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:

- 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;
- 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.

Learnings from the review of family and domestic violence related fatalities provides opportunity to influence policy development and service provision, to prevent or reduce the risk of future family and domestic violence related deaths. At the request of the State Government, the Ombudsman Western Australia commenced the responsibility for reviewing family and domestic violence fatalities on 1 July 2012.

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.

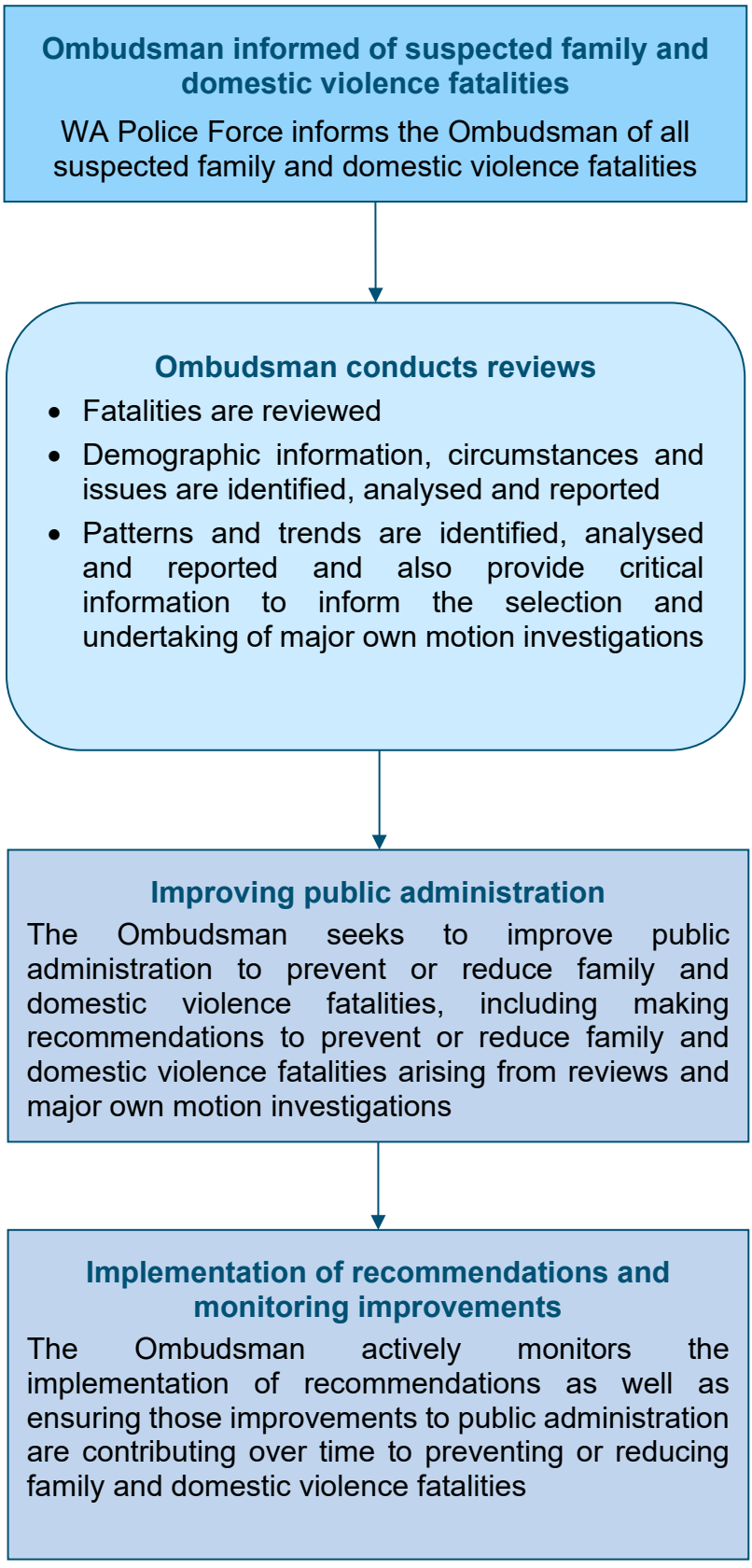
WA Police Force informs the Office of all family and domestic violence fatalities and provides information about the circumstances of the death together with any relevant information of prior WA Police Force contact with the person who died and the suspected perpetrator. A family and domestic violence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

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

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

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

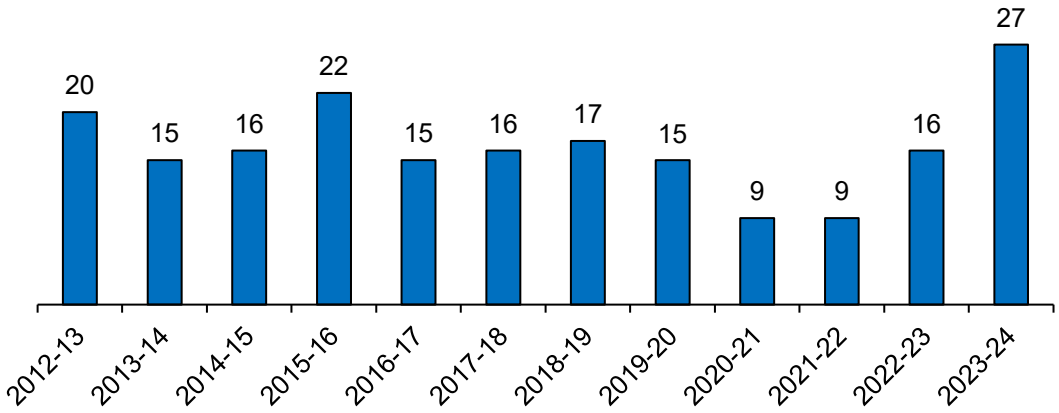
The Family and Domestic Violence Fatality Review Process



Analysis of Family and Domestic Violence Fatality Reviews

Number of family and domestic violence fatality reviews

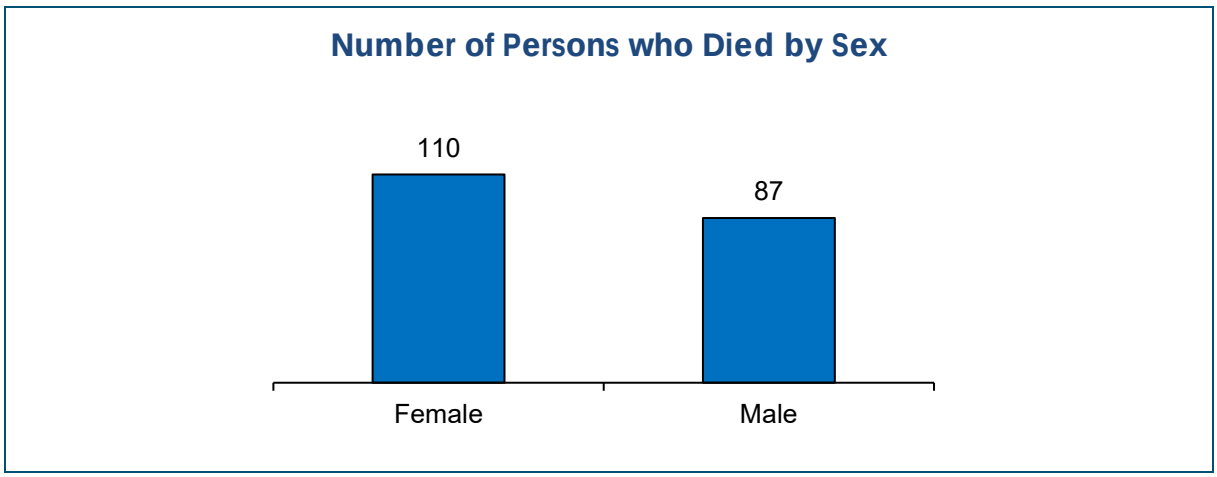
The chart below identifies the number of reviewable family and domestic violence fatalities notified to the Ombudsman. This chart reflects data of notification, not date of death.

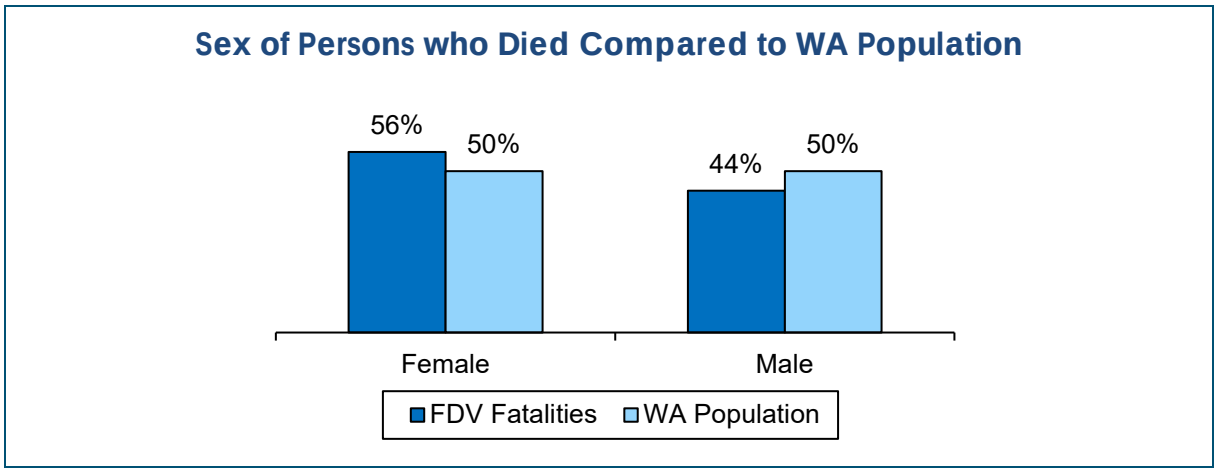


Demographic information identified from family and domestic violence fatality reviews

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.

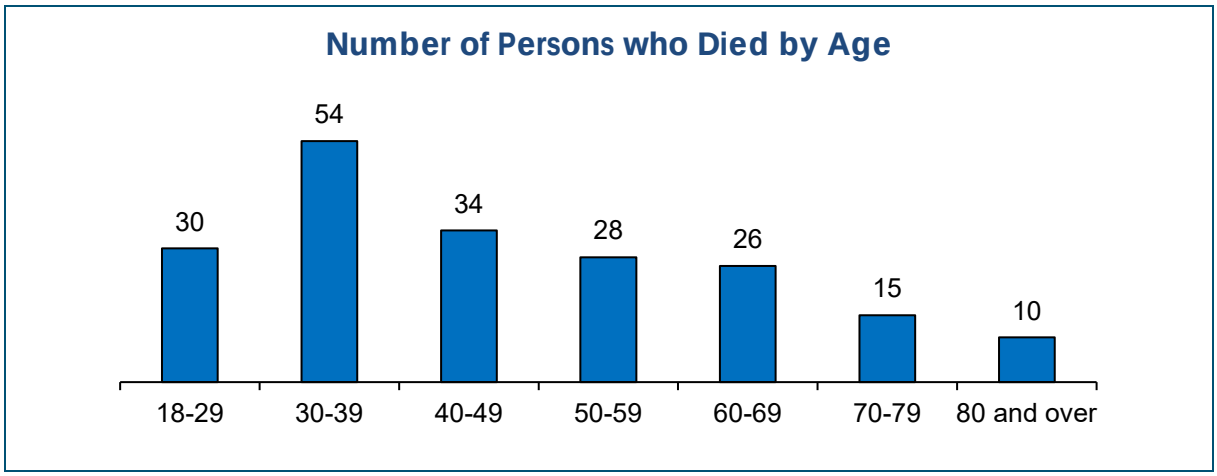
The following charts show characteristics of the persons who died for the 197 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2024. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

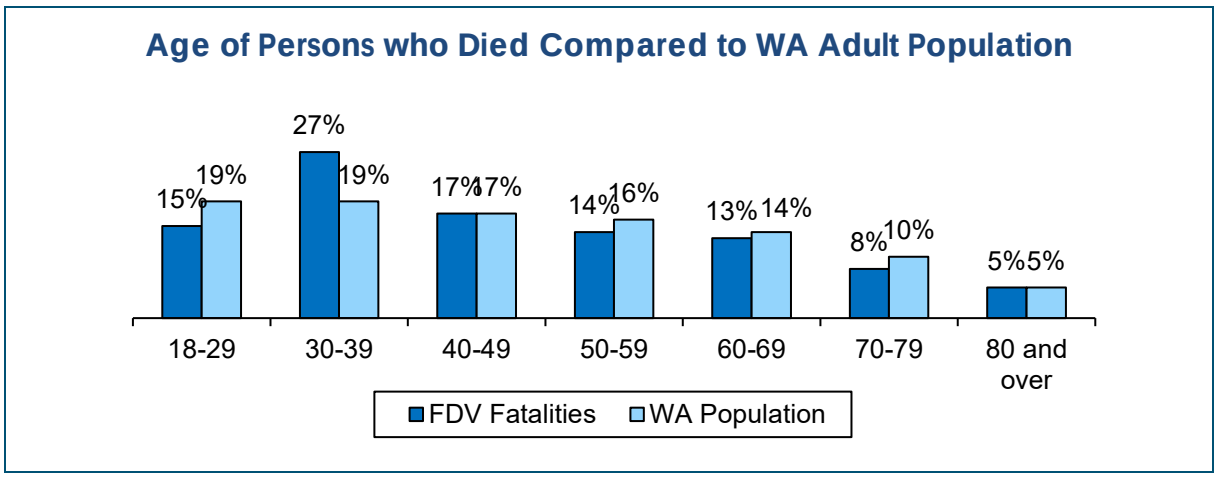




Information is collated on the sex of the deceased, and the suspected perpetrator, as identified in agency documentation provided to this Office. Compared to the Western Australian population, females who died in the 12 years from 1 July 2012 to 30 June 2024 were over-represented, with 56% of persons who died being female compared to 50% in the population.

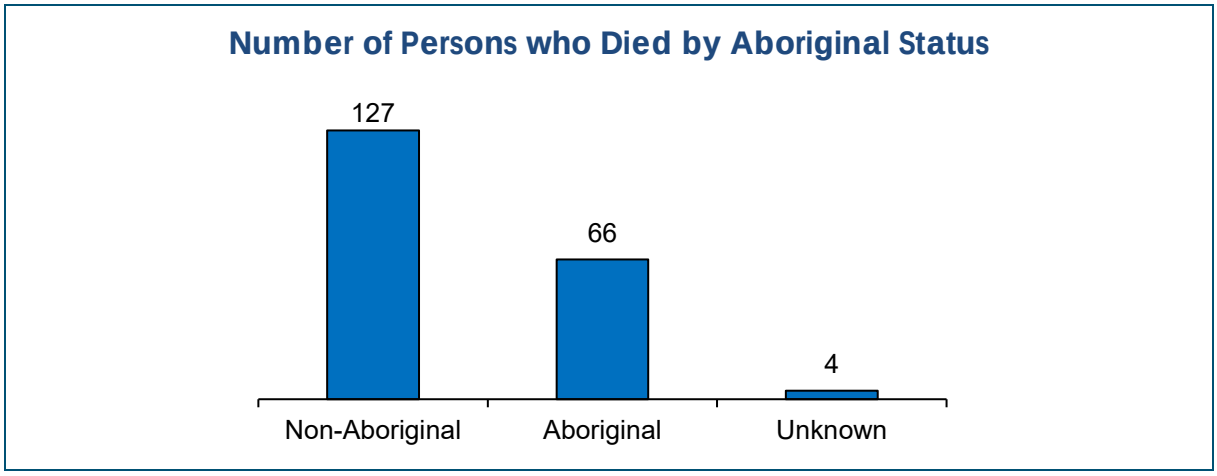
In relation to the 110 females who died, 98 involved a male suspected perpetrator, eight involved a female suspected perpetrator, one involved multiple suspected perpetrators of both sexes and three were apparent suicides. Of the 87 men who died, 30 involved a female suspected perpetrator, 33 involved a male suspected perpetrator, four involved multiple suspected perpetrators of both sexes and 20 were apparent suicides.

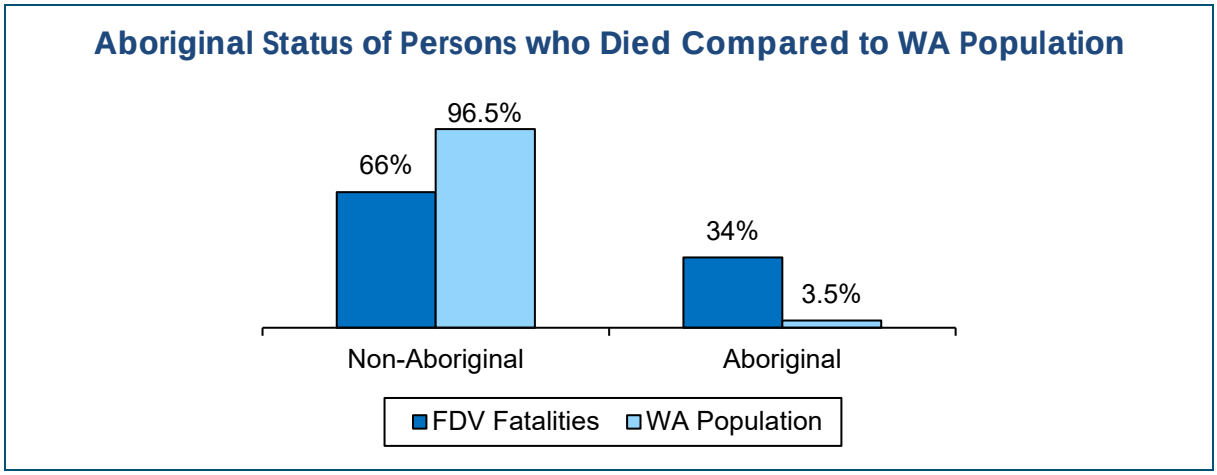




Note: Percentages may not add to 100% due to rounding.

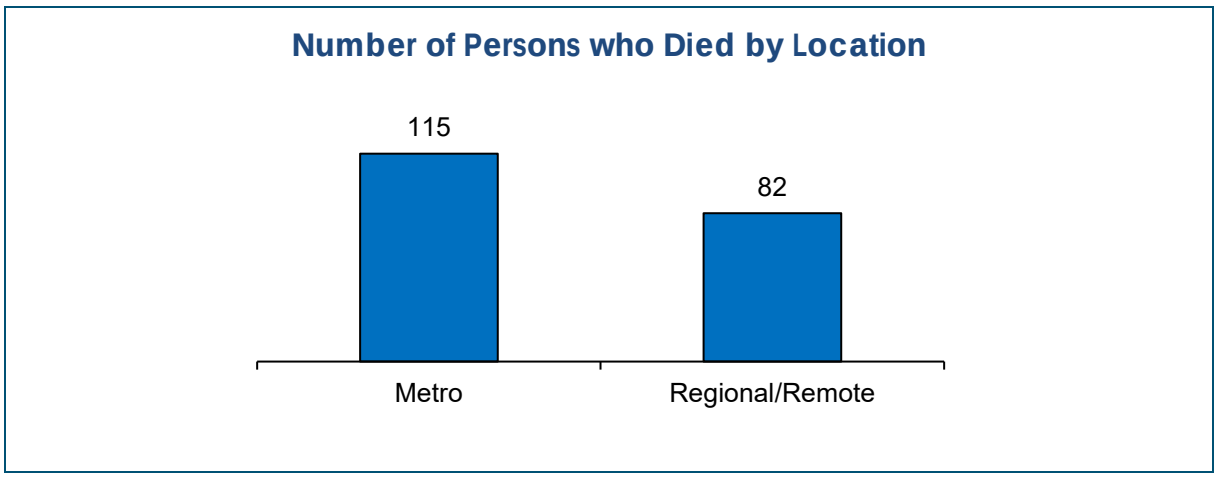
Compared to the Western Australian adult population, the age group 30-39 is over-represented, with 27% of persons who died being in the 30-39 age group compared to 19% of the adult population.

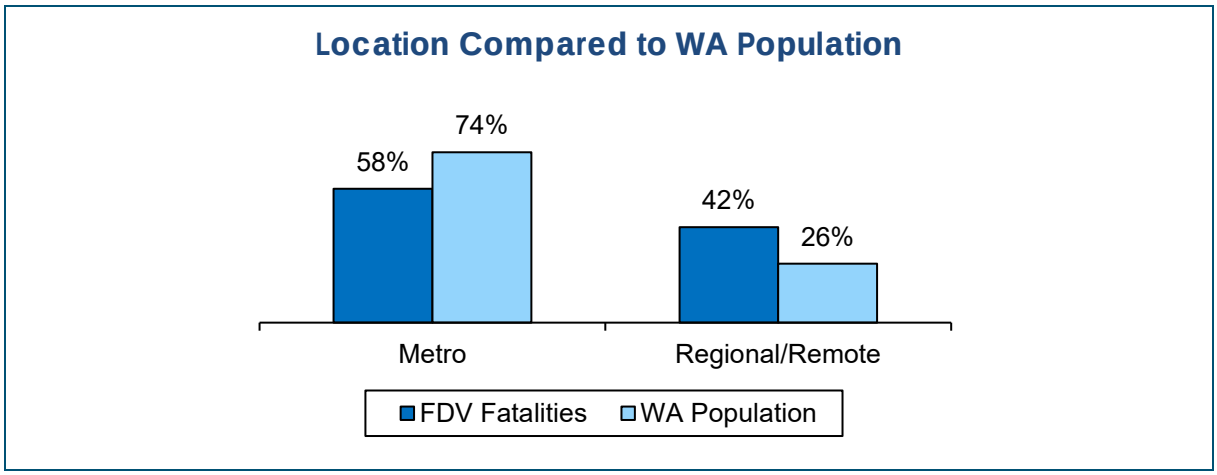




Note: In the above chart, percentages are based on those where Aboriginal status is known.

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 34% of people who died in the 12 years from 1 July 2012 to 30 June 2024 being Aboriginal compared to 3.5% in the population. Of the 66 Aboriginal people who died, 40 were female and 26 were male.





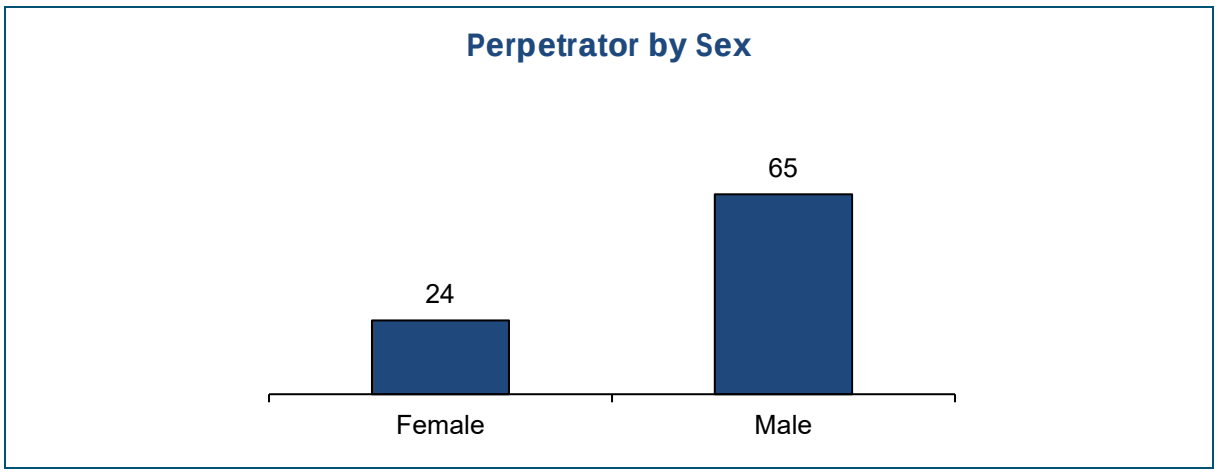
Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 42% of the people who died in the 12 years from 1 July 2012 to 30 June 2024 living in regional or remote locations, compared to 26% of the population living in those locations.

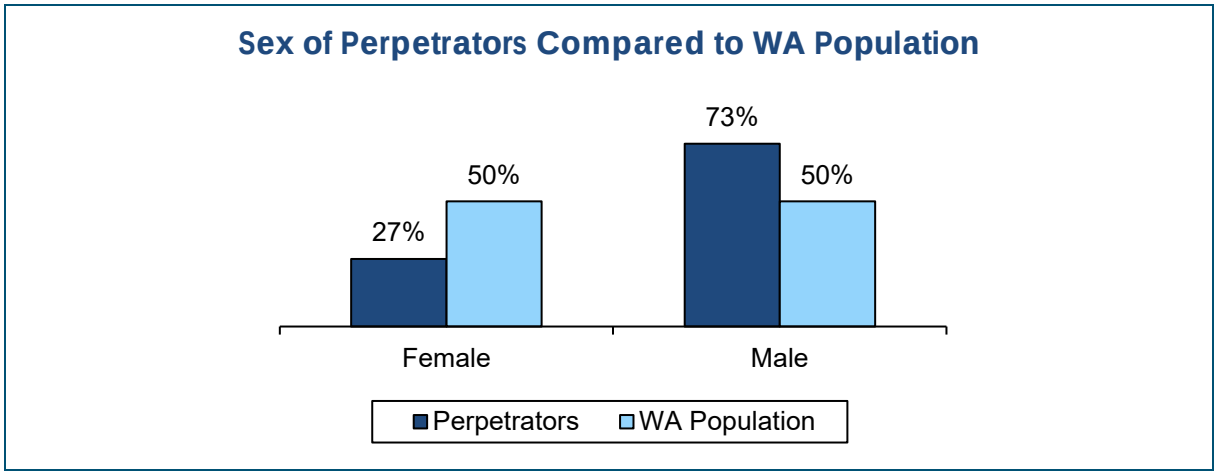
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2024 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2024.

Of the 197 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2024, coronial and criminal proceedings were finalised in relation to 89 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 89 perpetrators where both the coronial process and the criminal proceedings have been finalised.



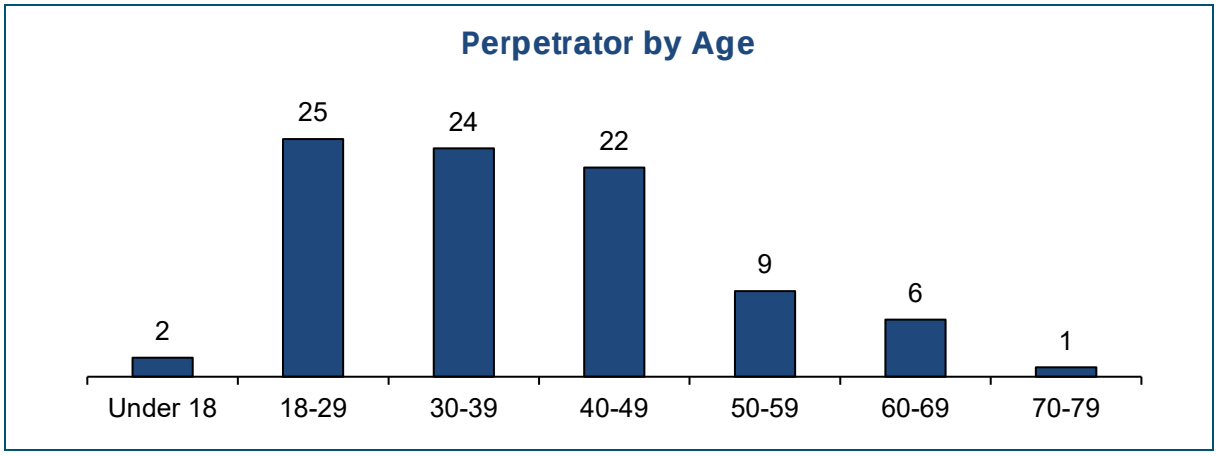


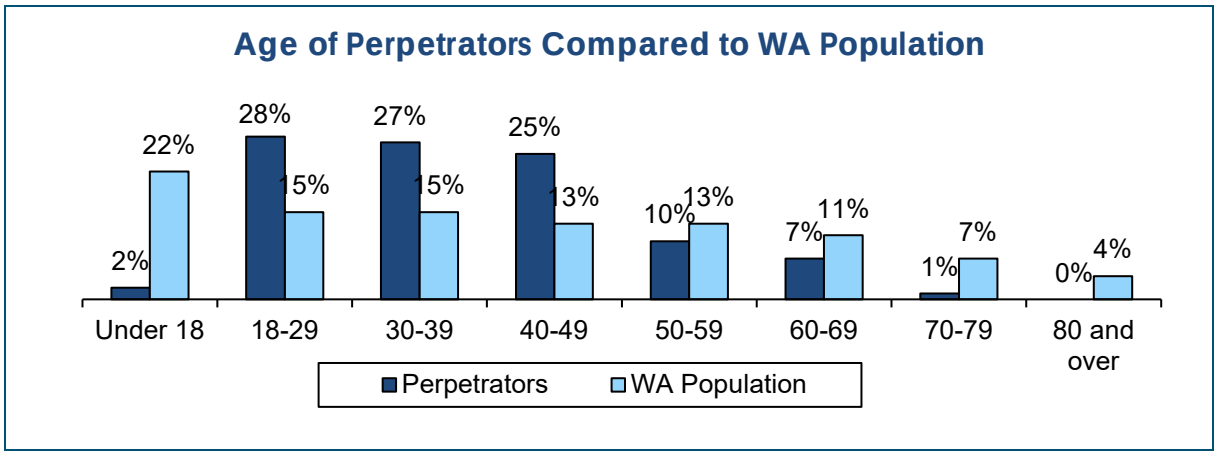
Compared to the Western Australian population, male perpetrators of fatalities in the 12 years from 1 July 2012 to 30 June 2024 were over-represented, with 73% of perpetrators being male compared to 50% in the population.

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

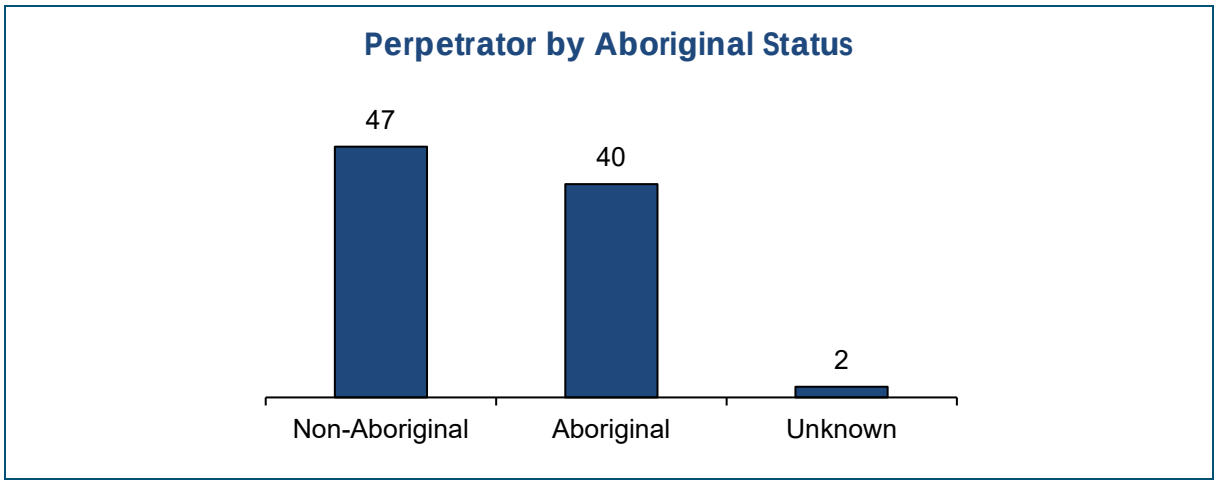
Of the 23 fatalities by the 24 female perpetrators, in 22 fatalities the person who died was male, and in one fatality the person who died was female. Of the 66 fatalities by

the 65 male perpetrators, in 49 fatalities the person who died was female, and in 17 fatalities the person who died was male.

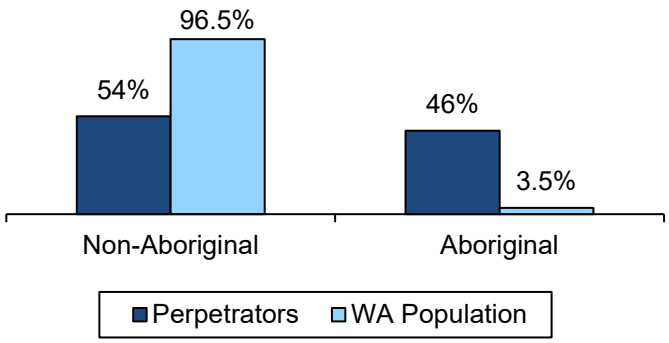




Compared to the Western Australian population, perpetrators of fatalities in the 12 years from 1 July 2012 to 30 June 2024 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 28% of perpetrators being in the 18-29 age group compared to 15% in the population, 27% of perpetrators being 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.



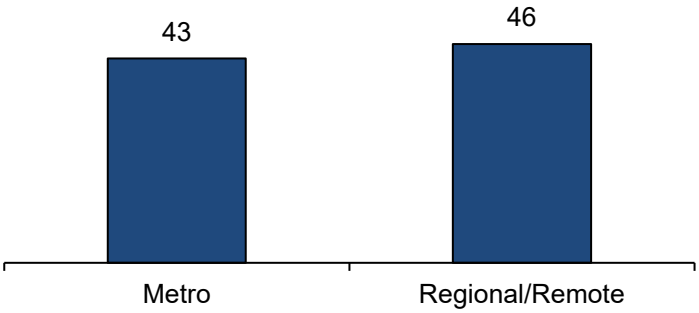
Aboriginal Status of Perpetrators Compared to WA Population



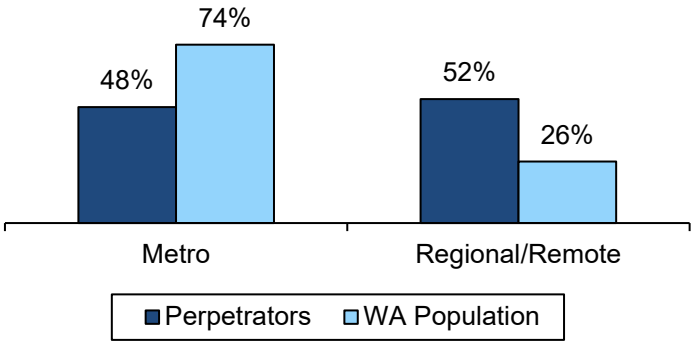
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the 12 years from 1 July 2012 to 30 June 2024 were over-represented with 46% of perpetrators (where Aboriginal status was recorded in information provided to this Office) being Aboriginal compared to 3.5% in the population.

In 38 of the 40 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location



Perpetrators by Location Compared to WA Population

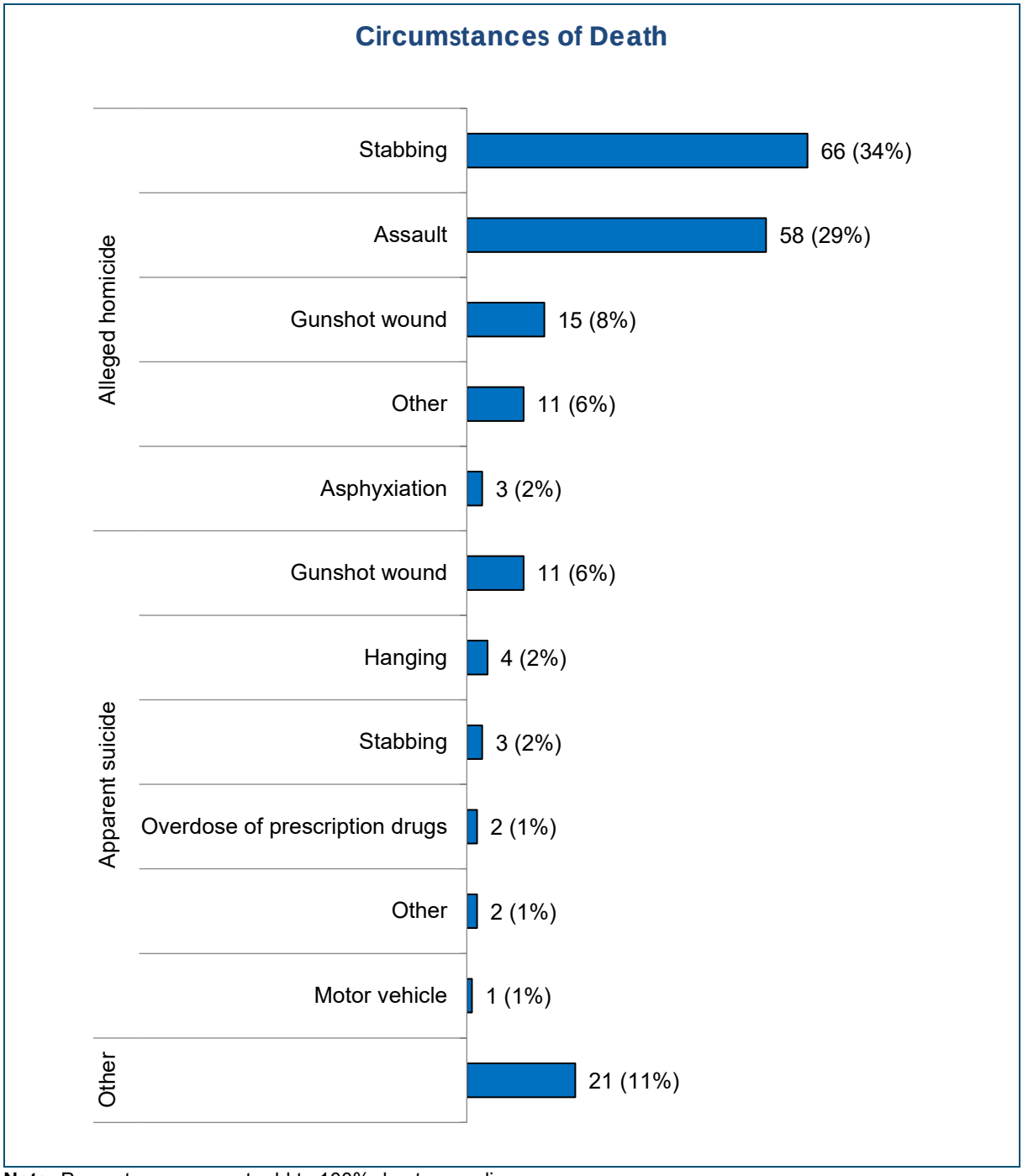


Compared to the Western Australian population, of the 89 fatalities from 1 July 2012 to 30 June 2024 for which coronial and criminal proceedings were finalised, regional or remote locations were over-represented, with 52% of the fatal incidents occurring in regional or remote locations compared to 26% of the population living in those locations.

Circumstances in which family and domestic violence fatalities have occurred

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

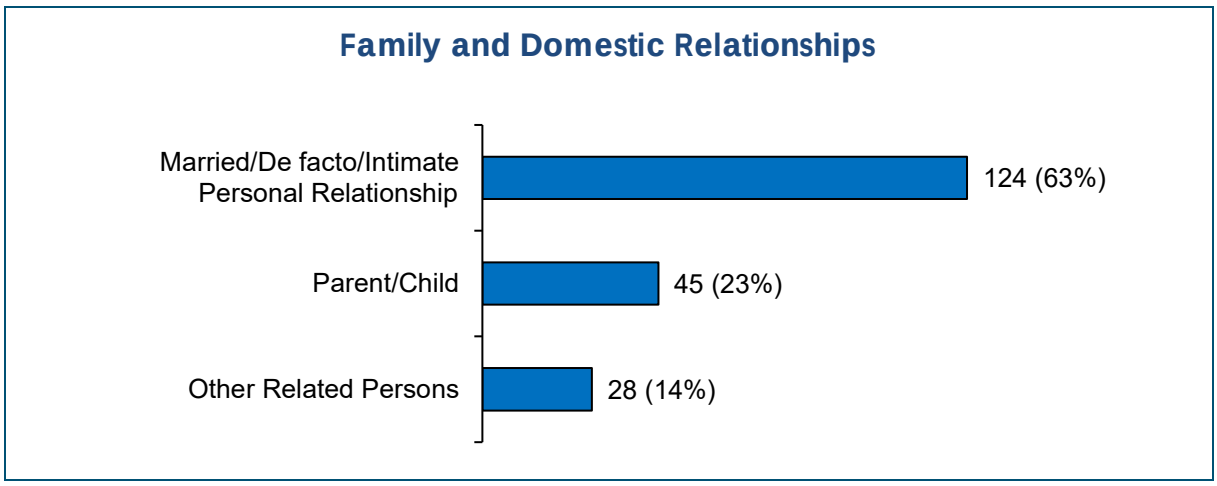
The following chart shows the circumstance of death as categorised by the Ombudsman for the 197 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2024.



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

Family and domestic relationships

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



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

Of the 197 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2024:

- 124 fatalities (63%) involved a married, de facto or intimate personal relationship, of which there were 100 alleged homicides, 17 apparent suicides and seven in other circumstances. The 124 fatalities included 24 deaths that occurred in 12 cases of alleged homicide/suicide and, in all 12 cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. Of the other five apparent suicides, four involved males and one involved a female. Of the remaining 88 alleged homicides, 63 (72%) of the people who died were female and 25 (28%) were male;
- 45 fatalities (23%) involved a relationship between a parent and adult child, of which there were 27 alleged homicides, six apparent suicides and 12 in other circumstances. Of the 27 alleged homicides, 12 (44%) of the people who died were female and 15 (66%) 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 28 people who died (14%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, 10 (36%) were female and 18 (64%) were male.

Issues Identified in Family and Domestic Violence Fatality Reviews

Having undertaken reviews of family and domestic violence fatalities since 1 July 2012, this Office has identified learnings for system improvements in how key stakeholder agencies work to promote the safety and wellbeing of women and children. The following issues reflect some of the common and current identified patterns and trends in these reviews:

- Beyond the limited legislated responsibilities relating specifically to family and domestic violence (ie the *Restraining Orders Act 1997* and *Criminal Code*) agencies develop policy and procedures in accordance with their commitment to National and State family and domestic violence strategies. While the intent is to promote perpetrator accountability and behaviour change, and victim safety, there is opportunity for improvement in agency implementation and facilitation of these policies. This Office has identified that competing demands across agencies can impact on policy compliance.
- Many key stakeholder agencies and community services are involved in the lives of the perpetrator and victim in the months leading up to the fatality. Reviews by this Office have identified a need for increased, timely information sharing and collaborative safety planning.
- Working with families in a culturally safe and responsive manner is critical. Common findings across reviews undertaken by this Office are the need for increased use of interpreters, improved mapping of cultural background and connections, an integrated trauma informed approach, and accessing expert consultation for assessment and safety planning that incorporates culturally aligned strategies.
- The nexus between family and domestic violence, drug and alcohol use, and/or mental health issues is prevalent in the fatalities reviewed by this Office. Findings indicate a need for improved understanding by agencies in working with these coexisting challenges, and increased pathways for effective treatment programs.

Often, agencies are working to address the issues identified in our reviews, and this Office will monitor the progression of this work and outcomes. The Ombudsman will also make recommendations to facilitate improvement in these areas and will track agency implementation of these recommendations and their impact in preventing or reducing the risk of future child deaths in similar circumstances.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following two recommendations were made by the Ombudsman in 2023-24 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. The WA Police Force provides a copy of the Family Violence Division's Regional District Health Check to this Office along with setting out any further actions that are required to ensure District compliance with family and domestic violence (**FDV**) practice requirements.

2. That the WA Police Force provides the Ombudsman with a copy of the Internal Investigation report, once completed, in relation to its response to protect Ms A's safety from 9 October 2021 to 24 October 2021.

The Ombudsman's *Annual Report 2024-25* will report on the steps taken to give effect to the six recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2022-23. The Ombudsman's *Annual Report 2025-2*6 will report on the steps taken to give effect to the two recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2023-24.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2021-22

The Ombudsman made one recommendation about ways to prevent or reduce family and domestic violence fatalities in 2021-22. The Office has requested that the relevant public authorities notify the Ombudsman regarding:

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

Recommendation 1: The WA Police Force provides a report to the Ombudsman by 1 October 2022 on the progress of discussions with the 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.

Steps taken to give effect to the recommendation

Through the Ombudsman's FDV fatality reviews, we have identified that when perpetrators of violence are being supervised on community-based orders, the Department of Justice is not always aware of contact the perpetrator may have with WA Police Force. This Office is of the view that improved information sharing would provide the Department of Justice with the timely opportunity to address perpetrator accountability through supervision of persons on community orders.

The WA Police Force provided this Office with a letter dated 21 September 2022, in which WA Police Force relevantly informed this Office that:

> The WA Police Force Family Violence Division has opened discussion with the Department of Justice (Adult Community Corrections) to create a working group whereby the type of information to be shared will be determined, any legal preclusions identified, and identified and technical solutions proposed to enable efficient and timely exchange.
>
> …
>
> On the 14 July 2022, an executive meeting was conducted and an agreement was reached to progress a working group to explore opportunities for improved information sharing for family violence interactions…
>
> Three subgroups are now being formed which include Business, Legal and Technical Advisory Groups to provide recommendations enabling the working group to reach agreement and resolve any identified issues that may hinder the realisation of an effective information sharing process.

This Office requested that WA Police Force inform the Office of any further information on the steps taken to give effect to the recommendation. In response, WA Police Force provided a letter to this Office dated 12 March 2024, in which the WA Police Force relevantly informed this Office that:

> The WA Police Force has established an information sharing working group with the DOJ to identify and resolve issues impacting information sharing access.
>
> An outcome from the group has led to the establishment of an expansion of DOJ's access to WA Police Force Systems with 70 additional Adult Community Correction (ACC) employees provided access to the WA Police Force Incident Management System (IMS) to proactively access pertinent data on Family Violence Incident Reports (FVIR).
>
> The WA Police Force provides DOJ with a daily report pertaining to family violence incidents that may be cross referenced by DOJ to identify any individuals subject to a DOJ order.

This Office is monitoring the effectiveness of this action, and the capacity of DOJ to use this IMS access to identify WA Police Force contact when supervising family and domestic violence perpetrators in the community, in current family and domestic violence fatality reviews.

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 2023-24, timely review processes have resulted in 62% of all reviews being completed within six months and 69% 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.

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

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

Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

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

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through working with public authorities and communities where individuals may be at risk of family and domestic violence to consider safety issues and potential areas for improvement, and to highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information, where appropriate, with other accountability and oversight agencies including Ombudsmen and family and domestic violence fatality review bodies in other States to facilitate consistent approaches and shared learning;
- Engaging with other family and domestic violence fatality review bodies in Australia through membership of the Australian Domestic and Family Violence Death Review Network (**the Network**). The Network worked in partnership with the Australia's National Research Organisation for Women's Safety (**ANROWS**) to publish the report Filicides in a domestic violence and family context 2010-2018 (First Edition 2024);
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

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

Key stakeholder relationships

There are a number of public authorities and other bodies that interact with, or deliver services to, those who are at risk of family and domestic violence or who have experienced family and domestic violence. Important stakeholders, with which the Office liaised as part of the family and domestic violence fatality review function in 2023-24, included:

- The Coroner;
- Relevant public authorities including:
  - WA Police Force
  - Health Service Providers
  - The Department of Justice
  - The Department of Communities;
- The Centre for Women's Safety and Wellbeing and relevant non-government organisations; and
- Research institutions including universities.