Family & 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 relation to this function. Information on the work has been divided as follows:

- Background;
- The role of the Ombudsman in relation to family and domestic violence fatalities;
- Patterns and trends identified from family and domestic violence fatality reviews;
- Issues identified from family and domestic violence fatalities;
- Emerging themes from family and domestic violence fatality reviews; 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. The *WA Strategic Plan for Family and Domestic Violence 2009-13* and *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating safer communities* include 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. 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.

5. 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.

6. 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.

7. 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.

8. Victims of family and domestic violence and abuse will not be held responsible for the perpetrator's behaviour.

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 2009-10* sets 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'.

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.

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

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

Information regarding reporting

The annual reporting of the work of the Office on its family and domestic violence fatality review responsibility will be developed 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.

There will also be reporting to Parliament of major own motion investigations, the first of which is examining issues associated with Violence Restraining Orders and their relationship with family and domestic violence fatalities. The investigation commenced in 2013-14 and the report of the investigation will be tabled in Parliament in 2014-15.

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

Information regarding the use of terms

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 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.

WAPOL 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 WAPOL contact with the person who died and the suspected perpetrator. A family and domestic violence fatality involves persons apparently in a 'family and domestic 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;

(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 —

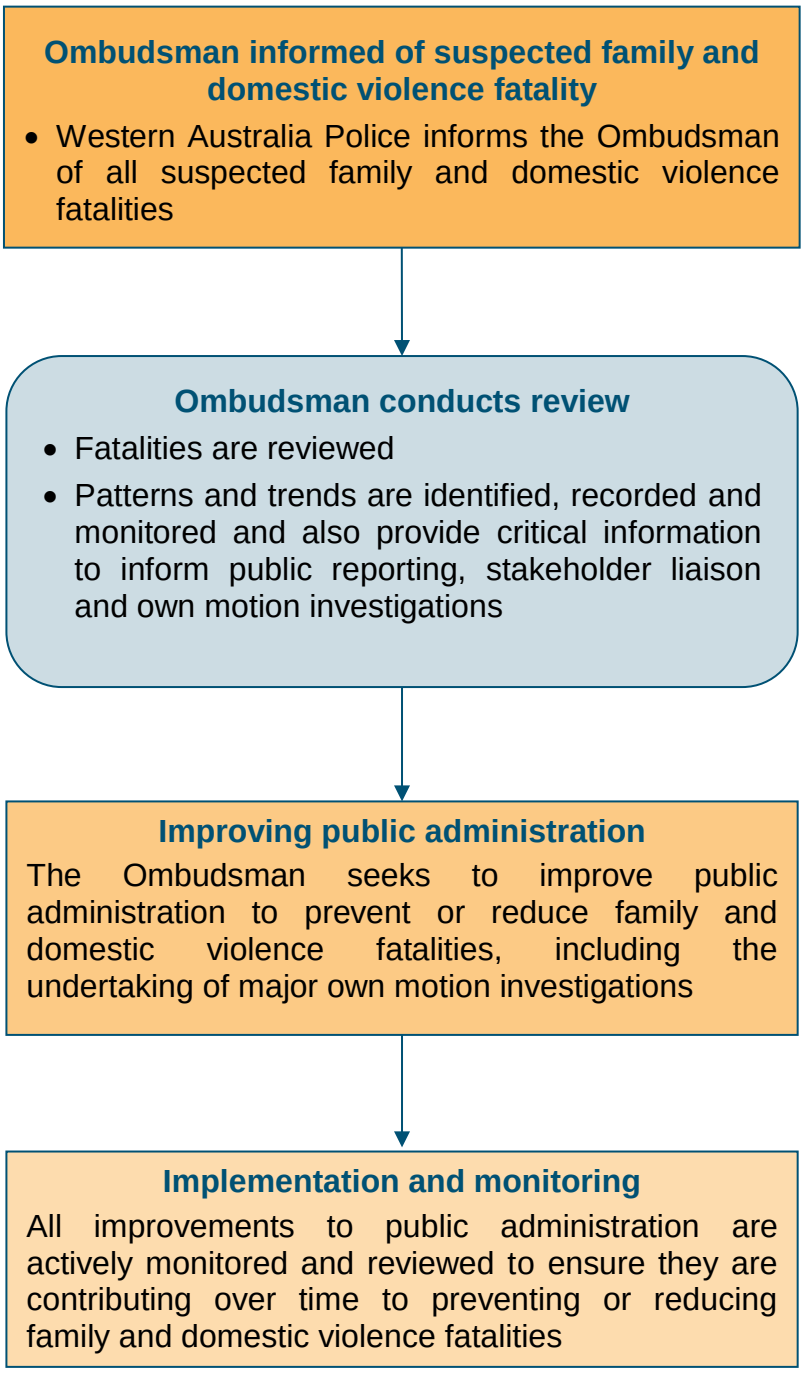
(i) Spouse or former spouse; or

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

If the relationship meets these criteria, 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



Number of family and domestic violence fatality reviews

In 2013-14, the number of reviewable family and domestic violence fatalities received was 15, compared to 20 in 2012-13.

Patterns and Trends Identified from Family and Domestic Violence Fatality Reviews

Information on interpretation of data

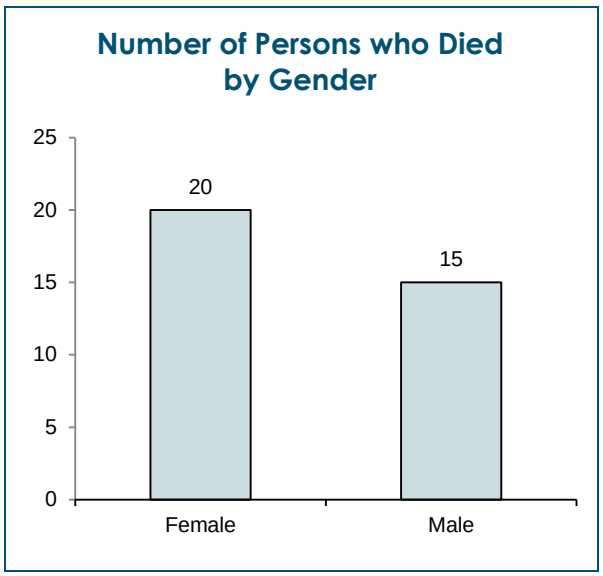
Information in this section is presented for the first two years of operation of the Ombudsman's family and domestic violence fatality review function. As the information in the following charts is based on two years of data only, very significant care should be undertaken in interpreting the data. In 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 inform the Ombudsman's own motion investigations relating to family and domestic violence fatalities.

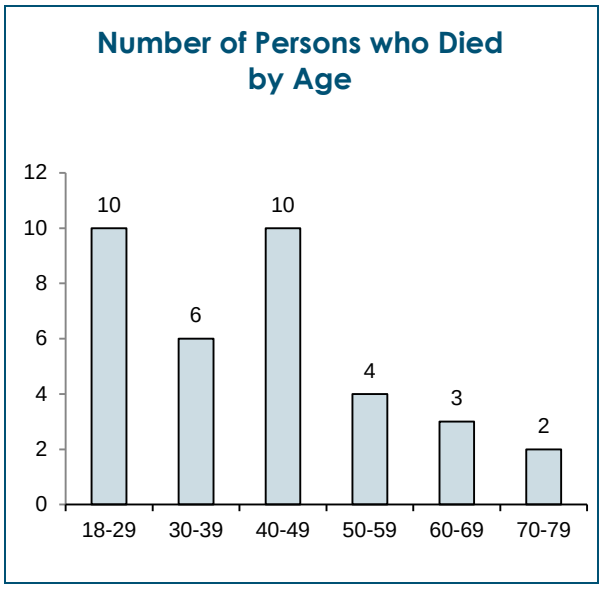
Characteristics of the persons who died

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

The following charts show characteristics for the persons who died for the 35 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2014. The numbers may vary from numbers previously reported as, during the course of a review, further information may become available.

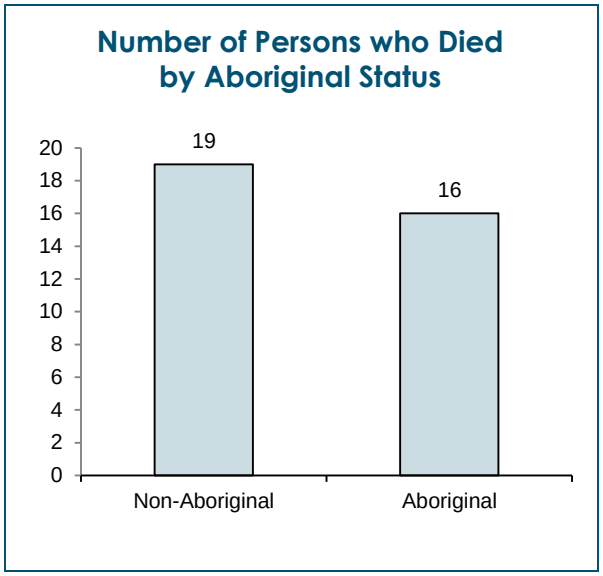


Compared to the Western Australian population, females who died in the two years from 1 July 2012 to 30 June 2014, were over-represented, with 57% of persons who died being female compared to 50% in the population.

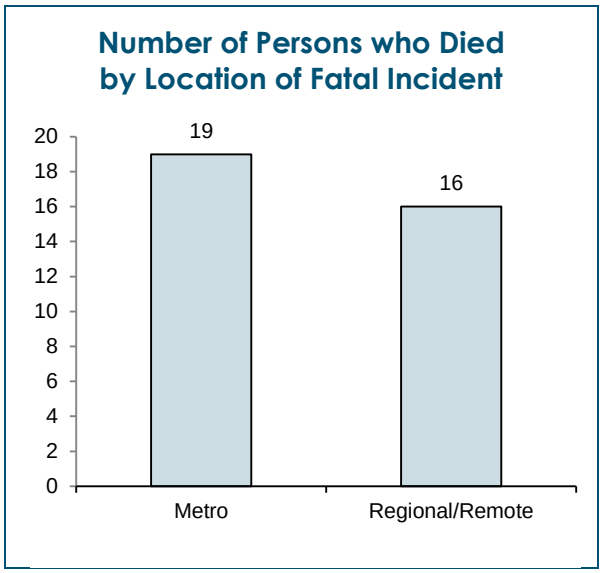


Compared to the Western Australian adult population, in the two years from 1 July 2012 to 30 June 2014:

- The age group 18-29 is over-represented, with 29% of people who died in this group compared to 17% in the population.
- The age group 40-49 is over-represented, with 29% of people who died in this group compared to 19% in the population.



Compared to the Western Australian population, Aboriginal persons who died were over-represented, with 46% of persons who died in the two years from 1 July 2012 to 30 June 2014 being Aboriginal compared to 3.1% in the population.



Compared to the Western Australian population, incidents in regional locations were over-represented, with 46% of fatal incidents occurring in regional or remote locations in the two years from 1 July 2012 to 30 June 2014, compared to 27% of the population living in those locations.

The *WA Strategic Plan for Family and Domestic Violence 2009-13* 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 the two years from 1 July 2012 to 30 June 2014, the Office reviewed 35 family and domestic violence fatalities. From information provided by WAPOL relating to the fatality:

- 20 persons who died (57%) were females (compared with 50% of the Western Australian population);
- 16 persons who died (46%) were identified as Aboriginal (compared to 3.1% of the Western Australian population); and
- 16 family and domestic violence fatalities (46%) occurred in regional areas (compared to 27% of the Western Australian population living in regional areas).

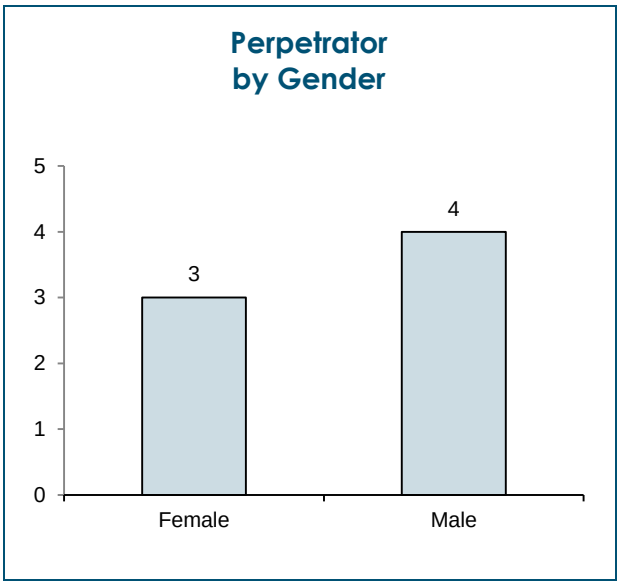
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Characteristics of the perpetrators

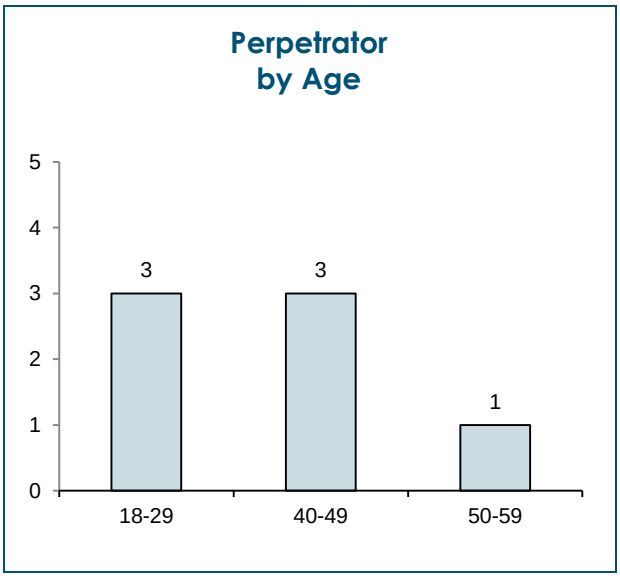
Information in this section relates only to family and domestic violence fatalities reviewed between 1 July 2012 and 30 June 2014 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2014.

Of the 35 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2014, coronial and criminal proceedings were finalised in seven cases.

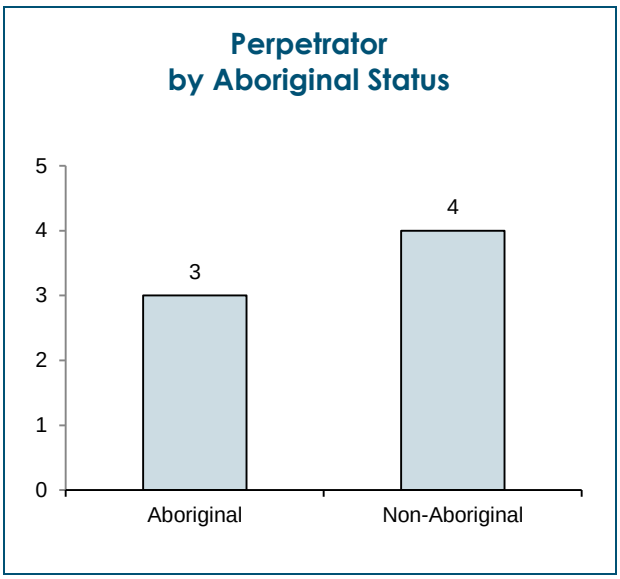
Information is obtained on a range of characteristics of the perpetrator including gender, age group and Aboriginal status. The following charts show characteristics for the seven perpetrators where both the criminal proceedings and the Coronial process have been finalised.



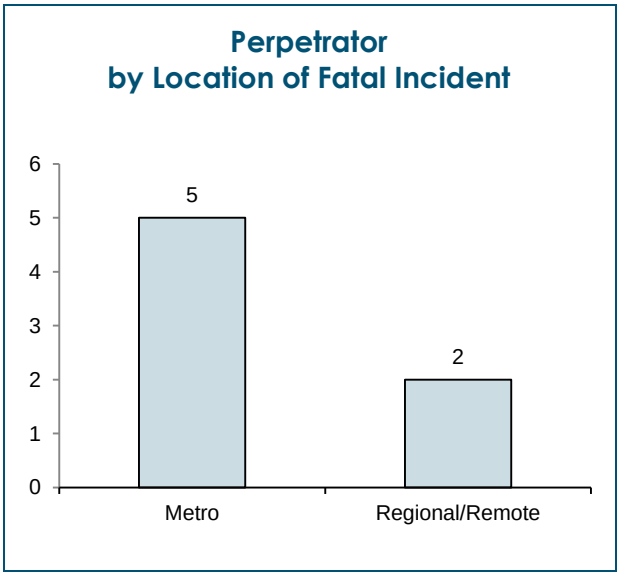
Two of the male perpetrators pleaded guilty to Manslaughter and two pleaded guilty to Murder. All three female perpetrators pleaded guilty to Manslaughter. Of the three female perpetrators, two had previously reported family and domestic violence against them by the person who died. None of the male perpetrators had previously reported family and domestic violence against them by the person who died.



The most common age groups for perpetrators were 18-29 and 40-49. These are also the most common age groups of the people who died.



In all cases, the perpetrator had the same Aboriginal status as the person who died.



The majority of fatal incidents occured in the metropolitan area.

Circumstances of family and domestic violence fatalities

Family and domestic violence fatalities 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:

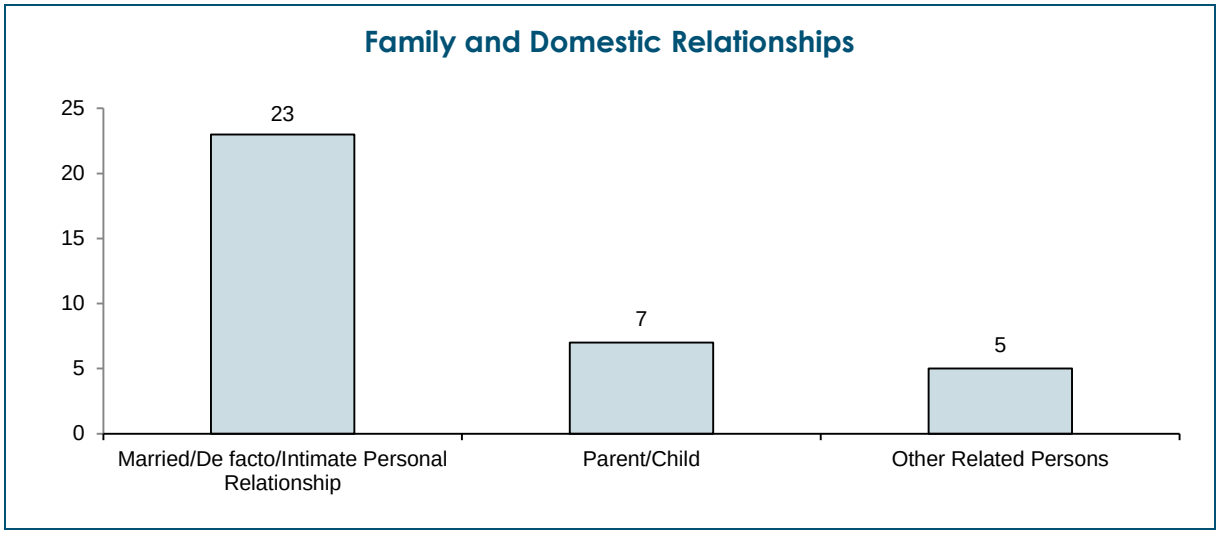
- Alleged homicide, including:
  - Stabbing;
  - Physical assault;
  - Gunshot wound;
  - Asphyxiation/suffocation;
  - Drowning; and
  - Other.

- Apparent suicide, including:
  - Gunshot wound;
  - 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 2013-14 were stabbing and physical assault.

Family and domestic relationships

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



Of the 35 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2014:

- 23 persons who died (66%) were the past or present partner of the suspected perpetrator, in a married, de facto or intimate personal relationship. Of these, 16 (70%) were female and 7 (30%) were male;
- 7 persons who died (20%) were either the parent or adult child of the suspected perpetrator. Of these, 3 (43%) were female and 4 (57%) were male. In three cases the person who died was the parent and in four cases the person who died was the adult child; and
- 5 persons who died (14%) were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, 1 was female and 4 were male.

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.

- Not identifying incidents as family and domestic violence.
- Not adequately implementing family and domestic violence policy and procedures.
- Not utilising appropriate mechanisms to ensure effective responses to family and domestic violence incidents and compliance with policy.
- Missed opportunities to promote victim and child safety.
- Missed opportunities for safety planning and use of protection orders including Violence Restraining Orders and Police Orders.
- Missed opportunities for inter-agency communication and collaboration to address family and domestic violence in regional and remote Aboriginal communities.
- Inaccurate recordkeeping.

Emerging themes from family and domestic violence fatality reviews

Information on interpretation of emerging themes

Information in this section is presented for the first two years of operation of the Ombudsman's family and domestic violence fatality review function. As the information in the following section is based on two years of data, care should be undertaken in interpreting the emerging themes.

Type of relationships

As identified above, the majority of family and domestic violence fatalities (23 or 66%) occurred between persons who, either at the time of death or at some earlier time, had been involved in a married, de facto or intimate personal relationship with the other person. The remainder of family and domestic violence fatalities (12 or 34%) 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'.

Response to previous reported incidents of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reported incidents of family and domestic violence between the parties. In 16 out of 23 intimate partner fatalities (69%), family and domestic violence incidents between the parties had been reported to WAPOL and, in some instances, to other public authorities, such as the Department of Health (**DOH**) and DCPFS. In three out of 12 of the non-intimate partner fatalities (25%), family and domestic violence incidents between the parties had been reported to WAPOL or other public authorities.

Cases with no previous reported incidents of family and domestic violence

In seven out of 23 intimate partner fatalities (30%), the fatal incident was the only family and domestic violence incident between the parties reported to WAPOL. It is important to note, however, research indicating under-reporting of family and domestic violence. The Australian Bureau of Statistics' *Personal Safety Survey 2012* 'collected information about a person's help seeking behaviours in relation to their experience of partner violence'. For example, this research found that (emphasis in original text):

> An estimated 190,100 women (80% of the 237,100 women who had experienced current partner violence) had **never** contacted the police about the violence by their current partner.

Non-intimate partner relationships

While the majority of family and domestic violence fatalities were intimate partner fatalities, the remainder (12 or 34%) occurred between persons who were related but not involved in an intimate partner relationship. Within this group there were seven parent/adult child fatalities and five fatalities where the parties were otherwise related.

Of the 12 non-intimate partner fatalities, five involved Aboriginal people, including three from regional and remote areas. In all three cases alcohol use was identified as a factor associated with violence.

Family and domestic violence involving Aboriginal people in regional and remote communities

Of the 35 family and domestic violence fatalities received, Aboriginal Western Australians who died were over-represented, with 16 (46%) persons who died being Aboriginal. In each case, the suspected perpetrator was also Aboriginal. Thirteen of these fatalities occurred in a regional or remote area of Western Australia, of which 10 were intimate partner fatalities.

The Ombudsman's review of family and domestic violence fatalities will continue to focus particular attention on the effectiveness of the administration of the responsibilities of public authorities in relation to reducing and preventing family and domestic violence involving Aboriginal people in regional communities.

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.

Own Motion Investigation into Family and Domestic Violence Fatalities

Through the review of family and domestic violence fatalities, the Ombudsman identified a pattern of cases in which Violence Restraining Orders (VROs) were in place.

For this reason, the Ombudsman has commenced a major own motion investigation into issues associated with VROs and their relationship with family and domestic violence fatalities, with a view to determining whether it may be appropriate to make recommendations to any public authority about ways to prevent or reduce family and domestic violence fatalities.

The report of this major own motion investigation will be tabled in Parliament in 2015.

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 process to inform the Ombudsman of family and domestic violence fatalities. 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 2013-14 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 (Head of the Department of Social Work, Curtin University);
- Ms Dorinda Cox (Consultant);
- Ms Angela Hartwig (Women's Council for Domestic and Family Violence Services WA);
- Ms Victoria Hovane (Consultant); and
- Associate Professor Carolyn Johnson (School of Population Health, University of Western Australia).

Observers from WAPOL, DCPFS, DOH, Department of Education, DCS, DOTAG and the Department of Aboriginal Affairs also attended the meetings.

In 2013-14, among other things, the Panel provided 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:
  - Western Australia Police;
  - The Department of Health;
  - The Department of Education;
  - The Department of Corrective Services;
  - The Department for Child Protection and Family Support;
  - The Department of Housing;
  - The Department of the Attorney General;
  - The Department of Aboriginal Affairs; 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 organisations 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.