

A Review of **Family and Domestic Violence** in Western Australia

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Content warning

This report contains information family and domestic violence and child abuse that may be distressing. We wish to advise Aboriginal and Torres Strait Islander readers that this report also includes information about Aboriginal and Torres Strait Islander people who have died.

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Acknowledgment of Country

The Ombudsman of Western Australia acknowledges all Aboriginal and Torres Strait Islander Traditional Custodians of Country and recognise their continuing connection to land, sea, culture and community. We pay our respects to Elders past and present, and recognise the strength, resilience and diversity of Aboriginal and Torres Strait Islander peoples in this land.

Where to find help and support

Lifeline	13 11 14	24/7 suicide prevention and crisis support. Provides all Australians access to crisis support and suicide prevention services.
Beyond Blue	1300 224 636	Free and confidential mental health counselling to anyone in Australia via phone, online chat, and email.
13 Yarn	13 92 76	Aboriginal and Torres Strait Islander crisis support line. The first national crisis support line for mob who are feeling overwhelmed or having difficulty coping. We offer a confidential one-on-one yarning opportunity with a Lifeline-trained Aboriginal & Torres Strait Islander Crisis Supporter who can provide crisis support 24 hours a day, 7 days a week.
Women's Domestic Violence Helpline*	1800 007 339	Support for all Western Australians including women, with or without children, who are experiencing family and domestic violence in Western Australia (including referrals to women's refuges).
Men's Domestic Violence Helpline*	1800 000 599	Information and referrals for men who are concerned about their violent and abusive behaviours, and for male victims of family and domestic violence in Western Australia.
1800RESPECT	1800 737 732	A national telephone and online counselling and referral service.
MensLine Australia	1300 78 99 78	24/7 support for men and boys dealing with family and relationship difficulties. Support for men who are concerned that their behaviour is hurting the people they care about.
Sexual Assault Resource Centre	(08) 6458 1828 or free call 1800 199 888	A range of free services to people affected by sexual violence.

* This helpline is operated by Department of Communities, and your call will be answered by a child protection worker.

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Executive summary

Family and domestic violence (**FDV**) has devastating impacts on individuals, families and communities across Western Australia. In the most tragic cases, it results in the loss of life.

Since 2012 we have reviewed 237 FDV fatalities involving 217 offenders. We examine events leading up to a death to strengthen practice and to prevent future harm. Our work has resulted in better risk assessment, improved information sharing, strengthened culturally safe practice, and increased accountability for people who use violence.

By independently identifying and recommending improvements to service and system gaps, we contribute to a safer, more effective FDV response system for all Western Australians.

The Western Australian Government has committed to addressing FDV through long-term strategies including Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020-2030 (**Path to Safety**) and the Strengthening Responses to Family and Domestic Violence System Reform Plan 2024-2029 (**System Reform Plan**). Together, these frameworks aim to ensure that all parts of the FDV response system work to reduce harm and improve outcomes for victim survivors.

Despite the hard work of many, and additional government resourcing, FDV remains a serious and growing issue for our community.

This report captures our FDV fatality review work alongside a thorough point-in-time investigation of the performance of Family and Domestic Violence Response Teams (**FDVRT**).

The FDVRT are multi-agency teams that coordinate responses to FDV incidents involving the Western Australia Police Force (**WA Police**), the Department of Communities (**Communities**), and the Coordinated Response Service (**CRS**). After police officers attend an FDV incident, the FDVRT works to share information, identify risks, and plan responses

to keep victim survivors safe and hold people who use violence to account. FDVRTs have been operating since 2013. There are currently 18 FDVRTs operating across WA.

We initiated this investigation because our FDV fatality reviews continued to identify familiar patterns, which suggests issues previously raised remain unresolved. These included inconsistent risk assessments, poor data collection, limited support for vulnerable groups, and a lack of follow-up action on agreed recommendations and commitments.

The FDVRT investigation was designed to test whether FDVRTs meet their operational requirements and if the model is functioning as intended. This was achieved by thoroughly examining a statistically reliable sample of 388 families who engaged with the FDVRT in November 2024.

The investigation determined that information necessary for victim survivor safety and wrap-around supports to be provided was not reaching support agencies, because it wasn't being collected as planned. The investigation revealed that 24 per cent of responses to risk and behaviour questions were categorised as unstated or unknown.

This system failure meant that victim survivor safety was not being optimised. It resulted in some victim survivors not receiving the supports they should have been getting.

Our independent application of the mandated risk assessment tool across the sample showed that 61 per cent of cases met the threshold for high risk of serious harm but the Multi-Agency Case Management (**MACM**) process that should have followed was followed in only 2.5 per cent of these cases.

In addition, the unmeasured effectiveness of FDVRTs means we can't be certain that victim survivor safety is always being enhanced in the way that is intended.

The investigation made nine recommendations focused on:

- strengthening governance and oversight of FDVRT
- improving risk assessment and data systems
- removing barriers to escalation of high risk cases
- improving support for vulnerable groups, including children
- strengthening accountability for people who use violence

The lesson for all public administrators is that relied upon procedures should only be varied knowingly and within a formal change control procedure. Calibrating a service response that is reliant on the actions of another becomes impossible where that prior action cannot be relied upon. This was and remains true for FDVRTs.

Communities and WA Police continue to deploy additional resources to better meet need, and to evolve their practices, including by developing better risk assessment and simpler data collection practices. Resolving differences on how risk and behaviour information should be collected will be an important contributing factor to victim survivor safety and the overall effectiveness of FDVRTs.

Although preventing harm remains an overriding goal not every incidence of harm can be prevented. Our fatality review work tells us that 72 per cent of offenders were male and 55 per cent of victims were

female. 1 in 6 victims were children. Stabbing was the leading manner of death. Distressingly, Aboriginal people account for 35 per cent of victims, despite being only 3.3 per cent of the population. This over-representation should never be normalised and should be understood in its broader historical and systemic context. Solutions will only be found by working authentically with Aboriginal communities.

In 2024-25, we finalised 14 FDV fatality reviews and made just one recommendation to both WA Police and the Department of Justice. In contrast, we made six recommendations to four separate agencies, arising from just one complex FDV fatality review in 2022-23, involving a young couple, both in their late teens, with children.

In presenting this report, I would like to acknowledge all victims and their families as well as all the front-line service teams in the community and the public sector who work as best they can to keep our community safe. I also acknowledge the commitment and dedication of the Child and Family Safety Team at Ombudsman WA and all those who advocate and work in this challenging area of public policy.

Our investigative work recognises the high pressure and dynamic environment and the complex and challenging issues which families and front-line workers navigate. Its purpose is not to assign blame but to identify systemic issues and opportunities to strengthen responses for the betterment of all West Australians.

Bevan Warner
OMBUDSMAN

Cultural review and expert contribution

Ombudsman WA acknowledges the significant contribution of Ms Alison Scott and Dr Hannah McGlade, who were engaged to undertake a cultural review of this report. Their work brought specialist expertise, deep professional knowledge, and lived and cultural insight to the data and findings presented. Both advisors applied their cultural expertise to carefully consider the interpretation and presentation of data, the language used, and the broader historical, cultural and systemic contexts that shape the experiences and outcomes of Aboriginal communities across WA.

A central issue raised by both advisors was that the significant over-representation of Aboriginal people in FDV data, is unacceptable and should never be normalised. They further emphasised the need for urgent action to address this issue and the importance of always interpreting this over-representation within its broader historical and systemic context. Ms Scott noted that:

Violence is not a cultural norm; rather, it is widely understood by Aboriginal leaders and researchers as linked to colonisation, dispossession, forced child removal and systemic oppression. Within this context, many Aboriginal practitioners argue that violence must be understood not only through a gendered lens, but also through the lens of historical and ongoing oppression.

Dr McGlade emphasised that the patterns identified in this report ‘warrants urgent consideration and engagement, in partnership with Aboriginal key stakeholders,’ and highlighted the importance of ‘culturally informed, trauma informed responses to address systemic injustices.’

In relation to the interpretation and presentation of FDV data, Ms Scott observed that:

The data presented in the report provided is unlikely to cause harm to Aboriginal people, as the findings largely reflect patterns already well documented and in the public domain. The significant over representation of Aboriginal people in FDV statistics is neither new nor unique to this report.

She further advised that, while the inclusion of Aboriginal specific data is appropriate at a high level, ‘its practical usefulness would be strengthened by more detailed breakdowns relating to Aboriginal people, where this can be done safely and ethically.’

Both advisors also highlighted the importance of Aboriginal Data Sovereignty in the interpretation and future use of Aboriginal data. Ms Scott referenced Priority Reform 4 under the National Agreement on Closing the Gap, which emphasises ‘place based, community driven data access that enables communities to make informed decisions and guide actions affecting their wellbeing.’

Importantly, both advisors drew attention to the absence of a formally recognised Aboriginal FDV peak body in Western Australia, and the implications this has for culturally informed oversight, representation and accountability in system level work. They also emphasised the importance of Aboriginal advisory input that is structured, community endorsed and grounded in cultural authority, lived experience and subject matter expertise.

The expert cultural contributions of Ms Scott and Dr McGlade provided valuable insights on the responsible use of Aboriginal data. Their insights reinforced the importance of early, ongoing and meaningful engagement with Aboriginal experts to support culturally safe, evidence informed decision making to ensure Aboriginal perspectives are authentically embedded in future work. Ombudsman WA thanks them once again for their important contributions.

1 Introduction

1.1 Background

FDV affects thousands of people across WA each day. It typically involves a pattern of abusive behaviours used to control or harm a partner or family member. These behaviours can include physical or sexual violence, emotional and psychological abuse, coercive control, financial abuse, stalking, harassment, social isolation, religious or spiritual abuse, and honour-based violence. FDV is largely gendered, with men most often perpetrating violence against women. Its impacts can be devastating, affecting the physical and mental wellbeing of victim survivors and causing life-long trauma for children who witness it. In some cases, FDV can lead to death.

Public understanding of FDV has grown since the 1970s, when it began to be recognised as a community issue rather than a private matter. The first women's refuge in WA opened in 1974, and by 1987, there were more than 20 refuges operating across the State. Since 2004, the State Government has released a series of strategic plans aimed at improving prevention, early intervention and service responses to FDV. In 2017, the first Minister for the Prevention of Family and Domestic Violence was appointed, and in 2020, the Government launched the Path to Safety strategy.

Increasing rates of FDV, combined with growing demand for services, led the non government sector to call for urgent action in 2023. In response, the Government established the Family and Domestic Violence Taskforce which delivered several commitments including the creation of a Lived Experience Advisory Group, new funding for specialist services, and the development of the System Reform Plan. This plan, released in 2024, aims to build a more connected, trauma informed and culturally safe FDV response system across WA.

1.2 Ombudsman jurisdiction

Role of the Ombudsman in reviewing family and domestic violence fatalities

Ombudsman WA has reviewed FDV related deaths since 2012 to identify opportunities for government agencies to better prevent harm. These reviews focus on homicides involving an intimate or familial relationship,¹ or deaths that occur in the context of FDV, such as bystanders intervening in an incident. Our reviews examine government agency involvement prior to the death, assess compliance with legislation and policy, identify opportunities for improvement and develop recommendations to strengthen future responses.

This work is undertaken by investigators with expertise in FDV and knowledge of relevant government agencies. Data analysts contribute to this process by maintaining comprehensive databases and analysing trends related to victims, offenders, types of violence, and service responses.

Our process for undertaking family and domestic violence fatality reviews

The review process begins when WA Police notify us of a suspected FDV related homicide. Additional information may then be requested from relevant government agencies. To determine whether a review should proceed, we consider whether the death occurred within an intimate or familial relationship or in the context of FDV, whether either party had recent agency contact, and whether the case presents learnings that can prevent future harm. Even when a matter does not progress to a full review, we still record key information to support broader system and trend analysis.

¹ 'Intimate or familial relationship' as defined by section 4 of the *Restraining Orders Act 1997*.

Where a review proceeds, we examine agency contact in the one to two years prior to the death. Reviews may include one or multiple agencies, including their interactions with non-government organisations and Aboriginal Community Controlled Organisations (**ACCOs**). We assess compliance with relevant requirements, service effectiveness, cultural safety, interagency communication, and the accessibility of support services.

Our reviews are not intended to assign blame. Their purpose is to identify system level issues, make practical recommendations, and support improvements that strengthen the system and reduce the risk of future fatalities.

We work collaboratively with agencies throughout the review process and monitor the implementation of our recommendations to ensure they are actioned in a timely and effective manner.

In-depth investigations

Some reviews identify issues requiring deeper analysis. These in-depth investigations aim to address systemic problems and improve safety. Past in-depth investigations relating to FDV include a 2023 *Investigation into family and domestic violence and suicide*² and a 2015 *Investigation into issues associated with violence restraining orders*.³

Our latest in-depth investigation regarding the operation and functioning of the FDVRT model is included in Chapter two of this report.

“FDV affects thousands of people across WA each day... its impacts can be devastating, affecting the physical and mental wellbeing of victim survivors and causing life-long trauma for children who witness it.”

2 Investigation into family and domestic violence and suicide.

3 Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities.

2 In-depth investigation into the Family and Domestic Violence Response Team model

2.1 Background

About the Family and Domestic Violence Response Team

The FDVRT was established in 2013 as WA's key response to FDV. This collaborative initiative involves Communities, WA Police, and the CRS. It is further expanding to incorporate Department of Justice representatives into each FDVRT over a four year period. The FDVRT model is designed to enhance the safety of victim survivors and increase accountability for people who use violence through timely, collaborative interventions following police call outs to FDV incidents. There are 18 FDVRTs in total across the State, with one FDVRT located in each Communities district and two FDVRTs located in the Pilbara region.

As the lead agency for FDV in the State, Communities oversees the policy and practice related to the FDVRT. FDVRT operations is governed by the FDVRT Operating Procedures (**Operating Procedures**), which outlines the role, responsibilities and daily functions of the FDVRT. They reflect the key areas of practice that must be adhered to by all members of the FDVRT in all regions, to support a baseline level of consistency across WA. Since its commencement, the FDVRT model has seen various enhancements, yet the Operating Procedures remained unchanged since 2017.

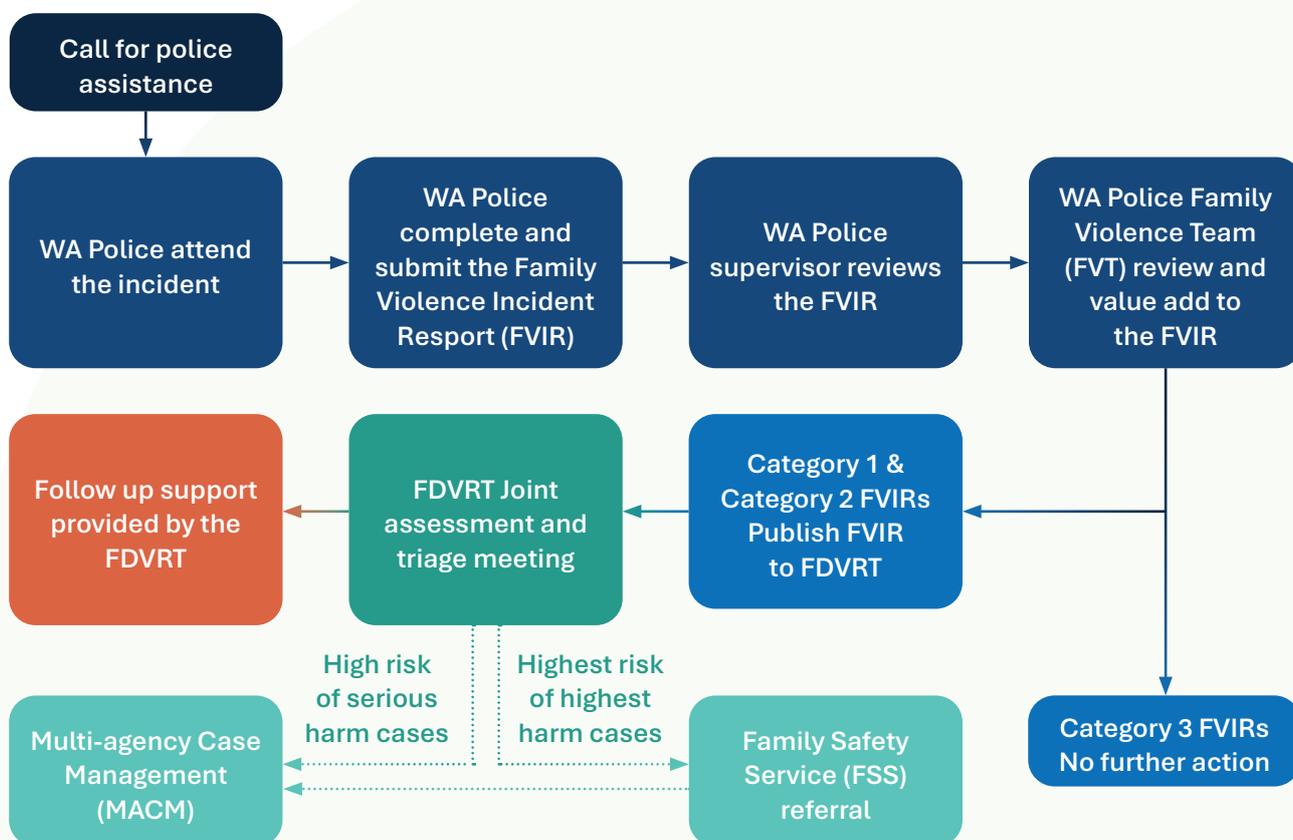


Figure 1: FDVRT process based on figures provided by the Department of Communities

In 2022, Communities established the Office for the Prevention of Family and Domestic Violence (OPFDV) to oversee key priorities to FDV. The FDVRT Central Support and Coordination Unit (FDVRT Central) was established within the OPFDV to provide overarching coordination and support to the FDVRTs and strengthen governance.

Since its establishment, the demand on the FDVRT model has continued to grow. Family Violence Incident Reports (FVIR) have risen from 47,818 in 2020-21 to 63,137 in 2024-25. This upward trend places additional pressure on the FDVRT model, requiring teams to respond to more cases each year while maintaining the quality and consistency of practice. The rising volume of reported incidents reflects both increased reporting and the ongoing prevalence of FDV in WA, emphasising the importance of a model capable of adapting to growing demand.

	Total FDV call outs	FDV call out resulting in WA Police attendance	FDV call outs resulting in an FVIR
2020-21	63,012	58,558	47,818
2021-22	59,636	55,910	44,693
2022-23	62,290	58,820	48,717
2023-24	66,472	62,913	54,240
2024-25	84,556	80,500	63,137

Table 1: Annual number of FDV incidents in Western Australia (2020-2025)

This upward trend places additional pressure on the FDVRT model, requiring teams to respond to more cases each year while maintaining the quality and consistency of practice.

Why we investigated

Through our FDV fatality reviews, we identified recurring patterns and themes that point to potential systemic issues in the operation of the FDVRTs.

These included:

- Non-compliance with Operating Procedures, including inconsistent use of the Common Risk Assessment and Risk Management Framework (**CRARMF**) Common Risk Assessment Tool (**Risk Assessment Tool**), and limited escalation to MACM for high risk cases.
- Weaknesses in data collection, with data not collected and used in a way that supports monitoring, evaluation or improvements to the FDVRT model.
- Limitations in culturally informed practice and the use of culturally informed risk assessment tools when working with Aboriginal families.
- Limited follow-up of safety planning actions, leaving some risks unresolved.
- Responses to children that focus mainly on Child Protection involvement and limited recognition of children as victim survivors in their own right.
- Inequities between metropolitan and regional resourcing, service provision and capability.
- Barriers to information sharing between FDVRT partner agencies, and with other government and community services.
- Insufficient consideration of prior FDVRT involvement where families were repeatedly triaged and earlier safety plans had not worked as intended.

These findings have been shared with Communities and WA Police, and in 2019, we recommended a formal evaluation of the FDVRT model. Subsequently, an external independent review was undertaken and a report was 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 then, significant reforms and additional resources have been directed toward improving the FDVRT model, however, we continue to identify familiar patterns, suggesting that some of the issues raised by the external independent review remain unresolved.

As WA’s key response to FDV, it is essential that the community can have confidence in the FDVRTs effectiveness. Recognising the ongoing concerns identified in our FDV fatality reviews, and the lack of clear evidence of system-wide improvement, we commenced this investigation. Our aim was to assess and establish a baseline for FDVRT compliance with operational requirements to determine whether the model is operating effectively.

The rollout of the Centralised Triage Team (**CTT**) began in regional areas in 2025, after our investigation commenced, and was not in place during the period under review. The impact of the CTT could not be assessed as part of our investigation, although it was taken into consideration when shaping our methodology and developing our findings and recommendations.

2.2 Methodology

What we investigated

We examined how the FDVRT model was operating in November 2024. This review period was chosen because it provided recent and representative data, with 2,738 FVIRs recorded across the State in that month.

Our investigation focused on:

- The key characteristics of a sample group of reported FDV incidents.
- Whether FDVRTs followed their operational requirements.
- Developing a comprehensive understanding of FDVRT practices across the system.

How we investigated

Case selection

We selected a stratified random sample of 400 FVIRs, based on incident volume in each district. The sample size was chosen to ensure it was statistically reliable.

Ten FVIRs could not be analysed due to policy requirements restricting publishing to the FDVRT, leaving 390 cases: 388 Category 1 FVIRs and two Category 2 FVIRs.⁴ The two Category 2 FVIRs were excluded because they are subject to different operational requirements. This resulted in a final sample group of 388 Category 1 cases.

Why stratified, incident-based sampling?

We selected a sample based on the number of reported FDV incidents in each district, rather than population size, to reflect the actual distribution of reported FDV across WA.

This ensured that:

- High incident districts had proportionally larger samples.
- Smaller districts with disproportionately high incident rates remained visible and well represented.
- Low incident, high population district did not distort the results.

Data sources

To understand both FDVRT operational requirements, and gain a detailed and systemic view of FDVRT practice, we reviewed:

- Documentation that establishes practice requirements: FDVRT Operating Procedures, WA Police Family Violence Team Manual, and related FDVRT specific practice guidance.
- Demographic data provided by WA Police for each case in the sample group, noting that WA Police acknowledged that some of the demographic data to identify Aboriginal people may have limitations in its accuracy.
- Direct access to the FVIR Triage application, which allowed us to extract further details on demographic details and FDVRT practice.
- Additional documentation supplied by Communities relevant to FDVRT operations.

⁴ According to FDVRT Operating Procedures 2017, Category 1 FVIR is defined as 'Incidents where an offence has been detected or there are indicators of high risk of harm.' Category 2 FVIR is defined as 'Incidents where there was sufficient concern evident for WA Police to determine that a Police Order was required but no offence was detected.' Category 3 FVIR is defined as 'No offence, no Police Order issued, no indicators of high risk.'

What is the FVIR Triage application?⁵

The FVIR Triage application is the primary database used by FDVRT members to share information and record decisions and outcomes of FDVRT assessment and triage meetings (**FDVRT triage meeting**).

Data collection and analysis

We developed a detailed data template of 45 fields to standardise data collection across the sample group.

Data was extracted by three representatives from Ombudsman WA and one representative from WA Police, each with extensive experience in FDV and a strong understanding of the FDVRT model.

For each case in the sample group, we independently applied the Risk Assessment Tool through a desktop review. While some CRARMF key risk factors could not be identified through a desktop review of the material assessed, the process provided a reasonable picture of both the risk level and FDVRT practice for each case within the sample group.

All relevant information was then extracted from the records in the FVIR Triage application and entered into the data templates, which was used as the basis for analysis.

What is the Risk Assessment Tool?

The Risk Assessment Tool is the structured tool that FDVRT members must use to assess the level of FDV risk in each case. It consists of a series of questions focused on evidence-based risk factors, which must be considered alongside professional judgement and, where possible, the victim survivors' own perception of risk. This process helps determine whether a victim survivor is at high risk of serious harm.

Definition of high risk of serious harm

'High risk of serious harm' means there is evidence of a serious risk to victim survivors' safety and wellbeing, and urgent action is necessary to prevent or lessen the risk this determination is based on:

- the presence of a number of lethality risk indicators,
- a history of physical violence, and/or professional judgement.

We undertook two main forms of data analysis for each case in the sample group:

- Demographic analysis, to understand who was engaging with the FDVRT.
- Practice and compliance analysis, to assess FDVRT practice against operational requirements and practice standards.

5 The Department of Communities provided us with the FVIR Triage Application: Decisions and Outcome Page Practice Guidance July 2024 which states that "The FDVRT partner must ensure all decisions, actions and outcomes are recorded clearly and succinctly in the FVIR Triage application".

Stakeholder engagement

We consulted with:

- Communities and WA Police throughout the investigation to share updates, discuss emerging findings, seek feedback and request further information.
- Sector peak bodies to gain insight into the community and sector experience with the FDVRT.

Who are the sector peak bodies?

- The Centre for Women's Safety and Wellbeing is the peak body for women's specialist FDV, community-based women's health and sexual assault services in WA.
- Stopping Family Violence is the peak body for men's behaviour change programs and perpetrator intervention in WA.

Limitations

This investigation relied heavily on the accuracy of records, therefore, limitations in the quality of demographic data affected our analysis. Reliable demographic information on vulnerable groups is not currently collected by Communities or WA Police. While WA Police undertook additional work to match data from their other databases, to identify Aboriginal people, they acknowledged that this data may have limitations in its accuracy.

The scope of this investigation was to review data extracted from the FVIR Triage application, as the primary source of information. Although individual agency files and systems were not examined as part of this review, the FDVRT are required to clearly and succinctly record all decisions, actions, and outcomes within the FVIR Triage application, in accordance with current practice guidance.⁶ Accordingly, the information captured in this application should provide sufficient evidence of the actions taken by the FDVRT.

How findings are presented

The original scope of the investigation was to assess compliance with operational requirements to determine effectiveness of the FDVRT model. As work progressed, our analysis also revealed practice issues and, in some areas, the absence of any practice requirements in areas critical for effective FDVRT functioning. To reflect this, our findings include both compliance-based findings and practice-based findings.

⁶ FVIR Triage Application: Decisions and Outcome Page Practice Guidance July 2024

2.3 Data

Total number of incidents n=388

Cohort overview

A total of 421 unique people who use violence and 416 unique victim survivors were identified.

Most reports involved intimate partner violence

Almost half of people who use violence were in an intimate partner relationship with the victim survivor (n=183, 42.9%). More than one-quarter were former intimate partners (n=116, 27.2%). Together, intimate partner violence accounted for 70 per cent of all cases (n=299, 70%).

Almost 85 per cent of people who use violence had prior involvement with the FDVRT

Almost 85 per cent of people who use violence had previously been recorded as the person using violence in FDVRT incidents (n= 351, 83.4%). Almost one-third had been recorded in more than 10 prior incidents (n=138, 32.8%) with the highest number of prior incidents linked to a single person using violence being 81 incidents.

Males were more likely to have perpetrated FDV

72 per cent of people who use violence identified as male (n = 305, 72.4%).

Most victim survivors were female

75 per cent of victim survivors identified as female (n= 315, 75.7%).

The largest age group in both cohorts was 35 to 39 years

Almost 20 per cent of people who use violence (n=82, 19.5%) and 16 per cent of victim survivors (n=68, 16.4%) were aged between 35-39. Around seven per cent of people using violence (n=28, 6.7%) and victim survivors (n=29, 7%) were under 18 years old.

Five per cent of victim survivors (n=21, 5%) were aged over 65.

Many children were directly affected

A total of 356 children were present across 40 per cent of the FDV incidents in the sample group (n=156, 40.2%)

There was high representation of Aboriginal people in the sample group

Almost half of the victim survivors (n=165, 39.7%) and people who use violence (n=184, 43.7%) identified as Aboriginal. 33 per cent of all victim survivors were Aboriginal females (n=138, 33.2%).

Assault-type offences made up the largest offence category

Assault type offences accounted for the majority of offences (n=357, 42%). The next most common were breach offences (n=254, 29.8%), followed by threats (n=79, 9.3%).

Police Orders were issued for over half of the incidents

Police Orders were issued in 77 per cent of incidents where no other protective order was in place (n=227, 77.2%).

The most frequently identified Risk and Behaviour factor by attending police officers was whether the person using violence has previously harmed the victim survivor

In 66 per cent of cases, the person using violence had previously harmed the victim survivor (n=258, 66.4%).

Almost one quarter of Risk and Behaviour responses recorded by attending police officers were recorded as ‘unstated’ or ‘unknown’

Half of the Risk and Behaviour factors were recorded as ‘no’ (n=5801, 51.6%), 25 per cent were recorded as ‘yes’ (n=2794, 24.8%) and 24 per cent were recorded as ‘unstated’ or ‘unknown’ (n=2675, 23.6%).

FDVRT triage meetings were held for all 388 Category 1 cases

The FDVRT attended FDVRT triage meetings for all cases in the sample group (n=388, 100%).

In most of the cases in the sample group, all three agencies attended FDVRT triage meetings

90 per cent of FDVRT triage meetings involved all three agencies (n=351, 90.5%).

There was minimal engagement with the Family Safety Service (FSS)

The FSS was already engaged with six families (n=6, 1.5%) and a referral was made in three additional cases (n=3, 0.8%).

Most of the next actions were assigned to a single agency

Next actions were most often allocated to the CRS (n=102, 26.2%). 88 cases were solely allocated to Communities (n=88, 22.7%), and the WA Police Family Violence Team (FVT) were allocated nine cases (n=9, 2.3%)⁷.

Joint agency responses were not as common

All three agencies were assigned follow-up in 12 cases (n=12, 3.1%). A joint response from Communities and the CRS was required in 19 cases (n=19, 4.9%). A joint response from the WA Police FVT and CRS was required in 37 cases (n=37, 9.5%), and the WA Police FVT and Communities in 18 cases (n=18, 4.6%). The remaining cases were allocated either no further action (n=87, 22.4%), or the response was not recorded (n=16, 4.1%).

Many families were open to Child Protection

A total of 118 families had an open period of contact with Child Protection⁸, and in 76 per cent of those cases, an interaction was created (n=90, 76.3%)⁹.

Almost 30 per cent of the open cases involved children in the care of the CEO of Communities

33 cases included children in the care of the CEO of Communities (n=33, 27.9%). Of those cases, 24 progressed to an interaction, one resulted in an intake to Child Safety Investigation, five resulted in a report sent to the case manager, and three resulted in no further action.

The CRS were unable to contact 65 families

Of the 65 unsuccessful contact attempts (n=65, 16.8%), all of these cases resulted in no further action (n=59, 90.8%) or unclear follow up action (n=5, 7.7%). 68 per cent of these cases met the threshold for high risk of serious harm (n=44, 67.7%).

Many cases were assigned no further action

A total of 103 cases were assigned no further action or follow up was unspecified (n=103, 26.5%). Almost half of these cases met the criteria for high risk of serious harm (n=49, 47.6%).

7 This refers to actions taken by the WA Police Family Violence Team after initial police attendance.

8 An open period of involvement means that Communities is actively investigating, assessing, or providing case management services to a child and/or their family.

9 An interaction, refers to the initial point of contact, report, or referral regarding a concern for a child’s safety, welfare, or development.

In most cases, a rationale was provided when no further action was required

Communities provided a rationale for 91 per cent of cases where no further action was required (n=212, 90.6%). The CRS provided a rationale for 87 per cent of no further action responses (n=164, 86.8%) and WA Police provided a rationale in 65 per cent of cases where no further action was recorded (n=45, 65.2%).

Documented referrals for people who use violence was uncommon

49 referrals were made to intervention programs for people who use violence (n=49, 15.2%). 22 referrals were made to Domestic Violence Outreach Services (n=22, 5.2%), 12 referrals were made to behaviour change programs (n=12, 2.8%) and 15 referrals to both services (n=15, 3.5%).

Behaviour change programs were unavailable for over half of the cases in the West Kimberly district

Of the 30 cases in the sample group from the West Kimberly District, 16 recorded that behaviour change programs were unavailable (n=16, 53.3%).

People who use violence were rarely referred to alcohol and/or other drug (AOD) and mental health services

Five per cent of people who use violence were referred to AOD and mental health services (n=20, 4.7%).

CRARMF key risk factors were documented in a quarter of the cases reviewed

CRARMF key risk factors were documented in 25.5 per cent of cases (n= 99, 26%).

CRARMF risk ratings were rarely assigned

A CRARMF risk rating was assigned to seven of the 388 cases reviewed (n=7, 1.8%).

Over 60 per cent of cases met the criteria for high risk of serious harm

According to our investigation, 61 per cent of cases met the criteria for high risk of serious harm (n=235, 60.5%), as outlined in the CRARMF.

MACM was rarely convened or considered for cases assessed as high risk of serious harm

MACM was convened for six cases (n=6, 2.5%) and considered for an additional two cases (n=2, 0.9%) assessed as high risk of serious harm.

There was limited adaptation for vulnerable groups by the FDVRT

Consideration for the needs of people from vulnerable groups was documented in five cases (n=5, 1.3%).

Incomplete or unclear record keeping was frequently observed

In over half of the cases, records were unclear or incomplete (n=231, 59.5%). In 36 per cent of these cases, outcome tracking was absent or unclear (n=83, 35.9%).

Good practice was most often evident at the individual level

In 72 cases, good practice was attributed to the actions of individual practitioners (n=72, 18.6%), which included 34 cases of strong individual responses (n=34, 8.8%) and 38 cases of comprehensive individual record keeping (n=38, 9.8%). Strong joint responses were observed in 22 cases (n=22, 5.8%).

2.4 Key Findings

Risk and Behaviour information recorded by WA Police was not adequate to inform the Family and Domestic Violence Response Team assessment and triage process

The FDVRT process relies heavily on the information collected by WA Police when they attend FDV incidents. Attending police officers are required to complete an FVIR through the 1ForceCore mobile application. Introduced in July 2023, this application allows FVIRs to be published directly from the incident. When completing the FVIR, attending police officers must record responses to a series of 30 Risk and Behaviour questions (commonly referred to as 1–9s), which are aligned to the CRARMF key risk factors. Once finalised, FVIRs automatically feed into the FVIR Triage application, which forms the basis of the FDVRT’s triage meetings.

The Risk and Behaviour questions are central to the FDVRT’s function because they provide up-to-date information that the FDVRT can use alongside agency records to build a complete picture of risk. We analysed the responses recorded by attending police officers in 29 out of the 30 Risk and Behaviour fields, which required a simple ‘yes’ or ‘no’ answer. We found that 24 per cent of these responses were categorised as ‘unstated’ or ‘unknown’.

To understand why almost a quarter of these fields were not completed, we considered WA Police’s process for completing the Risk and Behaviour questions, as summarised in Figure 4 on page 22.

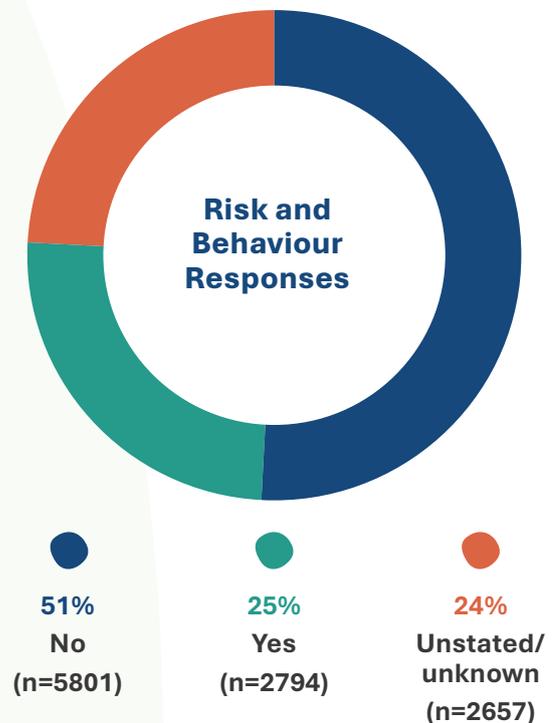


Figure 2: Risk and Behaviour Responses for the sample group (n=11,252)



Figure 3: Sum of each 'unstated' or 'unknown' Risk and Behaviour responses in the sample group (n=11,252)

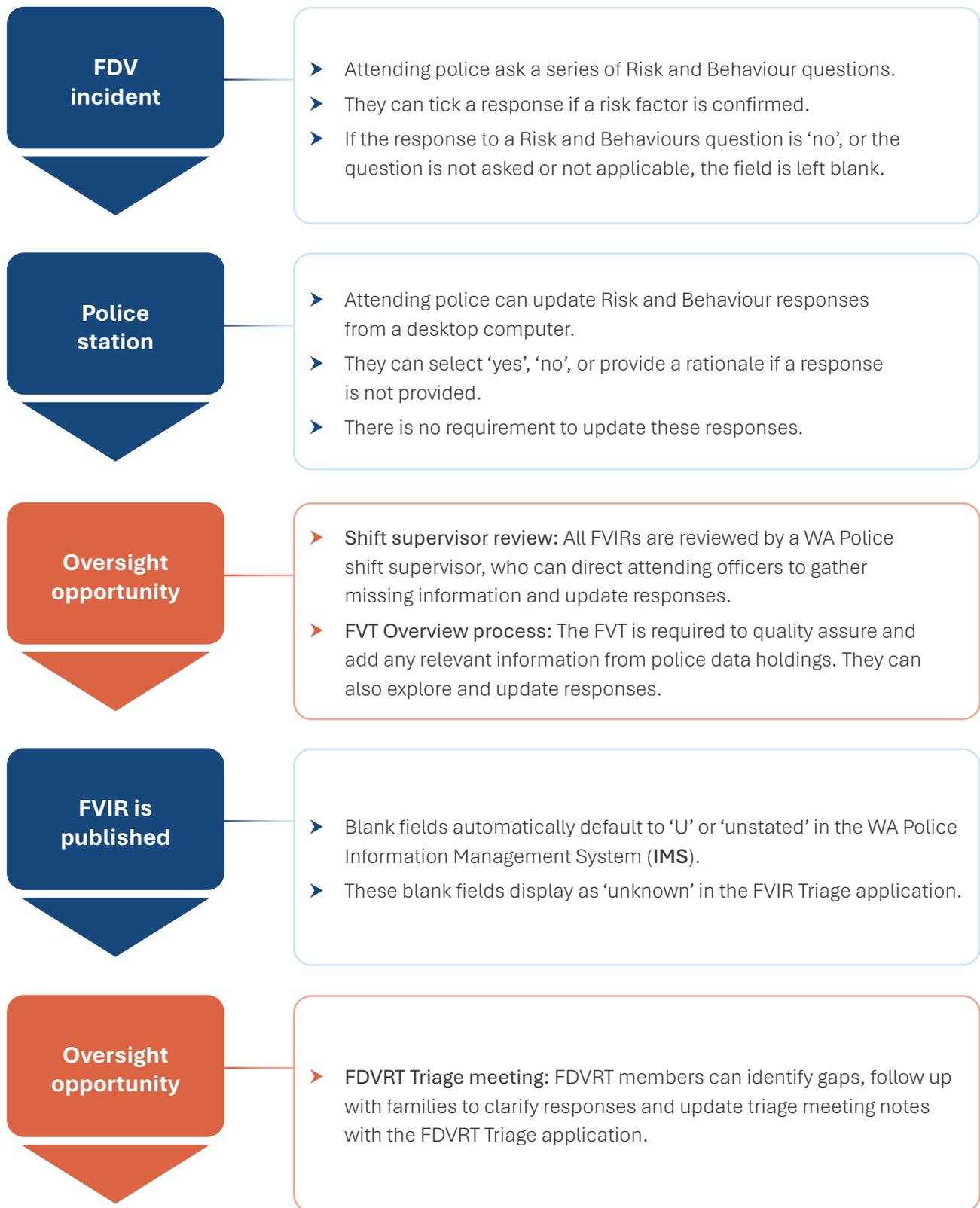


Figure 4: The process for completing and publishing Risk and Behaviour responses

Our investigation of this process identified both technological and oversight limitations that affect the completion of Risk and Behaviour questions. The 1ForceCore application does not allow attending police officers to select a clear ‘yes’ or ‘no’ response for each Risk and Behaviour question. As a result, responses recorded as ‘unstated’ or ‘unknown’ cannot be reliably interpreted. It remains unclear whether a question was not asked, not answered, or considered not applicable by the attending police officer.

Additionally, current oversight arrangements do not mandate that incomplete Risk and Behaviour responses are reviewed or addressed once a FVIR is published. With almost one quarter of responses recorded as ‘unstated’ or ‘unknown’, this suggests that incomplete information is not consistently identified or addressed before being relied upon by FDVRTs. These limitations reduce the FDVRT’s ability to distinguish between the absence of risk and the absence of information, meaning safety decisions may be made based on incomplete or unreliable information, reducing the effectiveness and consistency of the coordinated response.

During our investigation, WA Police indicated they had independently determined that it was no longer practical or appropriate to ask the full set of Risk and Behaviour questions at initial attendance and intended to reduce the number of questions asked. This represented a planned departure from settled practice that had not been previously aired or formally agreed with the other FDVRT partner agencies.

After being made aware of this, we initiated discussions with both WA Police and Communities. These discussions brought the issue to light and prompted further discussions between the agencies to reach a shared position on the collection of Risk and Behaviour information and its role in the FDVRT model. Through these discussions, WA Police and Communities acknowledged that unpredictable

or inconsistent collection of risk information can compromise victim survivor safety and the effectiveness of coordinated responses. There was broad agreement that the collection of risk relevant information by WA Police at initial attendance remains a critical component of their FDV response. Both agencies also recognised the need to improve how questions are asked, including better alignment with trauma-informed practice and minimising unnecessary repetition across incidents. Any future changes to the Risk and Behaviour questions are now agreed to be developed collaboratively, including consultation with relevant working groups.

While this alignment is a positive step, agreement alone is not sufficient to safeguard the system against future challenges. Real-world pressures, such as rising demand, resource constraints, and inevitable professional differences of opinion, mean that some divergence in practice is bound to occur over time, even among agencies that currently agree.

To protect the integrity of the FDVRT model going forward, it is essential that a formal measure is established to prevent any single agency from unilaterally departing from settled practice. Any proposed change or departure from the agreed approach should be subject to a documented, system-wide process, requiring consultation, review, and formal approval by the designated governance body. This process will help maintain accountability among all FDVRT partner agencies and ensure that victim survivor safety and coordinated service delivery is protected against ad-hoc or informal changes.

The Family and Domestic Violence Response Teams are not consistently complying with their operational requirements for assessing risk and escalating high risk cases to Multi-Agency Case Management

The Operating Procedures set clear requirements for FDVRT practice. Each day, representatives from WA Police, Communities, and the CRS are required to attend FDVRT triage meetings to review FDV incidents together. During these meetings, each agency shares relevant information, allowing the FDVRT to form a collective understanding of risk and determine the most appropriate response to enhance safety.

To assess risk, the FDVRT must adhere to the Minimum Standards for Risk Assessment outlined in the CRARME, which requires the use of the Risk Assessment Tool. The Risk Assessment Tool is designed to guide practitioners through a set of recognised evidence-based risk factors and requires them to determine whether a victim survivor is at high risk of serious harm. The outcome of this point-in-time assessment should be recorded in the FVIR Triage application and should inform the FDVRT's subsequent actions. According to the Operating Procedures, when a victim survivor is assessed as meeting the threshold for high risk of serious harm, the FDVRT must convene a MACM meeting.

What is a Multi-Agency Case Management meeting?

MACM is an integrated, interagency approach to support people at high risk of serious harm or death due to FDV. It brings together representatives from different agencies to share relevant information and provide short term, coordinated intervention that works to reduce or mitigate the identified risks.

MACM does not replace the work of individual agencies and does not remove the need for agencies to collaborate outside of these meetings.

Relevant finding from the external independent review 2020

The external independent review found that the number of MACM meetings were declining over time, attributing this trend partly to workload demands. The review noted that 'the declining number of MACM indicates the FDVRT are not responding adequately to cases of high risk with joint risk assessment and multi-agency safety planning and therefore compromising victim safety'. The external independent review recommended that FDVRT members receive training in organising and conducting MACM meetings (Recommendation 8).

Our investigation found that these operational requirements were not consistently followed. Of the 388 cases reviewed:

- CRARMF key risk factors were documented in only 99 cases, leaving no evidence that the Risk Assessment Tool was used in the remaining 289 cases.
- A risk rating was recorded in just seven cases.

Our independent application of the Risk Assessment Tool to all 388 cases showed that 235 met the threshold for high risk of serious harm. Despite this, FDVRTs convened MACM for six cases and considered MACM for an additional two cases.

This discrepancy between the number of cases that met the high risk of serious harm threshold and the actual escalation to MACM, highlights significant compliance issues. Although there are examples of good local practice, these approaches are not applied consistently across the State. (*Refer to the Case Studies on the following page*).

In response to the external independent review, Communities appointed 32 FSS officers (assigning two FSS officers to each FDVRT), to assist with facilitating MACM for the highest risk cases.

Our investigation found that the FDVRT referred cases to the FSS on only three occasions suggesting that the FSS initiative has not led to an increase in MACM. We discussed these findings with Communities, who clarified that, although practice guidance requires all decisions and outcomes to be documented in the FVIR Triage application, FDVRTs are not required to record referrals to the FSS in the application. This means that additional referrals to the FSS were likely made during this period but were not recorded in the system.

Communities also advised that they now report quarterly on the number of cases referred to the FSS and how many MACMs are convened by the

FSS. Between October 2023 and July 2025, the FSS held 671 initial MACM meetings. However, the data did not show how many of these meetings originated from FDVRT referrals, as the FSS also accept referrals from District Directors, which appear to account for approximately half of all referrals.

It should be noted that the FSS is only required to convene MACM for cases assessed as presenting the ‘highest risk of highest harm’. For all other high risk cases, the responsibility for convening MACM remains with the FDVRTs. The specific criteria used to determine which cases meet the ‘highest risk of highest harm’ threshold remains unknown.

Overall, our findings indicate that the FDVRTs are not consistently adhering to their operational requirements: there is limited use of the CRARMF Risk Assessment Tool, virtually no recording of the associated risk rating, and MACM is not consistently being convened for cases assessed as high risk of serious harm. These requirements are fundamental to the effective operation of the FDVRT model, so strengthening routine compliance in these areas is essential.

While we did not explore the barriers to compliance, these issues must be identified and addressed to accurately evaluate the effectiveness of the FDVRT model. At present, it is not possible to fully identify barriers to compliance given the use of the Risk Assessment Tool and escalation to MACM are not monitored or evaluated. Without monitoring, there is no visibility into whether gaps reflect workload pressures, practice inconsistencies, or systemic weaknesses. Establishing a monitoring and evaluation framework is therefore critical to understanding and resolving these issues. If sustained compliance to operational requirements cannot be achieved under current arrangements, it may be necessary to review and reconsider the design and operation of the FDVRT model itself.

Case study

Good practice in consistently applying the Risk Assessment Tool

In one of the 18 districts reviewed, CRARMF key risk factors were identified and documented in 75 per cent of cases (n=24, 75%). While the completed Risk Assessment Tools were not uploaded to the FVIR Triage application, this

approach highlights that strong compliance with procedural requirements is achievable. However, these approaches appear to be developed locally rather than consistently adopted across all FDVRTs.

Case study

Non-compliance with operational requirements

The victim survivor in this incident had been separated from the person using violence for six months. She had two children from a previous relationship and was two months pregnant at the time of the incident. The person using violence called WA Police, alleging that the victim survivor had assaulted him and damaged his property. However, when police officers attended, they found the pregnant victim survivor injured, and CCTV footage highlighted inconsistencies in the person using violence's account. Police officers correctly identified the person using violence as the primary aggressor.

The victim survivor reported substantial recent assaults perpetrated by her former partner and provided messages in which the person using violence threatened to kill her. The person using violence was arrested and charged, then released with protective bail conditions.

A review of the FVIR Triage application showed that the FDVRT did not document CRARMF key risk factors or a risk rating, which suggests the Risk Assessment Tool was not used to assess

risks in this case. Our own application of the Risk Assessment Tool identified several high risk factors: escalation in violence, recent separation, threats to kill, pregnancy, physical violence, use of weapons, and alcohol and drug use. We also noted the impact of FDV exposure on the victim survivor's two children. Based on these factors, we determined that this case met the threshold for high risk of serious harm.

With respect to decision making and follow-up actions, the FDVRT recorded that Communities were 'attempting to confirm pregnancy and gestation and recommend follow-up by CRS for FDV support.' However, other than Communities sending an email to the local hospital to confirm the pregnancy, no further actions were taken. The CRS stated they would refer the victim survivor to an FDV outreach service, but it is unclear if this happened. There is no documentation of additional follow-up actions or whether a MACM was considered or convened, despite the case clearly meeting the criteria for high risk of serious harm.

The Family and Domestic Violence Response Team model does not adequately accommodate the unique and complex needs of vulnerable groups who are at a greater risk of family and domestic violence

WA's key reform strategies – the Path to Safety, the System Reform Plan and the Aboriginal Family Safety Strategy 2022-2032 – commit to improving demographic visibility and building culturally safe, trauma informed responses designed with, and accountable to, vulnerable communities. These strategies, recognise that some groups are at higher risk of FDV or face additional barriers to safety, including Aboriginal women and children, people from CaLD backgrounds, LGBTIQ+ people and people living with disability. Each strategy calls for responses that are culturally safe and intersectional and require practice to be adapted to specific circumstances.

Relevant finding from the external independent review 2020

The external independent review identified that the FDVRT model 'fails in many ways in response to Aboriginal families and communities and culturally appropriate alternatives to the model are necessary. A range of alterations to the model were proposed although there was a general sense of helplessness/hopelessness that the issues raised in this review have already been broached many times without action being taken'. It recommended the development of a culturally appropriate model of working with Aboriginal people, particularly in remote locations (Recommendation 18) and training to ensure culturally secure practice across the FDVRTs (Recommendation 19).

Our investigation found little evidence that the FDVRT model has been adapted to meet the needs of vulnerable groups. Three key gaps were identified:

1. Inadequate demographic data capture

The FDVRT relies on the FVIR Triage application, which does not contain dedicated fields for recording whether a victim survivor or person using violence belongs to a vulnerable group. While this information may sometimes appear in free text narrative, there is no requirement or prompt to include it. As a result, the FDVRT cannot produce reliable demographic reporting to accurately identify who is using the service or where demand lies and cannot readily design appropriate and targeted service pathways.

Because reliable demographic capture was not available, we could not directly analyse FDVRT data to identify vulnerable groups within the sample group. WA Police undertook additional work, to match data from their other databases to identify Aboriginal people. Aboriginal identity was therefore used as an example of a vulnerable group in this investigation. Using this approach, we found that Aboriginal people made up 40 per cent of victim survivors and 44 per cent of people who use violence in the sample group. These findings reinforce the critical need to collect reliable data on vulnerable groups, to inform FDVRT model development and service pathways to meet the needs of the community. Importantly, this over representation of Aboriginal people in both categories must be understood within the context of ongoing systemic inequities and the enduring impacts of colonisation. Historical and structural disadvantages, including dispossession, intergenerational trauma, discrimination, and marginalisation, have contributed to heightened vulnerability and barriers to safety for Aboriginal communities. Addressing these issues requires not only improved data collection but also culturally informed, trauma-informed responses that recognise and actively work to redress these systemic injustices.



44% Aboriginal
 48% Non-Aboriginal
 8% Unknown

Male 70%
 Female 30%

Figure 5: Aboriginal status and gender distribution for people who use violence (n=421)



40% Aboriginal
 48% Non-Aboriginal
 12% Unknown

Male 16%
 Female 84%

Figure 6: Aboriginal status and gender distribution for victim survivors (n=416)

Although Aboriginal people make up a substantial proportion of people coming into contact with the FDVRT, the Operating Procedures contain no specific guidance on adapting the assessment or response process for Aboriginal families or for other vulnerable groups.

2. No clear practice requirements to meet the needs of vulnerable groups

Although Aboriginal people make up a substantial proportion of people coming into contact with the FDVRT, the Operating Procedures contain no specific guidance on adapting the assessment or response process for Aboriginal families or for other vulnerable groups. There are no embedded requirements to consult cultural experts, to use interpreters, or to use risk assessment tools that have been adapted for use with vulnerable groups.

In practice, we identified only five instances where the FDVRT had adapted their responses to meet the specific needs of a victim survivor or person using violence who identified as belonging to a vulnerable group. This points to a need for more explicit guidance and stronger coordination so that day to day practice aligns with strategic commitments. While Communities have indicated that the FSS would prioritise relationships with local ACCOs to embed cultural safety, we found little evidence of FSS engagement in the sample group.

3. The Risk Assessment Tool is not adapted for vulnerable groups

The FDVRT must use the Risk Assessment Tool to assess risk. In its current form, the CRARMF is developed on a westernised understanding of FDV and does not fully capture the complexity of issues faced by different vulnerable groups. It does not fully integrate appropriate language, risk factors and format to ensure it is safe and appropriate for use with diverse communities. This means important risk factors may be missed, and responses may not be tailored appropriately, leaving people from vulnerable groups without the support or protection they need.

In April 2025, Communities commenced a tender to contract an Aboriginal organisation to develop a dedicated, culturally appropriate FDV risk assessment tool, including practice guidance, to use with Aboriginal people across the service system. This is a positive step; however, it remains uncertain whether additional tools will be developed to meet the needs of other vulnerable groups.

Case study

Good practice in tailoring practice to meet the needs of a vulnerable victim survivor

The victim survivor in this incident was from a CaLD background and was dependent on her partner for her visa and work. She was isolated from her family and had limited knowledge of available protections. She had experienced serious and repeated FDV perpetrated by her partner.

The victim survivor contacted WA Police after being assaulted and threatened by her partner, who was intoxicated at the time. Due to fears for her safety and concerns about the impact on residency status, the victim survivor did not provide a statement.

After issuing a Police Order to protect the victim survivor, attending police officers documented

all high risk factors in the FVIR and submitted it for FDVRT assessment. Acknowledging the elevated risk due to the victim survivor's CaLD background and history of unreported FDV, the responding police officers also notified their supervisor by email to highlight the victim survivor's vulnerabilities and ensure urgent, culturally tailored FDVRT follow-up occurred.

The FDVRT responded by connecting the victim survivor with a migration support worker, community legal service, and an FDV outreach service. These supports offered ongoing tailored assistance and helped the victim survivor seek a Family Violence Restraining Order (**FVRO**).

When practice is not responsive to the needs and experiences of vulnerable groups, people who already face systemic barriers are more likely to receive responses that are inappropriate, ineffective, or unsafe. If these gaps remain unaddressed, vulnerable groups will remain at higher risk of harm, and the FDVRT model cannot deliver the protection and support it was designed to provide. By mapping service gaps and identifying systemic barriers to inform service pathway improvements, there is a greater opportunity to ensure that the FDVRT model addresses the needs of all vulnerable groups and delivers effective, safe support.

The Family and Domestic Violence Response Team is identifying where children are present at family and domestic incidents, but responses are limited to Child Protection intervention

Children exposed to FDV are a particularly vulnerable group, yet their experiences as victim survivors are often overlooked. These children are more likely to experience poor mental health, disrupted education, homelessness and long term social and health problems.¹⁰ While most children experience FDV in the family home, there is also growing recognition of young people experiencing violence in their own intimate partner relationships.¹¹

Given these risks, there is a clear need for age-appropriate assessments and referral pathways that respond to children in ways that reflect their specific circumstances. The CRARMF specifies that when a child is a victim survivor or witness to FDV, it must be treated as an occurrence of child abuse. This expectation is reinforced in the System Reform Plan, which emphasises the importance of acknowledging children as victim survivors in their own right and ensuring they receive a safe and sensitive response.

10 Campo, M. (2015). *Children's exposure to domestic and family violence: Key issues and responses*, Melbourne: Child Family Community Australia information exchange, Australian Institute of Family Studies. Retrieved from <https://aifs.gov.au/resources/policy-and-practice-papers/childrens-exposure-domestic-and-family-violence>.

11 Australian Institute of Health and Welfare, *Family, domestic and sexual violence: Children and Young People*, 2025.

Relevant finding from the external independent review 2020

The external independent review raised concerns about whether FVIRs accurately recorded when children were present and recommended that WA Police develop enhanced training and updated processes, to support police officers in gathering accurate information about children when attending FDV incidents (Recommendation 17). The external independent review also raised that the CRARMF, and existing service pathways for children, may require adjustment to fully meet the needs of children experiencing FDV.

WA Police has taken action in response to Recommendation 17, to improve the accuracy of recording when children are present at FDV incidents. In our sample group, attending police officers identified 356 children present. Of these, 212 children were assessed as meeting the threshold for high risk of serious harm.

Only 30 of these children were recorded as victim survivors in their own right. However, 219 children were referred for a Child Protection response. This shows that even when children are not directly labelled as victim survivors by WA Police, the FDVRT response often reflects an understanding that their exposure to violence requires intervention.

There were additional examples of good practice. Of the 118 cases open to Child Protection, 90 new interactions were created. Additionally, in the 33 cases where children were already in the care of the CEO of Communities, action was taken in

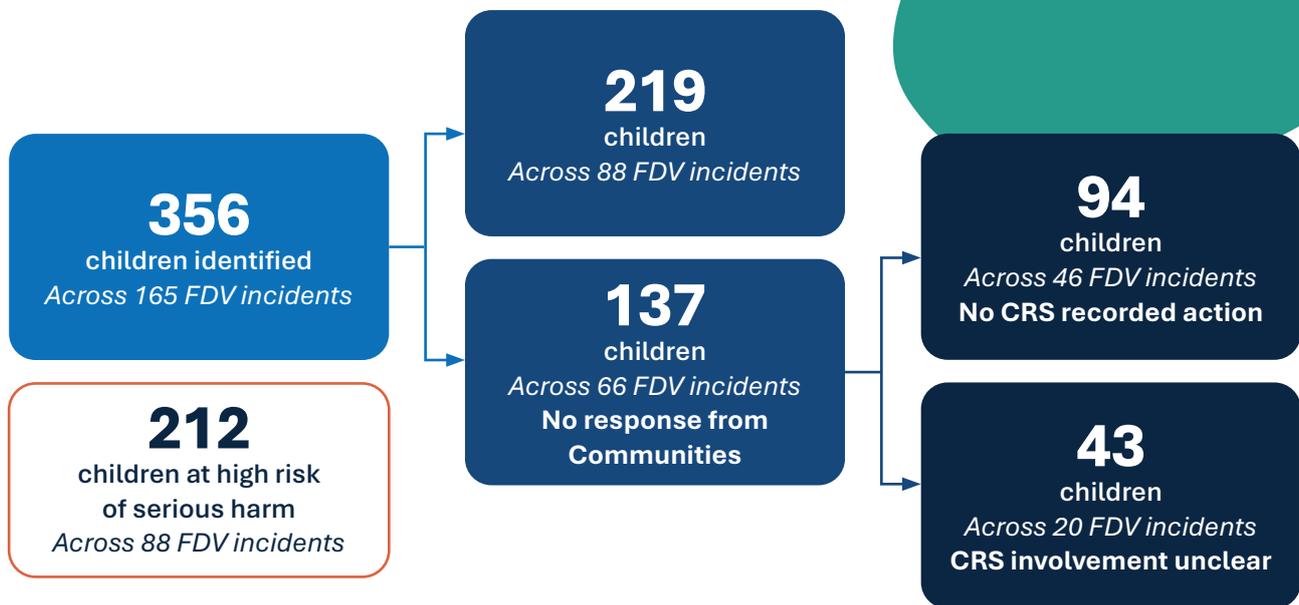


Figure 7: Children present at FDV incidents in sample group (n=388)

73 per cent of cases, through interactions and reports sent to case managers. These examples highlight that when children are recognised within the Child Protection system, Communities are often meeting their statutory obligations. Due to the scope of this investigation and limitations in the available data within the FVIR Triage application, we were unable to determine the nature or extent of support provided to these children.

Child Protection remains the only pathway used for children identified at FDV incidents. The remaining 137 children identified in the sample group did not receive any recorded follow-up or intervention, leaving many children who are harmed through exposure without recognition or support. The CRS can support children, but in practice, this rarely occurred. For 94 of these 137 children, no further action was recorded by the CRS. For the remaining 43 children, it was unclear whether the CRS provided support to the children identified or only to the adult victim survivor.

Although Child Protection is an important pathway, it cannot meet the needs of all children exposed to FDV. Many children may not require statutory intervention but would benefit from counselling, support services and other child-centred programs. Additionally, there are also no child focused adaptations to the Operating Procedures or Risk Assessment Tool, and the current tools do not adequately address the complexities involved in supporting children affected by FDV in both familial relationship and in youth intimate partner relationships.

When the FDVRT model consistently integrates children's needs into assessment and response beyond statutory Child Protection obligations, the system can more accurately identify and address the full extent of harm. Only by adopting a genuinely child-centred approach and monitoring and evaluating responses can the invisibility of children be addressed, revealing the true scale of the issue and enabling more effective protection and support for those most vulnerable.

There are limitations in the applicability of the Family and Domestic Violence Common Risk Assessment and Risk Management Framework Common Risk Assessment Tool to Family and Domestic Violence Response Team practice

The Risk Assessment Tool is the prescribed mechanism to guide FDVRT risk assessments and inform follow-up actions. However, as previously noted, we found that the FDVRT only used the Risk Assessment Tool in 25 per cent of cases in the sample group. Our investigation did not specifically examine the reasons for this inconsistent use.

However, in applying the Risk Assessment Tool to the 388 cases in the sample group, we identified several potential barriers that may limit its consistent use by the FDVRT:

- The Risk Assessment Tool is lengthy, and the time required to jointly complete this tool at an FDVRT triage meeting is resource intensive. While a comprehensive risk assessment may be necessary, the FDVRT model would need to be adequately resourced to undertake a risk assessment for each case using the Risk Assessment Tool.
- The Risk Assessment Tool is not embedded in the FVIR Triage application. Instead, it must be downloaded for electronic completion, or printed, and subsequently uploaded into the FVIR Triage application. These technical limitations make it challenging to consistently complete and upload the Risk Assessment Tool.
- The Risk Assessment Tool is based on a westernised understanding of intimate partner violence. It does not fully capture the complexity of issues faced by diverse communities and other familial relationships. This may be a deterrent to its use in all circumstances.

These challenges highlight the importance of ensuring that risk assessment tools are both practical and adaptable to the circumstances faced by FDVRTs. Equipping the FDVRT with a user-friendly and adaptable tool would empower teams to carry out assessments with greater consistency and confidence, ensuring responses are well-matched to the unique circumstances of every family and relationship they encounter.

The Family and Domestic Violence Response Team model does not have adequate measures in place to consistently engage with people who use violence and hold them accountable, beyond a justice response

Victim survivor safety cannot be genuinely achieved without holding the person using violence to account. While justice responses can impose criminal consequences, long term safety relies on supporting people who use violence to take responsibility for their behaviour. This depends on access to behaviour change programs and skilled engagement, supported by coordinated responses that prioritise victim survivor safety. The System Reform Plan reflects these principles by committing to a service system where people who use violence are visible, engaged and supported to change their behaviour.

Relevant finding from the external independent review 2020

The external independent review found there was a significant gap in the FDVRT model in addressing accountability for people who use violence. The review highlighted that:

- There was little evidence that FDVRTs were actively managing the risk posed by the person using violence, despite this being a core principle of the model.
- The FDVRT model focused heavily on victim survivors changing their circumstances, rather than people who use violence changing their behaviour.
- People who use violence often cycled through the FDVRT repeatedly without effective intervention.
- There was a lack of referral pathways and specialised programs for people who use violence, particularly in regional districts.
- The FDVRT require additional skills to engage meaningfully with people who use violence.
- Accountability approaches varied considerably across districts.

To address these issues, the external independent review recommended the following:

- Develop service options for people who use violence in both metropolitan and regional locations.
- Provide clear direction and guidance to the FVT in how police responses could include a greater focus on accountability.
- Develop training programs that better prepare police officers in the FDVRT to engage people who use violence.
- Consider a dedicated position with the FDVRT that focuses specifically on accountability for people who use violence.

Since the external independent review, actions have been taken to improve the FDVRT model response to people using violence, including the introduction of men's workers in five FDVRTs, training and supervision for working with people who use violence, and the phased inclusion of Adult Community Corrections officers into the FDVRT model.

Our investigation found that while some positive steps have been taken, these measures have not yet fully addressed the challenges in practice.

In our sample group, only 49 referrals were made to intervention programs for people who use violence.

This included 22 referrals to Domestic Violence Outreach Services, 12 referrals made by the FVT to behaviour change programs and 15 referrals to both services. The remaining 339 cases did not receive any referral for the person using violence and among these, 205 cases were assessed as being at high risk of serious harm. In some districts, programs were unavailable or at capacity, leaving the person using violence without access to intervention. For example, of the 30 cases assessed in one district, 16 stated that behaviour change programs were unavailable. Additionally, the CRS is unable to engage with the person using violence as they are only contracted to support adult victim survivors.

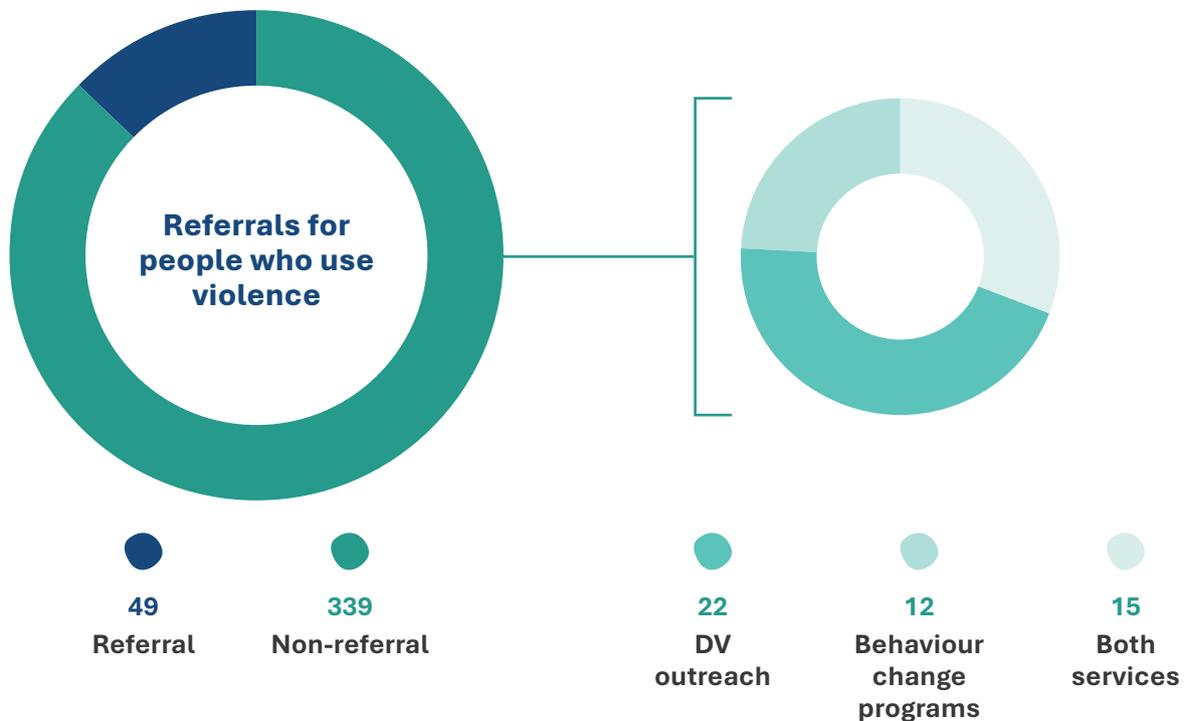


Figure 8: Referrals for people who use violence in the sample group (n=388)

We also found that 83 per cent of people who use violence had previous contact with the FDVRT, including one person recorded as the person using violence on 81 separate occasions. These findings align with those of the external independent review which highlighted that many people who use violence continue to cycle through the FDVRT, without effective follow-up or intervention to support behaviour change. While safety planning and referrals for victim survivors is essential, it is more effective if this occurs alongside targeted interventions with people who use violence. Without this balance, the responsibility for safety continues to fall to victim survivors to change their circumstances, rather than ensuring people who use violence are held accountable for their behaviour and are supported to change.

Communities have since indicated that the FSS can engage with people who use violence who are considered to pose the ‘highest risk’, but it remains unclear what this engagement entails or whether it is monitored. Additionally, Communities are partnering with Stopping Family Violence to implement a ‘Perpetrator Practitioner Pilot’ within the CTT. This pilot will introduce a specialist practitioner into the CTT for 12 months to participate in FDVRT triage meetings. Their role will be to map the behaviours of people who use violence and ensure they are brought into view in all conversations.

The Family and Domestic Violence Response Team does not have clear processes for circumstances where agencies are unable to contact the victim survivor

The Operating Procedures require risk assessments to be ongoing and responsive to change, and for services to monitor and review risk on a regular basis. However, there is no formal requirement setting out what should occur when attempts to contact the victim survivor is unsuccessful.

Relevant finding from the external independent review 2020

The external independent review found that many victim survivors and people who use violence were uncontactable and consequently received no service or support. It recommended quantifying the number of people that do not receive services or supports from FDVRT because they are uncontactable (Recommendation 2) and consider whether ceasing after three contact attempts was adequate (Recommendation 13).

Our investigation found that the lack of a clear process for circumstances where contact attempts are unsuccessful continues to be a challenge.

In our sample group of 388 cases, the CRS was solely responsible for follow-up in 102 cases. In 65 of these cases, contact with the family could not be established. No further action or reassessment was recorded in any of these cases, despite 68 per cent meeting the threshold for high risk of serious harm. These findings show that, although agencies are expected to monitor and reassess risk, in practice they are left without clear direction once contact attempts fail.

At a broader level, the FDVRT still lacks visibility of how often this occurs across the system. As a result, families may be left without support or intervention, and patterns of abuse may remain unmonitored or unaddressed.

In a recently publicly released internal investigation into the actions of police officers in the lead up to the murders of Jennifer and Gretl Petelczyc in Floreat in 2024, WA Police recommended that ‘when a partner agency’s post triage team is unable to contact a victim survivor, the case should be referred back to the FDVRT to take positive action to locate the victim, to enhance victim safety and their access to support services’ (Recommendation 17). We have been unable to establish the progress of this recommendation.

The Family and Domestic Violence Response Team model is operating without a strong data foundation

The System Reform Plan identifies information sharing as one of its four central pillars. It recognises that strong data is essential for improving service responses and commits to system upgrades that enhance data capture and information sharing.

Relevant finding from the external independent review 2020

The external independent review identified several issues with the FDVRT data system. It noted that ‘at best the current Information Technology system is ‘clunky’ and at worst it is dangerous. There is a significant risk of losing critical information while transferring (cut and pasting) information across multiple databases.’ It also found that there was no state-wide monitoring framework or operational group tasked with analysing FDVRT data, issues and workload. The external independent review further noted that ‘a shared multi-agency database accessible by all partner agencies was considered critically necessary’.

The external independent review made several relevant recommendations. It called for the establishment of a state-wide monitoring framework to analyse FDVRT data, issues and workloads (Recommendation 23), and the creation of a purpose-built shared multi-agency database or an expansion of the FDV Hub database to incorporate FDVRTs (Recommendation 39).

Since the external independent review, some initiatives have been introduced. The FVIR Triage application has been upgraded, and in 2023, WA Police, with support from Communities and the Department of Justice, developed a proof-of-concept data dashboard to provide real-time visibility of FDV trends and responses. However, the dashboard is not yet operational.

Our investigation found data limitations across several key areas

No shared, fit for purpose database

There is still no purpose-built multi-agency database for the FDVRT. The FVIR Triage application, designed to bring agency information together is not meeting the needs of the FDVRT. Each agency continues to rely on its own records, meaning information must be pieced together across multiple systems. This increases the likelihood of incomplete or inconsistent documentation. As a result, although the FDVRTs are required to clearly record all decisions, actions and outcomes in the FVIR Triage application, our investigation found that FVIR Triage records were incomplete in 59.5 per cent of cases. In 36 per cent of these cases, outcome tracking was either absent or unclear, meaning there was no visibility over whether risks were adequately managed.

The FVIR Triage application also lacks real time visibility and does not display trends across the State, making it impossible for agencies to build a full picture of risk or coordinate their responses effectively. Ultimately, without an integrated, purpose-built database, it is difficult to maintain robust and reliable records, which weakens both accountability and effective risk management.

No state-wide monitoring and evaluation framework

The FDVRT still does not have a state-wide monitoring and evaluation framework. This means that even if a shared database existed, there is no mechanism to analyse FDVRT data, identify trends, measure outcomes or check whether services are consistent across districts. This leaves agencies without a structured way to evaluate whether the model is working as intended or where improvements are needed.

Data is fragmented and inaccessible

The data that does exist is difficult to access and use. In our FDV fatality reviews, we have repeatedly sought system level data to understand whether FDVRT responses are effective and equitable. Communities could not provide reliable trend data or outcomes, suggesting that this information is not collated or monitored.

For this investigation, some data was available but not stored in a way that allowed easy extraction or analysis. We were required to manually collate and analyse much of the data ourselves, confirming that the data system is not built to generate the insights needed to inform practice improvements, evaluate impact and drive system reform. In addition, as set out in our earlier finding, the FDVRT is unable to generate reliable demographic data to show the cohort profile of those using the service. Without this, the FDVRT cannot evaluate whether responses are equitable or adapt services to meet the need of diverse communities.

Five years on from the external independent review, the FDVRT still lacks the strong data foundations that were identified as critical. This continues even though the System Reform Plan commitments to improve data capture and information sharing. Without these changes, the FDVRT cannot share information effectively, track outcomes, or ensure that services delivered fairly and consistently.

The Family and Domestic Violence Response Team model is not supported by a monitoring and evaluation framework to measure effectiveness or outcomes

All our findings point to the same underlying weakness: the FDVRT model continues to operate without a comprehensive monitoring and evaluation framework.

Relevant finding from the external independent review 2020

The external independent review identified an urgent and critical need for a focused team to support and guide the FDVRT with appropriate governance, monitoring and compliance processes due to there being no formal framework for the ongoing monitoring and quality assurance of practice standards. It also noted that the Operating Procedures were outdated and that two comprehensive monitoring and evaluation frameworks had been developed over time for the FDVRT but not implemented.

It recommended the development of a framework for the ongoing monitoring and quality assurance of practice standards (Recommendation 24).

In response to the external independent review, Communities introduced the Enhanced FDVRT Model, which included the establishment of the FDVRT Central. FDVRT Central was intended to operate as a dedicated, standalone function responsible for providing overarching coordination, strengthened governance, and consistent practice across FDVRTs. However, its role has gradually shifted, as reform work has taken precedence over core responsibilities.

Instead of focussing on governance and monitoring, FDVRT Central became heavily involved in reform projects, leaving limited capacity to oversee day-to-day practice. As a result, practice continues to vary widely between districts, and no monitoring and evaluation framework has been implemented to assure consistency or effectiveness.

Our analysis found various issues associated with the lack of monitoring and evaluation

Limited number of joint responses

While FDVRT Triage meetings appeared to take place, we found that responses typically defaulted to individual statutory responsibilities and were often delegated entirely to a single agency. Of the 388 cases reviewed, only 86 cases showed evidence of any form of joint response, and just 12 cases received a joint response from all three core agencies. While most of the actions taken by the FDVRT were consistent with individual agency mandates, they did not provide the joint, integrated response the FDVRT was designed to deliver. In practice, the FDVRT often worked as three separate agencies, each focused on their own obligations, rather than as one system working together to provide a collaborative response. Without monitoring the extent of joint responses, it is difficult to determine whether the FDVRT adds value beyond what individual agencies would deliver independently.

Reliance on individuals rather than systems

Good practice was more evident at the individual level. We found 72 examples of good individual practice, but only 22 clear examples of strong joint practice. Without a way to measure the quality of collaborative practice, outcomes rely heavily on the goodwill and expertise of individual practitioners. This leads to inconsistent levels of support for families depending on location, rather than a reliable, system-wide response.

Inconsistent management of high risk cases

A total of 103 cases in the sample group were assigned 'no further action' or left with unspecified follow-up actions. Of these, 49 cases met the criteria for a high risk of serious harm. This shows that even families assessed as high risk of serious harm can be left without intervention, with no system in place to identify or address these issues.

The issues arising from the lack of a monitoring and evaluation framework also extend across our earlier findings

Limited compliance with operational requirements

The Risk Assessment Tool was not consistently applied by the FDVRTs, and only a very small number of high risk cases were escalated to MACM. Without monitoring and evaluation, there is no visibility of whether the FDVRT are complying with operational requirements, and barriers to compliance cannot be identified or addressed. As a result, there is no assurance that victim survivors assessed as at high risk of serious harm are being identified or responded to appropriately.

Inadequate responses to vulnerable groups

There is little visibility of who is engaging with the FDVRTs, as demographic data on vulnerable groups was limited or absent. Without monitoring and evaluation, it is not possible to assess whether responses are adapted to different groups, or to identify where changes are needed to improve equity, cultural safety and effectiveness across the system.

Responses for children

The scale of service gaps for children is not visible, and there is no assurance that children are receiving appropriate, child-centred responses.

Limited referrals for people who use violence

Referrals for people who use violence were limited. The absence of monitoring and evaluation means there is no visibility of whether referrals are followed up, whether engagement with programs is effective, or whether repeat appearances are reducing over time.

No process when contact attempts are unsuccessful

Families that could not be contacted did not receive a response, including many assessed as high risk of serious harm. Without monitoring and evaluation, there is no visibility of how often this occurs, whether follow-up attempts are made, or whether families remain at risk without intervention.

Limited compliance with record keeping requirements

In more than half of the cases reviewed, records were unclear or incomplete. Risk assessments, decisions and follow-up actions were often not documented in the FVIR Triage application despite clear operational requirements to do so. Without a monitoring and evaluation framework in place, there is no way to check the accuracy and completeness of records, meaning poor practice goes unnoticed and unaddressed and potentially repeated.

Taken together, these findings point to a single systemic gap. Without oversight, monitoring and evaluation, there is no reliable way to measure whether FDVRTs are adhering to operational requirements, operating consistently, or delivering effective responses. Each limitation compounds the next, creating a cycle of unmanaged risk, weak accountability, and unmeasured effectiveness.

Although the external independent review highlighted this weakness in 2020, five years later and despite significant reform, the same issues remain largely unresolved. It is essential that the original purpose of FDVRT Central – as a dedicated function for governance and support to the FDVRTs – is either reaffirmed or fully established. A robust monitoring and evaluation framework must also be implemented to ensure effective oversight and consistent practice across the FDVRT model. Such a framework would highlight gaps, strengthen accountability, and support continuous learning by building on what is working well. Until these steps are taken, the FDVRT cannot reliably show it is achieving its intended outcomes.

“Our reviews are not intended to assign blame. Their purpose is to identify system level issues, make practical recommendations, and support improvements that strengthen the system and reduce the risk of future fatalities.”

2.5 Recommendations

Risk and Behaviour questions

1. The Department of Communities, coordinate with the Western Australia Police Force to establish a formal ratification process for any proposed change to settled FDVRT practice, requiring consultation with partner agencies and formal approval through the agreed governance arrangements before any changes are implemented.
-

Compliance with operational requirements

2. The Department of Communities undertake a review to identify the barriers preventing FDVRTs from complying with operational requirements related to record keeping, risk assessment and escalation of high risk cases to Multi-Agency Case Management.

Once the review is complete, the Department of Communities:

- Prepare a detailed report and action plan to address the identified barriers.
 - Implement the action plan and establish a process to track and monitor its progress.
-

Responses for vulnerable groups

3. The Department of Communities establish a process to identify when someone from a vulnerable group engages with the FDVRT and develop and apply specific guidance, clear response steps, and dedicated referral options to address the specific needs of people from vulnerable groups.
-

Responses for children

4. The Department of Communities develop a clear service pathway for every child identified at FDV incidents beyond Child Protection responses.
-

Responses for people who use violence

5. The Department of Communities identify further action for the FDVRT to focus on people who use violence beyond a justice response. This should include an up-to-date register of people who use violence engaging with the FDVRT, as well as maintaining a live directory behaviour change and outreach programs, detailing their capacity and eligibility.
-

Unsuccessful contact processes

6. The Department of Communities and the Western Australia Police Force expedite the implementation of Recommendation 17 from the internal investigation into the actions of police officers in the lead up to the murders of Jennifer and Gretl Petelcyc in 2024, or develop and implement a standardised process for cases where agencies are unable to contact a victim survivor.

Recommendation 17: When a partner agency's post triage team is unable to contact a victim survivor, the case should be referred back to the FDVRT to take positive action to locate the victim, to enhance victim safety and their access to support services.

Family and Domestic Violence Response Team database and system design

7. The Department of Communities and the Western Australia Police Force develop a purpose-built, multi-agency FDVRT database that embeds the approved risk assessment tool and accurately records all FDVRT and CTT activities. The system must consistently and reliably capture key details, including:
- Demographic information of the parties involved, including cultural background and other vulnerabilities.
 - Risk assessments, capturing key risk factors, risk ratings, and professional judgement.
 - Triage decisions, required actions, actions taken, and planned next steps in case management.
 - Outcomes of interventions, including services offered and whether contact attempts were successful.
 - Impact on safety for all involved.
 - MACM decisions and review dates.

The new database must capture the activities of all FDVRT partners, including the Department of Justice and FSS. It should generate comprehensive data reports to monitor trends and issues, provide thorough audit trails, and support ongoing quality assurance.

Monitoring, evaluation and state-wide oversight

8. The Department of Communities take immediate action to implement Recommendation 24 from the external independent review and develop an accompanying evaluation framework.

Recommendation 24: Develop a framework for the ongoing monitoring and quality assurance of practice standards.

9. The Department of Communities recommit to, or establish, the initial intent of FDVRT Central as a dedicated centralised team responsible for providing overarching oversight, coordination and support to the FDVRTs to strengthen governance and ensure consistent practice across all FDVRTs.

The Department of Communities and the Western Australia Police Force provide a report outlining the outcomes to the Ombudsman by 1 October 2026.

3 Family and Domestic Violence Fatality Review Findings

3.1 Key Findings from family and domestic violence fatality reviews finalised in 2024-25

We finalised 14 FDV fatality reviews in 2024-25, including the case outlined below. This review highlighted shortcomings in information sharing between WA Police and the Department of Justice, resulting in a recommendation aimed at improving inter-agency coordination.

Case review

This review examined a familial FDV fatality involving two adult siblings. The offender had a documented history of mental health challenges which were exacerbated by drug and alcohol use and inconsistent engagement with treatment services. During periods of poor mental health or intoxication, the offender was more likely to commit FDV against family members.

Due to a lack of housing, the offender was living with family, including the victim, at the time of the incident. The offender was also subject to a 12-month Community Supervision Order which required regular check-ins with a Community Corrections Officer, abstinence from drugs and alcohol, engagement with mental health treatment, and participation in a drug and alcohol program.

As the fatal incident occurred while the offender was subject to the Community Supervision Order, we examined contact by WA Police and the Department of Justice to identify learnings and areas for improvement.

Key Findings

Inadequate information between sharing agencies

Prior to the homicide, the offender was convicted of violent offences and placed on a 12-month Community Supervision Order. During the supervision period, WA Police had contact with the offender on 13 occasions. The Department of Justice was informed of only seven of these, and some notifications were delayed. This hindered effective monitoring by Community Corrections Officers.

Previous FDV fatality reviews identified similar communication gaps. Although WA Police has since granted the Department of Justice access to its IMS, real-time information sharing remains inconsistent.

Recommendation: WA Police and Department of Justice provide a report to the Ombudsman, within four months of the finalisation of this review, on the outcome of discussions to explore the development of an automated process interfacing directly with the Department of Justice's C-BIS, to facilitate real time information sharing of WA Police contacts with people being supervised on community-based orders.

WA Police is of the opinion that this recommendation more correctly falls within the scope of the Central Information Point initiative and will engage with the Office of Digital Government to determine if this can be captured within their scope of works.

This case also raised a number of issues related to recommendations made in other cases, which we continue to monitor.

Insufficient culturally sensitive and responsive practice

WA Police responses to alleged FDV incidents often lacked adequate cultural sensitivity. On several occasions, police officers did not fully consider the factors which may have contributed to the reported reluctance of alleged victims to provide corroborating statements. Consultation with Aboriginal cultural experts could have improved police responses in this case. While WA Police has since implemented some measures to address these issues – such as providing police officers with access to Aboriginal cultural information – challenges remain, including limited capacity and unclear procedures for seeking Aboriginal expertise. We will continue to monitor this issue.

Limited compliance with legislative obligations and practice guidance

In the months before the homicide, WA Police attended the family home following reports of FDV. We found that responses did not always align with policy requirements. Since then, WA Police has implemented new initiatives designed to improve compliance with FDV procedures, strengthen risk assessment processes, and enhance victim safety.

Poor management of complex needs during supervision

When the 12-month Community Supervision Order commenced, the offender was assessed as high risk of re-offending due to drug use and limited engagement with mental health treatment. We found that this risk was not adequately addressed through coordinated treatment planning or program participation. Previous reviews have highlighted the challenges in supporting individuals with co-occurring substance use and mental health issues.

Inadequate safety for victims

The family raised concerns about their safety, as the offender remained living with them due to the absence of alternative accommodation. While the Department of Justice's FDV Strategic Framework prioritises victim safety, it does not specifically address cases where offenders reside with victim survivors and there is no data on the prevalence of these cases. The Department of Justice does not have priority access to public housing. Future reviews will monitor this issue to determine if further action is required.

Other issues of significance

Our FDV fatality reviews during this period often identified significant operational gaps in the practice of the FDVRT. These gaps impacted the FDVRT's ability to manage risk and protect victim survivors effectively.

Similar concerns have been raised in previous FDV fatality reviews. In 2019, we recommended a formal evaluation of the FDVRT model resulting in an external independent review, published in August 2020. This review identified significant deficiencies in the model and made 40 recommendations to strengthen the FDVRT's structure and operations.

While Communities and WA Police have since worked to address these recommendations, subsequent FDV fatality reviews have continued to highlight recurring issues. In November 2024, we commenced an in-depth investigation into the FDVRT's operations. The findings from this investigation are detailed in Chapter 2.

4 Monitoring Family and Domestic Violence Fatality Review Recommendations

4.1 Monitoring recommendation implementation

We monitor the implementation of recommendations in three ways:

- **Early progress checks:** We may request updates a few months after a recommendation is made to confirm that appropriate action has commenced.
- **Follow-up in later reviews:** In subsequent FDV fatality reviews, we assess how previous recommendations have been put into practice and their impact on victim outcomes.
- **Annual reporting:** Each year, we formally request an update on actions taken to implement recommendations made two years earlier.

Implementation of recommendations arising from family and domestic violence fatality reviews in 2022-23

In 2022-23, we made six recommendations to four separate agencies. The recommendations related to our review of an intimate partner homicide (IPH) involving a young couple in regional WA, both in their late teens, with children.

WA Police

Recommendation 1: That WA Police provides this office with the amended version of its Family Violence Procedural Guidelines once finalised, confirming that all family and domestic violence incidents involving children will require submission of a Family Violence Incident Report and cannot be closed at computer aided dispatch.

Current status

The updated WA Police Family Violence Policy (dated 31 March 2025) and its associated procedural guidance now recognise children and young people as a vulnerable group, providing specific practice guidance to children. According to this guidance, whenever a child is exposed to FDV, police officers are required to complete an FVIR, and no discretion is permitted in these circumstances.¹²

WA Police note this recommendation has been completed and they will continue to monitor compliance.

Recommendation 2: WA Police accept that family and domestic violence and Aboriginal Family Violence is a crime of violence predominantly perpetrated by men (including young men) against predominantly women (including young women), that no culture accepts this violence and that it is condemned by all cultures, and that the role of WA Police, as first responders, is always to protect primary and secondary victims¹³ (i.e. children of primary victims) from violence, using every legal means possible. WA Police will continue to ensure that its recruitment, training and standards monitoring reflect this fact.

Current status

WA Police has actively strengthened their commitment through enhanced recruitment processes, comprehensive training, and ongoing standards monitoring. In 2025, this commitment was further reinforced with the release of updated Family Violence Policy and procedural guidelines.

12 A child is defined as anyone under 18 years of age, and exposure to FDV includes circumstances where a child 'sees, hears, is a victim or a suspect, is involved in any way or otherwise experiences the effects of the family violence'.

13 While we are unable to change the wording of a previous recommendation we acknowledge the advice provided by Ms Alison Scott 'The term secondary victim is "Children present at FDV are directly impacted by violence and should not be considered "secondary victims"... This outdated terminology minimises their trauma and fails to reflect contemporary understanding of children as active participants in family life.'

WA Police note this recommendation is completed and will continue to ensure recruitment, training and standards remain consistent with the Australia and New Zealand Policing Advisory Agency guidelines. WA Police will also monitor practices to ensure they align with the WA Police Force Code of Conduct and the Policing Fundamentals.

Department of Communities

Recommendation 3: That the Department of Communities undertakes an audit of the provision of case practice guidance, including supervision and consultation to the Regional Child Safety Team and Regional Intensive Family Support Team, with the outcome of this audit, and all relevant documentation, to be provided to the Ombudsman within six months of the completion of this family and domestic violence fatality review.

The audit should:

- a. Identify any barriers and contextual factors to the provision of case practice guidance, including supervision and consultation in the regional District in accordance with the Department of Communities' standards and practice requirements in all the circumstances; and
- b. Evaluate the quality and quantity of case practice guidance, including supervision and consultation delivered in the regional District from 1 January 2022 to 30 June 2022.

Current status

In March 2024, Communities reported on the Supervision and Consultation Audit Matrix which had been applied to 35 open cases in the specific regional District between 1 January 2022 and 30 June 2022. The audit identified barriers and contextual factors, including geographic challenges, social/cultural characteristics of the client population, and workforce recruitment and retention of suitably qualified child protection staff. Communities commenced a project aimed at elevating supervision quality across all Districts (due for completion in late 2025). Actions are also underway to address workforce issues in the specific regional District.

Recommendation 4: That the Department of Communities undertakes immediate and ongoing action to provide culturally safe and responsive practice in the context of Child Safety Investigations and Intensive Family Support, and associated statutory obligations, with Aboriginal children and families, across the State, while the long-term work of the Aboriginal Cultural Capability Reform Program is progressed. The Department of Communities will provide a report to the Ombudsman, within three months of the finalisation of this review, on the progress of the immediate and ongoing actions that are being implemented.

Current status

In March 2023, Communities provided a summary of actions undertaken to strengthen culturally safe and responsive practice. This included a jurisdictional scan of the minimum practice standards for culturally responsive practice, updates to the Aboriginal Practice Leader consultation form, and delivering a series of internal presentations and broadcasts to frontline staff to reinforce key requirements. Communities also reported on additional initiatives that were underway or planned to further support Communities' commitment to strengthening culturally safe and responsive practice.

In 2025, Communities reported on actions to promote culturally safe and responsive practice in the context of Child Safety Investigations and Intensive Family Support, which includes, although is not limited to:

- A District specific Cultural Learning Journey package for child protection staff as part of their local induction, supported by ongoing monthly cultural training sessions;
- Cultural awareness workshops specifically tailored to local cultural protocols and culturally appropriate ways of engaging with Aboriginal communities and individuals within the District;
- An Aboriginal Cultural Learning team within Communities' Learning and Development unit, and a suite of training modules including Quality Assuring Child Safety Investigations for delegated approval positions;
- Workforce support measures, including supervision training and culturally safe therapeutic support for Aboriginal staff;
- A Whole of Communities Approach to Family and Domestic Violence to support consistency in workforce development and FDV service delivery; and
- Strengthened practice guidance in the Child Protection Guide for completing Child Safety Investigations and providing Intensive Family Support.

WA Country Health Service

Recommendation 5: WA Country Health Service provides this office with an update, within six months of the finalisation of this review, on the progress of the 'audit' referred to in the WA Country Health Service Cultural Governance Framework, relating to current tools used to assess Aboriginal patient's 'physical, spiritual, social and emotional wellbeing', with respect to alleged FDV, mental health issues, adolescent substance use and child protection risk, across hospital and community health services, to confirm these tools are culturally valid, and that associated pathways for risk identified by these tools are culturally responsive and effective.

Current status

In 2025, the WA Country Health Service undertook an audit of culturally validated tools through the Cultural Governance Framework Implementation Project's consultation and co-design process, which informed the Cultural Governance Implementation Framework 2025–2030. The framework sets out specific actions to strengthen the organisations implementation of culturally safe and responsive policies, projects, strategies and initiatives, including the expansion of Aboriginal Health Impact Statements and Declarations and planned expansion of the Cultural Information Gathering Tool.

Department of Education

Recommendation 6: That the Department of Education reports back to the Ombudsman, six months following finalisation of this review, outlining its consideration of whether further action is required to:

- a. provide support to school aged children who are pregnant and/or parenting; and
- b. promote school aged pregnant and/or parenting students' engagement in education, in accordance with Part 2, Divisions 1 and 3 of the *School Education Act 1999*.

This consideration includes, but is not limited to:

- (i) minimum standards of practice.
- (ii) current guidance to schools and regions (including Participation Teams).
- (iii) culturally informed responsive practice for Aboriginal and Torres Strait Islander students, and Culturally and Linguistically Diverse students.

Current status

In 2025, the Department of Education confirmed that specific guidance, additional supporting information and a dedicated intranet page were developed for school staff to use to:

- Develop whole of school plans and identify training for staff in the event of a student becoming pregnant or becoming a parent;
- Meet the educational needs of young mothers and fathers who are students;
- Prepare effective education plans; and
- Access information and resources to help students to feel safe and supported at school.

This guidance encourages a case management approach, supports individual educational pathways, facilitates coordinated support services, and assists with the transition back to school after the birth of a child. Additionally, a fact sheet for school staff has been produced outlining how education and ongoing engagement serve as protective factors for students who are pregnant or parenting. Separate resources have also been tailored for Aboriginal and CaLD students. The Participation, Engagement and Transitions teams have developed a guide to support young people who are pregnant and/or parenting.

5 Data

5.1 Data source

We receive FDV fatality data from Communities, WA Police, and the Department of Justice, which is analysed into datasets and organised into data registers. The reported FDV fatality data detailed in this chapter met criteria to be included in the datasets, including:

- the death resulted from an intentional act, or failure to act;
- the location of the fatal incident was in WA; and
- the death occurred within the data reporting period – 1 July 2012 to 30 June 2025.

5.2 Types of deaths

The deaths are categorised into four distinct groups:

Intimate Partner Homicide (IPH)

The killing of a current or former intimate partner which may include marital, de facto or other intimate partner relationship.

Filicide

Where a parent kills a child under the age of 18 years and includes any person with parental responsibility for the child on more than a temporary basis (biological parent, an adoptive or foster parent, a step-parent, a parent's partner, or a grandparent who is the child's primary caregiver). Incidents of parents convicted with driving related offences causing the death of a child or children are not included in these criteria.

Other Familial Relationship Homicide

The relationship between the victim and perpetrator was familial or household-based including siblings, parents, adult children, extended family members, a non-related individual living in the same household.

Non-Intimate Partner Homicide and Non-Familial Relationship Homicide

A person is killed by another person with whom they have no intimate or familial relationship in an FDV context.

Details outlining the inclusion criteria for each of the four categories of death are provided in **Appendix 3**.

5.3 Snapshot

Between 2012 and 2025, we were notified of

237
FDV fatalities

55% of victims were female

72% of offenders were male



Drugs and alcohol feature in the majority of incidents

35% of victims identified as Aboriginal

42% of deaths involved stabbing

Regional WA was over-represented relative to population



48%

intimate partner homicides (IPH)



3 in 4

IPH involved a **male** killing a **female**

12%

filicides

61%

of filicide victims were female

57%

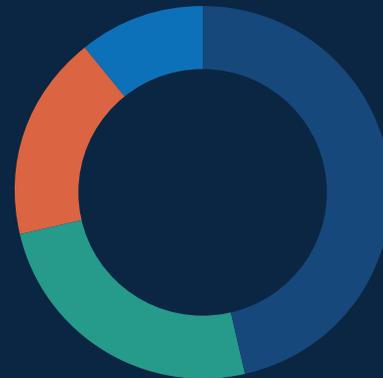
of filicide offenders were male

56%

of IPH had a reported history of FDV

Males who killed their female intimate partner were typically the primary perpetrator in prior reported FDV. In comparison, females who killed their male intimate partner were most often recorded as the victim in previously reported FDV, or prior violence had been perpetrated by both partners.

Nearly half of all filicide victims were under 1 year old



- 46.4% < 1 year
- 25% 1-4 years
- 17.9% 5-8 years
- 10.7% 9-12 years

35%

other familial relationship

60%

of victims were male and 80% of offenders were male

The most common type other familial relationship homicides involved a **son killing a parent**

5%

Non IPH, non-familial relationship

2 in 3

victims were male and 86% of offenders were male

Nearly half involved the victim being killed by their **current partner's former partner**

5.4 Overview of family and domestic violence fatality characteristics

Cohort overview

Between 1 July 2012 and 30 June 2025, we were notified of 237 FDV fatalities in WA. There was a total of 217 offenders¹⁴ and 237 victims.

Males were more likely to be offenders

72 per cent of offenders identified as male (n =156, 71.9%).

More than half of the victims were female

55 per cent of victims identified as female (n=131, 55.3%).

Most victims and offenders were aged in their 30s

The most common age group for offenders was 35-39 (n=34, 15.7%). The most common age group for victims was 30-34 (n=32, 13.5%). 16 per cent of victims were under 18 years old (n=37, 15.6%). 14 per cent of victims (n=32, 13.5%) were aged over 65.

There was high representation of Aboriginal victims

35 per cent of victims identified as Aboriginal (n=83, 35%). This highlights a clear over-representation of Aboriginal victims in FDV fatalities, considering Aboriginal people comprise 3.3 per cent of the WA population (ABS 2021 Census).

Stabbing was the most common manner of death

Stabbing was the leading manner of death, accounting for 42 per cent of FDV fatalities (n=99, 41.8%). Assault was the second most common, responsible for 38 per cent of fatalities (n=89, 37.5%). See figure 9.

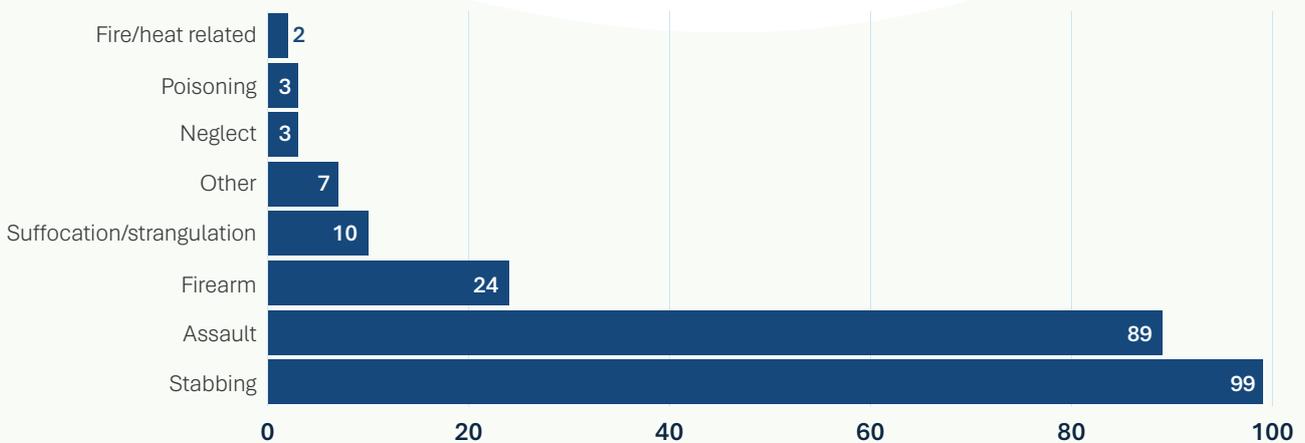


Figure 9: FDV fatalities – by manner of death

14 Three offenders were excluded from this data as they were police officers who lawfully killed FDV offenders during police operations.

The majority of FDV fatalities occurred in the Perth metropolitan area

Over 60 per cent of FDV fatalities took place within the Perth metropolitan area, which also includes the Peel region (n=148, 62.4%). Despite a smaller population, regional WA saw a notable number of deaths, with the Kimberley region alone accounting for 12 per cent of FDV fatalities (n=28, 11.8%).

Half of the FDV fatalities were categorised as IPH

Half of FDV fatalities were categorised as IPH (n=115, 48%). The next most prevalent category was other familial relationship homicides (n=82, 35%).

See figure 10.

5.5 Trends relating to types of death

Intimate Partner Homicide

Prevalence

Between 1 July 2012 and 30 June 2025, WA recorded 115 incidents of IPH in which 115 victims were killed by their intimate partners.¹⁵

See figure 11.

Offender outcomes

The majority of offenders were convicted in relation to the IPH

Most offenders were convicted of either murder, manslaughter or unlawful killing (n=76, 66%). Seven offenders were acquitted by trial, or charges did not proceed, in the circumstances of either the killing being deemed lawful (such as self-defence) or the offender deemed unfit to stand trial in the circumstance of mental impairment (n=7, 6%). 12 offenders suicided at the time of the fatal incident (n=12, 10%).

Criminal proceedings are currently in progress for 19 offenders (n=19, 17%).¹⁶ Data relating to the cases that are progressing through the criminal justice system is not included in this report from this point onward, bringing the number of incidents and offenders and victims down to 96.

See figure 12.

Victim and offender characteristics

A high proportion of IPH involved males killing females

The majority of IPHs involved a male offender killing a current or former female intimate partner (n=69, 72%) compared to 26 per cent of cases where a female offender killed a current or former male intimate partner (n=25, 26%). Two per cent involved a male killing a current or former male intimate partner (n=2, 2%).

The victims age range was between 17 to 90 years

The highest number of female victim deaths occurred between ages 30 and 34 (n=13, 14%) and the highest number of male victim deaths occurred between age 40 and 44 (n=7, 7%).

The offender age range was between 17 to 88 years

Most offenders were aged between 25 and 44 (n=52, 54%).

15 In eight IPH incidents, more than one person was charged in connection with the death. In such circumstances, we identified the intimate partner as the primary offender, and only reported on this primary offender.

16 Correct as at 1 September 2025. Only cases with court outcomes finalised before 1 September 2025 were updated in this section.

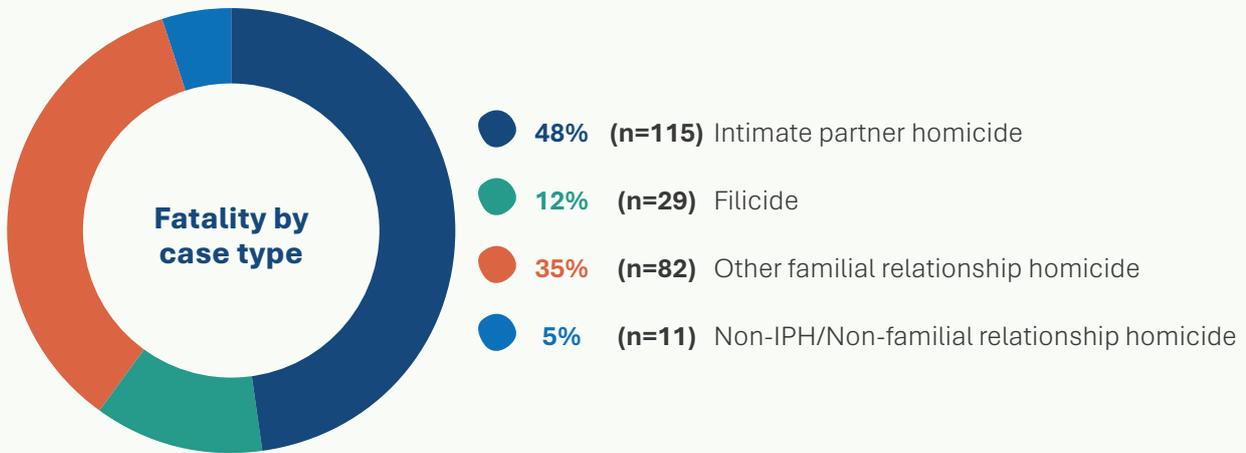


Figure 10: FDV fatality – by case type (n=237)



Figure 11: IPH in WA between July 2012 and June 2025 (n=115)

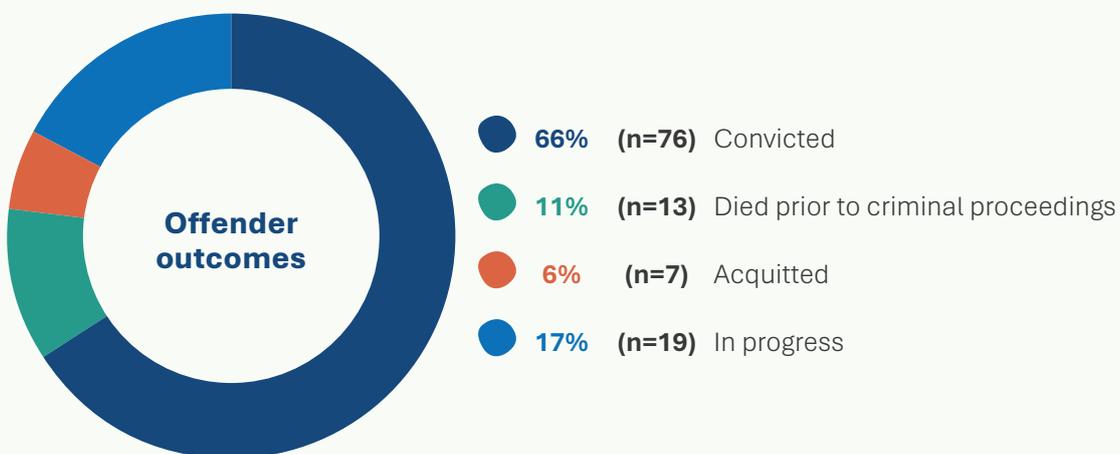


Figure 12: Offender outcomes for IPH (n=115)

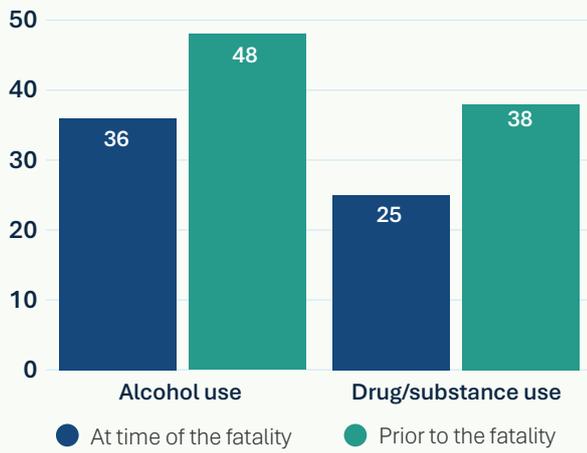


Figure 13: Alcohol and/or drug use prior to death and at time of death among offenders in IPH (n = 96)

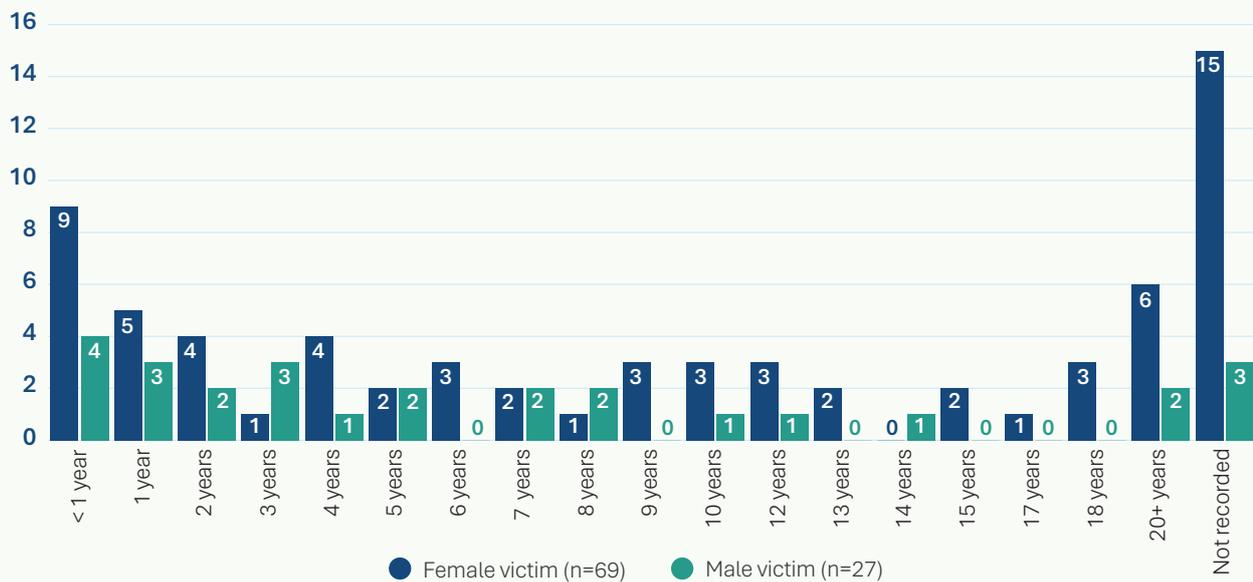


Figure 14: Length of relationship by gender of victim (n=96)¹⁷

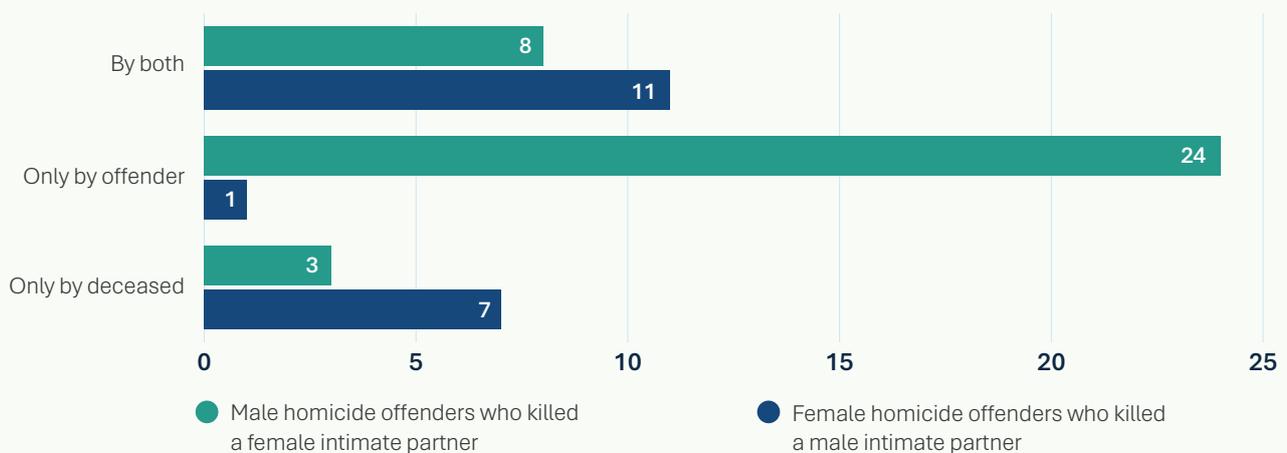


Figure 15: Direction of previous FDV in opposite-sex IPH cases where a history of FDV was recorded (n=95)

17 Eighteen cases (15 female, three male) had insufficient information to determine relationship length and were grouped as 'Not recorded'.

Aboriginal people were over-represented among IPH victims

41 per cent of all IPH victims identified as Aboriginal (n=39, 41%). This highlights a clear over-representation in these deaths, considering Aboriginal people aged 17 years and over comprise 2.8 per cent of the WA population (ABS 2021 Census).

Nearly one quarter of offenders had documented mental health concerns at the time of the homicide

Mental health concerns were identified for 20 offenders at the time of the homicide (n=20, 21%).

Alcohol and drug use were contributory factors in many IPH

Nearly 40 per cent of offenders were affected by alcohol at the time of the fatality (n=36, 38%) and half had a documented history of alcohol abuse (n=48, 50%). Over one quarter of offenders were affected by drugs at the time of the fatality (n=25, 26%) and 40 per cent had a history of drug abuse (n=38, 40%). **See figure 13.**

Relationship characteristics

Most IPH victims were killed by a current intimate partner

Among female victims, 78 per cent were killed by a current male intimate partner (n=54, 78%). Among male victims, almost all were killed by a current female intimate partner (n=24, 93%). The remaining two male victims were killed by a current male intimate partner (n=2, 7%).

It was more common for deaths to occur in relationships of less than one year

The highest number of deaths among both male and female victims occurred in relationships of less than one year (n=13, 14%). **See figure 14.**

Many IPH involved a recorded history of FDV between the offender and victim

Just over half of IPH incidents (n=54, 56%) were characterised by previous FDV between the offender and victim.

Where a history of FDV was recorded, males were more likely to be the primary perpetrators of violence

In almost 70 per cent of cases where a male offender killed a female intimate partner, previous violence was perpetrated by the male against the female (n=24, 69%). In cases where a female offender killed a male intimate partner, previous violence was more commonly either perpetrated by the male against the female (n=7, 28%) or involved a history of both partners being violent towards each other (n=11, 44%).

See figure 15.

Protection orders were not commonly in place at the time of the homicide

In most of the IPH, there was no history of protection orders in place at the time of death (n=56, 58%). Only seven victims had either an active Police Order or FVRO in place at the time of the fatality.

Incident characteristics

Most IPH occurred in the Perth Metropolitan area

Nearly two-thirds of IPH occurred in the Perth metropolitan area, which includes the Peel region (n=58, 60%). While the majority of incidents were concentrated in the Perth metropolitan region, the number of deaths in regional WA is notable when considered against its smaller population.

Most IPH incidents occurred in a private residence

Most IPH incidents occurred in private residential settings (n=71, 74%), with the majority in a shared residence between the victim and the offender (n=45, 47%). In the Perth metropolitan area, more than three-quarters of IPH incidents took place in a private residence (n=49, 84%), whereas public locations accounted for a larger proportion of incidents in regional areas (n=16, 42%).

The victim and offender often had children together

In approximately one third of cases, the victim and offender had children together, which included biological, adopted and foster children (n=31, 32%).

Many IPH were the result of stabbing

Stabbing accounted for almost half of all the IPH (n=42, 44%), followed by assault with other weapon (n=24, 25%). See figure 17.

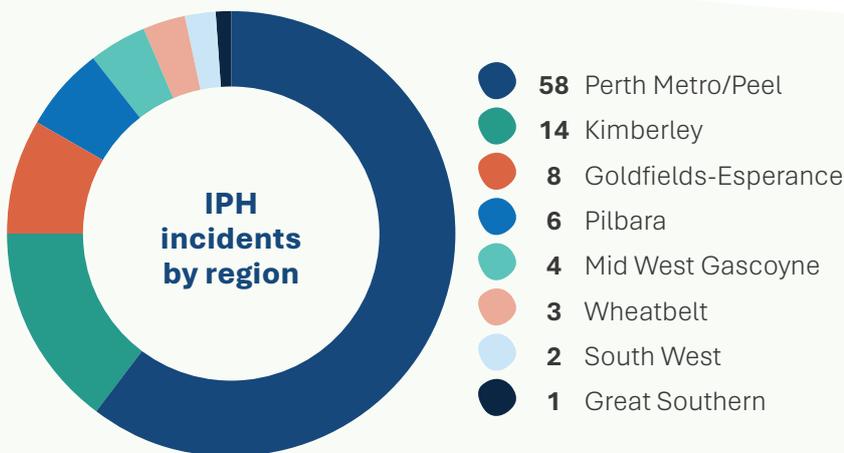


Figure 16: IPH incidents by region (n=96)

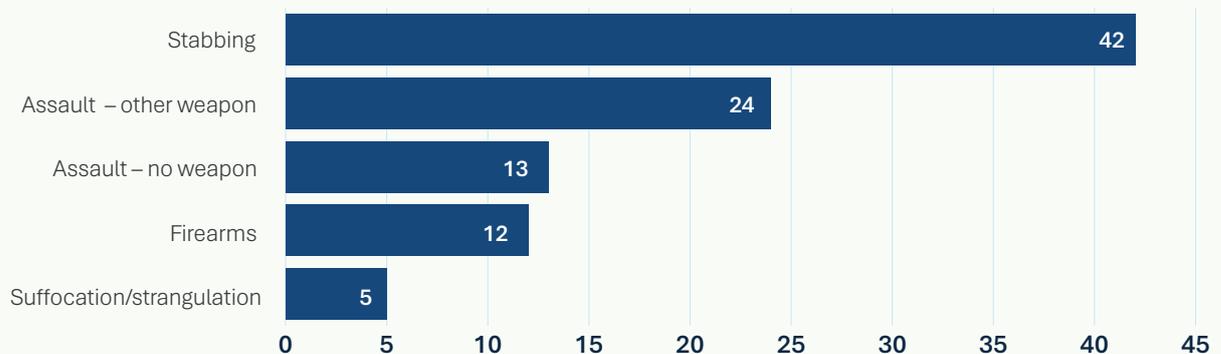


Figure 17: IPH incidents by manner of death (n=96)

5.6 Filicide

Prevalence

There were 29 children who died by way of filicide in WA between 1 July 2012 and 30 June 2025. The deaths were perpetrated by 23 offenders over 21 incidents, with two incidents involving two offenders. In six incidents, more than one child was killed. **See figure 18.**

Offender outcomes

Most offenders were convicted in relation to the filicide

The majority of offenders were convicted of either murder, manslaughter or unlawful killing (n=16, 69%). Two offenders were acquitted by trial (n=2, 9%) in the circumstance of a mental impairment. Three offenders suicided at the time of the fatal incident (n=3, 13%).

Criminal proceedings are currently in progress for two offenders (n=2, 9%).¹⁸ The incidents relating to the outstanding criminal proceedings are not included in the data from this point onward, making the number of offenders 21 and victims 28. **See figure 19.**

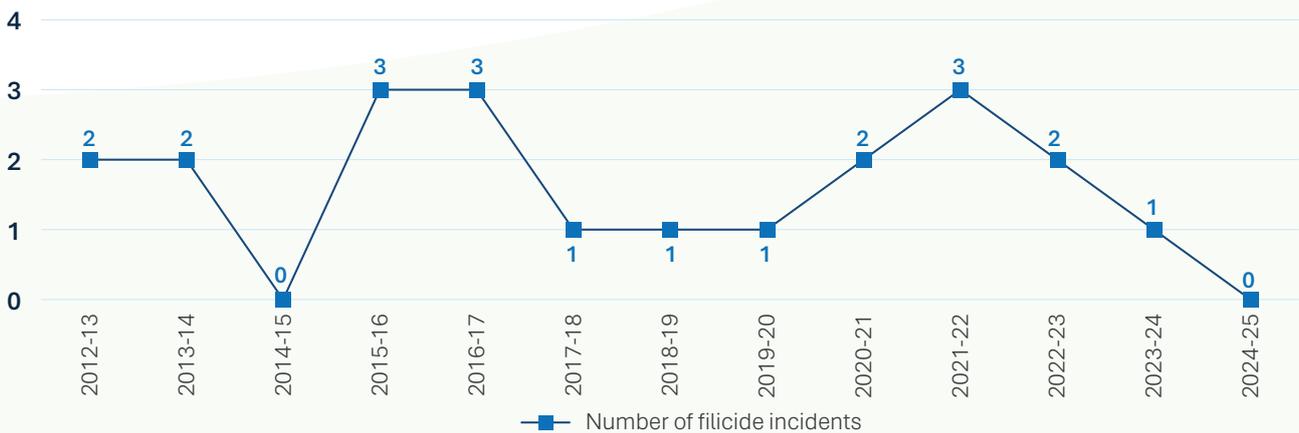


Figure 18: Filicide incidents in WA, 1 July 2012 to 30 June 2025 (n=21)

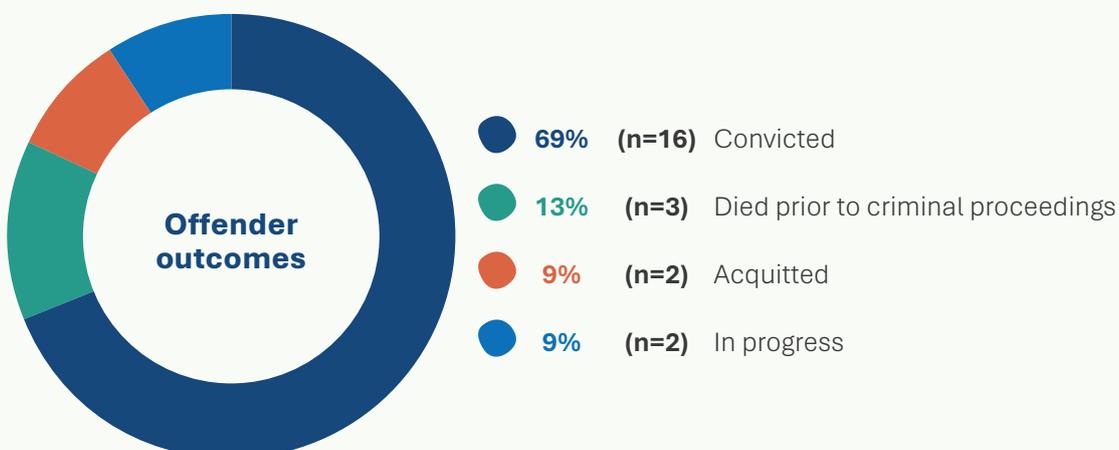


Figure 19: Offender outcomes — filicide (n=23)

18 Correct as at 1 September 2025. Only cases with court outcomes finalised before 1 September 2025 were updated in this section.

Victim and offender characteristics

Over half of all filicide victims were female

The majority of filicide victims were female (n=17, 61%).

Over half of filicide offenders were male

Nearly 60 per cent of offenders were male (n=12, 57%).

Nearly half of filicide victims were aged less than one year

The largest proportion of victims were aged less than one year (n=13, 46%). The youngest filicide victim was one month old and the oldest was 10 years old.

See figure 20.

The offender age range was between 15 and 50 years

The youngest offender was 15 years of age and the oldest 50 years. The largest proportion of offenders were aged 35-39 years (n=6, 29%). The median age of male offenders was 26.5 years old and 36 years old among female offenders.

Aboriginal children were over-represented among filicide victims

Aboriginal children represented 32 per cent of all filicide victims (n=9, 32%). This highlights a clear over-representation of filicide amongst Aboriginal children in WA given Aboriginal children only represent 6 per cent of the WA child population.¹⁹

Relationship characteristics

Most filicide victims were killed by a biological parent

A high proportion of filicides were perpetrated by a biological parent of the child (n=17, 81%). The remaining 19 per cent of offenders were a step-parent (n=4, 19%).

Incident characteristics

Most filicides occurred in the Perth metropolitan area

The majority of filicides occurred in the Perth metropolitan area, which includes the Peel region (n=14, 70%). **See figure 21.**

Most filicides occurred in a shared residence

The majority of filicides occurred in a 'shared residence', which is defined as a home shared by the offender and child (n=16, 80%). This was followed by a public place (n=3, 15%) and the deceased's child's home (n=1, 5%).

Many filicides were the result of an assault

More than one quarter of all filicide victims were killed by assault with no weapon (n=8, 29%). There were no filicide incidents by shooting.

See figure 22.

Many victims had contact with Communities prior to their death

Almost two thirds of all filicide victims had contact with Communities in the two years prior to the death (n=17, 61%). Of these, almost half were an open case to Communities (n=9, 53%).

19 2021 Western Australia, Census Community Profiles, Australian Bureau of Statistics.

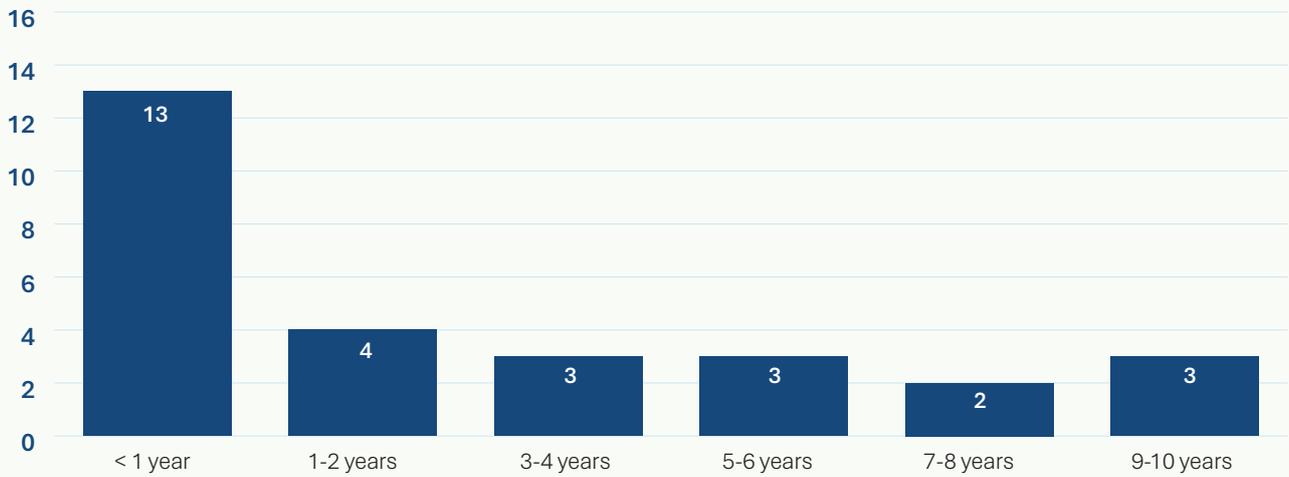


Figure 20: Filicide victim by age group (n=28)

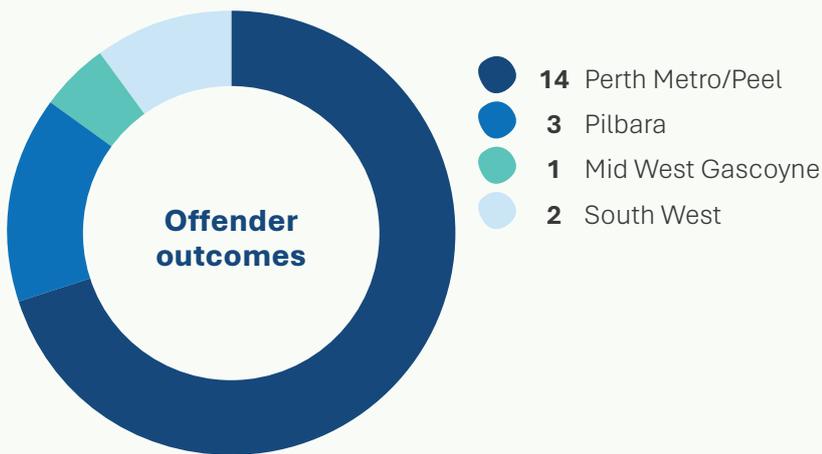


Figure 21: Filicide incidents in WA (n=20)

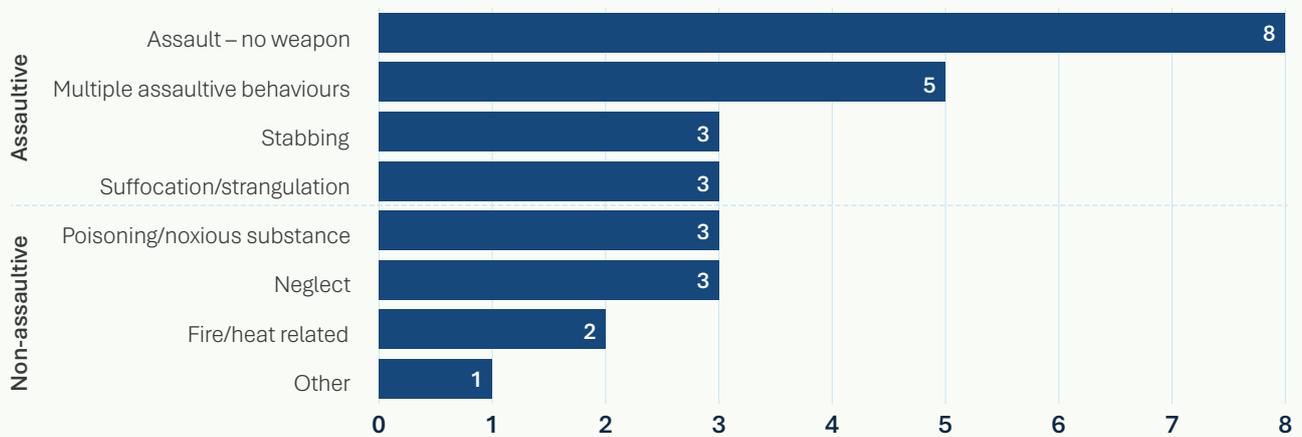


Figure 22: Filicide victim by manner of death (n=28)

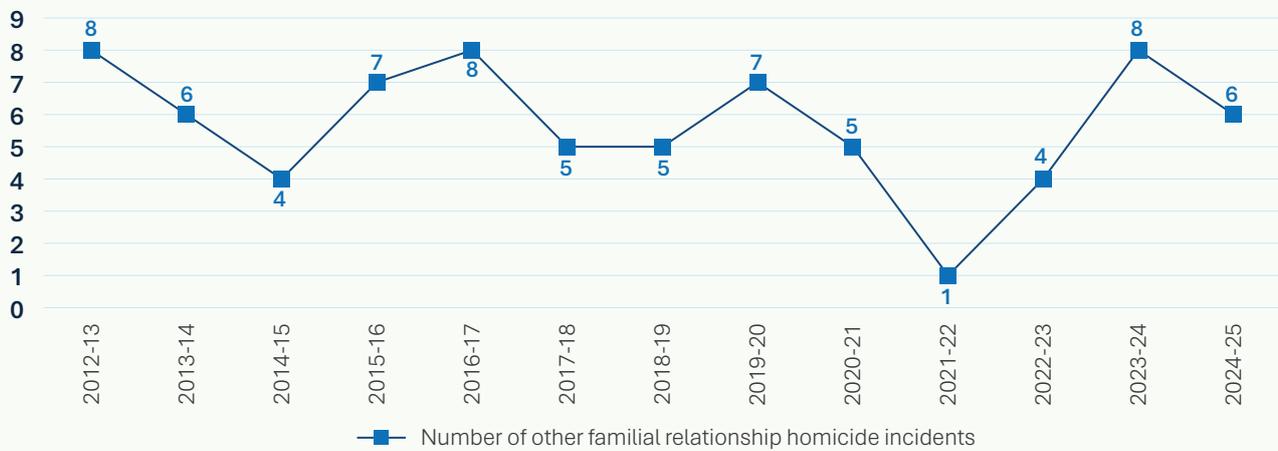


Figure 23: Other familial relationship homicide incidents (n=74)

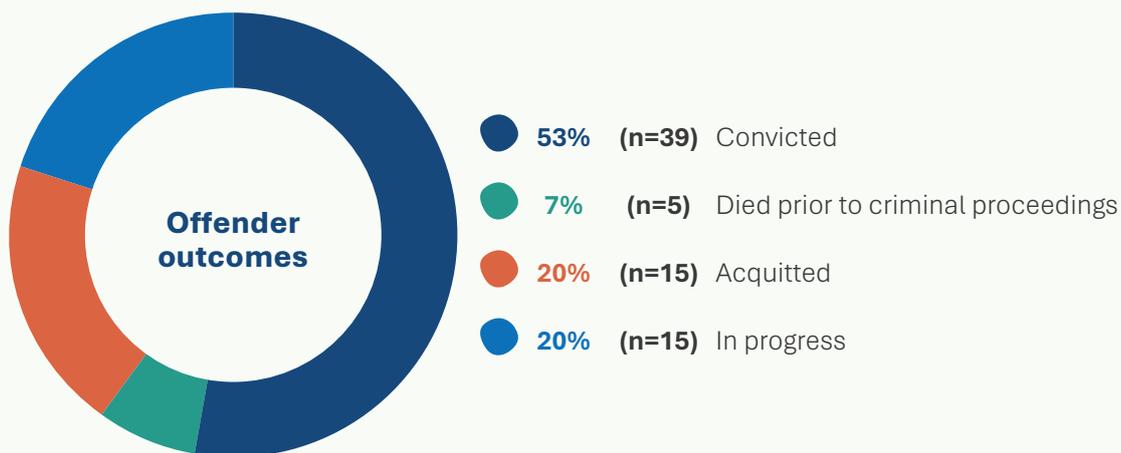


Figure 24: Offender outcomes – other familial relationship homicide (n=74)

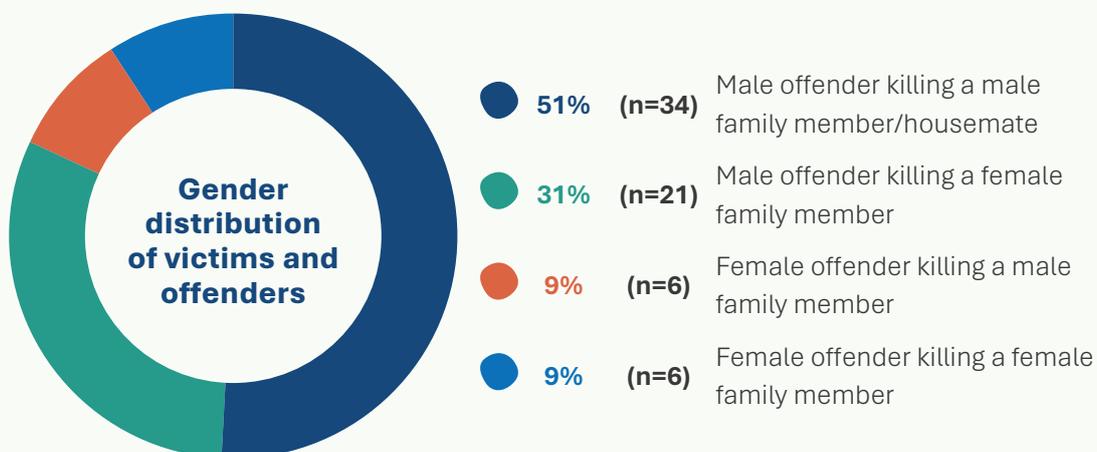


Figure 25: Gender distribution of victims and offenders in other familial homicide (n=67 victims)

5.7 Other Familial Relationship Homicide

Prevalence

There were 74 incidents of other familial relationship homicides in WA between 1 July 2012 and 30 June 2025, perpetrated by 74 offenders and involving 82 victims. Five incidents involved multiple victims, resulting in 18 fatalities across five incidents (n=18, 22%). There were no incidents involving multiple offenders.

See figure 23.

Offender outcomes

Most offenders were convicted

More than half of the offenders were convicted of either murder, manslaughter, or unlawful killing (n=39, 53%). 20 per cent were acquitted at trial or had charges withdrawn, including cases deemed lawful (such as self-defence) or where the offender was found not fit to stand trial due to mental impairment (n=15, 20%). In five cases the offender died before charges could proceed (n=5, 7%).²⁰

Criminal proceedings are currently underway for 15 offenders (n=15, 20%²¹).

These cases have been excluded from the dataset from this point onwards. As a result, the dataset will include 59 offenders and 67 victims, across 59 incidents (noting that some incidents involved a single offender and multiple victims). See figure 24.

Victim and offender characteristics

Most victims of other familial relationship homicide were male

Males made up 60 per cent of victims (n=40, 60%).

Most offenders of other familial relationship homicide were male

The majority of offenders were male (n=47, 80%). In the five incidents that involved multiple victims, all five offenders were male.

See figure 25.

The ages of victims were more evenly distributed across different age groups

The highest proportion of victim deaths occurred in the 35-39 years (n=7, 10%) and 65-69 year age group (n=7, 10%) brackets.

The most common age group for offenders was between 40 and 44 years

Offenders were more commonly aged between 40-44 years (n=12, 20%), followed by 15-19 years (n=10, 17%).

Aboriginal people were over represented among other familial relationship homicide victims

28 per cent of victims identified as Aboriginal (n=19, 28%).

20 Four of these deaths were suicides and one was a medical death in custody.

21 Correct as at 1 September 2025. Only cases with court outcomes finalised before 1 September 2025 were updated in this section.

Alcohol and drug use was common among offenders

Half of the offenders had a history of alcohol abuse prior to the incident (n=27, 47%).
See figure 26.

Documented mental health concerns were common for offenders

Mental health concerns were recorded for nearly 40 per cent of offenders at the time of the fatality (n=22, 38%).

Relationship characteristics The largest proportion of other familial relationship homicides involved a son killing a parent

More than one third of all offenders were sons who killed a parent (n=24, 36%), with the victims split evenly between mothers and fathers.
See figure 27.

Less than half had a recorded history of FDV

In 39 per cent of other familial relationship homicides, there was a recorded history of FDV between the offender and the victim (n=26, 39%).

Incident characteristics Most other familial relationship homicides occurred in the Perth metropolitan area

The Perth metropolitan area (which includes the Peel region), was the primary location for other familial relationship homicides.

Residential settings were the most common place other familial relationship homicides occurred

Most incidents occurred in residential settings (n=56, 95%), and the remainder of incidents (n=3, 5%) occurred in a public place.

Stabbing was the most common manner of death

The most common manner of death was stabbing (n=37, 63%), followed by assault with other weapon (n=11, 19%).
See figure 29.

Some incidents involved multiple fatalities

Five incidents involved multiple fatalities, resulting in 18 fatalities across the five incidents (n=18, 22%). All five offenders in these incidents were male. There were no incidents involving multiple offenders.

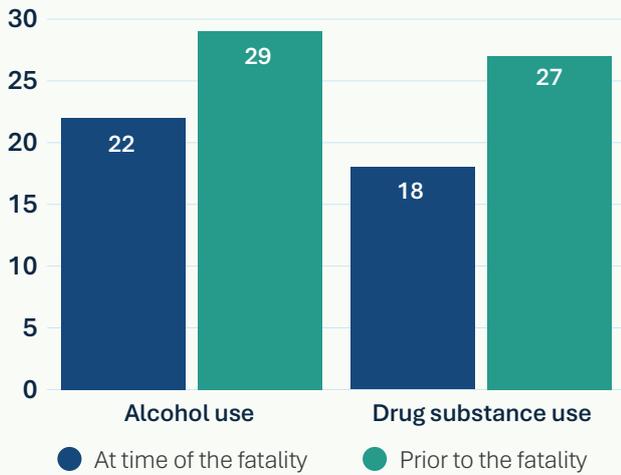


Figure 26: Alcohol and/or drug use prior to the fatality and at time of the fatality among offenders (n =59 offenders)

Relationship of offender to victim	Female victim	Male victim	Total
Son	12	12	24
Brother	3	5	8
Father	2	4	6
Daughter	2	1	3
Mother	0	2	2
Sister	2	0	2
Other	6	16	22
Total	27	40	67

Figure 27: Relationship of offender to victim in other familial relationship homicides (n=67 victims)

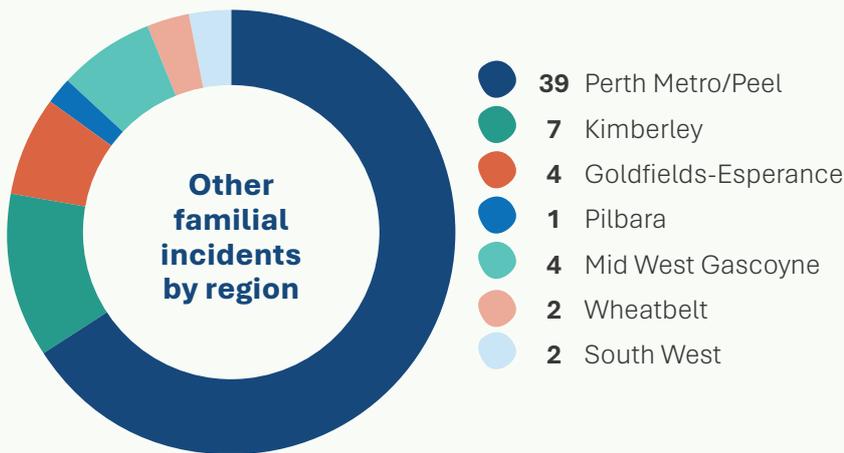


Figure 28: Other familial relationship homicide incidents by WA region (n=59 incidents)

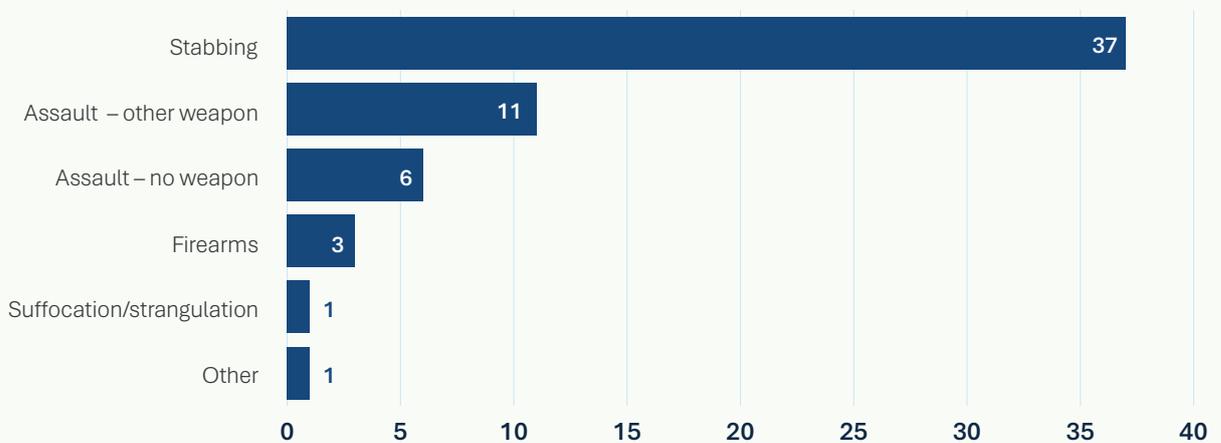


Figure 29: Other familial relationships homicide incidents by manner of death (n=59 incidents)

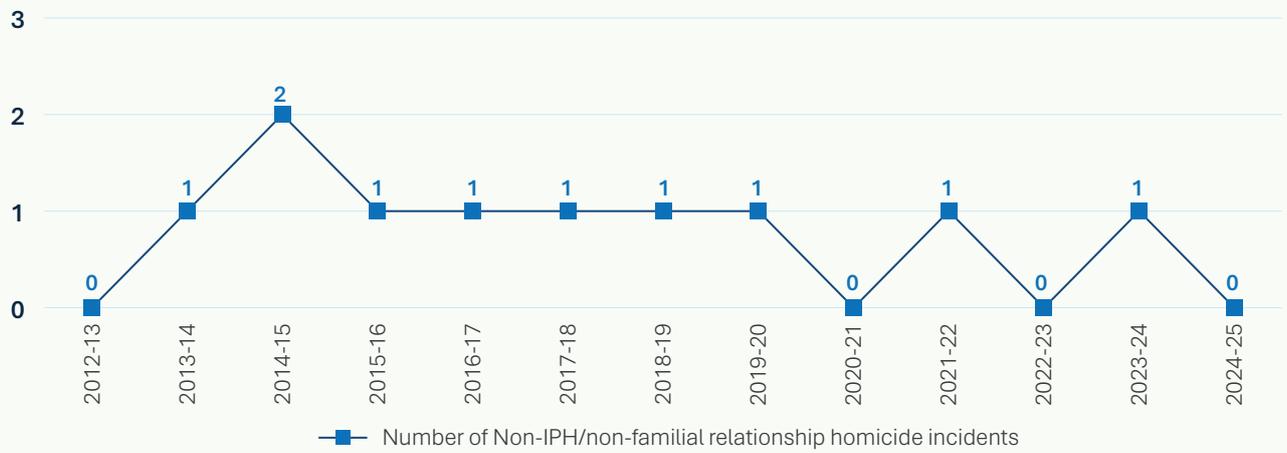


Figure 30: Non-IPH/non-familial relationship homicide incidents in WA, July 2012 to June 2025 (n=10)

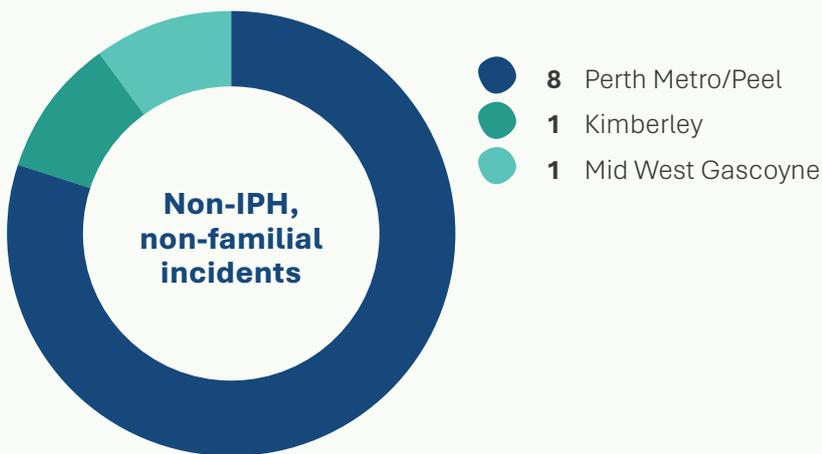


Figure 31: Non-IPH, non-familial homicide incidents in WA (n=10)

Manner of death	Number of incidents	%
Stabbing	5	50%
Firearms	4	40%
Lawful killing	(3)	(30%)
Unlawful killing	(1)	(10%)
Assault – other weapon	1	10%
Total	10	100%

Figure 32: Non-IPH, non-familial relationship homicide incidents by manner of death (n=10)

5.8 Non-Intimate Partner Homicides and Non-Familial Relationship Homicides

Prevalence

There were 10 Non-IPH and Non-Familial Relationship incidents in WA between 1 July 2012 and 30 June 2025, resulting in 11 deaths.²² These homicides were perpetrated by seven offenders (excluding three police officers who lawfully killed FDV offenders during police operations). This cohort represents the smallest number of victims across all homicide categories in the reporting period. See figure 30.

Offender outcomes

Most offenders were convicted of murder (n=5, 71%). One offender was acquitted by trial, in the circumstance of self-defence (n=1, 14%). One offender suicided at the time of the fatal incident (n=1, 14%).

Victim and offender characteristics

The majority of victims and offenders were male

Males accounted for 64 per cent of victims (n=7, 64%). Most offenders were also male (n=6, 86%), while only one offender was female (n=1, 14%). One of the male offenders was responsible for more than one death in a single incident killing two victims in the same family.

Victims and offenders were mostly aged between 25 and 44 years

The ages of the victims ranged from 18 to 73 years, with a median age of 38. 55 per cent of victims were aged between 25 and 44 years (n=6, 55%).

Offenders were aged between 27 and 74 years old, with a median age of 33. 57 per cent of offenders were aged between 25 and 44 years (n=4, 57%).

Most victims did not identify as Aboriginal

Nine per cent of victims identified as Aboriginal (n=1, 9%), with the majority of victims identifying as non-Aboriginal (n=10, 91%).

Relationship characteristics

Most cases involved the victim being killed by their partner's former or current partner

Just under half of non-IPH and non-familial relationship homicides involved the victim being killed by their partner's former or current partner (n=5, 45%). Three were lawfully killed by police officers when

the officers were responding to incidents of FDV (n=3, 27%), while one bystander was killed while intervening in a domestic argument (n=1, 9%). Two victims in the same family were killed in the same homicide incident (n=2, 18%).

Incident characteristics The Perth metropolitan area was the most common place incidents occurred

Most victims were killed in the Perth metropolitan area, which includes the Peel region. (n=8, 80%). See figure 31.

Most incidents occurred in a private residence

Private residence was the most common place in which fatalities occurred (n=9, 90%). One fatality occurred in a public place (n=1, 10%).

Stabbing accounted for half of all deaths

The most common manner of death was stabbing (n=5, 50%), followed by firearms (n=4, 40%). See figure 32.

²² One incident involved two adult deaths

6 Appendices

Appendix 1

A note on Terminology

Throughout this report, we have clarified terminology in the relevant sections. The following terminology is used across the report, and has a particular meaning in the work we do.

Aboriginal

In this report, the term 'Aboriginal' encompasses WA's diverse language groups and also recognises Torres Strait Islanders who live in WA. The use of the term 'Aboriginal' in this way is not intended to imply equivalence between Aboriginal and Torres Strait Islander cultures, though similarities do exist.

Where we provide data on Aboriginal and non-Aboriginal status, this is reliant on Government agency records. Some records do not record this information, and in this report we represent this status as 'unknown'.

Victim and offender

Throughout the report, when we discuss FDV fatalities and our reviews of these deaths, we use 'victim' to refer to the person who died, and 'offender' to refer to the person whose action, or inaction, resulted in the lawful, or unlawful death.

Victim survivor and person using violence

Throughout the report, particularly the section of this report that discusses our investigation of the FDVRT operation and functioning, we use 'victim survivor' to refer to the person who was subject to the FDV, and 'person using violence' to refer to the person who perpetrated the FDV.

Family and domestic violence

FDV often involves a pattern of behaviour, used to harm or control an intimate partner or family member. This may include physical, sexual, emotional or psychological abuse, controlling behaviour, threats, and social isolation.

Family and domestic violence fatalities

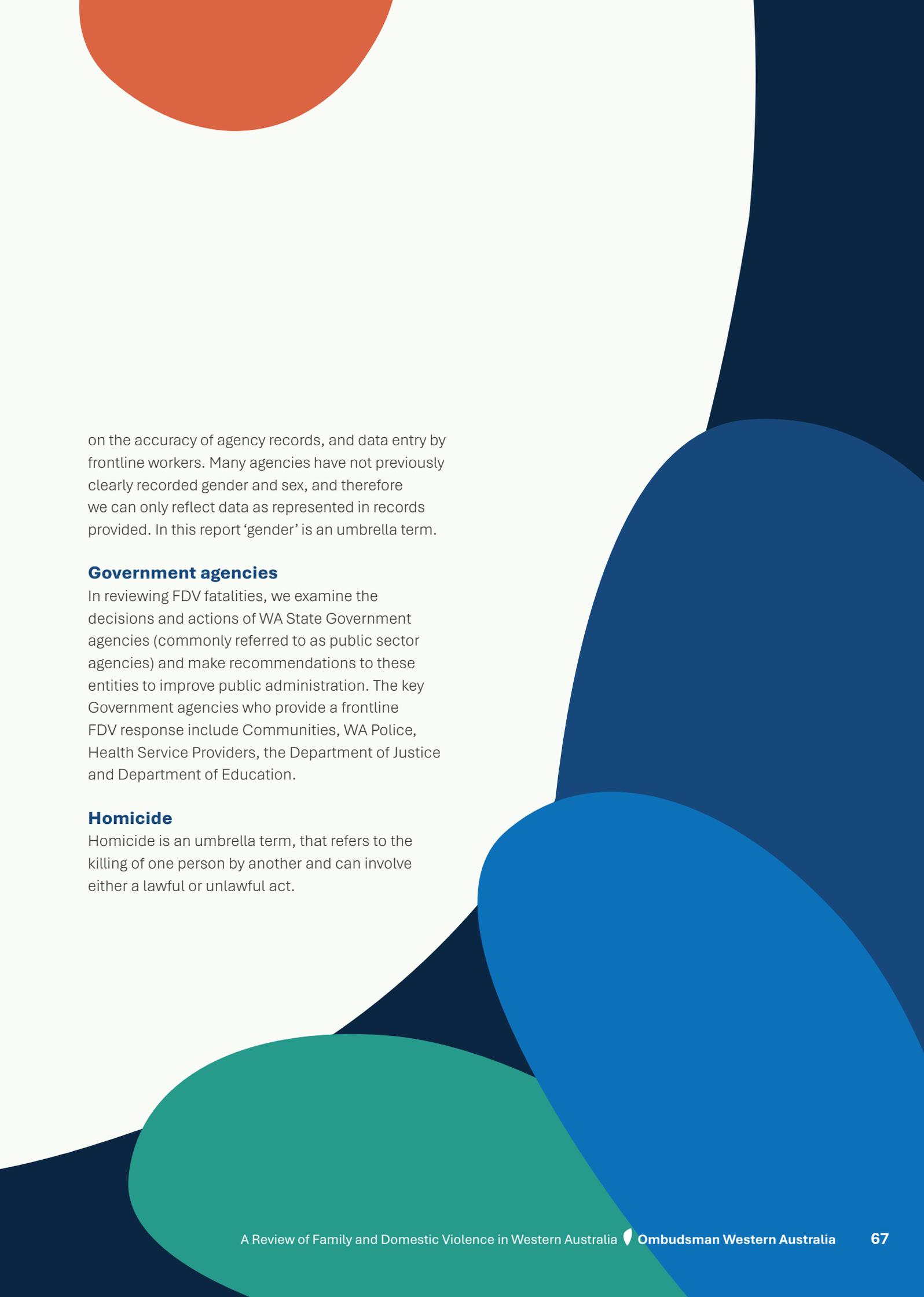
In our work, we define FDV fatalities to include a homicide that has occurred between two parties (the victim and the offender) who had an intimate or familial relationship as defined by section 4 of the *Restraining Orders Act 1997*, or where the homicide occurred in the context of FDV.

Family and domestic risk assessment and safety planning

Government agency FDV responses are informed by assessing FDV risk and developing a commensurate risk management safety plan. FDV risk assessment is informed by evidenced based risk factors. In WA, the CRARMF is the authorised FDV risk assessment framework and Government agencies are encouraged to use the CRARMF and the associated Common Risk Assessment Tool.

Gender

We have used the term 'gender' throughout this report to identify a person's gender identity. We note that a person's identified gender may differ from a person's biological sex classification. Our data relies



on the accuracy of agency records, and data entry by frontline workers. Many agencies have not previously clearly recorded gender and sex, and therefore we can only reflect data as represented in records provided. In this report 'gender' is an umbrella term.

Government agencies

In reviewing FDV fatalities, we examine the decisions and actions of WA State Government agencies (commonly referred to as public sector agencies) and make recommendations to these entities to improve public administration. The key Government agencies who provide a frontline FDV response include Communities, WA Police, Health Service Providers, the Department of Justice and Department of Education.

Homicide

Homicide is an umbrella term, that refers to the killing of one person by another and can involve either a lawful or unlawful act.

Glossary of terms and acronyms

Term or acronym	Meaning
Communities	<p>The Department of Communities</p> <p>WA's major human services department and the lead agency for coordinating strategy and policy direction in the prevention of family and domestic violence.</p>
CRARMF	<p>Family and Domestic Violence Common Risk Assessment and Risk Management Framework</p> <p>A framework for use by all government agencies and community sector services to promote a consistent collaborative and seamless approach to identifying and responding to family and domestic violence.</p>
CRARMF key risk factors	<p>A set of risk factors associated with a greater likelihood and/or severity of future FDV. The FDVRT are required to incorporate these risk factors into their risk assessments.</p>
CRS	<p>Coordinated Response Service</p> <p>Non-Government family violence support service provider within the FDVRT. Contracted by Communities to provide direct service delivery to victims of family and domestic violence to improve safety and hold perpetrators to account.</p>
CTT	<p>Centralised Triage Team</p> <p>A joint response team including WA Police and Communities staff that triages all FVIR's for all regional FDVRT locations. The team operates seven days a week.</p>
FDV	<p>Family and domestic violence</p> <p>Any violent, threatening, coercive or controlling behaviour that occurs in current or past family, domestic or intimate relationships. This may include physical, sexual, emotional, financial or psychological abuse, controlling behaviour, threats, and social isolation.</p>
FDVRT	<p>Family and Domestic Violence Response Team</p> <p>An integrated response model lead by Communities in partnership with WA Police, the Department of Justice, and non-government family and domestic violence service providers (CRS).</p>
FDVRT Central	<p>Family and Domestic Violence Response Team Central Support and Coordination Unit</p> <p>A team of staff from Communities, WA Police and the Department of Justice which provide an overarching coordination and support to the FDVRTs to support operation and continual improvement of the model to its optimal potential.</p>

Term or acronym	Meaning
FDVRT Triage meeting	<p>FDVRT assessment and triage meetings</p> <p>A daily meeting involving representatives from WA Police, Communities, and CRS, where participants collaboratively review family and domestic violence incidents, share information, and jointly assess risk. The FDVRT uses this process to identify and implement the most appropriate actions to improve the safety and wellbeing of those impacted by family and domestic violence.</p>
FSS	<p>Family Safety Service</p> <p>The FSS provides specialised support to families and individuals at the ‘highest risk of high harm’. The FSS also convene MACM for these highest risk cases.</p> <p>32 FSS officers (two officers in each FDVRT) have been appointed across the State.</p>
FVIR	<p>Family Violence Incident Report</p> <p>A report generated on the WA Police Incident Management System that documents WA Police actions and observations from attendance to family violence incidents.</p>
FVIR Triage application	<p>The primary database used by members of the FDVRT to share information and record decisions and outcomes of FDVRT triage meetings.</p>
FVRO	<p>Family Violence Restraining Order</p> <p>A court order against a family member. It is designed to stop threats of violence, violence, or behaviour or patterns of behaviour that coerce, control or cause one to be fearful</p>
FVT	<p>Family Violence Team</p> <p>A WA Police team that fulfils WA Police’s obligations to the FDVRT, including supporting victims and holding people who use violence to account by completing actions in line with WA Police core business.</p>
MACM	<p>Multi-Agency Case Management Meeting</p> <p>An integrated, interagency approach to support people at high risk of serious harm or death due to FDV. It brings together representatives from different agencies to share relevant information and provide short term, coordinated intervention that works to reduce or mitigate the identified risks.</p>

Term or acronym	Meaning
Operating Procedures	<p>FDVRT Operating Procedures</p> <p>The FDVRT Operating Procedures establish the framework for how the FDVRT functions. They outline the roles, responsibilities, and operations of the FDVRT, setting out practice standards that all members are required to follow.</p>
OPFDV	<p>Office for the Prevention of Family and Domestic Violence</p> <p>A directorate within Communities established to elevate the profile of family and domestic violence and provide the stewardship needed within Communities and across government to deliver improved outcomes in the areas of primary prevention, Aboriginal family safety, victim survivor safety and perpetrator accountability.</p>
Risk and Behaviour questions (commonly referred to as 1–9s)	<p>A set of 30 questions asked by WA Police on attendance to a family violence incident, which are aligned to the CRARMF key risk factors, and documented in the FVIR to inform the risk assessment completed by the FDVRT</p>
Risk Assessment Tool	<p>CRARMF Common Risk Assessment Tool</p> <p>The structured tool that FDVRT members must use to assess the level of family and domestic violence risk in each case.</p>
WA Police	<p>Western Australia Police Force</p> <p>Western Australia law enforcement agency.</p>

Appendix 2

Summary of agency responses to the in-depth investigation into the FDVRT

We provided the draft report and preliminary findings to Communities and WA Police and where appropriate, we addressed their comments within the report. Further details regarding the submissions from each agency are outlined below:

Department of Communities

In a letter dated 6 March 2026, Communities made four observations.

First, Communities noted the ‘point in time’ nature of the review and requested a qualification be added explaining that the investigation provides an overview of FDVRT operation from November 2024, which pre-dates significant reform and investment to increase FDVRT capacity and improve operation aligned with the FDV System Reform Plan. Communities also noted the investigation provides a baseline from which future evaluation work can assess operation of the FDVRT model.

Second, Communities noted that the investigation primarily relied on data from the FVIR Triage application and requested amendments to the report to specify that the methodology did not capture subsequent actions taken and recorded in designated systems by partner agencies.

Third, Communities observed that the ‘Data’ section of the report contained information that could be misleading:

- (p.14-15) *‘Minimal engagement with the Family Safety Services’* – this infers under-utilisation, but it is important to note that FSS was not fully implemented at this time, only available and operational in nine districts at the time of the Investigation;
- (p.15) *‘Documented referrals for people who use violence are uncommon’* – provides data on whether referrals were initiated straight away at the point of triage, it does not capture engagement or referrals made as part of follow-up actions which would be captured in agency records (not reviewed as part of this investigation).
- (p. 15) *‘Behaviour change programs were unavailable for over half of the cases in the West Kimberley district’* – Communities notes that community-based men’s behaviour change programs are funded in Broome and Derby and that a commitment has been made to a program in Bidyadanga. Communities suggests that this data be qualified by context about the remoteness of some of the people identified in FVIRs.
- (p.15) *‘People who use violence were rarely referred to AOD and mental health services’* – provides data on whether referrals were initiated straight away at the point of triage, it does not capture engagement or referrals made as part of follow-up actions which would be captured in agency records (not reviewed as part of this investigation).

Fourth, Communities raised concerns about making ‘practice observations’ when the original scope of the investigation was to assess compliance with operational requirements. Specifically, they observed that the report proposed activities relating to children and persons using violence that were beyond the scope of the FDVRT model and the System Reform Plan. Communities considered that these findings were problematic as:

1. *They do not accurately represent the relationship between the FDVRT and the wider service system response to family and domestic violence which has attracted significant investment in its own right in parallel to FDVRT reform. Notwithstanding the additional investment, the resources that an FDVRT has to draw on is dependent on the services funded and available in the district...*
2. *They do not accurately reflect the FDVRT operational context, which includes:*
 - *initial desktop assessment where early triage decisions are informed by the information available in the Family Violence Incident Report and agency databases;*
 - *assertive outreach (or cold-calling) to engage people who may not wish to be contacted or may not wish to engage in services at that time. It is this context that makes appropriate and effective use of statutory responses (police, child protection and justice) so important; and*
 - *high volume client presentation, contributing to the FDVRT predominantly having a role in brief intervention to support immediate safety and connection...*

Communities sought an amendment to Recommendation 4, noting that it supported the intention of this recommendation but that it could be interpreted to:

... require a uniform response which is unlikely to be suitable for the varying needs of children (including developmental), the diversity of the service environment in every location and the service context e.g. that some people cannot be contacted or refuse engagement.

In making these four observations, Communities noted that it had:

... a vested interest in seeing the Investigation report appropriately representing the role of FDVRT, the immediate service context (including in relation to demand and the wider service system) and importantly the existing reforms in progress.

Western Australia Police Force

In a letter dated 10 March 2026, WA Police acknowledged that Communities was the lead agency for addressing FDV and responsible for the FDVRT model. WA Police committed to working closely with Communities and partner agencies to improve responses to FDV and implement the System Reform Plan.

WA Police noted the point in time nature of the review:

... the Family Violence Fatality Review pertains to incidents from 2024 and wishes to advise that substantial operational changes have been implemented since the commencement of your review. These include introducing the Central Triage Team (CTT) in regional Western Australia and securing government-approved funding for additional Full-Time Equivalents (FTE) to support the CTT Metropolitan rollout beginning 1 July 2026.



WA Police provided additional responses to three recommendations that pertained to WA Police. In response to Recommendation 1, WA Police noted that discussions were underway with relevant stakeholders as part of a review of the CRARMF, which will:

...assess the number and content of the risk and behaviour questions and help determine how these can be asked in a more effective and trauma informed manner. The outcome of this review will then be formally considered by the FDVRT partners and the Risk Assessment Working Group – System Reform Plan.

In response to Recommendation 7, WA Police noted a commitment to leveraging technology and facilitating effective information sharing. WA Police noted its willingness to assist Communities to prepare any submission to fund the design and implementation of a shared FDV database.

In response to Recommendation 6, WA Police noted the ongoing implementation of a new process when agencies are unable to contact a victim survivor:

If contact with the victim survivor cannot be established, the matter is referred to the FDVRT, where information is reviewed and exchanged to facilitate contact by the most appropriate agency. This process will be further refined through the statewide rollout of the CTT, scheduled to commence on 1 July 2026.

Appendix 3

Inclusion criteria for types of family and domestic fatalities

1. Intimate Partner Homicide – inclusion criteria

In this report, IPH is identified as the killing of a current or former partner. This means that the following criteria is met:

- the offender is a current or former intimate partner. This may include marital, de facto or other intimate relationship.
- the death results from an intentional act, or failure to act,
- the location of the fatal incident is in WA,
- the death occurred within the data reporting period – 1 July 2012 to 30 June 2025.

2. Filicide – inclusion criteria

In this report, filicide is defined as where a parent kills a child under the age of 18 years. This means that the following criteria is met:

- the offender is a parent or parent equivalent, i.e. any person with parental responsibility for the child on a more than temporary basis (e.g. a biological parent, an adoptive or foster parent, a step-parent, a parent's partner, or a grandparent who is the child's primary caregiver),
- the victim is a child or children under 18 years of age,
- the death results from an intentional act, or failure to act,
- the location of the fatal incident is in WA,
- the death occurred within the data reporting period – 1 July 2012 to 30 June 2025.

Incidents of parents convicted with driving related offences causing the death of a child or children are not included in this criteria.

3. Other familial relationship homicide – inclusion criteria

In this report, other familial homicide is defined as the killing of a relative or household member, where the case is not classified as IPH or filicide. This means the following criteria is met:

- the relationship between the victim and the offender was familial or household-based, but not intimate partner or filicide – this includes siblings, parents, adult children, extended family members, and non-related individuals residing in the same household,
- the death results from an intentional act, or failure to act,
- the location of the fatal incident is in WA,
- the death occurred within the data reporting period – 1 July 2012 to 30 June 2025.

4. Non-IPH/non-familial relationship homicide – inclusion criteria

In this report, non-IPH/non-familial relationship homicide is defined as a person killed by another person with whom they have no intimate or familial relationship. This means that the following criteria is met:

- The victim is a person killed intentionally,
- The offender is a person with no intimate or familial relationship to the victim,
- The death occurred in a family or domestic violence context,
- The location of fatal incident is in WA,
- The death occurred within the data reporting period – 1 July 2012 to 30 June 2025.





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