Factors affecting risk - Other Resources

Australia

- **ANROWS, *Personal Safety Survey 2016 Fact Sheet* (2017).**

Family Court of Australia, *Family Violence Best Practice Principles, 4th edition* (2016)

The Best Practice Principles are applicable in all cases involving family violence or child abuse (or the risk of either) in proceedings before courts exercising jurisdiction under the *Family Law Act* 1975 (Cmth), and provide useful background information for decision makers, legal practitioners and individuals involved in these cases including an explanation of the definition of 'family violence' and 'abuse' under the Family Law Act and the different types of violence and abuse.

The Best Practice Principles recognise:

- the harmful effects of family violence and abuse on victims
- the prominence given to the issue of family violence in the Family Law Act, and
- the principles guiding the case management system for the disposition of cases involving allegations of abuse of children.

Section C deals with the interim hearing stage and introduces the 'PPP' screening tool as a useful mechanism in the assessment of risk. This screening tool analyses risk by reference to three factors: the potency (of violence), pattern (of violence and coercive control) and primary perpetrator indicators (PPP). The screening tool is not a predictive device but does give a useful framework of factors to look for when considering the risk of family violence.

Toivonen, Cherie and Corina Backhouse, *National Risk Assessment Principles for domestic and family violence* (ANROWS, 2018).

This resource identifies *lethality/high-risk factors*, including (pp 12-15):

- History of family and domestic violence;
- Separation (actual or pending);
- Intimate partner sexual violence;
- Non-lethal strangulation (or choking);
- Stalking;

- Threats to kill;
- Perpetrator's access to, or use of weapons;
- Escalation (frequency and/or severity);
- Coercive control; and
- Pregnancy and new birth.

It also identifies *other risk factors*, including (pp 15-16):

- Victim's self-perception of risk;
- Suicide threats and attempts;
- Court orders and parenting proceedings;
- Misuse of drugs or excessive alcohol consumption;
- Isolation and barriers to help-seeking; and
- Abuse of pets and other animals.

This resource outlines the 9 key principles for assessing risk (pp 5-11):

- Survivors' safety is the core priority of all risk assessment frameworks and tools;
- A perpetrator's current and past actions and behaviours bear significant weight in determining risk;
- A survivor's knowledge of their own risk is central to any risk assessment;
- Heightened risk and diverse needs of particular cohorts are taken into account in risk assessment and safety management;
- Risk assessment tools and safety management strategies for Aboriginal and Torres Strait Islander peoples are community-led, culturally safe and acknowledge the significant impact of intergenerational trauma on communities and families;
- To ensure survivors' safety, an integrated, systemic response to risk assessment and management, whereby all relevant agencies work together, is critical;
- Risk assessment and safety management work as part of a continuum of service delivery;
- Intimate partner sexual violence must be specifically considered in all risk assessment processes; and
- All risk assessment tools and frameworks are built from evidence-based risk factors.

International

Domestic Abuse, Stalking and Honour Based Violence (DASH 2009), *Risk Identification, Assessment and Management Model* (updated 2019).

This checklist was implemented across all police services in the UK from March 2009. It aims to turn a reactive response to domestic violence, 'it's just a domestic,' into a proactive 'you must ask' questions approach. It provides police services and other partner agencies with a common checklist for identifying, assessing and managing risk.

Who is the DASH for ?

'The DASH is for all professionals working with victims of domestic abuse, stalking and harassment and honour based violence'.

- There is also a risk checklist for victims of domestic abuse, stalking and honour based violence. This is called the 'Victim-DASH' (V-DASH 2010).
- There are also further screening questions on stalking. This again has been adapted for victims to use.

Gentile Long, J and Wilkinson, J, Stalking: effective strategies for prosecutors, Strategies in Brief, Aequitas, Issue 11, April 2012.

This American resource briefly outlines 3 strategies for successful investigation and prosecution of stalking offences:

1. Recognise the danger stalkers pose to their victims;
2. Work with experts to understand and respond to stalking; and
3. Collaborate and coordinate with other allied criminal justice professionals.

Judicial Council of California's Domestic Violence Practice and Procedure Task Force, *Bench guide for recognizing dangerousness in domestic violence cases*.

This US-based resource is designed for use by judicial officers in proceedings involving domestic violence. The checklist is not exhaustive but lists factors most commonly present when there is a risk of serious harm or death. These factors include the perpetrator owning a gun, the perpetrator using drugs, and the physical violence increasing in severity or frequency over the past year.

National Domestic Violence Fatality Review Initiative website.

This aim of this US based organisation is ' to provide technical assistance for the reviewing of domestic violence related deaths with the underlying objectives of preventing them in the future, preserving the safety of battered women, and holding accountable both the perpetrators of domestic violence and the multiple agencies and organizations that come into contact with the parties.' The website provides access to a range of helpful resources including video lectures from some America's most well-known experts on

domestic and family violence. The focus of many of these lectures is on understanding risk.

Stalking Resource Center, National Center for Victims of Crime, AEquitas, Office on Violence Against Women, Prosecutor's Guide to Stalking, October 2015.

This American resource is intended to assist prosecutors in:

- analyzing the elements of their stalking statute(s);
- recognizing stalking in cases where it has been employed by the offender in connection with some other criminal offense;
- appreciating the strategic value of charging stalking in cases where it is related to other criminal offenses;
- determining what evidence is necessary to prove the elements of the crime and ensuring that such evidence is properly documented and preserved; and
- effectively prosecuting a stalking charge.

***Training Institute of Strangulation Prevention* website (United States).**

Includes information on signs and symptoms and impact of strangulation, and online training resources. A single-page downloadable fact sheet emphasises:

- 10% of women who experience intimate partner violence experience strangulation
- Strangulation is the obstruction of blood vessels and/or airflow in the neck resulting in asphyxia – loss of consciousness can occur with 5-10 seconds, death within 4-5 minutes
- 79% of women are strangled manually (with hands); 38% report losing consciousness; 13% are strangled along with sexual assault/abuse, 9% are also pregnant; 97% involve blunt force trauma
- There is a 7-fold increase in risk of homicide for victims who been previously strangled compared to those never strangled
- Often there is no external evidence of injury – only half of victims have visible injuries, and of these, only 15% could be photographed
- Strangulation can cause: physical, neurological and psychological injuries and delayed fatality

State and Territory Police Risk Assessment Tools

ACT

- **The screening tool used by the Australian Federal Police (ACT Policing) is not publicly available.**

NSW

Department of Justice (NSW), *Safer Pathways: Domestic Violence and Child Protection Guideline* s (2014).

This deals specifically with risk factors affecting young people and children. These include (p9): “current or past ADVO or family law contact orders due to violence; the adult victim is pregnant; conflict over visitation/custody issues; a child/young person in the home is not a biological child of the perpetrator; recent or imminent divorce or separation; stalking, sexual assault of a parent/carer, or extremely controlling behaviour by the perpetrator; perpetrator has mental health issues that have resulted in violent or aggressive behaviour in the past; perpetrator frequently uses alcohol or drugs; perpetrator or victim has a history of exposure to domestic violence; victim has been in prior relationships where domestic violence occurred; recent or prolonged unemployment or financial issues causing stress or family friction; weapons in the home; cruel treatment of animals/family pets by the perpetrator.”

New South Wales, Domestic Violence Safety Assessment Tool and Guide (2015)

For use by non-government service providers and government agencies other than NSW Police Force. The DVSAT as primarily been designed for use in intimate partner violence situations.
Tool: https://www.facs.nsw.gov.au/__data/assets/file/0010/592948/DVSAT.pdf

Guide: https://www.facs.nsw.gov.au/__data/assets/file/0009/593064/DVSAT_guide.pdf

NT

- **Northern Territory Police, *Family Safety Framework*. See the ‘Form’ and ‘Practice Manual’.**

QLD

Non-inquest findings into the death of Rinabel Tiglao Blackmore, Coroners Court of Queensland (Cairns), 4 April 2019.

The following is a summary of the key facts relating to the domestic violence related death of Ms Blackmore and the key findings of Northern Coroner, Nerida Wilson. There are other matters raised in the Coroner’s findings relating to police responses that are not covered in this summary.

Key facts:

Ms Blackmore migrated to Australia from the Philippines in 1991; English was not her first language. After separating from her husband (with whom she had three sons) in 2014, she moved from Brisbane to Middlemount in central Queensland to continue a relationship with Mr Dickson that had commenced prior to the separation from her husband. Ms Blackmore was concerned that her family would not approve of her living with a man she was not married to, so she was secretive about her relationship with Mr Dickson, her living arrangements and whereabouts. Ms Blackmore's reluctance to tell her family about the new relationship was a source of consternation for Mr Dickson and was allegedly the trigger for two separate (although causally connected) episodes of domestic violence in the 48 hours prior to her death.

Ms Blackmore spent the 2014 Christmas period in Brisbane whilst Mr Dickson visited friends in Bundaberg. During their time apart, Mr Dickson exhibited controlling and jealous behaviours. He demanded that Ms Blackmore take photos of the people she was with so that he could satisfy himself that she wasn't cheating on him. Mr Dickson sent messages to Ms Blackmore's male friends from her mobile phone, impersonating her, and asking when they were free to have sex again, in an attempt to 'catch her out' for alleged infidelity.

On 28 December 2014, Ms Blackmore travelled from Brisbane to Bundaberg to meet and stay overnight with Mr Dickson at a local motel. An argument ensued in the motel room, with Mr Dickson asking Ms Blackmore why he was her "dirty little secret", and then pushing and grabbing her on the shoulders. They then both went to the motel's front office where the manager witnessed Mr Dickson and Ms Blackmore in a tug of war over a handbag, Ms Blackmore saying she wanted to break up, and Mr Dickson becoming more agitated as he tried to convince Ms Blackmore to get into the car with him. Ms Blackmore whispered to the manager to call the police. When Mr Dickson went outside to sit in his car, Ms Blackmore told the manager that he (Mr Dickson) had earlier put his hands around her neck, that she was frightened for her life, and that if the manager didn't get the police he (Mr Dickson) would kill her.

The police attended the motel, took statements from the parties, and told Mr Dickson that they would be applying for a protection order on Ms Blackmore's behalf. The police supervised the return of personal effects to Ms Blackmore and the exchange of their respective mobile phones. Ms Blackmore told the police she intended to catch a train to Rockhampton. Mr Dickson then left the motel, as did the police. Not long after however, Mr Dickson returned to the motel and Ms Blackmore told the manager that Mr Dickson had taken $400 from her bag. The manager became concerned for Ms Blackmore's safety and assisted her to be collected by a friend.

The Application for a Protection Order prepared by the police included grounds that it was necessary and desirable to protect the aggrieved due to the respondent's violent nature and history and the aggrieved's level of fear towards the respondent.

Ms Blackmore asked a friend to drive her to Middlemount so she could collect her property and passport from Mr Dickson's unit. They arrived in the early hours of 30 December 2014. Before the friend left Ms Blackmore, they agreed on a code in case Ms Blackmore was in trouble and the police should be called.

Mr Dickson told police that when he arrived at his unit around lunchtime on 30 December 2014, Ms Blackmore was waiting for him so she could retrieve her possessions. He said he and Ms Blackmore had sex on two occasions, they fell asleep, and then argued. He admitted to grabbing Ms Blackmore around the collar bone or shoulder, shaking and squeezing her, resulting in red marks on her shoulders and around her neck. He also admitted to making contact with her lip causing it to bleed. Mr Blackmore claimed that Ms Blackmore was screaming at him to stop, while also crying and saying that she loved him and didn't want to leave him.

Mr Dickson told police that late in the evening of 30 December 2014 he and Ms Blackmore decided to drive to Brisbane in his vehicle. He said initially Ms Blackmore sat in the rear while Mr Dickson drove as she appeared to be searching for something in one of her bags. A later examination of the vehicle revealed that Mr Dickson had taken possession of Ms Blackmore's mobile phone and had put it in the driver's door well. Mr Dickson said Ms Blackmore subsequently climbed over to the front passenger seat, complaining of motion sickness; then another argument ensued involving Mr Dickson screaming verbal abuse at Ms Blackmore. Mr Dickson denied using any physical violence against Ms Blackmore while they were in the vehicle. Mr Dickson told police he was driving the vehicle at around 100km per hour when Ms Blackmore suddenly opened the door and exited the vehicle. Mr Dickson told police he then took steps to locate Ms Blackmore, keep her alive, contact emergency services and assist in her transfer to hospital.

Ms Blackmore's head injuries resulted in her death on 2 January 2015. There were no alcohol or drugs detected in her system.

Mr Dickson pleaded guilty to (the alternative charge of) manslaughter of Ms Blackmore, and served time. See para 135 on pages 15-16 for the Judge's sentencing remarks.

Key findings by the Coroner:

- Ms Blackmore's death occurred at separation and during a period of prolonged violence perpetrated by her intimate partner. She died within 40 hours of her first and only report of domestic violence to police. In the 40 hours preceding her exit from the vehicle, Ms Blackmore had been subjected to several causally connected episodes of verbal abuse and significant physical violence by Mr Dickson.
- Ms Blackmore's actions were a desperate act of self-preservation. The Coroner found that it is more probable than not that Ms Blackmore exited the vehicle to escape the terror of the events unfolding inside whilst in fear for her life.
-

Ms Blackmore was all the more vulnerable by virtue of the fact she was a Filipino woman, English was not her first language, and she resided in Middlemount (a remote and isolated location). Her physical isolation was compounded by her isolation from family, including her children. Her support network and resources were extremely limited.

- **Queensland Police, 'Chapter 9: Domestic Violence' in *Operational Procedures Manual* (Issue 70, 5 June 2019), Appendix 9.1 'Domestic Violence Protective Assessment Framework'.**

SA

- **The Family Safety Framework (FSF) was developed under the auspice of the South Australian Government's Women's Safety Strategy and Keeping Them Safe - Child Protection Agenda, to drive improved, integrated service responses to violence against women and children in South Australia.**

  Office for Women (SA), *Family Safety Framework*.

TAS

Ron Mason and Roberta Julian, 'Analysis of the Tasmania Police Risk Assessment Screening Tool (RAST)' (Final Report, Tasmanian Institute of Law Enforcement Studies, 2009) 38.

Explains the risk assessment tool used in Tasmania to understand risk in domestic violence cases. Evaluates the success of this system. Importantly, notes risk factors in a number of categories. Looks at the issue from a law enforcement perspective. Makes a distinction between high risk factors generally and high risk factors for re-offending (p 4).

Identifies consensus in literature that, 'important risk factors include: a history of violent behaviour; a history of physical, sexual or emotional abuse toward the partner; access to lethal weapons; antisocial behaviour and attitudes; relationship instability (recent divorce or separation); lifestyle stressors (employment, finances); history of family violence from family of orientation; mental health issues or personality disorder; resistance to change; and, attitudes that support violence toward women' (p25). RAST data also indicates some correlation between firearms and increased risk assessment scores (p21).

VIC

Department of Human Services (Vic), *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (updated 9/2017).

This document has been produced in a human services context. Therefore, when approaches to risk assessment are addressed (p 19), it is not from a judicial perspective. Of particular importance are the conclusions drawn on page 20. The authors note, "In the context of family violence, it is critical that the work of professionals recognises and respects that women and children already have their own knowledge and methods to identify, analyse and evaluate risk. Research has found that victims are often good predictors of their own level of risk so their perspectives must be included in the process of assessing risk."

Figure 5 (pp27-9) includes risk factors that affect the likelihood and severity of family violence, including suicide. Importantly, the authors make a distinction between these factors, and factors affecting risk of ongoing and continued violence (p 30). This distinction is lacking in much of the other literature. The authors favour a standardised approach to risk assessment. They note the elements of such an approach as "victim's assessment of risk, evidence-based risk factors, and professional judgement" (Figure 6, p 44).

See also: Victoria Police, *Code of Practice For the Investigation of Family Violence* (3rd ed, 2017), 27.

Judicial College of Victoria (2021) *Assessing Risk* (webpage).

The Judicial College of Victoria has collated a collection of resources on coercive control and family violence which includes a number of risk assessment resources, which include:

Magistrate Noreen Toohey (2021) The buck stops here, Court Talk Podcast.

- **Judicial College of Victoria (2021) Family violence risk factors: the intimate terrorism of family violence (Common risk factors checklist).**
- **Judicial College of Victoria (2021) The Victorian Family Violence Multiple-Agency Risk Assessment and Management Framework (MARAM).**

WA

- **Department for Child Protection (WA), *The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework* (Second Edition, 2015).**

Domestic and Family Violence Death Review Documents

National

Australian Domestic and Family Violence Death Review Network (2018), Australian Domestic and Family Violence Death Review Network Data Report: 2018, New South Wales Domestic Violence Death Review Team, Sydney.

Abstract: The Australian Domestic and Family Violence Death Review Network ('the Network') was established in 2011 and represents a unique collaboration between domestic and family violence death review mechanisms across Australia. Network members have specialist expertise in domestic and family violence related issues and access to extensive information pertaining to domestic and family violence deaths. This is critical to providing a more informed, holistic understanding of the circumstances and context of a domestic and family violence related death.

In recent years, the Network has undertaken extensive work to develop a National Minimum Dataset of domestic and family violence related deaths and this report presents key findings from this specialised dataset.

This report demonstrates the breadth of information and data that is held by the Network, and its unique ability to collect and report on data in relation to domestic and family violence related deaths.

Australia's National Research Organisation for Women's Safety and the Australian Domestic and Family Violence Death Review Network (2018), *Australian Domestic and Family Violence Death Review Network national data update*, ANROWS.

Extract: The Australian Domestic and Family Violence Death Review Network (the Network) was established in 2011 to identify, collect, analyse and report data on domestic and family violence related deaths across Australia. The aim of the Network is to identify limitations and potential areas for improvement in systemic responses to domestic and family violence.

The Network comprises members of each of the death review teams from all of the Australian states and territories. Members of the Network have specialist expertise in domestic and family violence related issues, and are able to access information from Coroners Courts, Ombudsman's offices or government agencies to produce an informed and holistic understanding of the circumstances and the context of a domestic and family violence related death.

The Network published the inaugural Death Review Network Data Report in May 2018 which provided national data with respect to all intimate partner homicides that occurred in a domestic violence context between 2010 and 2014.

ANROWS and the Australian Domestic and Family Violence Death Review Network are working in collaboration to update the Australian Domestic and Family Violence Death Review Network Data Report 2018 to include intimate partner homicide data from July 2010 to June 2018.

This project will also include an analysis of data held by members of the Network to identify the common

risk factors in relation to intimate partner homicide in Australia, and establish a national minimum data set for filicide.

ACT

ACT data for the Australian Domestic and Family Violence Death Review Network is provided by the National Coronial Information System with the approval of the ACT Coroner's Court.

Community Services ACT, *Safer Families Reforms*, ACT Government (webpage).

Reducing the risk of deaths from family violence: As part of the *Safer Families Reforms* package commenced in the 2016-17 ACT budget a total of $831,000 has been allocated over four years to fund the establishment of the ACT Domestic and Family Violence Death Review function. Information relating to domestic and family violence deaths will be analysed to make recommendations for service and system-wide improvements that would prevent similar deaths occurring in the future. This initiative will allow the ACT to fully participate in the work of the national family violence death review network and share national data and learnings to reduce deaths through family violence.

Domestic Violence Prevention Council (2016) *Findings and Recommendations from the Review of Domestic and Family Violence Deaths in the Australian Capital Territory: Public Report*, ACT Government.

Extract: This report summarises the findings and recommendations of the Review of Domestic and Family Violence Deaths in the Australian Capital Territory that occurred between 2000 and 2012. This one off retrospective review, analysed deaths that were no longer before the courts or coroner when cases were identified in May 2015. A total of eleven cases involving external assault were reviewed, identifying common themes among the deaths. Twenty-eight recommendations for action were identified.

In many of the cases reviewed, a person was killed in circumstances where there was no recorded history of physical violence prior to the death, but there were patterns of non physical family violence, including coercive and controlling behaviours by perpetrators against victims. The review found there was a general lack of understanding of what constitutes domestic and family violence, especially the non-physical manifestations of familyviolence1–by victims themselves, family, friends, neighbours, services (including government services), doctors, counsellors, lawyers, co-workers and the general community. Greater awareness is needed in the community about what domestic and family violence looks like, and that an absence of physical violence in a relationship does not necessarily mean a lower risk of harm for the victim. Many of the victims did not access help from police, domestic violence services or other frontline responders to violence. They did however, have contact with service providers unrelated to domestic violence (such as with healthcare and legal professionals). There is a need for better awareness about the risk factors from "first responders" because while such contact may not directly relate to domestic and

family violence, they nonetheless provide an opportunity for early intervention. The review identified that there was a lack of awareness or consideration of risk factors such as pregnancy, separation and new relationships by first responders. The term “family violence” is used throughout the report to refer to physical and non-physical forms of coercion and control that occur in families. At times the report differentiates between violence between intimate partners and violence between other family members.

Justice and Community Safety Directorate (2018) *Family Violence Death Review (FVDR) Draft Models for the ACT*, ACT Government.

This report sets out draft models to be considered for family violence death review in the ACT.

NSW

Coroner’s Court New South Wales, *Domestic violence death review* (Government of New South Wales).

The Domestic Violence Death Review Team (DVDRT) was established in 2010 pursuant to the Coroners Act 2009 NSW to review deaths occurring in the context of domestic violence in New South Wales. This page details the role, function and membership of the DVDRT and provides links to the annual reports of the DVDRT to Parliament. It also provides a link to reports of the national Domestic and Family Violence Death Review Network.

NT

Northern Territory information for the Australian Domestic and Family Violence Death Review Network is provided by the Coroner’s Office of the Northern Territory.

QLD

Queensland Coroners Court, *Review of deaths from domestic and family violence* (Queensland Government).

The Domestic and Family Violence Death Review and Advisory Board (“the Board”) was established pursuant to the Coroners Act 2003 (Qld) in response to a key recommendation of the he Special Taskforce on Domestic and Family Violence Final Report, Not Now, Not Ever: Ending domestic and family violence in Queensland (Queensland Government).

This page details the role, function and membership of the Board and provides links to the Systemic and Annual Reports of the Board to Parliament, as well as a statistical overview of Queensland domestic and family violence data, research reports and submissions.

TAS

Tasmanian data for the Australian Domestic and Family Violence Death Review Network is provided by the National Coronial Information System with the approval of the Tasmanian Coroner's Court.

VIC

Coroners Court of Victoria, *Victorian Systemic Review of Family Violence Deaths*, State of Victoria.

Coroners Court of Victoria (2012) *Victorian Systemic Review of Domestic Violence Deaths: First Report*, State of Victoria.

Executive Summary: This Victorian Systemic Review of Family Violence Deaths (VSRFVD) commenced operation in the Coroners Court of Victoria in 2009. Led by the State Coroner, it focuses attention on the context in which family violence-related homicides and homicide-suicide incidents occur. Through coroners' findings, comments and recommendations, the VSRFVD contributes to strengthening the response to family violence in this state. This report presents the key findings of the VSRFVD during 2009-2012. It draws upon the analysis of deaths involving infants, children and adults, across a range of relationship categories. Findings from the two main activities of the VSRFVD are presented in detail: data collection and analysis, and in-depth case review.

Coroners Court of Victoria (2020) *Victorian Systemic Review of Family Violence Deaths: Review of Family Violence Related Homicides: 1 January 2011 to 31 December 2015*, State of Victoria.

Extract: The Victorian Systemic Review of Family Violence Deaths (VSRFVD) at the Coroners Court of Victoria (CCOV) is led by the State Coroner and examines the context in which family violence-related deaths occur. Through coroners' findings, comments and recommendations, the VSRFVD contributes to strengthening the response to family violence in Victoria.

To assist the work of the VSRFVD, and coroners, the CCOV captures data relating to homicides in Victoria using the Victorian Homicide Register (VHR). The VHR records every homicide reported to the CCOV and captures a range of information pertaining to the homicide victim and offender. In cases identified as family violence related homicides, further information regarding the dynamics of the relationship between the homicide victim and offender, any family violence history and risk factors are captured.

The VSRFVD 'First Report' was published in 2012 and used data relating to homicides from 1 January 2000 to 31 December 2010 to explore the factors and circumstances in which family violence homicide deaths occur. This report builds on that initial dataset, presenting data in relation to family violence homicides which occurred between 1 January 2011 and 31 December 2015.

Of the 257 homicide related deaths reported during this time period, where the coronial investigation was closed, 97 deaths were identified as family violence related deaths where coding into the VHR had been

completed. Those deaths arose from 82 separate homicide incidents perpetrated by 86 homicide offenders. Data from these deaths was examined for the purposes of this report.

WA

Western Australian data for the Australian Domestic and Family Violence Death Review Network has been provided by the National Coronial Information System with the approval of the Western Australian Coroner's Court.

Ombudsman Western Australia, Family and Domestic Violence Fatality Review (Western Australian Government).

This is the section of the Ombudsman's 2019-20 Annual Report which relates to Family and Domestic Violence Fatality Review. It sets out the work of the Ombudsman in the area, including:

- The role of the Ombudsman in relation to family and domestic violence fatality reviews;
- Analysis of family and domestic violence fatality reviews;
- Issues identified in family and domestic violence fatality reviews;
- Recommendations;
- Major own motion investigations arising from family and domestic violence fatality reviews;
- Other mechanisms to prevent or reduce family and domestic violence fatalities; and
- Stakeholder liaison.