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 *Fourth Action Plan 2019-2022* is currently being developed, and is due for release in 2019.

The *WA Strategic Plan for Family and Domestic Violence 2009-13*, included 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. 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.
5. 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.
6. 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.
7. Victims of family and domestic violence and abuse will not be held responsible for the perpetrator's behaviour.
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.

In 2017, the State Government released the *Stopping Family and Domestic Violence Policy*, which sets out 21 new initiatives for responding to family and domestic violence. This document supersedes *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities* (**State Strategy**) and the *Freedom from Fear Action Plan 2015*. Also in 2017, the first Minister for the Prevention of Family and Domestic Violence was appointed. In 2018, the Department of Communities has convened a family and domestic violence policy consortium, comprising representatives from government, community sector services, Aboriginal Community Controlled Organisations and academia, to develop a comprehensive project plan for the development of a 10-year across-government

strategy to reduce family and domestic violence. The Office, as an observer, has contributed to this policy consortium. The findings and recommendations from the Ombudsman's family and domestic violence fatality reviews and major own motion investigations will contribute to the development of this new State strategy.

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

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

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 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

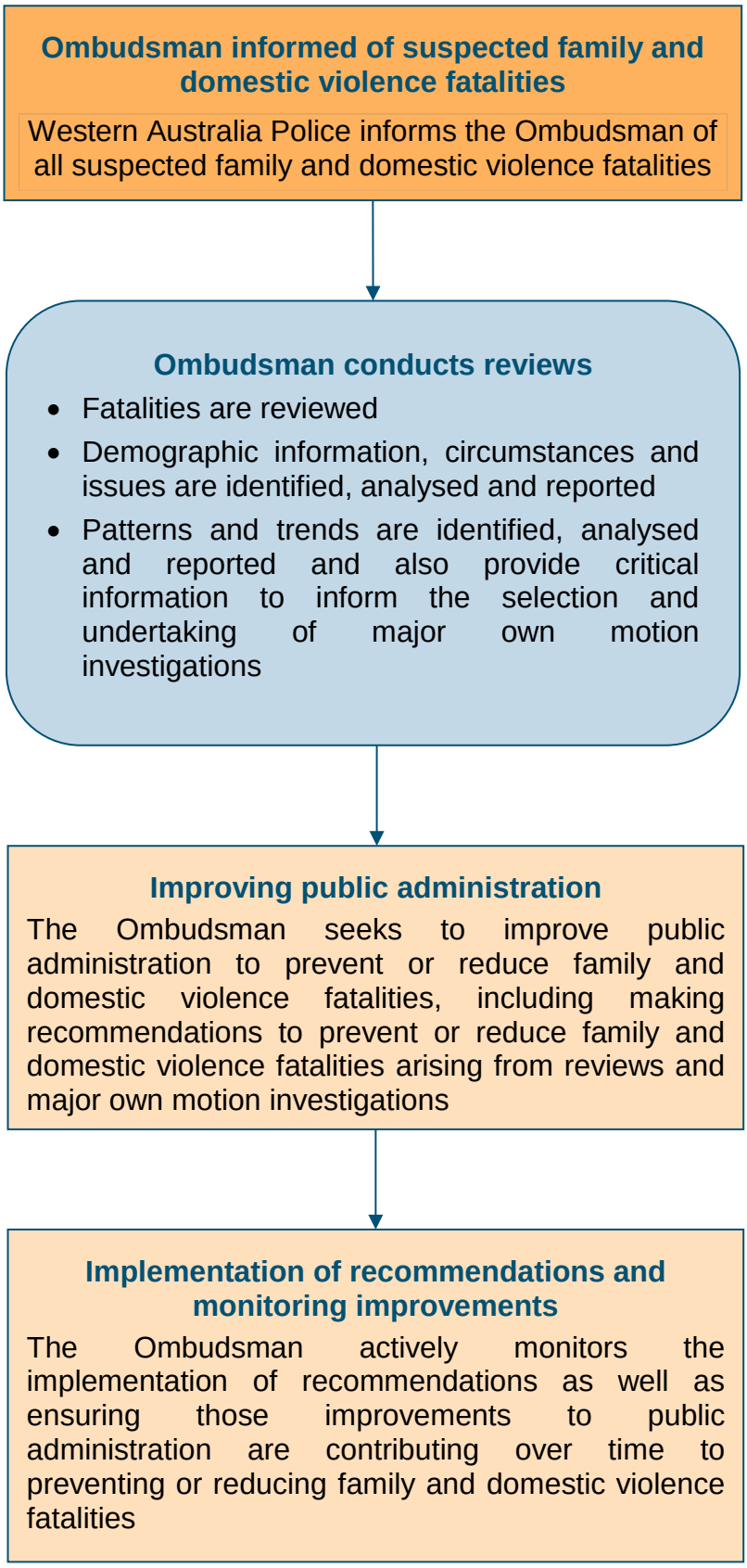
  (ii) De facto partner or former de facto partner.

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



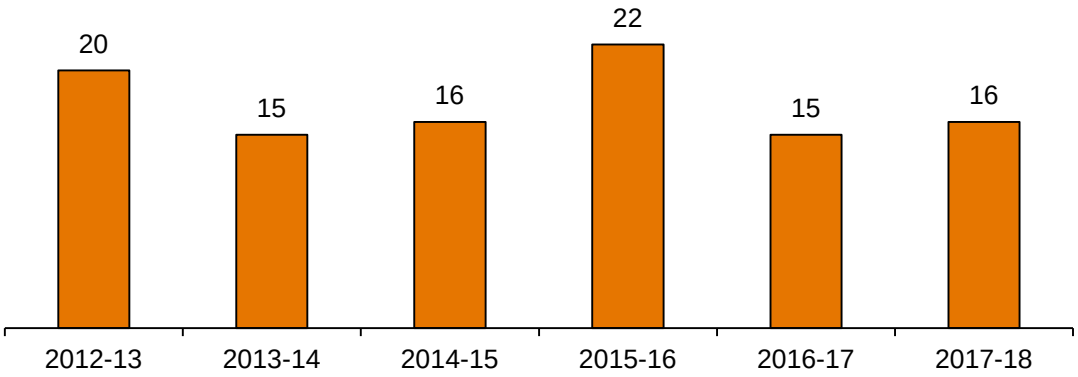
Analysis of Family and Domestic Violence Fatality Reviews

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

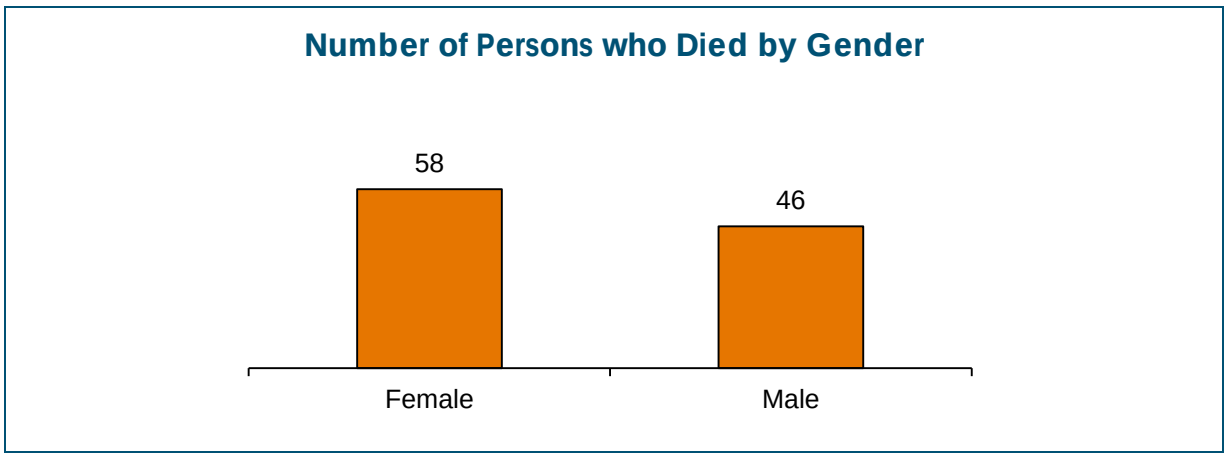
In 2017-18, the number of reviewable family and domestic violence fatalities received was 16, compared to 15 in 2016-17, 22 in 2015-16, 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

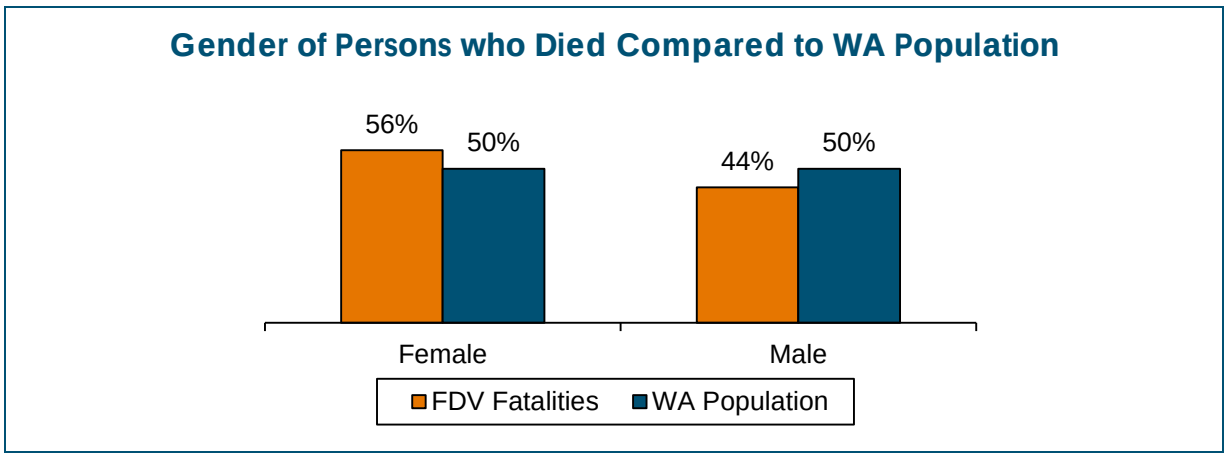


Demographic information identified from family and domestic violence fatality reviews

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

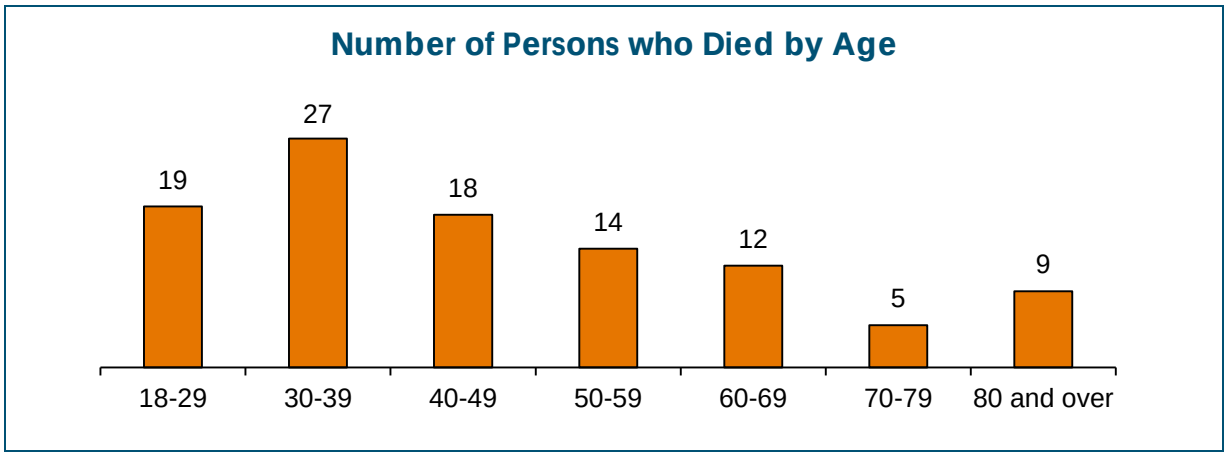
The following charts show characteristics of the persons who died for the 104 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2018. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

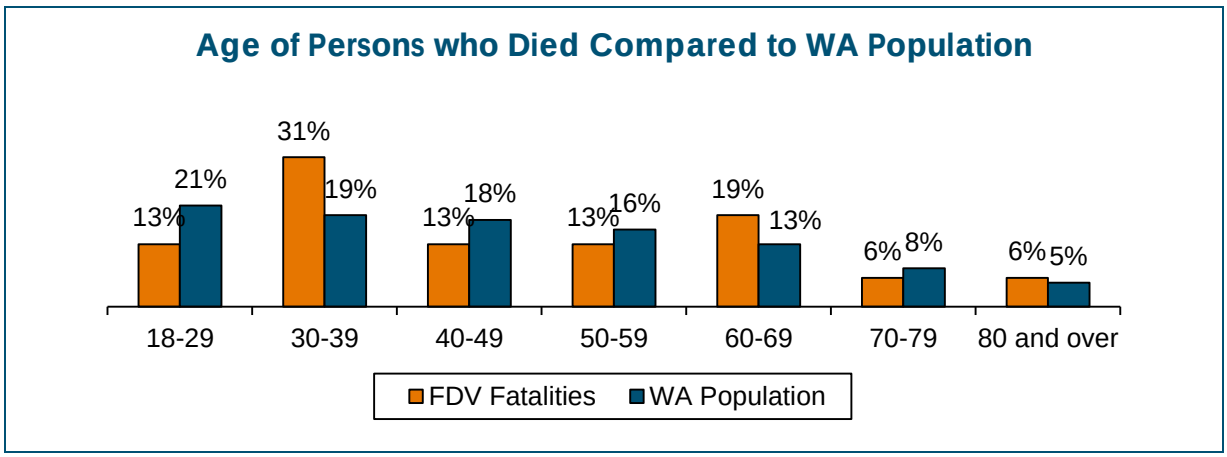




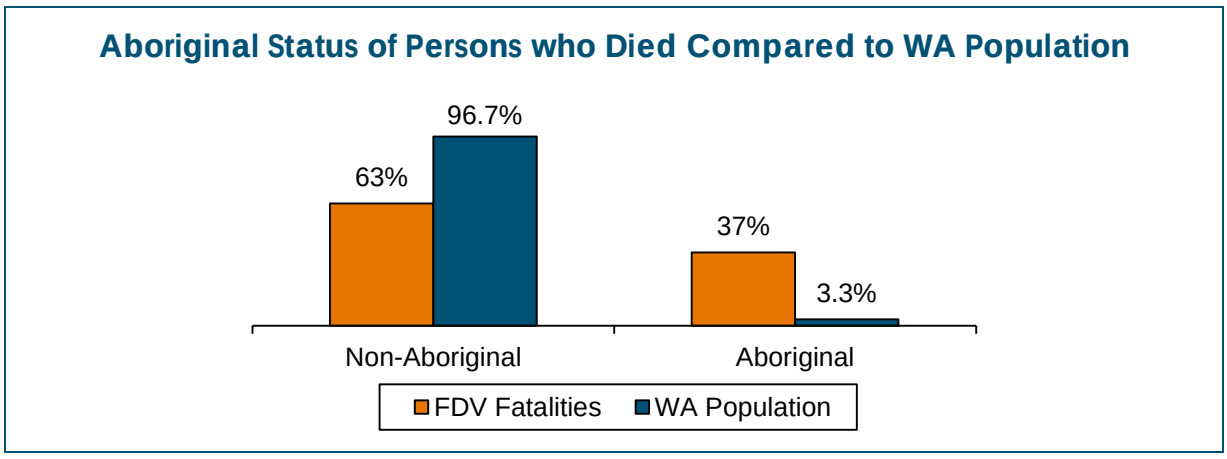
Compared to the Western Australian population, females who died in the six years from 1 July 2012 to 30 June 2018, were over-represented, with 56% of persons who died being female compared to 50% in the population.

In relation to the 58 females who died, 54 involved a male suspected perpetrator, three involved a female suspected perpetrator, and one involved multiple suspected perpetrators of both genders. Of the 46 men who died, eight were apparent suicides, 19 involved a female suspected perpetrator, 17 involved a male suspected perpetrator and two involved multiple suspected perpetrators of both genders.

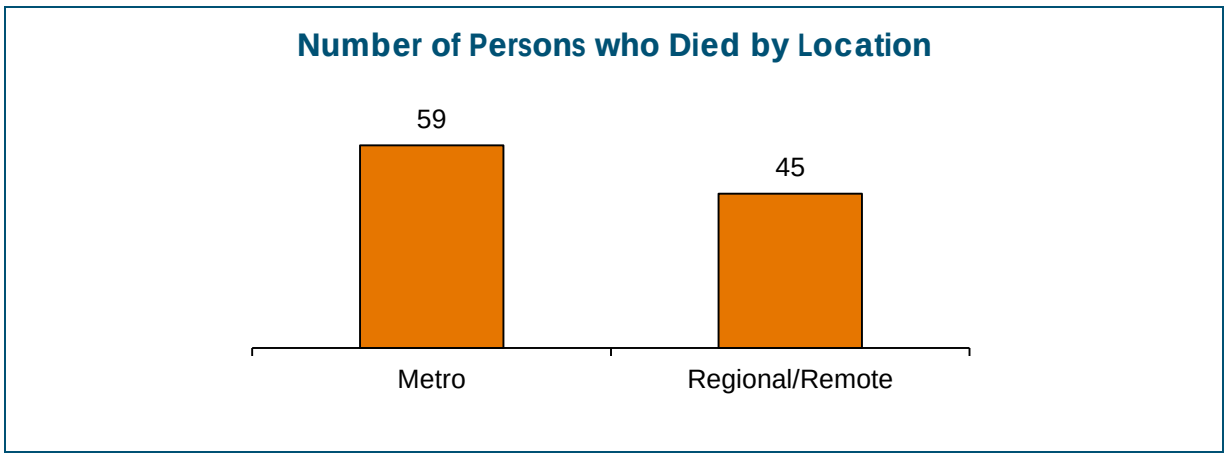


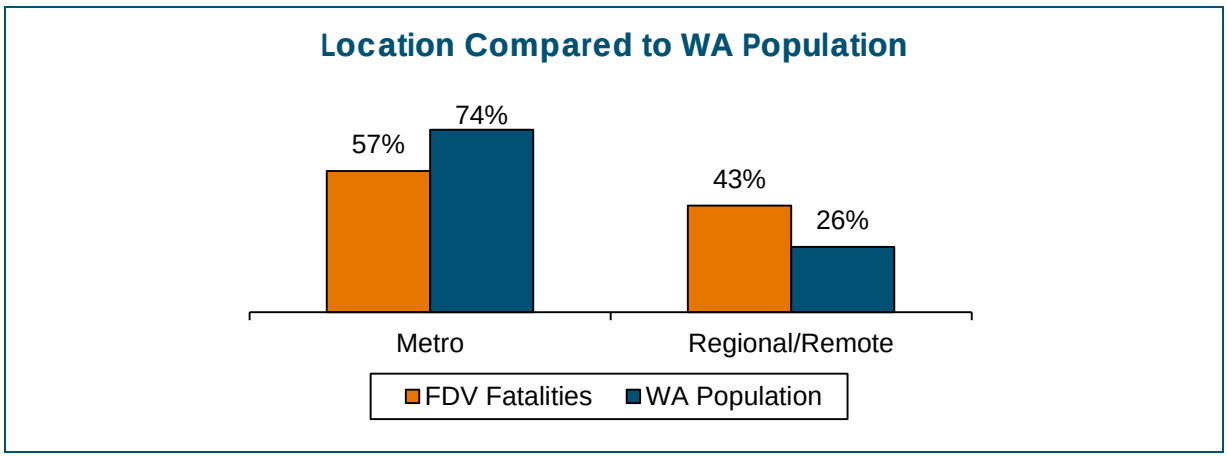


Compared to the Western Australian population, the age groups 30-39 and 60-69 are over-represented, with 31% of persons who died being in the 30-39 age group compared to 19% of the population, and 19% of persons who died being in the 60-69 age group compared to 13% of the population.



Compared to the Western Australian population, Aboriginal people who died were over-represented, with 37% of people who died in the six years from 1 July 2012 to 30 June 2018 being Aboriginal compared to 3.3% in the population. Of the 39 Aboriginal people who died, 23 were female and 16 were male.





Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 43% of the people who died in the six years from 1 July 2012 to 30 June 2018 living in regional or remote locations, compared to 26% of the population living in those locations.

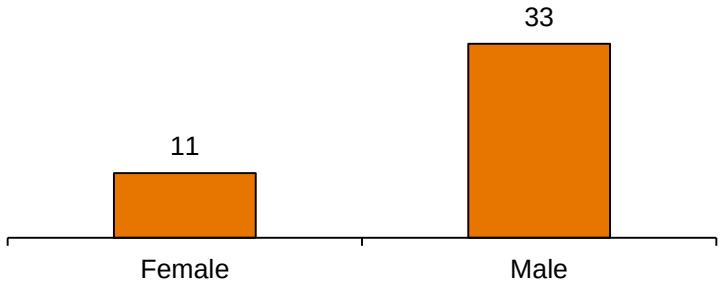
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2018 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2018.

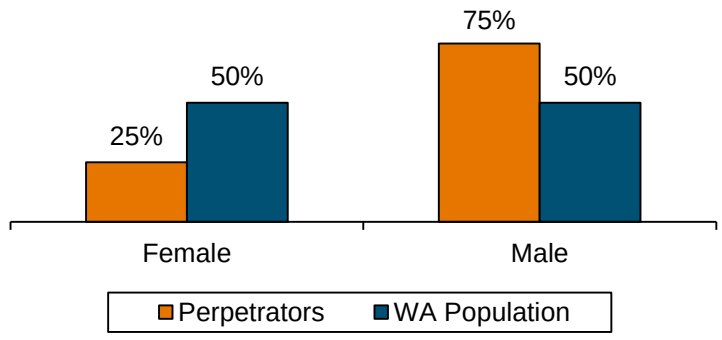
Of the 104 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2018, coronial and criminal proceedings were finalised in 44 cases.

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 44 perpetrators where both the coronial process and the criminal proceedings have been finalised.

Perpetrator by Gender



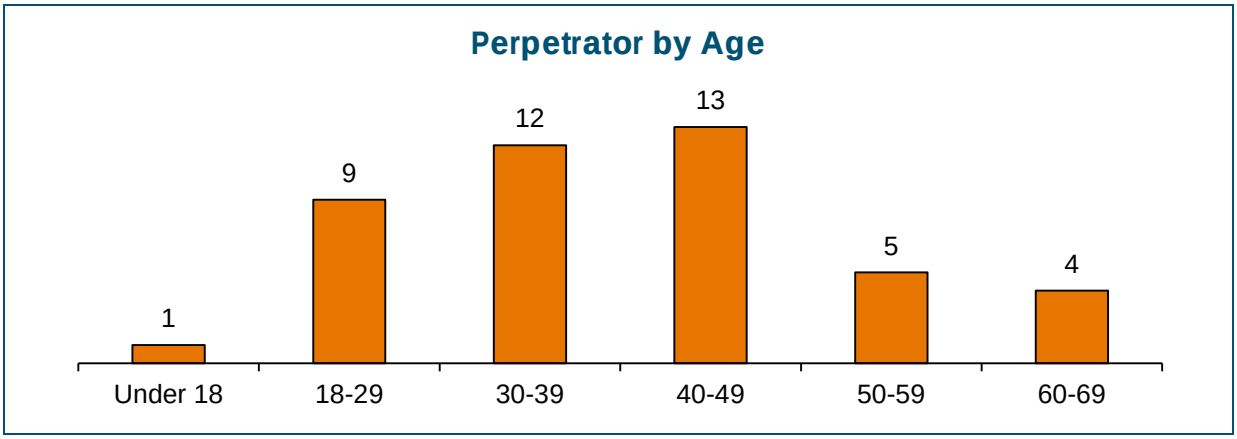
Gender of Perpetrators Compared to WA Population

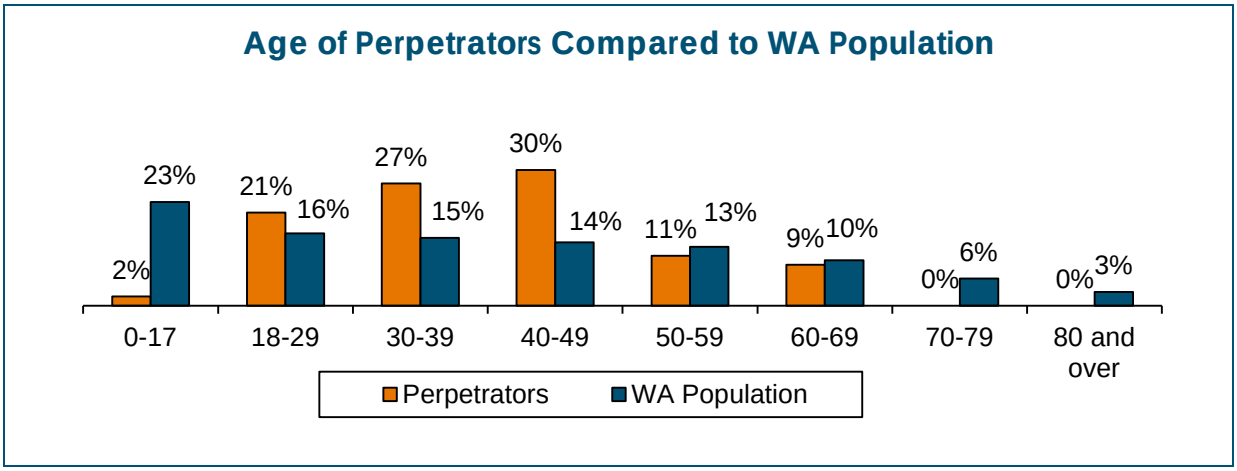


Compared to the Western Australian population, male perpetrators of fatalities in the six years from 1 July 2012 to 30 June 2018 were over-represented, with 75% of perpetrators being male compared to 50% in the population.

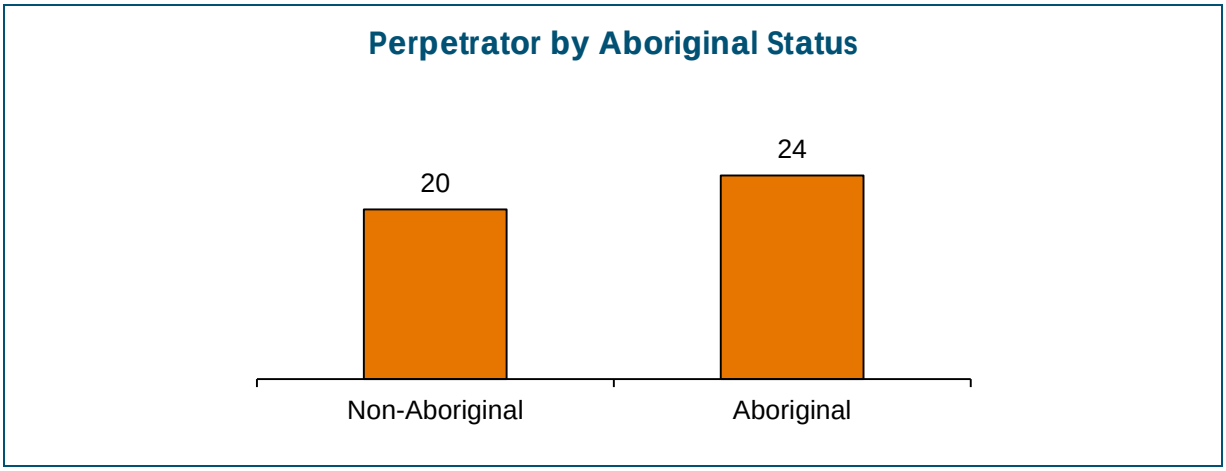
Ten males were convicted of manslaughter and 23 males were convicted of murder. Eight females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death and two females were convicted of murder.

In the 11 fatalities where the perpetrator was female, the person who died was male. Of the 33 fatalities where the perpetrator was male, in 27 fatalities the person who died was female, and in six fatalities the person who died was male.

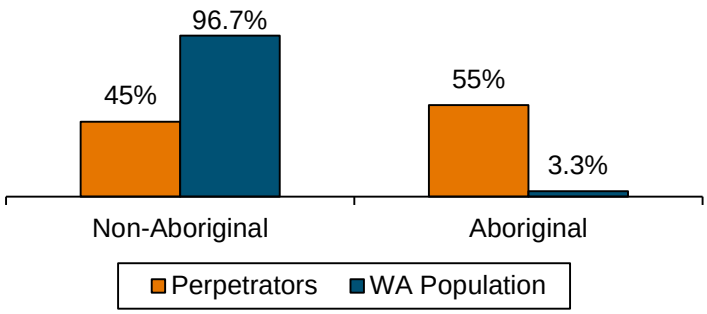




Compared to the Western Australian population, perpetrators of fatalities in the six years from 1 July 2012 to 30 June 2018 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 21% of perpetrators being in the 18-29 age group compared to 16% in the population, 27% of perpetrators being in the 30-39 age group compared to 15% in the population, and 30% of perpetrators being in the 40-49 age group compared to 14% in the population.



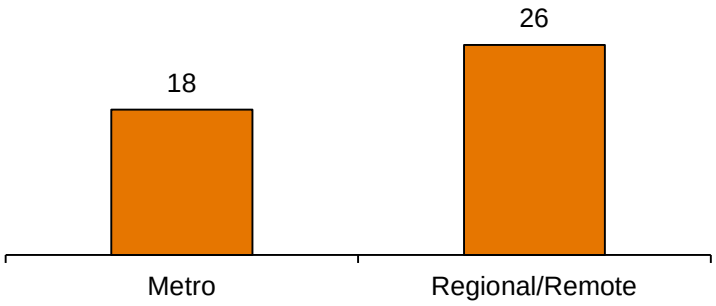
Aboriginal Status of Perpetrators Compared to WA Population



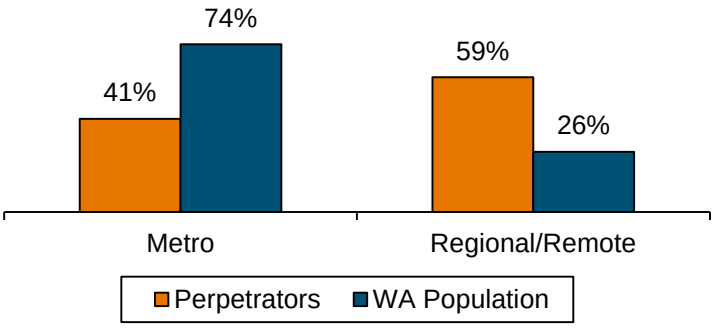
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the six years from 1 July 2012 to 30 June 2018 were over-represented with 55% of perpetrators being Aboriginal compared to 3.3% in the population.

In 22 of the 24 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location



Perpetrators by Location Compared to WA Population



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

Compared to the Western Australian population, the people who died in the six years from 1 July 2012 to 30 June 2018, who were living in regional or remote locations, were over-represented, with 59% 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

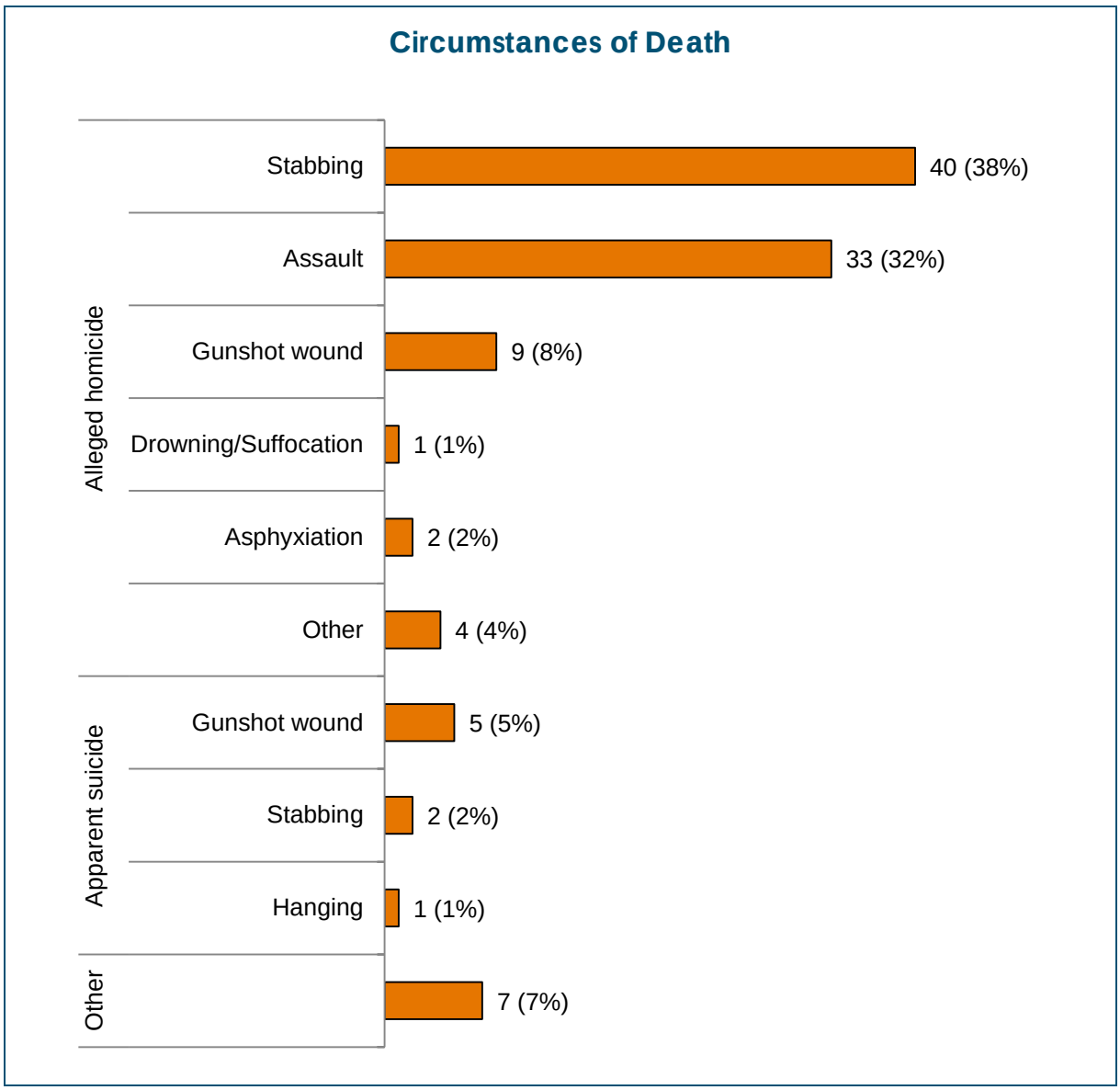
Information provided to the Office by WAPOL about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

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.

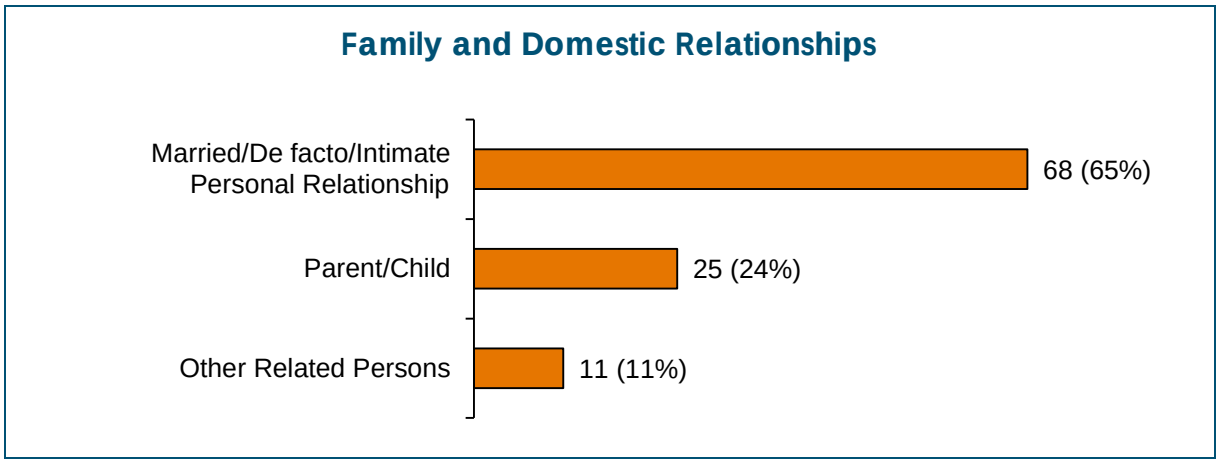
The principal circumstances of death in 2017-18 were alleged homicide by gunshot wound and stabbing.

The following chart shows the circumstance of death as categorised by the Ombudsman for the 104 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2018.



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 104 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2018:

- 68 fatalities (65%) involved a married, de facto or intimate personal relationship, of which there were 59 alleged homicides, seven apparent suicides and two in other circumstances. The 68 fatalities included 12 deaths that occurred in six cases of alleged homicide/suicide and, in all six cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. The seventh apparent suicide involved a male. Of the remaining 53 alleged homicides, 38 (72%) of the people who died were female and 15 (28%) were male;
- 25 fatalities (24%) involved a relationship between a parent and adult child, of which there were 20 alleged homicides, one apparent suicide and four in other circumstances. Of the 20 alleged homicides, six (30%) of the people who died were female and 14 (70%) were male. Of these 20 fatalities, in 13 cases (65%) the person who died was the parent or step-parent and in seven cases (35%) the person who died was the adult child or step-child; and
- There were 11 people who died (11%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, four (36%) were female and seven (64%) were male.

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

State policy and planning to reduce family and domestic violence fatalities

At the time of writing this report, the Communities website *Family and Domestic Violence Strategic Planning* page (available at www.dcp.wa.gov.au) states Communities is the lead agency responsible for family and domestic violence strategic planning in Western Australia. Communities is currently leading the development of a 10-year across-government strategy to reduce family and domestic violence.

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 *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, identifies actions for achieving its agreed Primary State Outcomes, priorities among these actions, and allocation of responsibilities for these actions to specific state government departments and authorities.

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

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 90 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2018.

For 60 (67%) 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 30 (33%) 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 90 finalised reviews, the circumstances of the fatality were as follows:

- For the 60 intimate partner fatalities, 51 were alleged homicides, seven were apparent suicides, and two were other circumstances; and
- For the 30 non-intimate partner fatalities, 24 were alleged homicides, one was an apparent suicide, and five were other circumstances.

Intimate partner relationships

Of the 51 intimate partner relationship fatalities involving alleged homicide:

- There were 36 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 21 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In 13 of these fatalities the person who died was female and in eight the person who died was male;
- There were 24 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, nine at the residence of the person who died or the residence of the suspected perpetrator, five at the residence of family or friends, and 13 at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 26 fatalities where the person who died lived in regional and remote areas, and in 19 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 30 non-intimate partner fatalities, there were 21 fatalities involving a parent and adult child and nine fatalities where the parties were otherwise related.

Of the 24 non-intimate partner fatalities involving alleged homicide:

- There were six fatalities where the person who died was female and the suspected perpetrator was male, three where the person who died was female and the suspected perpetrator was female, 11 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 12 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, nine 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 seven 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 31 (61%) of the 51 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2018, alleged family and domestic violence between the parties had been reported to WAPOL and/or to other public authorities. In seven (29%) of the 24 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2018, 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

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 38 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 disability;
- None of the fatalities involved a deceased person who identified as lesbian, gay, bisexual, trans or intersex;
- 22 fatalities involved a deceased Aboriginal person; and

- 22 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 then State Strategy nor the *Achievement Report to 2013* identified any actions to improve the collection of data relating to different communities experiencing higher rates of family and domestic violence, for example through the collection of cultural, demographic and socioeconomic data. In the report, the Ombudsman recommended that:

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

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

In relation to data collation about communities over-represented in family and domestic violence, and how this is used to inform evidence-based strategies tailored to addressing family and domestic violence in these communities, the Ombudsman will continue to monitor the development, implementation and effectiveness of the proposed 10-year family and domestic violence strategy for Western Australia, and plan for responding to Aboriginal family violence.

Identification of family and domestic violence incidents

Of the 38 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 family and domestic violence 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.
>
> 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 the *Family and Domestic Violence Practice Guidance*, in particular, that '[w]here a VRO is considered desirable or necessary but a decision is made for the Department not to apply for the order, the non-abusive adult victim should be given an active referral for legal advice and help from an appropriate service'.

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

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

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that in relation to Recommendations 44, 45, 46 and 47 DCPFS had taken steps and proposed steps to be taken to give effect to all these recommendations. The 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 *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, DCPFS specifically identifies and incorporates opportunities for state government departments and authorities to deliver information and advice about violence restraining orders, beyond the initial response by WAPOL.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family

and domestic violence fatalities, November 2016, identified that DCPFS had taken steps to give effect to this recommendation.

The findings and recommendations from the Ombudsman's family and domestic violence fatality reviews and major own motion investigations will contribute to the development of the 10-year across-government strategy to reduce family and domestic violence. The Office will also monitor the implementation of Recommendation 14 from the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015 in the development of the new state strategy.

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

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

The findings from the Ombudsman's family and domestic violence fatality reviews and the own motion investigations will contribute to the development of the 10-year across-government strategy to reduce family and domestic violence.

Provision of support to victims experiencing family and domestic violence

In November 2015, Communities 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 2017-18, 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

Case Study A

Mr A had been in prison for offences that had occurred in the context of family and domestic violence. Following his release from prison, Mr A fatally assaulted his intimate partner, Ms Z. Mr A has been convicted of murder. The Ombudsman made the following recommendation in 2017-18:

> DOJ considers what additional action can be taken to promote the safety of family and domestic violence victims and the community, prior to the release of all prisoners convicted of offences committed in the context of family and domestic violence and assessed as a high risk of committing further offences, irrespective of whether they are released on parole or to freedom, and provides a report to the Ombudsman by 31 December 2017 outlining actions to address this issue.

Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 31 (61%) of the 51 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2018, 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 20 (39%) of the 51 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2018, 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 2016* (www.abs.gov.au) collected information about help seeking behaviours, noting that:

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

and

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

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

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

Family violence involving Aboriginal people

Of the 90 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2018, Aboriginal Western Australians were over-represented, with 29 (32%) persons who died being Aboriginal. In all but one case, the suspected perpetrator was also Aboriginal. There were 23 of these 28 fatalities where the person who died lived in a regional or remote area of Western Australia, of which 19 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, 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 household; lack of transport on rural and remote communities; and a general lack of culturally secure services.
> (Blagg, H, Bluett-Boyd, N and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 13).

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

> This research report undertakes a critical inquiry into responses to family violence in a number of remote communities from the perspective of Aboriginal people who either work within the family violence space or have had experience of family violence. It explicitly foregrounds Indigenous knowledge of family violence, arguing that Indigenous knowledge departs from what we call in this report "mainstream knowledge"1 in a number of critical respects. The report is based on qualitative research in three sites in Australia: Fitzroy Crossing (Western Australia), Darwin (Northern Territory), and Cherbourg (Queensland). It supports the creation of a network of regionally based Indigenous family violence strategies owned and managed by Indigenous people and linked to initiatives around alcohol reduction, intergenerational trauma, social and emotional wellbeing, and alternatives to custody. The key theme running through our consultations was that innovative practice must be embedded in Aboriginal law and culture. This recommendation runs counter to accepted wisdom regarding intervention in family and domestic violence, which tends to assume that gender trumps other differences, and that violence against women results from similar forms of oppression, linked to gender inequalities and patriarchal forms of power. While not disputing the role of gender and coercion in underpinning much violence against Indigenous women, we, nonetheless, claim that a distinctively Indigenous approach to family violence necessitates exploring causal factors that reflect specifically Indigenous experiences of colonisation and its aftermath.
> (page 9)

The Ombudsman's reviews and report have identified that Aboriginal victims want the violence to end, but not necessarily always through the use of 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 that is specifically tailored to preventing and reducing Aboriginal family violence. This can be summarised as three key points.

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

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

further suggests that combating violence is likely to require approaches that are informed by and respond to this experience of family violence.

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

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

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

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

In 2017, the State Government released the *Stopping Family and Domestic Violence Policy*, which sets out 21 new initiatives for responding to family and domestic violence. This document supersedes *Western Australia's Family and Domestic Violence Strategy to 2022* and the *Freedom from Fear Action Plan 2015*. Also in 2017, the first Minister for the Prevention of Family and Domestic Violence was appointed. In 2018, Communities has convened a family and domestic violence policy consortium, comprising representatives from government, community sector services, Aboriginal Community Controlled Organisations and academia, to develop a comprehensive project plan for the development of a 10-year across-government strategy to reduce family and domestic violence. The Office, as an observer, has contributed to this policy consortium. The findings and recommendations from the Ombudsman's family and domestic violence fatality reviews and major motion investigations will contribute to the development of this new state strategy.

Case Study

Case Study B

As part of a review of a family and domestic violence fatality, to further understand how agencies are working together, and with Aboriginal people and communities, the Office convened a roundtable in November 2017. The roundtable was attended by Aboriginal cultural consultants as well as relevant public sector agencies.

Further, the Ombudsman's major own motion investigation, tabled in Parliament on 19 November 2015, titled *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* specifically considered issues of agency engagement with Aboriginal Family Violence. In particular, Recommendations 4, 5 and 6 which state:

> **Recommendation 4**
>
> DCPFS, as the lead agency responsible for family and domestic violence strategic planning in Western Australia, develops a strategy that is specifically tailored to preventing and reducing Aboriginal family violence, and is linked to, consistent with, and supported by *Western Australia's Family and Domestic Violence Prevention strategy to 2022: Creating Safer Communities*.
>
> **Recommendation 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.
>
> **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.

Further again, these recommendations have been examined in *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* which was tabled in Parliament on 10 November 2016.

To further examine the implementation of these recommendations, this Office requested clarification from Communities as the lead agency responsible for family and domestic violence strategic planning in Western Australia. This Office was informed that Communities will develop a 10-year family and domestic violence strategy for Western Australia, which will include a specific plan for responding to the issue of Aboriginal Family Violence. The Office made the following recommendation:

> Communities provides the Ombudsman with a report on the steps taken to give effect to Recommendations 4, 5 and 6 of the Ombudsman's major own motion investigation report *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* by 31 December 2018.

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 findings from the Ombudsman's family and domestic violence fatality reviews and the own motion investigations will contribute to the development of the 10-year across-government strategy to reduce family and domestic violence, and monitor the implementation of Recommendation 16 from the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015.

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

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

In the report, the Ombudsman recommended that:

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

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

The findings and recommendations from the Ombudsman's family and domestic violence fatality reviews and major own motion investigations will contribute to the development of the 10-year across-government strategy to reduce family and domestic violence.

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

Of the 29 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2018 involving Aboriginal people, 23 (79%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Twelve (41%) 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.

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 Communities 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 Communities 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'.

Case Study

Case Study C

The Ombudsman's review of a family and domestic violence fatality identified limitations in data being captured, including Aboriginal status of the victim and perpetrator, to inform family violence service development and evaluation. The Office made the following recommendation:

- Communities takes steps to ensure data being captured by the Family and Domestic Violence Region Team (**FDVRT**) process includes Aboriginal status of the victim and perpetrator, to inform FDVRT and family violence service development and evaluation.

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.
> (National Council to Reduce Violence against Women and their Children, 2009, *Background Paper to Time for Action, The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009–2021*, Australian Government, p. 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/national-framework-for-action-to-prevent-alcohol-related-family-violence/) 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 75 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2018, 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	3	3	3	7
Suspected perpetrator only	3	12	7	10
Both person who died and suspected perpetrator	22	24	6	11
Total	**28**	**39**	**16**	**28**

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 (and correct at the time of writing this report).

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 *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, 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. The Office will monitor the development, implementation and effectiveness of the proposed *Western Australian Alcohol and Drug Interagency Strategy 2018-2022*, and the 10-year across-government strategy to reduce family and domestic violence, in responding to family and domestic violence and co-occurrence with alcohol and drugs.

Co-occurrence of mental health issues

As 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 Communities' *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 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.
- Missed opportunity to collate data relevant to informing the development, and evaluation, of strategies and services to reduce or prevent family and domestic violence.
- Not undertaking sufficient inter-agency communication to enable effective case management and collaborative responses.
- 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 2017-18 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. DOJ develops a family and domestic violence policy to direct and co-ordinate its commitment to achieving the Primary State Outcomes of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022*. Further, the family and domestic violence policy identifies the needs of Aboriginal people and includes specifically tailored strategies for preventing and reducing Aboriginal family violence which are linked to, and consistent with, *Western Australia's Family and Domestic Violence Prevention Strategy to 2022*.

2. DOJ develops a process to identify all offenders convicted of offences that occurred in the context of family and domestic violence entering the prison system and reports on this group in offender statistics and other relevant reports.

3. DOJ considers, as part of its current review into prisoner management, the

management of prisoners serving an effective sentence of six months or less for an offence that occurred in the context of family and domestic violence who have been identified as a high risk of re-offending and develops strategies to promote perpetrator accountability and support these prisoners to cease their violent behaviour.

4. DOJ is to provide a report to the Ombudsman within six months of the finalisation of this family and domestic violence fatality review outlining actions taken by DOJ to review its information release and sharing policies to support greater collaboration processes to promote the safety of victims of offences that occurred in the context of family and domestic violence.

5. That DOJ considers, in the context of current agency program review and resourcing provisions, what steps will be taken to improve the rate of prisoners assessed as requiring family and domestic violence treatment programs assessing these programs during their imprisonment to promote perpetrator accountability and support these prisoners to cease their violent behaviour, in accordance with DOJ's responsibilities for offender management and rehabilitation and commitment to promoting perpetrator accountability and victim safety as outlined in the *Western Australia's Family and Domestic Violence Prevention Strategy to 2022*, and provides a report to the Ombudsman by [nominated date] outlining the steps taken to address this issue.

6. DOJ provides a report to the Ombudsman, within three months of the finalisation of this review, outlining work undertaken by the Adult Justice Services Division to address 'the gap' identified by DOJ, in its letter [relevant to this family and domestic violence fatality review], regarding the assessment of 'domestic violence offenders ... in the custodial environment'.

7. DOJ considers what additional action can be taken to promote the safety of family and domestic violence victims and the community, prior to the release of all prisoners convicted of offences committed in the context of family and domestic violence and assessed as a high risk of committing further offences, irrespective of whether they are released on parole or to freedom, and provides a report to the Ombudsman by [nominated date] outlining actions to address this issue.

8. Communities takes steps to ensure data being captured by the Family and Domestic Violence Response Team process includes Aboriginal status of the victim and perpetrator, to inform Family and Domestic Violence Response Team and family violence service development and evaluation.

9. Communities provides the Ombudsman with a report on the steps taken to give effect to Recommendations 4, 5 and 6 of the Ombudsman's major own motion investigation report *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* by [nominated date].

The Ombudsman's *Annual Report 2018-19* will report 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. The Ombudsman's *Annual Report 2019-20* will report on the steps taken to give effect to the nine recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2017-18.

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. The Office has requested that the relevant public authorities notify the Ombudsman regarding:

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

Recommendation 1: That WAPOL considers whether action is required to strengthen processes associated with the receipt, assessment and verification of intelligence related to threats to kill made in family and domestic relationships, to ensure the prioritisation of victim safety and perpetrator accountability.

Steps taken to give effect to the recommendation

The Office requested that WAPOL inform the Office of the steps taken to give effect to the recommendation. In response, WAPOL provided a range of information in a letter to this Office dated 9 August 2017 (**the WAPOL Letter**).

In the WAPOL Letter, WAPOL relevantly informed the Office that:

> WA Police has implemented actions to strengthen processes associated with the receipt, assessment and verification of intelligence related to threats to kill and to ensure prioritisation of victim safety and perpetrator accountability.
>
> Regular, formal meetings are held between WA Police and the Department of Corrective Services (**DCS**) Intelligence Services to review and facilitate improved operational response to intelligence gathered by DCS personnel.
>
> Where DCS identify allegations of serious imminent, threats to life, WA Police are notified and resources tasked immediately. In circumstances where a threat is serious but not imminent, a report is recorded on the Intelligence Data Management (IDM) system and assessed by an intelligence co-ordinator for further consideration.
>
> An Incident Report is generated on the WA Police Incident Management System (IMS) and allocated to a relevant business area for investigation.
>
> Where family violence is identified as a factor, the Incident Report is 'flagged' with a marker, ensuring District Family Protection Units are notified and Family and

Domestic Violence Response Team (FDVRT) protocols are applied.

Additional advantages of recording the information on IMS include the provision of a formal trigger to place investigative accountability on business units and individual officers and a compliance mechanism to ensure timely investigation within the WA Police Investigation Framework.

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

Recommendation 2: That WAPOL considers whether action is required to strengthen processes and procedures to promote that the interrogation of data systems identifies contemporaneous and relevant information upon which to inform the allocation of matters to the appropriate WAPOL division for action.

Steps taken to give effect to the recommendation

The Office requested that WAPOL inform the Office of the steps taken to give effect to the recommendation. In response, WAPOL provided a range of information in a letter to this Office dated 9 August 2017.

In the WAPOL Letter, WAPOL relevantly informed the Office that:

WA Police has implemented actions to strengthen processes associated with the receipt, assessment and verification of intelligence related to threats to kill and to ensure prioritisation of victim safety and perpetrator accountability.

Regular, formal meetings are held between WA Police and the Department of Corrective Services (**DCS**) Intelligence Services to review and facilitate improved operational response to intelligence gathered by DCS personnel.

Where DCS identify allegations of serious imminent, threats to life, WA Police are notified and resources tasked immediately. In circumstances where a threat is serious but not imminent, a report is recorded on the Intelligence Data Management (IDM) system and assessed by an intelligence co-ordinator for further consideration.

An Incident Report is generated on the WA Police Incident Management System (IMS) and allocated to a relevant business area for investigation.

Where family violence is identified as a factor, the Incident Report is 'flagged' with a marker, ensuring District Family Protection Units are notified and Family and Domestic Violence Response Team (FDVRT) protocols are applied.

Additional advantages of recording the information on IMS include the provision of a formal trigger to place investigative accountability on business units and individual officers and a compliance mechanism to ensure timely investigation within the WA Police Investigation Framework.

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

Recommendation 3: That WAPOL considers current procedures to determine whether action is required to strengthen the timely provision of intelligence to WAPOL prosecutors to inform bail applications and associated bail conditions.

Steps taken to give effect to the recommendation

The Office requested that WAPOL inform the Office of the steps taken to give effect to the recommendation. In response, WAPOL provided a range of information in a letter to this Office dated 9 August 2017.

In the WAPOL Letter, WAPOL relevantly informed the Office that:

> WA Police policy and training directs investigating officers to provide timely intelligence to prosecutors in order to inform bail conditions. This is predominately confined to intelligence held within WA Police databases due to Information Technology (IT) limitations existing across agencies, as platforms do not readily interact and have limited interoperability.
>
> WA Police Prosecuting personnel are sometimes restricted in opportunity to engage in comprehensive intelligence gathering, particularly when applications for bail are made at the discretion of the accused person and the timing of such actions are often unknown and at short notice.
>
> Dialogue is ongoing to explore the possibility of strengthening systems, however a number of issues exist including lack of access to intelligence held by other agencies and limitation of access to external agencies outside of office hours which may preclude this.

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

Recommendation 4: That WAPOL takes all reasonable steps to ensure that actions allocated to WAPOL arising from the Family and Domestic Violence Response Team (FDVRT) triage meetings are undertaken in a timely manner and consistent with the FDVRT Operating Procedures and WAPOL's Family and Domestic Violence Policy.

Steps taken to give effect to the recommendation

The Office requested that WAPOL inform the Office of the steps taken to give effect to the recommendation. In response, WAPOL provided a range of information in a letter to this Office dated 9 August 2017.

In the WAPOL Letter, WAPOL relevantly informed the Office that:

> The current WA Police policies and procedures have recently been reviewed and provide advice and accountabilities to WA Police personnel involved in the FDVRT process. All police FDVRT actions are allocated to relevant Victim Safety Unit or Family Protection Unit who are accountable for actioning tasks and record the actions on an IMS running sheet.
>
> The implementation of a threshold for reports to the FDVRT is scheduled for tiered implementation across the state in July and August 2017. The threshold intends to focus the resources of the FDVRT on the families most in need of support, to

maximise effort.

The reduced volume of reports forwarded for FDVRT attention will provide the capacity to complete triage in a timely manner and actively engage in support actions and interventions allocated.

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

Recommendation 5: That WAPOL takes all reasonable steps to ensure its cumulative knowledge associated with the circumstances of recidivist family and domestic violence offending, in addition to perpetrator offending histories, is utilised at FDVRT triage meetings to inform the identification of high risk cases for referral and management via multi-agency case management.

Steps taken to give effect to the recommendation

The Office requested that WAPOL inform the Office of the steps taken to give effect to the recommendation. In response, WAPOL provided a range of information in a letter to this Office dated 9 August 2017.

In the WAPOL Letter, WAPOL relevantly informed the Office that:

> The implementation of a threshold for reports to the FDVRT is scheduled to be implemented across the State in July and August 2017. The threshold intends to focus the resources of the FDVRT on families most in need of support, to maximise effort.
>
> The reduced volume of reports for FDVRT attention will afford the Family Protection and Victim Support Units capacity to interrogate WA Police databases and 'value add' to reports prior to publishing for FDVRT triage.

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

Recommendation 6: That the Department of Health (DOH) considers amending and/or supplementing DOH's *Guideline for Responding to Family and Domestic Violence 2014*, to provide its staff with guidance on implementing the outlined procedures associated with identifying and responding to family and domestic violence in circumstances where a patient presents as intoxicated.

Steps taken to give effect to the recommendation

The Office requested that DOH inform the Office of the steps taken to give effect to the recommendation. In response, DOH provided a range of information in a letter to this Office dated 6 September 2017 (**the DOH Letter**).

In the DOH Letter, DOH relevantly informed the Office that:

> …on 1 July 2016, the Health Services Act 2016 commenced operation introducing a contemporary, devolved governance model for the WA Health system. The *Health Services Act 2016* clarifies roles and responsibilities at each level of the system, establishing the Director General of the Department of Health as the System Manager responsible for the overall management of the WA health system and the

Health Service Providers (Child and Adolescent Health Service, North Metropolitan Health Service, East Metropolitan Health Service, South Metropolitan Health Service and WA Country Health Service and Health Service Support) as separate statutory authorities…

Policy Governance Arrangements

The *Health Services Act 2016* introduced the concept of Policy Frameworks to the WA health system. On 1 July 2016 Operational Directives, Information Circulars and other policy documents relevant to the governance of the WA health system were allocated to one of the 19 policy frameworks and issued to the WA health system by the System Manager. Policy frameworks are binding on Health Service Providers.

On 5 April 2017 the *WA Health System Policy Governance Policy* was issued to govern policy frameworks and the policy documents that sit within them. The WA health system is still in a transitional phase.

Operational Directives issued prior to 1 July 2016 do not reflect the new governance model therefore the roles and responsibilities of Health Service Providers and the Director General, as System Manager in some cases are not clear. However, the Department of Health is about to embark on a process of reviewing and refining each policy framework so all policy documents within each framework are reflective of the new governance model, mandatory requirements are clear, and compliance and monitoring processes well-articulated and undertaken on a regular basis.

One policy issue that has yet to be resolved is the issue of statewide policy. Statewide policy is policy that is developed by subject matter experts within Health Service Providers and is intended to apply to the entire WA health system. This is a complex issue as Health Service Providers do not have the power under the *Health Services Act 2016* to:

- Issue policy frameworks;
- Monitor another Health Service Provider's performance; or
- Monitor another Health Service Provider's compliance with a policy.

One example of a statewide policy is Operational Directive 0523/14 *Responding to Family and Domestic Violence (Guidelines and Reference Manual)* (**OD 0523/14**). This policy is developed by the Women's Health, Genetics and Mental Health Directorate located at the Women and Newborn Health Service within the North Metropolitan Health Service. Due to the statewide policy issue not being resolved, OD 0523/14 was not allocated to a policy framework at 1 July 2016. The OD remains in force, however, as it is not part of a policy framework it is therefore not mandated on Health Service Providers under the Health Services Act 2016. Work is currently progressing in resolving the statewide policy issue…

…Once the issues regarding statewide policy are resolved, it will become clearer as to how this policy can be mandated on the WA health system and how compliance and evaluation of the policy will occur

In the meantime, the Women's Health, Genetics and Mental Health Directorate are currently in the process of updating OD 0523/14 and this policy will be reviewed and amended to reflect the new governance model, along with other required process updates.

[DOH] note that family violence was discussed at the August 2017 COAG Health Council and that it is a critical issue for the WA health system to address. Therefore, [DOH] will prioritise resolving the policy governance arrangements and clarifying the roles and responsibilities of the System Manger and the Health Service Providers in

this area…

It is also noted by this Office that during the review of this family and domestic violence fatality, DOH informed the Office in a letter dated 4 June 2015 that:

> Recommendation [6] is currently being considered by the Women Newborn Health Service's (WNHS) Women's Clinical Care Unit, as a component of the current FDV education and training sessions. Alcohol and drug use is a major risk factor for FDV, as outlined in the current assessment form. The WNHS Women's Health Clinical Support Program FDV trainer organised a videoconference forum with the WACHS Kimberley which occurred on 18 May 2015. At least 7 sites amounting to over 50 people attended this event. The issue of people presenting intoxicated was discussed at this forum.

In the context of the introduction of the *Health Services Act 2016*, this Office notes the work being undertaken to clarify how Operational Directive 0523/14 *Responding to Family and Domestic Violence (Guidelines and Reference Manual)* can be mandated on the WA health system and how compliance and evaluation will be undertaken.

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

Recommendation 7: That DOH liaises with the relevant community service and Communities to clarify information relating to the criteria for referral and services available from the relevant community service, and updates the family and domestic violence Local Service Information sheet accordingly.

Steps taken to give effect to the recommendation

The Office requested that DOH inform the Office of the steps taken to give effect to the recommendation. In response, WACHS provided a range of information in a letter to this Office dated 15 June 2017 (**the WACHS Letter**), containing a report prepared by WACHS.

In the WACHS Letter, WACHS relevantly informed the Office that:

> Family and Domestic Violence folders in each department outline:
>
> - Information for staff
> - WACHS procedures and guidelines
> - Documentation – screening and assessment tools/Referral forms – FDV950, FDV951, FDV952
> - Local support services
> - Contact phone numbers
> - Patient education – handouts/pamphlets

In its June 2017 report, WACHS further relevantly informed the Office that:

> FDV951 Assessment form – comprehensive 12 page document is completed. Tick box checklist which prompts for referrals and is signed and dated.

Operational Directive 0523/14 *Responding to Family and Domestic Violence (Guidelines and Reference Manual)* includes a template titled *Local Service Information*, which can be provided to patients who attend health services when

family and domestic violence is a presenting issue.

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

Recommendation 8: That DOH ensures the knowledge and views of clinicians, and other health services throughout the Region, are incorporated in current planning to address the issues of family and domestic violence in the Region.

Steps taken to give effect to the recommendation

The Office requested that DOH inform the Office of the steps taken to give effect to the recommendation. In response, WACHS provided a range of information in a letter to this Office dated 15 June 2017, containing a report prepared by WACHS.

In the WACHS Letter, WACHS relevantly informed the Office that:

> Broome Hospital nursing staff are encouraged to discuss alerting police to FDV assaults with the patient whilst in ED – if consent is not provided and FDV considered High Risk as per FDV951 the case is referred … for assessment +/- information sharing with the Kimberley FDV response team comprised of WAPOL, CPFS and Anglicare; as per MOU and Section 28B of the *Children and Community Services Act 2004*.
>
> A BHS representative attends Multi Agency Case Management meetings for identified high risk patients and place High risk alerts … in patient files which direct clinician response.

In providing information to this Office for the review, WACHS stated:

> …the emergency department doctors often have to make assumptions about whether a case is FDV. There is regularly a lack of information by women about what has happened. The incidents are often without consequence and it is thought that disclosure has a potential to lead to "punishment" for the victim at home. Other victims are intoxicated (alcohol or drugs) … there is a perception of multi-system failure often due to lack of safe housing; limitations on what police can do; and shelters/refuges not answering the phone after 10.00pm; or declining to provide assistance…

It is noted by this Office that during the review of this family and domestic violence fatality, DOH informed the Office in a letter dated 4 June 2015 that:

> The Kimberley region currently has a DCPFS working group. The DCPFS conducted consultations in all Kimberley towns, through local working groups and in the second half of 2014. WACHS Kimberley was represented at these consultations. The Kimberley Family Violence Regional Plan is not yet a pubic document, however is close to public release which addresses care for victims, and perpetrators, of FDV. The draft Kimberly Family Violence Regional Plan outlines a 2015-2016 work plan, in which WACHS Kimberley will be the lead agency to implement strategies and initiatives identified by the working group.

Safer Families, Safer Communities Kimberley Family Violence Regional Plan 2015 - 2020 was finalised in 2015.

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

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

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of family and domestic violence fatalities. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2017-18, timely review processes have resulted in one half of reviews being completed within three months and 67% 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

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

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through 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 Office 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 2017-18 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);
- Dr Michael Wright (Health Sciences, Curtin University)
- Mr Ralph Mogridge (Consultant); and
- Associate Professor Carolyn Johnson (Consultant).

In 2017-18, observers from Western Australia Police, the Department of Communities, the Department of Health, the Department of Education, the Department of Justice, and the Mental Health Commission 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 2017-18, included:

- The Coroner;

- Relevant public authorities including:
  - Western Australia Police;
  - The Department of Health and Health Service Providers;
  - The Department of Education;
  - The Department of Justice;
  - The Department of Communities;
  - The Mental Health Commission; and
  - Other accountability and similar agencies including the Commissioner for Children and Young People;
- The 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, complaint 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.

A Senior Aboriginal Advisor was appointed in January 2018 to assist the Principal Aboriginal Liaison Officer in this important work. Through the leadership of the Principal Aboriginal Liaison Officer, and Senior Aboriginal Advisor, 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.