plan. Strategic planning is overseen by the FDV Governance Council, comprising senior representatives from State and Commonwealth Government agencies and the Women's Council for Domestic and Family Violence Services (WA), with input from the FDV Advisory Network.

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, consistent with the National Plan:

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 [the State Strategy], identifies actions for achieving [the State Strategy's] agreed Primary State Outcomes, priorities among these actions, and allocation of responsibilities for these actions to specific state government departments and authorities.



[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.

Type of relationships

The Ombudsman finalised 78 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2017.

For 51 (65%) 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 27 (35%) 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 78 finalised reviews, the circumstances of the fatality were as follows:

- For the 51 intimate partner fatalities, 43 were alleged homicides, six were apparent suicides, and two were other circumstances; and
- For the 27 non-intimate partner fatalities, 21 were alleged homicides, one was an apparent suicide, and five were other circumstances.

Intimate partner relationships

Of the 43 intimate partner relationship fatalities involving alleged homicide:

- There were 28 fatalities where the person who died was female and the suspected perpetrator was male, one where the person who died was female and there were multiple suspected perpetrators of both genders, 11 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 two where the person who died was male and there were multiple suspected perpetrators of both genders;
- There were 18 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In ten of these fatalities the person who died was female and in eight the person who died was male;
- There were 21 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, eight at the residence of the person who died or the residence of the suspected perpetrator, five at the residence of family or friends, and nine at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 21 fatalities where the person who died lived in regional and remote areas, and in 16 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 27 non-intimate partner fatalities, there were 18 fatalities involving a parent and adult child and nine fatalities where the parties were otherwise related.





Of the 21 non-intimate partner fatalities involving alleged homicide:

- There were five fatalities where the person who died was female and the suspected perpetrator was male, two where the person who died was female and the suspected perpetrator was female, 10 where the person who died was male and the suspected perpetrator was male, and four where the person who died was male and the suspected perpetrator was female;
- There were five non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 10 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, eight at the residence of the person who died or the residence of the suspected perpetrator, and three at the residence of family or friends or in a public place; and
- There were six 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 26 (60%) of the 43 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2017, alleged family and domestic violence between the parties had been reported to WAPOL and/or to other public authorities. In five (24%) of the 21 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2017, alleged family and domestic violence between the parties had been reported to WAPOL and/or other public authorities.

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

Principle 7 of the State Strategy states that:

An effective system will acknowledge that to achieve substantive equality, partnerships must be developed in consultation with specific communities of interest including people with a disability, people from diverse sexualities and/or gender, people from Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds (page 5).

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 31 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:

- Three fatalities involved a deceased person with a disability;
- None of the fatalities involved a deceased person who identified as lesbian, gay, bisexual, trans or intersex;

- 19 fatalities involved a deceased Aboriginal person; and
- 18 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 State Strategy nor the *Achievement Report to 2013* identify 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 [the State Strategy], 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 over-represented 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. The Office will continue to monitor, and report on the steps being taken to implement this recommendation.

Identification of family and domestic violence incidents

Of the 31 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, WAPOL 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 have identified missed opportunities to identify family and domestic violence in interactions.

In the report, the Ombudsman made two recommendations (Recommendations 7 and 39) that WAPOL 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 WAPOL 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 implement these recommendations.





Provision of agency support to obtain a violence restraining order

As identified above, WAPOL is likely to receive the majority of reports of family and domestic violence. WAPOL is not currently required by legislation or policy to provide victims with information and advice about violence restraining orders when attending the scene of acts of family and domestic violence. However, its attendance at the scene affords WAPOL with the opportunity to provide victims with information and advice about:

- What a violence restraining order is and how it can enhance their safety;
- How to apply for a violence restraining order; and
- What support services are available to provide further advice and assistance with obtaining a 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 WAPOL's response to FDV incidents through the review of 75 Domestic Violence Incident Reports (associated with 30 fatalities). The report found that WAPOL 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; and

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 WAPOL had taken steps and/or 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 implement these recommendations.

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 its Family and Domestic Violence Practice Guidance, in particular, that '[w]here a [violence restraining order] 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 has 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 Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Support during the process of obtaining a 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 violence restraining order, and that these opportunities are acted upon, not just by WAPOL but by all State Government departments and authorities. In the report the Ombudsman recommended that:

Recommendation 14: In developing and implementing future phases of [the State Strategy], 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. The Office will continue to monitor, and report on, the steps being taken to implement this recommendation.



Support when a 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 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 [the State Strategy], 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. The Office will continue to monitor, and report on, the steps being taken to implement 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 www.dcp.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. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

In 2016-17, through the reviews of family and domestic violence fatalities, the Office has continued to examine compliance with family and domestic violence policy, in relation to promoting victim safety, and has made recommendations to agencies to improve family and domestic violence policy compliance.



Case Study A

DCPFS received information regarding nine alleged family and domestic violence incidents involving Mr and Ms A including seven incidents where their children were present.

The Office recommended that:

- The Department takes all reasonable steps to ensure that DCPFS's Family and Domestic Violence Response Team triage assessments align with DCPFS's policies and practice requirements associated with responding to family and domestic violence and child safety and wellbeing concerns.

Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 26 (60%) of the 43 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2017, prior family and domestic violence between the parties had been reported to WAPOL 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 behaviors, in accordance with the intent of the State Strategy.

Fatalities with no prior reported family and domestic violence

Based on the information available to the Office, in 17 (40%) of the 43 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2017, the fatal incident was the only family and domestic violence between the parties that had been reported to WAPOL 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 2012](#) 'collected information about a person's help seeking behaviours in relation to their experience of partner violence'.

For example, this research found that:

*An estimated 190,100 women (80% of the 237,100 women who had experienced current partner violence) had **never** contacted the police about the violence by their current partner [Original emphasis].*

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 78 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2017, Aboriginal Western Australians were over-represented, with 25 (32%) persons who died being Aboriginal. In each case, the suspected perpetrator was also Aboriginal. There were 20 of these fatalities where the person who died lived in a regional or remote area of Western Australia, of which 16 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, June 2012, Indigenous Justice Clearinghouse, New South Wales, 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).*

The Ombudsman’s reviews and report have identified that Aboriginal victims want the violence to end, but not necessarily always through the use of violence restraining orders.

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 (linked to the State Strategy and consistent with, and supported by, the State 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 [the State Strategy]; and

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. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.



Case Study B

The Ombudsman's review of this fatality identified WAPOL attendance at multiple alleged family violence incidents relating to Ms B and her family between July 2014 and June 2015, participation in the associated Family and Domestic Violence Response Team (FDVRT) triage meetings and provision of follow-up by the Local Policing Team.

The Office made the following recommendations:

- That WAPOL's Metropolitan District, Aboriginal and Community Diversity Unit, and State Family Violence Unit review WAPOL's response to this Aboriginal family violence from July 2014 to June 2015, to identify any learnings to guide Districts in working with Aboriginal family violence, and provides a report on the outcome to the Ombudsman by 31 December 2017.
- That WAPOL reviews, considers and, if appropriate, amends the current WAPOL FDV Policy, to include strategies that are specifically tailored to preventing and reducing Aboriginal family violence.

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. The Office will continue to monitor, and report on, the steps being taken to implement this recommendation.





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 Office will continue to monitor, and report on, the steps being taken to implement this recommendation.

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 Office will continue to monitor, and report on, the steps being taken to implement this recommendation.

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

Of the 25 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2017 involving Aboriginal people, 20 (80%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Eleven (44%) of the Aboriginal people who died lived in the Kimberley region, which is home to 1.4 per cent of all people and 19 per cent of Aboriginal people in the Western Australian population.

Building on the work of the State Strategy, the *Freedom from Fear: Working towards the elimination of family and domestic violence in Western Australia Action Plan 2015* was launched in September 2015. This Action Plan includes the priority to 'Target communities and populations at greatest risk' and 'Develop and implement a plan for the Kimberley region' identifying that:

In comparison to other regional and metropolitan locations in Western Australia the Kimberley region has the highest rates, per head of population, of reported family and domestic violence and hospitalisations for domestic assault. (page 10).

In identifying the Kimberley as a region of priority for an improved response to family and domestic violence, *Safer Families, Safer Communities Kimberley Family Violence Regional Plan 2015-2020 (the Kimberley Plan)* (available at www.dcp.wa.gov.au) was launched in October 2015. The Kimberley Plan aims to:

...increase the health, safety and wellbeing of women, children and men living in the Kimberley region by working towards a reduction in family violence. The Kimberley Plan which sets out a framework for responding to family violence, includes strategies that will benefit all members of the Kimberley community as well as priority areas targeted at responding to Aboriginal family violence (page 4).

... This will be achieved through a whole of community approach that promotes:

- 1. shared responsibility for the safety and wellbeing of children, individuals and families;*
- 2. developing culture and community based responses to family violence;*
- 3. building strong and safe communities; and*
- 4. developing services and a service system that is integrated, culturally secure, client centered, accessible and effective (page 10).*

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 DCPFS 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'.



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 discussed 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 National Plan (available at www.dss.gov.au) observes that:

Alcohol is usually seen as a trigger, or a feature, of violence against women and their children rather than a cause. Research shows that addressing alcohol in isolation will not automatically reduce violence against women and their children. This is because alcohol does not, of itself, create the underlying attitudes that lead to controlling or violent behaviour (page 29).

The National Plan and the *National Drug Strategy 2010-2015* identify initiatives to address alcohol and drug use, and the co-occurrence with family and domestic violence. The Foundation for Alcohol Research and Education's *National framework for action to prevent alcohol-related family violence* (available at www.fare.org.au/preventalcfv/) states:

Integrated and coordinated service models within the AOD [alcohol and other drug] and family violence sectors in Australia are rare. Historically, the sectors have worked independently of each other despite the long-recognised association between alcohol and family violence. Part of the reason is that models of treatment for alcohol use disorders have traditionally been focused towards the needs of individuals and in particular, men (page 36).

On the information available, relating to the 64 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2017, 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	2	3	2	7
Suspected perpetrator only	3	12	6	9
Both person who died and suspected perpetrator	19	20	5	8
Total	24	35	13	24

The Ombudsman's reviews and *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, have identified that in Western Australia, the State Strategy does not mention or address alcohol and its relationship with family and domestic violence. However, the goal of the Mental Health Commission's *Drug and Alcohol Interagency*



Strategic Framework for Western Australia 2011-2015 (the Framework) is to 'prevent and reduce the adverse impacts of alcohol and other drugs in the Western Australian community' (page 5). This Framework is currently being revised by the Mental Health Commission, in consultation with the Drug and Alcohol Strategic Senior Officers Group, as stated at www.mhc.wa.gov.au.

As one of these adverse impacts, the Framework highlights 'violence and family and relationship breakdown' as a result of 'problematic drug and alcohol use' (page 3). 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 concerns of stakeholders are consistent with the research literature as outlined in the report. Given the level of recorded alcohol use associated with the Ombudsman's reviews, in the report the Ombudsman recommended that:

Recommendation 3: DCPFS, in collaboration with the Mental Health Commission and other key stakeholders, includes initiatives in Action Plans developed under [the State Strategy] which recognise and address the co-occurrence of alcohol use and 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 in relation to Recommendation 3, the Mental Health Commission and DCPFS had taken steps and proposed steps to be taken to give effect to this recommendation. The Office will continue to monitor, and report on, the steps being taken to implement this recommendation.

Co-occurrence of mental health issues

As with alcohol and drug use, it is noted that the State Strategy does not mention mental health issues and the relationship with family and domestic violence. Though it is noted that in screening for family and domestic violence, the *Western Australia Family and Domestic Violence Common Risk Assessment and Risk Management Framework (Second edition)* (available at www.dcp.wa.gov.au) states that:

*Perpetrators often present with issues that coexist with their use of violence, for example, alcohol and drug misuse or **mental health concerns**. These coexisting issues are not to be blamed for the violence, but they may exacerbate the violence or act as a barrier to accessing the service system or making behavioural change.*



The primary focus of referral for perpetrators of family and domestic violence should be the violence itself. Coexisting issues may be addressed simultaneously, where appropriate (page 53, our emphasis).

and

*Family and domestic violence may be present, but undisclosed when a woman presents at a service for assistance with other issues such as health concerns, financial crisis, legal difficulties, parenting problems, **mental health concerns**, drug and/or alcohol misuse or homelessness (page 29, our emphasis).*

The DCPFS's *Western Australia Family and Domestic Violence Common Risk Assessment and Risk Management Framework* identifies mental health as a potential risk factor for family and domestic violence, and indicates that screening should be undertaken by mental health services (page 29).

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 adequately informing staff of family and domestic violence policies and procedures.
- Not providing culturally informed practice guidance for responding to Aboriginal family violence.
- Not adequately implementing family and domestic violence policies and procedures.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities to address family and domestic violence victim safety.
- Not undertaking sufficient inter-agency communication to enable effective case management and collaborative responses.
- Missed opportunities to seek cultural consultation to enable effective case management and collaborative processes in the context of ongoing reported Aboriginal family violence.
- Inaccurate recordkeeping.



Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following nine recommendations were made by the Ombudsman in 2016-17 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. DCPFS reiterates to Metropolitan District Team Leaders, Assistant District Director and District Director that, consistent with Chapter 4.1 *Assessment and Investigation Processes* and Chapter 1.2 *Signs of Safety – Child Protection Practice Framework* of the *Casework Practice Manual*, approval of Safety and Wellbeing Assessments requires documented evidence that key decisions have been informed by the administration of the *Signs of Safety Child Protection Framework* and compliance with Safety and Wellbeing Assessment practice requirements.
2. DCPFS reviews this family and domestic violence fatality and the findings of the Standards Monitoring Unit's Metropolitan District Final Reports of 2012, 2014 and 2016 with a view to considering whether ongoing improvements can be made to policy and practice that would promote the effective administration of DCPFS's assessment and investigation processes and *Signs of Safety Child Protection Framework* consistent with practice requirements.
3. DCPFS provides a report to the Ombudsman within six months of the finalisation of this review outlining actions taken by the Metropolitan District to give effect to Recommendation 2.
4. That the WA Country Health Service (**WACHS**) regional hospital develops strategies to ensure emergency department staff are able to comply with the *Department of Health Family and Domestic Violence Policy February 2014* and *Guideline for Responding to Family and Domestic Violence 2014*, and that WACHS provides a report to the Ombudsman by 31 December 2017 setting out the strategies that have been developed.
5. That the WACHS regional hospital consults with DCPFS (the lead agency responsible for family and domestic violence strategic planning in WA) to complete and maintain the *Local Service Information* list included in the *Guideline for Responding to Family and Domestic Violence 2014* to ensure WACHS regional hospital staff can provide current information on family and domestic violence support service options to all family and domestic violence victims and perpetrators as relevant.
6. DCPFS takes all reasonable steps to ensure that DCPFS's Family and Domestic Violence Response Team triage assessments align with DCPFS's policies and practice requirements associated with responding to family and domestic violence and child safety and wellbeing concerns.
7. WAPOL takes all reasonable steps to ensure that identified child safety and wellbeing concerns are reported to DCPFS consistent with procedural requirements included in the Commissioner's Operations and Procedures Manual.



8. That WAPOL's Metropolitan District, Aboriginal and Community Diversity Unit, and State Family Violence Unit review WAPOL's response to this Aboriginal family violence from July 2014 to June 2015, to identify any learnings to guide Districts in working with Aboriginal family violence, and provides a report on the outcome to the Ombudsman by 31 December 2017.
9. That WAPOL reviews, considers and, if appropriate, amends the current WAPOL FDV Policy, to include strategies that are specifically tailored to preventing and reducing Aboriginal family violence.

The Ombudsman will table a report in Parliament in 2018-19 on the steps taken to give effect to the nine recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2016-17.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2015-16

The Ombudsman made eight recommendations about ways to prevent or reduce family and domestic violence fatalities in 2015-16. In 2016-17, 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.

The Ombudsman will table a report in Parliament in 2017-18 on the steps taken to give effect to the eight recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2015-16.

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 2016-17, timely review processes have resulted in one half of reviews being completed within three months and 75% 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.



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

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*. The report is available at:

www.ombudsman.wa.gov.au/familydomesticviolencereport.

About the report

On 19 November 2015, the Ombudsman tabled the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* in the Western Australian Parliament. Through that investigation, the Ombudsman found that a range of work had been undertaken by state government departments and authorities to administer their relevant legislative responsibilities, including their responsibilities arising from the *Restraining Orders Act 1997*. The Ombudsman also found, however, that there is important further work that should be done. This work, detailed in the findings of the report, includes a range of important opportunities for improvement for state government departments and authorities, working individually and collectively, across all stages of the violence restraining order process.



Arising from the findings in the report, the Ombudsman made 54 recommendations to four government agencies about ways to prevent or reduce family and domestic violence fatalities. Each agency agreed to these recommendations.

Importantly, the Ombudsman also indicated that the Office would actively monitor the implementation of these recommendations and report to Parliament on the results of this monitoring.

Objectives

- The objectives of the November 2016 report were to consider (in accordance with the *Parliamentary Commissioner Act 1971*):
 - 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.

Methodology

- First, the Office sought from the relevant agencies a report on the steps taken to give effect to the recommendations, such report to include evidence regarding the steps taken. The relevant agencies being:
 - Department for Child Protection and Family Support;
 - Department of the Attorney General;
 - Mental Health Commission; and





- Western Australia Police.
- Second, where further information, clarification or validation was required, the Office met with the relevant agencies;
- Third, for a number of recommendations, the Office conducted fieldwork to collect further information regarding the steps taken to give effect to the recommendations;
- Fourth, the Office reviewed all information it obtained and made draft findings;
- Fifth, the Office developed a draft report;
- Sixth, the Office provided the draft report to the relevant agencies; and
- Seventh, the Office developed a final report.

Summary of findings

- The Ombudsman is pleased that in relation to all of the recommendations in the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, the relevant agencies have either taken steps, or propose to take steps (or, in some cases, both) to give effect to the recommendations.
- In no instances did the Office find that no steps had been taken to give effect to the recommendations.
- It is particularly pleasing that, in giving effect to the recommendations, important improvements have been achieved when compared to the findings identified in the report.

Giving effect to the recommendations

- In the report, 22 recommendations were directed to WAPOL.
 - Steps have been taken (and, in some cases, are also proposed to be taken) to give effect to nine recommendations; and
 - Steps are proposed to be taken to give effect to 13 recommendations.
- In the report, 26 recommendations were directed to DCPFS.
 - Steps have been taken (and, in some cases, are also proposed to be taken) to give effect to 17 recommendations;
 - Steps are proposed to be taken to give effect to seven recommendations; and
 - The steps taken to give effect to two recommendations, Recommendations 5 and 6, are contingent on giving effect to Recommendation 4.
- In the report, six recommendations were directed to DOTAG.
 - Steps have been taken (and, in some cases, are also proposed to be taken) to give effect to four recommendations; and
 - Steps are proposed to be taken to give effect to two recommendations.

The Office will continue to monitor, and report on, the steps being taken to give effect to these recommendations.

Identifying and overcoming barriers to the effective implementation of family and domestic violence policies and practice guidance

In the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, the Ombudsman recommended that:

Recommendation 54: 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.*

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:

The review report and action plan have been provided to the Office within 12 months of the tabling of the [Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities], and will be reviewed by the Office and the results of this review reported on in the Office's 2016-17 Annual Report.

In 2016-17, the review report and action plan were comprehensively reviewed by the Office. The Office's analysis and findings will be the subject of a report on the steps taken to give effect to the recommendations arising from child death reviews and family and domestic violence fatality reviews to be tabled in Parliament in 2017-18.

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 the Panel, and other mechanisms, 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 and New Zealand through meetings with the Australian Domestic and Family Violence Death Review Network;
- 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 WAPOL to develop and support the implementation of the process to inform the Ombudsman of family and domestic violence fatalities. Regular liaison occurs at senior officer level between the Office and WAPOL.

The Ombudsman's Advisory Panel

The Panel is an advisory body established to provide independent advice to the Ombudsman on:

- Issues and trends that fall within the scope of the family and domestic violence fatality review function;
- Contemporary professional practice relating to the safety and wellbeing of people impacted by family and domestic violence; and
- Issues that impact on the capacity of public authorities to ensure the safety and wellbeing of individuals and families.

The Panel met four times in 2016-17 and during the year the following members provided a range of expertise:

- Professor Steve Allsop (National Drug Research Institute of Curtin University);
- Ms Jocelyn Jones (Health Sciences, Curtin University);
- Professor Donna Chung (Head of the Department of Social Work, Curtin University);
- Ms Dorinda Cox (Consultant);
- Ms Angela Hartwig (Women's Council for Domestic and Family Violence Services WA);
- Ms Victoria Hovane (Consultant); and
- Associate Professor Carolyn Johnson (Consultant).

In 2016-17, observers from Western Australia Police, the Department for Child Protection and Family Support, the Department of Health, the Department of Education, the Department of Corrective Services, the Department of the Attorney General, the Mental Health Commission and the Department of Aboriginal Affairs also attended the meetings.



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 2016-17, included:

- The Coroner;
- Relevant public authorities including:
 - Western Australia Police;
 - The Department of Health;
 - The Department of Education;
 - The Department of Corrective Services;
 - The Department for Child Protection and Family Support;
 - The Department of Housing;
 - The Department of the Attorney General;
 - The Department of Aboriginal Affairs;
 - The Mental Health Commission; and
 - Other accountability and similar agencies including the Commissioner for Children and Young People;
- The Women's Council for Domestic and Family Violence Services WA and relevant non-government organisations; and
- Research institutions including universities.

Aboriginal and regional communities

In 2016, the Ombudsman appointed a Principal Aboriginal Liaison Officer 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, complaints resolution involving Aboriginal people and own motion investigations.
- 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.

Through the Principal Aboriginal Liaison Officer, the Panel and outreach activities, work was undertaken through the year to continue to build relationships relating to the family and domestic violence fatality review function with Aboriginal and regional communities, including by communicating with:

- Key public authorities that work in metropolitan and 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 family and domestic violence fatality review function and its purpose.



Building on the work already undertaken by the Office, as part of its other functions, including its child death review function, networks and contacts have been established to support effective and efficient family and domestic violence fatality reviews.

In 2016-17, the Principal Aboriginal Liaison Officer and the Assistant Ombudsman Reviews met with Aboriginal community members, and government and non-government service providers in Geraldton, to hear from them about what they believe is working well, what is not working well, and what they believe needs to happen in relation to preventing and reducing Aboriginal family and domestic violence fatalities. Key messages given to the Office by stakeholders in these meetings were the need for Aboriginal leadership and involvement of Aboriginal people in service planning and decision-making, the need for the direct funding to local Aboriginal community controlled services and the need for improved collaboration between service providers. The learnings from these meetings will inform the Office's understanding of family and domestic violence reviews. Further regional visits to listen to, and engage with, the Aboriginal community about ways to prevent or reduce Aboriginal child deaths will be undertaken by the Office in 2017-18.

