Family and Domestic Violence Fatality Review

Overview

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

- Background;
- The role of the Ombudsman in relation to family and domestic violence fatality reviews;
- The family and domestic violence fatality review process;
- Analysis of family and domestic violence fatality reviews;
- Patterns, trends and case studies relating to family and domestic violence fatality reviews;
- Issues identified in family and domestic violence fatality reviews;
- Recommendations;
- 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*, which

established the 'groundwork for the National Plan', and the *Second Action Plan 2013-2016: Moving Ahead* and the *Third Action Plan 2016-2019*, which build upon this work. The *Fourth Action Plan 2019-2022: Turning the Corner* (available at www.dss.gov.au), as the final action plan of the National Plan, sets out an 'agenda to achieve change by: improving existing initiatives, addressing gaps in previous action plans, providing a platform for future policy to reduce domestic, family and sexual violence'.

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* set out 10 key actions to progress the development and implementation of the integrated response in 2009-10, including the need to '[r]esearch models of operation for family and domestic violence fatality review committees to determine an appropriate model for Western Australia' (page 2).

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

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

In 2017, the State Government released the *Stopping Family and Domestic Violence Policy*, which 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* (**former State Strategy**)

and the *Freedom from Fear Action Plan 2015*. Also in 2017, the first Minister for the Prevention of Family and Domestic Violence was appointed. In 2018, the Department of Communities (**Communities**) commenced working on the development of a *10 Year Strategy for Reducing Family and Domestic Violence* (**State Strategy**). 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 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 Force (**WA Police Force**) and 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 WA Police Force to have occurred in circumstances of family and domestic violence are described in this report as family and domestic violence fatalities. For the purposes of this report the person who has died due to suspected family and domestic violence will be referred to as 'the person who died' and the person whose actions are suspected of causing the death will be referred to as the 'suspected perpetrator' or, if the person has been convicted of causing the death, 'the perpetrator'.

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

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

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

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

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

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

(d) One of whom is a child who —

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

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

  or

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

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

'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

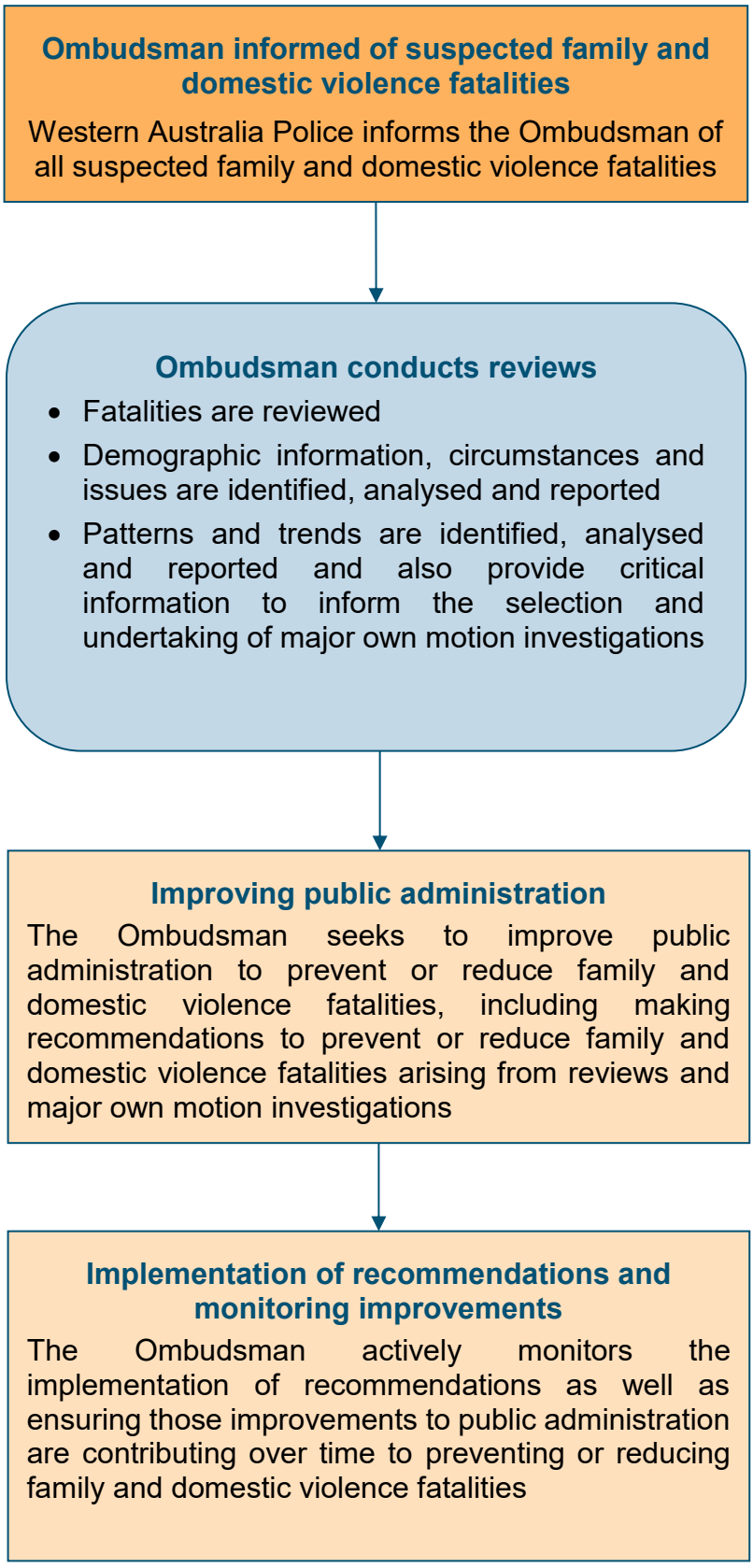
  (ii) De facto partner or former de facto partner.

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



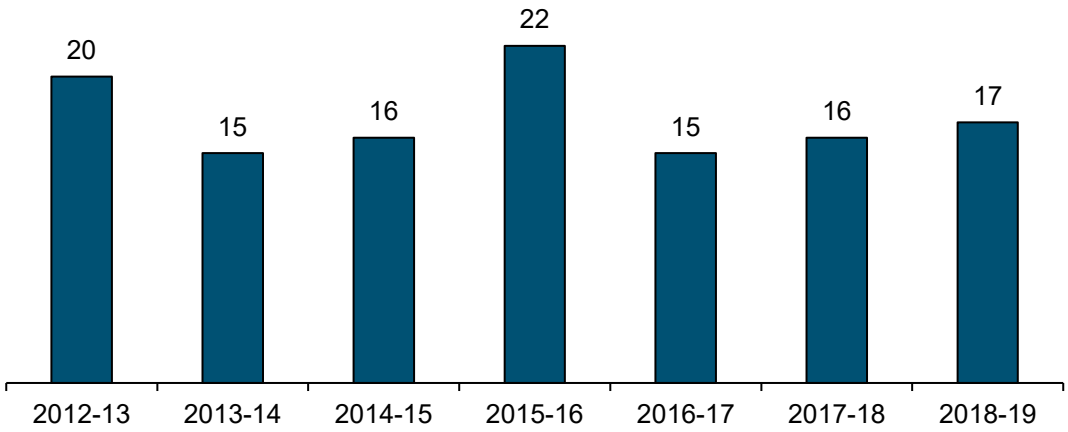
Analysis of Family and Domestic Violence Fatality Reviews

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

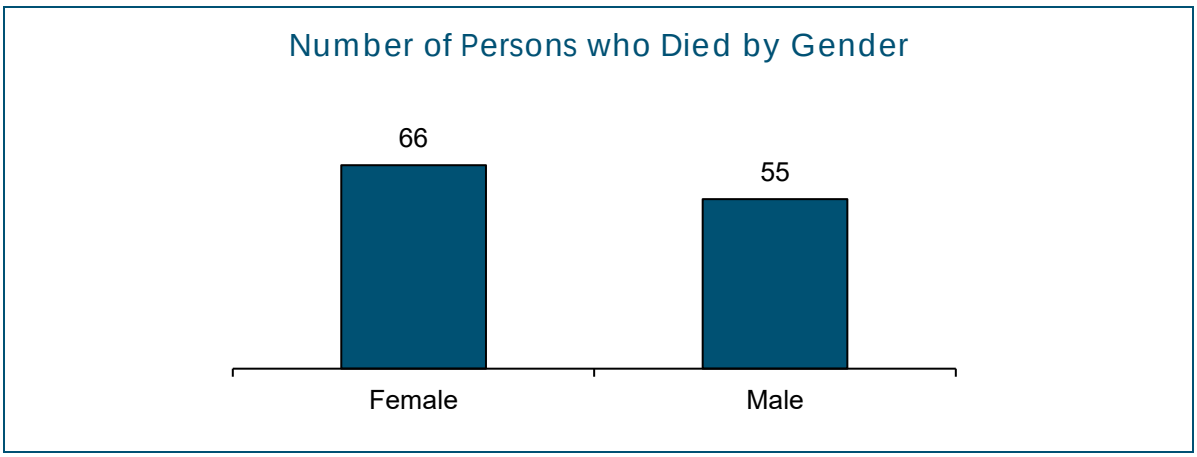
In 2018-19, the number of reviewable family and domestic violence fatalities received was 17, compared to 16 in 2017-18, 15 in 2016-17, 22 in 2015-16, 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

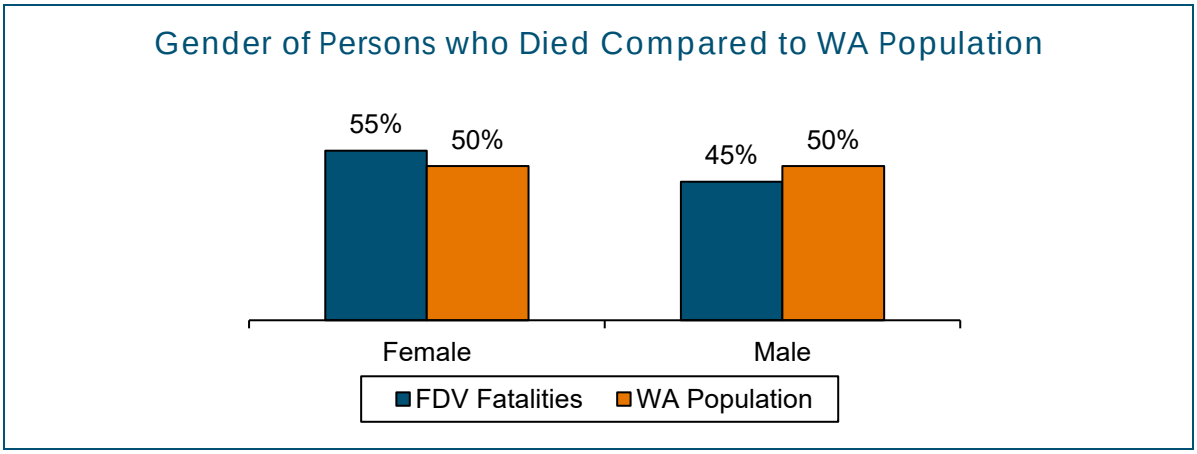


Demographic information identified from family and domestic violence fatality reviews

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

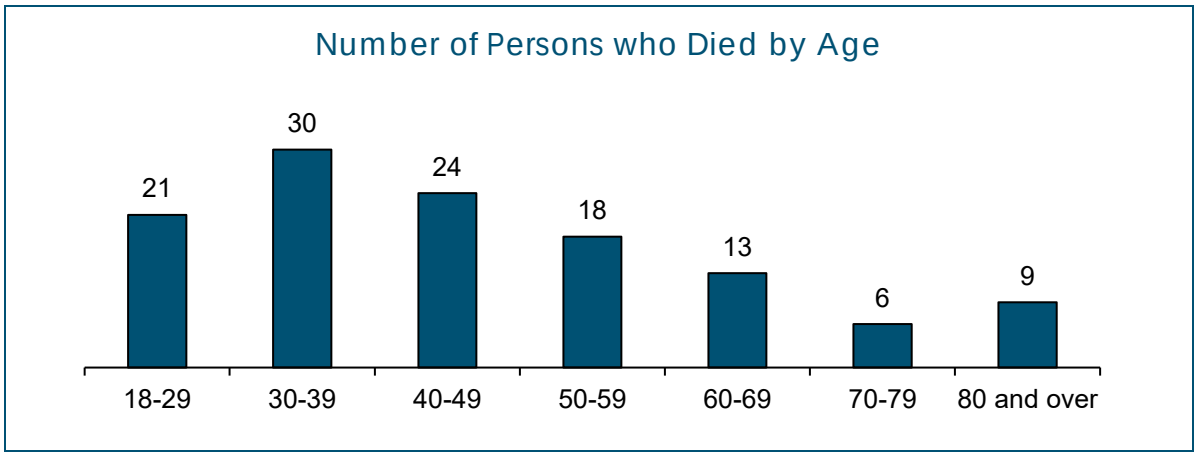
The following charts show characteristics of the persons who died for the 121 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2019. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

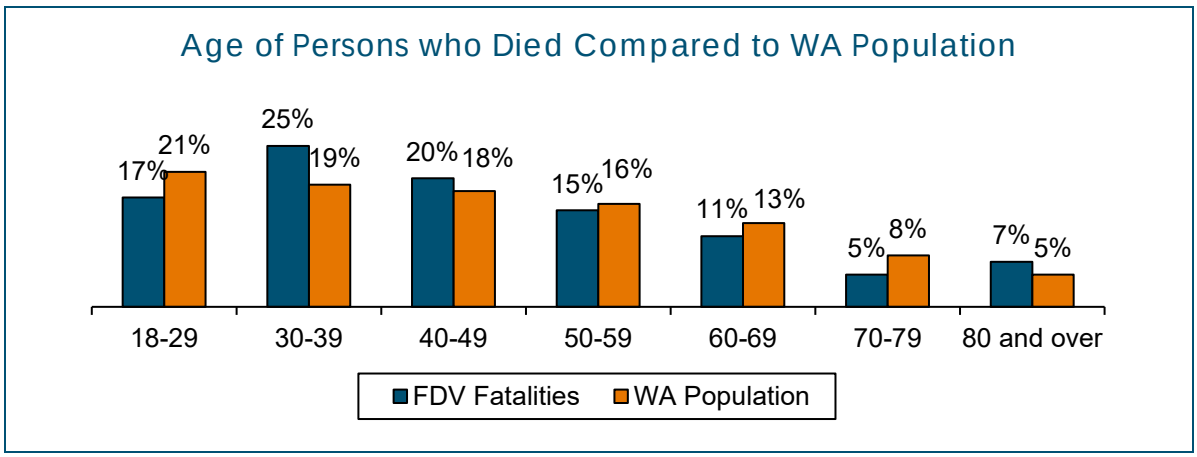




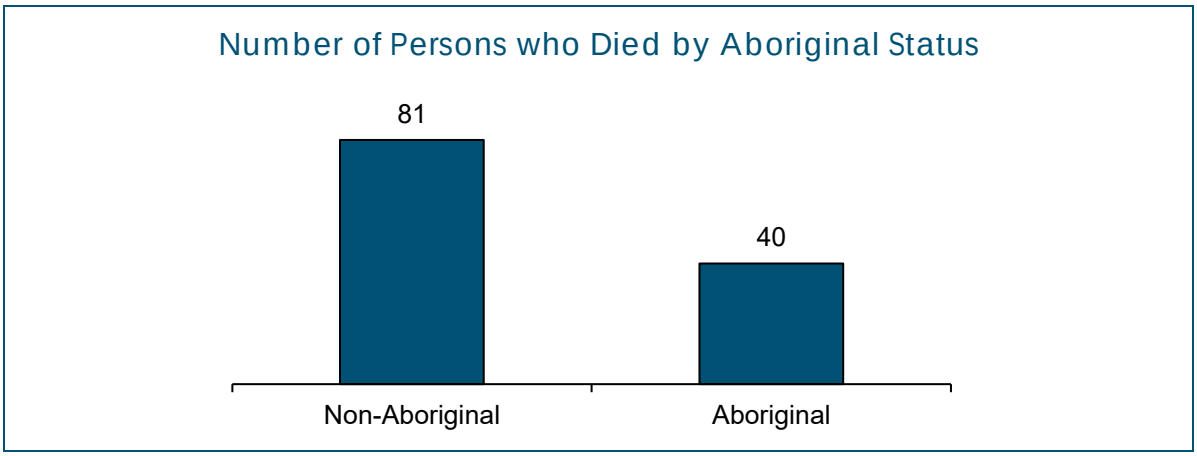
Compared to the Western Australian population, females who died in the seven years from 1 July 2012 to 30 June 2019, were over-represented, with 55% of persons who died being female compared to 50% in the population.

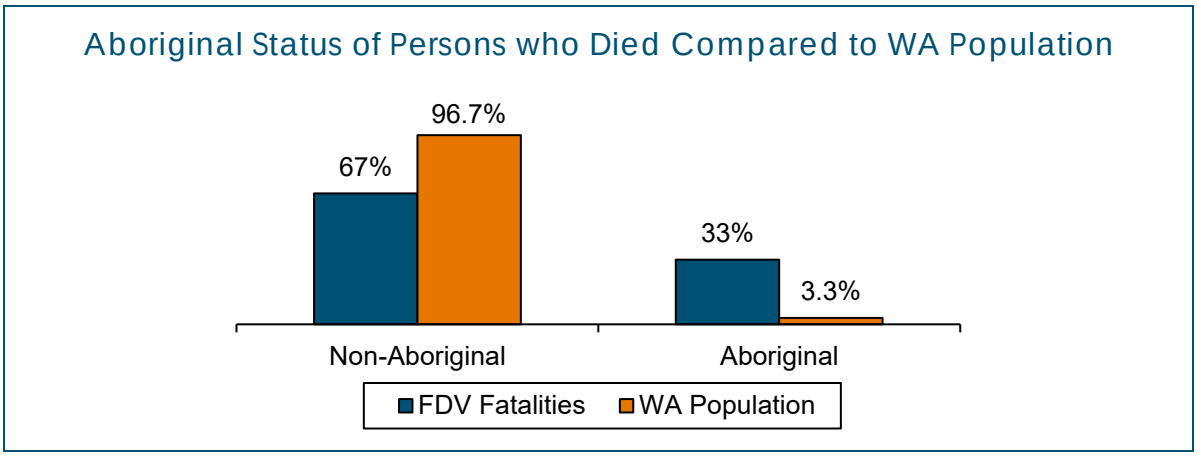
In relation to the 66 females who died, 61 involved a male suspected perpetrator, four involved a female suspected perpetrator, and one involved multiple suspected perpetrators of both genders. Of the 55 men who died, nine were apparent suicides, 24 involved a female suspected perpetrator, 20 involved a male suspected perpetrator and two involved multiple suspected perpetrators of both genders.



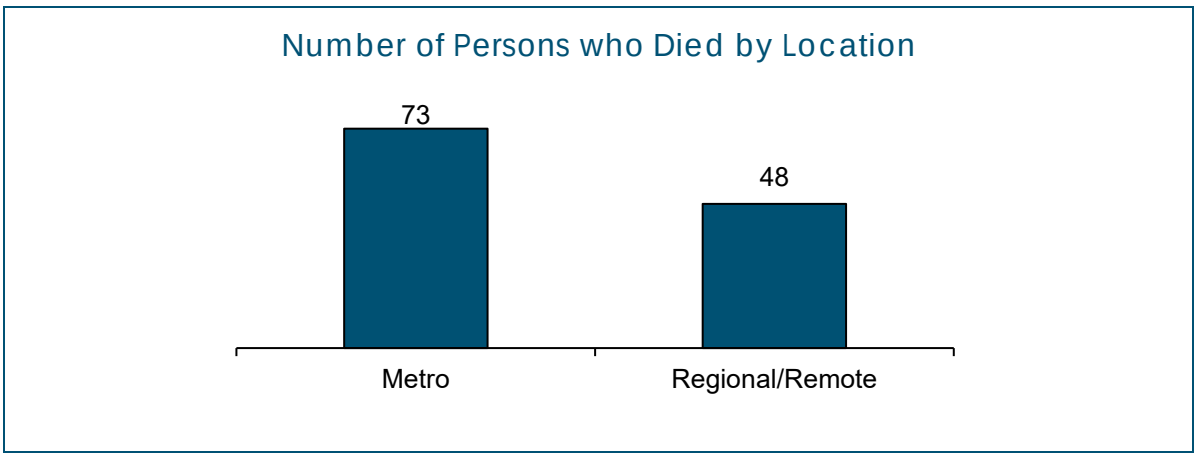


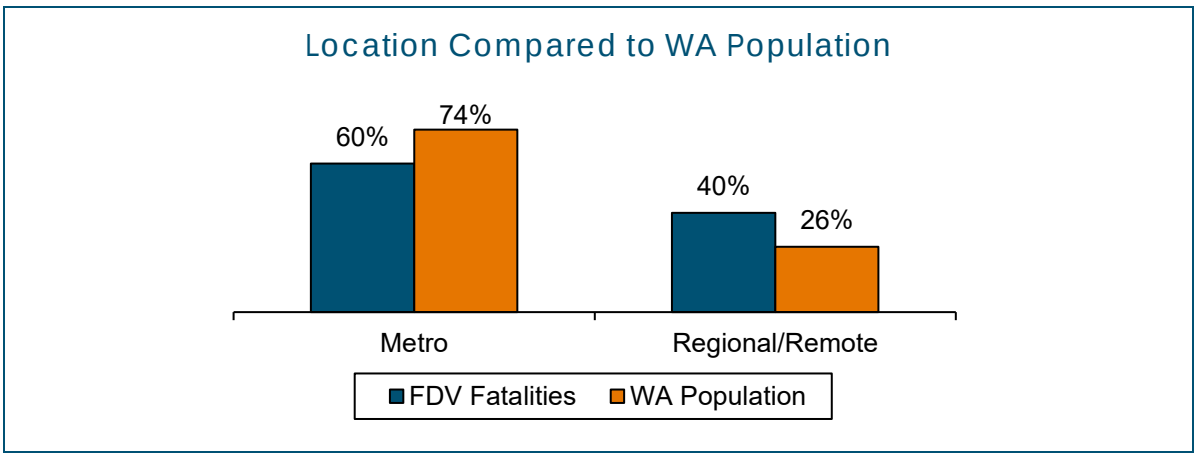
Compared to the Western Australian population, the age groups 30-39, 40-49 and 80 and over are over-represented, with 25% of persons who died being in the 30-39 age group compared to 19% of the population, 20% of persons who died being in the 40-49 age group compared to 18% of the population and seven per cent of persons who died being in the 80 and over age group compared to five per cent of the population.





Compared to the Western Australian population, Aboriginal people who died were over-represented, with 33% of people who died in the seven years from 1 July 2012 to 30 June 2019 being Aboriginal compared to 3.3% in the population. Of the 40 Aboriginal people who died, 23 were female and 17 were male.





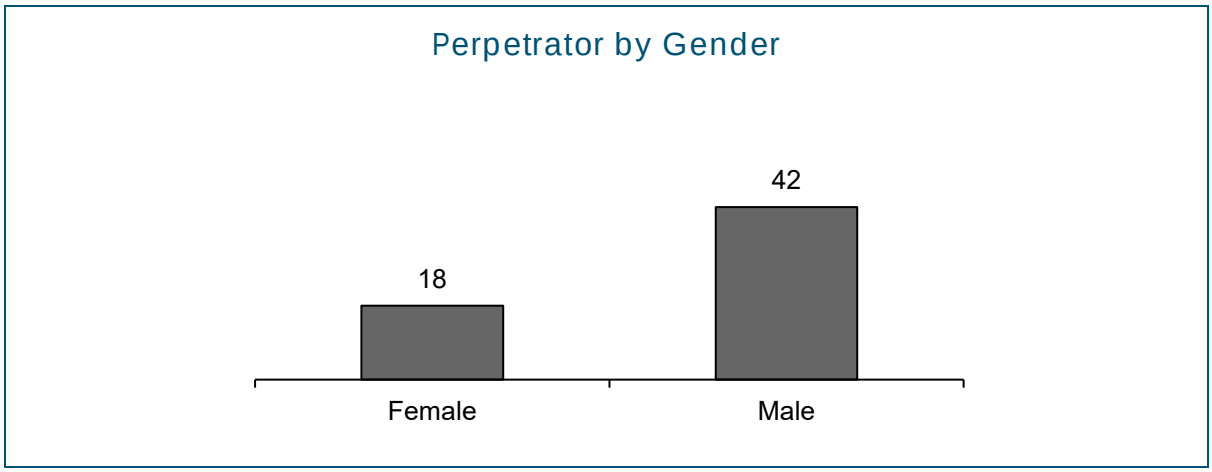
Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 40% of the people who died in the seven years from 1 July 2012 to 30 June 2019 living in regional or remote locations, compared to 26% of the population living in those locations.

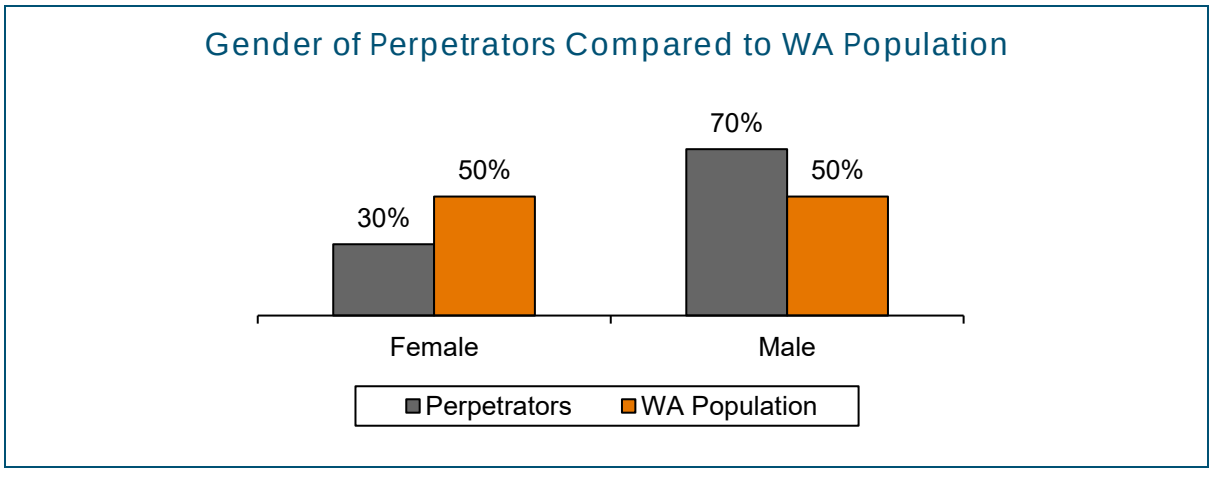
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2019 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2019.

Of the 121 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2019, coronial and criminal proceedings were finalised in relation to 60 perpetrators.

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



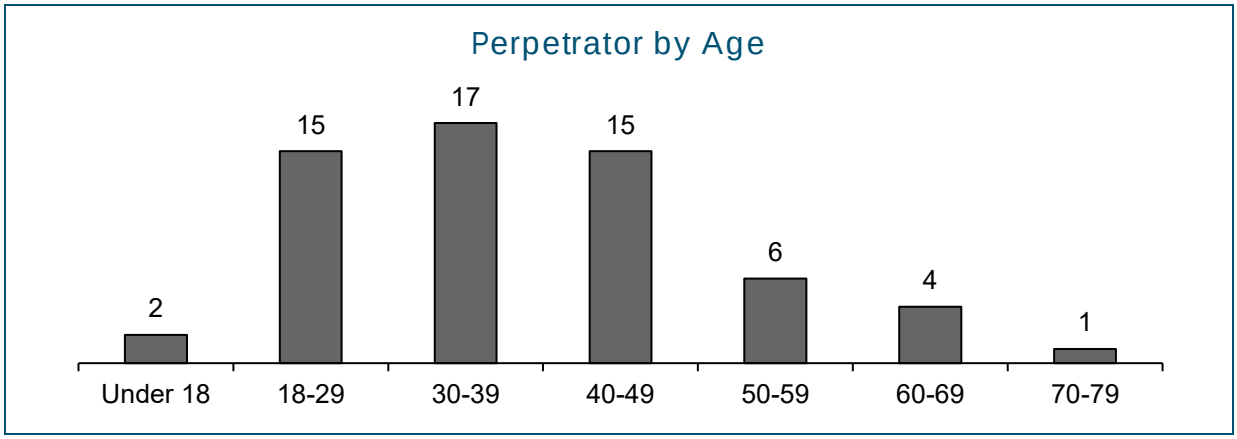


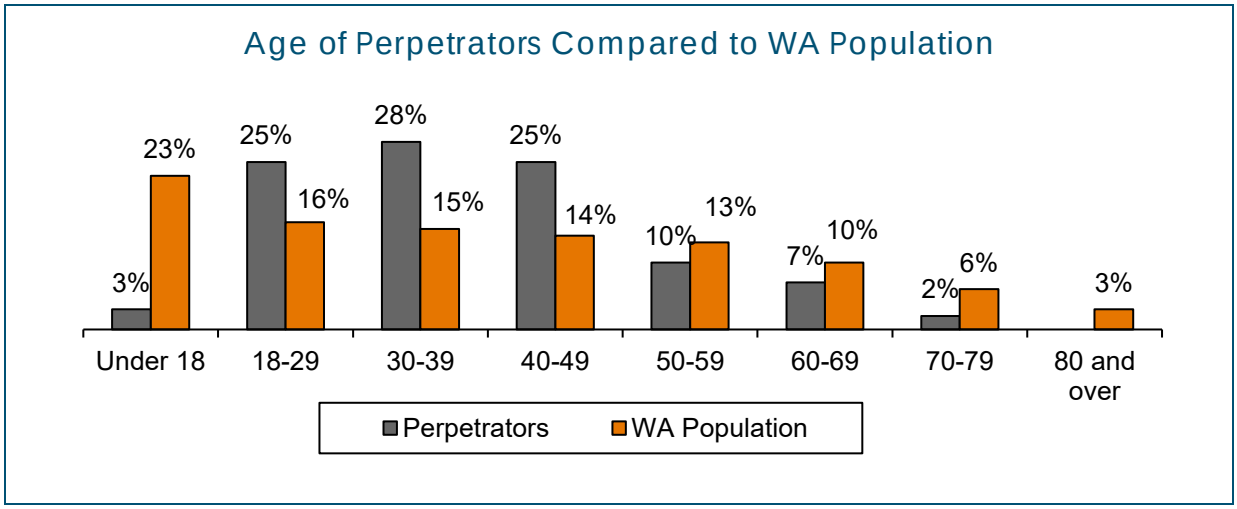
Compared to the Western Australian population, male perpetrators of fatalities in the seven years from 1 July 2012 to 30 June 2019 were over-represented, with 70% of perpetrators being male compared to 50% in the population.

Fourteen males were convicted of manslaughter and 28 males were convicted of murder. Nine females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death, one female was convicted of accessory after the fact to murder and seven females were convicted of murder.

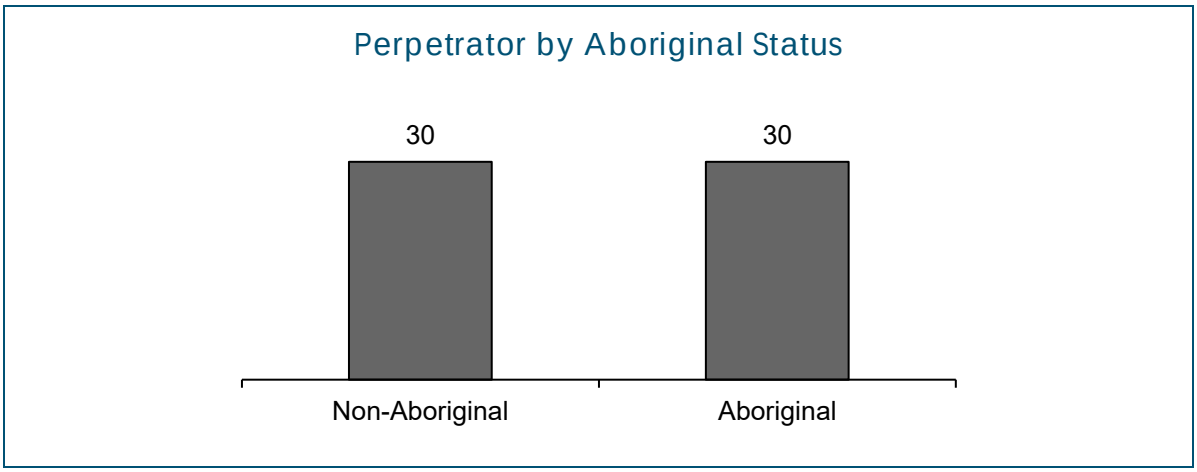
Of the fatalities by the 18 female perpetrators, in 16 the person who died was male, and in two fatalities the person who died was female. Of the 42 fatalities by the 42 male

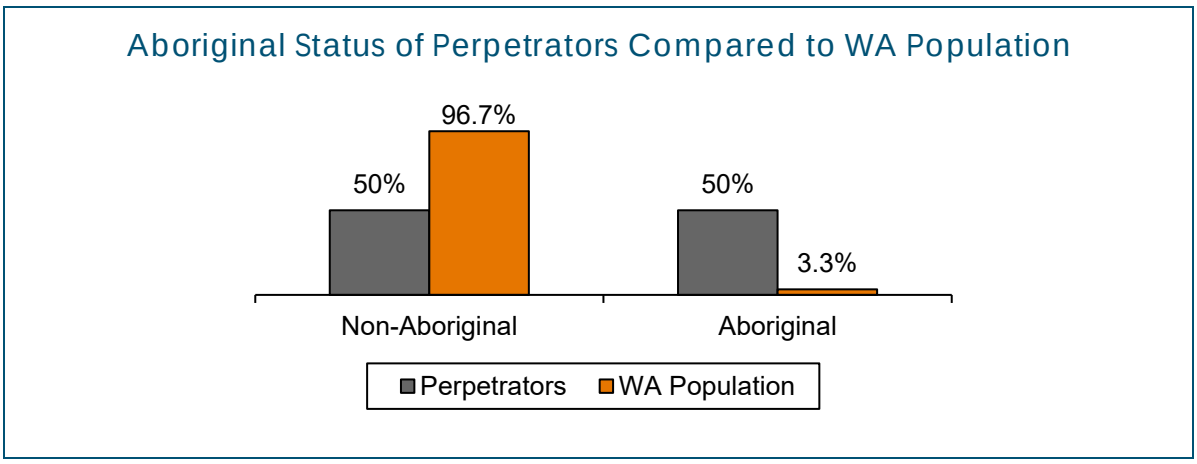
perpetrators, in 34 the person who died was female, and in eight fatalities the person who died was male.





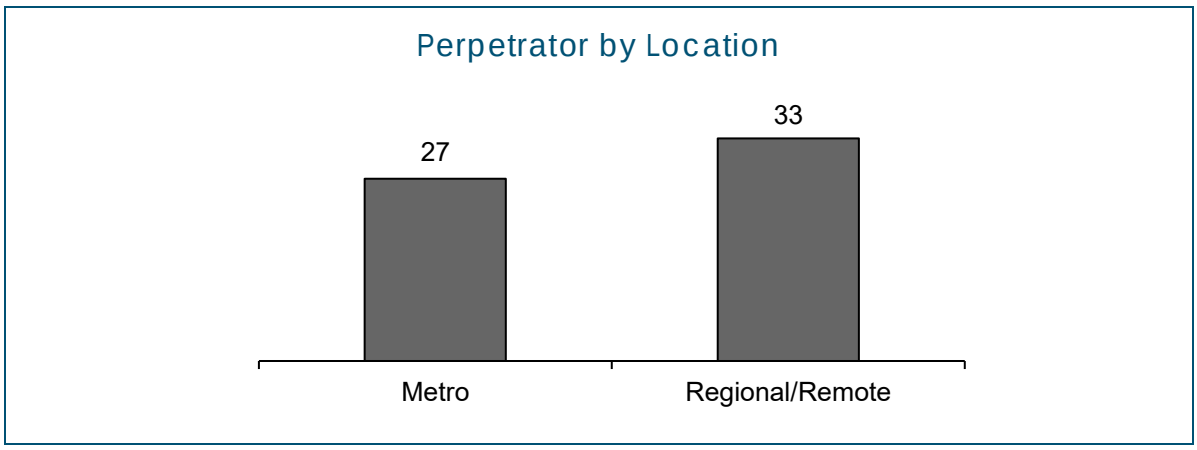
Compared to the Western Australian population, perpetrators of fatalities in the seven years from 1 July 2012 to 30 June 2019 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 25% of perpetrators being in the 18-29 age group compared to 16% in the population, 28% of perpetrators being in the 30-39 age group compared to 15% in the population, and 25% of perpetrators being in the 40-49 age group compared to 14% in the population.

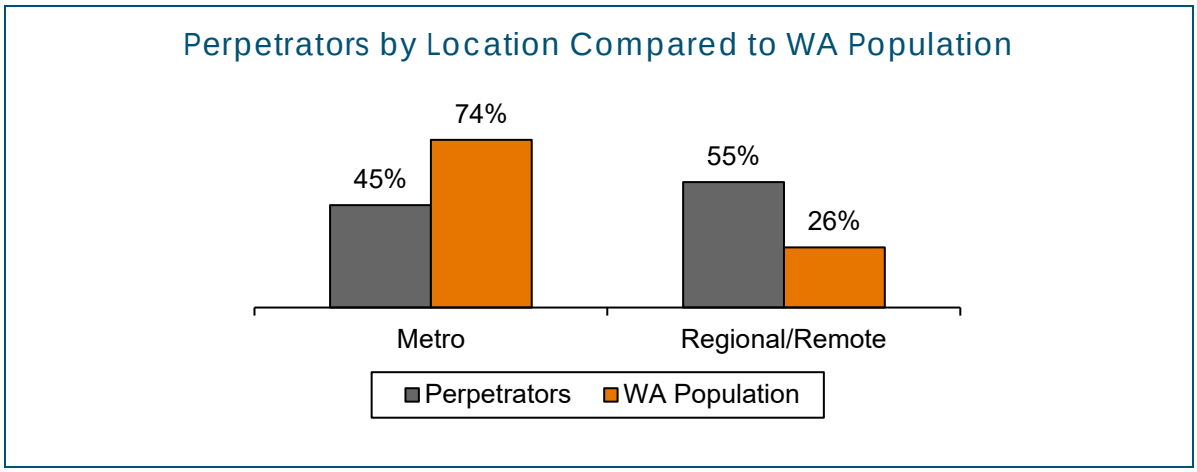




Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the seven years from 1 July 2012 to 30 June 2019 were over-represented with 50% of perpetrators being Aboriginal compared to 3.3% in the population.

In 28 of the 30 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.





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

Compared to the Western Australian population, the people who died in the seven years from 1 July 2012 to 30 June 2019, who were living in regional or remote locations, were over-represented, with 55% 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

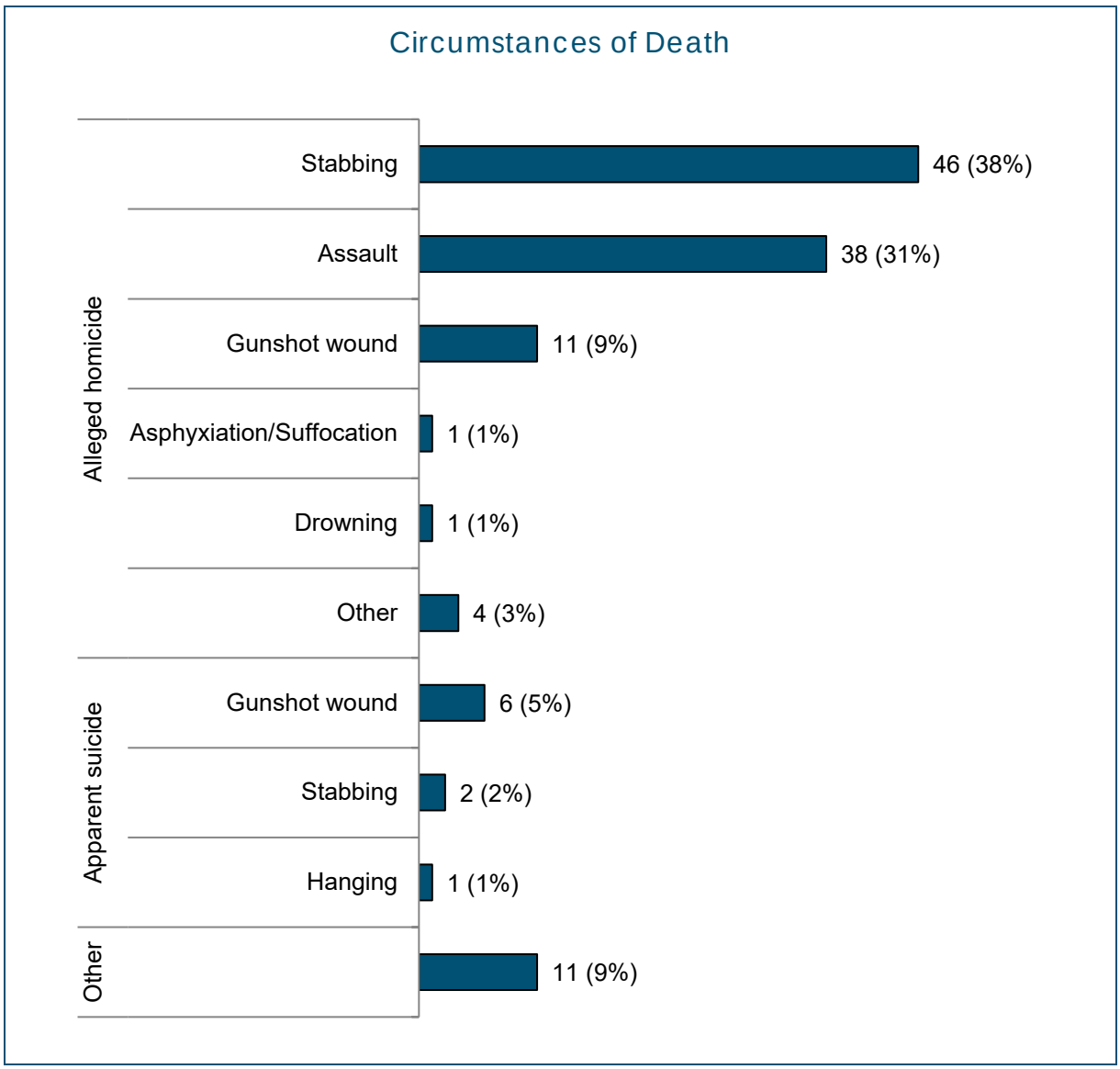
Information provided to the Office by WA Police Force about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

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

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

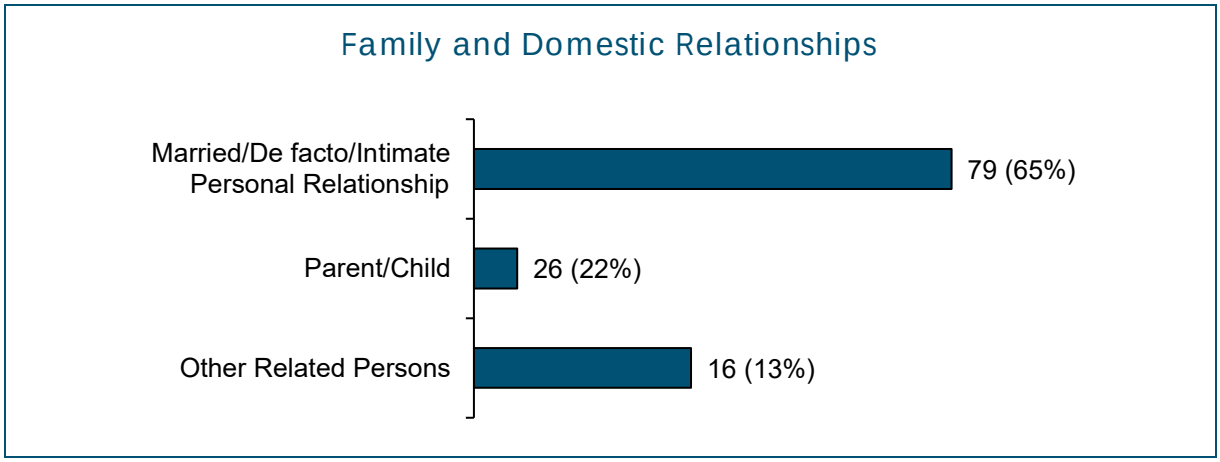
The principal circumstances of death in 2018-19 were alleged homicide by physical assault and stabbing.

The following chart shows the circumstance of death as categorised by the Ombudsman for the 121 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2019.



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 121 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2019:

- 79 fatalities (65%) involved a married, de facto or intimate personal relationship, of which there were 67 alleged homicides, eight apparent suicides and four in other circumstances. The 79 fatalities included 14 deaths that occurred in seven cases of alleged homicide/suicide and, in all seven cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. The eighth apparent suicide involved a male. Of the remaining 60 alleged homicides, 41 (68%) of the people who died were female and 19 (32%) were male;
- 26 fatalities (21%) involved a relationship between a parent and adult child, of which there were 19 alleged homicides, one apparent suicide and six in other circumstances. Of the 19 alleged homicides, six (32%) of the people who died were female and 13 (68%) were male. Of these 19 fatalities, in 12 cases (63%) the person who died was the parent or step-parent and in seven cases (37%) the person who died was the adult child or step-child; and
- There were 16 people who died (13%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, six (37%) were female and 10 (63%) were male.

Patterns, Trends and Case Studies Relating to Family and Domestic Violence Fatality Reviews[1]

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 the State Strategy.

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.

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

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

domestic violence fatalities, November 2016, identified that steps have been taken to give effect to the Ombudsman's recommendation. the Ombudsman will continue to monitor the development, implementation and effectiveness of Action Plans in regard to the State Strategy.

Type of relationships

The Ombudsman finalised 106 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2019.

For 69 (65%) of the finalised reviews of family and domestic violence fatalities, the fatality occurred between persons who, either at the time of death or at some earlier time, had been involved in a married, de facto or other intimate personal relationship. For the remaining 37 (35%) of the finalised family and domestic violence fatality reviews, the fatality occurred between persons where the relationship was between a parent and their adult child or persons otherwise related (such as siblings and extended family relationships).

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

For the 106 finalised reviews, the circumstances of the fatality were as follows:

- For the 69 intimate partner fatalities, 57 were alleged homicides, eight were apparent suicides, and four were other circumstances; and
- For the 37 non-intimate partner fatalities, 29 were alleged homicides, one was an apparent suicide, and seven were other circumstances.

Intimate partner relationships

Of the 57 intimate partner relationship fatalities involving alleged homicide:

- There were 41 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, 12 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 23 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In 15 of these fatalities the person who died was female and in eight the person who died was male;
- There were 27 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 10 at the residence of the person who died or the residence of the suspected perpetrator, six at the residence of family or friends, and 14 at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 28 fatalities where the person who died lived in regional and remote areas, and in 20 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 37 non-intimate partner fatalities, there were 23 fatalities involving a parent and adult child and 14 fatalities where the parties were otherwise related.

Of the 29 non-intimate partner fatalities involving alleged homicide:

- There were six fatalities where the person who died was female and the suspected perpetrator was male, four where the person who died was female and the suspected perpetrator was female, 14 where the person who died was male and the suspected perpetrator was male, and five where the person who died was male and the suspected perpetrator was female;
- There were seven non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 11 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 11 at the residence of the person who died or the residence of the suspected perpetrator, and seven at the residence of family or friends or in a public place; and
- There were nine 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 33 (58%) of the 57 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2019, alleged family and domestic violence between the parties had been reported to WA Police Force and/or to other public authorities. In eight (28%) of the 29 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2019, alleged family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities.

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

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

Of the 41 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 in a same-sex relationship with the suspected perpetrator;
- 25 fatalities involved a deceased Aboriginal person; and
- 23 of the people who died lived in regional/remote Western Australia.

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

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

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

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 State Strategy, and plan for responding to Aboriginal family violence.

Identification of family and domestic violence incidents

Of the 41 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, WA Police Force was the agency to receive the majority of these reports. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, noted that DCPFS may become aware of family and domestic violence through a referral to DCPFS and subsequent assessment through the duty interaction process. Identification of family and domestic violence is integral to the agency being in a position to implement its family and domestic violence policy and processes to address perpetrator accountability and promote victim safety and support. However, the Ombudsman's reviews and own motion investigations 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 WA Police Force and DCPFS ensure all reported family and domestic violence is correctly identified and recorded. *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that WA Police Force and DCPFS had proposed steps to be taken to give effect to these recommendations. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Provision of agency support to obtain a violence restraining order

As identified above, WA Police Force is likely to receive the majority of reports of family and domestic violence. WA Police Force 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 WA Police Force 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 WA Police Force's response to family and domestic violence incidents through the review of 75 Domestic Violence Incident Reports (associated with 30 fatalities). The report found that WA Police Force recorded the provision of information and advice about violence restraining orders in 19 of the 75 (25%) instances. In the report, the Ombudsman recommended that:

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

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that WA Police Force had taken steps and/or proposed steps to be taken to give effect to these recommendations. 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 WA Police Force but by all State Government departments and authorities. In the report the Ombudsman recommended that:

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

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

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 State 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 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 State 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 2018-19, 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.

Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 33 (58%) of the 57 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2019, prior family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities. The Ombudsman's reviews identify where perpetrators have a history of reported violence, with one or more partners, and examines steps taken to hold perpetrators to account for their actions and support them to cease their violent behaviors, in accordance with the intent of the former State Strategy.

The Ombudsman's reviews have examined processes for the rehabilitation of perpetrator behaviours, where perpetrators of family and domestic violence are imprisoned.

Case Study

Case Study A

Mr A fatally assaulted his intimate partner, Ms Z. Mr A has been convicted of murder. In the three years prior to this family and domestic violence fatality, Mr A had spent 79% of this time under the direction of DOJ (in prison and on Community Supervision Orders), including for offences that had occurred in the context of family and domestic violence. The Ombudsman's review examined rehabilitation support, as provided by DOJ during this timeframe, and made the following recommendation:

As DOJ develops its agency family and domestic violence strategy, DOJ considers this case in:

- Developing specific strategies to ensure the provision of effective rehabilitation and treatment services for young offenders convicted of offences that occurred within the context of family and domestic violence to assist these young offenders to cease their violent behaviour;
- Developing strategies to promote the safety of young victims of family and domestic violence; and
- Ensuring rehabilitation pathways for Aboriginal youth have been co-designed by Aboriginal people and accord with cultural protocols relating to gender in program delivery.

Fatalities with no prior reported family and domestic violence

Based on the information available to the Office, in 24 (42%) of the 57 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2019, the fatal incident was the only family and domestic violence between the parties that had been reported to WA Police Force and/or other public authorities. It is important to note, however, research indicating under-reporting of family and domestic violence. The Australian Bureau of Statistics' *Personal Safety Survey 2016* (www.abs.gov.au) collected information about help seeking behaviours, noting that:

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

and

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

The Ombudsman's reviews provide information on family and domestic violence fatalities where there is no previous reported history of family and domestic violence, including cases where information becomes available after the death to confirm a

history of unreported family and domestic violence, drug or alcohol use, or mental health issues that may be relevant to the circumstances of the fatality.

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

Family violence involving Aboriginal people

Of the 106 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2019, Aboriginal Western Australians were over-represented, with 33 (31%) persons who died being Aboriginal. In all but one case, the suspected perpetrator was also Aboriginal. There were 25 of these 32 fatalities where the person who died lived in a regional or remote area of Western Australia, of which 20 were intimate partner fatalities.

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

Contextual Factors for family violence involving Aboriginal people

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

> …violence against women within the Indigenous Australian communities need[s] to be understood within the specific historical and cultural context of colonisation and systemic disadvantage. Any discussion of violence in contemporary Indigenous communities must be located within this historical context. Similarly, any discussion of "causes" of violence within the community must recognise and reflect the impact of colonialism and the indelible impact of violence perpetrated by white colonialists against Indigenous peoples
>
> … A meta-evaluation of literature…identified many "causes" of family violence in Indigenous Australian communities, including historical factors such as: collective dispossession; the loss of land and traditional culture; the fragmentation of kinship systems and Aboriginal law; poverty and unemployment; structural racism; drug and alcohol misuse; institutionalisation; and the decline of traditional Aboriginal men's role and status - while "powerless" in relation to mainstream society, Indigenous men may seek compensation by exerting power over women and children...

(Blagg, H, Bluett-Boyd, N, and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 3).

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

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

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

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

The Ombudsman's reviews and report have identified that Aboriginal victims want the violence to end, but not necessarily always through the use of 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. The Ombudsman's reviews have continued to monitor the implementation of these recommendations.

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 State Strategy, and the Office will continue to monitor, and report on, the steps being taken to implement Recommendation 16 from the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015.

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

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

In the report, the Ombudsman recommended that:

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

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

The 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 State Strategy to reduce family and domestic violence.

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

Of the 33 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2019 involving Aboriginal people, 25 (76%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Fourteen (42%) of the Aboriginal people who died lived in the Kimberley region, which is home to 1.4% of all people and 19% 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 Communities developing 'a strategy that is specifically tailored to preventing and reducing Aboriginal family violence' that would encompass all regions of Western Australia and would ensure actively inviting and encouraging 'the involvement of Aboriginal people in a full and

active way at each stage and level of the process' and being 'comprehensively informed by Aboriginal culture'.

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, *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, 2009, p. 29).

The National Plan and the *National Drug Strategy 2017-2026* 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 86 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2019, 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	4	3	7
Suspected perpetrator only	6	14	10	13
Both person who died and suspected perpetrator	26	28	8	15
Total	**35**	**46**	**21**	**35**

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 former State Strategy did not mention or address alcohol use co-ocurring with family and domestic violence. The Mental Health Commission's *Western Australian Alcohol and Drug Interagency Strategy 2018-2022* acknowledges that 'alcohol and other drug use problems can be linked to a range of negative effects on children and families including…family arguements, injury, neglect, abuse, and violence' (page 29, www.mhc.wa.gov.au). 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 family and domestic violence fatalities as identified in 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 implementation and effectiveness of the *Western Australian Alcohol and Drug Interagency Strategy 2018-2022*, and the State Strategy to reduce family and domestic violence, in responding to family and domestic violence and co-occurrence with alcohol and drugs.

Co-occurrence of mental health issues

As with alcohol and drug use, it is noted that the former State Strategy did 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).

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

Case Study

Case Study B

Mr B fatally assaulted a family member. Prior to this family and domestic violence fatality Mr B had been under the management of a mental health service provider. The Ombudsman's review examined actions taken by the mental health service provider to assess Mr B's risk of violence and the development of an associated safety plan, and made the following recommendation:

In meeting DOH's *Clinical Care of People With Mental Health Problems Who May Be At Risk of Becoming Violent or Aggressive Policy* requirement to develop a local policy for the clinical care of people with mental health problems who may be at risk of becoming violent or aggressive by June 2019, the East Metropolitan Health Service considers the issues identified in this review.

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 intervention when responding to Aboriginal family violence.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities to provide perpetrator rehabilitation support.
- Missed opportunities to address family and domestic violence victim safety.
- Missed opportunity to assess risk of harm and develop strategies to reduce or prevent family and domestic violence in the context of mental health issues and/or drug and alcohol use.
- Not undertaking sufficient family and 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 two recommendations were made by the Ombudsman in 2018-19 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. In meeting DOH's *Clinical Care of People With Mental Health Problems Who May Be At Risk of Becoming Violent or Aggressive Policy* requirement to develop a local policy for the clinical care of people with mental health problems who may be at risk of becoming violent or aggressive by June 2019, the East Metropolitan Health Service considers the issues identified in this review.
2. As DOJ develops its agency family and domestic violence strategy, DOJ considers this case in:
   - Developing specific strategies to ensure the provision of effective rehabilitation and treatment services for young offenders convicted of offences that occurred within the context of family and domestic violence to assist these young offenders to cease their violent behaviour;
   - Developing strategies to promote the safety of young victims of family and domestic violence; and
   - Ensuring rehabilitation pathways for Aboriginal youth have been co-designed by Aboriginal people and accord with cultural protocols relating to gender in program delivery.

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. The Ombudsman's *Annual Report 2020-21* will report on the steps taken to give effect to the two recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2018-19.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2016-17

The Ombudsman made nine recommendations about ways to prevent or reduce family and domestic violence fatalities in 2016-17. The Office has requested that the relevant public authorities[2] 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.

[2] In this section, Department refers to, prior to 1 July 2017, the Department for Child Protection and Family Support, and subsequent to 1 July 2017, Communities.

Recommendation 1: The Department reiterates to Metropolitan District Team Leaders, Assistant Director and District Director that, consistent with Chapter 4.1 *Assessment and Investigation Processes* and Chapter 1.2 *Signs of Safety – Child Protection Practice Framework* of the *Casework Practice Manual*, approval of Safety and Wellbeing Assessments requires documented evidence that key decisions have been informed by the administration of the *Signs of Safety Child Protection Framework* and compliance with Safety and Wellbeing Assessment practice requirements.

Steps taken to give effect to the recommendation

This Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 15 April 2019, containing a report prepared by the Department (**the Department's report**).

In the Department's report, the Department relevantly informed this Office that:

> A copy of the Ombudsman's preliminary view was forwarded to the relevant Metropolitan District. The District Director acknowledged this recommendation and undertook to meet with the Assistant District Director and Team Leaders to reiterate key decision-making points and the approval processes for Safety and Wellbeing Assessments (SWAs).

In outlining the implementation of Recommendation 1, the Department's report also referred this Office to the response for Child Death Review Recommendation 9, in which the Department relevantly informed this Office that:

> **District Response**
>
> The relevant Metropolitan District Director affirms that all Safety and Wellbeing Assessments (SWA) will be approved by a Team Leader, Senior Practice Development Officer, Assistant District Director or District Director only. Further, all SWA's will evidence a safety plan, and all safety plans developed in case practice must be approved by a Team Leader prior to being placed on the file and provided to family and services. Team Leaders will ensure safety plans are focused on actions and behaviour that create and sustain safety.
>
> **Safety and Wellbeing Assessment Project**
>
> To give effect to this recommendation, Communities undertook a review of Safety and Wellbeing Assessments (SWA) in 2018, via the SWA Project, to promote better critical thinking and documented analysis of information concerning allegations of abuse, and to bring about better clarity and consistencies of SWA's across the state.
>
> …
>
> State-wide roll out of the SWA Project will include a 2-day compulsory training package commencing May 2019. Each District will develop local strategies via SWA Champions, with ongoing review, evaluation and monitoring to occur over a 12-month period.
>
> **Professional Development**
>
> The relevant Metropolitan District Director reports Child Protection Workers have completed, and are scheduled to complete the following training:
>
> - Family and Domestic Violence (FDV) training October and December 2017 with ongoing training by FDV Champions to occur throughout 2019
> - Drug and Alcohol policy and practice workshop in 2017

- Safety and Wellbeing Assessment training on 3 January 2019
- The Impact of Methamphetamine Use on Parents 10 April 2019
- Signs of Safety training will occur in the second quarter of 2019
- Collaborative education workshops with Adolescent Mental Health Service – dates to be confirmed

It is also noted that the Department's report indicated that information provided by the Department for 2016-17 Child Death Review Recommendations 25 and 26 are also relevant to this response.

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

Recommendation 2: The Department reviews this family and domestic violence fatality and the findings of the Standards Monitoring Unit's Metropolitan District Final Reports of 2012, 2014 and 2016 with a view to considering whether ongoing improvements can be made to policy and practice that would promote the effective administration of the Department's assessment and investigation processes and *Signs of Safety Child Protection Framework* consistent with practice requirements.

Steps taken to give effect to the recommendation

This Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 15 April 2019, containing a report prepared by the Department.

In the Department's report, the Department relevantly informed this Office that:

> During 2017, Communities reviewed the findings of the OWA's FDV fatality review as well as the final 2012, 2014 and 2016 Standard and Monitoring Reports. As a result of these reviews, relevant Metropolitan District developed a range of actions to improve practice.

The Department's report further references a letter to this Office, dated 29 November 2017, which reports on actions that have been taken to give effect to Recommendation 2. This letter is detailed in Recommendation 3, below.

In the Department's report, the Department also relevantly informed this Office that:

> In 2018, Communities undertook a review of the Safety and Wellbeing Assessment (SWA), as part of the SWA Project. As a result of the review, a number of recommendations were endorsed by Communities Service Delivery Joint Executive Meeting. This included renaming SWA's to Child Safety Investigations (CSIs) to strengthen the requirement for investigation. Other work from this project includes redeveloping the Assessment and Investigation Casework Practice Manual (CPM) entry to support staff with:
>
> - Achieving compliance with a 30-day timeframe for CSI completion
> - Writing assessments which are grounded in the Signs of Safety framework
> - Aligning CSIs to legislative requirements
>
> Throughout 2019, Communities will be delivering state-wide training for all child protection staff, on the redeveloped CSI processes.

It is also noted that Department's report indicated that information provided by the Department for Child Death Review Recommendations 25 and 26 are also relevant to this response.

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

Recommendation 3: The Department provides a report to the Ombudsman within six months of the finalisation of this review outlining actions taken by the Metropolitan District to give effect to Recommendation 2.

Steps taken to give effect to the recommendation

The Department provided this Office with a letter dated 29 November 2017, in which the Department relevantly informed this Office that:

> Findings from the 2012, 2014 and 2016 SMU reports have been reviewed by the Department.
>
> - In 2012 the monitors identified ten commendations and nine required actions.
> - In 2014 the monitors identified eight commendations and six required actions, and in 2016 the monitors identified 14 commendations and six required actions.
> - Across all three SMU reports, the required actions were satisfactorily completed within the required timeframe. Only one required action was consistently noted across all three SMU reports, and was in relation to Safety and Wellbeing Assessments (SWA) and Initial Inquiries not being completed within the required timeframes.
> - Whilst SWA compliance is an ongoing issue, it is recognized that the relevant Metropolitan district manage a high workload and staff turnover. To alleviate workload pressure and to improve SWA and Initial Inquiry compliance, the relevant Metropolitan district have utilised the Department's state-wide relieving team (SRT) when required.
>
> The Department's SRT began operation in April 2017. This team can assist where districts may be experiencing unusually high workload demands or where workers are required to target a particular area of practice. The SRT is available for country and metropolitan deployment for up to two weeks at a time.
>
> As a result of the Department reviewing the FDV fatality, the relevant Metropolitan district has identified areas from improvement and has developed a set of actions. The following actions have been taken to give effect to recommendation two:
>
> - All staff will be provided with two-day FDV training. Nineteen staff attended the first FDV training, which was held at the relevant Metropolitan office on 11 and 12 October 2017. The remaining staff will attend the FDV training on 5 and 6 December.
> - Two drug and alcohol workshops, held at the relevant Metropolitan office on 7 and 21 June 2017, were provided to staff in the relevant Metropolitan district. Each of these workshops was attended by approximately forty Child Protection Workers. This was done in conjunction with the South Metropolitan Drug and Alcohol Office. These workshops have increased staff awareness of the impact of drug and alcohol use on parents.
> - An FDV networking workshop has been planned for 29 November 2017, with the local Domestic Violence Support Worker and front-end Child Protection Workers. This workshop seeks to increase staff knowledge of local support services for victims of FDV. It should also increase skills to assess FDV using the Common Risk Assessment and Risk Management Framework (CRARMF) risk assessment tool.

- Relevant Metropolitan district's management team has been closely monitoring the Family Violence Incident Reports (FVIR) triage process and the workload of the Senior Child Protection Worker – Family and Domestic Violence (SCPW-FDV). This is to ensure that SCPW-FDV can be available for Multidisciplinary Case Consultations (MCC).
- MCCs have been implemented in the relevant Metropolitan District, with a minimum of four per week being undertaken. These meetings consider different professional perspectives and provide an opportunity to support staff to apply appropriate policy and practice guidance to child protection cases.

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

Recommendation 4: That the WA Country Health Service (WACHS) regional hospital develops strategies to ensure emergency department staff are able to comply with the *Department of Health Family and Domestic Violence Policy February 2014* and *Guideline for Responding to Family and Domestic Violence 2014*, and that WACHS provides a report to the Ombudsman by 31 December 2017 setting out the strategies that have been developed.

Steps taken to give effect to the recommendation

WACHS provided this Office with a letter dated 14 December 2017, with an attachment setting out the strategies that have been developed. In this letter WACHS relevantly informed this Office that:

> In February and March 2017 the Hedland Health Campus Emergency Department teams began reviewing and compiling relevant guidelines and directives, along with local services to whom referrals could be made.
>
> These discussions were formalised with the Clinical Practice Improvement Coordinator, under the guidance of the Regional Nurse Director and Regional Medical Director, coordinating a project to implement processes for assessment, treatment and referral of adults at risk of Family and Domestic Violence.

This letter also provided a copy of this project plan.

This Office subsequently requested that WACHS updates the Office on the steps taken to give effect to the recommendation. In response, WACHS provided a range of information in a letter to this Office dated 26 April 2019, containing a report prepared by WACHS (**the WACHS report**).

In the WACHS report, WACHS relevantly informed this Office that:

- WACHS has implemented a policy - WACHS Identifying and Responding to Family and Domestic Violence which aims to:
  - Ensure consistent minimum standards for clinicians with regard to identifying and responding to disclosures of family and domestic violence.
  - Support early detection of clients at risk of family and domestic violence.
  - Improve staff awareness of the possible indicators of family and domestic violence.
  - Improve the safety of women and children.
- Ensure compliance with S28b Children and Community Services Act 2004.
- Family and Domestic Violence forms for screening, assessment and referral to other agencies have been developed and published which will support monitoring and audit.

- A Family and Domestic Violence toolkit has been developed and introduced outlining resources available to staff and includes:
  - Referral guidelines.
  - Resources for Clients.
  - Local Family and Domestic Violence resource guide for each WACHS region.
  - Clinical guidance material for Clinicians.
  - Education and training resources.
  - Support for employees who are victims of Family and Domestic violence.
  - Links to Women and Newborn Health Services.

…Note: As a minimum, new WACHS policies are communicated to all staff through a fortnightly CE eNews, and are available online through HealthPoint. This process is also complemented by local communication as well as WACHS induction processes.

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

Recommendation 5: That the WACHS regional hospital consults with the Department (the lead agency responsible for family and domestic violence strategic planning in WA) to complete and maintain the *Local Service Information* list included in the *Guideline for Responding to Family and Domestic Violence 2014* to ensure WACHS regional hospital staff can provide current information on family and domestic violence support service options to all family and domestic violence victims and perpetrators as relevant.

Steps taken to give effect to the recommendation

This Office requested that WACHS 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 26 April 2019, containing a report prepared by WACHS.

In the WACHS report, WACHS relevantly informed this Office that:

1. WACHS Central Office has established regular meetings with Child Protection Family Support Services and WAPOL to strengthen the relationships and ensure improved processes are in place across all regions to enable coordinated responses for children at risk and those at risk of domestic violence.
2. WACHS has developed a policy that aims to:
   - Ensure consistent minimum standards for WACHS clinicians with regard to identifying and responding to disclosures of family and domestic violence;
   - Support early detection of clients at risk of family and domestic violence;
   - Improve staff awareness of the possible indicators of family and domestic violence;
   - Improve the safety of women and children; and
   - Ensure compliance with S28b, Children and Community Services Act 2004.

It is noted that in response to Recommendation 4, WACHS had informed this Office that:

- A Family and Domestic Violence toolkit has been developed and introduced outlining resources available to staff and includes:
  - Referral guidelines.
  - Resources for Clients.
  - Local Family and Domestic Violence resource guide for each WACHS region.

- Clinical guidance material for Clinicians.
- Education and training resources.
- Support for employees who are victims of Family and Domestic violence.
- Links to Women and Newborn Health Services.

As indicated above, the WACHS *Family and Domestic Violence toolkit* includes a *Local Family and Domestic Violence resource guide* for each WACHS region. WACHS provided this Office with a copy of *Family and Domestic Violence Local Resource Guide: Pilbara*, and indicated a similar resource is available for each WACHS region. Our review of the *Family and Domestic Violence Local Resource Guide: Pilbara*, which was last updated in March 2019, confirms this resource provides contact details for local and state-wide family and domestic violence support services.

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

Recommendation 6: The Department takes all reasonable steps to ensure that the Department's Family and Domestic Violence Response Team triage assessments align with the Department's policies and practice requirements associated with responding to family and domestic violence and child safety and wellbeing concerns.

Steps taken to give effect to the recommendation

This Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 15 April 2019, containing a report prepared by the Department.

In the Department's report, the Department relevantly informed this Office that:

> Communities have undertaken the following actions, to give effect to his recommendation:
>
> - During June and July 2018, Communities worked closely with Western Australia Police Force (WA Police Force) to deliver two-day FDV training to new Police Officer recruits to the Family and Domestic Violence Response Teams. Communities, attended all six training sessions and delivered a comprehensive session on child protection.
>
> - In November 2018, updated Practice Guidance for Senior Child Protection Worker - Family and Domestic Violence (SCPW-FDV) was drafted. The updated guidance now includes a requirement that all SCPW-FDV are trained in and use the Central Intake Interaction Tool, to guide their assessments of child safety.
>
> Communities is committed to working closely with the WA Police Force and the Family and Domestic Violence Coordinated Response Services (CRS) to continuously improve the quality of assessment or FDV and child safety wellbeing concerns.

The Office notes that in July 2017 the Department commenced operation of the Central Intake Team which the Department has informed was established to 'create a consistent approach to managing work coming into the Department'. The Department's report states the Department's representative on Family and Domestic Violence Response Teams will now use the same assessment tool used by the Central Intake Team (the Central Intake Interaction Tool) when triaging notifications.

The Department's report indicates that the use of this tool will ensure Family and Domestic Violence Response Team triage assessments will align with policies and practice requirements associated with responding to family and domestic violence and child safety and wellbeing concerns.

It is also noted that information provided by the Department for Child Death Review Recommendation 25 is also relevant to this response.

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

Recommendation 7: Western Australia Police Force (WA Police Force) takes all reasonable steps to ensure that identified child safety and wellbeing concerns are reported to the Department consistent with procedural requirements included in the Commissioner's Operations and Procedures Manual.

Steps taken to give effect to the recommendation

This Office requested WA Police Force inform the Office of the steps taken to give effect to the recommendation. In response, WA Police Force provided a range of information in a letter to this Office dated 27 March 2019, containing a report prepared by WA Police Force.

In the report, WA Police Force relevantly informed this Office that:

> In August 2016 a review was undertaken in consultation with the Department of Communities and Crisis Care as to the frequency and suitability of referrals made by police to the respective agencies where children at risk were found to be present at Family Violence (FV) incidents.
>
> 1. The feedback provided by the key stakeholders involved in the review suggested that at that point in time they did not hold any concerns about the timeliness of referrals when police had immediate concerns for welfare children at FV incidents.
> 2. General Broadcast numbered 180209 issued on 12 February 2018 titled 'Child Protection Concern Referrals' re-enforced the police requirement to notify the Department of Communities when there are wellbeing concerns for children, in line with the Commissioner's Operations and Procedures Manual.
> 3. This is further re-enforced within the current WA Police Force Code of Practice for the Investigation of Family Violence under the sub-title 'Safety and Wellbeing of Young People and Children' which is available to all police officers when accessing the Family Violence portal on the Intranet site. An intranet monitor count indicates the portal has been accessed over 6500 times since July 2017.

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

Recommendation 8: That WA Police Force's Metropolitan District, Aboriginal and Community Diversity Unit, and State Family Violence Unit review WA Police Force's response to this Aboriginal family violence from July 2014 to June 2015, to identify any learnings to guide Districts in working with Aboriginal family violence, and provides a report on the outcome to the Ombudsman by 31 December 2017.

Steps taken to give effect to the recommendation

WA Police Force provided this Office with a letter dated 5 January 2018, which confirmed that this review had been undertaken. The letter provided detail on five leanings from this review, which were as follows:

Learning 1: Initial Police Response and Engagement

Despite police sharing information with a range of diversionary and support services, there was an identified difficulty between linking with support services on a voluntary basis, and a requirement to engage. WA Police Force will continue to support and encourage victims of family violence to seek assistance with specialised support services, however, the subsequent engagement is at the will of those referred.

Managing families experiencing complex and high levels of dysfunction is challenging, however WA Police Force is committed to providing a co-ordinated response to affected individuals and families to ensure they receive referrals to available appropriate support services.

The WA Police Force will:

Continue to enforce law, prevent reoccurrence of crime; and coordinate efforts to connect affected individuals and families to appropriate support services.

Learning 2: Coordinated Police Response

The Aboriginal Affairs Division, previously called the Aboriginal and Community Diversity Unit (ACDU) is the current agency resource able to offer assistance and support to police engaging with Aboriginal families who are victims of family violence. Local police did not engage with ACDU in respect to the issues confronted at the deceased's residence.

In 2015, police operated District Victim Support Units. Those units are now replaced with expanded metropolitan Family Violence Teams. In 2015, the South Metropolitan VSU [Victim Support Unit] advised they were unaware of the role of the ACDU in 2015 and had they been, would have readily enlisted their support in engaging with the deceased and her family.

WA Police Force will:

Increase police awareness and visibility of the Aboriginal Affairs Division through internal promotion, including a 'From the Line' publication to highlight the availability of the Aboriginal Affairs Division to provide expert advice on cases of complex family violence within the Aboriginal community.

Learning 3: Information Sharing

A lack of consolidated information holdings exists in relation to individuals and members of families experiencing complex dysfunction and officers responding to incidents are required to inform themselves prior to attendance. In the case of critical incidents, this opportunity may be limited due to time required to research multiple police systems, whilst providing an expedient response.

WA Police Force will:

Continue participation to deliver outcomes for the Community Safety and Family Support Cabinet Sub-Committee including the creation of a framework for information sharing and risk assessment for the relevant government agencies, including a central secure database accessible for WA Police Force, Departments of Health, Communities, Justice and Local Government, and continue to develop improvements in information sharing through the development of the State Operations Control Centre (SOCC) and the WA Police Force Mobility project.

Learning 4: Police Information Holdings

WA Police Force documentation of the interaction with the deceased was not recorded in line with WA Police policy CF-01.00 'Using IMS to conduct case and file management'.

The use of the Intelligence Data Management system (IDM) to record interactions with the deceased conflicted with this policy, which recognises the need to manage investigations by creating an accountable record of any actions undertaken upon IMS. Whilst the officer was reminded of this policy and the need to correctly document any future interactions of a similar nature, the potential remains for well-intentioned staff to record interactions in one of multiple disparate and discrete police information recording systems.

WA Police Force continue to work on solutions to improve uniform holdings supporting full mobility.

WA Police Force will:

Reinforce awareness of WA Police Force Policy CF-01.00 through an internal broadcast which was disseminated to agency personnel on 14 December 2017 and an endeavour will be made to monitor outcomes.

Learning 5 – Cultural Security

The term 'cultural security' in relation to working with Aboriginals suggests an obligation on organisations and individuals to move beyond cultural awareness to actively ensuring cultural needs are met for individuals. Cultural needs are included in practices so all Aboriginals have access to this level of service, not just in those places where there are particularly culturally competent workers. WA Police Force recognises opportunities exist to improve cultural competency, so frontline officers have a greater understanding of the varied issues faced by Aboriginal people. Complexities encountered when working with Aboriginal families following calls for assistance to family violence matters are difficult for police to resolve alone.

Broader understanding of the impact that colonisation has had on Aboriginal people and how our shared history has resulted in intergenerational trauma, ill health, the loss of and culture, language and custom for Aboriginal people and the ongoing disadvantage they experience today will improve policing responses.

WA Police Force will:

Develop a strategy to provide greater cultural security; ensuring that adequate practices are put in place so that interactions between members of WA Police Force and Aboriginal people meet cultural needs.

The Commissioner of Police has directed the development of a strategy to improve partnerships and build positive relationships between police and Aboriginal people. The strategy known as 'Aboriginal Strategic Directions Pathways' is under development by the Aboriginal Affairs Division.

The Aboriginal Affairs Division is consulting with internal and external government and non-government partners to provide opportunity for a co-designed strategy.

The aim of the strategy will include minimizing the overrepresentation of Aboriginal people in the criminal justice system, with a focus on culture, family violence, youth diversion and repeat victimisation.

In addition, the University of Notre Dame has recently undertaken an independent review of the concept of 'cultural security' within WA Police Force curriculum, delivery of training and associated policies pertaining to Aboriginal people and engagement. A mapping report identifying areas of strength and weakness is forthcoming.

This Office subsequently requested that WA Police Force updates the Office on the steps taken to give effect to the recommendation. In response, WA Police Force provided a range of information in a letter dated 27 March 2019, containing a report prepared by WA Police Force.

In the report, WA Police Force relevantly informed this Office that:

1. A preliminary Code of Practice for the investigation of all reports of FV has been developed. All WA Police Force officers have access to this document which articulates their roles and responsibilities when attending an FV incident. The WA Police Force is engaging an external consultant to deliver prevention and response strategies for all of the community including vulnerable groups such as the elderly, Aboriginal and Torres Strait Islanders, the disabled and others, to be included in the Code of Practice
2. As part of an operational restructure, 56 staff have been allocated to Metropolitan Family Violence Teams with increased focus on the management of Family and Domestic Violence Response in collaboration with Department of Communities and non-government sectors.
3. Multi-Agency Case Management Meetings have been instigated by the WA Police Force bringing greater volumes of at risk victims and their children into the view of government and support sector services.
4. The WA Police Force recently signed a MOU with the National Indigenous Critical Response Service which is set up to provide culturally appropriate support to Aboriginal families impacted by traumatic events, including FV.
5. In 2018 the WA Police Force established the Aboriginal Affairs Division. Edition 698 'From the line' published on 25 October 2018 detailed the role of this new Division to build, foster and sustain better relationships with the Aboriginal people and communities of Western Australia.
6. The State Government provided a commitment to create a framework for information sharing and risk assessment for relevant government agencies. Data sharing legislation is being drafted by the Department of the Premier and Cabinet and a multi-agency implementation group in response to Service Priority Review recommendations.
7. General Broadcast numbered 171214 issued on 14 December 2017 directed agency personnel to manage FV incidents using the appropriate agency-based computer systems Incident Management System (IMS) or Computer Aided Dispatch (CAD). Internal reviews are conducted within the Family Violence Unit to monitor compliance with this broadcast and other matters associated with response and recording of FV, Feedback is provided to officers as needed to ensure consistency and accountability of service provisions.
8. The Commissioner of Police has established the Aboriginal Police Advisory Forum which met for the first time on 4 September 2018. The forum comprised of the Police Executive and eight Aboriginal leaders from all parts of Western Australia. The forum intends to meet quarterly to raise and discuss issues of importance and to influence and provide feedback on existing policing programs and/or contemporary Aboriginal concerns.

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

Recommendation 9: That WA Police Force reviews, considers and, if appropriate, amends the current WA Police Force FDV Policy, to include strategies that are specifically tailored to preventing and reducing Aboriginal family violence.

Steps taken to give effect to the recommendation

This Office requested that WA Police Force inform the Office of the steps taken to give effect to the recommendation. In response, WA Police Force provided a range of information in a letter to this Office dated 27 March 2019, containing a report prepared by WA Police Force.

In the WA Police Force report, WA Police Force relevantly informed this Office that:

> The State Government has made a recommendation training include contemporary understandings of the nature and dynamics of Family Violence; and specific issues in relation to Family Violence for Aboriginal communities, multicultural communities, persons with disability, children who are exposed to FDV and children who are perpetrators of FDV.
>
> 1. The WA Police Force have established a new Aboriginal Affairs Division. The Divisions initial program of works will include the development of a strategy to improve partnerships and build positive relationships between police and Aboriginal people. The planning phase has commenced. In addition to the strategic direction documents, the Division will also be creating a Reconciliation Action Plan. Both pieces will require extensive external consultation to ensure Aboriginal people and organisations are self-determining in the frameworks which impact on their communities. The aim of this program of work is to build respect for Aboriginal culture and traditions which leads to better relationships. Good relationships will enable positive and effective partnerships to be developed to address and statistically reduce Aboriginal people as high volume perpetrators and casualties of FV.
> 2. The WA Police Force is engaging an external consultant to communicate with vulnerable groups, including Aboriginal people, to identify opportunities for localised co-designed prevention and response strategies, ensuring the needs of all vulnerable groups are met. Though these recommendations will be utilised to enhance the state-wide Code of Practice, the recommendations themselves should not be to the detriment of specific place based needs of the community. Funding has been allocated to meet this election commitment.. Once finalised, the Code of Practice will be published as an outward facing document on the WA Police Force website.

It is also noted that the Department, the lead agency for family and domestic violence, is currently coordinating work to develop a 10-year across-government strategy to reduce family and domestic violence. 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. WA Police Force is participating in this policy development.

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

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

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of family and domestic violence fatalities. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2018-19, timely review processes have resulted in 50% of reviews being completed within three months and 75% of reviews completed within 12 months.

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

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

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 Ombudsman's Advisory Panel (**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 WA Police Force to develop and support the implementation of the process to inform the Office of family and domestic violence fatalities. Regular liaison occurs at senior officer level between the Office and WA Police Force.

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 three times in 2018-19 and during the year the following members provided a range of expertise:

- Professor Steve Allsop (National Drug Research Institute of 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 2018-19, observers from Western Australia Police Force, the Department of Communities, the Department of Health, the Department of Education, and the Department of Justice 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 2018-19, included:

- The Coroner;
- Relevant public authorities including:
  - Western Australia Police Force;
  - 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.