If you need crisis support, call Lifeline on 13 11 14, or call Kids Helpline on 1800 55 1800, 24 hours a day. For general support, talk to your GP or local health professional.

2 About the investigation

2.1 Role and functions of the Western Australian Ombudsman

2.1.1 Role of the Ombudsman

The Ombudsman is an independent, impartial officer of the Western Australian Parliament who investigates the administration of the laws of Parliament. The Ombudsman reports directly to Parliament, rather than to the government of the day or a particular Minister.

2.1.2 Functions of the Ombudsman

The Ombudsman has four principal functions derived from his governing legislation, the *Parliamentary Commissioner Act 1971* (**the Act**) and other legislation, codes and service delivery arrangements, as follows:

- Receiving, investigating and resolving complaints about State government agencies, local governments and universities;
- Reviewing certain child deaths and family and domestic violence fatalities;
- Improving public administration for the benefit of all Western Australians through own motion investigations, and education and liaison programs with public authorities; and
- Undertaking a range of additional functions.

2.2 The Ombudsman's Child Death Review function

The Ombudsman commenced the review of certain child deaths on 30 June 2009 following the passage of the *Parliamentary Commissioner Amendment Act 2009*. The Ombudsman reviews investigable child deaths. Section 19A(3) of the Act defines an investigable death as follows:

> An investigable death occurs if a child dies and any of the following circumstances exists –
>
> (a) in the 2 years before the date of the child's death, the CEO [the Chief Executive Officer of the Department for Child Protection and Family Support] had received information that raised concerns about the wellbeing of the child or a child relative of the child;
>
> (b) in the 2 years before the date of the child's death, the CEO, under section 32(1) of the CCS Act [*Children and Community Services Act 2004*], had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child;
>
> (c) in the 2 years before the date of the child's death, any of the actions listed in section 32(1) of the CCS Act was done in respect of the child or a child relative of the child;
>
> (d) protection proceedings are pending in respect of the child or a child relative of the child;
>
> (e) the child or a child relative of the child is in the CEO's care.

For these investigable deaths, the Ombudsman's functions are outlined in section 19B(3) of the Act, as follows:

(a) to review the circumstances in which and why the deaths occurred;

(b) to identify any patterns or trends in relation to the deaths;

(c) to make recommendations to any department or authority about ways to prevent or reduce investigable deaths.

To facilitate the review of investigable child deaths, the Department for Child Protection and Family Support receives information from the State Coroner on reportable deaths of children and notifies the Ombudsman of these deaths. The notification provides the Ombudsman with a copy of the information provided to the Department for Child Protection and Family Support by the State Coroner about the circumstances of the child's death together with a summary outlining the Department for Child Protection and Family Support's past involvement with the child.

2.3 Rationale for the investigation

Through the review of the circumstances in which and why child deaths occurred, the Ombudsman identified a pattern of cases in which young people appeared to have died by suicide (in this report, young people are defined as those under 18 years of age). The Ombudsman decided to undertake an investigation into these deaths with a view to determining whether it may be appropriate to make recommendations to any State government department or authority about ways to prevent or reduce such deaths.

2.4 Objectives of the investigation

The objectives of the investigation were to:

- develop a detailed understanding of young people's involvement with State government departments and authorities before their deaths, including the nature and extent of their involvement;
- identify any patterns and trends in: demographic characteristics and social circumstances of young people who died by suicide; the circumstances of the suicides; the risk factors for suicide demonstrated by the young people; and their involvement with State government departments and authorities; and
- based on this understanding, identify ways that State government departments and authorities can prevent or reduce suicide by young people, and make recommendations to these departments and authorities accordingly.

2.5 Methodology

To undertake the investigation, the Office of the Ombudsman (**the Office**):

1. Conducted a literature review;
2. Conducted consultation;
3. Collected and analysed data;

4. Developed a preliminary view; and

5. Developed a final view.

2.5.1 Literature review

The Office conducted a review of relevant national and international literature regarding suicide by young people. The information drawn from this review is referred to as **the research literature** throughout this report.

2.5.2 Consultation

The Office consulted with government and non-government organisations.

2.5.3 Data collection and analysis

The Office analysed 36 deaths in which a young person had either died by suicide (for those deaths where the State Coroner has completed an investigation and found that the cause of death was suicide) or was suspected of having died by suicide (for those deaths where the State Coroner has not yet completed an investigation).

The Office collected a significant amount of information about each of the 36 young people from State government departments and authorities, hospitals and health services administered by the Department of Health, non-government schools and registered training organisations. These organisations are listed in Figure 1 below.

The Office comprehensively analysed the information collected using qualitative and quantitative techniques to develop draft findings. The Office also consulted relevant stakeholders regarding the results of this analysis as well as engaging people with expertise in the area of suicide by young people to critically comment on the data collection, analysis and draft findings.

2.5.4 Preliminary view

The Office provided relevant State government departments and authorities with our draft findings and draft recommendations about ways that State government departments and authorities can prevent or reduce suicide by young people.

2.5.5 Final view

Having considered and incorporated comments, where appropriate, by State government departments and authorities, the Office prepared this final report of the investigation to be tabled in the Western Australian Parliament.

Each of the recommendations contained in this report will be monitored by the Ombudsman to ensure their implementation and effectiveness in relation to the findings made in this investigation.

Figure 1: Organisations from which data was collected about the young people who died by suicide

Department of the Attorney General	Department of Training and Workforce Development
Department for Child Protection and Family Support	Disability Services Commission
Department of Corrective Services	Drug and Alcohol Office
Department of Education	Government and non-government schools
Department of Education Services	Government and non-government registered training organisations
Department of Health	Hospitals and health services, which comprise WA Health
Department of Housing	Office of the State Coroner
Department of Local Government and Communities	Western Australia Police