Family and Domestic Violence Fatality Review

On 1 July 2012, the Office commenced an important new function to review family and domestic violence fatalities. This section sets out the work of the Office in its first year of operation in relation to its family and domestic violence fatality review function. During the first year of operation of this new function, significant work has been undertaken to develop structures and processes to ensure the function is undertaken effectively and efficiently. Information on this work has been divided as follows:

- Background;
- The role of the Office in family and domestic violence fatality reviews;
- The family and domestic violence fatality review process;
- Notifications and reviews;
- Patterns and trends identified from family and domestic violence fatality reviews;
- Issues arising from family and domestic violence fatality reviews;
- Major own motion investigations;
- Other mechanisms to prevent or reduce family and domestic violence fatalities; and
- Stakeholder liaison.

It is important to note that the annual reporting of the work of the Office on its family and domestic violence fatality review function will, in a very similar manner to annual reporting of the child death review function undertaken by the Office, develop over future annual reports, in accordance with information identified from undertaking reviews over multiple years. This will include case studies and further information and analysis on underlying patterns and trends over time arising from family and domestic violence fatality reviews.

Additionally, in 2013-14 the Office will commence its first major own motion investigation into family and domestic violence fatalities to be tabled in Parliament in 2014. This own motion investigation, the first of a series of major own motion investigations to be undertaken by the Office as part of its family and domestic violence fatality review function, will comprehensively examine critical issues, patterns or trends arising from individual reviews of family and domestic violence fatalities undertaken by the Office.

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. The *WA Strategic Plan for Family and Domestic Violence 2009-13* (**WA Strategic Plan**) includes the following principles:

1. Family and domestic violence and abuse is a fundamental violation of human rights and will not be tolerated in any community or culture.
2. Preventing family and domestic violence and abuse is the responsibility of the whole community and requires a shared understanding that it must not be tolerated under any circumstance.
3. The safety and wellbeing of those affected by family and domestic violence and abuse will be the first priority of any response.
4. Perpetrators of family and domestic violence and abuse will be held accountable for their behaviour and acts that constitute a criminal offence will be dealt with accordingly.
5. Responses to family and domestic violence and abuse can be improved through the development of an all-inclusive approach in which responses are integrated and specifically designed to address safety and accountability.
6. An effective system will acknowledge that to achieve substantive equality, partnerships must be developed in consultation with specific communities of interest including people with a disability, people from diverse sexualities and/or gender, people from Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds.
7. Victims of family and domestic violence and abuse will not be held responsible for the perpetrator's behaviour.
8. Children have unique vulnerabilities in family and domestic violence situations, and all efforts must be made to protect them from short and long term harm.

The associated *Annual Action Plan 2009-10*, identified a range of strategies including a 'capacity to systematically review family and domestic violence deaths and improve the response system as a result'. The Annual Action Plan set out 10 key actions to progress the development and implementation of the integrated response in 2009-10, including the need to 'research models of operation for family and domestic violence fatality review committees to determine an appropriate model for Western Australia' (also see *Western Australia's Family and Domestic Violence Prevention Strategy to 2022*).

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.

Establishment of the Family and Domestic Violence Fatality Review Role

It was essential to the success of the establishment 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 was important that stakeholders understood the role of the Ombudsman, and the Office was able to understand the critical work of all key stakeholders.

Working arrangements were established to support implementation of the role with Western Australia Police (**WAPOL**) and the Department for Child Protection and Family Support (**DCPFS**) and with other agencies, such as the Department of Corrective Services (**DCS**) and the Department of the Attorney General (**DOTAG**), and relevant courts.

The Office's Child Death Review Advisory Panel was expanded to include the new family and domestic violence fatality review role. Through the Ombudsman's Advisory Panel (**the Panel**), and regular liaison with key stakeholders, the Office gains valuable information to ensure its review processes are timely, effective and efficient.

The Office has also accepted invitations to speak at relevant seminars and events to explain its role in regard to family and domestic violence fatality reviews, engaged with other family and domestic violence fatality review bodies in Australia and New Zealand and, since 1 July 2012, has met regularly via teleconference with the Australian Domestic and Family Violence Death Review Network.

The Role of the Office in Family and Domestic Violence Fatality Reviews

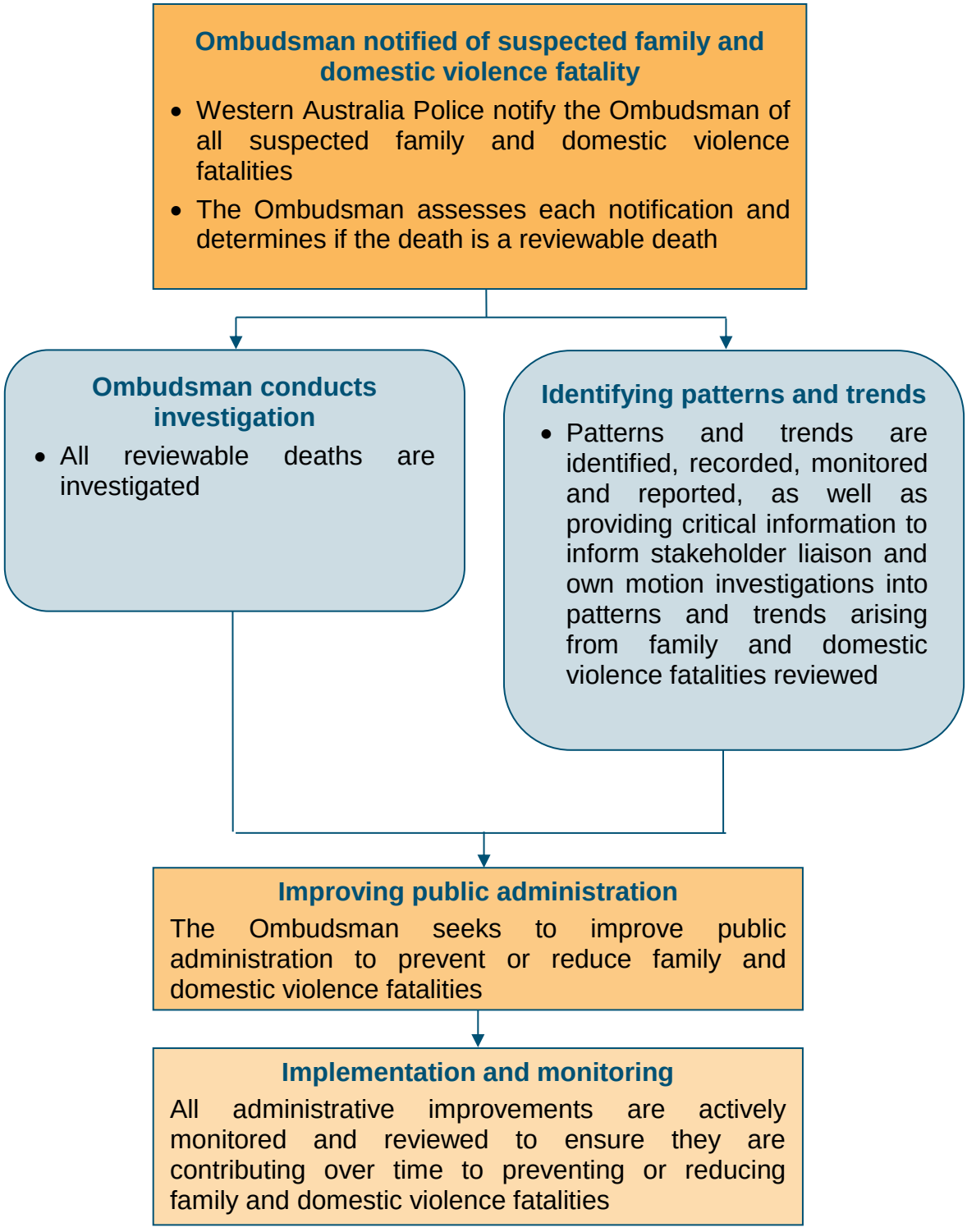
Overview

The Office reviews certain deaths suspected to have occurred in the context of family and domestic violence to:

- identify the circumstances in which and why a person died;
- identify patterns and trends arising from fatalities; and
- to improve public administration to prevent or reduce family and domestic violence fatalities.

Where WAPOL suspects that a fatality has arisen in circumstances of family and domestic violence, the fatality is reported to the Ombudsman who conducts a review pursuant to his own motion investigation powers.

The Family and Domestic Violence Fatality Review Process



Notifications and Reviews

Information in relation to those fatalities that are suspected by WAPOL to have occurred in circumstances of family and domestic violence are described in this report as family and domestic violence fatalities. For the purposes of this report the person who has died due to family and domestic violence will be referred to as 'the person who died'.

Upon the finalisation of Coronial and court proceedings, the Ombudsman can, and will, report upon the demographics, risk factors and social and environmental characteristics, patterns and trends of the perpetrators of family and domestic violence as part of this report.

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

WAPOL notify the Office of all suspected family and domestic violence fatalities. The notification provides the Ombudsman with information about the circumstances of the death together with any relevant information of prior WAPOL contact with the person who died.

The Ombudsman assesses all family and domestic violence fatality notifications to determine if the relationship between the deceased person and the suspected perpetrator is a family and domestic relationship, as defined by section 4 of the *Restraining Orders Act 1997*. More precisely, the Office considers whether the fatality involves persons apparently in a 'family and domestic relationship', being a relationship between two people:

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

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

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

(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;

(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, it is determined to be a reviewable death, and an investigation is conducted. The extent of an investigation 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 violence relationship with a 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 deceased person; 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.

Number of Family and Domestic Violence Fatality Notifications and Reviews

During 2012-13, there were 20 reviewable family and domestic violence fatalities from a total of 22 notifications.

Patterns and Trends Identified from Family and Domestic Violence Fatality Reviews

Important Information on Interpretation of Data

Information in this section is presented for the commencement year of the operation of the Ombudsman's family and domestic violence fatality review function. As the information in the following charts is based on one year of data only, very significant care should be undertaken in interpreting the data. In subsequent reporting years, information will be presented across multiple years and include analysis of underlying patterns and trends.

By examining family and domestic violence fatalities, the Ombudsman is able to capture data relating to demographics, risk factors and social and environmental characteristics and identify patterns and trends in relation to these deaths. When family and domestic violence fatality reviews are finalised, all relevant issues are identified and recorded and, over time, these issues indicate relevant patterns and trends in relation to family and domestic violence fatalities.

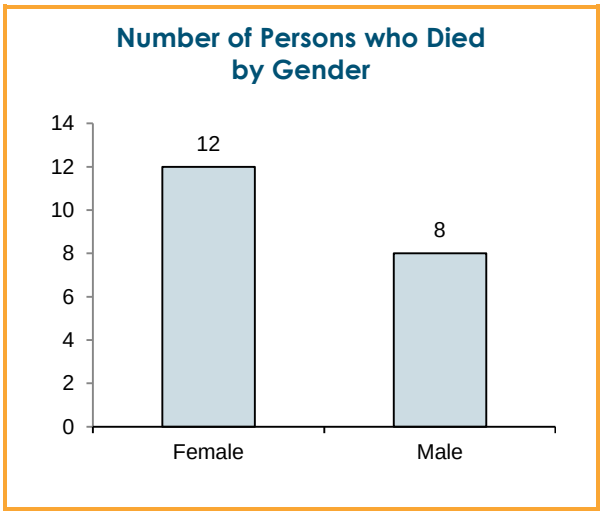
These patterns and trends are identified, recorded, monitored, reported and analysed. The patterns and trends also inform the Ombudsman's own motion investigations relating to family and domestic violence fatalities.

It is important to note that the Office, as part of undertaking its family and domestic violence fatality review function, will report information about demographics, risk factors, social and environmental characteristics and patterns and trends in relation to perpetrators of family and domestic violence following the finalisation of relevant Coronial and criminal proceedings.

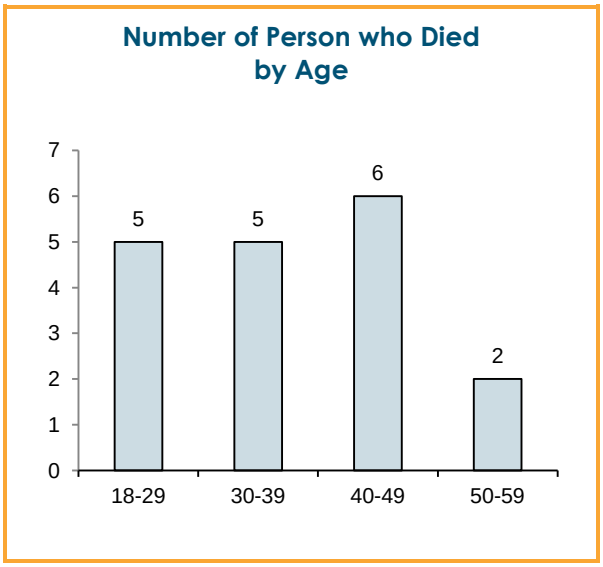
Characteristics of the persons who died

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

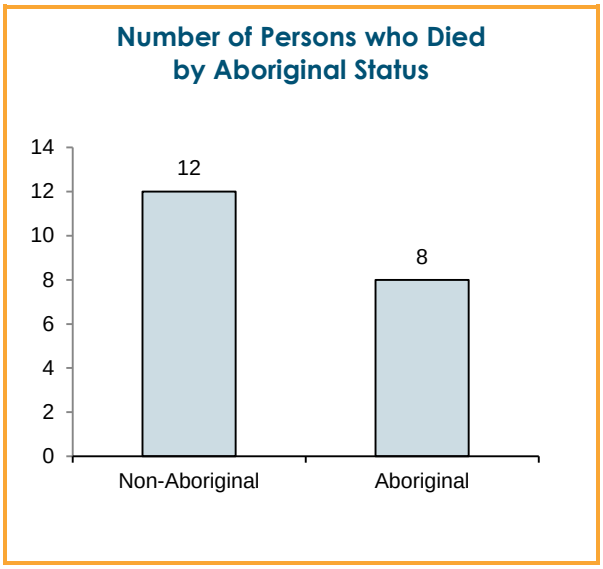
The following charts show characteristics for the persons who died for the 20 family and domestic violence fatality reviews in 2012-13.



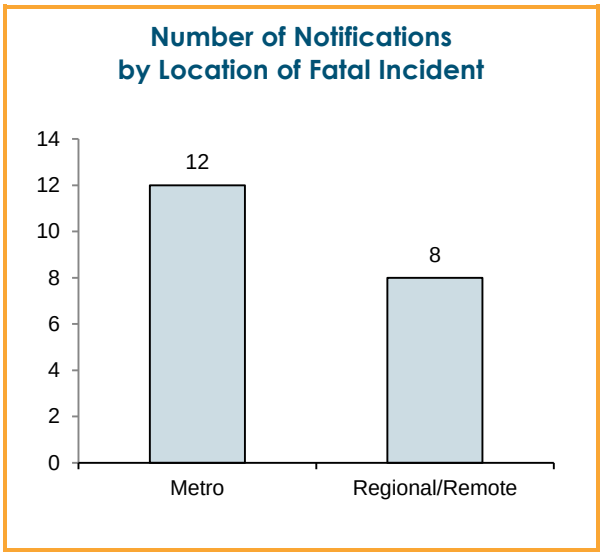
Compared to the Western Australian population, females who died were over-represented, with 60% of persons who died being female compared to 50% in the population.



Compared to the Western Australian adult population, the age group 40-49 is over-represented, with 30% of people who died in this age group compared to 19% in the population.



Compared to the Western Australian population, Aboriginal persons who died were over-represented, with 40% of persons who died being Aboriginal compared to 3.1% in the population.



Compared to the Western Australian population, incidents in regional locations were over-represented, with 40% of fatal incidents occurring in regional or remote locations compared to 27% of the population living in those locations.

The WA Strategic Plan notes that:

> *While there has been debate about the reliability of research that quantifies the incidence of family and domestic violence, there is general agreement that …*
>
> - *An overwhelming majority of people who experience family and domestic violence are women, and*
> - *Aboriginal women are more likely than non-Aboriginal women to be victims of family violence.*

More specifically, with respect to the impact on Aboriginal women in Western Australia, the WA Strategic Plan notes that:

> *Family and domestic violence is particularly acute in Aboriginal communities. In Western Australia, it is estimated that Aboriginal women are 45 times more likely to be the victim of family violence than non-Aboriginal women, accounting for almost 50 per cent of all victims.*

In 2012-13, the Office reviewed 20 family and domestic violence fatalities. From information provided by WAPOL as part of their notification of the fatality:

- 12 (or 60%) were females (compared with 50% of the Western Australian population);
- 8 (or 40%) of persons who died were identified as Aboriginal (compared to 3.1% of the Western Australian population); and
- 8 (or 40%) of family and domestic violence fatalities occurred in regional areas (compared to 27% of the Western Australian population living in regional areas).

In its work, the Office will place a focus on ways that government agencies can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration will also be given to issues relevant to regional and remote Western Australia.

Circumstances of Family and Domestic Violence Fatalities

Family and domestic violence fatality notifications received by the Ombudsman include 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.

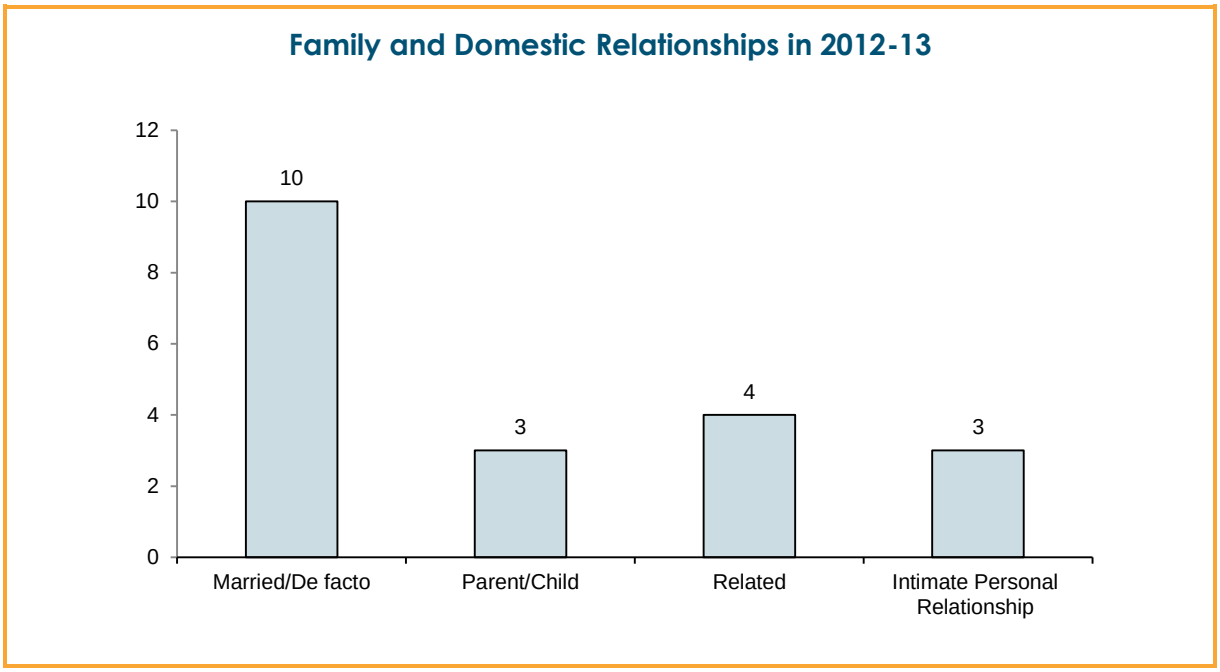
Family and domestic violence fatalities may occur through alleged homicide or apparent suicide and the circumstances of death are categorised by the Ombudsman as:

- Alleged homicide, including:
  - Stabbing;
  - Physical assault;
  - Gunshot wound;
  - Asphyxiation/suffocation;
  - Drowning; and
  - Other.
- Apparent suicide, including:
  - Overdose of prescription or other drugs;
  - Motor vehicle accident;
  - Hanging; and
  - Drowning.
- Other, including fatalities where it is not clear whether the circumstances of death are alleged homicide or apparent suicide.

The principal circumstances of death in 2012-13 were stabbing and physical assault.

Family and Domestic Relationships

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



Issues Identified in Family and Domestic Violence Fatalities

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.

- Management of people who are subject to Community Based Orders.
- Rehabilitation of people with a history of convictions for family and domestic violence and non-family and domestic violence offences.
- Identification and management of repeated alleged family and domestic violence incidents.
- Responses to breaches of Violence Restraining Orders.
- Multiple agency cooperation and collaboration in the management of responses to family and domestic violence.

Major Own Motion Investigations

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.

Details of own motion investigations are provided in the Own Motion Investigations and Administrative Improvement section.

In 2013-14, the Ombudsman will commence a major own motion investigation in relation to family and domestic violence fatalities.

Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

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

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through the Panel, and other mechanisms, working with public authorities and communities where individuals may be at risk of family and domestic violence to consider safety issues and potential areas for improvement, and to highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information, where appropriate, with other accountability and oversight agencies including Ombudsmen and family and domestic violence fatality review bodies in other States to facilitate consistent approaches and shared learning;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

Efficient and effective liaison has been established with WAPOL to develop and support the implementation of the family and domestic violence fatality notification process. Regular liaison occurs at senior officer level between the Office and WAPOL.

The Ombudsman's Advisory Panel

The Panel established for child death reviews has been expanded to provide independent advice to the Ombudsman on:

- Issues and trends that fall within the scope of the family and domestic violence fatality review function;
- Contemporary professional practice relating to the safety and wellbeing of people impacted by family and domestic violence; and
- Issues that impact on the capacity of public authorities to ensure the safety and wellbeing of individuals and families.

The Panel met four times in 2012-13 and during the year the following members provided a range of expertise:

- Professor Steve Allsop (Director, National Drug Research Institute, Curtin University);
- Ms Sue Ash (Chief Executive Officer, Uniting Care West);
- Professor Donna Chung (School of Population Health, University of Western Australia);
- Ms Cissy Cox (Group Coordinator, Social Outreach and Advocacy, St John of God Health Care);
- Ms Angela Hartwig (Women's Council for Domestic and Family Violence Services WA);
- Ms Vicky Hovane (Consultant);
- Ms Jocelyn Jones (Health Sciences, Curtin University); and
- Professor Helen Milroy (Director, Centre for Aboriginal Medical and Dental Health, University of Western Australia).

Observers from WAPOL, DCPFS, Department of Health (**DOH**), Department of Education (**DOE**), DCS and the Department of Aboriginal Affairs (**DAA**) and a representative of the Minister for Child Protection also attended the meetings.

In 2013-14, among other things, the Panel will be asked to provide advice to the Ombudsman regarding the first major own motion investigation in relation to family and domestic violence fatalities.

Other Key Stakeholder Relationships

There are a number of public authorities and other organisations 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 liaises as part of the family and domestic violence fatality review function, include:

- The Coroner;
- Relevant public authorities including:
  - WAPOL;
  - The DOH;
  - The DOE;
  - The DCS;
  - The DCPFS;
  - The Department of Housing;
  - The DAA; and
  - Other accountability and similar agencies including the Commissioner for Children and Young People;
- The Women's Council for Domestic and Family Violence Services WA and relevant non-government organisations; and
- Research institutions, including universities.

Aboriginal and Regional Communities

Through the Panel and outreach activities, work was undertaken through the year to build relationships relating to the family and domestic violence fatality review function with Aboriginal and regional communities, including by communicating with:

- Key public authorities that work in metropolitan and regional areas;
- Non-government agencies that provide key services; such as health services to Aboriginal people; and
- Aboriginal community leaders to increase the awareness of the family and domestic violence fatality review function and its purpose.

Building on the work already undertaken by the Office, as part of its other functions, including its child death review function, networks and contacts have been established to support effective and efficient family and domestic violence fatality reviews.

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