Child Death Review

Overview

This section sets out the work of the Office in relation to its child death review function. Information on this work has been set out as follows:

- Background;
- The role of the Ombudsman in relation to child death reviews;
- The child death review process;
- Analysis of child death reviews;
- Patterns, trends and case studies relating to child death reviews;
- Issues identified in child death reviews;
- Recommendations;
- Timely handling of notifications and reviews;
- Major own motion investigations arising from child death reviews;
- Other mechanisms to prevent or reduce child deaths; and
- Stakeholder liaison.

Background

In November 2001, prompted by the coronial inquest into the death of a 15 year old Aboriginal girl at the Swan Valley Nyoongar Community in 1999, the (then) State Government announced a special inquiry into the response by government agencies to complaints of family violence and child abuse in Aboriginal communities.

The resultant 2002 report, *Putting the Picture Together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities*, recommended that a Child Death Review Team be formed to review the deaths of children in Western Australia (Recommendation 146). Responding to the report, the (then) Government established the Child Death Review Committee (**CDRC**), with its first meeting held in January 2003. The function of the CDRC was to review the operation of relevant policies, procedures and organisational systems of the (then) Department for Community Development in circumstances where a child had contact with the Department.

In August 2006, the (then) Government announced a functional review of the (then) Department for Community Development. Ms Prudence Ford was appointed the independent reviewer and presented the report, *Review of the Department for Community Development: Review Report* (**the Ford Report**) to the (then) Premier in January 2007. In considering the need for an independent, inter-agency child death review model, the Ford Report recommended that:

- The CDRC together with its current resources be relocated to the Ombudsman (Recommendation 31); and
- A small, specialist investigative unit be established in the Office to facilitate the independent investigation of complaints and enable the further examination, at the discretion of the Ombudsman, of child death review cases where the child was known to a number of agencies (Recommendation 32).

Subsequently, the *Parliamentary Commissioner Act 1971* was amended to enable the Ombudsman to undertake child death reviews, and on 30 June 2009, the child death review function in the Office commenced operation.

In 2018, the (then) Minister for Health requested that the Office of the Chief Medical Officer within the Department of Health consider the establishment of a Child Death Register and comprehensive review mechanism for all child deaths in Western Australia. The Office of the Chief Medical Officer facilitated a series of stakeholder meetings, and in late 2019 it was determined that this function would be provided by the Ombudsman.

From 1 July 2020, the Ombudsman has received notifications of all child deaths in WA. Notification (and associated information) is provided by Communities, the Department of Health, and the Department of Justice, Registry of Births, Deaths and Marriages (**Births, Deaths and Marriages**). The Ombudsman:

- Considers all child deaths through the collection and analysis of state-wide data, including trend reporting (the WA Child Death Register); and
- Ensures all child deaths in the State are reviewed by the Ombudsman, or where appropriate, by an existing medical death review mechanism.

The Role of the Ombudsman in Relation to Child Death Reviews

The child death review function enables the Ombudsman to review investigable deaths. Investigable deaths are defined in the Ombudsman's legislation, the *Parliamentary Commissioner Act 1971* (see Section 19A(3)), and occur when a child dies in any of the following circumstances:

- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children and Community Services Act 2004*, the CEO had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child; and
    - Any of the actions listed in section 32(1) of the *Children and Community Services Act 2004* was done in respect of the child or a child relative of the child.

- The child or a child relative of the child is in the CEO's care or protection proceedings are pending in respect of the child or a child relative of the child.

In addition to determining if a child death is an investigable death, since 1 July 2020, the Ombudsman also identifies whether the child death will be reviewed by the Coroner (reportable deaths) or an existing medical review mechanism (including *Perinatal and infant mortality review committee* and a Health Service Provider's *Mortality Review Committee*). The Ombudsman will review all investigable deaths as well as those child deaths that are not reviewed by one of these existing death review mechanisms.

The Ombudsman can also review other notified child deaths. Under Section 16 of the *Parliamentary Commissioner Act 1971*, the Ombudsman may determine to undertake a child death review under his own motion, where a child death may not be defined as an investigable death in accordance with Section 19A(3).

In undertaking a child death review, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths. The Ombudsman may also undertake major own motion investigations arising from child death reviews (discussed later in this section).

In reviewing child deaths the Ombudsman has wide powers of investigation, including powers to obtain information relevant to the death of a child and powers to recommend improvements to public administration about ways to prevent or reduce child deaths across all agencies within the Ombudsman's jurisdiction. The Ombudsman also has powers to monitor the steps that have been taken, are proposed to be taken or have not been taken to give effect to the recommendations.

The Child Death Review Process

The Ombudsman is notified of all child deaths that occur in WA

Births, Deaths and Marriages notifies the Ombudsman of all registered child deaths

The Department of Health notifies the Ombudsman of all child deaths known to Health Service Providers

Communities notifies the Ombudsman of all child deaths notified to it by the Coroner (those deaths that are reportable to the Coroner)

The Ombudsman reconciles the data from the three notification sources to identify the individual child deaths. Each child death notification is assessed to determine:

- whether the death is an investigable death or a non-investigable death; and
- whether a review will be conducted by an existing medical death review mechanism (including the *Perinatal and infant mortality review committee* and Health Service Provider *Mortality Review Committee*).

Ombudsman conducts review

- All investigable deaths are reviewed
- All deaths that are not reported to the Coroner, and not reviewed by an existing medical death review mechanism are reviewed
- Other deaths can be reviewed

Identifying patterns and trends

- Data on all child deaths is obtained, and reconciled
- Patterns and trends are identified, analysed and reported and also provide critical information to inform the selection and undertaking of major own motion investigations

Improving public administration

The Ombudsman seeks to improve public administration to prevent or reduce child deaths, including making recommendations to prevent or reduce child deaths arising from reviews and major own motion investigations

Implementation of recommendations and monitoring improvements

The Ombudsman actively monitors the implementation of recommendations as well as ensuring those improvements to public administration are contributing over time to preventing or reducing child deaths

Analysis of Child Death Reviews

By reviewing child deaths, the Ombudsman is able to identify, record and report on a range of information and analysis, including:

- The number of child death notifications and reviews;
- The comparison of investigable deaths over time;
- Demographic information identified from child death notifications;
- Circumstances in which child deaths have occurred;
- Social and environmental factors associated with investigable child deaths;
- Analysis of children in particular age groups; and
- Patterns, trends and case studies relating to child death reviews.

Notifications and reviews

Since 1 July 2020, the Ombudsman receives information on all child deaths in Western Australia. This includes information about the circumstances of the child's death together with a summary outlining the past involvement, if any, of Communities with the child and the child's family.

The Ombudsman assesses all child death notifications received to determine if the death is, or is not, an investigable death. If the death is an investigable death, it must be reviewed. If the death is a non-investigable death, it can be reviewed. The Ombudsman also identifies if the child death is reported to the Coroner, or will be reviewed by an existing medical death review mechanism, and will review those deaths that do not fall into one of these categories. The extent of a review depends on a number of factors, including the circumstances surrounding the child's death and the level of involvement of Communities or other public authorities in the child's life. Confidentiality of the child, family members and other persons involved with the case is strictly observed.

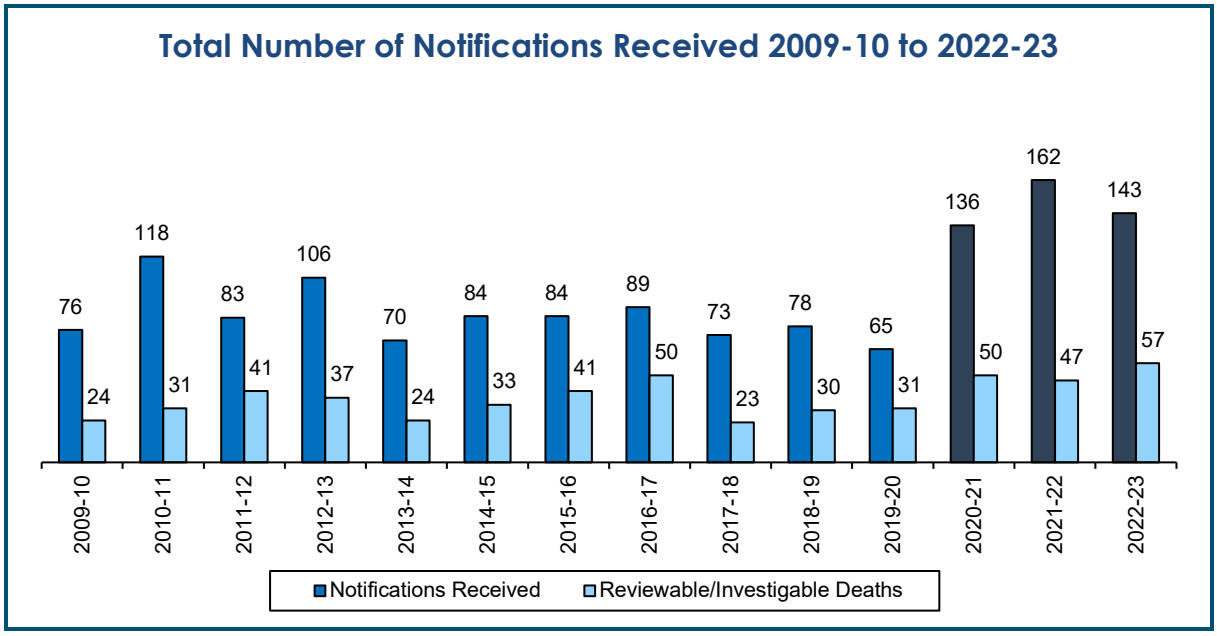
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner or the certifying medical practitioner.

Number of child death notifications and reviews

Expanded data on child deaths

From 1 July 2020, the Ombudsman has received notifications of all child deaths in Western Australia, including those notified from Communities, the Department of Health, and Births, Deaths and Marriages. Accordingly, the Ombudsman is able to expand the data reported in relation to child deaths, providing an even more comprehensive understanding of child deaths in Western Australia. The data for the years 2020-21 and 2021-22, as previously reported, has also been updated in this year's annual report.

During 2022-23, there were 57 child deaths that were investigable and subject to review from a total of 143 child death notifications received.



Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Comparison of investigable deaths over time

The Ombudsman commenced the child death review function on 30 June 2009. Prior to that, child death reviews were undertaken by the CDRC with the first full year of operation of the CDRC in 2003-04.

The following table provides the number of deaths that were determined to be investigable by the Ombudsman or reviewable by the CDRC compared to all child deaths in Western Australia for the 20 years from 2003-04 to 2022-23. It is important to note that an investigable death is one which meets the legislative criteria and does not necessarily mean that the death was preventable, or that there has been any failure of the responsibilities of Communities.

Comparisons are also provided with the number of child deaths reported to the Coroner and deaths where the child or a relative of the child was known to Communities. It should be noted that children or their relatives may be known to Communities for a range of reasons.

Year	A	B	C	D
	Total WA child deaths (excluding stillbirths) (See Note 1)	Child deaths reported to the Coroner (See Note 2)	Child deaths where the child or a relative of the child was known to Communities (See Note 3)	Reviewable/ investigable child deaths (See Note 4 and Note 5)
2003-04	177	92	42	19
2004-05	212	105	52	19
2005-06	210	96	55	14
2006-07	165	84	37	17
2007-08	187	102	58	30
2008-09	167	84	48	25
2009-10	201	93	52	24
2010-11	203	118	60	31
2011-12	150	76	49	41
2012-13	193	121	62	37
2013-14	156	75	40	24
2014-15	170	93	48	33
2015-16	178	92	61	41
2016-17	181	91	60	50
2017-18	138	81	37	23
2018-19	175	81	37	30
2019-20	140	67	38	31
2020-21	139	77	46	50
2021-22	162	68	36	47
2022-23	147	87	54	57

Notes

1. The data in Column A has been provided by Births, Deaths and Marriages. Child deaths within each year are based on the date of death rather than the date of registration of the death. The CDRC included numbers based on dates of registration of child deaths in their Annual Reports in the years 2005-06 through to 2007-08 and accordingly the figures in Column A will differ from the figures included in the CDRC Annual Reports for these years because of the difference between dates of child deaths and dates of registration of child deaths. The data in Column A is subject to updating and may vary from data published in previous Annual Reports.
2. The data in Column B has been provided by the Office of the State Coroner. Reportable child deaths received by the Coroner are deaths reported to the Coroner of children under the age of 18 years pursuant to the provisions of the *Coroners Act 1996*. The data in this section is based on the number of deaths of children that were reported to the Coroner during the year.
3. 'Communities' refers to the Department of Communities from 2017-18, Department for Child Protection and Family Support for the year 2012-13 to 2016-17, Department for Child Protection for the years 2006-07 to 2011-12 and Department for Community Development (**DCD**) prior to 2006-

07. The data in Column C has been provided by Communities and is based on the date the notification was received by Communities. For 2003-04 to 2007-08 this information is the same as that included in the CDRC Annual Reports for the relevant year. In the 2005-06 to 2007-08 Annual Reports, the CDRC counted 'Child death notifications where any form of contact had previously occurred with Communities: recent, historical, significant or otherwise'. In the 2003-04 and 2004-05 Annual Reports, the CDRC counted 'Coroner notifications where the families had some form of contact with DCD'.

4. The data in Column D relates to child deaths considered reviewable by the CDRC up to 30 June 2009 or child deaths determined to be investigable by the Ombudsman from 30 June 2009. It is important to note that reviewable deaths and investigable deaths are not the same, however, they are similar in effect. The definition of reviewable death is contained in the Annual Reports of the CDRC. The term investigable death has the meaning given to it under section 19A(3) of the *Parliamentary Commissioner Act 1971*.

5. The number of investigable child deaths shown in a year may vary, by a small amount, from the number shown in previous annual reports for that year. This occurs because, after the end of the reporting period, further information may become available that requires a reassessment of whether or not the death is an investigable death.

Demographic information identified from child death reviews

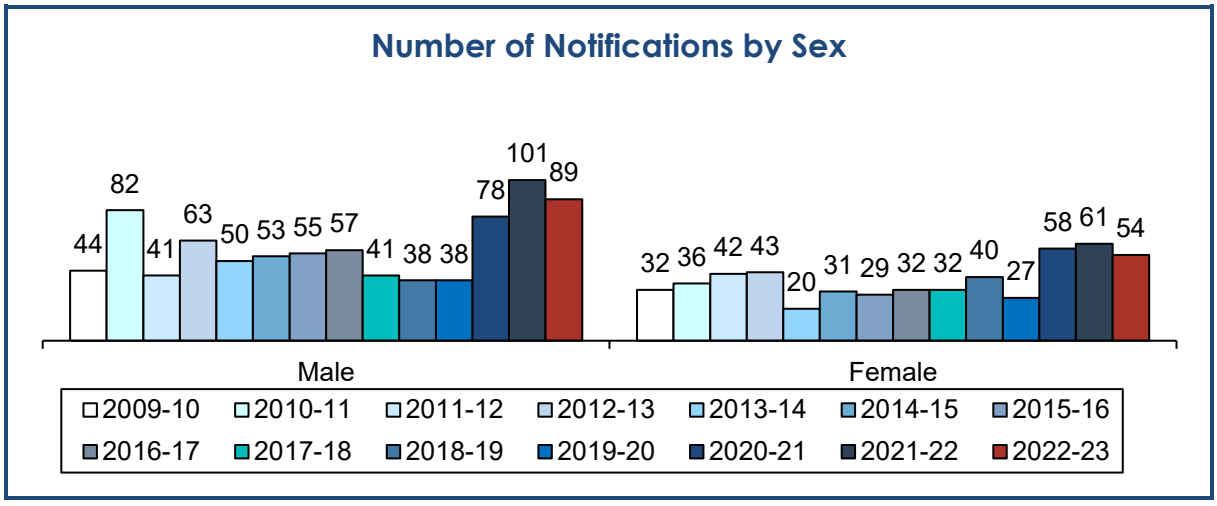
Information is obtained on a range of characteristics of the children who have died including sex, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected by Communities in order to prevent or reduce deaths.

The following charts show:

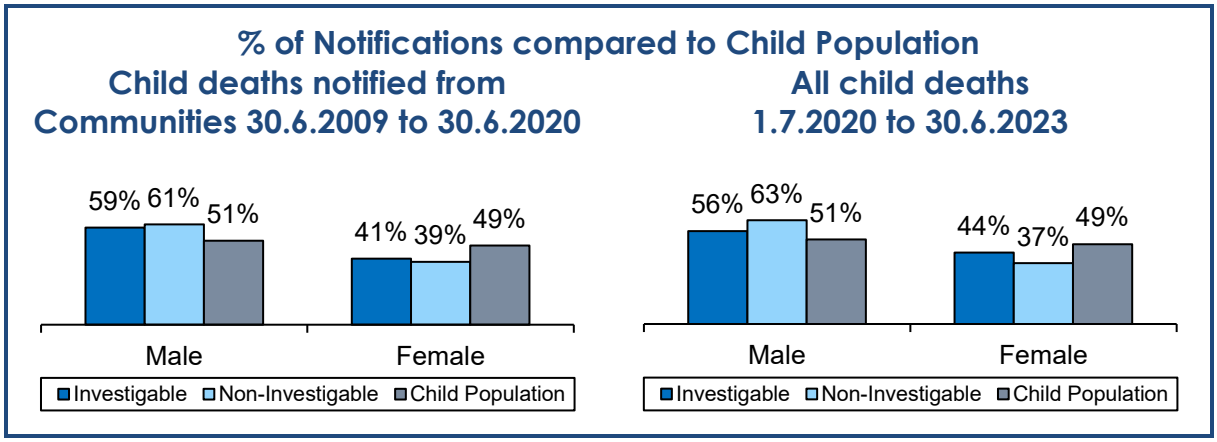
- The number of children in each group for each year from 2009-10 to 2022-23; and
- For the period from 30 June 2009 to 30 June 2023, the percentage of children in each group for both investigable deaths and non-investigable deaths, compared to the child population in Western Australia.

Males and females

Information is collated on a child's sex (male or female) as identified in agency documentation provided to this Office. As shown in the following charts, considering all 14 years, male children are over-represented compared to the population for both investigable and non-investigable deaths.



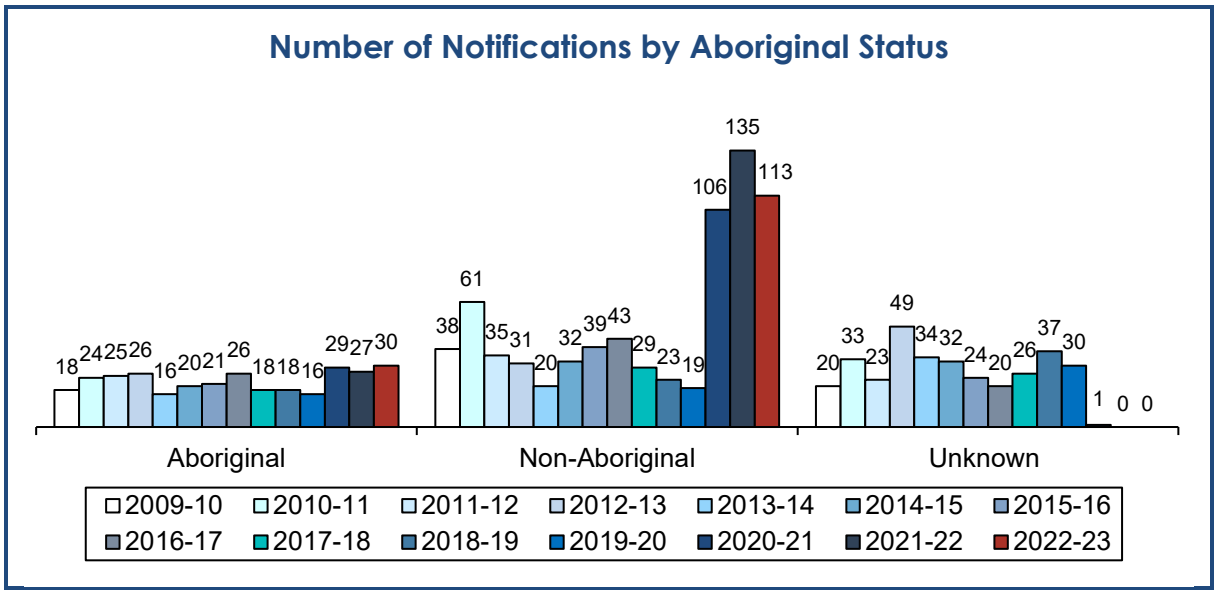
Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



Further analysis of the data shows that, considering all 14 years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

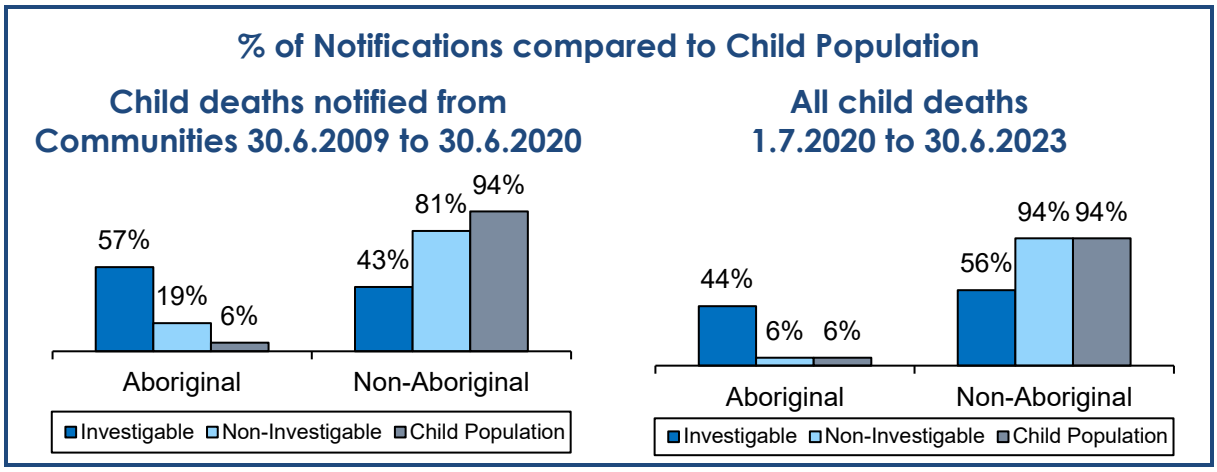
Aboriginal status

Information on Aboriginal status is collated where a child, or one/both of their parents, identify as Aboriginal to agencies they have contact with, and this is recorded in the documentation provided to this Office. As shown in the following charts, Aboriginal children are over-represented compared to the population in all deaths and more so for investigable deaths.



Note 1: The "Aboriginal" category in the charts includes children who are Torres Strait Islander and children who are both Aboriginal and Torres Strait Islander. Use of the term "Aboriginal" reflects the dominant heritage of First Nations people in Western Australia.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



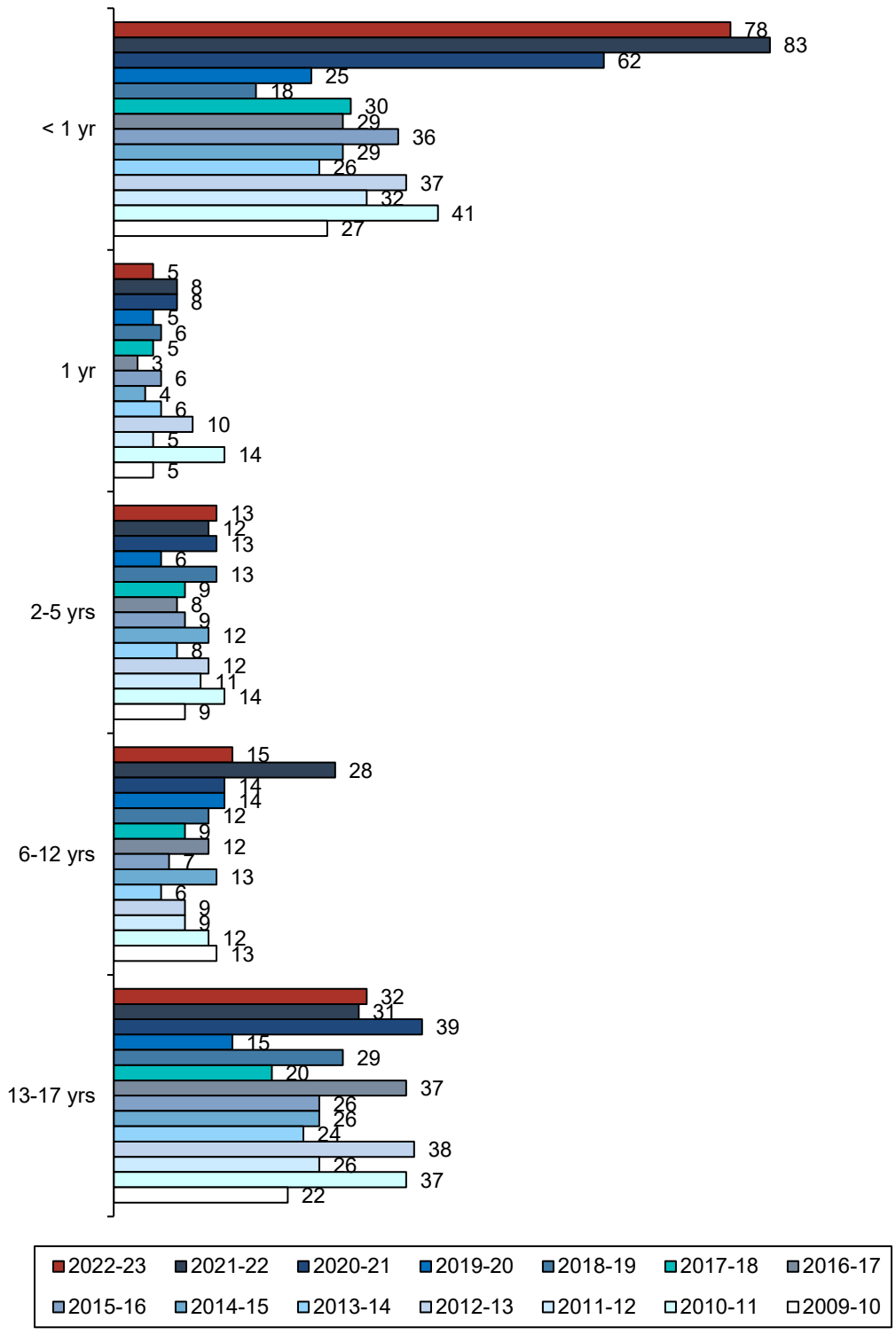
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

Further analysis of the data shows that Aboriginal children are more likely than non-Aboriginal children to be under the age of one and living in regional and remote locations.

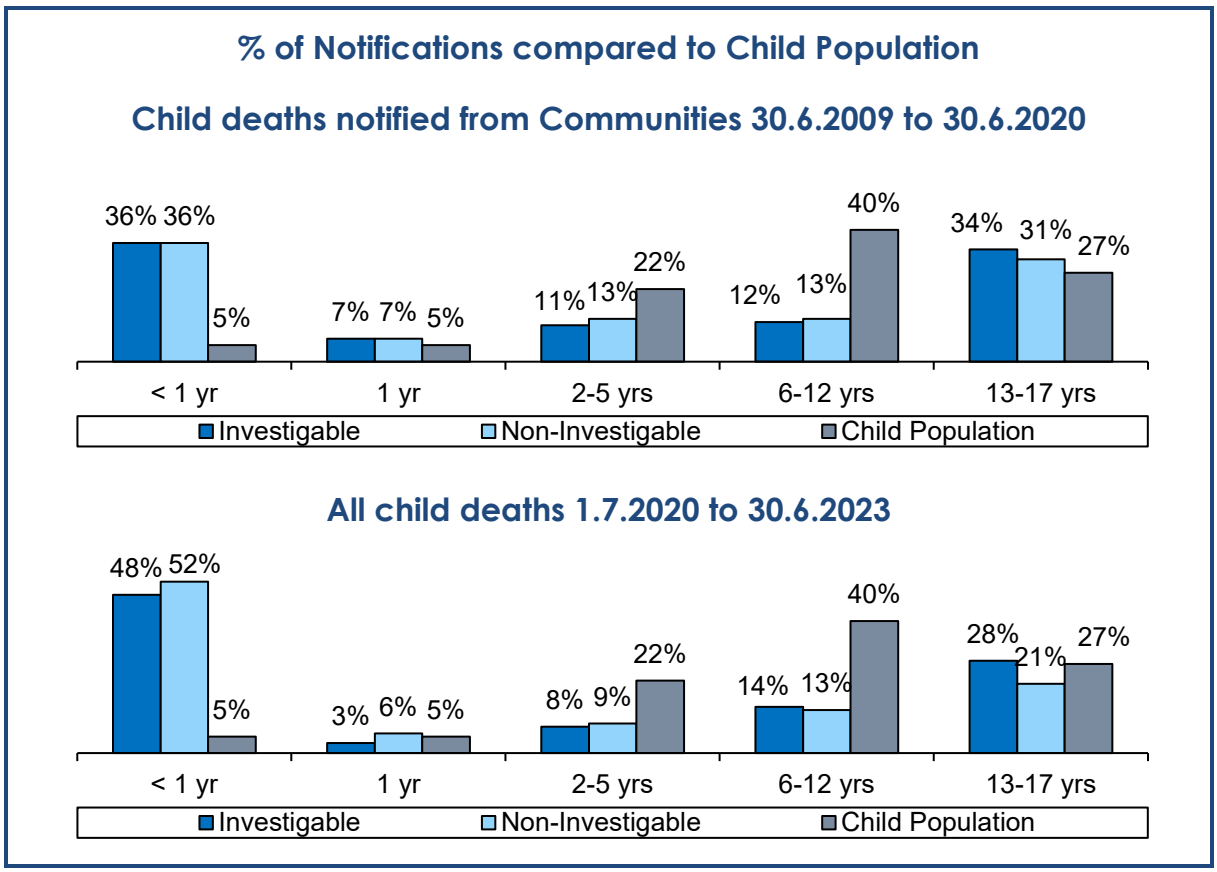
Age groups

As shown in the following charts, children under one year, children aged one year, and children aged between 13 and 17 are over-represented compared to the child population as a whole for both investigable and non-investigable deaths.

Number of Notifications by Age of Child



Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

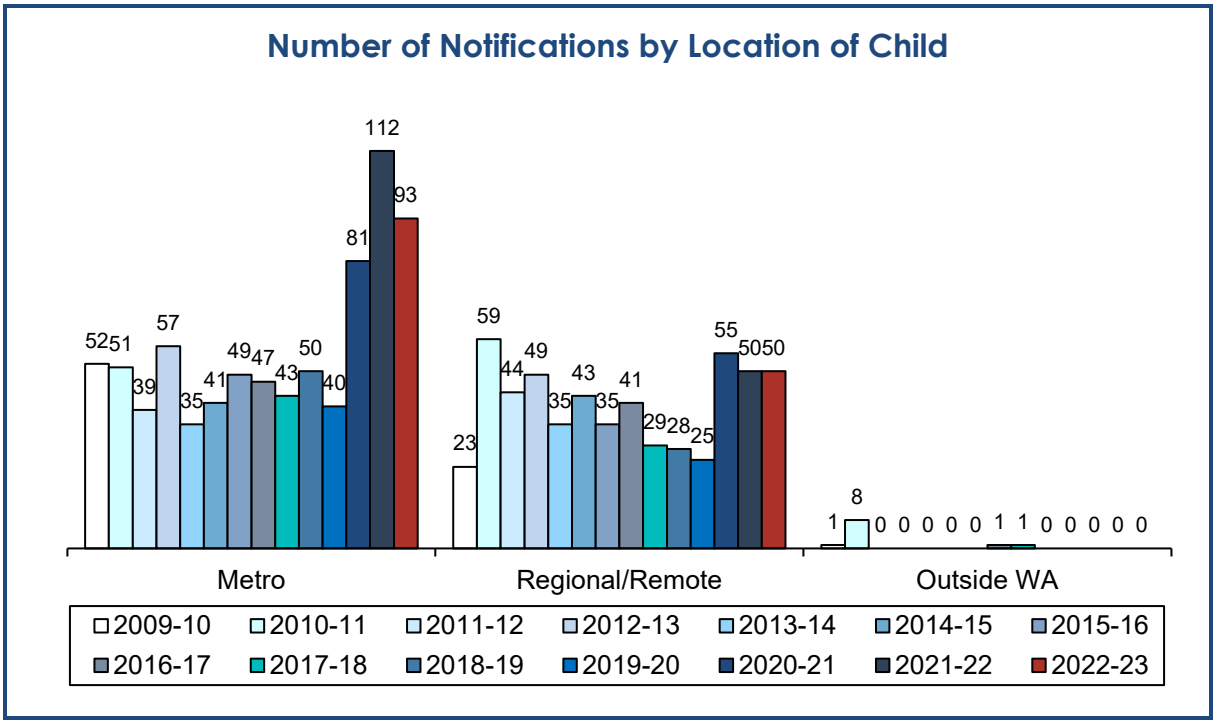


Note: Percentages may not add to 100 per cent due to rounding.

A more detailed analysis by age group is provided later in this section.

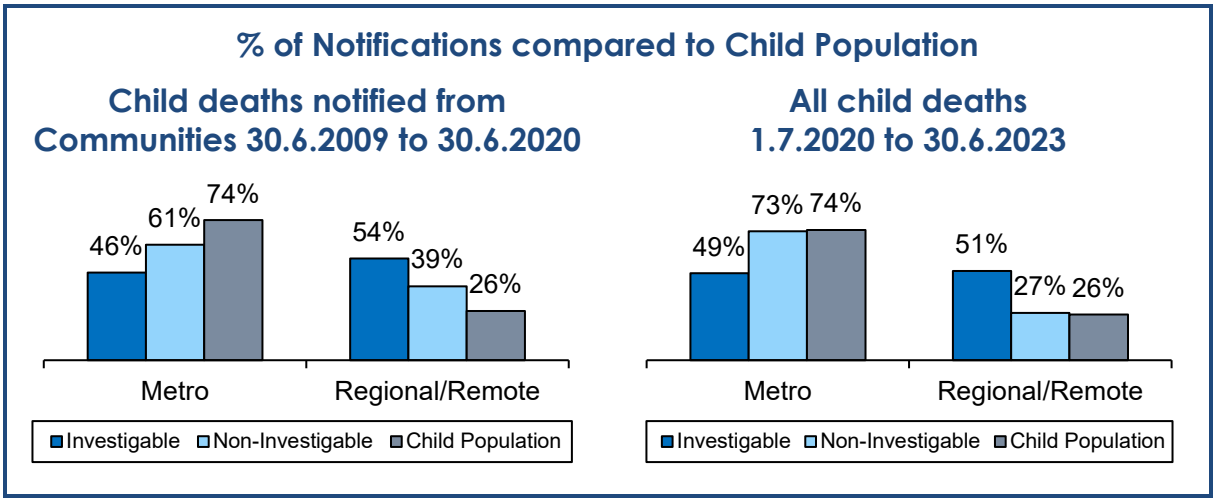
Location of residence

As shown in the following charts, children in regional locations are over-represented compared to the child population as a whole, and more so for investigable deaths.



Note 1: Outside WA includes children whose residence is not in Western Australia, but the child died in Western Australia. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the place of residence of the child.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



Further analysis of the data shows that 73% of Aboriginal children who died were living in regional or remote locations when they died. Most non-Aboriginal children who died lived in the metropolitan area but the proportion of non-Aboriginal children who died in regional areas (31%) is higher than would be expected based on the child population.

Circumstances in which child deaths have occurred

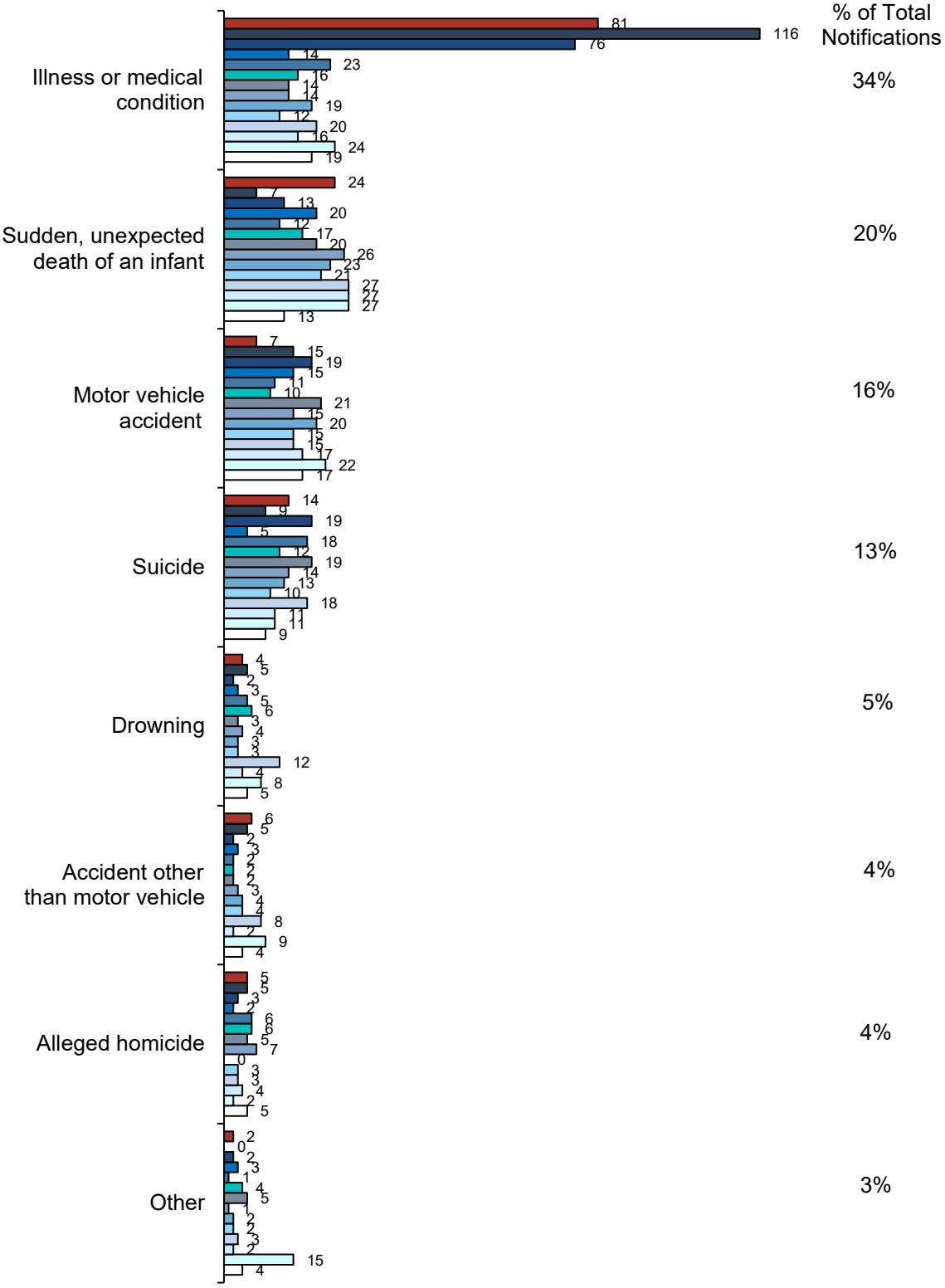
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally be finalised prior to the Coroner's determination of cause of death.

The circumstances of death are categorised by the Ombudsman as:

- Sudden, unexpected death of an infant – that is, infant deaths in which the likely cause of death cannot be explained immediately;
- Motor vehicle accident – the child may be a pedestrian, driver or passenger;
- Illness or medical condition;
- Suicide;
- Drowning;
- Accident other than motor vehicle – this includes accidents such as house fires, electrocution and falls;
- Alleged homicide; and
- Other.

The following chart shows the circumstances of notified child deaths for the period 30 June 2009 to 30 June 2023.

Circumstances of Child Deaths



Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

Note 2: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Note 3: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 4: Percentages may not add to 100 per cent due to rounding.

The main circumstances of death for the 1,367 child death notifications received in the 14 years from 30 June 2009 to 30 June 2023 are illness or medical condition (34%), sudden, unexpected deaths of infants (20%) and motor vehicle accidents (16%).

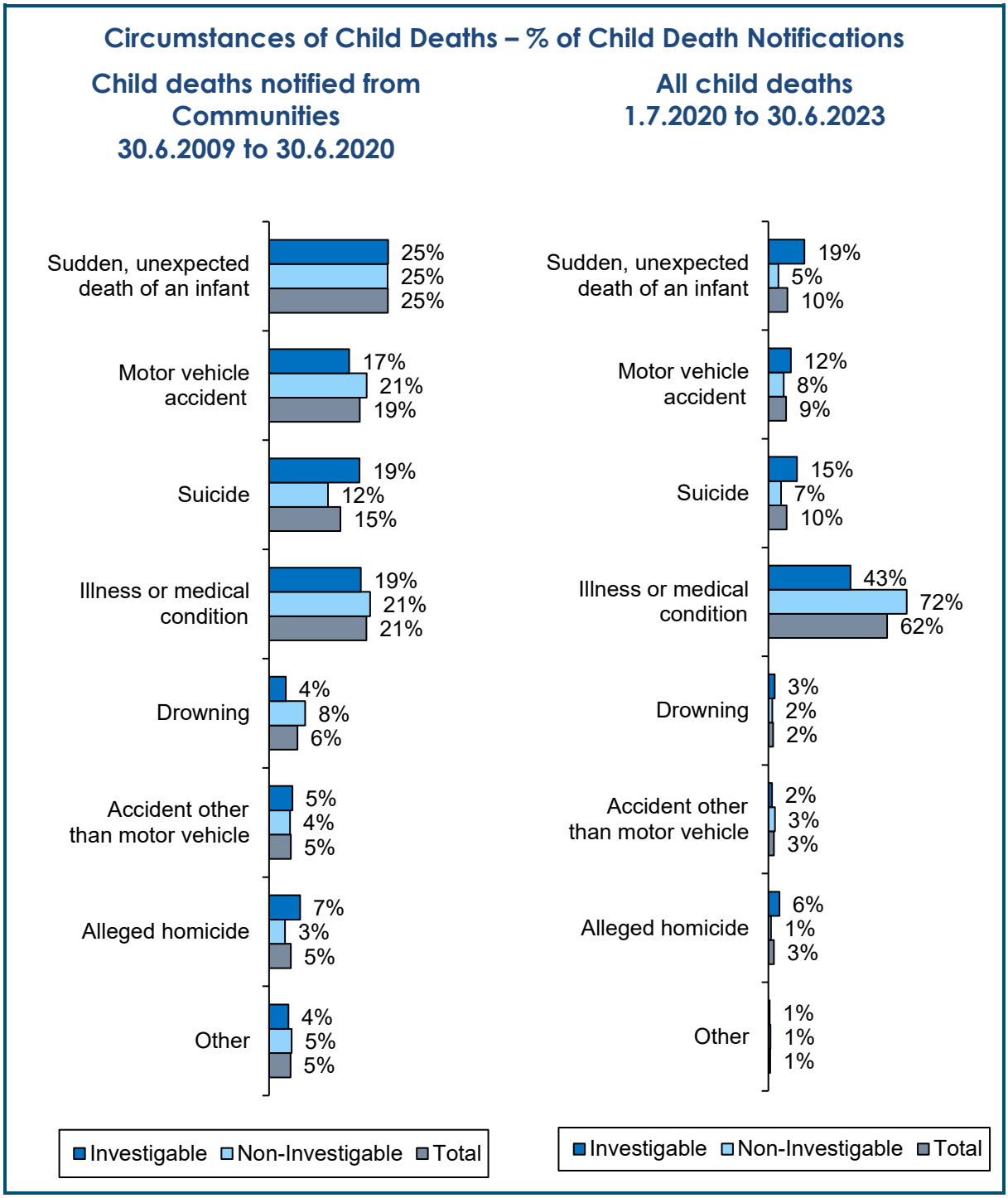
For the period 30 June 2009 to 30 June 2020, when the Ombudsman received notifications from Communities about child deaths reported to the Coroner, the main circumstances of death were:

- Sudden, unexpected deaths of infants, representing 25% of the total child death notifications over this period (17% of the child death notifications received in 2009-10, 23% in 2010-11, 33% in 2011-12, 25% in 2012-13, 30% in 2013-14, 27% in 2014-15, 31% in 2015-16, 22% in 2016-17, 23% in 2017-18, 15% in 2018-19, and 31% in 2019-20); and
- Motor vehicle accidents, representing 25% of the total child death notifications over this period (22% of the child death notifications received in 2009-10, 19% in 2010-11, 20% in 2011-12, 14% in 2012-13, 21% in 2013-14, 24% in 2014-15, 18% in 2015-16, 24% in 2016-17, 14% in 2017-18, 14% in 2018-19, and 23% in 2019-20.

For the period 1 July 2020 to 30 June 2023, when the Ombudsman received notifications of all child deaths in Western Australia, the main circumstances of death were:

- Illness or medical condition, representing 62% of the total child death notifications over this period (56% of child death notifications received in 2020-21, 72% in 2021-22 and 57% in 2022-23); and
- Sudden, unexpected deaths of infants, representing 10% of the total child death notifications over this period (10% of child death notifications received in 2020-21, 4% in 2021-22 and 17% in 2022-23).

The following chart provides a breakdown of the circumstances of death for child death notifications for investigable and non-investigable deaths.



Note: Percentages may not add to 100 per cent due to rounding.

Considering all 14 years, there are three areas where the circumstance of death shows a higher proportion for investigable deaths than for deaths that are not investigable. These are:

- Suicide;
- Alleged homicide; and
- Sudden, unexpected death of an infant.

Longer term trends in the circumstances of death

The CDRC also collated information on child deaths, using similar definitions, for the deaths it reviewed. The following tables show the trends over time in the circumstances of death. It should be noted that the Ombudsman's data shows the information for all notifications received, including deaths that are not investigable, while the data from the CDRC relates only to completed reviews.

Ombudsman from 30 June 2009

The figures on the circumstances of death from 2009-10 relate to all notifications received by the Ombudsman during the year including cases that are not investigable and are not known to Communities. These figures are much larger than previous years as the CDRC only reported on the circumstances of death for the cases that were reviewable and that were finalised during the financial year.

The figures from 2020-21 relate to all child deaths in Western Australia received by the Ombudsman during the year, while prior to this, the Ombudsman received deaths notified by Communities from deaths reported to the Coroner only. Therefore, the figures for certain circumstances of death, such as illness, medical condition and sudden, unexpected death of an infant are larger than earlier years, as these deaths can also be notified to the Ombudsman from sources other than the Coroner.

Year	Accident Other Than Motor Vehicle	Motor Vehicle Accident	Illness or Medical Condition	Asphyxiation /Suffocation	Alleged Homicide	Drowning	SUDI *	Suicide	Other
2009-10	4	17	7		5	5	25	9	4
2010-11	9	22	17		2	8	34	11	15
2011-12	2	17	12		4	4	31	11	2
2012-13	8	15	15		3	12	32	18	3
2013-14	4	15	9		3	3	24	10	2
2014-15	4	20	14		0	3	28	13	2
2015-16	3	15	11		7	4	29	14	1
2016-17	2	21	9		5	3	25	19	5
2017-18	2	10	6		6	6	27	12	4
2018-19	2	11	19		6	5	16	18	1
2019-20	3	15	10		2	3	24	5	3
2020-21	2	19	30		3	2	59	19	2
2021-22	5	15	41		5	5	82	9	0
2022-23	6	7	81		5	4	24	14	2

* Sudden, unexpected death of an infant – includes Sudden Infant Death Syndrome

Note 1: The data for the Ombudsman is based on the notifications received by the Ombudsman during the year. The types of circumstances are as used in the Ombudsman's Annual Reports. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Note 2: The data from 2020-21 onwards includes all child deaths in Western Australia that were notified to the Ombudsman during the year. This includes deaths notified from Communities, the Department of Health and Births, Deaths and Marriages. Prior to this, the Ombudsman only received and reported deaths notified from Communities of deaths reported to the Coroner.

Social and environmental factors associated with investigable child deaths

A number of social and environmental factors affecting the child or their family may impact on the wellbeing of the child, such as:

- Family and domestic violence;
- Drug or substance use;
- Alcohol use;
- Parenting;
- Homelessness; and
- Parental mental health issues.

Reviews of investigable deaths often highlight the impact of these factors on the circumstances leading up to the child's death and, where this occurs, these factors are recorded to enable an analysis of patterns and trends to assist in considering ways to prevent or reduce future deaths.

It is important to note that the existence of these factors is associative. They do not necessarily mean that the removal of this factor would have prevented the death of a child or that the existence of the factor necessarily represents a failure by Communities or another public authority.

The following table shows the percentage of investigable child death reviews associated with particular social and environmental factors for the period 30 June 2009 to 30 June 2023.

Social or Environmental Factor	% of Finalised Reviews from 30.6.2009 to 30.6.2023
Family and domestic violence	74%
Parenting	64%
Drug or substance use	48%
Alcohol use	44%
Parental mental health issues	30%
Homelessness	23%

One of the features of the investigable deaths reviewed is the co-existence of a number of these social and environmental factors. The following observations can be made:

- Where family and domestic violence was present:
  - Parenting was a co-existing factor in over two-thirds of the cases;
  - Alcohol use was a co-existing factor in over half of the cases;
  - Drug or substance use was a co-existing factor in over half of the cases;
  - Homelessness was a co-existing factor in over a quarter of the cases; and

- Parental mental health issues were a co-existing factor in over a third of the cases.

- Where alcohol use was present:
  - Parenting was a co-existing factor in over three quarters of the cases;
  - Family and domestic violence was a co-existing factor in nearly nine in 10 cases;
  - Drug or substance use was a co-existing factor in over two thirds of the cases; and
  - Homelessness was a co-existing factor in over a third of the cases.

Reasons for contact with Communities

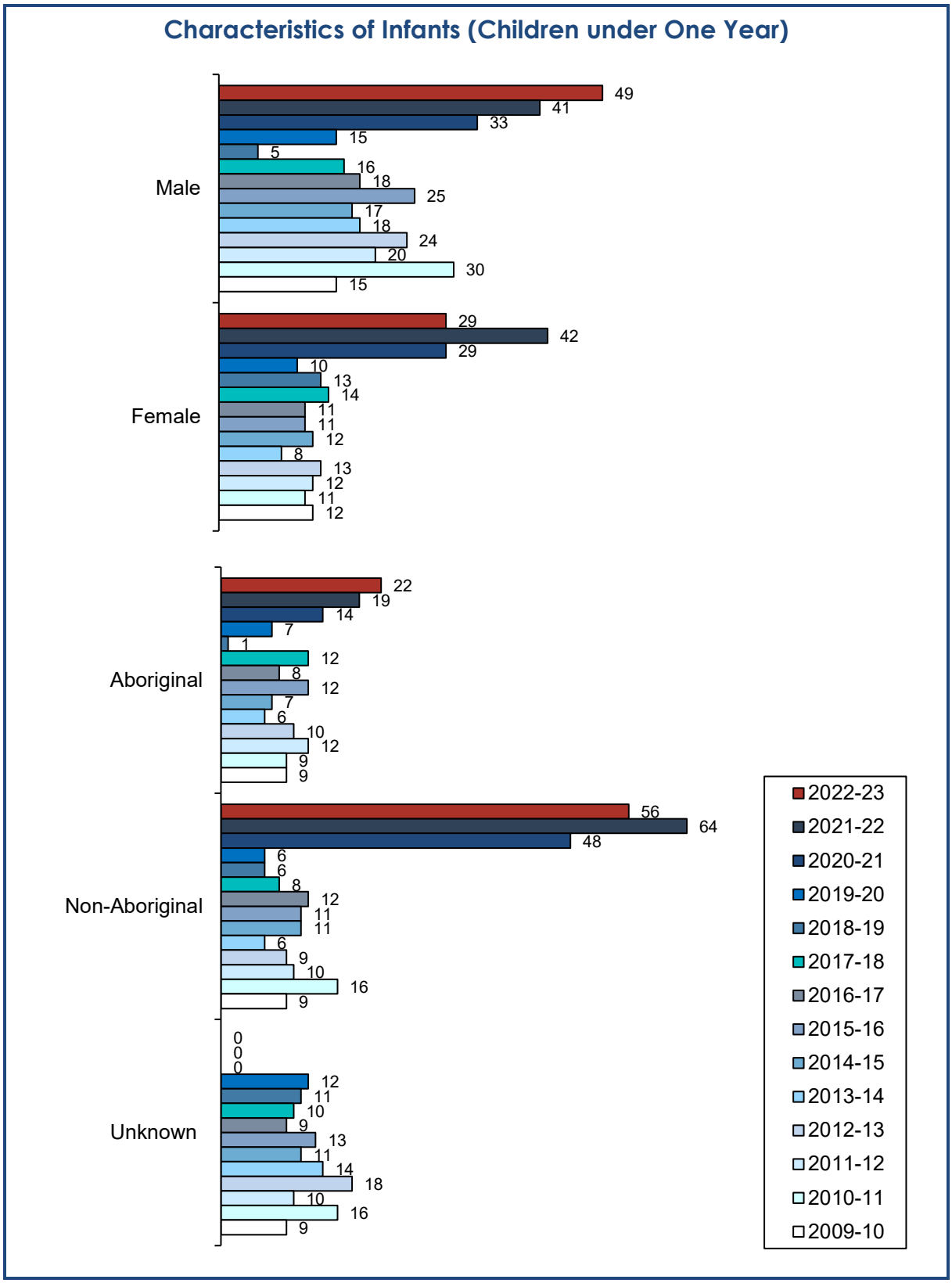
In child deaths notified to the Ombudsman in 2022-23, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

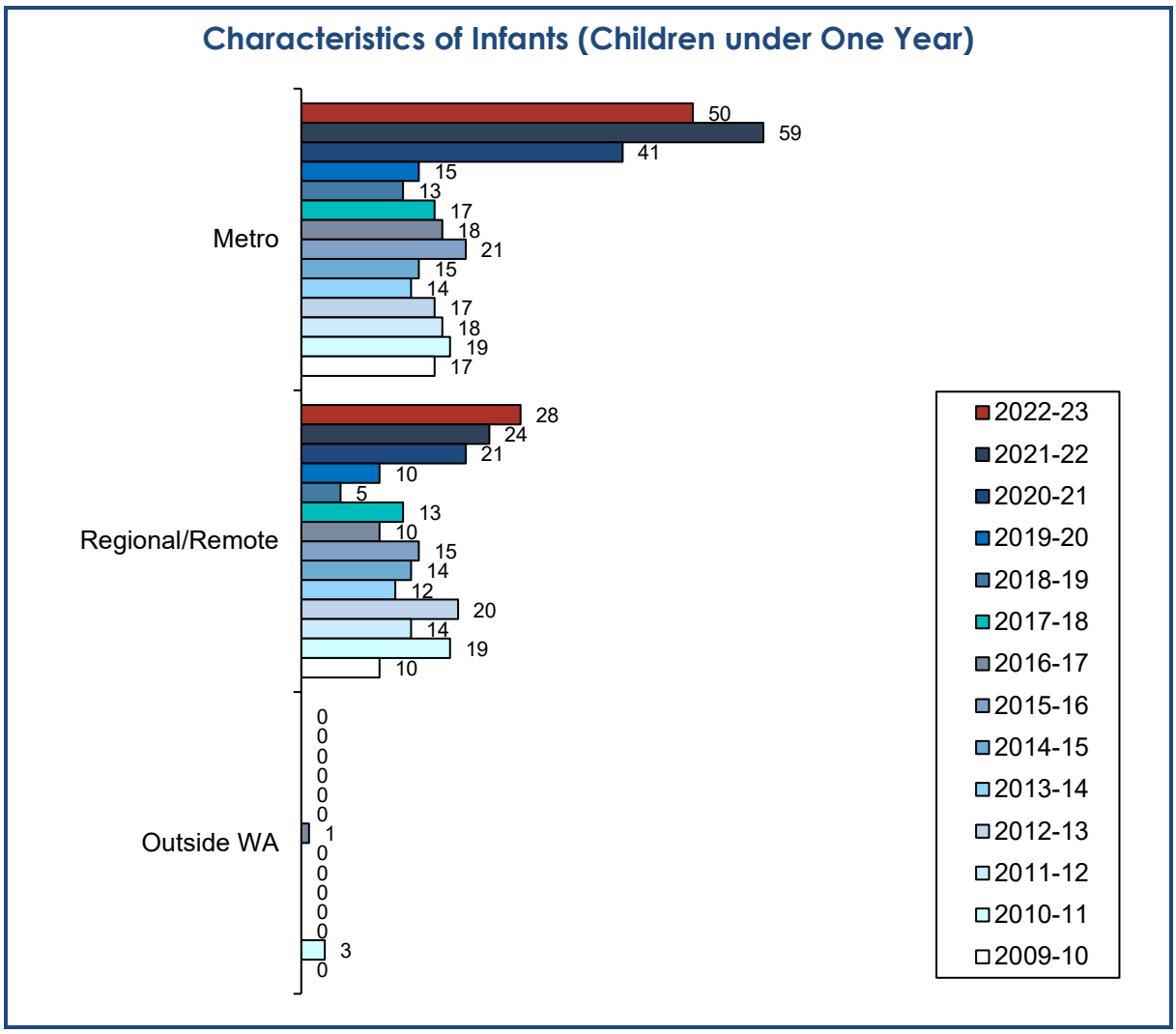
Analysis of children in particular age groups

In examining the child death notifications by their age groups, the Office is able to identify patterns that appear to be linked to childhood developmental phases and associated care needs. This age-related focus has enabled the Office to identify particular characteristics and circumstances of death that have a high incidence in each age group, and refine the reviews to examine areas where improvements to public administration may prevent or reduce these child deaths. The following section identifies four groupings of children: under one year (**infants**); children aged 1 to 5; children aged 6 to 12; and children aged 13 to 17, and demonstrates the learning and outcomes from this age-related focus.

Deaths of infants

Of the 1,367 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2023, there were 553 (40%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.





Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

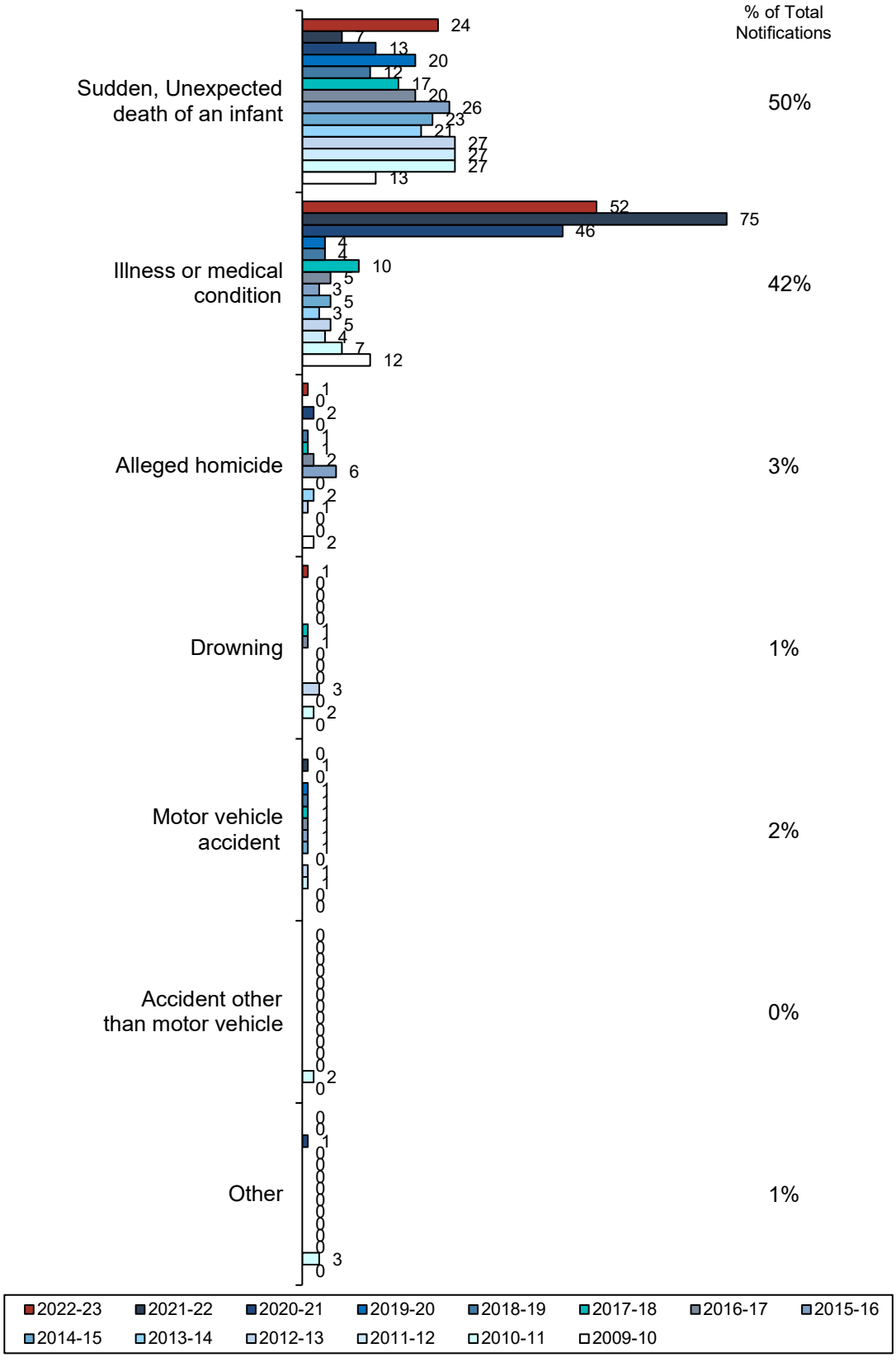
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these infant deaths, there was an over-representation compared to the child population for:

- Males – 60% of investigable infant deaths and 58% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 63% of investigable deaths and 16% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 54% of investigable infant deaths and 30% of non-investigable deaths of infants, living in Western Australia, were children living in regional or remote locations compared to 26% in the child population.

An examination of the patterns and trends of the circumstances of infant deaths showed that of the 553 infant deaths, 277 (50%) were categorised as sudden, unexpected deaths of an infant and 81% of these (224) appear to have occurred while the infant had been placed for sleep. There were also 42% of infant deaths (235) in circumstances of illness or medical condition, however the majority of these (173) were notified to the Ombudsman under the expanded jurisdiction from 1 July 2023. There were a small number of other deaths as shown in the following charts.

Circumstances of Infant Deaths (Children under One Year)



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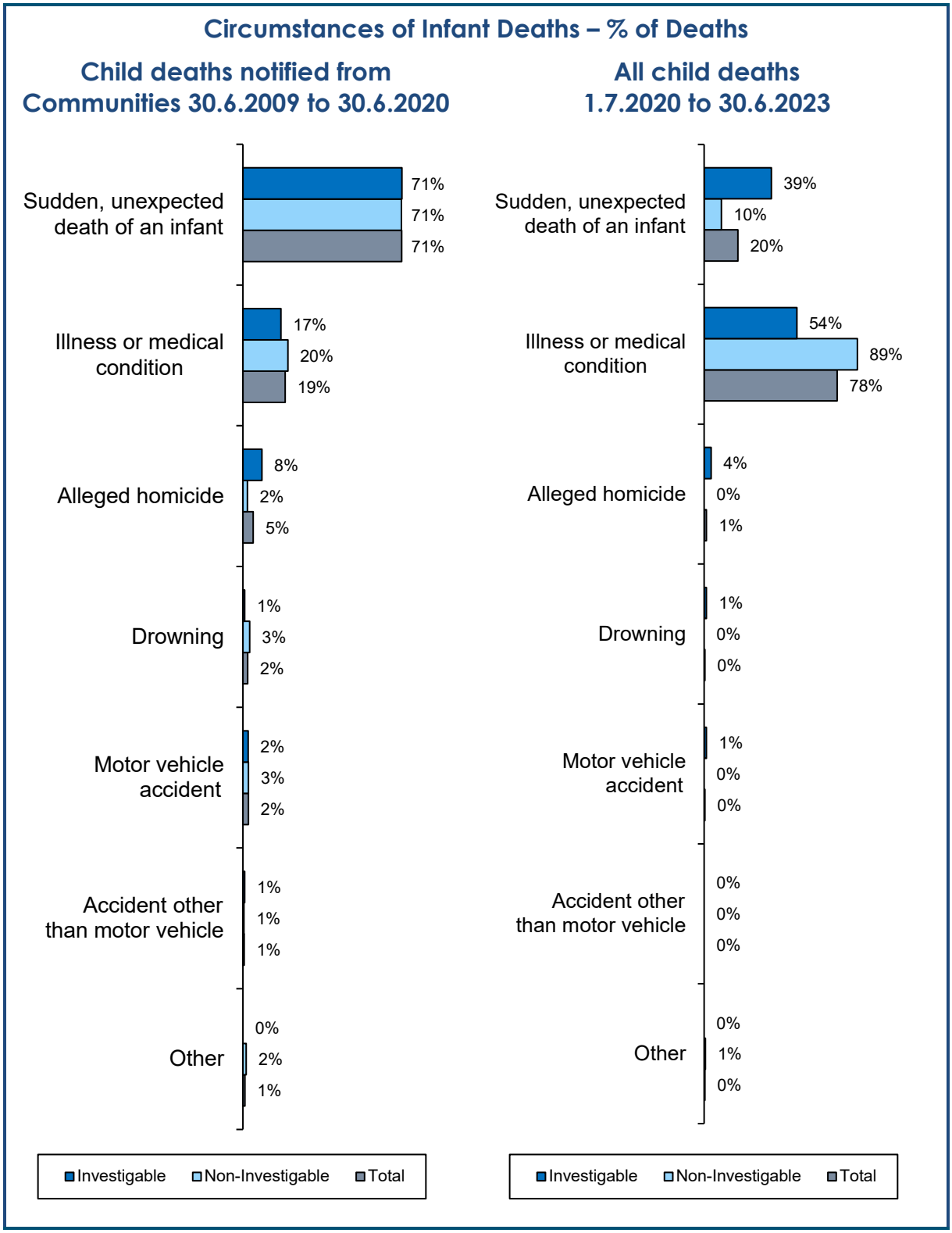


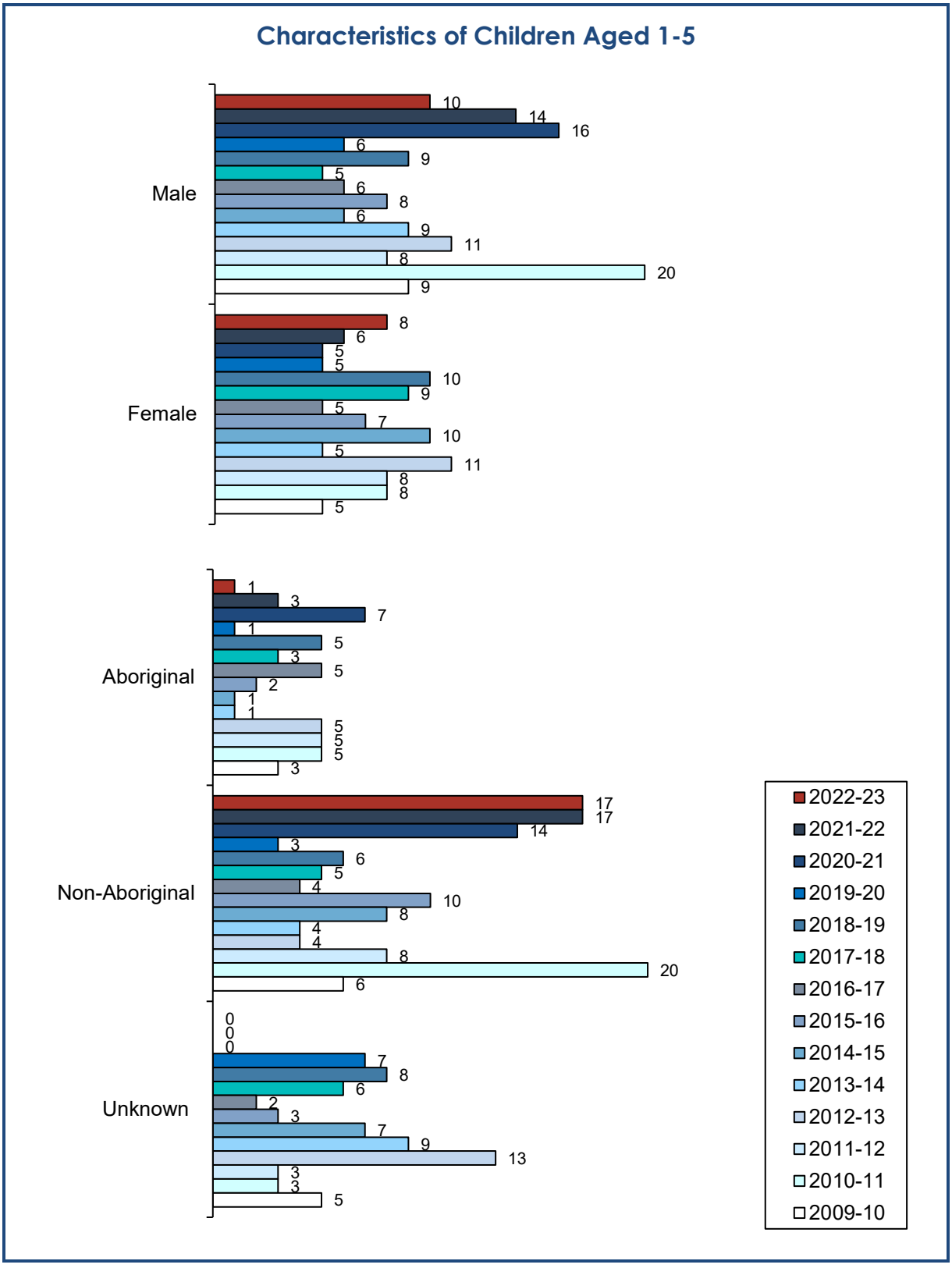
Note: Percentages may not add to 100 per cent due to rounding.

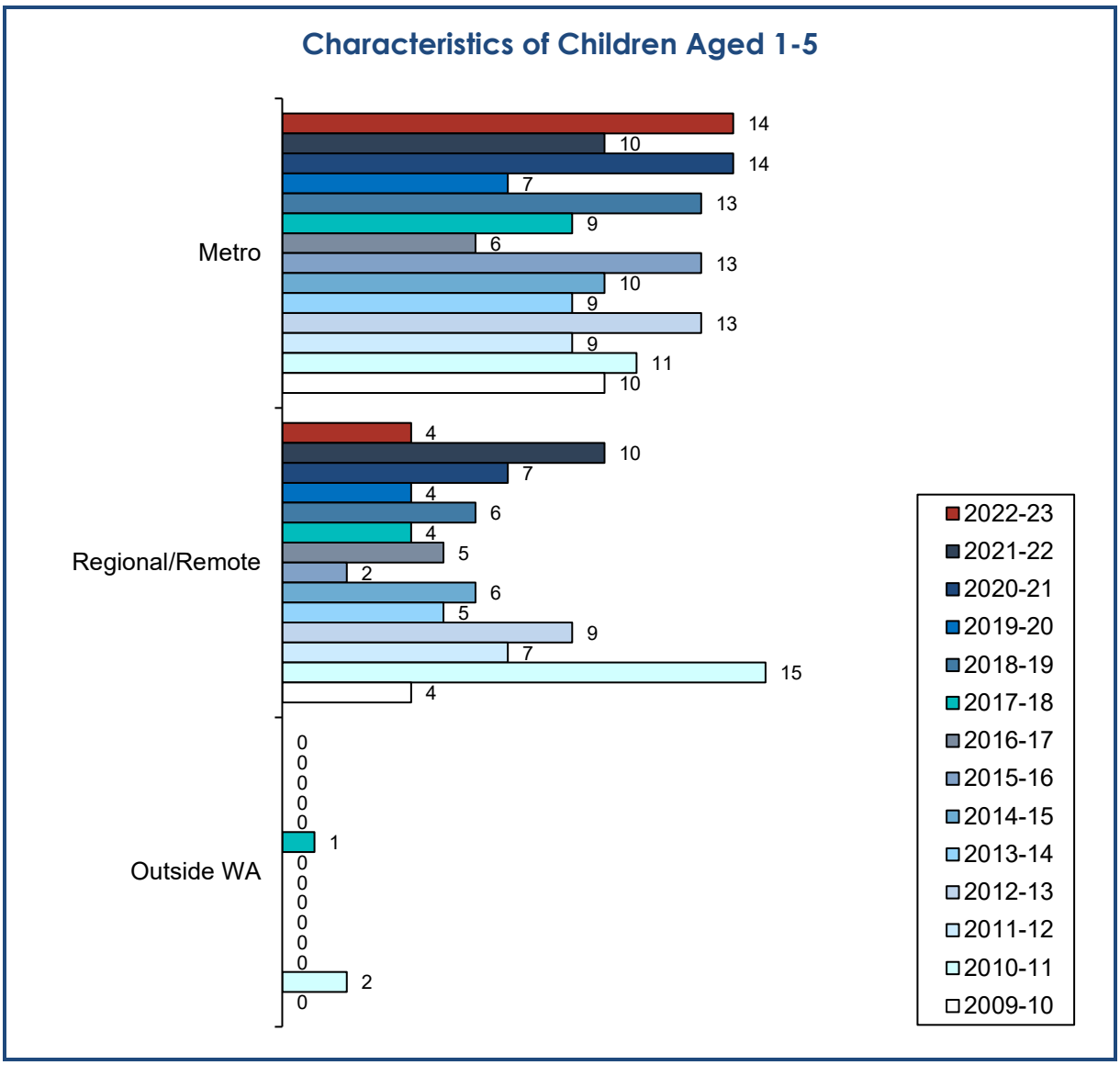
Two hundred and five deaths of infants were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 1,367 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2023, there were 239 (17%) related to children aged from 1 to 5 years.

The characteristics of children aged 1 to 5 are shown in the following chart.





Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

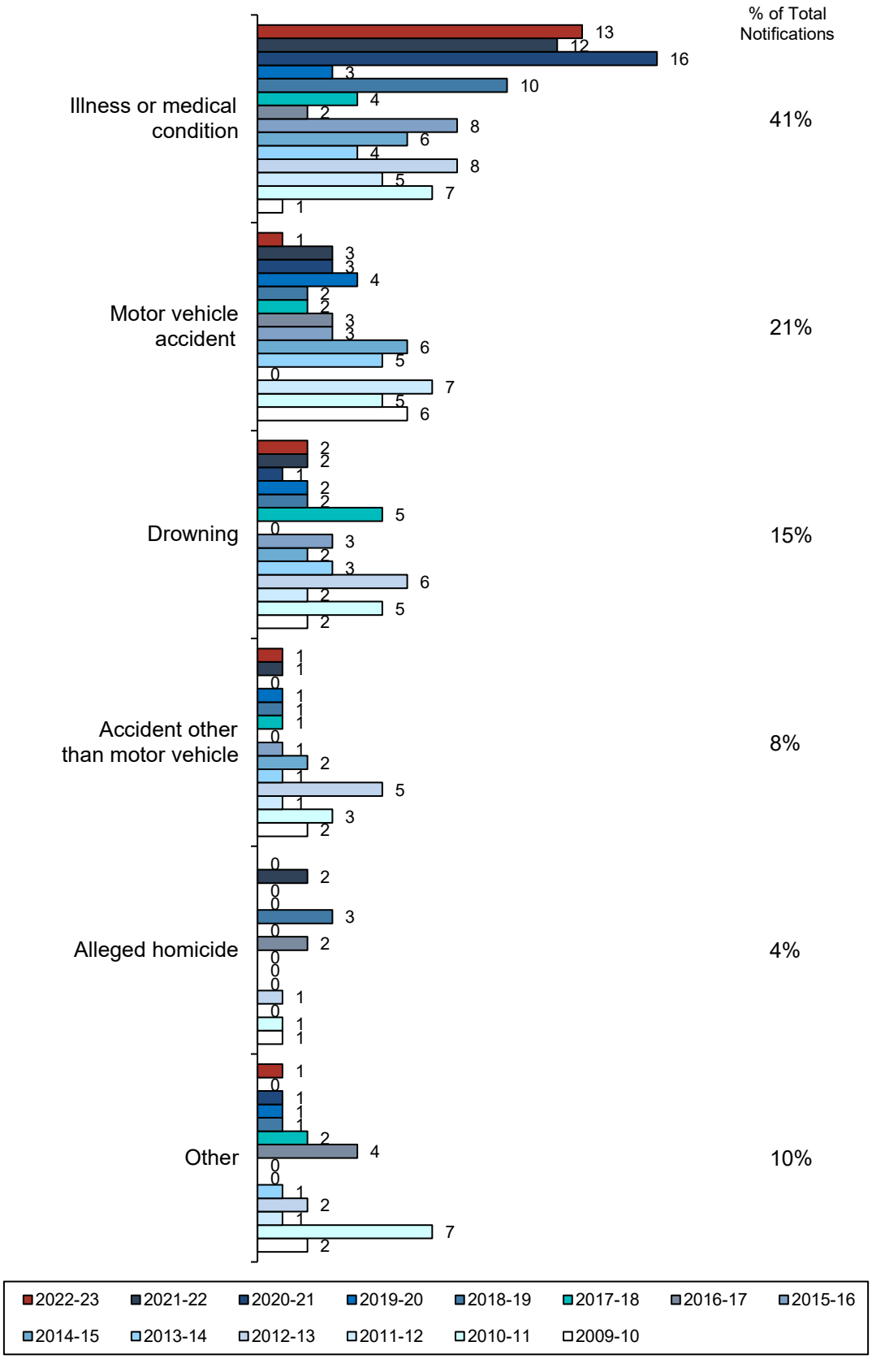
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 55% of investigable deaths and 58% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Aboriginal children – 49% of investigable deaths and 12% of non-investigable deaths of children aged 1 to 5 were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 45% of investigable deaths and 33% of non-investigable deaths of children aged 1 to 5, living in Western Australia, were children living in regional or remote locations compared to 26% in the child population.

As shown in the following chart, illness or medical condition is the most common circumstance of death for this age group (41%), followed by motor vehicle accidents (21%) and drowning (15%).

Circumstances of Deaths of Children Aged 1-5



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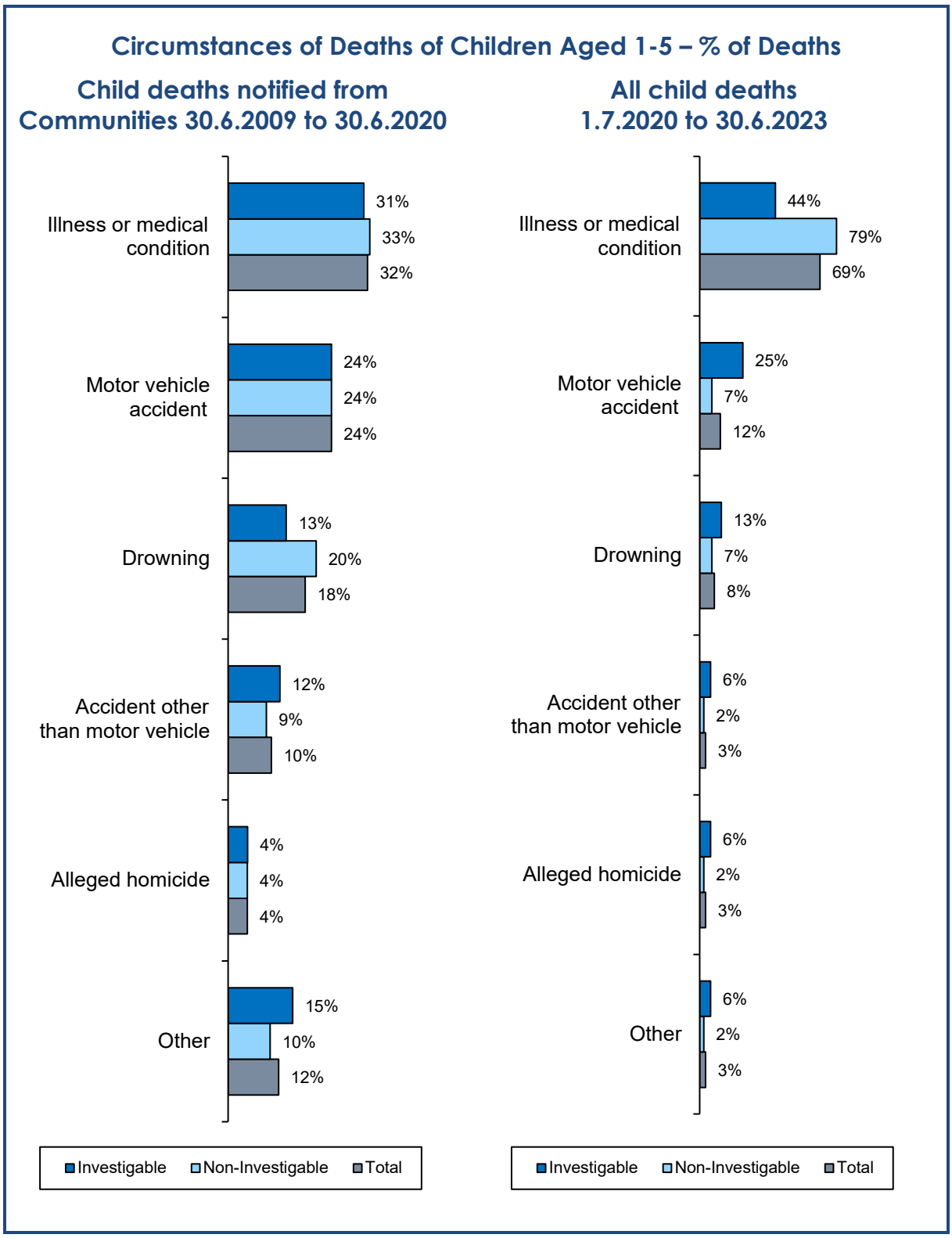
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



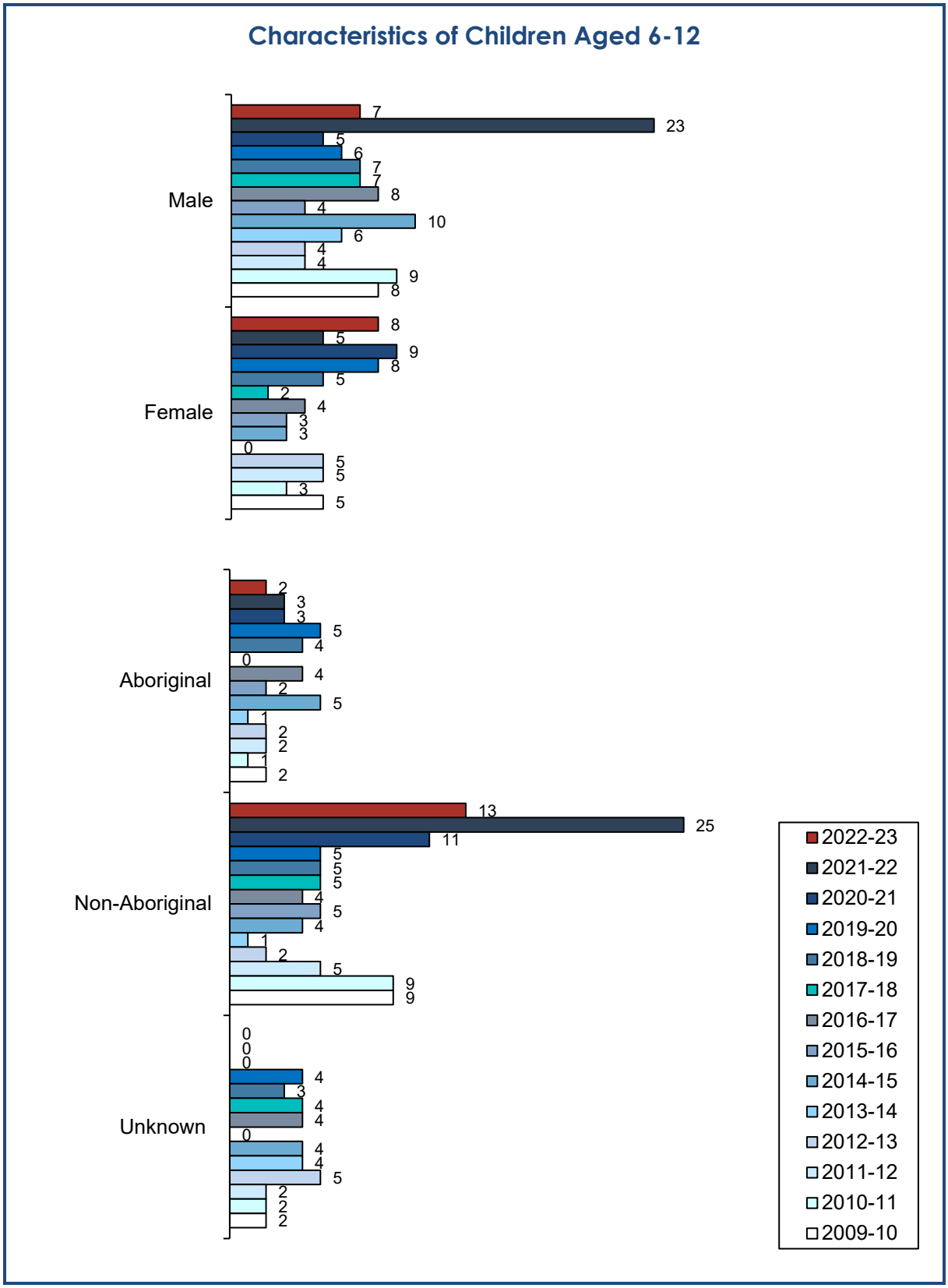
Note: Percentages may not add to 100 per cent due to rounding.

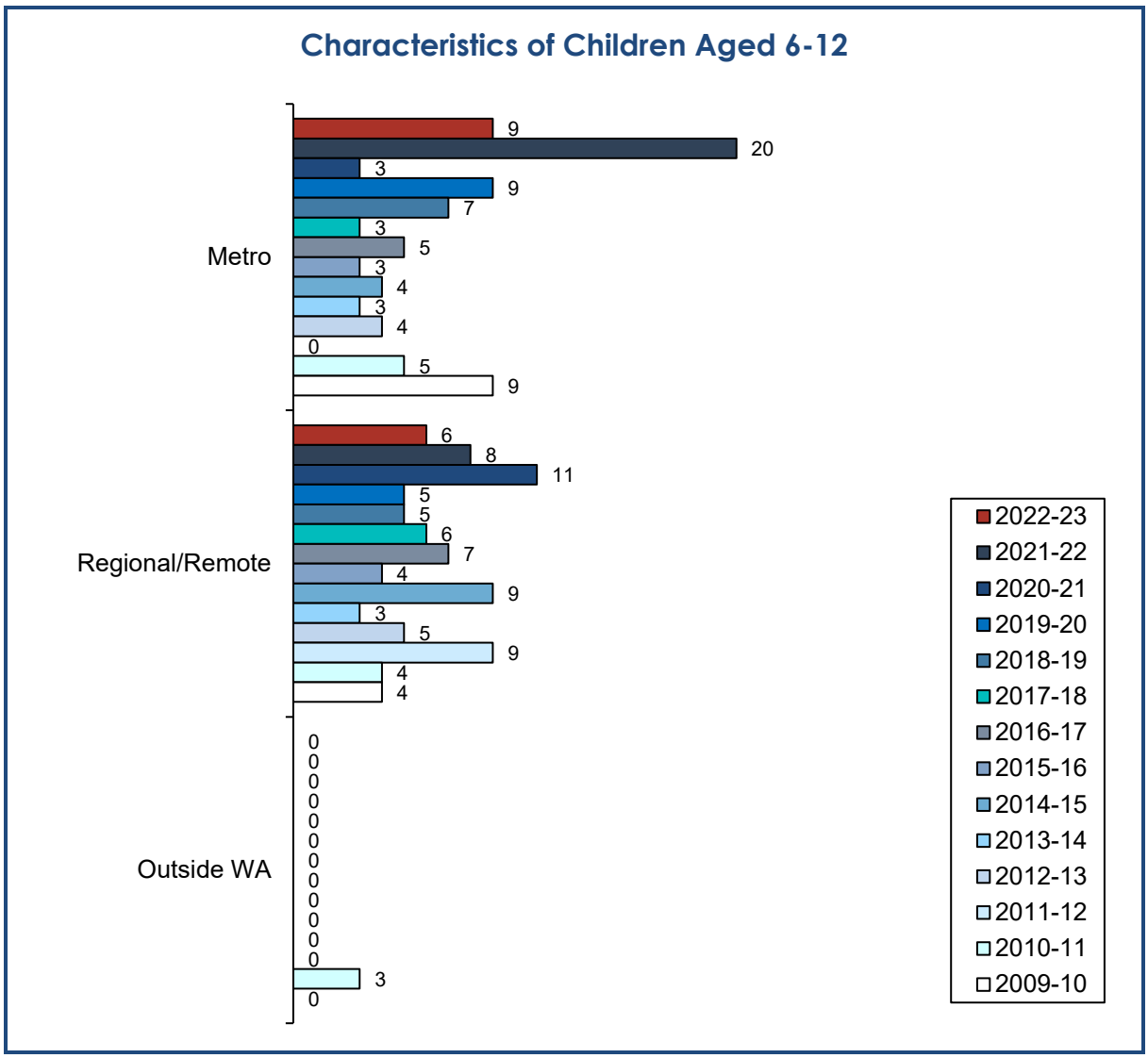
Eighty three deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of children aged 6 to 12 years

Of the 1,367 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2023, there were 173 (13%) related to children aged from 6 to 12 years.

The characteristics of children aged 6 to 12 are shown in the following chart.





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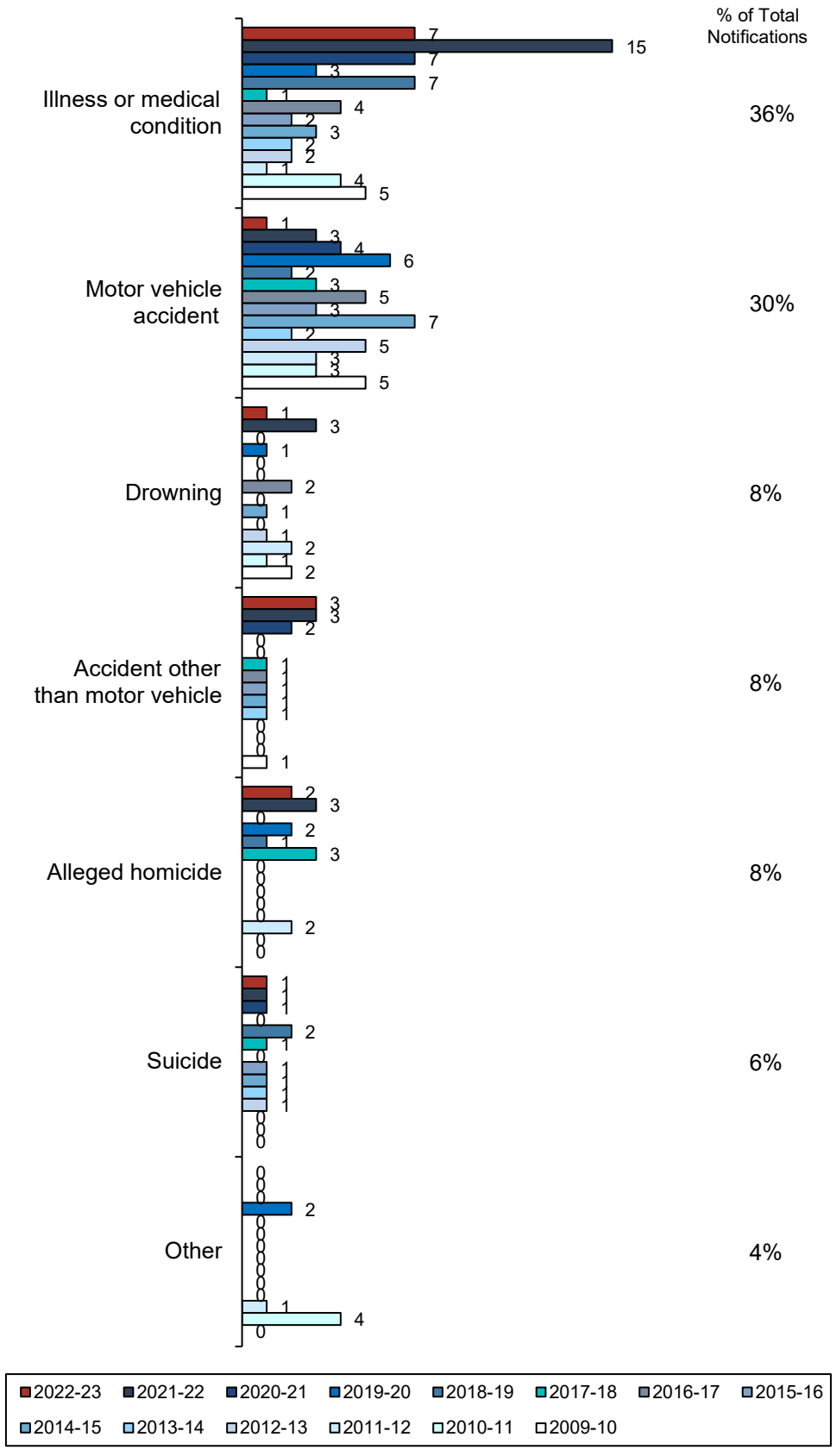
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 55% of investigable deaths and 67% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population;
- Aboriginal children – 47% of investigable deaths and 10% of non-investigable deaths of children aged 6 to 12 were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 58% of investigable deaths and 46% of non-investigable deaths of children aged 6 to 12, living in Western Australia, were children living in regional or remote locations compared to 26% in the child population.

As shown in the following chart, illness or medical conditions are the most common circumstance of death for this age group (36%), followed by motor vehicle accidents (30%).

Circumstances of Deaths of Children Aged 6-12



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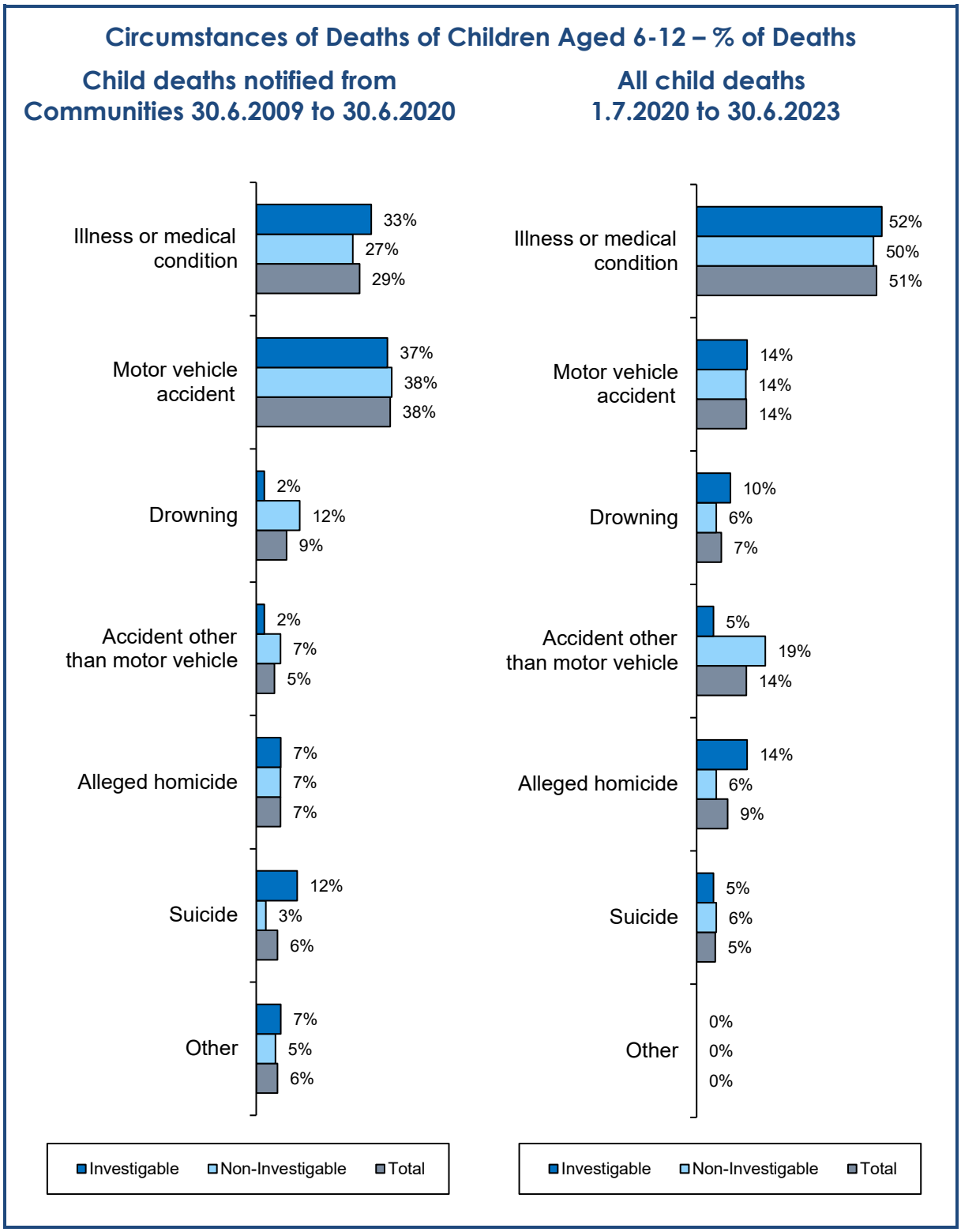
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



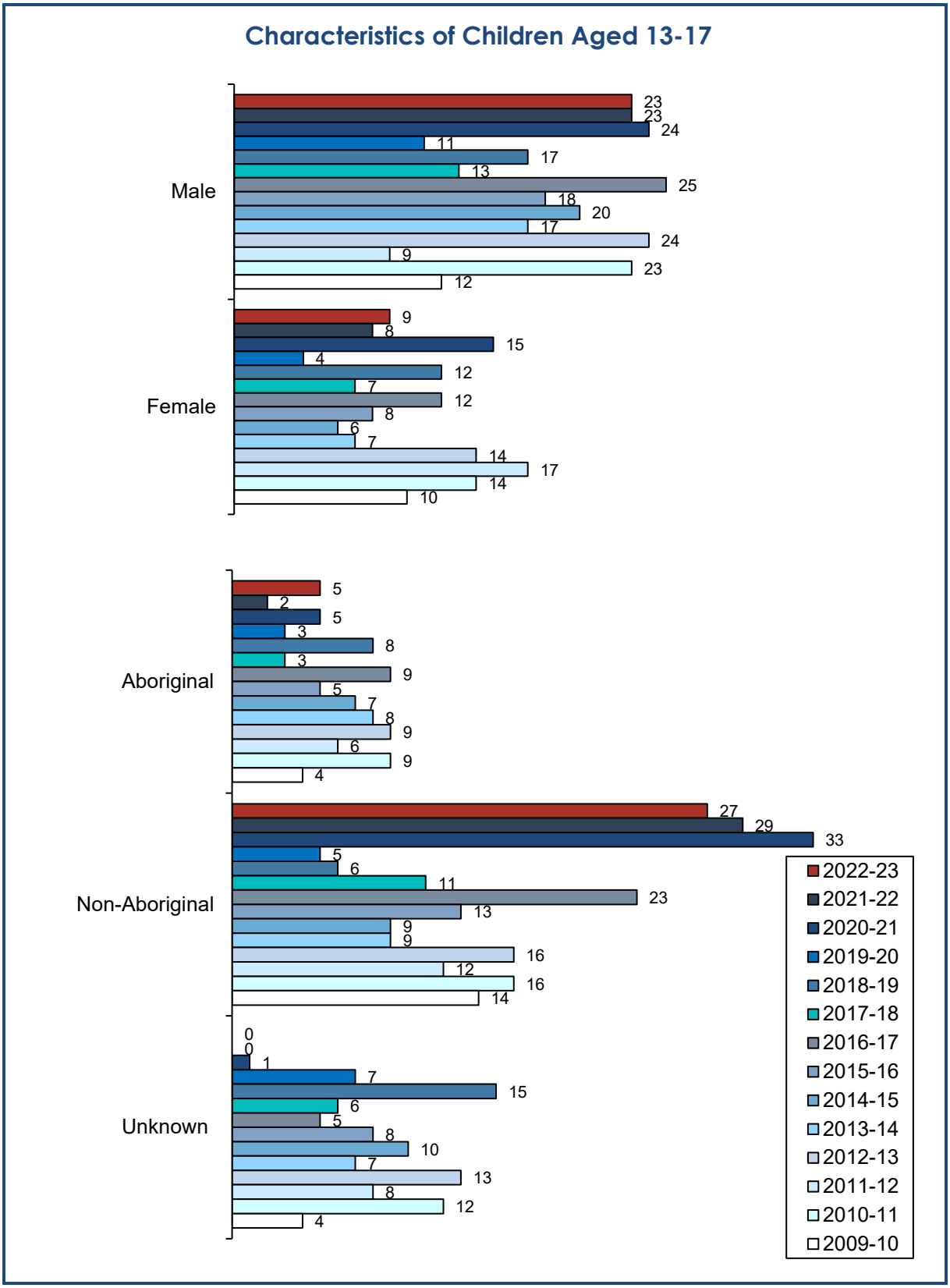
Note: Percentages may not add to 100 per cent due to rounding.

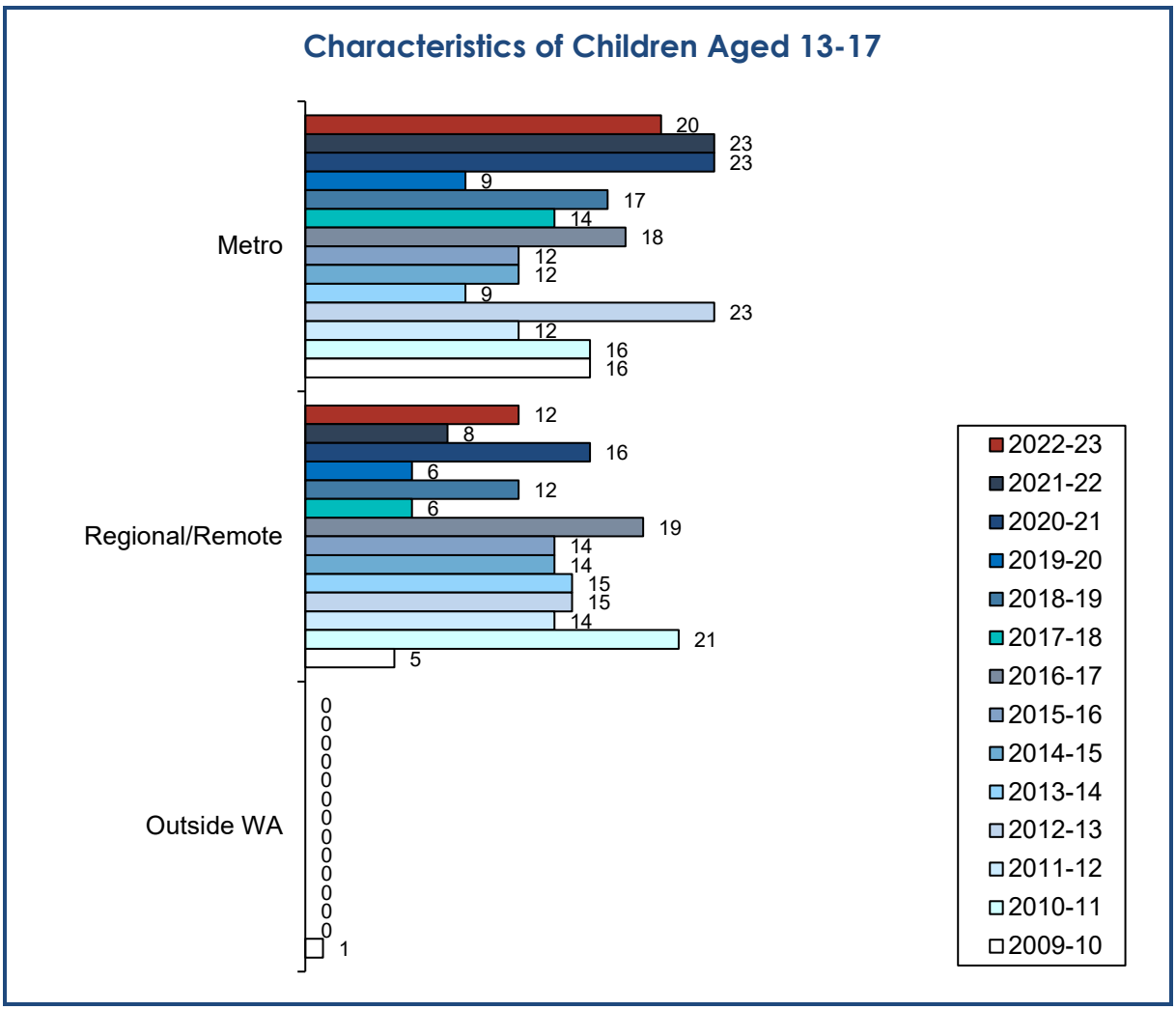
Sixty four deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of children aged 13 – 17 years

Of the 1,367 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2023, there were 402 (29%) related to children aged from 13 to 17 years.

The characteristics of children aged 13 to 17 are shown in the following chart.





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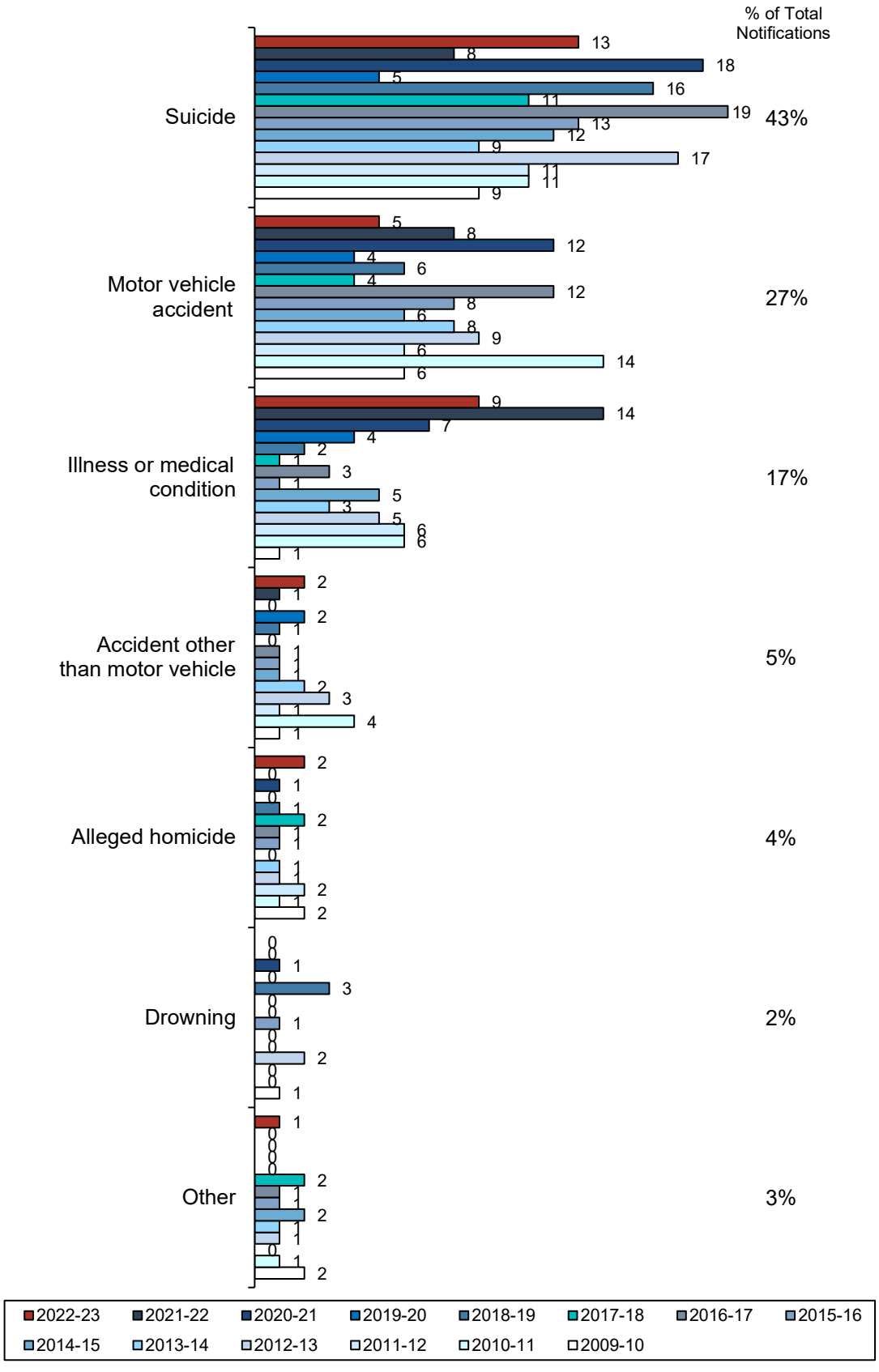
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 60% of investigable deaths and 68% of non-investigable deaths of children aged 13 to 17 were male compared to 51% in the child population;
- Aboriginal children – 45% of investigable deaths and 9% of non-investigable deaths of children aged 13 to 17 were Aboriginal compared to 6% in the child population; and
- Children living in regional or remote locations – 53% of investigable deaths and 38% of non-investigable deaths of children aged 13 to 17, living in Western Australia, were living in regional or remote locations compared to 26% in the child population.

As shown in the following chart, suicide is the most common circumstance of death for this age group (43%), particularly for investigable deaths, followed by motor vehicle accidents (27%) and illness or medical condition (17%).

Circumstances of Deaths of Children Aged 13-17



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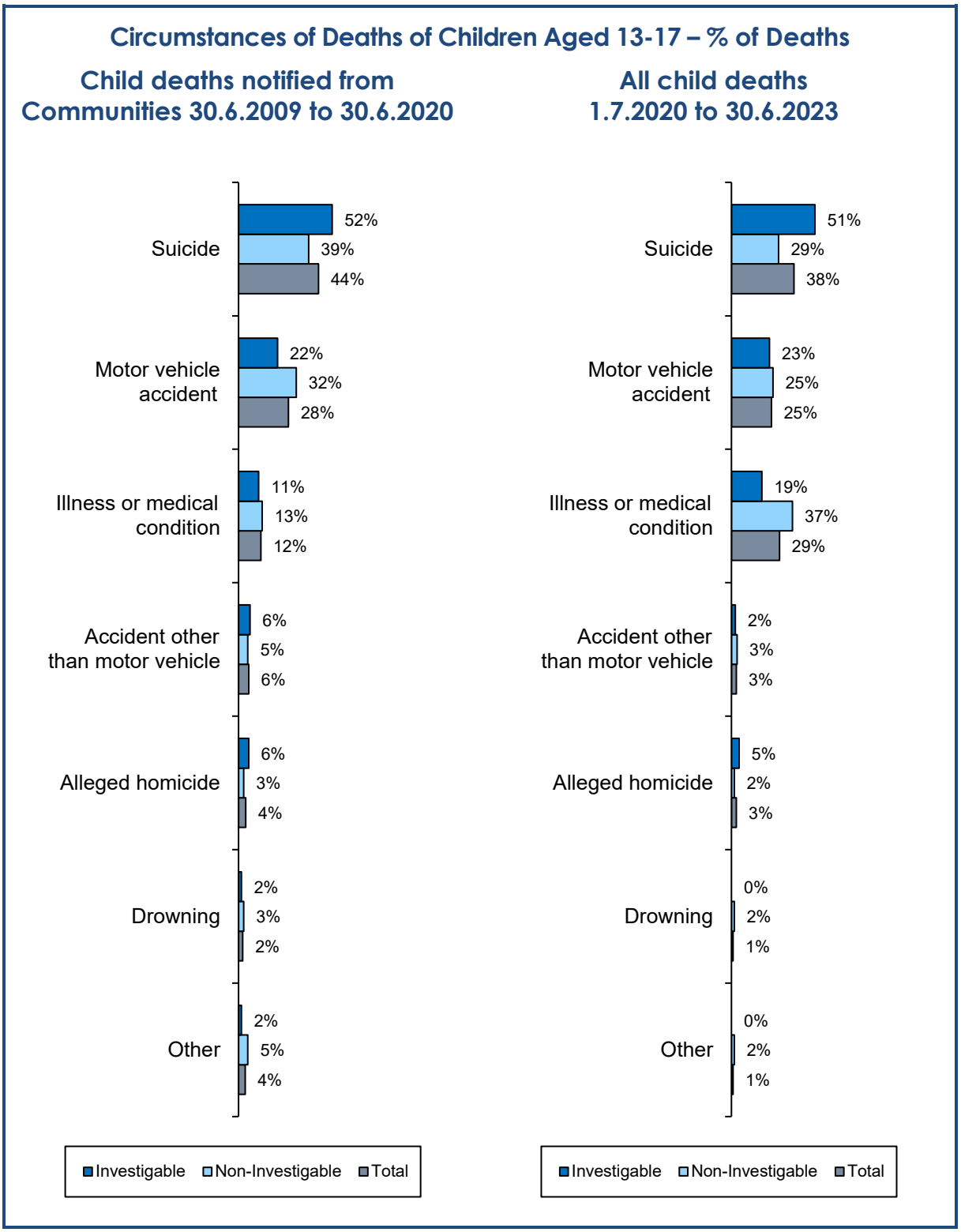


Note: Percentages may not add to 100 per cent due to rounding.

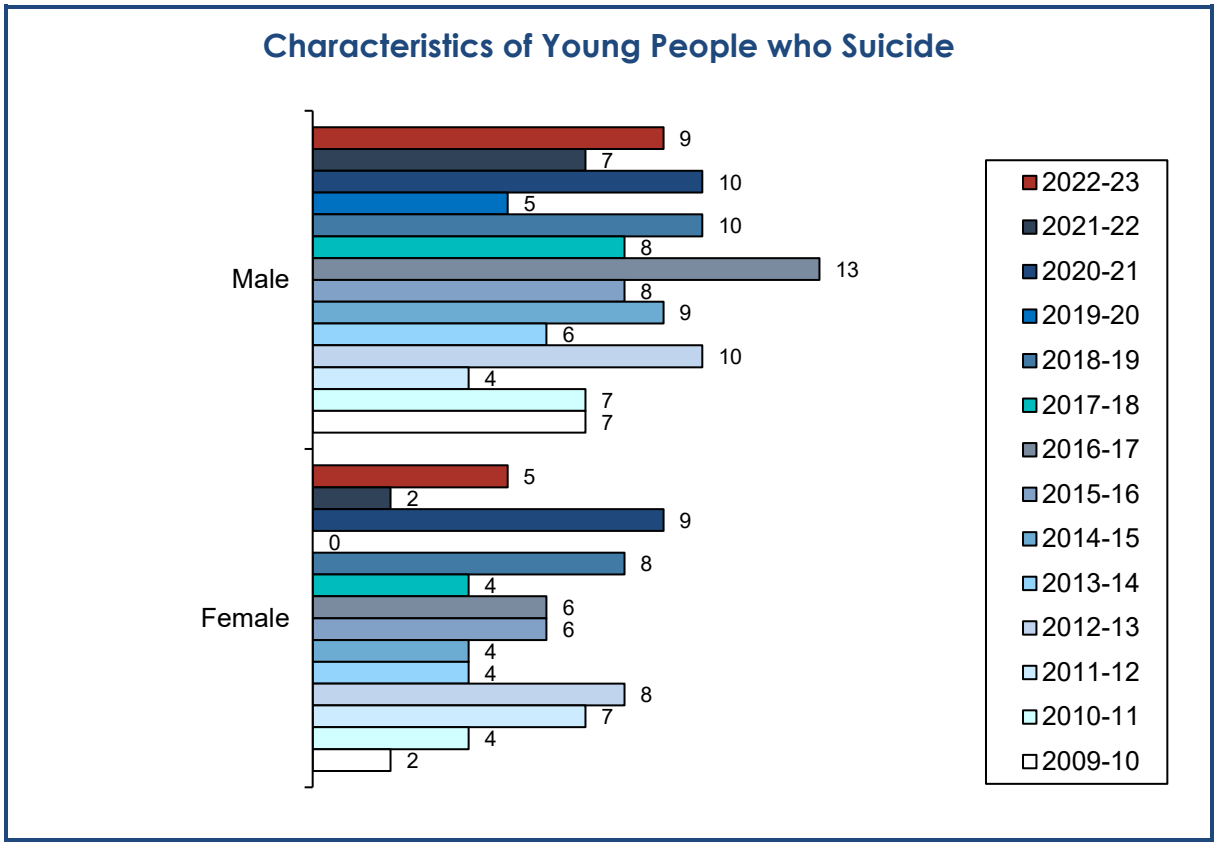
One hundred and sixty eight deaths of children aged 13 to 17 years were determined to be investigable deaths.

Suicide by young people

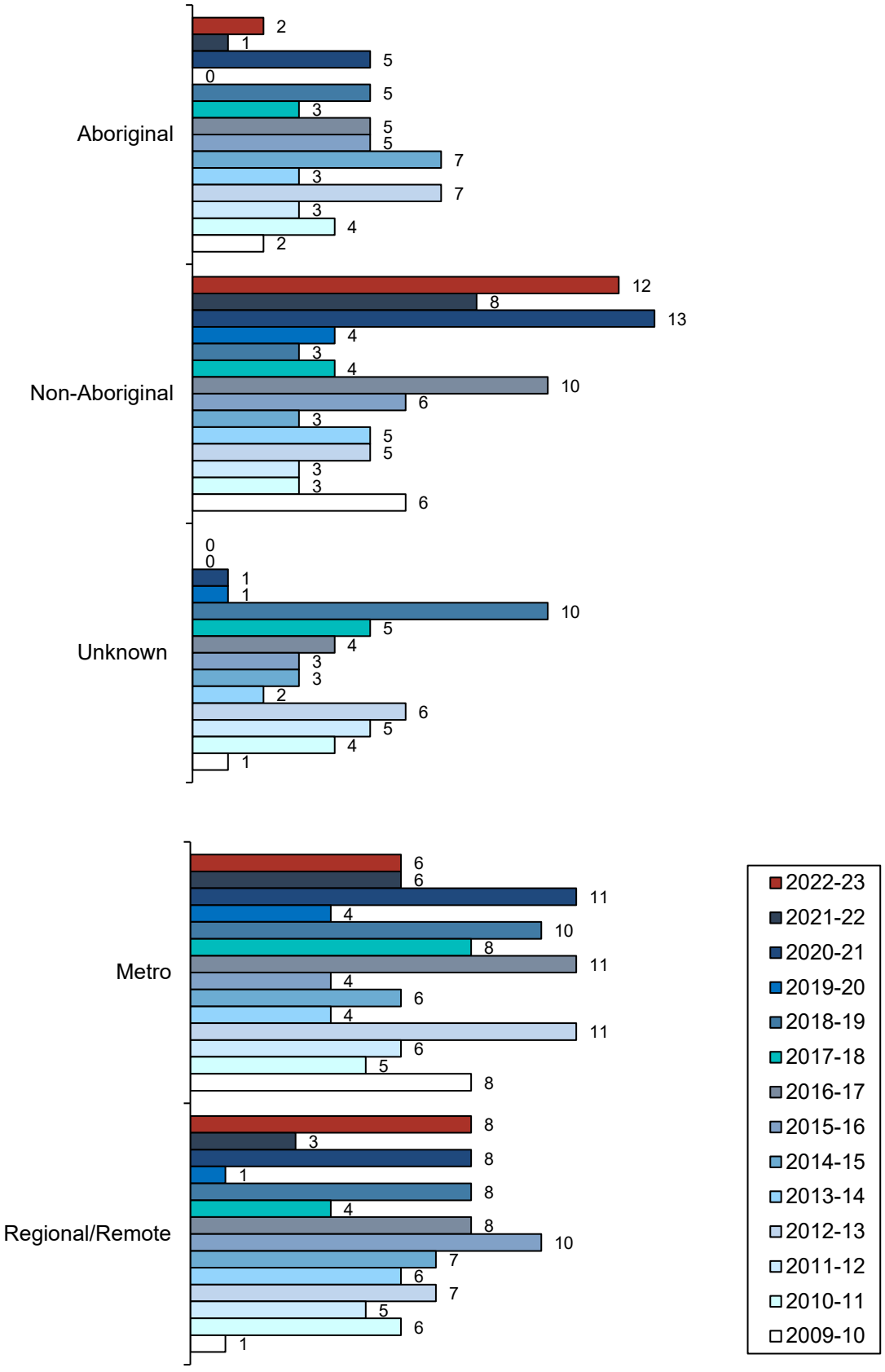
Of the 182 young people who apparently took their own lives from 30 June 2009 to 30 June 2023:

- Ten were under 13 years old;
- Twelve were 13 years old;
- Twenty were 14 years old;
- Thirty nine were 15 years old;
- Forty seven were 16 years old; and
- Fifty four were 17 years old.

The characteristics of the young people who apparently took their own lives are shown in the following chart.



Characteristics of Young People who Suicide



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Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 54% of investigable deaths and 71% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 137 apparent suicides by young people where information on the Aboriginal status of the young person was available, 55% of the investigable deaths and 11% of non-investigable deaths were Aboriginal young people compared to 6% in the child population; and
- Young people living in regional and remote locations – the majority of apparent suicides by young people occurred in the metropolitan area, but 57% of investigable suicides by young people and 33% of non-investigable suicides by young people were young people who were living in regional or remote locations compared to 26% in the child population.

Deaths of Aboriginal children

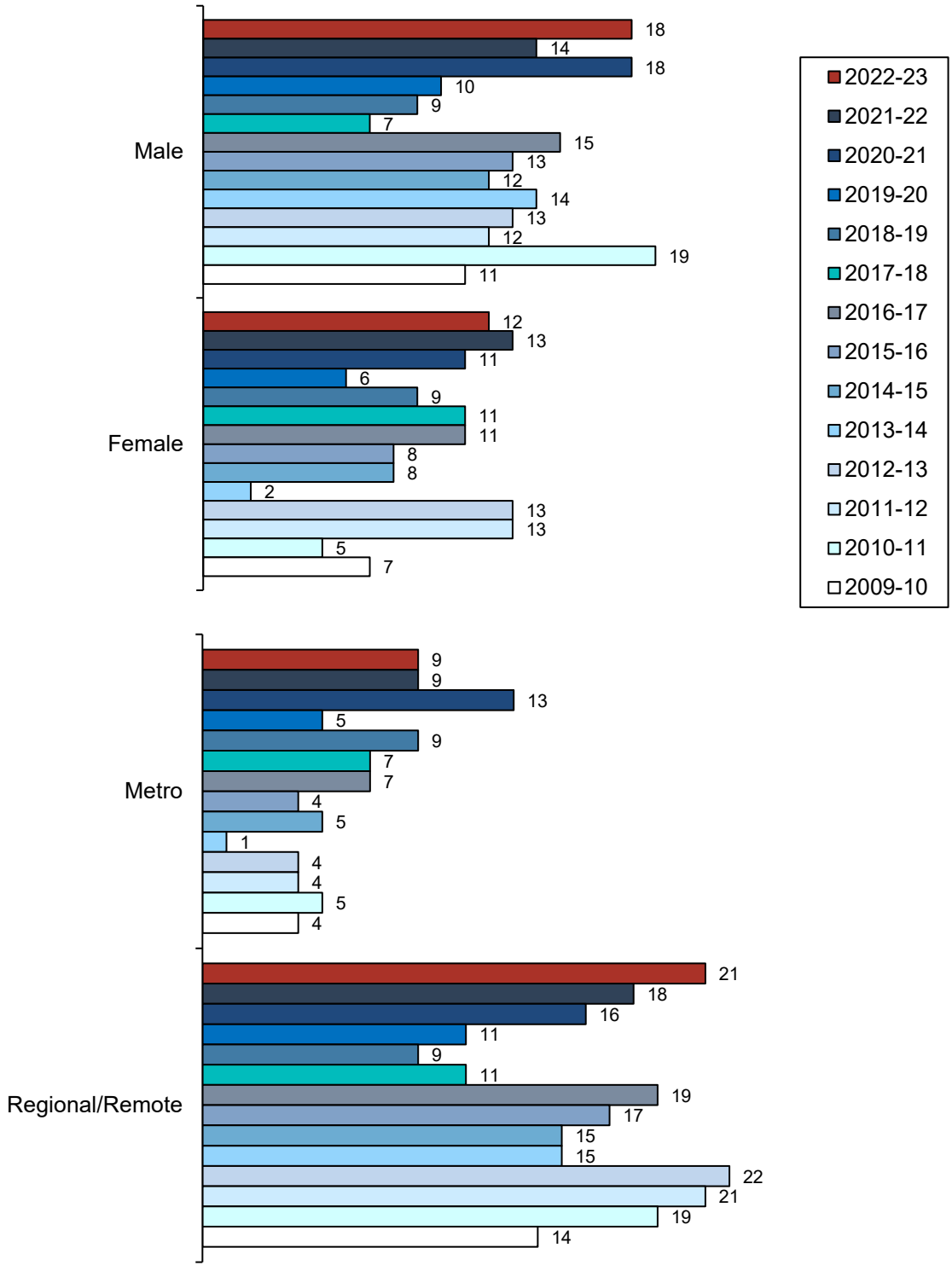
Of the 1,038 child death notifications received from 30 June 2009 to 30 June 2023, where the Aboriginal status of the child, or their parent/s, was recorded by agencies they had contact with in documentation provided to this Office, 314 (30%) of the children were identified as Aboriginal.[1]

For the notifications received:

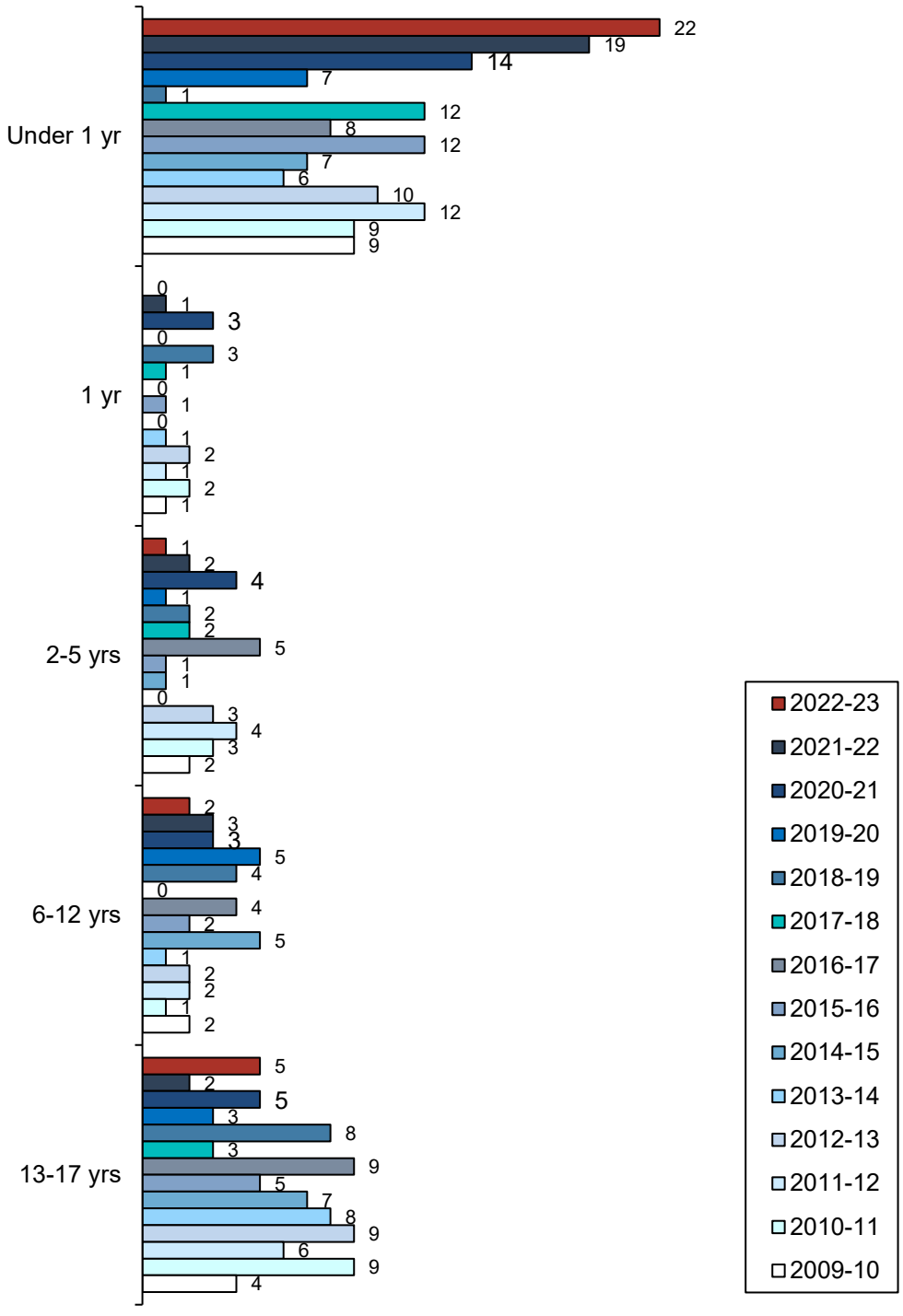
- Over the 14 year period from 30 June 2009 to 30 June 2023, the majority of Aboriginal children who died were male (59%). For 2022-23, 60% of Aboriginal children who died were male;
- Most of the Aboriginal children who died were under the age of one or aged 13-17; and
- The deaths of Aboriginal children living in regional communities far outnumber the deaths of Aboriginal children living in the metropolitan area. Over the 14 year period, 73% of Aboriginal children who died lived in regional or remote communities.

[1] "Aboriginal" includes children who are Torres Strait Islander and children who are both Aboriginal and Torres Strait Islander. Use of the term "Aboriginal" reflects the fact that the principal heritage of the first Western Australians are Aboriginal Western Australians and is in no way intended to exclude Torres Strait Islander people.

Characteristics of Aboriginal Children who Died



Characteristics of Aboriginal Children who Died



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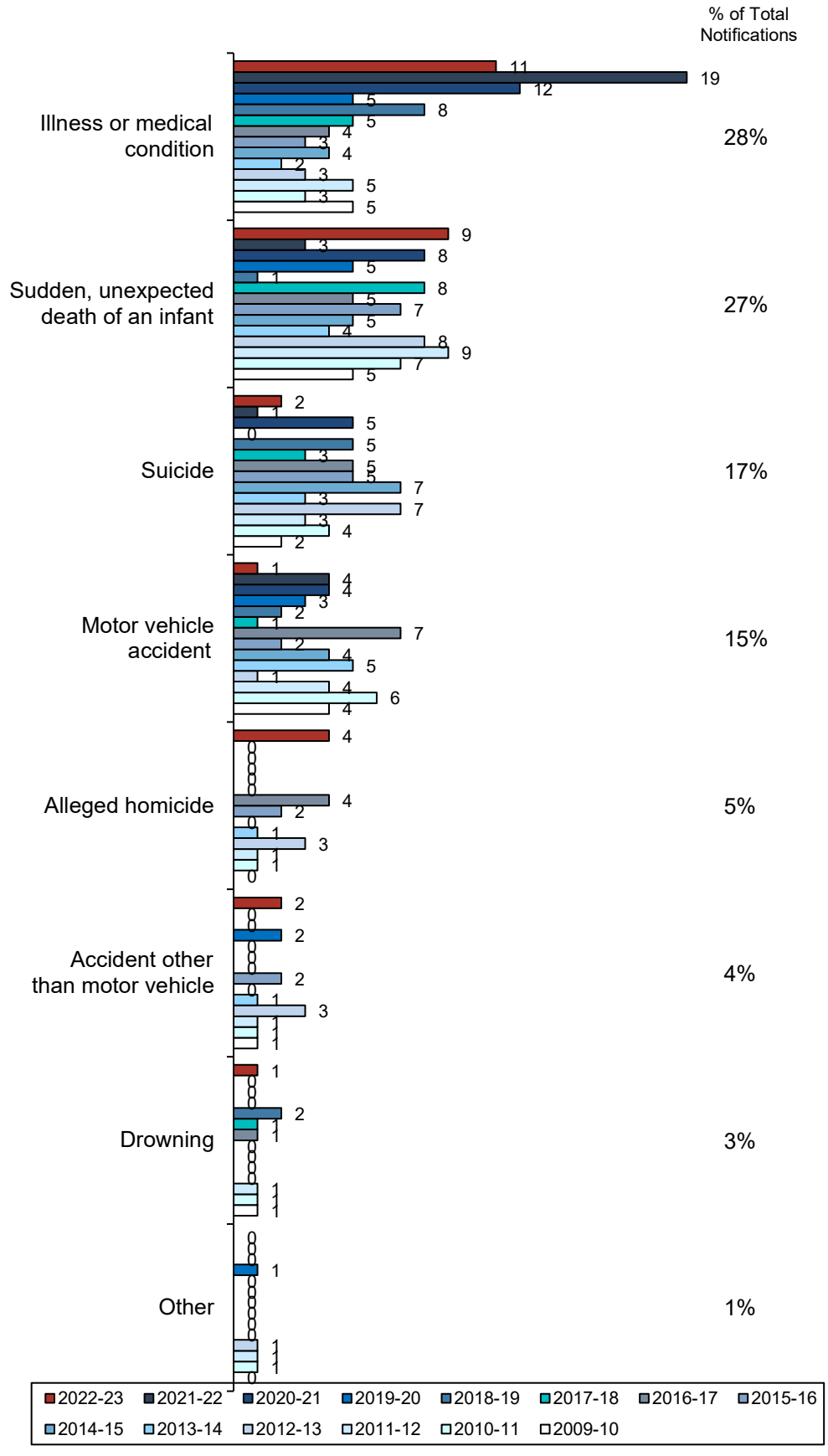
As shown in the following chart, illness or medical condition (28%), sudden, unexpected deaths of infants (27%), suicide (17%), and motor vehicle accidents (15%) are the largest circumstance of death categories for the 314 Aboriginal child death notifications received in the 14 years from 30 June 2009 to 30 June 2023. However, 42 (47%) of reported deaths in circumstances of illness or medical condition are in the three years since 1 July 2020 when the jurisdiction expanded to all child deaths.

Circumstances of Deaths of Aboriginal Children



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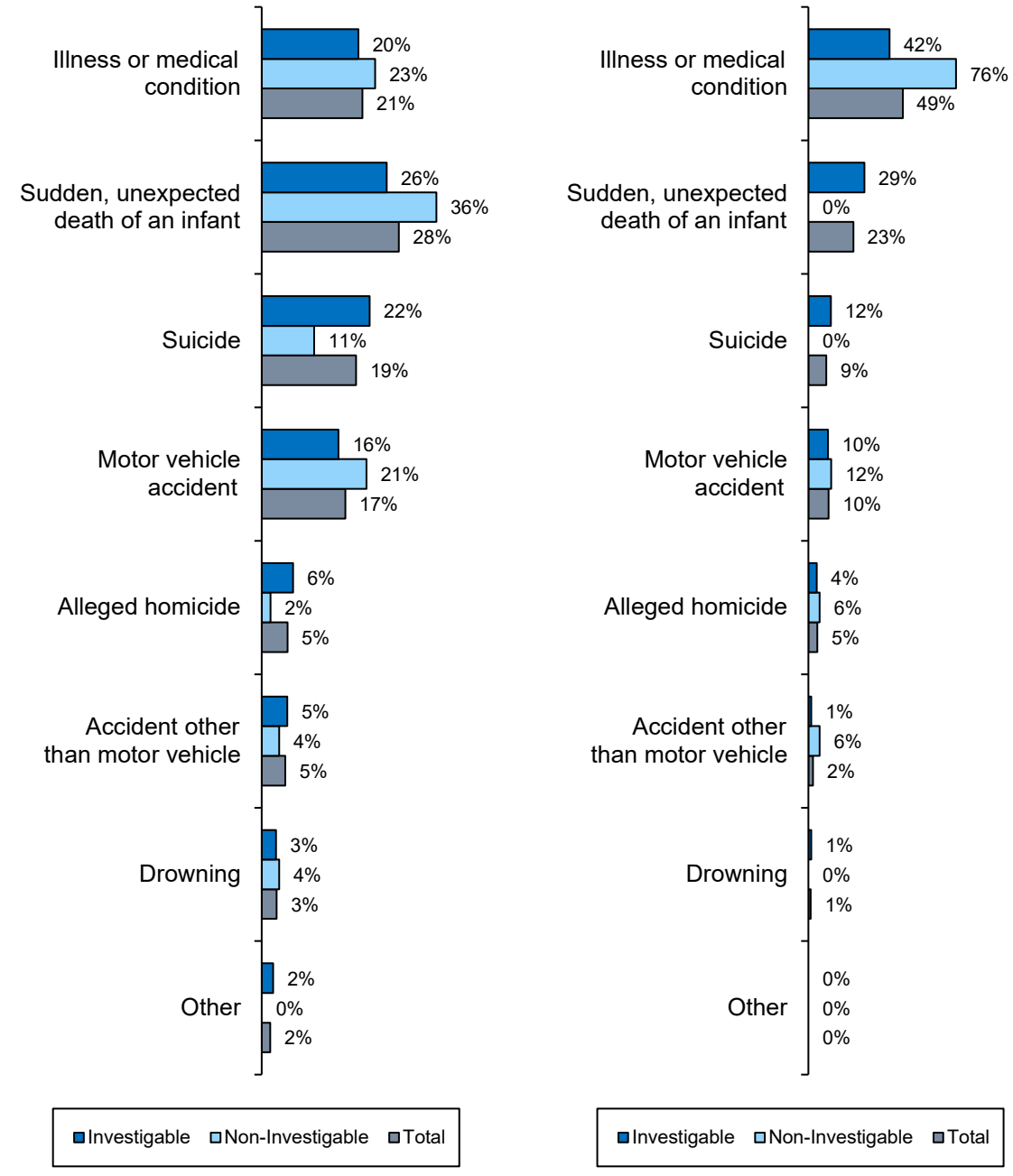
Circumstances of Aboriginal Child Deaths – % of Deaths



Note: Percentages may not add to 100 per cent due to rounding.

Patterns, Trends and Case Studies Relating to Child Death Reviews

Deaths of infants

Sleep-related infant deaths

Through the undertaking of child death reviews, the Office identified a need to undertake an own motion investigation into the number of deaths that had occurred after infants had been placed to sleep, referred to as 'sleep-related infant deaths'.

The investigation principally involved the Department of Health but also involved the (then) Department for Child Protection and the (then) Department for Communities. The objectives of the investigation were to analyse all sleep-related infant deaths notified to the Office, consider the results of our analysis in conjunction with the relevant research and practice literature, undertake consultation with key stakeholders and, from this analysis, research and consultation, recommend ways the departments could prevent or reduce sleep-related infant deaths.

The investigation found that the Department of Health had undertaken a range of work to contribute to safe sleeping practices in Western Australia, however, there was still important work to be done. This work particularly included establishing a comprehensive statement on safe sleeping that would form the basis for safe sleeping advice to parents, including advice on modifiable risk factors, that is sensitive and appropriate to both Aboriginal and culturally and linguistically diverse communities and is consistently applied state-wide by health care professionals and non-government organisations at the antenatal, hospital-care and post-hospital stages. This statement and concomitant policies and practices should also be adopted, as relevant, by the (then) Department for Child Protection and the (then) Department for Communities.

The investigation also found that a range of risk factors were prominent in sleep-related infant deaths reported to the Office. Most of these risk factors are potentially modifiable and therefore present opportunities for the departments to assist parents, grandparents and carers to modify these risk factors and reduce or prevent sleep-related infant deaths.

The report of the investigation, titled *Investigation into ways that State Government departments and authorities can prevent or reduce sleep-related infant deaths,* was tabled in Parliament in November 2012. The report made 23 recommendations about ways to prevent or reduce sleep-related infant deaths, all of which were accepted by the agencies involved.

The implementation of the recommendations is actively monitored by the Office.

Case Study

Baby A

Baby A died while co-sleeping with a parent. In the year prior to Baby A's death, Communities had received 10 notifications relevant to the safety and wellbeing of Baby A and Baby A's older sibling. In reviewing these notifications and associated documented actions, the Ombudsman's review identified that Central Intake Team actions were not fully compliant with practice requirements. As previous child death reviews undertaken by the Ombudsman had noted similar issues, further examination by this office of Central Intake Team governance and monitoring identified areas for improvement. The Ombudsman made the following recommendation:

> Communities provides the Ombudsman with a report within three months of the finalisation of this review that outlines Communities' current and/or proposed schedule and framework for Central Intake Team reporting to:
>
> 1. enable monitoring of notification management and outcomes;
> 2. provide analysis on notification characteristics for trend analysis; and
> 3. inform management and executive of operational performance and efficiency.

Deaths of children aged 1 to 5 years

Deaths from drowning

The *Royal Life Saving Society – Australia: National Drowning Report 2014* (available at www.royallifesaving.com.au) states that:

> Children under five continue to account for a large proportion of drowning deaths in swimming pools, particularly home swimming pools. It is important to ensure that home pools are fenced with a correctly installed compliant pool fence with a self-closing and self-latching gate…
> (page 8)

The report of the investigation, titled *Investigation into ways to prevent or reduce deaths of children by drowning*, was tabled in Parliament on 23 November 2017. The report made 25 recommendations about ways to prevent or reduce child deaths by drowning, all of which were accepted by the agencies involved.

The Ombudsman's *Investigation into ways to prevent or reduce deaths of children by drowning* noted that for 47 per cent of the child drownings examined, the fatal drowning incident occurred in a private swimming pool. Further, that for 66 per cent of the hospital admissions for drowning examined, the non-fatal drowning incident occurred in a swimming pool. It was also noted that for fatal drownings examined, children aged one to four years who died by drowning, the incident more frequently occurred in a private swimming pool. Of the 25 recommendations made by the Ombudsman in the *Investigation into ways to prevent or reduce deaths of children by drowning*, 22 related to the construction and inspection of residential pool fencing.

A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce deaths of children by drowning, tabled in Parliament in November 2018, identified that steps have been taken to give effect to the Ombudsman's recommendations.

The *Royal Life Saving National Drowning Report 2021* noted that for 1 July 2020 to 30 June 2021, nationally '[drowning] deaths among children aged 0-4 years increased by 9% compared with the 10-year average and 108% compared with last year'.

Deaths of children aged 6 to 12 years

The Ombudsman's examination of reviews of deaths of children aged six to 12 years has identified the critical nature of certain core health and education needs. Where these children are in the CEO's care, inter-agency cooperation between Communities, the Department of Health and the Department of Education (**DOE**) in care planning is necessary to ensure the child's health and education needs are met. Where multiple agencies may be involved in the life of a child and their family, it is important that agencies work collaboratively, and from a culturally informed position where relevant, to promote the child's safety and wellbeing.

Care planning for children in the CEO's care

Through the undertaking of child death reviews, the Office identified a need to undertake an investigation of planning for children in the care of the CEO of the (then) Department for Child Protection – a particularly vulnerable group of children in our community.

This investigation involved the (then) Department for Child Protection, the Department of Health and DOE and considered, among other things, the relevant provisions of the *Children and Community Services Act 2004*, the internal policies of each of these departments along with the recommendations arising from the Ford Report.

The investigation found that in the five years since the introduction of the *Children and Community Services Act 2004*, these three departments had worked cooperatively to operationalise the requirements of the Act. In short, significant and pleasing progress on improved planning for children in care had been achieved, however, there was still work to be done, particularly in relation to the timeliness of preparing care plans and ensuring that care plans fully incorporate health and education needs, other wellbeing issues, the wishes and views of children in care and that they are regularly reviewed.

The report of the investigation, titled *Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004*, was tabled in Parliament in November 2011.

The report made 23 recommendations that were designed to assist with the work to be done, all of which were agreed to by the relevant departments.

The implementation of the recommendations is actively monitored by the Office.

Deaths of primary school aged children from motor vehicle accidents

In 2022-23, the Ombudsman received one notification of the death of a child aged six to 12 years in the circumstances of motor vehicle accident. This death occurred in regional or remote Western Australia. Considering all 14 years from 30 June 2009 to 30 June 2023, 67% of notifications of the deaths of children aged six to 12 in the circumstances of motor vehicle accidents occurred in regional or remote Western Australia.

Deaths of children aged 13 to 17 years

Suicide by young people

Of the child death notifications received by the Office since the commencement of the Office's child death review responsibility, nearly a quarter related to children aged 13 to 17 years old. Of these children, suicide was the most common circumstance of death, accounting for 43% of deaths. Furthermore, and of serious concern, Aboriginal children were very significantly over-represented in the number of young people who died by suicide. For these reasons, the Office decided to undertake a major own motion investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people.

The objectives of the investigation were to analyse, in detail, deaths of young people who died by suicide notified to the Office, comprehensively consider the results of this analysis in conjunction with the relevant research and practice literature, undertake consultation with government and non-government stakeholders and, if required, recommend ways that agencies can prevent or reduce suicide by young people.

The Office found that State Government departments and authorities had already undertaken a significant amount of work that aimed to prevent and reduce suicide by young people in Western Australia, however, there was still more work to be done. The Office found that this work included practical opportunities for individual agencies to enhance their provision of services to young people. Critically, as the reasons for suicide by young people are multi-factorial and cross a range of government agencies, the Office also found that this work included the development of a collaborative, inter-agency approach to preventing suicide by young people. In addition to the Office's findings and recommendations, the comprehensive level of data and analysis contained in the report of the investigation was intended to be a valuable new resource for State Government departments and authorities to inform their planning and work with young people. In particular, the Office's analysis suggested this planning and work target four groups of young people that the Office identified.

The report of the investigation, titled *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, was tabled in Parliament in April 2014 (**the 2014 Investigation**). The report made 22 recommendations about ways to prevent or reduce suicide by young people, all of which were accepted by the agencies involved.

Preventing suicide by children and young people 2020, tabled in Parliament in September 2020, identified that steps have been taken to give effect to the Ombudsman's recommendations from the 2014 Investigation and examined a further 79 deaths by suicide that occurred following the 2014 Investigation. Further details are provided in the Own Motion Investigations, Monitoring and Improvement section of this Annual Report.

Issues Identified in Child Death Reviews

The following are the types of issues identified when undertaking child death reviews.

It is important to note that:

- Issues are not identified in every child death review; and
- When an issue has been identified, it does not necessarily mean that the issue is related to the death of a child.

- Not undertaking sufficient intra-agency and inter-agency communication to enable effective case management and collaborative responses to promote child safety and wellbeing.
- Not appropriate culturally responsive practice.
- Not adequately assessing the need for an interpreter.
- Missed opportunity to appropriately consider child care arrangements when arresting a parent.
- Not taking action consistent with legislative responsibilities of the *Children and Community Services Act 2004*, and associated policy, to determine whether children were in need of protection or whether action was required to safeguard child wellbeing.
- Not taking action consistent with legislative responsibilities of the *Children and Community Services Act 2004* for a child in the CEO's care.
- Not providing approvals to decisions in accordance with the instrument of delegations.
- Not adequately meeting Central Intake Team practices to appropriately respond to child wellbeing reports.
- Not adequately meeting policies and procedures relating to Child Safety Investigations and safety planning.
- Not adequately meeting policies and procedures relating to *Intensive Family Support*.
- Not adequately meeting policies and procedures relating to high-risk infants, including placement on the Monitored List in contravention of practice requirements.
- Not adequately meeting policies and procedures relating to pre-birth planning.
- Not adequately meeting policies and procedures relating to family and domestic violence.
- Not adequately meeting policies and procedures relating to the assessment of parental drug and alcohol use, and mental health issues.
- Not sufficient governance, monitoring and evaluation of the efficiency and effectiveness of agency operations including the Central Intake Team and management of the Monitored List.
- Not meeting recordkeeping requirements.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce child deaths. The following four recommendations were made by the Ombudsman in 2022-23 arising from child death reviews (certain recommendations may be de-identified to ensure confidentiality).

1. That Communities considers the findings of this review, (and as appropriate the outcomes of any other relevant reviews of the deaths of children by the Ombudsman), and provides the Ombudsman, within three months of the finalisation of this review, with:

   a) a safety plan considered appropriate in the circumstances of a high-risk infant's post-birth hospital discharge, that exemplifies Communities use of its legislative powers under the *Children and Community Services Act 2004*, to promote child wellbeing and safety; and

   b) a response on whether there are any systemic issues across Communities in developing adequate safety plans, and if improvement is required, outlines Communities plans to strengthen systems, processes and best practice associated with the administration of safety plans to support improved outcomes for vulnerable children and families in the circumstances of alleged parental substance use, mental health issues and perpetration of family and domestic violence. This response should include the role of the Chief Practitioner.

2. That Communities provides a report to the Ombudsman on the progress of the implementation of the 'system enhancements being developed to prevent High-Risk Infants (HRIs) from being placed on the Monitored List' by 31 March 2023.

3. Communities provides the Ombudsman with a report within three months of the finalisation of this review that outlines Communities' current and/or proposed schedule and framework for Central Intake Team reporting to:

   1. enable monitoring of notification management and outcomes;
   2. provide analysis on notification characteristics for trend analysis; and
   3. inform management and executive of operational performance and efficiency.

4. That Communities undertakes an internal review to ascertain how the issues identified in this child death review occurred and provides a report to the Ombudsman, within six months of the finalisation of this review, outlining the review findings and whether action is required to facilitate:

   - Timely service of s.143 proposals in accordance with the requirements of the *Children and Community Services Act 2004*;
   - Incorporation of all Children's Court outcomes relevant to the Department's decision making for a child's safety and wellbeing; and
   - Adherence to the CEO's Instrument of Delegation for approvals relevant to decisions and actions for a child in CEO care.

The Ombudsman's *Annual Report 2023-24* will report on the steps taken to give effect to the eight recommendations made about ways to prevent or reduce child deaths in 2021-22. The Ombudsman's *Annual Report 2024-25* will report on the steps taken to give effect to the four recommendations made about ways to prevent or reduce child deaths in 2022-23.

Steps taken to give effect to the recommendations arising from child death reviews in 2020-21

The Ombudsman made eight recommendations about ways to prevent or reduce child deaths in 2020-21. The Office has requested that the relevant public authorities notify the Ombudsman regarding:

- The steps that have been taken to give effect to the recommendations;
- The steps that are proposed to be taken to give effect to the recommendations; or
- If no such steps have been, or are proposed to be taken, the reasons therefor.

Recommendation 1: That Communities provides a report to the Ombudsman, within four months of the finalisation of this review, detailing Communities' strategies and/or practice guidelines for recognising and responding to reports of alcohol, drug and volatile substance use by children and young people.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 15 February 2021, in which Communities relevantly informed this Office that:

> Summarised in Table 1 below is information regarding Communities child protection practice guidance concerning young people who are using alcohol, drugs, or volatile substances, including identifying areas where guidance can be strengthened.
>
> The key points are:
>
> - practice guidance does not currently include information about when a wellbeing concern, such as a child using alcohol, drugs, or volatile substances, may be an indicator of abuse and neglect.
> - the interaction tool, which is used to inform decisions about intake for Child Safety Investigations, does not currently include a child's at-risk behaviours as a domain.
> - practice guidance focuses on responding to a child using alcohol, drugs, or volatile substances through family support. It currently doesn't direct when a child protection response is required, including in circumstances of wellbeing concerns co-presenting with emotional abuse - family and domestic violence, neglect, cumulative abuse and/or parent unable to provide adequate care; and
> - for children in care, the practice guidance is clearer, requiring child protection workers to refer to appropriate services, collaborate with the provider to ensure a collaborative approach, update the quarterly care review, and consult with their Team Leader.

> In addition, some districts have localised processes for responding to children using drugs, alcohol and volatile substances including 'Youth At Risk Meetings' and Volatile Substance Use meetings…

Table 1, as included in Communities' letter dated 15 February 2021, provides a summary of practice guidance at that time, indicating where improvements were required.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> On 15 February 2021, Communities provided a Progress Update to the Ombudsman…outlining the practice guidance available at the time, to assist child protection workers in recognising and responding to reports of alcohol, drug and volatile substance use by children and young people. The Progress Update identified that Communities' practice guidance in relation to at-risk youth could be strengthened and outlines Communities' Specialist Child Protection Unit was undertaking a cohort review of a sub-set of child deaths and family and domestic violence fatalities, which would inform an update of practice guidance.
>
> Current Status
>
> *Strengthening practice guidance*
>
> - Since the [Communities letter dated 15 February 2021] was provided to the Ombudsman, the Community Services Division progressed work to develop new CPM practice guidance in relation to at-risk youth.
> - This work was informed by findings from oversight agency child death reviews and FDV fatality reviews, and by internal analysis of themes and trends in child deaths and FDV fatalities.
> - In August 2021, the CPM entry 1.4.1 *Alcohol and other drug use – at risk young people* was uploaded. This entry includes guidance in relation to Volatile Substance Use.
>
> *At Risk Youth Strategy 2022-2027 (the Strategy)*
>
> - In March 2021 the Central Review Team met with the Community Services Division and provided input on findings from oversight agency reviews and internal analysis of themes and trends in child deaths and FDV fatalities, to be used to inform the Strategy. On 19 September 2022 Communities advised the Ombudsman of the availability of the Strategy online…

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 2: Communities provides the Ombudsman with a copy of the Australian Centre for Child Protection 'independent evaluation of the Interaction Tool' and/or a report outlining the findings and outcomes of the independent evaluation of the Centralised Intake Model, Interaction Tool and its state-wide implementation, when available.

Steps taken to give effect to the recommendation

Communities has now provided this Office with a copy of the Australian Centre for Child Protection, *Final Report: Review of the Central Intake Interaction Tool (November 2020)* and the Quantum Consulting Australia, *Review of the Central Intake Interaction Tool: Final Report (November 2021).* These reports included recommendations to improve effectiveness of the Interaction Tool.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> On 30 June 2022, Communities provided the *Review of the Central Intake Interaction Tool* (the Review), to the Ombudsman.
>
> Current status
>
> The Review contains 18 recommendations for Communities' consideration. Communities Statewide Referral and Response Service developed three documents which detail Communities' response to, and planning for implementation of, the Review recommendations:
>
> - the *Interaction Tool Project on a Page*;
> - *Interaction Tool program logic*; and
> - *Quantum Consulting Australia Recommendations Response*.
>
> On 19 September 2022, Communities provided the Ombudsman with the above noted three documents.
>
> The Interaction Tool Project, involving the embedding of the Interaction Tool into Assist (commencing 1 March 2023) supports the implementation of recommendations one, two, three, 14 and 15 from the Review. Recommendations 16, 17 and 18 relate to plans to evaluate the Interaction Tool after its embedment into Assist. The implementation of these recommendations will include data analysis at a later date.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 3: WA Country Health Service (WACHS) considers the findings of this child death review of Infant A, along with the findings of the child death reviews of Infant B and Infant C and actions taken by WACHS to implement the Ombudsman's associated June 2018 recommendations, to determine whether further action is required to:

- **Ensure that where risk indicators for an unborn child/infant are identified, appropriate assessments are undertaken and documented in accordance**

with the Department of Health Guidelines for Protecting Children 2015 (revised May 2017, or any subsequent revisions);

- **Ensure that where inquiries or referrals are made with Communities, all relevant risk information is shared;**
- **Improve understanding of the provisions under the *Child and Community Services Act 2004* (CCS Act) to protect health service providers from liability when they disclose confidential information related to the wellbeing of an unborn child/infant; and**
- **Improve knowledge of Communities' referral assessment processes (including what information is considered under the 22 prompts of the Interaction tool and the Casework Practice Manual section 2.2.18 High-risk infants) and the threshold for Communities in determining that action is required under the CCS Act, to promote effective communication and collaboration by WACHS in ensuring an unborn child/infant is safe from harm.**

Steps taken to give effect to the recommendation

WACHS provided this Office with a letter dated 15 October 2020, in which WACHS relevantly informed this Office that:

> Following this incident, with consideration given to the findings of this review, and lessons learnt from previous incidents that have occurred…I can confirm WACHS Region has implemented changes in order to prevent similar occurrences in the future. Please note that the following processes and regular meetings are now in place in the Region:
>
> 1. Hospital midwifery and maternity nursing staff now complete a mandatory FDV learning module.
> 2. The Clinical Midwives in the hospital Antenatal clinic complete FDV screening during the booking (initial) appointment. If risks are found, then a Child at Risk (CAR) alert is generated and entered onto the electronic patient record. All patients with CAR alerts are reviewed at the weekly High Risk Antenatal Meeting.
> 3. Introduction of a weekly High Risk Antenatal meeting…
> 4. A monthly hospital interdisciplinary Risk Assessment Group oversees the management of Child at Risk assessments…
> 5. A monthly Interagency Children at Risk Meeting…
>
> In addition, under the direction of the WACHS Clinical Director, Paediatrics the WACHS Child Protection Reference Group has been established to provide clinical advice and leadership regarding WACHS wide approach to Child Protection and includes clinical representatives from all the regions, the State Protection of Children Coordination Unit, Perth Children's Hospital Child Protection Unit and Department of Communities. This group will coordinate WACHS wide implementation of strategies arising from recommendations made by the Ombudsman in Child Death and Family and Domestic Violence Death cases.

This Office requested that WACHS inform the Office of any further information on the steps taken to give effect to the recommendation. In response, WACHS provided a range of information in a letter to this Office dated 8 May 2023, containing a report prepared by WACHS.

In WACHS's report, WACHS relevantly informed this Office that:

WACHS has collectively reviewed the three child death reviews.

Following are initiatives which have been implemented (or have commenced) since October 2022 when WACHS provided a letter outlining steps taken to address the recommendations associated with review of the death of Infant A.

Ensure that where risk indicators for an unborn child/infant are identified, appropriate assessments are undertaken and documented in accordance with the Department of Health Guidelines for Protecting Children 2020 (most recent revision)

- The *Guidelines for Protecting Children 2020* includes comprehensive information to support staff with recognising, responding, recording, and reporting child and abuse and neglect. This document underpins development of WACHS policies and practices.
- WACHS maternity services conduct risk assessments for all mothers and children (including unborn children) across a range of clinical and social criteria. Those identified to be at risk are provided with additional support from a social worker.
- WACHS updated its WebPAS Child at Risk Alert procedure to highlight requirements to establish Alerts for unborn children at risk.
- WACHS has established new a policy: Social Work Guidelines for high-risk families during pregnancy and the first year of life. This document guides the operational processes for WACHS social workers when they are involved with identifying, supporting, and managing vulnerable and high-risk families. The *Guidelines for Protecting Children 2020* is a key reference.
- Infants (including unborn infants) identified by WACHS maternity services as being at risk are referred to hospital-based interdisciplinary 'Baby at risk' meetings to plan follow-up required for the child and family. A standard term of reference is being developed for use by all relevant WACHS hospitals.
- The WACHS procedure for Special Referral to Child Health Services (from maternity services) is under review. Additional risk factors have been added to strengthen sharing information about social circumstances and home environments.
- The Stork Perinatal Database and the hard-copy form (used by private maternity providers) is being updated to reflect the strengthened risk criteria for Special Referrals to Child Health Services. This work has been collaborative across health service providers in WA Health.
- Emergency Department (ED) teams across WACHS have established paediatric injury forms to assist with the assessment of suspicious injury in children. The form is based on that used by Perth Children's Hospital.
- ED teams are able to access information from other WACHS services, such as:
    - the WebPAS Child at Risk Alert, which is well used across WACHS including maternity and mental health services.
    - the Community Health Information System (CHIS) for clinical information collected by child health nurses and/or child development (allied health) clinicians.
- ED teams implement safety-net meetings to plan follow-up actions required to protect children. This includes inquiries or referrals made to the Department of Communities.

- Work is currently underway to strengthen identification and responses by ED teams for cases of family and domestic violence, including situations involving children and/or unborn infants. Assessment proforma and related processes are being trialled and evaluated in WACHS hospitals.

Ensure that where inquiries or referrals are made with Communities, all relevant risk information is shared

- The WA Health *Guidelines for Protecting Children 2020* includes a chapter 'Reporting child abuse' with comprehensive information about formal notifications of a concern of child abuse. Figure 7. (p.56) guides WA health system staff on information to include in a report to the Department of Communities.
- The *Guidelines for Protecting Children 2020* has been distributed across WACHS and is used to inform development of all relevant WACHS policies, procedures, and protocols.
- WACHS has established new a policy: Social Work Guidelines for high-risk families during pregnancy and the first year of life. It includes communicating with and making referrals to the Department of Communities.
- Clinical Nurse Specialists (CNSs) are employed in community health teams in each of the WACHS regions. The work of CNSs supports families and children at risk and supports community health nurses working with vulnerable families. The CNSs are in frequent contact with Department of Communities staff and their work is closely aligned with WA Health *Guidelines for Protecting Children 2020*.

Improve understanding of the provisions under the Child and Community Services Act 2004 (CCS Act) to protect health service providers from liability when they disclose confidential information related to the wellbeing of an unborn child/infant

- The Statewide Protection of Children Coordination Unit (SPOCC Unit) has long provided resources and in-person or virtual training for WACHS staff. This includes supporting WACHS staff to understand the *Children and Community Services Act 2004* and the responsibilities of Health staff under the Act.
- Since 2022, the focus of SPOCC work shifted to provision of videos and other resources to support education relating to child abuse.
- In 2023 WACHS aims to work with SPOCC to develop a suite of online training for WACHS clinicians. This will enable WACHS to refine and monitor training for staff.
- A Child Safety toolbox SharePoint page has been developed for WACHS staff as a one-stop-shop for information and resources relating to child safety and protection.

Improve knowledge of Communities' referral assessment processes (including what information is considered under the 22 prompts of the Interaction tool and the Casework Practice Manual section 2.2.18 High-risk infants) and the threshold for Communities in determining that action is required under the CCS Act, to promote effective communication and collaboration by WACHS in ensuring an unborn child/infant is safe from harm.

- Please note, the Department of Communities' 22 prompts of the Interaction tool and the Casework Practice Manual section 2.2.18 High-risk infants and associated threshold for the Department of Communities in determining that action, is not readily accessible to WACHS staff.

- The WA Health *Guidelines for Protecting Children 2020* has been distributed across WACHS and is used to inform development of WACHS policies, procedures, and protocols.

Other related initiatives

- WACHS is working strategically with the Department of Communities to better identify, protect and care for children at risk of child abuse and neglect.
- WACHS actively participated in a working group to establish a new Memorandum of Understanding (MOU) between the Departments of Health and Communities.
- The MOU was signed in late 2022 and there is a shared plan to update the associated schedules that define specific processes, roles, and responsibilities.
- In the WACHS regions, key staff participate in interagency meetings and communications to monitor local children at risk. Monthly meetings, involving key staff from WACHS, Department of Communities and other agencies relevant to the local communities, operate in most regions. Regular meetings are being reinstated in some areas following service disruptions.
- A Health Navigator Pilot Program is being trialled in the South West and Mirrabooka areas. The aim of the Pilot Program is to design and test new ways of working to improve collaboration and coordination between services to better meet the health needs of children and young people in out of home care in WA.
- WACHS recently established the Engagement procedure for community child health and child development services. This new procedure outlines the responsibilities of staff to provide accessible and equitable services that enhance family engagement. Importantly, it guides staff in situations when non-engagement raises concerns about a child's safety and wellbeing.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 4: The Department of Justice provides the Ombudsman with a report by 30 June 2021, outlining the outcomes of the quality assurance project to assess compliance with Chapter 19 of the Adult Community Corrections Handbook in the management of Community Based Orders to ensure:

- **Referrals are made to Communities where children are at risk;**
- **Proactive information sharing with Communities to protect the safety of an adult victim of family and domestic violence; and**
- **Collaborative case management where continued concerns are held for the safety of children or an adult victim of family and domestic violence.**

Steps taken to give effect to the recommendation

DOJ provided this Office with a letter dated 22 June 2021, in which DOJ relevantly informed this Office that:

> The Department of Justice, Corrective Services, Adult Community Corrections (ACC) utilises an ACC Quality Improvement and Operational Endorsement Framework to provide quality assurance oversight of offender case management practices.

The framework requires ACC team leaders, managers, and directors to regularly undertake a 'sample review' of ACC offender cases, and where necessary provide advice and directions on any actions required to be undertaken. The review and outcomes are recorded in the Department's Community Business Information System (C-BIS) database for the management of offenders in the community.

It is noted for the purpose of this report to the Ombudsman, that monthly data (set out below) is represented in averages for a three-month period up to 1 May 2021. The figures provide an overall number of cases reviewed.

In January 2021, a directive was sent to all ACC managers that (as a part of the above framework) they are to incorporate each of the elements of the Ombudsman's recommendation when reviewing offender cases where children or adult victims of FDV may be at risk. These requirements commenced on 25 January 2021.

For the three-month period up to 1 May 2021, ACC randomly sampled an average of 85 cases per month. For the purpose of the Ombudsman's recommendation, an average of 39 cases (per month) were considered relevant to child and/or adult safety. These were identified from cases managing offenders subject to community supervision orders for offences committed in an FDV context.

To provide a further level of scrutiny, ACC managers are also required to provide a detailed running sheet to the ACC Directorate on a monthly basis of the 'sample cases' reviewed and to include any remedial actions undertaken where necessary.

The above directive was further reinforced with ACC managers at subsequent leadership meetings and the additional level of scrutiny as detailed above will remain in place until further notice.

While the above process has only been in place for a relatively short period of time, it is evident from the sample group that the three elements of the Ombudsman's recommendation where relevant are a focus of case management practices.

It is also evident that ACC is taking relevant remedial action to ensure that case managers submit appropriate referrals to the Department of Communities, and that follow up and engagement with Communities occurs as necessary in the management of the particular case. For the three-month period to 1 May 2021, remedial action was required for an average of 18 cases per month.

ACC will continue to monitor the above process until such time that the Ombudsman's recommendation is embedded in offender case management practices.

DOJ provided this Office with a subsequent letter dated 1 July 2022, in which DOJ relevantly informed this Office that:

- On 22 June 2021, DOJ reported to the Ombudsman on the initial outcomes of the ACC sample review regarding the identification and reporting of child risk factors. For the three months (January 2021 to 1 May 2021) an average of 85 cases per month were randomly sampled and of those an average of 39 cases (per month) were considered relevant to child and/or adult safety. Remedial action by case managers was required for an average of 18 (of the 39) cases (per month) or 46%.
- The review was then extended for 12 months – June 2021 to end May 2022 inclusive – with the results as follows:
    - A total of 1124 cases were randomly sampled representing an average of 94 cases per month.

- Of the 1124 cases, a total of 577 cases (or 51%) were considered relevant to child and/or adult safety (and were identified from cases where the community supervision order was made for a Family Domestic Violence offence).
- Of the 577 FDV cases reviewed, remedial action requiring follow-up with the Department of Communities Child Protection and Family Services (DCPFS) was identified in 117 cases.
  - The total number of cases per month identified as requiring remedial action was approximately 10 (whereas for the initial sample review the number was 18 cases per month).
  - This represents approximately 20% of the cases requiring remedial action (whereas for the initial review nearly half the cases reviewed required remedial action).

- The review results over the past 12 months indicate improved compliance with Chapter 19 of the ACC Handbook, to ensure appropriate information sharing with the Department of Communities where children or adult victims may be at risk.
- The results also indicate the practice of referring and liaising with the Department of Communities and undertaking a collaborative case management approach is being embedded into ACC practice. Consequently, the manual recording for this review exercise will no longer be undertaken.
- The wider 'dip sampling' of ACC cases will continue as part of compliance under the ACC Quality Improvement and Endorsement Framework. This is in addition to the regular review of cases conducted as part of ACC case management practices.

This Office requested that DOJ inform the Office of any further steps taken to give effect to the recommendation. In response, DOJ provided a range of information in a letter to this Office dated 15 March 2023, containing a report prepared by DOJ.

In the DOJ's report, DOJ relevantly informed this Office that:

> Random review is continuing as per the regular 'dip sampling' of cases under the ACC Quality Improvement and Endorsement Framework. This is in addition to the regular review of cases conducted as part of ACC case management practices.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 5: That Communities considers whether any action is required to ensure, when a family arranged placement occurs during a Child Safety Investigation, that action is taken to assess the appropriateness of the family arranged placement in the child's best interests, provide associated safety planning and supports to this placement including consideration of whether a protection order (supervision) is required and reports back to the Ombudsman on the outcome of this consideration by 30 April 2021.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 4 May 2021, in which Communities relevantly informed this Office that:

> Communities' role in family arranged placements.

Where family arranged placements occur during Child Safety Investigations (CSI), Communities actions to consider whether the family arranged placement is in the child's best interests, provide support to families and undertake safety planning to promote children's safety are underpinned by the *Signs of Safety Child Protection Practice Framework (Signs of Safety)*. Mechanisms which further prompt these steps include the provision of the Establishment Payment, which is used by Districts to support family arranged placements with a one-off payment to the family carer. *Casework Practice Manual entry 1.2.3 Establishment payment to informal relative carers* outlines practice guidance which supports child protection workers to consider whether family arrangement placements are in a child's best interests and practice requirements for child protection workers to:

> *undertake a CSI and develop a safety plan with the family using Signs of Safety, taking into consideration the families proposed living arrangement for the child. You must include steps and actions which will be taken if the situation changes after the child moves into the living arrangement for example if the parents withdraw their support of the living arrangement or if the carer is unable or unwilling to continue to provide care for the child.*

Communities is further strengthening assessment and safety planning responses via the *Signs of Safety 100 Days of Trainin*g which includes *Safety Planning Bootcamps* being delivered in every District during 2021. Further to this, the *Signs of Safety Knowledge Hub* supports child protection workers to strengthen safety planning responses.

<u>The use of a Protection Order (Supervision) in a family arranged placement.</u>

Where CSI's are carried out, child protection workers assess the parent's capacity to protect the child and consider whether the child is in need of protection, which includes the use of a Protection Order (Supervision).

In relation to CSI's where a family arranged placement occurs, Section 50(3) of the *Children and Community Services Act 2004* (the Act) sets out that Protection Orders (Supervision) are not to be used to ensure that specified children are cared for by people other than the parent:

> *A protection order (supervision) must not include a condition about -*
>
> *a. The person or persons with whom the child is to live, unless the condition relates to the child living with a parent of the child specified in the order; or*
>
> *b. Who is to have responsibility for the day-to-day care, welfare, and development of the child.*

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023 in which Communities relevantly informed this Office that:

This recommendation has been actioned.

<u>Current Status - Legislation</u>

On 14 October 2021, new child protection laws were passed by the Western Australian Parliament. Most of the amendments in the *Children and Community Services Amendment Act 2021* (Amendment Act) became operational on 19 October 2021. Section 50(3) of the Act now sets out that Protection Orders (Supervision) are not to be used to specify who a child is to live with or who will care for the child:

> *A protection order (supervision) may include a condition requiring the child to live with a specified parent of the child, but otherwise must not include a condition about –*

a. *The person or persons with whom the child is to live; or*

b. *Who is to have responsibility for the day-to-day care, welfare, and development of the child.*

Current status - Safety planning in informal family care arrangements

To strengthen safety planning and culturally responsive practice in Informal Family Care Arrangements, on 21 September 2022 Communities delivered an Informal Family Care Arrangement Practice Clinic, to over 70 attendees. The majority of the attendees were Aboriginal Practice Leaders, Senior Practice Development Officers and Team Leaders.

The focus of the Practice Clinic was the development of robust safety plans, identifying safety networks and discussions on culturally responsive practice in Informal Family Care Arrangements. Discussions were held on the importance of decisions being family led, balanced with Communities' legislative responsibilities and the best interests of the child.

Communities is currently drafting a new CPM entry in relation to Informal Family Care Arrangements and reviewing associated guidance in relation to the Establishment Payment.

Communities is anticipating that further training on Safety Planning will be delivered by Elia International to Communities staff…

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 6: Communities provides a report to the Ombudsman within six months of the finalisation of this child death review outlining actions taken and/or proposed by Communities' 'working party' established to review executive governance and oversight processes for children placed on the Monitored List, inclusive of children not in the Chief Executive Officer's care.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 9 November 2021, in which Communities relevantly informed this Office that:

Communities is committed to reviewing the oversight processes for children placed on the Monitored List.

Communities is taking steps to implement this recommendation through the Reviews and Recommendations Oversight Group (the Oversight Group). Communities recently established the Oversight Group to endorse work packages and have oversight of the implementation of all internal and external recommendations delivered to Communities. The Oversight Group consists of senior officers who represent a cross-section of Communities and hold decision-making authority within their business area.

The Oversight Group has endorsed a problem definition for the Monitored List Review. Problem definitions are the first step to scope one or more recommendations into a service and/or operations improvement-focussed project. Once endorsed, problem definitions are developed into project scopes.

Communities is currently undertaking the scoping for the Monitored List Review project, and this will be presented to the Oversight Group for endorsement. Once the project scope is endorsed, the Oversight Group will allocate the work to a lead business area, which will be responsible for implementing the project and providing regular progress updates.

Communities' letter dated 9 November included a copy of the *Monitored List Review Problem Definition* which had been endorsed by the Oversight Group in September 2021.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> Current Status
>
> Communities recognises that High Risk Infants are particularly vulnerable and must not be placed on the Monitored List. Work to enhance systems to strengthen executive governance and oversight of children placed on the Monitored List and to prevent High Risk Infants from being placed on to Monitored Lists has been undertaken across the agency. This work has included the SRRS driving changes internally within their District and the Community Services Division progressing a broader project in relation to the Monitored List, as part of the Workload Management Project.
>
> Statewide Referral and Response Service
>
> SRRS has taken steps to promote the assessment and identification of High-Risk Infants, including:
>
> - All Interactions where there is FDV and/or a High-Risk Infant now requires a Team Leader consultation before completion, regardless of Interaction outcome (no further action, Intake or Intake to Child Safety Investigation).
> - On 1 March 2023, as part of the Interaction Tool project, the Interaction Tool was embedded into Assist. This change resulted in:
>   - high-risk infant practice guidance is now outlined in the guidance section on the system, which is visible to Child Protection Workers when completing the age section of the Interaction Tool;
>   - the Interaction Tool includes a hyperlink to the High-Risk Infant Checklist, for easy accessibility by Child Protection Workers;
>   - the questions included in the Checklist are included in the suggested questions in the relevant sections of the Interaction Tool;
>   - High-Risk Infants are now identified via a 'tick box' in Interactions. Family groups subject to an intake which include a High-risk Infant now automatically proceed to a Priority-One referral; and
>   - Priority One Child Safety Investigations (CSI's) which include a High-risk Infant are referred to Districts via three channels:
>   1. an email to the District's 'frontdesk' inbox with the details of the case;
>   2. an automated email to the District Director, Assistant District Director and Child Safety Team Leader which alerts them to the new CSI which includes a High-risk infant; and

3. a telephone call from SRRS to the District to confirm that District staff have received the email referrals in relation to new CSI's including High-risk infants.

Community Services Service Design and Operational Improvement

Communities' Community Services Division, in consultation with the Specialist Child Protection Unit, has undertaken steps to review and strengthen processes and systems associated to Workload Management and the Monitored List. This includes:

- A review of the Casework Practice Manual (CPM) entries in relation to the Monitored List.
- On 17 December 2022, the CPM was amended to reflect consistent advice across all entries, that any child under three years of age cannot be placed on the Monitored List. This includes children in the care of the CEO and unborn infants open to Pre-birth planning.
- This change in practice was discussed in District Director, Assistant District Director and Regional Executive Director meetings and communicated via an action bulletin to all practice teams in the Districts.
- To further embed this change in practice, the Workload Management Project Team undertook an audit of all District Monitored Lists and worked with those Districts with higher numbers of children aged under three years of age on the Monitored List to discuss allocation of work, prioritisation, and oversight processes.
- In February and March 2023, the Workload Management Project Team delivered three practice clinics, to discuss case supervision in the context of Workload Management, to educate and support greater oversight of cases on the Monitored List.
- The Workload Management Team have worked with a consultant to develop a trial 'dashboard' to provide Districts with greater visibility and oversight of their caseloads and the ability to readily identify where cases with children aged under three have been placed on a Monitored List. The dashboard clearly highlights these children's details. The dashboard is currently in a testing phase and has not yet been implemented broadly.
- On 9 January 2023, Communities commenced generating an automated email each Monday, which is sent to all District Directors. The email includes information on the individual children and family groups who have been on the Monitored List for more than 14 days, and the length of time the child and family group had been on the List, including children who are aged under three years.
- In addition to the weekly email, a daily report is generated and sent to District Directors, Assistant District Directors, and Team Leaders, which lists all activities where the High-Risk Infant checkbox in Interactions has been ticked.

In March 2023, the Executive Director Service Delivery endorsed a decision for:

- A weekly automated email to be sent to all Regional Executive Directors, commencing 27 March 2023. It is planned for Regional Executive Directors to receive information on this new process, including their role in provision of increased governance of the Monitored List, at the next Regional Executive Directors meeting on 4 April 2023.

- As part of the monthly workload management reporting, a monthly report is generated and made available to Regional Executive Directors, which lists children under three years of age who are on the Monitored List, at the time of the report being run (the first Friday of each month).
- Regional Executive Directors will be responsible for providing feedback to the Executive Director, Community Services regarding the status of each of the cases on the Monitored List involving children under three years of age, within five calendar days of receiving the monthly workload management report data.
- Communities is continuing to explore further options for systems enhancements to align with practice guidance preventing children aged under three years being placed on the Monitored List.

It is noted that these steps taken were also informed by further child death reviews undertaken by this Office in 2022-23 (see Recommendations section).

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

The Office will continue to monitor, and report on, the steps being taken to give effect to the recommendations including through the undertaking of reviews of child deaths, and family and domestic violence fatalities, and in the undertaking of major own motion investigations.

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of child deaths. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2022-23, timely review processes have resulted in 62% of all reviews being completed within six months.

Major Own Motion Investigations Arising from Child Death Reviews

In addition to taking action on individual child deaths, the Office identifies patterns and trends arising out of child death reviews to inform major own motion investigations that examine the practices of public authorities that provide services to children and their families.

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

Preventing suicide by children and young people 2020

About the report

As part of the Ombudsman's responsibility to review the deaths of Western Australian children, on 24 September 2020, *Preventing suicide by children and young people 2020* was tabled in Parliament. The report is comprised of three volumes:

- Volume 1 an executive summary;

- Volume 2 an examination of the steps taken to give effect to the recommendations arising from the report of the Ombudsman's 2014 major own motion investigation, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (**the 2014 Investigation**); and
- Volume 3, the report of the Ombudsman's 2020 major own motion investigation, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people* (**the 2020 Investigation**).

Arising from the 2014 Investigation, the Ombudsman made 22 recommendations about ways that State government departments and authorities can prevent or reduce suicide by young people directed to the Mental Health Commission, the (then) Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education broadly aimed at:

- developing differentiated strategies for suicide prevention relevant to each of the four groups of young people who died by suicide for inclusion in the Western Australian Suicide Prevention Strategy (Recommendations 1, 2 and 3);
- improving service delivery and the rate at which operational policy is implemented into practice within the Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education (Recommendations 4 - 21); and
- promoting inter-agency collaboration between the Mental Health Commission, Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education, through consideration of a joint case management approach and shared tools for use with young people experiencing multiple risk factors associated with suicide (Recommendation 22).

Importantly, the Ombudsman also indicated that the Office would actively monitor the implementation of these recommendations and report to Parliament on the results of the monitoring.

Objectives

The objectives of Volume 2 of the September 2020 report *Preventing suicide by children and young people 2020* were to consider (in accordance with the *Parliamentary Commissioner Act 1971*):

- The steps that have been taken to give effect to the recommendations;
- The steps that are proposed to be taken to give effect to the recommendations; or
- If no such steps have been, or are proposed to be taken, the reasons therefore.

Volume 2 also considered whether the steps taken, proposed to be taken or reasons for taking no steps:

- seem to be appropriate; and
- have been taken within a reasonable time of the making of the recommendations.

After reviewing information arising from the reviews of the lives of children and young people who died by suicide following the 2014 Investigation along with current literature on suicide by children and young people, the Ombudsman decided to commence a new own motion investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people.

The objectives of the 2020 Investigation were to:

- further develop and build upon the detailed understanding of the nature and extent of involvement between the children and young people who died by suicide and State government departments and authorities;
- identify any continuing, new or changed patterns and trends in the demographic characteristics and social circumstances of the children and young people who died by suicide; circumstances of the deaths by suicide; risk factors associated with suicide experienced by the children and young people; and their contact 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 children and young people, and make recommendations to these departments and authorities accordingly.

Methodology

As detailed in Volume 2 of the Report, in order to inform its consideration of whether the steps taken to give effect to the recommendations of the 2014 Investigation, the Office:

- sought from the (then) Mental Health Commissioner, the (then) Director General of the Department for Child Protection and Family Support, the Director General of the Department of Health, and the (then) Director General of the Department of Education a report on the steps that had been taken, or were proposed to be taken, to give effect to the recommendations arising from the 2014 Investigation;
- where further information, clarification or validation was required, met with the relevant State government departments and authorities and collected additional information relevant to suicide by young people in Western Australia;
- reviewed and considered the information provided by the Mental Health Commission, the (then) Department for Child Protection and Family Support, the Department of Health and the Department of Education and the additional information, clarification or validation obtained by the Office; together with relevant current national and international literature regarding suicide by children and young people and the associated risk factors;
- developed a draft report;
- provided the draft report to relevant State government departments and authorities for their consideration and response; and
- developed a final report including findings and recommendations.

Additionally, in order to undertake the 2020 Investigation contained in Volume 3 of the Report, the Office:

- conducted a review of relevant national and international literature regarding suicide by children and young people;
- consulted with government and non-government organisations;
- collected data from State government departments and authorities about each of the 79 children and young people who died by suicide during the 2020 Investigation period (**the 79 children and young people**);
- analysed the data relating to the 79 children and young people using qualitative and quantitative techniques to develop draft findings;

- consulted relevant stakeholders regarding the results of the Office's analysis as well as engaging external professionals with expertise regarding suicide by children and young people to critically comment and review the data collection, analysis and draft findings;
- developed a preliminary view and provided it to relevant State government departments and authorities for their consideration and response; and
- developed a final view including findings and recommendations.

Summary of Findings: Giving effect to the recommendations arising from the 2014 Investigation

The Office is very pleased that in relation to all of the recommendations arising from the 2014 Investigation, the Mental Health Commission, Department of Health, Department of Education and the (then) Department for Child Protection and Family Support had either taken steps, or propose to take steps (or both) to give effect to the recommendations. In no instances did the Office find that no steps had been taken to give effect to the recommendations.

As detailed in Volume 2 of the report, of the 25 recommendations arising from the 2014 Investigation:

- three recommendations were directed to the Mental Health Commission and steps have been taken to give effect to all three recommendations;
- five recommendations were directed to the Department of Health and steps have been taken (and in some cases, are also proposed to be taken) to give effect to all five recommendations;
- six recommendations were directed to the (then) Department for Child Protection and Family Support and steps have been taken (and in some cases, are also proposed to be taken) to give effect to four recommendations and steps are proposed to be taken to give effect to two recommendations;
- seven recommendations were directed to the Department of Education and steps have been taken (and in some cases, are also proposed to be taken) to give effect to six recommendations and steps are proposed to be taken to give effect to one recommendation; and
- one recommendation was directed to the Mental Health Commission, working together with the Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education, and steps have been taken to give effect to this recommendation.

Summary of Findings: the 2020 Investigation

Arising from the findings of the 2020 Investigation, the Ombudsman made seven recommendations to four government agencies about preventing suicide by children and young people, including the development of a suicide prevention plan for children and young people to focus and coordinate collaborative and cooperative State Government efforts.

The Ombudsman is very pleased that each agency has agreed to these recommendations and has, more generally, been positively engaged with the 2020 Investigation. These recommendations are notable not by their number, but by the fact that the Ombudsman has sought to make highly targeted, achievable

recommendations regarding critical issues. Further, the Ombudsman has ensured that the recommendations do not duplicate the work of other investigations and inquiries.

The new information gathered, presented and comprehensively analysed in the 2020 Investigation will be, the Ombudsman believes, a very valuable repository of knowledge for government agencies, non-government organisations and other institutions in the vital work that they undertake in developing and assessing the efficacy of future suicide prevention efforts in Western Australia.

Preventing suicide by children and young people is a shared responsibility requiring collaboration, cooperation and a common understanding of past deaths, risk assessment and responsibilities. The complex and dynamic nature of the risk and protective factors associated with suicide requires a varied and localised response, informed by data about self-harm and suicide, and other indicators of vulnerability experienced by our children and young people. Ultimately, suicide by children and young people will not be prevented by a single program, service or agency working in isolation. Preventing suicide by children and young people must be viewed as part of the core, everyday business of each agency working with children and young people.

The 115 children and young people who died by suicide considered as part of the Ombudsman's 2014 and 2020 Investigations will not be forgotten by their parents, siblings, extended family, friends, classmates and communities. The Ombudsman extends his deepest personal sympathy to all that continue to grieve their immeasurable loss.

It is the Ombudsman's sincerest hope that the extensive new information in this report about suicide by children and young people, and its recommendations, will contribute to preventing these most tragic deaths in the future.

The Office will continue to monitor, and report on, the steps being taken to give effect to these recommendations.

The full report, *Preventing suicide by children and young people 2020* is available at: www.ombudsman.wa.gov.au/SuicideByChildrenAndYoungPeopleReport2020.

Monitoring recommendations from major own motion investigations

The Office also actively monitors the steps taken to give effect to recommendations arising from own motion investigations, including:

- *Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004*, which was tabled in Parliament in November 2011;
- *Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths*, which was tabled in Parliament in November 2012;
- *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, which was tabled in Parliament in April 2014;
- *Investigation into ways to prevent or reduce deaths of children by drowning*, which was tabled in Parliament in November 2017; and
- *Preventing suicide by children and young people 2020*, which was tabled in Parliament in September 2020.

Details of the Office's monitoring of the steps taken to give effect to recommendations arising from own motion investigations are provided in the Own Motion Investigations, Monitoring and Improvement section.

Other Mechanisms to Prevent or Reduce Child Deaths

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

- Assisting public authorities by providing information about issues that have arisen from child death reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of a child or a child's siblings;
- Through working with public authorities and communities where children may be at risk to consider child safety issues and potential areas for improvement, and highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information with other accountability and oversight agencies including Ombudsmen in other States to facilitate consistent approaches and shared learning;
- Engaging with other child death review bodies in Australia and New Zealand through interaction with the Australian and New Zealand Child Death Review and Prevention Group;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of child deaths; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

The Department of Communities

Efficient and effective liaison has been established with Communities to support the child death review process and objectives. Regular liaison occurs at senior executive level, to discuss issues raised in child death reviews and how positive change can be achieved.

Key stakeholder relationships

There are a number of public authorities and other bodies that interact with, or deliver services to, children and their families. Important stakeholders with which the Office liaised in 2022-23 as part of the child death review jurisdiction include:

- The Coroner;
- Public authorities that have involvement with children and their families including:
    - Department of Communities;
    - Department of Health;
    - Health Service Providers;

- Department of Education;
- Department of Justice;
- The Mental Health Commission;
- WA Police Force; and
- Other accountability and similar agencies including the Commissioner for Children and Young People and the Office of the Chief Psychiatrist;

- Non-government organisations; and
- Research institutions including universities.

A Memorandum of Understanding has been established by the Ombudsman with the Commissioner for Children and Young People and a letter of understanding has been established with the Coroner.

Aboriginal and regional communities

In 2016, the Ombudsman established a Principal Aboriginal Consultant position to:

- Provide high level advice, assistance and support to the Corporate Executive and to staff conducting reviews and investigations of the deaths of certain Aboriginal children and family and domestic violence fatalities in Western Australia, complaint resolution involving Aboriginal people and own motion investigations; and
- Raise awareness of and accessibility to the Ombudsman's roles and services to Aboriginal communities and support cross cultural communication between Ombudsman staff and Aboriginal people.

In 2022-23, the Ombudsman created a critical new executive position, Assistant Ombudsman Aboriginal Engagement and Collaboration, which was filled by Laurence Riley in August 2022. This is the first time in the fifty year history of the Office that an Assistant Ombudsman position, and member of Corporative Executive, has been dedicated to Aboriginal Western Australians.

Significant work was undertaken throughout 2022-23 to continue to build relationships relating to the child death review jurisdiction with Aboriginal and regional communities, for example by communicating with:

- Key public authorities that work in regional areas;
- Non-government organisations that provide key services, such as health services to Aboriginal people; and
- Aboriginal community members and leaders to increase the awareness of the child death review function and its purpose.

Additional networks and contacts have been established to support effective and efficient child death reviews. This has strengthened the Office's understanding and knowledge of the issues faced by Aboriginal and regional communities that impact on child and family wellbeing and service delivery in diverse and regional communities.