Family and Domestic Violence Fatality Review

Overview

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

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

Background

The *National Plan to 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', 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, [and] providing a platform for future policy to reduce domestic, family and sexual violence'.

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

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

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

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 This document superseded *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities* (**former State Strategy**) and the *Freedom from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

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

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

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

implementation and ongoing operation of the role. It is important that stakeholders understand the role of the Ombudsman, and the Office understands the critical work of all key stakeholders.

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

The Ombudsman's Child Death Review Advisory Panel's scope was expanded to include the new family and domestic violence fatality review role. Through the Ombudsman's Advisory 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 and since 1 July 2012, has participated as a Member of the Australian Domestic and Family Violence Death Review Network.

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

Information regarding the use of terms

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

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

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

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

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

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

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

(d) One of whom is a child who —

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

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

or

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

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

'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

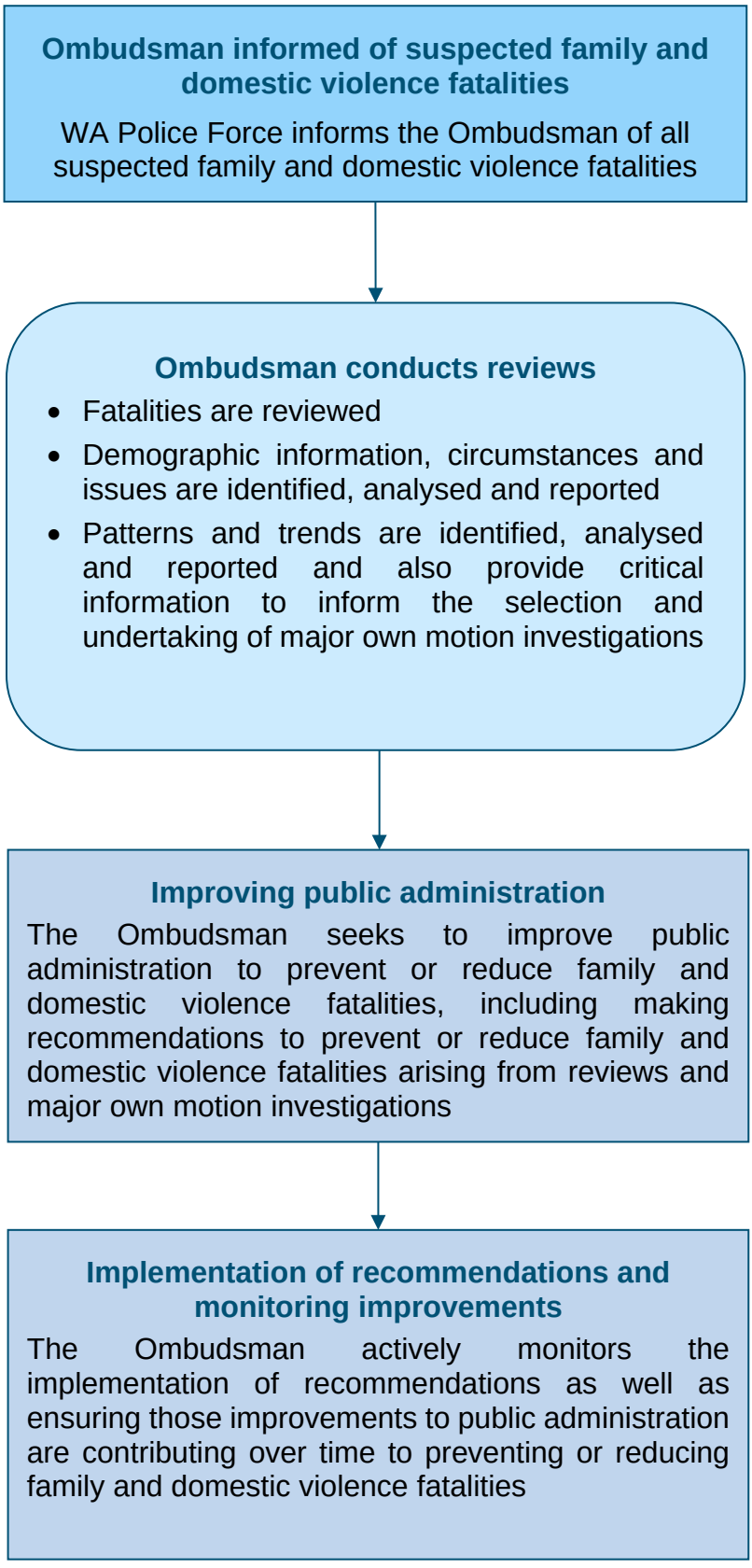
(ii) De facto partner or former de facto partner.

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



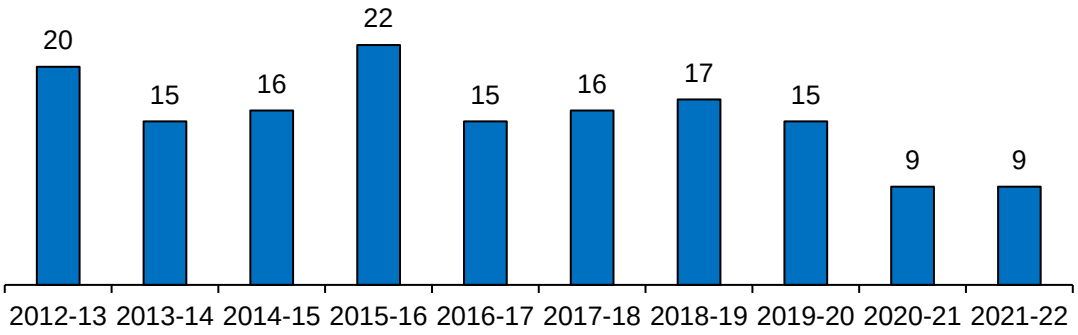
Analysis of Family and Domestic Violence Fatality Reviews

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

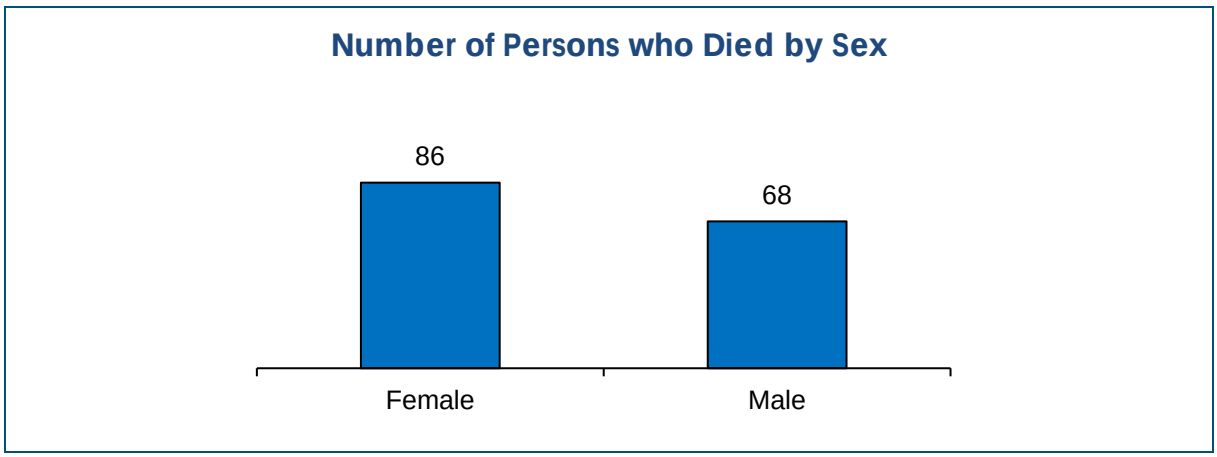
In 2021-22, the number of reviewable family and domestic violence fatalities received was nine, compared to nine in 2020-21, 15 in 2019-20, 17 in 2018-19, 16 in 2017-18, 15 in 2016-17, 22 in 2015-16, 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

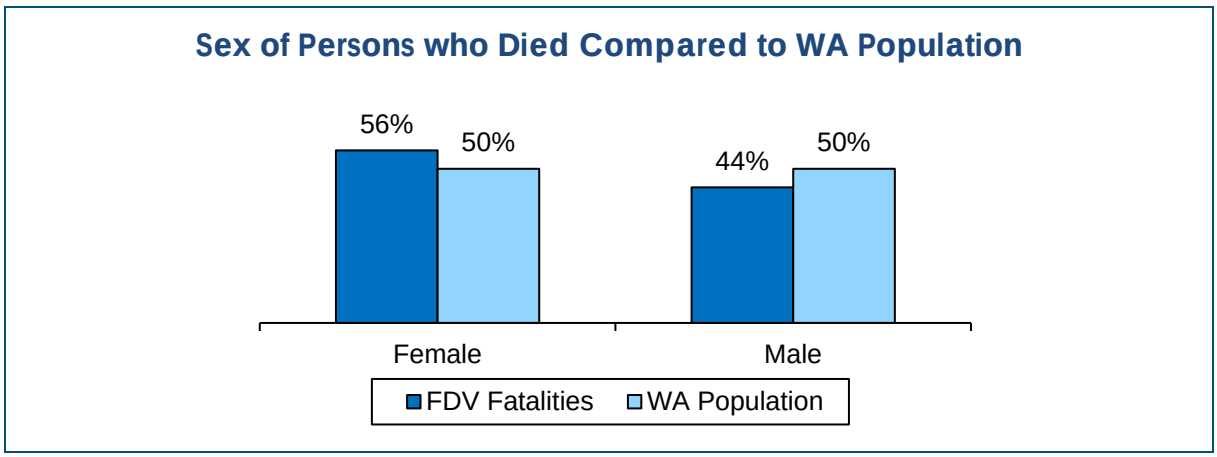


Demographic information identified from family and domestic violence fatality reviews

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

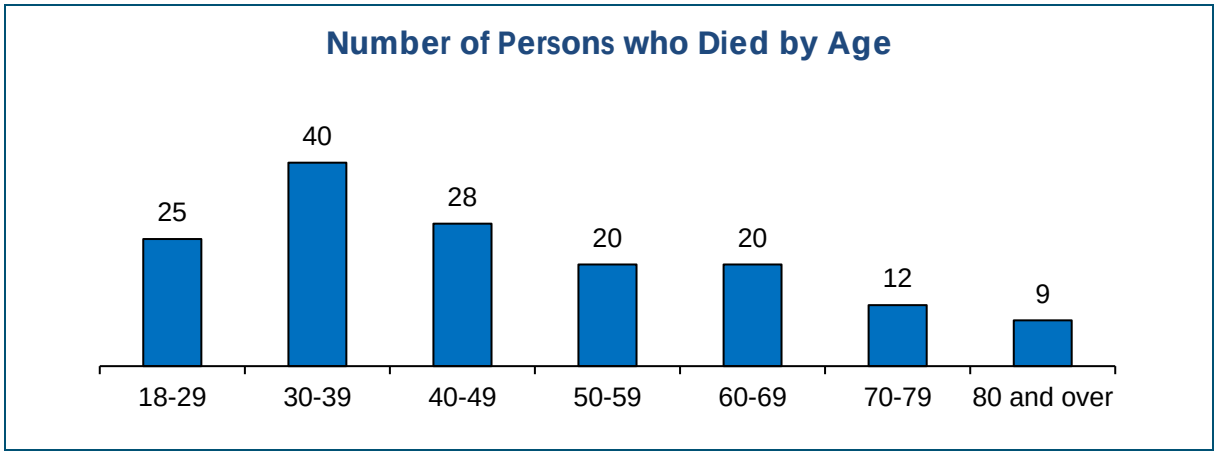
The following charts show characteristics of the persons who died for the 154 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2022. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

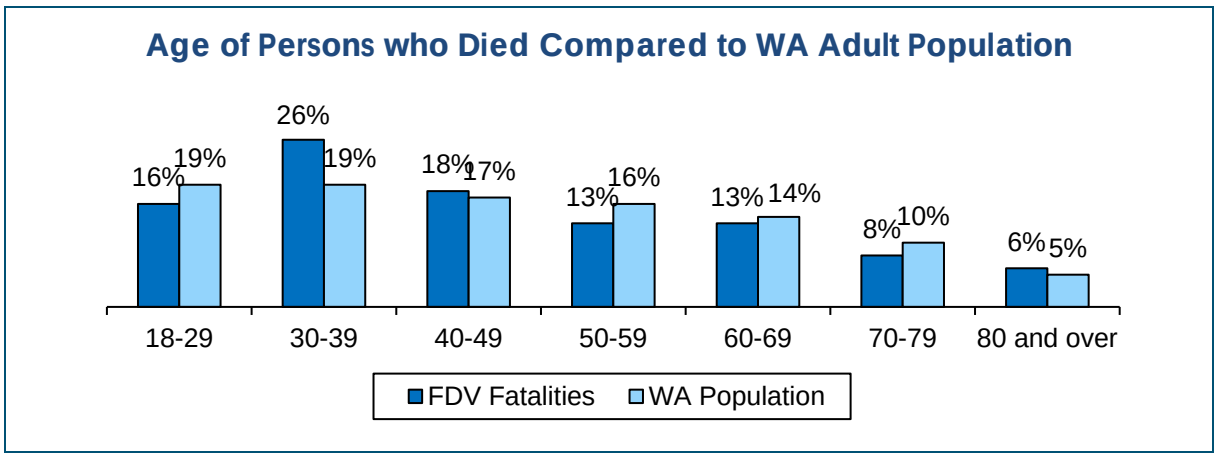




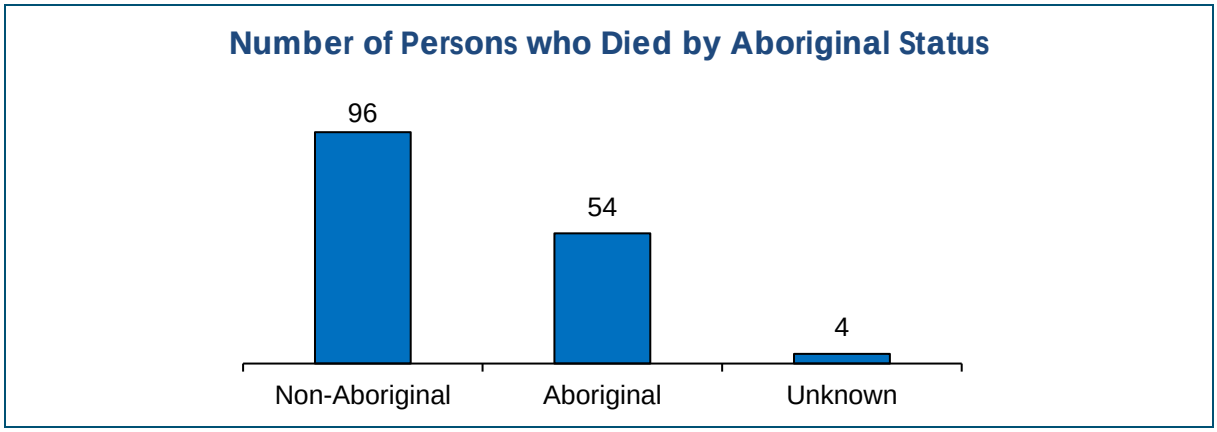
Information is collated on the sex of the deceased, and the suspected perpetrator, as identified in agency documentation provided to this Office. Compared to the Western Australian population, females who died in the 10 years from 1 July 2012 to 30 June 2022 were over-represented, with 56% of persons who died being female compared to 50% in the population.

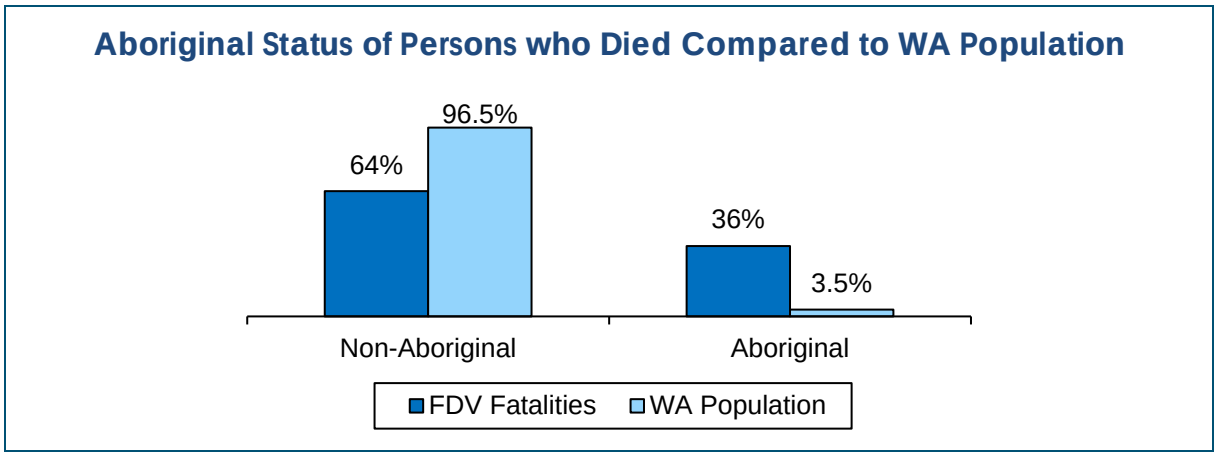
In relation to the 86 females who died, 80 involved a male suspected perpetrator. Of the 68 men who died, 12 were apparent suicides, 25 involved a female suspected perpetrator, 28 involved a male suspected perpetrator and three involved multiple suspected perpetrators of both sexes.





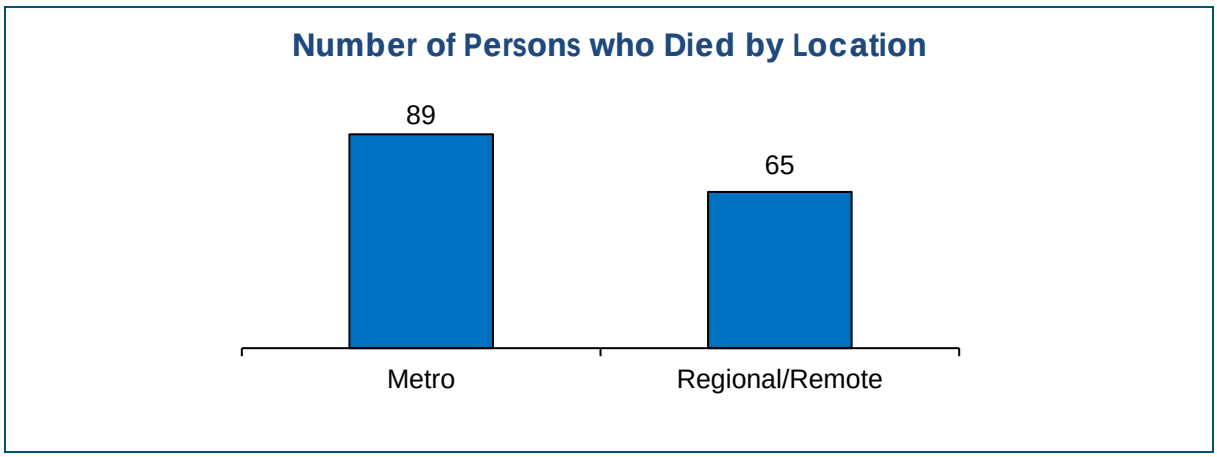
Compared to the Western Australian adult population, the age groups 30-39, 40-49 and 80 and over are over-represented, with 26% of persons who died being in the 30-39 age group compared to 19% of the adult population, 18% of persons who died being in the 40-49 age group compared to 17% of the adult population and six per cent of persons who died being in the 80 and over age group compared to five per cent of the adult population.

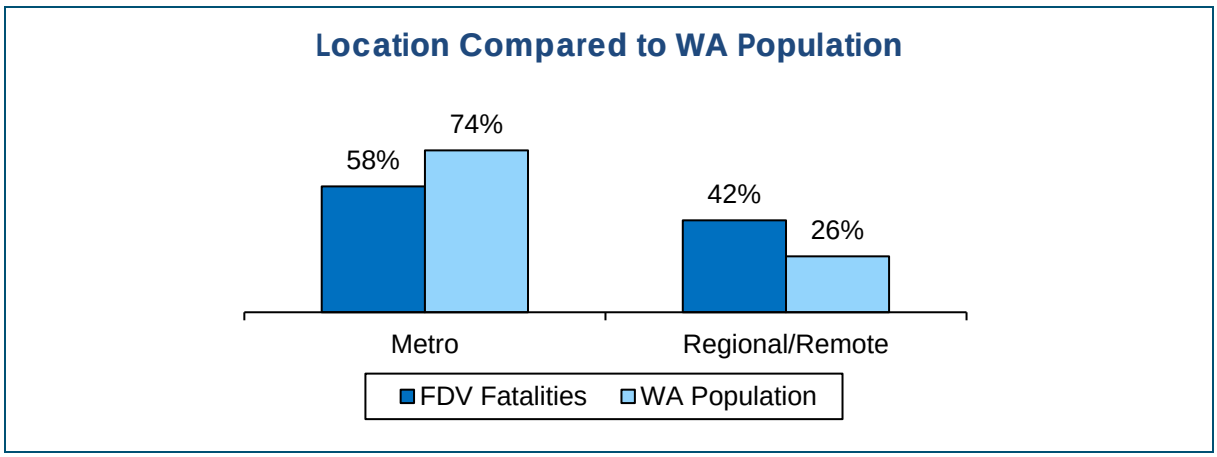




Note: In the above chart, percentages are based on those where Aboriginal status is known.

Information on Aboriginal status is collated where the deceased, and suspected perpetrator, identify as Aboriginal to agencies they have contact with, and this is recorded in the documentation provided to this Office. Compared to the Western Australian population, Aboriginal people who died were over-represented, with 36% of people who died in the 10 years from 1 July 2012 to 30 June 2022 being Aboriginal compared to 3.5% in the population. Of the 54 Aboriginal people who died, 33 were female and 21 were male.





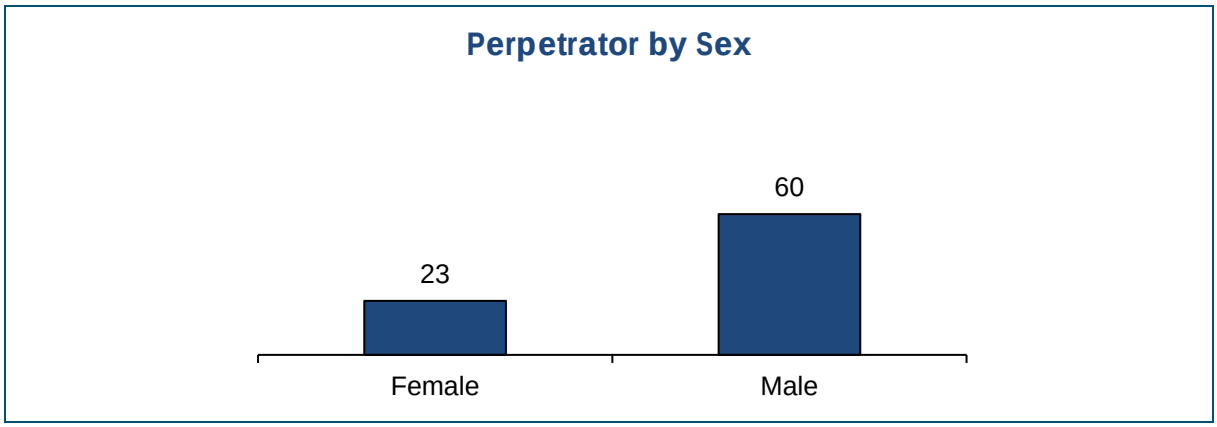
Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 42% of the people who died in the 10 years from 1 July 2012 to 30 June 2022 living in regional or remote locations, compared to 26% of the population living in those locations.

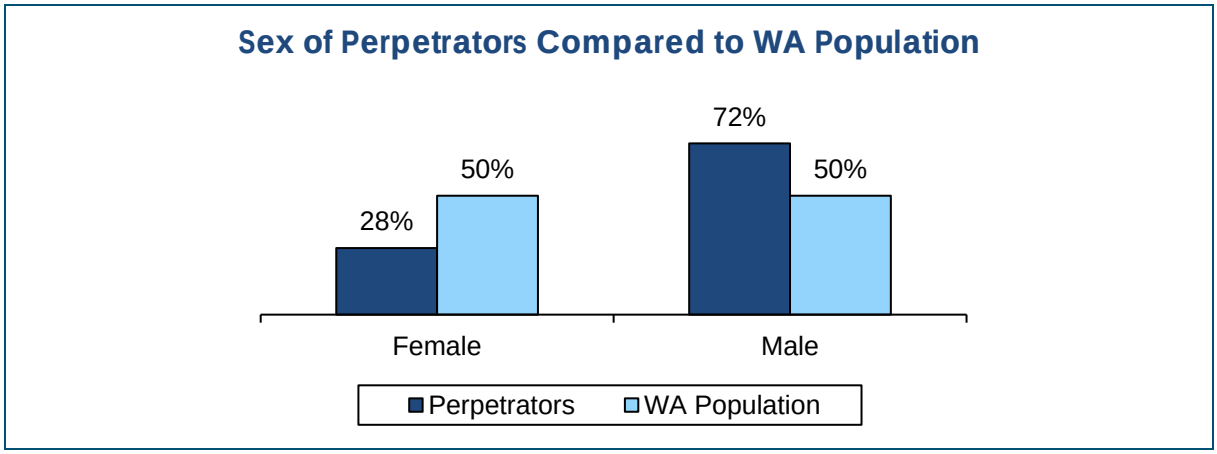
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2022 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2022.

Of the 154 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2022, coronial and criminal proceedings were finalised in relation to 83 perpetrators.

Information is obtained on a range of characteristics of the perpetrator including sex, age group and Aboriginal status. The following charts show characteristics for the 83 perpetrators where both the coronial process and the criminal proceedings have been finalised.

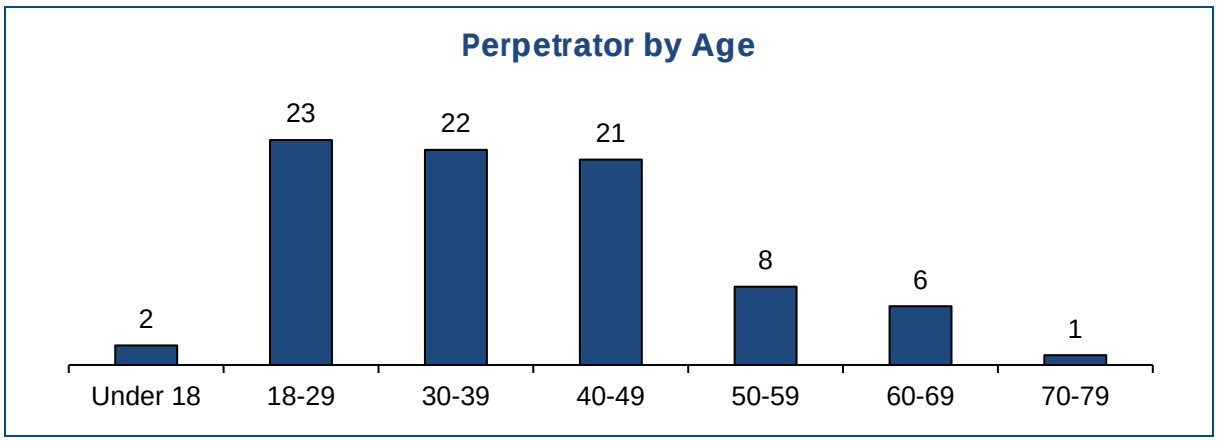


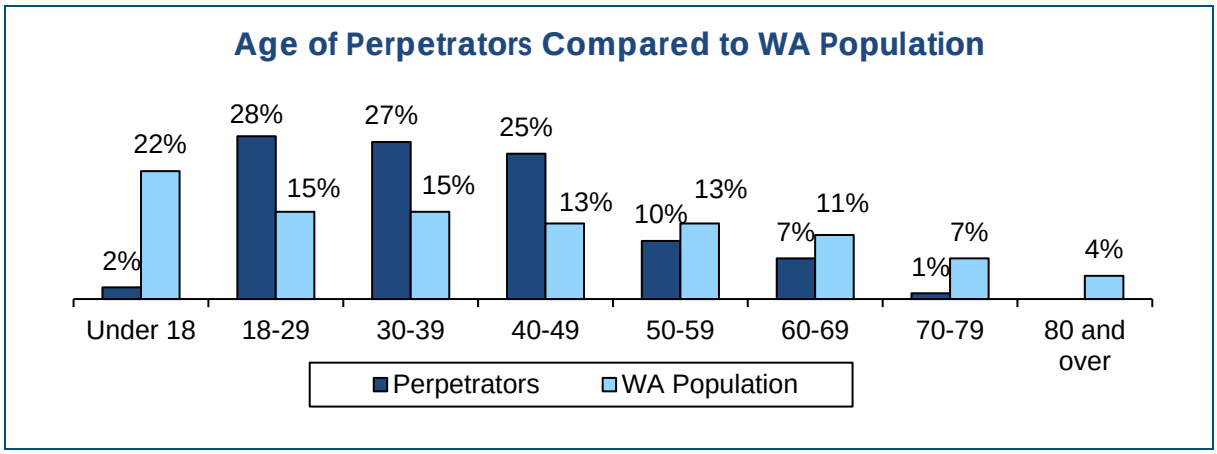


Compared to the Western Australian population, male perpetrators of fatalities in the 10 years from 1 July 2012 to 30 June 2022 were over-represented, with 72% of perpetrators being male compared to 50% in the population.

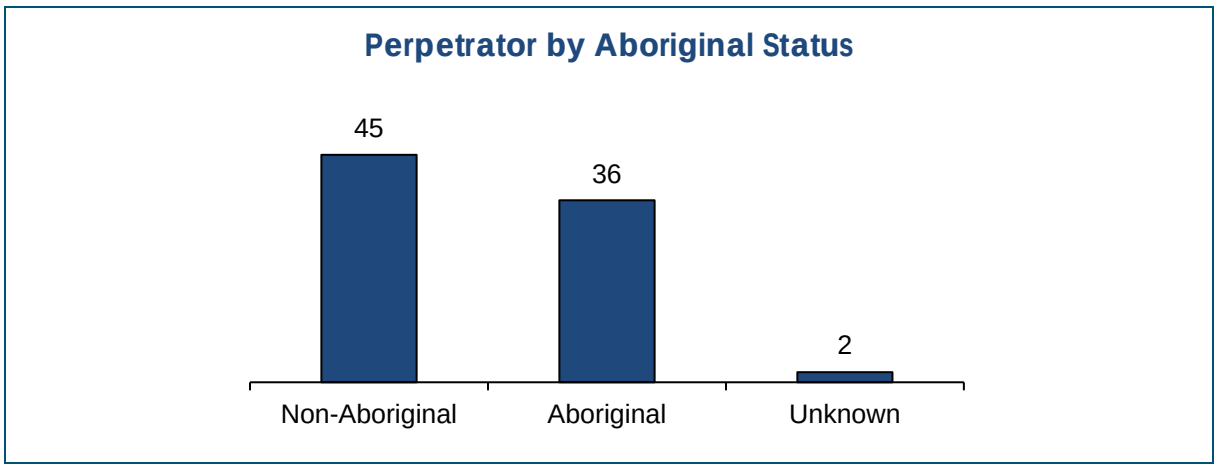
Eighteen males were convicted of manslaughter and 42 males were convicted of murder. Eleven females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death and 11 females were convicted of murder.

Of the 22 fatalities by the 23 female perpetrators, in 21 fatalities the person who died was male, and in one fatality the person who died was female. Of the 61 fatalities by the 60 male perpetrators, in 46 fatalities the person who died was female, and in 15 fatalities the person who died was male.

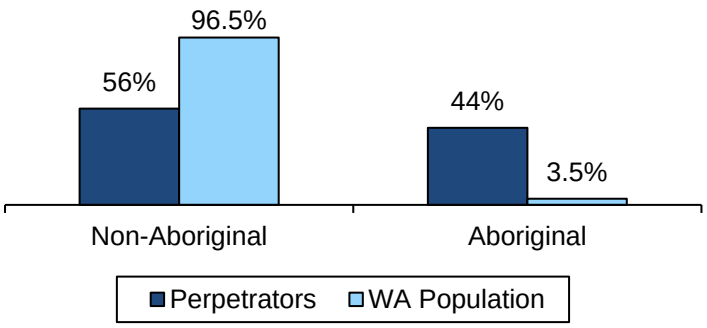




Compared to the Western Australian population, perpetrators of fatalities in the 10 years from 1 July 2012 to 30 June 2022 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 28% of perpetrators being in the 18-29 age group compared to 15% in the population, 27% of perpetrators being 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 13% in the population.



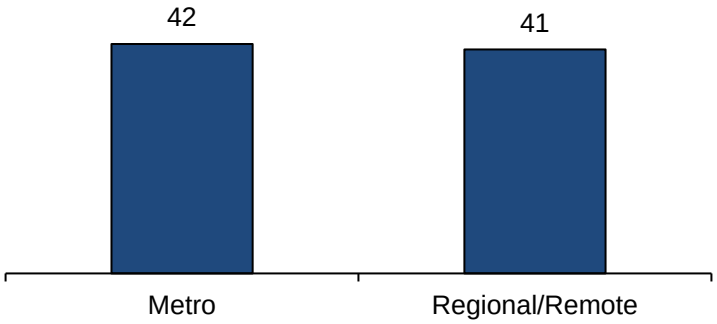
Aboriginal Status of Perpetrators Compared to WA Population



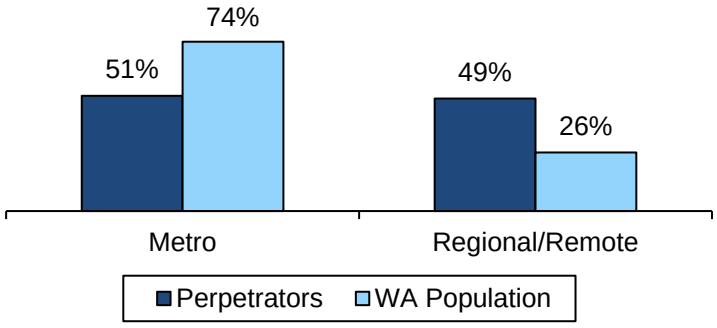
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the 10 years from 1 July 2012 to 30 June 2022 were over-represented with 44% of perpetrators (where Aboriginal status was recorded in information provided to this Office) being Aboriginal compared to 3.5% in the population.

In 34 of the 36 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location



Perpetrators by Location Compared to WA Population



Compared to the Western Australian population, the people who died in the 10 years from 1 July 2012 to 30 June 2022, who were living in regional or remote locations, were over-represented, with 49% 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

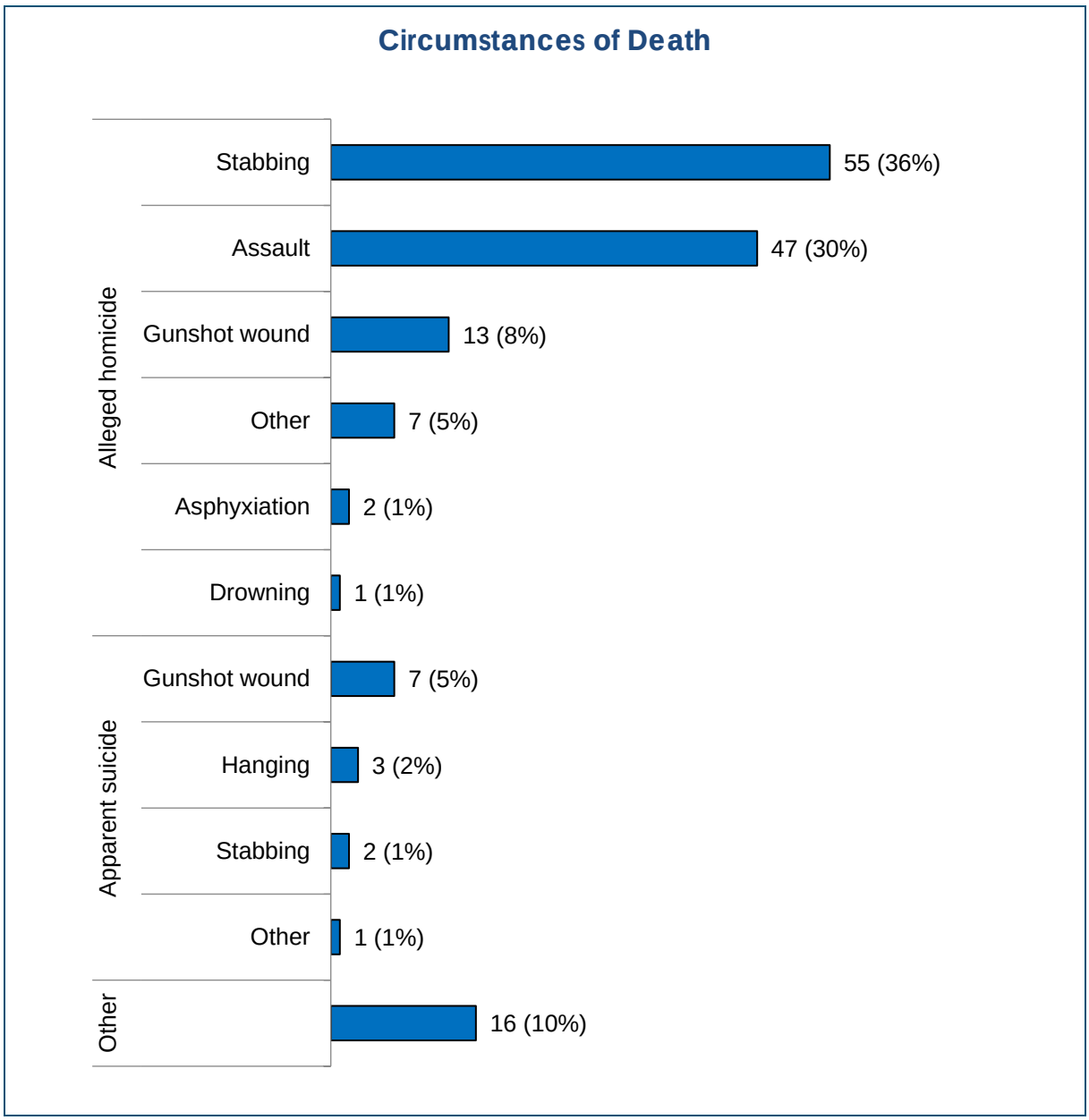
Information provided to the Office by WA Police Force about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

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.

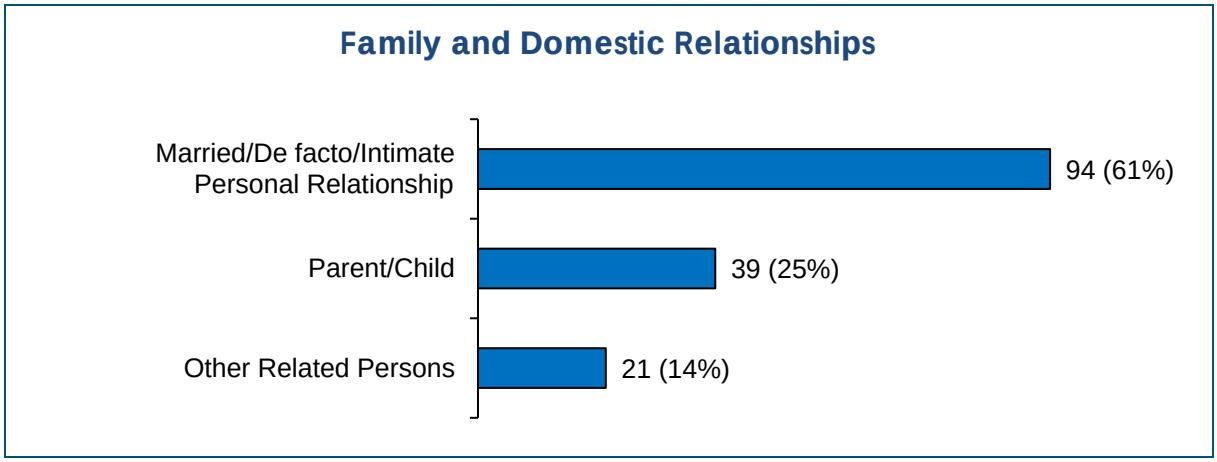
The principal circumstances of death in 2021-22 were alleged homicide by physical assault and stabbing.

The following chart shows the circumstance of death as categorised by the Ombudsman for the 154 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2022.



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 154 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2022:

- 94 fatalities (61%) involved a married, de facto or intimate personal relationship, of which there were 79 alleged homicides, nine apparent suicides and six in other circumstances. The 94 fatalities included 16 deaths that occurred in eight cases of alleged homicide/suicide and, in all eight cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. The ninth apparent suicide involved a male. Of the remaining 71 alleged homicides, 51 (72%) of the people who died were female and 20 (28%) were male;
- 39 fatalities (25%) involved a relationship between a parent and adult child, of which there were 27 alleged homicides, four apparent suicides and eight in other circumstances. Of the 27 alleged homicides, 10 (37%) of the people who died were female and 17 (63%) were male. Of these 27 fatalities, in 20 cases (74%) the person who died was the parent or step-parent and in seven cases (26%) the person who died was the adult child or step-child; and
- There were 21 people who died (14%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, eight (38%) were female and 13 (62%) 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

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

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

[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).

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

Type of relationships

The Ombudsman finalised 147 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2022.

For 90 (61%) 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 57 (39%) 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 147 finalised reviews, the circumstances of the fatality were as follows:

- For the 90 intimate partner fatalities, 75 were alleged homicides, nine were apparent suicides, and six were other circumstances; and
- For the 57 non-intimate partner fatalities, 44 were alleged homicides, three were apparent suicides, and 10 were other circumstances.

Intimate partner relationships

Of the 75 intimate partner relationship fatalities involving alleged homicide:

- There were 55 fatalities where the person who died was female and the suspected perpetrator was male, 16 where the person who died was male and the suspected perpetrator was female, one where the person who died was male and the suspected perpetrator was male, and three where the person who died was male and there were multiple suspected perpetrators of both sexes;
- There were 30 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In 20 of these fatalities the person who died was female and in 10 the person who died was male;
- There were 35 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 13 at the residence of the person who died or the residence of the suspected perpetrator, eight at the residence of family or friends, and 19 at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 38 fatalities where the person who died lived in regional and remote areas, and in 28 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 57 non-intimate partner fatalities, there were 38 fatalities involving a parent and adult child and 19 fatalities where the parties were otherwise related.

Of the 44 non-intimate partner fatalities involving alleged homicide:

- There were 13 fatalities where the person who died was female and the suspected perpetrator was male, three where the person who died was female and the suspected perpetrator was female, 22 where the person who died was male and the suspected perpetrator was male, and six where the person who died was male and the suspected perpetrator was female;
- There were 13 non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 18 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 17 at the residence of the person who died or the residence of the suspected perpetrator, and nine at the residence of family or friends or in a public place; and
- There were 19 fatalities where the person who died lived in regional and remote areas.

Prior reports of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reports of alleged family and domestic violence between the parties. In 46 (61%) of the 75 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2022, alleged family and domestic violence between the parties had been reported to WA Police Force and/or to other public authorities. In 16 (36%) of the 44 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2022, 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 62 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, from the records available:

- Four (6%) fatalities involved a deceased person with disability;
- None of the fatalities involved a deceased person in a same-sex relationship with the suspected perpetrator;
- 36 (58%) fatalities involved a deceased Aboriginal person; and
- 34 (55%) of the people who died lived in regional/remote Western Australia.

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

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

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

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

Identification of family and domestic violence incidents

Of the 62 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, WA Police Force was the agency to receive the majority of these reports. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, noted that DCPFS may become aware of family and domestic violence through a referral to DCPFS and subsequent assessment through the duty interaction process. Identification of family and domestic violence is integral to the agency being in a position to implement its family and domestic violence policy and processes to address perpetrator accountability and promote victim safety and support. However, the Ombudsman's reviews and own motion investigations continue to identify missed opportunities to identify, and respond to, family and domestic violence in interactions.

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

Provision of agency support to obtain a violence restraining order

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

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

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

Support to victims in reported incidences of family and domestic violence

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

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

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

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

Support to obtain a violence restraining order on behalf of children

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

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

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

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

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

Support during the process of obtaining a family violence restraining order

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

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

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

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

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

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

Support when a family violence restraining order has not been granted

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

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

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

Provision of support to victims experiencing family and domestic violence

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

The purpose of risk assessment is to determine the risk and safety for the adult victim and children, taking into consideration the range of victim and perpetrator risk factors that affect the likelihood and severity of future violence.

Risk assessment must be undertaken when family and domestic violence has been identified…

Risk assessment is conducted for a number of reasons including:

- evaluating the risk of re-assault for a victim;
- evaluating the risk of homicide;
- informing service system and justice responses;
- supporting women to understand their own level of risk and the risk to children and/or to validate a woman's own assessment of her level of safety; and
- establishing a basis from which a case can be monitored.

(pages 36-37)

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

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

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

Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 46 (61%) of the 75 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2022, prior family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities. The Ombudsman's reviews identify where perpetrators have a history of reported violence, with one or more partners, and examines steps taken to hold perpetrators to account for their actions and support them to cease their violent behaviours, 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 or supervised on community based orders. In 2021-22, the Ombudsman's reviews have continued to examine opportunities to improve information sharing across agencies, to address perpetrator behaviours, and has made one associated recommendation.

Case Study

Ensuring interagency communication and collaboration to promote perpetrator accountability

In reviewing a family and domestic violence fatality involving a perpetrator on a community order, the Ombudsman has identified the need to improve processes to ensure relevant interagency communication and collaboration. The Ombudsman made the following recommendation:

> The WA Police Force provides a report to the Ombudsman by 1 October 2022 on the progress of discussions with DOJ regarding information exchange when WA Police Force have contact with an individual subject to a community order, and the creation of a protocol to facilitate information sharing.

Fatalities with no prior reported family and domestic violence

Based on the information available to the Office, in 29 (39%) of the 75 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2022, 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 147 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2022, Aboriginal Western Australians were over-represented, with 49 (33%) persons who died being Aboriginal. In all but four cases, the suspected perpetrator

was also Aboriginal. There were 38 of these 49 fatalities where the person who died lived in a regional or remote area of Western Australia, of which 28 were intimate partner fatalities.

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

Contextual factors for family violence involving Aboriginal people

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

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

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

> Indigenous women continuously balance off the desire to stop the violence by reporting to the police with the potential consequences for themselves and other family members that may result from approaching the police; often concluding that the negatives outweigh the positives. Synthesizing the literature on the topic reveals a number of consistent themes, including: a reluctance to report because of fear of the police, the perpetrator and perpetrator's kin; fear of "payback" by the offender's family if he is jailed; concerns the offender might become "a death in custody"; a cultural reluctance

> to become involved with non-Indigenous justice systems, particularly a system viewed as an instrument of dispossession by many people in the Indigenous community; a degree of normalisation of violence in some families and a degree of fatalism about change; the impact of "lateral violence" … which makes victims subject to intimidation and community denunciation for reporting offenders, in Indigenous communities; negative experiences of contact with the police when previously attempting to report violence (such as being arrested on outstanding warrants); fears that their children will be removed if they are seen as being part of an abusive house-hold; lack of transport on rural and remote communities; and a general lack of culturally secure services.
>
> (Blagg, H, Bluett-Boyd, N and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 13).

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

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

The Ombudsman's reviews and report have identified that Aboriginal victims want the violence to end, but not necessarily always through the use of family violence restraining orders. The Ombudsman's reviews have also examined agency action to facilitate co-design of locally based solutions to promote Aboriginal family and community safety. In 2020-21, the Ombudsman has made four recommendations that seek to support community led solutions. The implementation of these recommendations is being monitored, and will be reported on in the Annual Report 2022-23.

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. Subsequent to these recommendations, Action Item 5 of the First Action Plan intends to '[c]o-design the Aboriginal Family Safety Strategy with Aboriginal people and communities'. In March 2022 Communities released the draft *Aboriginal Family Safety Strategy* for community consultation. This Office will continue to monitor the finalisation and implementation of the *Aboriginal Family Safety Strategy*.

Limited use of violence restraining orders

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities,* November 2015, identified that while Aboriginal people are significantly over-represented as victims of family and domestic violence, they are less likely than non-Aboriginal people to seek a violence restraining order. The report examined the research literature and views of

stakeholders on the possible reasons for this lower use of violence restraining orders by Aboriginal people, identifying that the process for obtaining a violence restraining order is not necessarily always culturally appropriate for Aboriginal victims and that Aboriginal people in regional and remote locations face additional logistical and structural barriers in the process of obtaining a violence restraining order.

In the report, the Ombudsman recommended that:

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

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

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

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

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

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

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

The Ombudsman's reviews of the family and domestic violence fatalities of Aboriginal people and prior reported family violence between the parties, identify a high co-occurrence of alcohol consumption and family violence. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, examined the research literature on the relationship between alcohol use and family and domestic violence and found that the research literature regularly identifies alcohol as 'a significant risk factor' associated

with intimate partner and family violence in Aboriginal communities (Mitchell, L, *Domestic violence in Australia – an overview of the issues*, Parliament of Australia, 2011, Canberra, accessed 16 October 2014, pp. 6-7). As with family and domestic violence in non-Aboriginal communities, the research literature suggests that 'while alcohol consumption [is] a common contributing factor … it should be viewed as an important situational factor that exacerbates the seriousness of conflict, rather than a cause of violence' (Buzawa, E, Buzawa, C and Stark, E, *Responding to Domestic Violence*, Sage Publications, 4th Edition, 2012, Los Angeles, p. 99; Morgan, A. and McAtamney, A. 'Key issues in alcohol-related violence,' *Australian Institute of Criminology*, Canberra, 2009, viewed 27 March 2015, p. 3).

In the report, the Ombudsman recommended that:

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

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

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

Of the 49 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2022 involving Aboriginal people, 38 (78%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Nineteen (39%) of the Aboriginal people who died lived in the Kimberley region, which is home to 1.3% of all people and 16% of Aboriginal people in the Western Australian population.

As outlined above, *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to Recommendations 4 and 6 of the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015. These recommendations related to DCPFS developing 'a strategy that is specifically tailored to preventing and reducing Aboriginal family violence' that would encompass all regions of Western Australia and would ensure actively inviting and encouraging 'the involvement of Aboriginal people in a full and active way at each stage and level of the process' and being 'comprehensively informed by Aboriginal culture'. Subsequent to these recommendations, Item 5 of the First Action Plan intends to '[c]o-design the Aboriginal Family Safety Strategy with Aboriginal people and communities'. The Ombudsman's reviews have also examined agency action to facilitate co-design of locally based solutions to promote Aboriginal family and community safety. In 2020-21, the Ombudsman made four recommendations that seek to support community led solutions. The implementation of these recommendations is being monitored, and will be reported on in the Annual Report 2022-23.

Factors co-occurring with family and domestic violence

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

Co-occurrence with alcohol and other drug use

Consistent with the research literature relating to the co-occurrence between alcohol consumption and/or drug use and incidents of family and domestic violence (as outlined in the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015), the 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 119 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2022, the Office's reviews identify where alcohol use and/or drug use are factors associated with the fatality, and where there may be a history of alcohol use and/or drug use.

	ALCOHOL USE		DRUG USE	
	Associated with fatal event	Prior history	Associated with fatal event	Prior history
Person who died only	4	5	5	8
Suspected perpetrator only	11	11	19	19
Both person who died and suspected perpetrator	39	47	13	23
Total	**54**	**63**	**37**	**50**

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-occurring 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 arguments, 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 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.

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 responsive practice when working with Aboriginal families.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities to provide perpetrator rehabilitation support.
- Not adequately investigating offences in the context of family and domestic violence.
- Missed opportunities to address family and domestic violence victim safety.
- Missed opportunity to facilitate safe accommodation.
- Missed opportunity to assess risk of harm and develop strategies to reduce or prevent family and domestic violence in the context of mental health issues and/or drug and alcohol use.
- Not undertaking sufficient family, intra-agency and inter-agency communication to enable effective case management and collaborative responses.
- Not adequately meeting policy and procedures of the Family and Domestic Violence Response Team.
- Not taking action consistent with legislative responsibilities of the *Children and Community Services Act 2004*, and associated policy, to determine whether children were in need of protection or whether action was required to safeguard child wellbeing.
- Inaccurate recordkeeping.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following recommendation was made by the Ombudsman in 2021-22 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. The WA Police Force provides a report to the Ombudsman by 1 October 2022 on the progress of discussions with DOJ regarding information exchange when WA Police Force have contact with an individual subject to a community order, and the creation of a protocol to facilitate information sharing.

The Ombudsman's *Annual Report 2022-23* will report on the steps taken to give effect to the eight recommendation made about ways to prevent or reduce family and domestic violence fatalities in 2020-21. The Ombudsman's *Annual Report 2023-24* will report on the steps taken to give effect to the recommendation made about ways to prevent or reduce family and domestic violence fatalities in 2021-22.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2019-20

The Ombudsman made two recommendations about ways to prevent or reduce family and domestic violence fatalities in 2019-20. The Office has requested that the relevant public authorities notify the Ombudsman regarding:

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

Recommendation 1: Within three months of the finalisation of this review, Communities provides a report to the Ombudsman outlining Communities' plan for monitoring and evaluating the Family and Domestic Violence Response Team function and operation to ensure this service is providing an efficient, effective and collaborative response to families impacted by family and domestic violence, is improving victim safety, and is addressing perpetrator accountability.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 7 October 2019, in which Communities relevantly informed this Office that:

> The following points highlight the planning progress to date:
>
> - Following receipt of the recommendation, Communities convened a Family and Domestic Violence Response Team (FDVRT) Review Planning Group (the planning group) which consists of executive and senior officers from Communities and the Western Australia Police Force.

- Four planning group meetings have been convened. The purpose of the meetings was to decide on the appropriate level of review and redesign needed for the FDVRT model. It has been agreed that a phased service design approach will be taken.
- An FDVRT Review and Redesign Project Plan has been drafted, which includes the intended approach for completing phase one of the service design approach (review). The Plan will be provided to the Communities Policy Committee for approval on 8 October 2019. Once approved, the final plan will be forwarded to your office.
- It is proposed that Phase One of the approach will discover and define the challenges and issues with the FDVRT model, and will identify the core elements necessary for an effective and efficient operational model.
- Phase One will occur over six months, with the start date dependant on available funding to resource an external consultant to assist with review of the FDVRT model. This process will identify local issues and concerns, as well as national and international comparisons for the next phase. This project will be funded internally.
- Phase Two will consist of broad-level thinking and engagement with key stakeholders to co-design an innovative, efficient and effective FDVRT model.
- A redesigned FDVRT model will have funding implications for final co-design and for implementation at Phase Three.

Going forward, the planning group will support the FDVRT Review and Redesign Project with governance and reporting.

This Office requested further information of the steps taken to give effect to this recommendation. In response, Communities provided a range of information in an email to this Office dated 20 December 2021. Communities relevantly informed this Office that:

The project team have finalised the design of the enhanced Family Domestic Violence Response Team (FDVRT) service delivery model. The project team includes representatives from Communities, Justice and Police who have worked consultatively to implement the agreed deliverables, including:

- The inclusion of Justice Officers in the co-located FDVRT.
- Development of a Central Support and Coordination Team to provide governance of the model and ensure ongoing continuous improvement across the structure, policy, process and training. This is a tripartite arrangement, staffed by representatives of Communities, Police and Justice.

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

Recommendation 2: DOJ provides the Ombudsman with a report by 31 July 2020, that outlines, for the period 1 July 2019 to 30 June 2020:

- **The number of offenders who were sentenced for offences that occurred in the context of family and domestic violence;**
- **How many of these offenders were assessed as eligible and recommended for family and domestic violence rehabilitation intervention (individual or group); and**
- **How many of these offenders who were recommended for family and domestic violence rehabilitation intervention have since completed the intervention (individual or group).**

Steps taken to give effect to the recommendation

DOJ provided this Office with a letter dated 31 July 2020, in which DOJ relevantly informed this Office that:

- The Department identified 731 offenders who were sentenced for offences that occurred in the context of FDV.
- Of the 731 offenders, the Department assessed 167 (23%) offenders' treatment needs and of these, 118 offenders (71%) were assessed as eligible and recommended for FDV rehabilitation intervention (individual or group).
- It is noted that 160 (28%) of the 564 offenders not assessed for treatment needs are engaged in the Department's assessment process and may be recommended for an FDV intervention in the future and 348 (62%) are ineligible to access a treatment program due to their sentence length being less than six months.
- Of the 118 offenders recommended for FDV rehabilitation intervention, 6 (5%) have completed the intervention, 29 (24%) are enrolled in an intervention and 52 (44%) will be enrolled in an intervention following the pending release of the Offender Programs schedule.

This Office requested DOJ provide any additional information relevant to the implementation of this recommendation. In response, DOJ provided a letter to this Office dated 30 March 2022, which relevantly informed this Office that:

> Further to this, the Department continues to identify and assess the risks of FDV offenders including those at high-risk of re-offending.
>
> The Department is in the process of developing a program of works to prioritise and update the suite of criminogenic treatment programs across adult prisons and for offenders managed in the community.
>
> The Department is currently progressing an Offender Programs Review Implementation Project. This focuses on rehabilitation through contemporary, evidence-based, innovative and effective criminogenic/non-criminogenic programs that target the specific needs of our offender cohort to break the cycle of offending.
>
> This project will implement a significant program of works that will augment the Department's current offender program suite and address identified gaps in service delivery. FDV rehabilitation programs are identified as a priority area for this project.

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

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

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of family and domestic violence fatalities. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2021-22, timely review processes have resulted in 41% of all reviews being completed within six months and 67% of reviews completed within 12 months.

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

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

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

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

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

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

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

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

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

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

The Office has now concluded its review of the (now) Department of Communities' (**Communities**) review report. The Office has considered the *Family and Domestic Violence Practice Guidance Review Report* and that Communities has conducted a project to review its family and domestic violence practice guidance. The focus of the review conducted by Communities was to identify and recommend amendments to Communities' family and domestic violence practice guidance. The review did not include any actions 'to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance'. Further, while

Communities identified several issues which potentially relate to barriers to effective implementation, a range of Communities' 'proposed actions' to overcome these potential barriers were not considered to be appropriate.

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

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

> Communities acknowledges this finding and confirms it is a priority for Communities to address and implement the intent of the recommendation. It was the intent of the *Family and Domestic Violence Practice Guidance Review Report* (the report) and the *Family and Domestic Violence Practice Guidance Implementation* to do so. The report did help to identify a range of issues that limit the implementation of policy and practice guidance, and Communities has undertaken numerous activities and processes to address these. These include:
>
> - new toolkits for assessment and safety planning in cases of emotional abuse - family and domestic violence, which aim to support child protection workers to form an evidence-based professional judgement, and include practice examples of how to gather information to inform assessments, analyse the information, and practice examples of safety planning;
> - mandatory training concerning family and domestic violence for new and current employees to have a focus on effectively engaging perpetrators, including assessments within the training and in the field;
> - workshops and presentations with Team Leader and Senior Practice Development Officer groups to encourage strong leadership within districts of the policy and practice guidance;
> - case consultation with child protection workers to provide opportunities for staff to reflect on and plan their practice;
> - a centralised intake model in July 2017, including a 'threshold tool' to provide a consistent response to child protection referrals;
> - a partnership with Curtin University, the University of Melbourne and the Safe and Together Institute in order to integrate techniques in working with perpetrators into practice; and
> - a practice audit is currently being undertaken to assess the implementation to date of the family and domestic violence practice guidance, and to establish a baseline from which further audits or reviews of practice can be measured. The audit examines 50 cases (three from each district) at various stages of Communities' Child Protection and Family Support division involvement, identifies areas for practice improvement and provides opportunities to work with districts to improve understanding of key issues in the intersection between child protection and family and domestic violence.

Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

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

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through the Ombudsman's Advisory 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 through membership of the Australian Domestic and Family Violence Death Review Network (**the Network**). The Network worked in partnership with the Australia's National Research Organisation for Women's Safety (**ANROWS**) to publish the *Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2010-2018, Second Edition 2022*. This collaboration is also working to develop analysis of the common risk factors in family and domestic violence homicides in Australia based on the breadth of information that is available to the Network. Additionally, the collaboration will develop a national dataset of the characteristics of the deaths of children by parents to inform prevention initiatives at a national level;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

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

The Ombudsman's Advisory Panel

The Ombudsman's Advisory 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 Ombudsman's Advisory Panel met three times in 2021-22.

Key stakeholder relationships

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

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

Aboriginal and regional communities

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

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

A Senior Aboriginal Advisor position was established in January 2018 to assist the Principal Aboriginal Consultant in this important work, and in 2021-22, the Ombudsman created a critical new executive position, Assistant Ombudsman Aboriginal Engagement and Collaboration, which was advertised in April 2022.

Significant work was undertaken throughout 2021-22 to continue to build relationships relating to the child death review jurisdiction with Aboriginal and regional communities, for example by communicating with:

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

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