Preventing Harm

We have important functions to prevent child related harm.

Image credit: Shutterstock

Reportable Conduct Scheme – child focussed oversight

Trauma Warning/Reader Advisory

This report contains descriptions and discussions of child abuse, including sexual abuse, neglect and institutional harm. These accounts may be distressing or triggering for some readers, particularly those with lived experience of trauma.

We acknowledge the courage of victim survivors and the profound impact of abuse. If you feel overwhelmed or need support at any point, please consider reaching out to a trusted support service or mental health professional.

If you need support, you can contact one of the following services:

- Lifeline: 13 11 14
- 1800RESPECT (24/7 national sexual assault, domestic and family violence counselling service): 1800 737 732
- Blue Knot Foundation (support for adult survivors of childhood trauma): 1300 657 380
- Beyond Blue: 1300 22 4636
- Kids Helpline (for 5 to 25 year-olds): 1800 55 1800
- 13YARN (for Aboriginal and Torres Strait Islander people): 13 92 76

Acknowledgement of victim survivors

We acknowledge victim survivors of sexual abuse which has occurred within organisational settings in Western Australia. We share the responsibility to demand the changes necessary to safeguard children and young people today and for generations to come, and we approach this task with commitment, compassion, and hope.

Playing our part in Keeping Kids Safe

Our objective is to promote the safety of children, prevent child abuse and ensure organisations respond appropriately to allegations of child abuse. We are responsible for administering the Reportable Conduct Scheme (Scheme) in Western Australia. The Scheme covers over 4,000 organisations across the state, including in regional and remote areas. The complex nature of the Scheme means that the capacity of organisations to implement relevant policy and procedures varies enormously.

The Scheme

We provide external oversight of organisations who notify us of 'reportable conduct' (allegations of harm against children and young people by their employees).

The protection of children is the paramount consideration and informs all aspect of our oversight role.

In administering the Scheme, we:

- assess for compliance and risk in the initial notifications, including by providing guidance on the risk-management responses of an organisation;
- monitor, oversee and review an organisation's investigation into a reportable conduct allegations and where appropriate make recommendations to improve processes and responses; and
- notify the Director General of the Department of Communities (Working With Children Screening Unit) of a substantiated finding of reportable conduct.

Our approach to oversight

Our oversight role is designed to support and reinforce the implementation of good practices in organisations. Whilst our role includes ensuring organisations meet their legislative requirements, we take a skills-based approach and play an active role in education and outreach for organisations.

Risk-based lens

Our approach to administering the Scheme is grounded in risk-based principles that prioritise proportionality, responsiveness and efficient use of our finite resources. This risk-based lens guides all discretionary decision making within the oversight of the Scheme. This method enables us to target our resources effectively – supporting systemic and cultural change, safeguarding vulnerable children and upholding robust standards of administrative practice.

The Ombudsman's report, 'Western Australia's Reportable Conduct Scheme: A review of systems to protect children', highlighted that only 39.3% of organisations had implemented all required systems to identify and deal with reportable conduct.

Read more in the Major Investigations section of this report.

CASE STUDY

Reportable Conduct Scheme detects repeat alleged offender

An individual had substantiated allegations of child abuse made against them in two separate remote communities. The individual was first found to have engaged in reportable conduct during 2022, before the Reportable Conduct Scheme commenced. A second investigation into the individual was underway in late 2023, after the Scheme was operational, and we were notified by the employer organisation.

We immediately recognised the individual had prior findings against them. As the Scheme was designed, we can link separate incidents of sub-criminal behaviours committed by the same individual in a central database.

The outcome of the 2023 investigation by the employer organisation was a reprimand and order to undertake improvement action.

The individual moved from the remote community to a new location about 450km away, and to a different employer.

In late 2024, we were notified about new allegations against the individual in the new location. We identified the prior reportable conduct and the investigation involving the individual. This information was not available to the organisation at which individual was employed.

The employer organisation issued the individual with reprimands, and they had their registration revoked due to substantiated findings which demonstrated a pattern of behaviour. We also referred the matter to the Working with Children Screening Unit for review of the individual's Working With Children assessment.

During both investigations involving our office, the WA Police Force were advised of the allegations and evidence, but their cases were closed without charge as the behaviour did not meet the elements of a criminal offence. Without the Reportable Conduct Scheme, the individual's behaviour may have gone formally unrecorded, and a pattern of behaviour would not have been established.

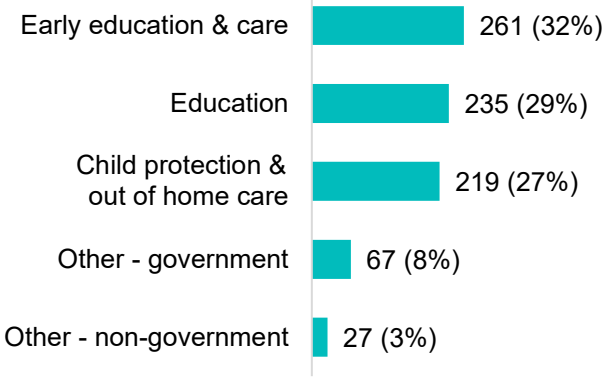
We played a vital role in ensuring the investigation was conducted thoroughly and quickly, and, by linking previous findings to the individual, was able to demonstrate a concerning pattern of behaviour. We were also able to refer the matter to the Working with Children Screening Unit for further investigation. This demonstrates the vital role of the Scheme in WA and our work in keeping kids safe.

Notifications received

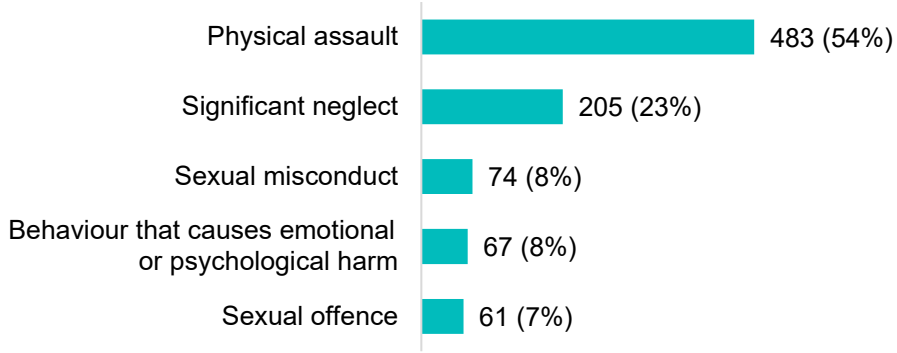
We received 877 notifications in 2024-25. Of these, 68 we determined to be outside our jurisdiction.

The following data relates to the **809 notifications** that were considered within our jurisdiction.

Sectors

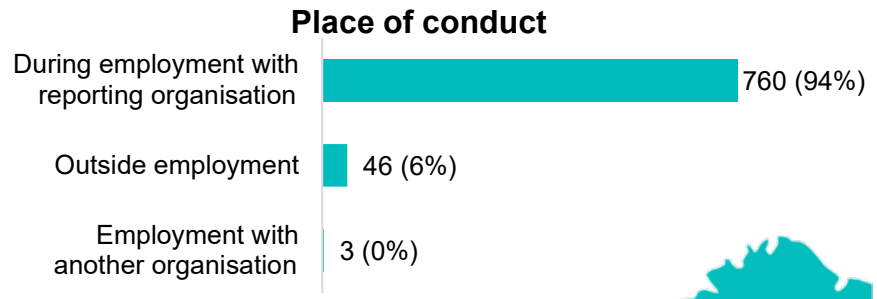


Conduct types



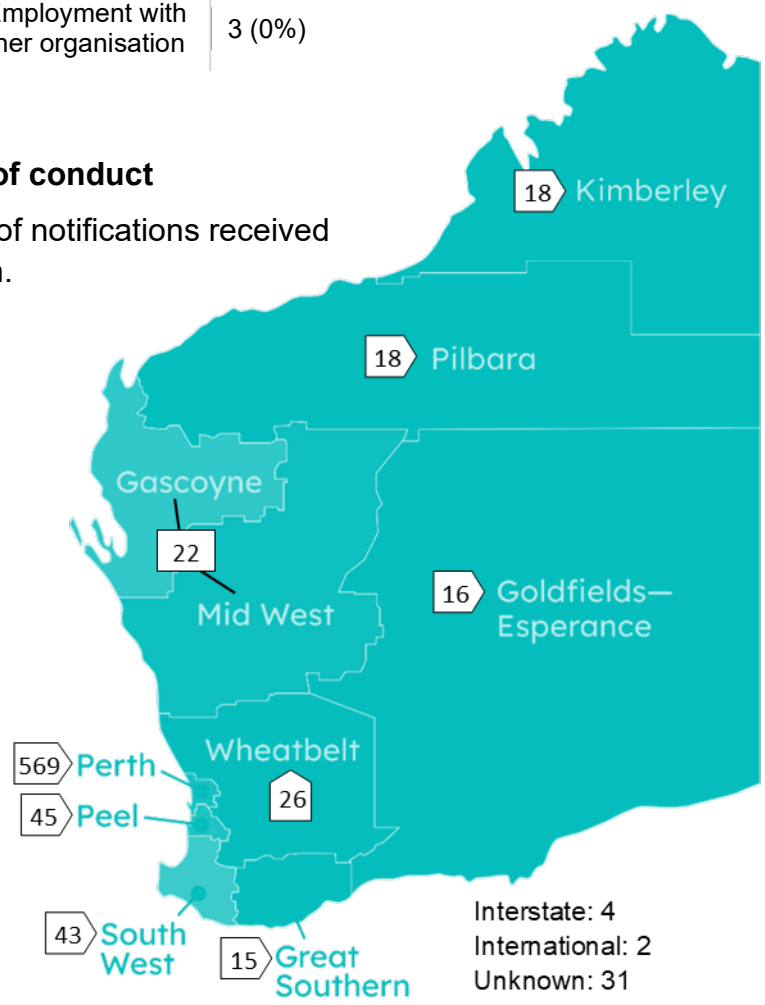
A further breakdown of this data is provided in Appendix 3.

Place of conduct



Region of conduct

Number of notifications received by region.



Education and outreach snapshot

We have a role to educate and provide advice to organisations, including by supporting them to make continuous improvement in the identification and prevention of reportable conduct.

We also play a part in guiding organisation as they build robust internal reporting mechanisms and policies that support a culture of child safety.

Over 4,000 organisations fall within the jurisdiction of the Scheme, and many of these organisations operate in remote and regional areas. Our education and outreach functions have taken us far and wide, from the Pilbara region, including Jigalong community and Newman, to the Goldfields region and Kalgoorlie, all the way to Albany in the Great Southern.

In 2024-25, our outreach events and engagements have been a combination of face-to-face workshops, online webinars, direct organisation contacts via phone or in person and information sessions for a sector or individual organisation. We have been listening to feedback from outreach event participants, and from organisations in regional areas. In the 2025-26 year we look forward to expanding and improving our outreach efforts by engaging further with sector peak bodies, regional communities and Aboriginal Community Controlled Organisations, as well as reviewing the types and accessibility of our online resources.

Total events: 53 (16 regional)

- Information sessions: 39
- Workshops: 10
- Co-hosted forums: 4

Organisations reached: 360

Individuals reached: 980

(estimated, as some organisations and individuals may have attended multiple events)

> "The training was excellent … the case study was very relevant and helped the learning process. The handouts were very useful and much appreciated. It was such an interesting morning and I really appreciate your commitment to support local government toward a greater understanding of reportable conduct and investigations"
>
> (Local Government participant)

> "It was very good and covered everything that I needed to know with good practical examples"
>
> (Local Government participant)

Education Materials

In mid-2024, we determined that different types of resources were needed for organisations that had commenced undertaking reportable conduct investigations and needed more support in meeting the legislative requirements of the Scheme, which are at times 'technical' and nuanced.

Accordingly, we developed templates for organisations to adapt and use in their own investigations and communications. These templates simplify the legal requirements and allow organisations to focus their energies on conducting robust investigations and managing risk.

497
enquiries resolved by our dedicated Enquiry Line

21
resources published on our website.

Systems wide changes

We not only assess the responses of organisations to individual allegations of reportable conduct but also examine the broader systems and policies of an organisation for reporting, responding and preventing child abuse. The review of these systems may result in administrative improvements, which we then record and monitor. This is a powerful part of the Reportable Conduct Scheme as it enshrines cultural change within organisations, and ensures robust policies and reporting, which provides the best possible environment for child safety.

In 2024-25, there were 238 improvement actions made by organisations as a result of our involvement.

CASE STUDY

Powerful stories of cultural change

A religious organisation investigated an employee for allegations of sexual misconduct. The misconduct included grooming behaviours outside of service hours and sometimes using social media. At the end of the investigation, we alerted the religious organisation to the lack of internal policies to deal with such allegations in the future.

The religious organisation reviewed their policies and made the following changes:

- developed and implemented a social media policy to deal with the growing complexity of online engagement by staff and youth;
- undertook an organisation wide Child Safety Self-Assessment; and
- ensured that at all team meetings there is a mandatory discussion of child safety, including debriefing of incidents, practical scenarios and discussions on how child safety is part of everyday practice.

CASE STUDY

Regional not-for-profit children's service improves systems to protect children

> "We've protected our children and we've protected future children because [the subject of allegation is] now a flagged person"

This is how Anita[2], the Director of a regional not-for-profit children's service, described the impact of her organisation's recent reportable conduct investigation. We sat down with Anita to understand the organisational development journey that her and the organisation went on during their first reportable conduct investigation.

Anita first learned about the Reportable Conduct Scheme (Scheme) through the organisation's child protection policy when she commenced an investigation into physical assault allegations by an employee against children in the organisation's care.

While Anita experienced the notification process as being straightforward, challenges arose in the investigation because of unfamiliarity with the Scheme, limited corporate support as the organisation was small and the management committee were volunteers, personnel changes and managing conflicts of interest arising from the service's place in a tight-knit regional community.

To navigate the organisation's engagement with the Scheme, Anita and the management committee drew on multiple support options from the Ombudsman's office. Prior to notifying us of the reportable allegations, Anita read information about the Scheme on our website. She contacted the Reportable Conduct Enquiry Line for further advice. After making her organisation's notification, Anita regularly engaged our investigation officer who provided feedback on processes to strengthen the organisation's compliance with the Scheme. Anita also used our template documents, describing them as 'the biggest support' enabling the organisation to efficiently and comprehensively meet procedural fairness obligations and complete their investigation.

> "It was good knowing it was a template that all we had to do was fill in the gaps… That was a really, really big help"

As the organisation's investigation continued, risks were reassessed, and risk management actions were revised. The employee, while initially subject to additional supervision, was suspended, and ultimately resigned. The outcome of the organisation's investigation substantiated reportable conduct by the employee.

Anita reflected that knowing that the Ombudsman may refer substantiated reportable conduct findings to the Working With Children Screening Unit was an important motivator to completing a thorough investigation. It cemented her understanding of the

[2] Name changed to protect confidentiality

value of the Scheme in keeping children safe.

> "All you're doing [through the reportable conduct investigation] is doing right by the children and if [the investigation] comes back that it didn't happen…[then] we've done our job. But … at the end of the day [the substantiated findings]… went to the Ombudsman, it went to Working With Children Screening Unit and … it's on record, so if it was to happen again … it would be flagged"

During our subsequent outreach visit to their town, Anita and her colleagues participated in a reportable conduct workshop. One of the highlights of the workshop for them was discovering there were even more resources available online to improve their understanding of the Scheme.

> "The tips and tricks, you know they're all coded on the website and its really easy if you follow them"

The organisation's engagement with the Scheme led them to take significant actions to strengthen child safety. This included all the voluntary management committee members and service management team undergoing human resources training to give them confidence to manage employee performance if future child safety concerns arise. The organisation also revised their child protection policy to clearly differentiate obligations related to child safety concerns arising from employee behaviour versus a child's own parents or carers. They also upgraded their CCTV system, purchasing new hardware to overcome the limitations of their current system which had not captured footage of the alleged incidents they had investigated.

However, the biggest shift was one of cultural change in the organisation. Anita described important attitudinal shifts towards valuing and trusting the voices of children and in employees and the importance of speaking up if they notice child safety issues.

> "[The employee who initially reported the allegations] was reassured you can speak up, it's okay [to be] protecting the children … I think it was just the awareness of speak up, it will be dealt with, it will be followed through…"

On a personal level, Anita reflected her confidence has increased to address any future reportable allegations.

> "I'd be heaps more confident now, I think I would know exactly what to do, I would know who I need to contact and what kind of information I would need to start with"

Anita's story reflects a positive evolution in organisational culture and capacity for improving child safety. This is a journey that we see repeated across many organisations engaged with the Scheme, and one we look forward to continuing to support through our capacity building focus.

Reviews of certain deaths

The following section discusses our work in reviewing the **deaths of children**, and **deaths that occur in the context of family and domestic violence**. These deaths are tragic, and we honour these lost lives in the work we do. We acknowledge their family, friends and community.

This information may cause distress for some people. If you need support, you can contact one of the following services:

- Lifeline: 13 11 14
- Beyond Blue: 1300 22 4636
- Kids Helpline: 1800 55 1800 (for 5 to 25 year-olds)
- 13YARN: 13 92 76 (for Aboriginal and Torres Strait Islander people).

What our death reviews are about

Learning from deaths are important to improve the way public sector agencies support vulnerable people in the community, and to prevent future deaths in similar circumstances.

We receive notifications of certain deaths that occur in Western Australia, and are responsible for undertaking reviews to identify opportunities for system improvements. The Ombudsman can then make recommendations to public authorities to improve how they support vulnerable children and family and domestic violence victims. We monitor the implementation of these recommendations, and their effectiveness, to confirm that our work is contributing to good outcomes.

Ultimately, our goal is to ensure that services respond more effectively to children and families at risk, so that preventable deaths can be avoided.

How do we work

When we receive a notification, we assess the available information to determine whether a review is needed. We consider factors such as:

- the circumstances in which the death occurred. Examination of certain types of deaths (including suicide, homicide, residential pool drownings, and children experiencing neglect) may have greater potential for system learnings;
- whether the deceased, or their family, had pre-existing vulnerabilities (e.g. family violence, child protection, health issues) and associated contact with public authorities;
- whether the death is being reviewed by other mechanisms (e.g. Courts or medical review), and what the scope of that review would entail; and
- was the death potentially preventable and is there opportunity to learn from the death and influence system change.

When we undertake a review, we examine the actions of public authorities involved in the months leading up to the death. We also look at patterns across

multiple deaths to highlight systemic issues and guide future investigations.

The main agencies we work with, to consider their decisions and actions, are Western Australia Police Force, Department of Health and other public health services, Department of Communities (Child Protection), Department of Justice, and the Department of Education. We identify whether there were missed opportunities or gaps in service provision, and the barriers to good practice. We consult with agencies to verify our findings.

Our work is about determining system issues and not blaming individuals. The review is not a public process like a court hearing, and families of the deceased are not involved. We take great care to maintain confidentiality of individuals throughout our process. We report publicly on our de-identified review findings, themes and recommendations.

We also collate demographic and environmental data on each death. We make sure this data is accurate and stored securely so that we can analyse and report on this data.

Reporting on child deaths and family and domestic violence fatalities

In the past, summary data and review findings were included in the Ombudsman WA Annual Report. To better inform public understanding, and to guide policy development and service delivery, we intend to improve our reporting.

We intend to issue a separate 'Family and Domestic Violence Fatality Review' report in December 2025. This report will examine patterns and provide data on Western Australian family and domestic violence fatalities and key findings from our death reviews. Importantly, this report will also include findings from our current investigation into the operation of Family and Domestic Violence Response Teams.

The first 'Child Death Review' report is intended for release in 2026.

We are developing a future reporting plan that will make our work more accessible for researchers, through the release of one-off publications on review themes supported by data analysis and a more accessible Ombudsman WA website. We will be working with relevant community stakeholders to inform the development of this reporting plan.

Notification of WA child deaths

We receive notification of all deaths of children and young people, up to 18 years of age, in Western Australia. In 2024-25, we were informed of the deaths of 161 children and young people.

We identify if there have been concerns for the safety and wellbeing of the deceased child, or a child relative, reported to the Department of Communities (as the State's child protection agency) in the two years before the death occurred. Or, whether they had been in the care of the Department of Communities.

In 2024-25, of the 161 child death notifications received, 59 children (or their child relative) had contact with the Department of Communities for child protection reasons in the two years prior to the death.

Table 1 contains the number of child deaths notified in the past five years.

Of the 161 child death notifications received in 2024-25, after an initial assessment, it was determined that 61 required further review. Of these 61 reviews, 31 were finalised after a simple review process in 2024-25. Thirty-six child death notifications received in 2024-25 were progressed for more complex review.

We closed 157 child death reviews in 2024-25. Of these, 113 had been notifications received in 2024-25. A further 44 child death reviews closed in 2024-25 had been notified in previous years.

Table 1. Number of child deaths notified in the last 5 years

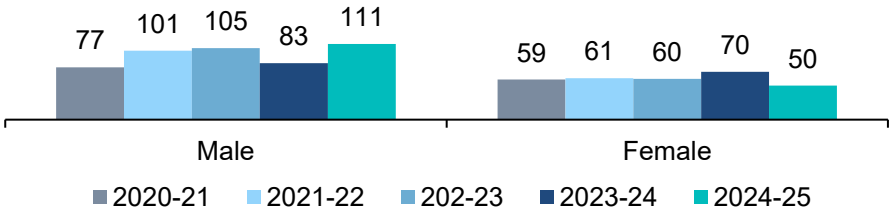
Year	Contact with Department of Communities (child protection) in two years prior to death	No Department of Communities (child protection) contact in two years prior to death	Total notified child deaths
2020-2021	50	86	136
2021-2022	47	115	162
2022-2023	63	102	165
2023-2024	47	106	153
2024-2025	59	102	161

Note: This table relates to the date the death was first notified to the Ombudsman, not the actual date of death. Due to a lag in death registration and the notification of relevant death data, the number of death notifications typically increases for the most recent reporting year.
In the 2023–2024 Annual Report, data reflected that 139 child deaths were notified. As additional data was processed in 2024–2025, this figure was updated to 153 child deaths notified for 2023–2024.

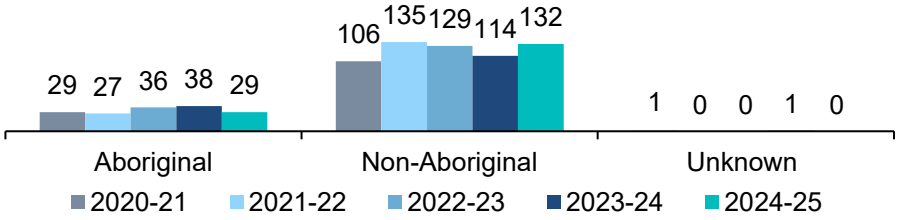
Characteristics of children who died

The charts on this page show the characteristics of the child deaths notified to us in 2024-25. Note that this information is based on the date notified to us, not the date of death. Data in future reports may vary as more information becomes available.

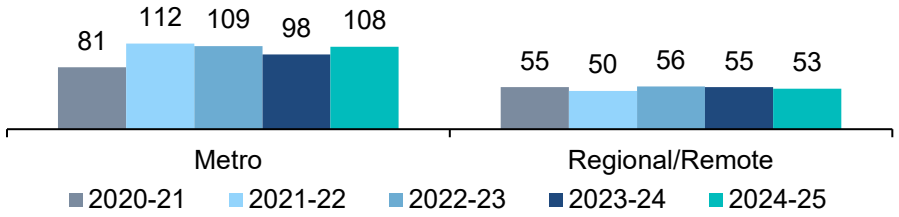
Child death notification by sex



Child death notifications by Aboriginal[3] status



Child death notifications by location



Child death notifications by age

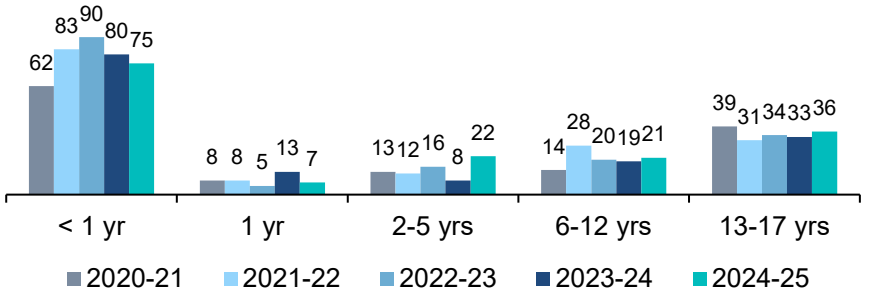


Table 2. Circumstances of child deaths in the last 5 years

	2020-21	2021-22	2022-23	2023-24	2024-25
Illness or medical condition	76	116	103	98	96
Sudden, unexpected death of an infant	13	7	24	16	22
Motor vehicle accident	19	15	8	13	16
Suicide	19	9	13	11	14
Accident other than motor vehicle	2	5	7	5	2
Drowning	2	5	4	6	4
Alleged homicide	3	5	5	2	0
Other	2	0	1	2	7
Total	**136**	**162**	**165**	**153**	**161**

[3] The use of 'Aboriginal' in this chart includes children who are Torres Strait Islander and children who are both Aboriginal and Torres Strait Islander.

Notification of WA family and domestic violence fatalities

We receive notifications of all suspected family and domestic violence homicides in WA. This may include:

- where a person is killed by a current or former intimate partner;
- where a person is killed by a non-intimate family member (including Aboriginal kinship relationships) or someone with which they reside; or
- where there is no intimate or familial relationship, but the death occurs in the context of family and domestic violence, such as where a bystander is killed intervening in a family and domestic violence incident.

Our family and domestic violence fatality reviews include all deceased, where they are 18 years of age and older. Where the deceased victim of a family and domestic violence fatality is younger than 18 years, they have been included as a child death notification.

In 2024-25, we were informed of 14 suspected family and domestic violence homicides. Nine involved suspected intimate partner homicide, four involved a familial relationship, and the remaining notification was a fatality involving housemates.

Table 3 contains the number of family and domestic violence deaths notified in the past five years.

Table 3. Number of FDV deaths notified in the last 5 years

Year	Suspected intimate partner homicide	Suspected non-intimate familial homicide	In FDV context	Total notified deaths
2020-21	3	6	1	10
2021-22	4	2	-	6
2022-23	11	2	1	14
2023-24	11	11	-	22
2024-25	9	5	-	14

In this five-year period, we also received notification of 11 people who had died by suicide after having killed an intimate partner or family member, and four people who had died by suicide directly in the context of an FDV incident where no one else was killed.

Of the 14 family and domestic violence fatality notifications received in 2024-25, after an initial assessment, it was determined that 12 required further review. Of these 12 reviews, one was finalised in 2024-25. Eleven family and domestic violence fatality notifications received in 2024-25 were progressed for more complex review.

We closed 14 family and domestic violence fatality reviews in 2024-25. Of these, three had been notifications received in 2024-25. A further 11 family and domestic violence fatality reviews closed in 2024-25 had been notified in previous years.

Family and domestic violence and suicide

We are not notified of all suicides, where family and domestic violence may have been a contributing factor. However, we acknowledge that family and domestic violence is potentially a significant contributing factor to many suicides. To identify learnings from such deaths, we examined the background of family and domestic violence in all suicides that occurred over a one-year-period. In 2022, we published our report 'Investigation into family and domestic violence and suicide'.

Major themes and learnings

Across both child death and family and domestic violence fatality reviews, we commonly identify, and have made recommendations on:

- the barriers to compliance with agency policy and practice requirements, resulting in missed opportunities to effectively intervene earlier. The need to improve staff training and address workforce issues, to provide oversight to critical decision-making, and to develop appropriate service pathways for vulnerable children and adults.
- a need for improved assessment of risk and safety planning for vulnerable people.
- missed opportunities for information sharing, and coordination of a service response, between agencies.
- an overrepresentation of Aboriginal people in deaths, and the need for improvement in culturally responsive and safe interventions.
- high rates of preventable deaths occurring in the context of alcohol and drug abuse, and mental health issues, highlighting the importance of expertise in intervention and the need for integrated service delivery pathways.
- an overrepresentation of deaths occurring in regional WA, highlighting the need for improved equity in service delivery across the State.

Our reviews highlight the value of strong frontline services backed by clear policies, staff training, and effective oversight mechanisms.

We commonly identify missed opportunities for information sharing, and coordination of a service response, between agencies.

Our achievements

In 2024-25 we made six recommendations to agencies to improve how they support vulnerable children and family and domestic violence victims, and to prevent or reduce the risk of future deaths in similar circumstances.

The following two case studies provide examples of the work we do. More details of these review findings, and the impact of recommendation implementation and outcomes, will be provided in future separate reporting on child death and family and domestic violence fatality reviews.

As a member of the Australian Domestic and Family Violence Death Review Network, and in partnership with Australia's National Research Organisation for Women's Safety (ANROWS), we have contributed to the national understanding of family and domestic violence through landmark research.

Most recently, we provided WA data and collaborated on the joint publication 'Australian Domestic and Family Violence Death Review Network data report: Filicides in a domestic and family violence context 2010-2018' which was released in July 2024.

We commenced an investigation into the operation and function of the DSVFR programme. We have collated data from 400 episodes of contact, and will be reporting on our findings later in 2025.

As a member of the Australian and New Zealand Child Death Review & Prevention Group, and in partnership with the Australian Institute of Health and Wellbeing, we have collaborated on work to progress national data reporting.

CASE STUDIES

Child Death Review – recommendation to improve interagency coordination for children and young people at risk

Children and young people who have disengaged from school, and cannot be located by the Department of Education, are placed on a Student whose Whereabouts is Unknown list (the SWU List). In some circumstances, these children and young people may be experiencing difficult life circumstances and be at risk of harm, including suicide or death by misadventure. Through our child death reviews, we have identified that while these individuals are on the SWU List, they may have contact with other agencies. It is important that updated contact details are then shared with the Department of Education to create an opportunity to re-engage the individual in school and to provide supports to improve their safety and wellbeing.

In 2024-25, we examined the Department of Communities' processes relating to the SWU List. We identified there was opportunity to improve these processes, to facilitate timely information sharing to re-engage these children and young people with education supports. We recommended that the Department of Communities pilots a way of reviewing the SWU List and improving coordination with the Department of Education.

The Department of Communities undertook an initial pilot, and reported back that between July and October 2024, the Department of Communities was able to provide the Department of Education with updated contact details for 17 children and young people whose names had been placed on the SWU List in that time. The Department of Communities reported that further work was being undertaken to improve this process for interagency information sharing. We will continue to monitor the outcomes of this work, and its effectiveness in promoting safety and wellbeing.

Family and Domestic Violence Fatality Review – commencement of an investigation into the operation and functioning of the Family and Domestic Violence Response Team (FDVRT) model

The FDVRT model was established in 2013, as a partnership between the Department of Communities, WA Police Force and contracted Coordinated Response Services. FDVRTs are based in 17 districts across WA and provide a risk assessment following a police callout for family and domestic violence. FDVRTs then manage the risk levels through safety planning or referral to support services as needed. The FDVRT model aims to improve the safety of child and adult victims through timely, early and coordinated intervention. It also works to hold perpetrators of family and domestic violence to account, and to facilitate referrals and engagement with behaviour change services and programmes.

Through our reviews, we identified patterns and themes which indicated potential systemic issues for improvement in relation to the FDVRT operation and functioning, including:

- compliance with FDVRT Operating Procedures, use of the approved risk assessment tool (CRARMF) and instigation of Multi Agency Case Management where the level of risk from family and domestic violence is assessed high;

- data collation to inform enhancing the FDVRT model and service provision;
- use of culturally informed practice and culturally safe risk assessment tools when working with Aboriginal families;
- successful follow-up to safety planning actions identified by the FDVRT;
- appropriate child protection responses for children, both as witnesses and victims of family and domestic violence;
- equity in FDVRT resourcing, service provision and capability for regional districts;
- information sharing within FDVRT partner agencies, as well as with other relevant government and community sector agencies; and
- critical consideration of prior FDVRT involvement where families were repeatedly triaged and safety plans did not work as intended.

These findings have been shared with the Department of Communities and WA Police Force, and in 2019 we recommended a formal evaluation of the FDVRT model be undertaken. Subsequently, an independent evaluation was completed and a report released in August 2020. The report made 40 recommendations to improve the FDVRT operation and functioning, including that there was an 'urgent and critical need for a focussed team to support and guide the FDVRTs with appropriate governance, monitoring and compliance processes'.

Since 2020, the Department of Communities and WA Police Force have done significant work to improve the FDVRT model. This has included the establishment of FDV Central within the Department of Communities to support the FDVRT model.

Subsequent reviews continue to identify issues relating to FDVRT intervention and in November 2024 we determined to undertake further investigation into the operation, functionality and effectiveness of the FDVRT model.

The findings of this investigation will be reported on later in 2025.