Our Performance in 2015-16

This section of the report compares results with targets for both financial and non-financial indicators and explains significant variations. It also provides information on achievements during the year, major initiatives and projects, and explains why this work was undertaken.

Summary of Performance

Key Performance Indicators

Key Effectiveness Indicators

The Ombudsman aims to improve decision making and administrative practices in public authorities as a result of complaints handled by the Office, reviews of certain child deaths and family and domestic violence fatalities and own motion investigations. Improvements may occur through actions identified and implemented by agencies as a result of the Ombudsman's investigations and reviews, or as a result of the Ombudsman making specific recommendations and suggestions that are practical and effective. Key Effectiveness Indicators are the percentage of these recommendations and suggestions accepted by public authorities and the number of improvements that occur as a result of Ombudsman action.

Key Effectiveness Indicators	2014-15 Actual	2015-16 Target	2015-16 Actual	Variance from Target
Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies	100%	100%	**100%**	Nil
Number of improvements to practices or procedures as a result of Ombudsman action	99	100	**156**	+56

Another important role of the Ombudsman is to enable remedies to be provided to people who make complaints to the Office where service delivery by a public authority may have been inadequate. The remedies may include reconsideration of decisions, more timely decisions or action, financial remedies, better explanations and apologies. In 2015-16, there were 245 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman.

Comparison of Actual Results and Budget Targets

Public authorities have accepted every recommendation made by the Ombudsman, matching the actual results of the past four years and meeting the 2015-16 target.

In 2007-08, the Office commenced a program to ensure that its work increasingly contributed to improvements to public administration. Consistent with this program, the number of improvements to practices and procedures of public authorities as a result of Ombudsman action has, in 2015-16, exceeded the 2014-15 actual result (99) and the 2015-16 target (100). There may, however, be fluctuations from year to year, related to the number and nature of investigations and reviews finalised by the Office in any given year.

Key Efficiency Indicators

The key efficiency indicators relate to timeliness of complaint handling, the cost per finalised allegation about public authorities, the cost per finalised notification of child deaths and family and domestic violence fatalities, the cost to monitor the Infringement Notices provisions of *The Criminal Code* and the cost of monitoring and inspection functions.

Key Efficiency Indicators	2014-15 Actual	2015-16 Target	2015-16 Actual	Variance from Target
Percentage of allegations finalised within three months	98%	95%	95%	Nil
Percentage of allegations finalised within 12 months	100%	100%	100%	Nil
Percentage of allegations on hand at 30 June less than three months old	96%	90%	93%	+3%
Percentage of allegations on hand at 30 June less than 12 months old	100%	100%	100%	Nil
Average cost per finalised allegation	$1,857	$1,890	$1,886	-$4
Average cost per finalised notification of death	$18,983	$18,950	$18,597	-$353
Cost to monitor the Infringement Notices provisions of *The Criminal Code*	$413,586	$858,000	$851,068	-$6,932
Cost of monitoring and inspection functions*	N/A	$415,000	$413,821	-$1,179

*As 2015-16 is the first year of this Key Efficiency Indicator there is no comparable data in prior years.

Comparison of Actual Results and Budget Targets

The 2015-16 actual results for each of the Key Efficiency Indicators relating to allegations on hand and allegations finalised matched or exceeded the 2015-16 target. Overall, all 2015-16 actual results represented significant improvement in the efficiency of complaint resolution over the last five years.

The average cost per finalised allegation in 2015-16 ($1,886) is comparable to the 2014-15 actual result ($1,857) and met the 2015-16 target ($1,890). Since 2007-08, the efficiency of complaint resolution has improved significantly with the average cost per finalised allegation reduced by a total of 36% from $2,941 in 2007-08 to $1,886 in 2015-16.

The average cost per finalised notification of death ($18,597) is comparable to the 2014-15 actual result ($18,983) and met the 2015-16 target ($18,950).

The cost to monitor the Infringement Notices provisions of *The Criminal Code* ($851,068) met the 2015-16 target ($858,000). The 2015-16 actual result is higher than the 2014-15 actual result ($413,586), in line with the approved funding for the function in 2015-16. The cost of monitoring and inspection functions ($413,821) met the 2015-16 target ($415,000).

For further details, see the Key Performance Indicator section.

Summary of Financial Performance

The majority of expenses for the Office (73%) relate to staffing costs. The remainder is primarily for accommodation, communications and office equipment.

Financial Performance	2014-15 Actual	2015-16 Target ('000s)	2015-16 Actual ('000s)	Variance from Target ('000s)
Total cost of services (sourced from Statement of Comprehensive Income)	$10,331	$11,227	$10,663	-$564
Income other than income from State Government (sourced from Statement of Comprehensive Income)	$2,463	$1,989	$2,048	+$59
Net cost of services (sourced from Statement of Comprehensive Income)	$7,867	$9,238	$8,615	-$623
Total equity (sourced from Statement of Financial Position)	$2,303	$1,532	$2,837	+$1,305
Net increase in cash held (sourced from Statement of Cash Flows)	$873	-$255	$395	+$650
Staff Numbers	**Number**	**Number**	**Number**	**Number**
Full time equivalent (FTE) staff level at 30 June	60	71	65	-6

Comparison of Actual Results and Budget Targets

The variation between the 2015-16 actual results and the targets for the Office's total cost of services, net cost of services and the net increase in cash held is primarily due to temporary vacancies arising from staff movements during the year. The net increase in cash held also included asset purchases committed in 2015-16 but paid in 2016-17.

The variation between the 2015-16 actual result and the target for total equity is primarily due to temporary vacancies arising from staff movements, asset purchases committed in 2015-16 but paid in 2016-17 and funds from 2014-15, for the function to monitor the Infringement Notices provisions of *The Criminal Code*, that were unspent due to the change in the commencement of the function to March 2015.

For further details see Note 27 'Explanatory Statement' in the Financial Statements section.

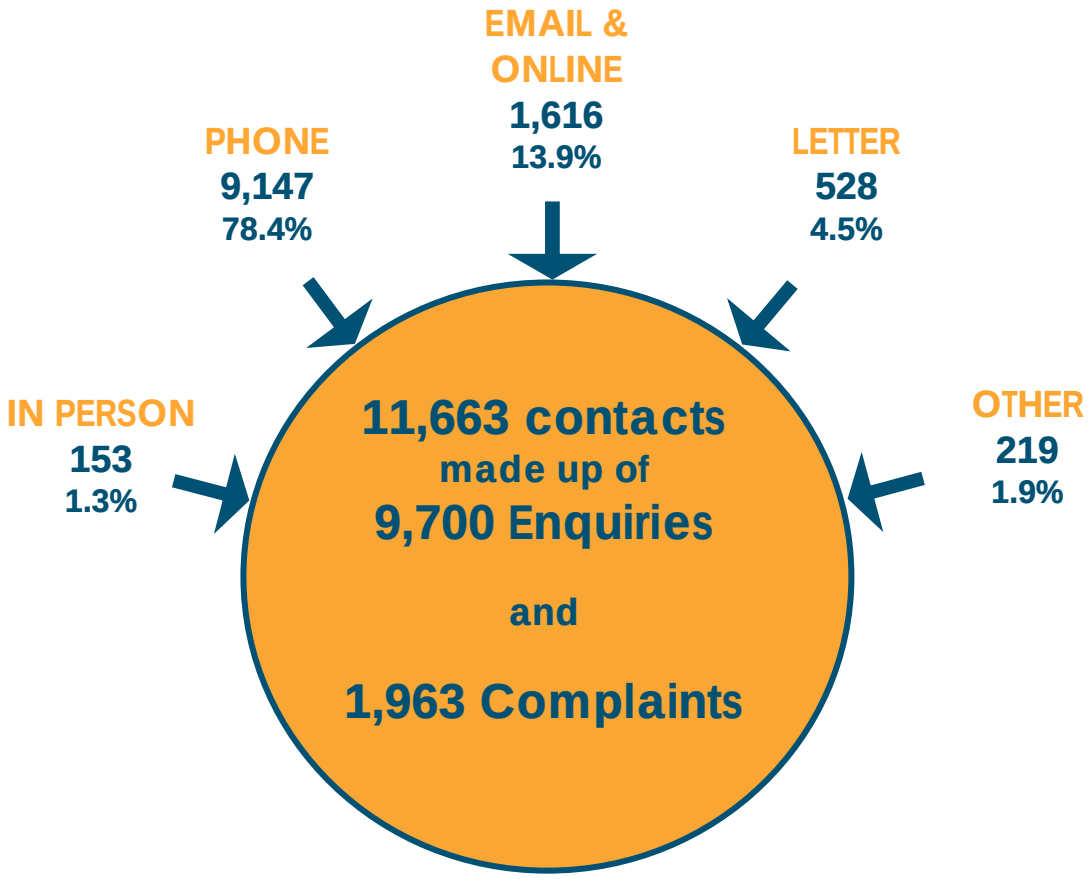
Complaint Resolution

One of the core Ombudsman functions is to resolve complaints received from the public about the decision making and practices of State Government agencies, local governments and universities (commonly referred to as public authorities). This section of the report provides information about how the Office assists the public by providing independent and timely complaint resolution and investigation services or, where appropriate, referring them to a more appropriate body to handle the issues they have raised.

Contacts

In 2015-16, the Office received 11,663 contacts from members of the public consisting of:

- 9,700 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 1,963 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

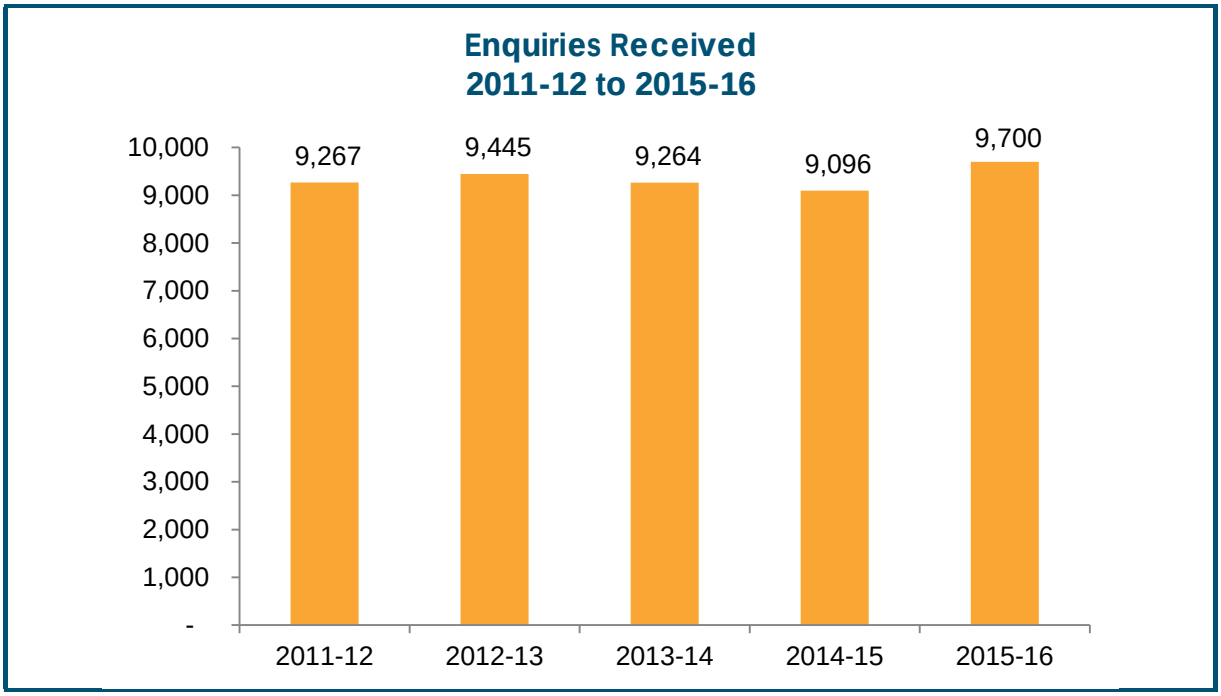


Enquiries Received

There were 9,700 enquiries received during the year.

For enquiries about matters that are within the Ombudsman's jurisdiction, staff provide information about the role of the Office and how to make a complaint. For approximately half of these enquiries, the enquirer is referred back to the public authority in the first instance to give it the opportunity to hear about and deal with the issue. This is often the quickest and most effective way to have the issue dealt with. Enquirers are advised that if their issues are not resolved by the public authority, they can make a complaint to the Ombudsman.

For enquiries that are outside the jurisdiction of the Ombudsman, staff assist members of the public by providing information about the appropriate body to handle the issues they have raised.

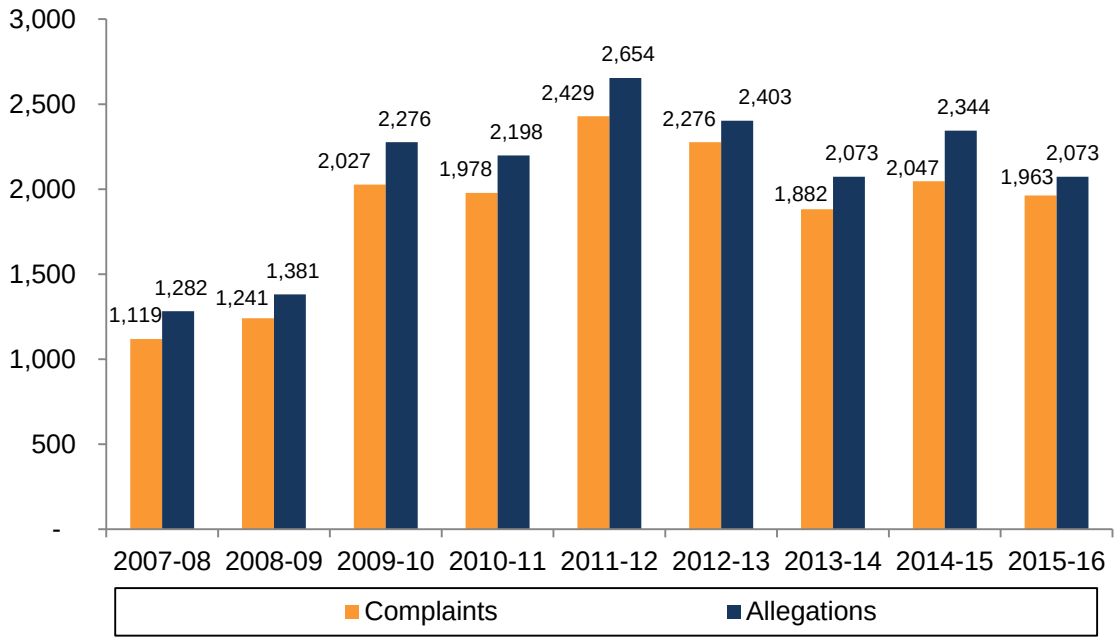


Enquirers are encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

Complaints Received

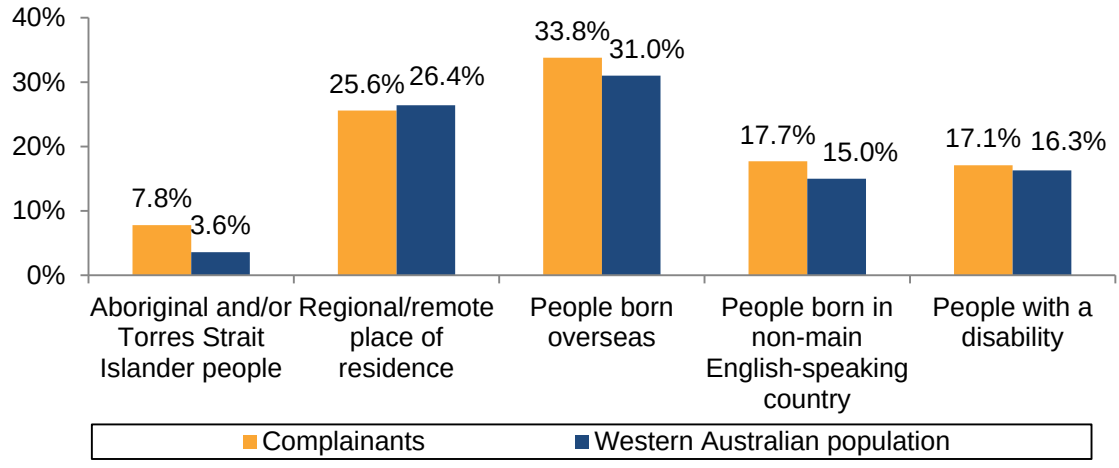
In 2015-16, the Office received 1,963 complaints, with 2,073 separate allegations, and finalised 1,887 complaints. There are more allegations than complaints because one complaint may cover more than one issue.

Total Number of Complaints and Allegations Received 2007-08 to 2015-16



NOTE: The number of complaints and allegations shown for a year may vary in this and other charts by a small amount from the number shown in previous annual reports. This occurs because, during the course of an investigation, it can become apparent that a complaint is about more than one public authority or there are additional allegations with a start date in a previous reporting year.

Characteristics of Complainants

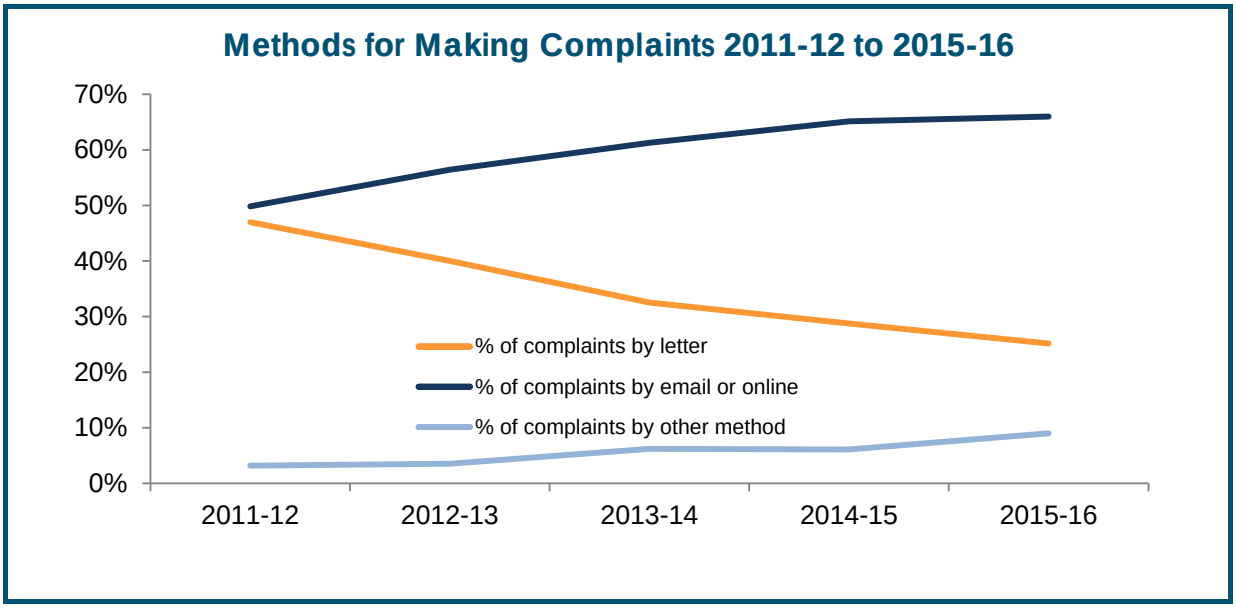


NOTE: Non-main English-speaking countries as defined by the Australian Bureau of Statistics are countries other than Australia, the United Kingdom, the Republic of Ireland, New Zealand, Canada, South Africa and the United States of America. Being from a non-main English-speaking country does not imply a lack of proficiency in English.

How Complaints Were Made

The increase in the use of email and online facilities to lodge complaints has continued in 2015-16, increasing from 65% in 2014-15 to 66% in 2015-16. The proportion of people using email and online facilities to lodge complaints has increased by 16% since 2011-12, when 50% were received in this way.

During the same period, the proportion of people who lodge complaints by letter has reduced from 47% to 25%. The remaining complaints were received by a variety of means, including by fax, during regional visits and in person.



Resolving Complaints

Early resolution involves facilitating a timely response and resolution of a complaint.

Where it is possible and appropriate, staff use an early resolution approach to investigate and resolve complaints. This approach is highly efficient and effective and results in timely resolution of complaints. It gives public authorities the opportunity to provide a quick response to the issues raised and to undertake timely action to resolve the matter for the complainant and prevent similar complaints arising again. The outcomes of complaints may result in a remedy for the complainant or improvements to a public authority's administrative practices, or a combination of both. Complaint resolution staff also track recurring trends and issues in complaints and this information is used to inform broader administrative improvement in public authorities and investigations initiated by the Ombudsman (known as own motion investigations).

Time Taken to Resolve Complaints

Timely complaint handling is important, including the fact that early resolution of issues can result in more effective remedies and prompt action by public authorities to prevent similar problems occurring again. The Office's continued focus on timely complaint resolution has resulted in ongoing improvements in the time taken to handle complaints.

Timeliness and efficiency of complaint handling has substantially improved over time due to a major complaint handling improvement program introduced in 2007-08. An initial focus of the program was the elimination of aged complaints.

Building on the program, the Office developed and commenced a new organisational structure and processes in 2011-12 to promote and support early resolution of complaints. There have been further enhancements to complaint handling processes in 2015-16, in particular in relation to the early resolution of complaints.

Together, these initiatives have enabled the Office to maintain substantial improvements in the timeliness of complaint handling.

In 2015-16:

- The percentage of allegations finalised within 3 months was 95%; and
- The percentage of allegations on hand at 30 June less than 3 months old was 93%.

95% of allegations were finalised within 3 months.

Following the introduction of the Office's complaint handling improvement program in 2007-08, very significant improvements have been achieved in timely complaint handling, including:

- The average age of complaints has decreased from 173 days to 27 days; and
- Complaints older than 6 months have decreased from 40 to 1.

Complaints Finalised in 2015-16

There were 1,887 complaints finalised during the year and, of these, 1,290 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 701 were finalised at initial assessment, 561 were finalised after an Ombudsman investigation and 28 were withdrawn.

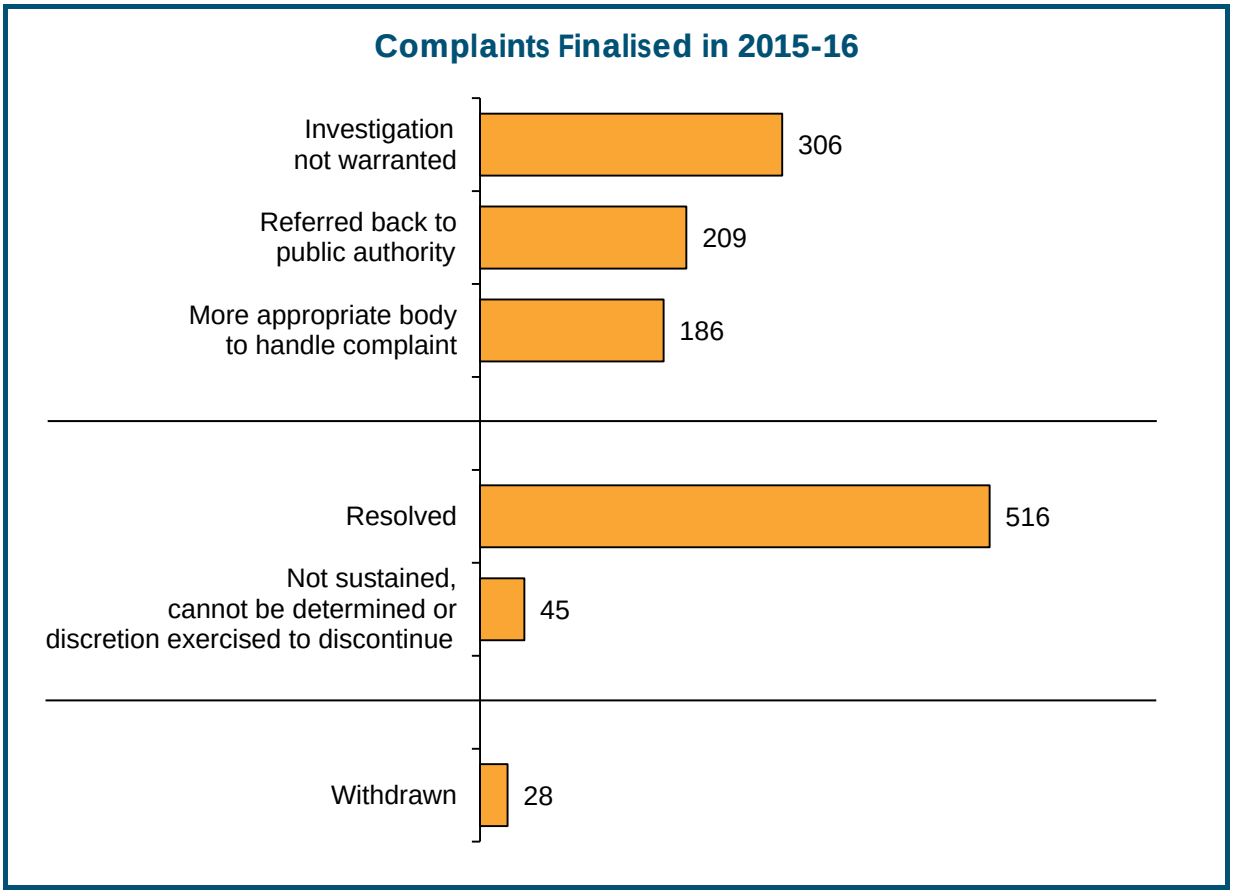
Complaints finalised at initial assessment

Nearly a third (30%) of the 701 complaints finalised at initial assessment were referred back to the public authority to provide it with an opportunity to resolve the matter before investigation by the Ombudsman. This is a common and timely approach and often results in resolution of the matter. The person making the complaint is asked to contact the Office again if their complaint remains unresolved. In a further 186 (27%) complaints finalised at the initial assessment, it was determined that there was a more appropriate body to handle the complaint. In these cases, complainants are provided with contact details of the relevant body to assist them.

Complaints finalised after investigation

Of the 561 complaints finalised after investigation, 92% were resolved through the Office's early resolution approach. This involves Ombudsman staff contacting the public authority to progress a timely resolution of complaints that appear to be able to be resolved quickly and easily. Public authorities have shown a strong willingness to resolve complaints using this approach and frequently offer practical and timely remedies to resolve matters in dispute, together with information about administrative improvements to be put in place to avoid similar complaints in the future.

The following chart shows how complaints about public authorities in the Ombudsman's jurisdiction were finalised.



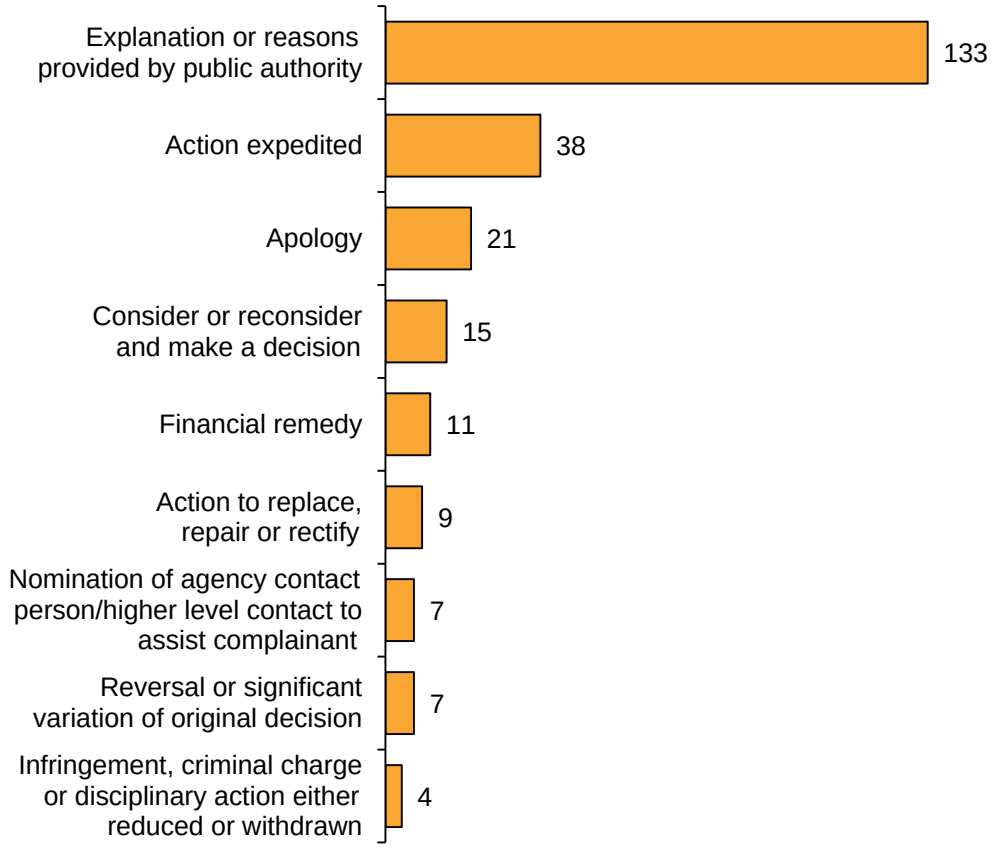
Note: Investigation not warranted includes complaints where the matter is not in the Ombudsman's jurisdiction.

Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2015-16, there were 245 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman, an increase of 16% from 211 in 2014-15. In some cases, there is more than one action to resolve a complaint. For example, the public authority may apologise and reverse their original decision. In a further 143 instances, the Office referred the complaint to the public authority following its agreement to expedite examination of the issues and to deal directly with the person to resolve their complaint. In these cases, the Office follows up with the public authority to confirm the outcome and any further action the public authority has taken to assist the individual or to improve their administrative practices.

The following chart shows the types of remedies provided to complainants.

Remedial Action to Assist the Complainant in 2015-16



Case Study

Decision reconsidered after Ombudsman involvement

A person had their licence and other identification documents stolen. They applied to a public authority to have one of their documents replaced, however, the public authority rejected their application as they were unable to provide a primary form of identification. The person complained to the Office that they needed the document quickly and they were unable to obtain the replacement primary identification in the required timeframe.

Following enquiries by the Office, the public authority agreed that it had scope for discretion to provide the document if it was satisfied of a person's identity through provision of other established documents and verification of personal information held on the public authority's database. The public authority wrote to the complainant and explained that, due to their particular circumstances, the complainant could obtain a replacement licence by providing multiple forms of secondary identification.

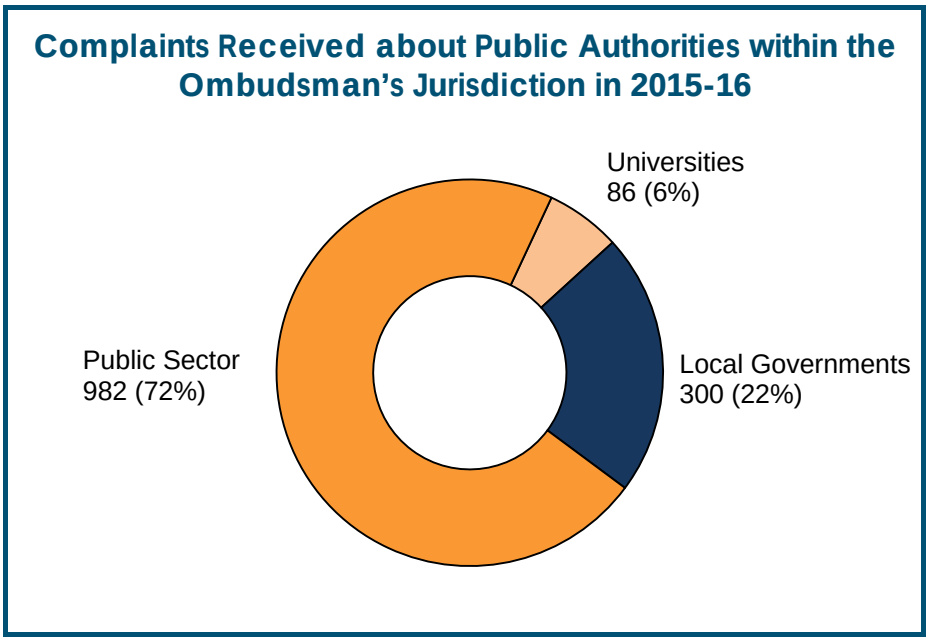
Outcomes to improve public administration

In addition to providing individual remedies, complaint resolution can also result in improved public administration. This occurs when the public authority takes action to improve its decision making and practices in order to address systemic issues and prevent similar complaints in the future. Administrative improvements include changes to policy and procedures, changes to business systems or practices and staff development and training.

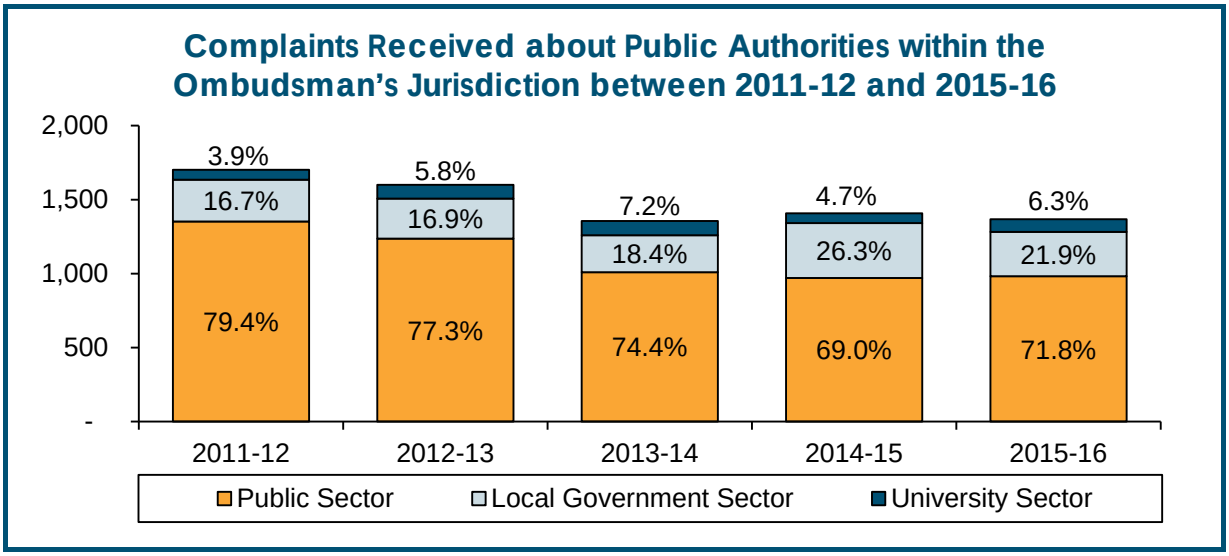
About the Complaints

Of the 1,963 complaints received, 1,368 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 595 complaints were about bodies outside the Ombudsman's jurisdiction. In these cases, Ombudsman staff provided assistance to enable the people making the complaint to take the complaint to a more appropriate body.

Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (982 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (300 complaints); and the university sector (86 complaints).

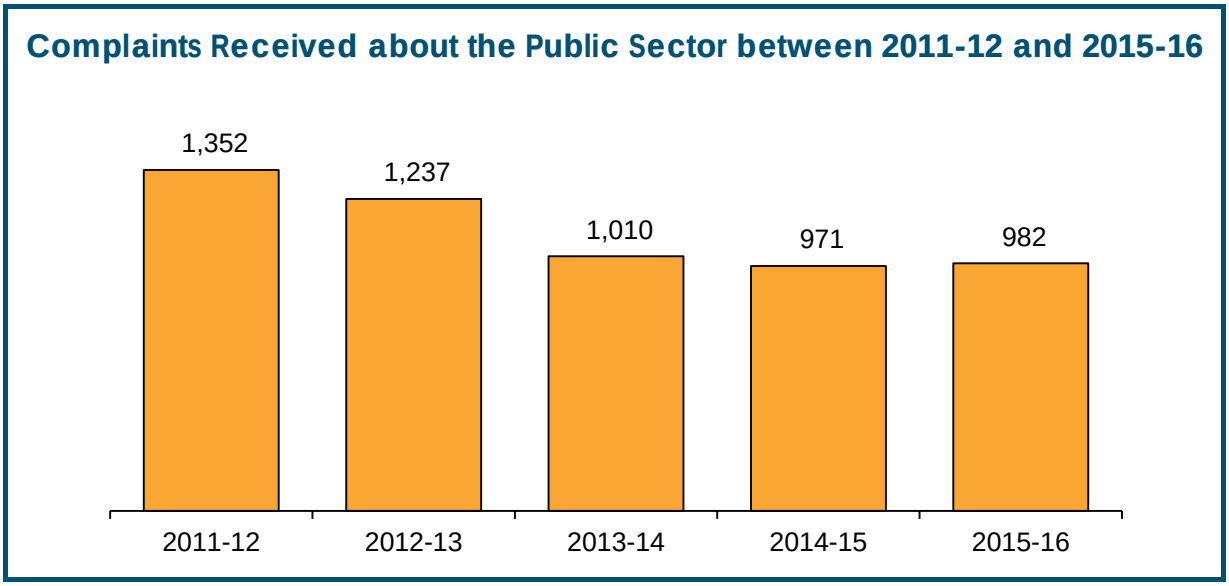


The proportion of complaints about each sector in the last five years is shown in the following chart.



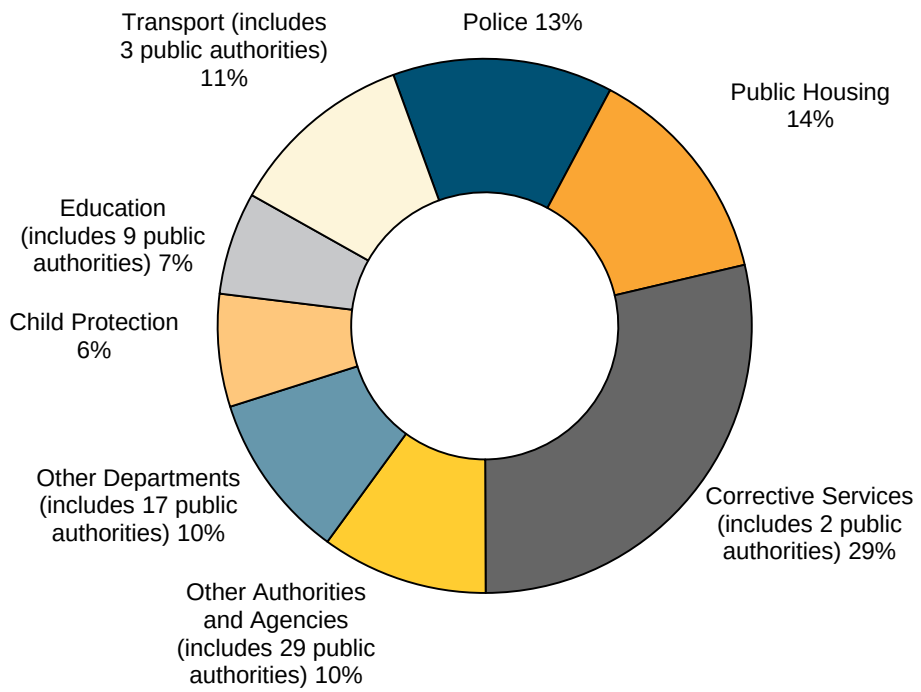
The Public Sector

In 2015-16, there were 982 complaints received about the public sector and 940 complaints were finalised. The number of complaints about the public sector as a whole since 2011-12 is shown in the chart below.



Public sector agencies are very diverse. In 2015-16, complaints were received about 63 agencies as shown in the following chart.

Complaints Received about the Public Sector in 2015-16



Of the 982 complaints received about the public sector in 2015-16, 80% were about six key areas covering:

- Corrective services, in particular prisons (281 or 29%);
- Public housing (133 or 14%);
- Police (131 or 13%);
- Transport (111 or 11%);
- Education – public schools and institutes of technology (67 or 7%). Information about universities is shown separately under the University Sector; and
- Child protection (61 or 6%).

The remaining complaints about the public sector (198) were about 46 other State Government departments, statutory authorities and boards. For 41 (89%) of these agencies, the Office received five complaints or less.

Outcomes of complaints about the public sector

There were 220 actions taken by public sector bodies as a result of complaints finalised in 2015-16. These resulted in 178 remedies being provided to complainants and 42 improvements to public sector practices.

The following case study illustrates the outcomes arising from complaints about the public sector. Further information about the issues raised in complaints and the outcomes of complaints is shown in the following tables for each of the six key areas and for the other public sector agencies as a group.

Case Study

Significant remedial action to rectify processing error

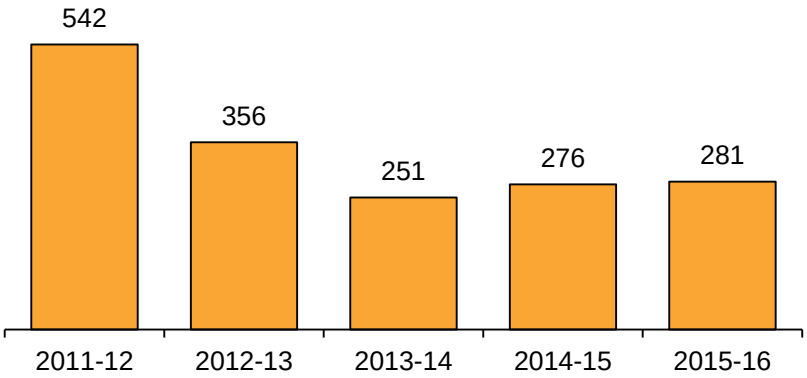
A person found out their licence had been suspended without their knowledge. When they contacted the public authority, they were informed that an unrelated address had been entered against their personal details. This resulted in their licence renewal notification, registration papers, subsequent suspension notices and fines being sent to the wrong address. The person complained to the Office about the error and the costs they would have to incur for re-licencing.

Following enquiries by the Office, the public authority undertook an investigation which revealed that the change of address was made in error when a staff member processed an unrelated person's change of details. The public authority apologised, corrected the error, withdrew the fines, offered to reimburse the person for the cost of temporary permits and re-licencing, and provided training to the staff member to prevent the mistake reoccurring.

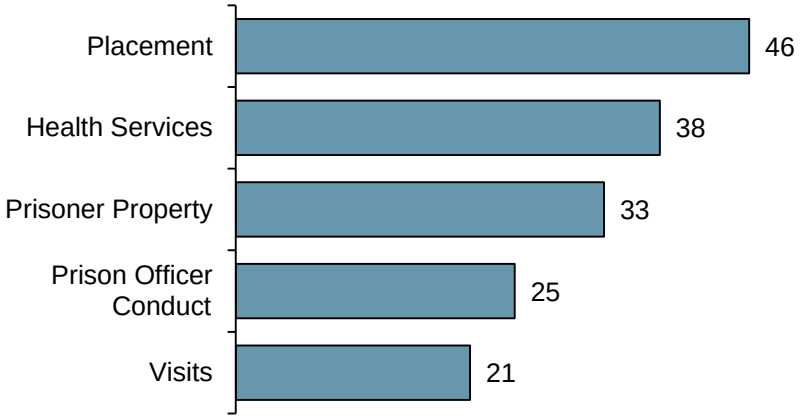
Public Sector Complaint Issues and Outcomes

Corrective Services

Complaints received



Most common allegations



Other types of allegations

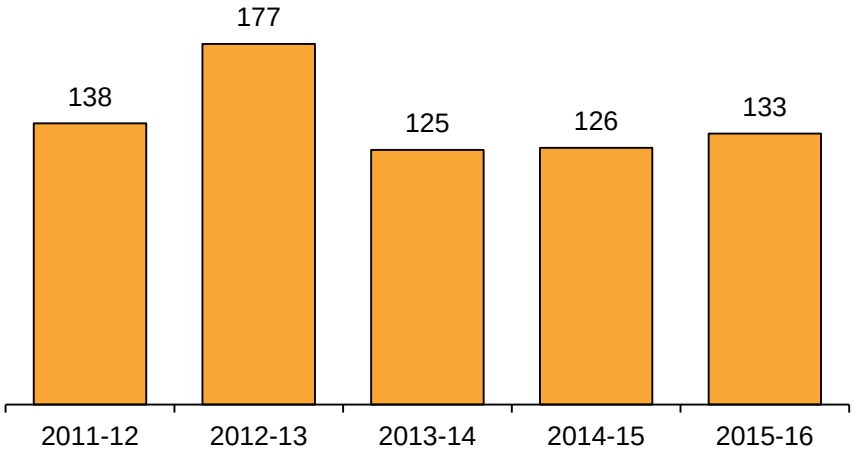
- Facilities and conditions;
- Discipline;
- Communication; and
- Sentencing, parole and reintegration issues.

Outcomes achieved

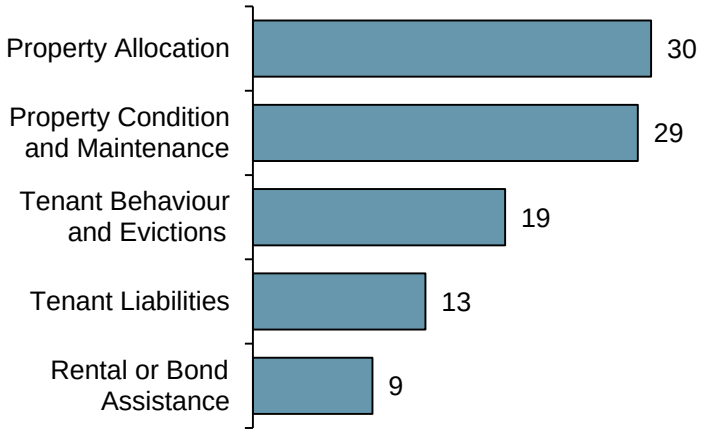
- Action to replace, repair or rectify a matter;
- Apology given;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Change to business systems or practices; and
- Staff training.

Public Housing

Complaints received



Most common allegations



Other types of allegations

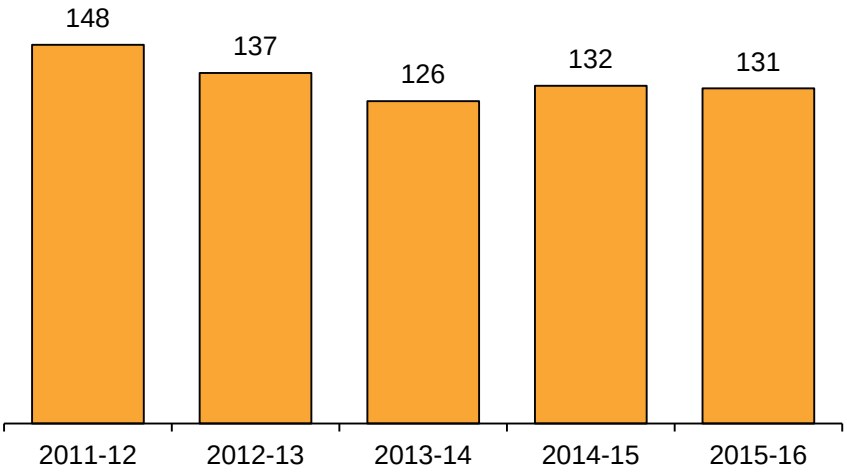
- Property transfers;
- Debt repayments;
- Personal information and privacy issues; and
- Rental sales.

Outcomes achieved

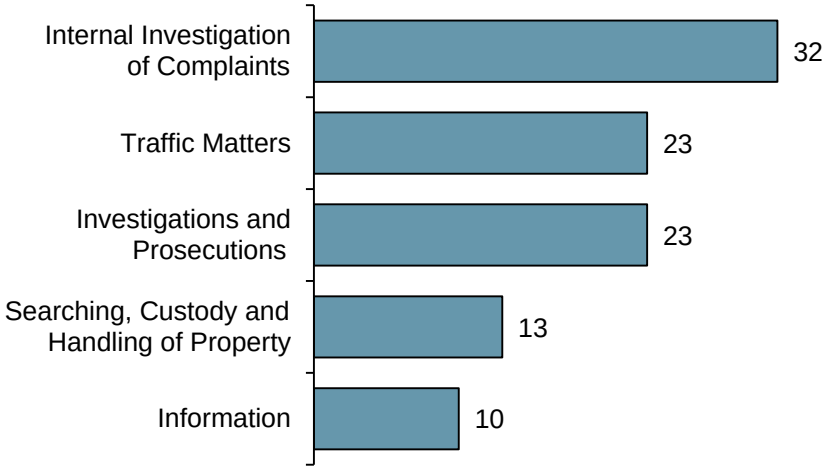
- Act of grace payment;
- Monetary charge reduced;
- Action to replace, repair or rectify a matter;
- Apology given;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Change to business systems or practices; and
- Update to publications or website.

Police

Complaints received



Most common allegations



Other types of allegations

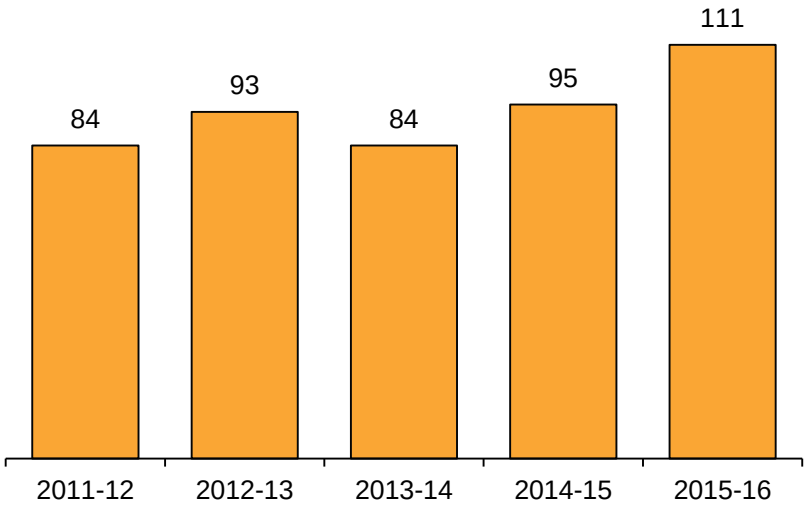
- Improper conduct;
- Management issues; and
- Arrest and detention issues.

Outcomes achieved

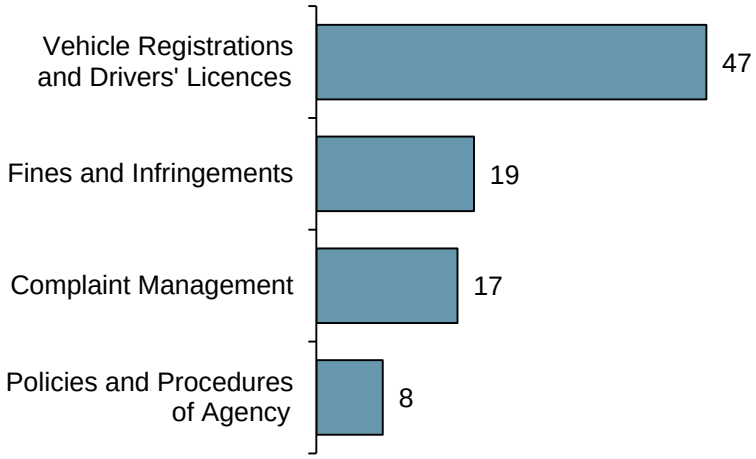
- Infringement withdrawn;
- Action to replace, repair or rectify a matter;
- Apology given;
- Action expedited; and
- Explanation given or reasons provided.

Transport

Complaints received



Most common allegations



Other types of allegations

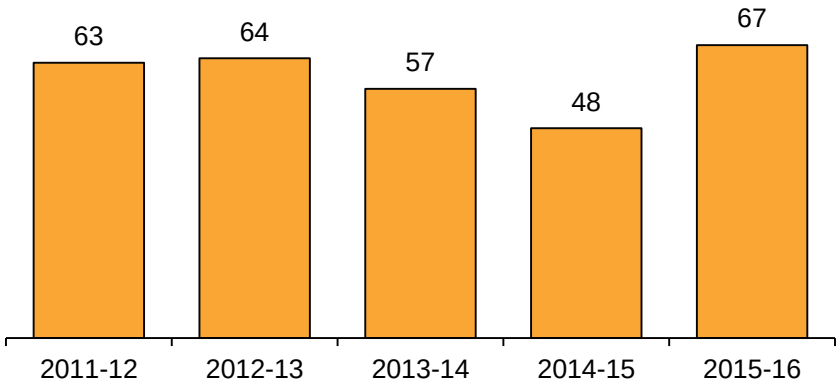
- Other decision or action by officer or agency;
- Conduct of officer; and
- Personal information and privacy issues.

Outcomes achieved

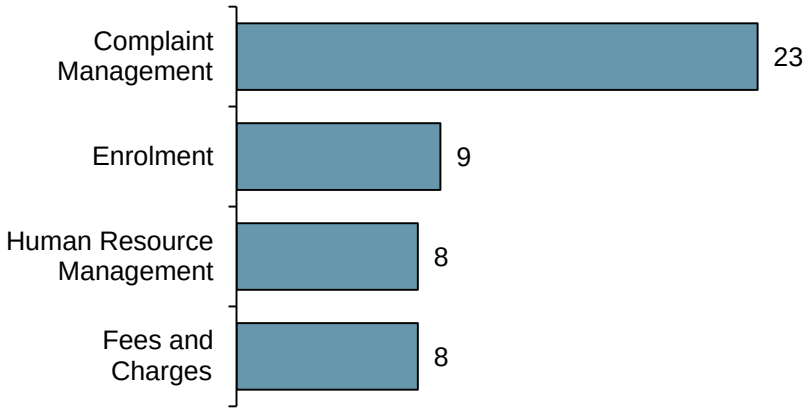
- Monetary charge reduced, withdrawn or refunded;
- Infringement withdrawn;
- Action to replace, repair or rectify a matter;
- Apology given;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to business systems or practices;
- Change to policy or procedure; and
- Improved recordkeeping.

Education

Complaints received



Most common allegations



These figures include appeals by overseas students under the *National Code of Practice for Registration Authorities and Providers of Education and Training to Overseas Students 2007* relating to TAFE colleges and other public education agencies. Further details on these appeals are included later in this section.

Other types of allegations

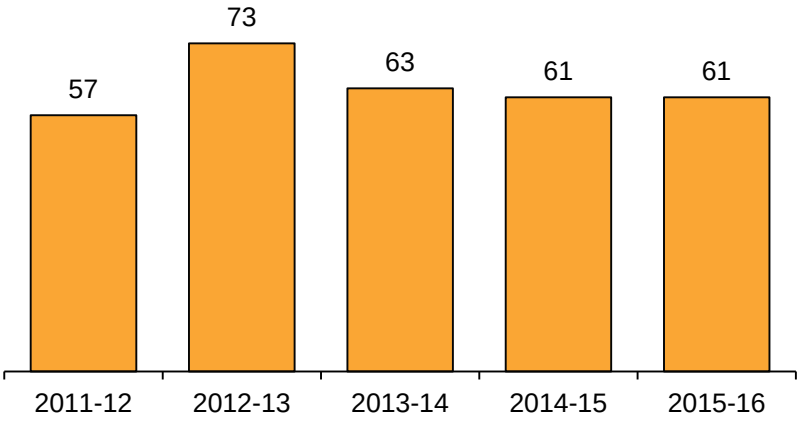
- Academic misconduct;
- Student care; and
- Personal information and privacy issues.

Outcomes achieved

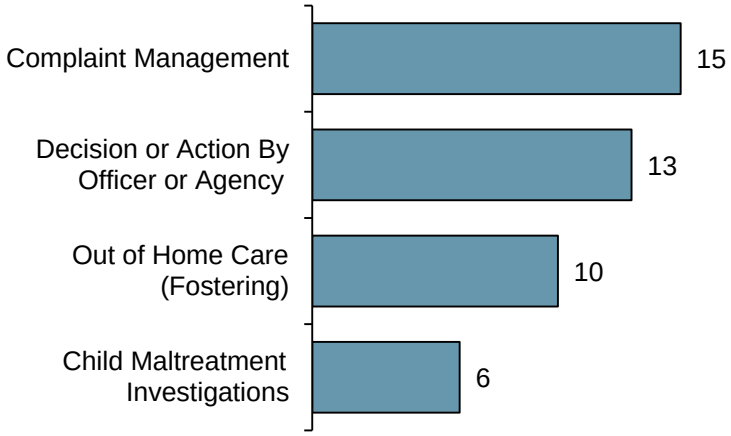
- Reversal or significant variation of original decision;
- Monetary charge reduced or withdrawn;
- Action to replace, repair or rectify a matter;
- Apology given;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Change to business systems or practices;
- Conduct an audit or review;
- Update to publications or website; and
- Staff training.

Child Protection

Complaints received



Most common allegations



Other types of allegations

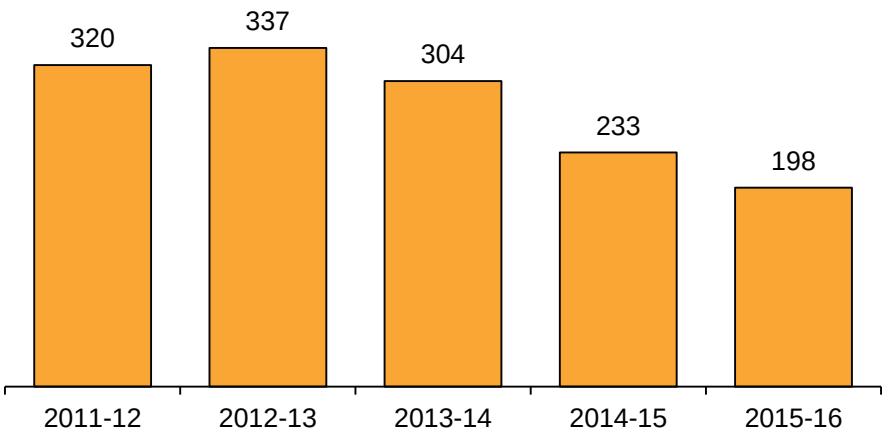
- Personal information and privacy issues;
- Human resource management issues; and
- Special assistance.

Outcomes achieved

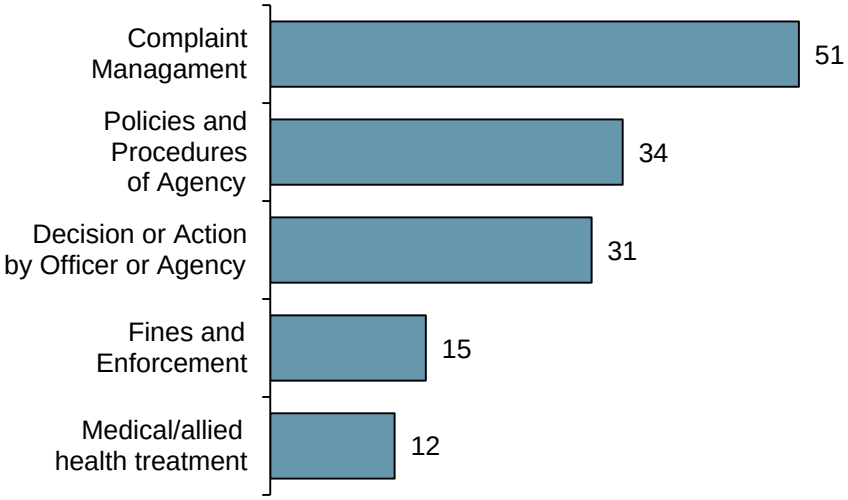
- Reversal or significant variation of original decision;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to policy or procedure; and
- Change to business systems or practices.

Other Public Sector Agencies

Complaints received



Most common allegations



Other types of allegations

- Conduct of officer or agency;
- Personal information and privacy issues; and
- Human resource issues.

Outcomes achieved

- Reversal or significant variation of original decision;
- Act of grace payment;
- Monetary charge refunded;
- Apology given;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Conduct an audit or review; and
- Update to publications.

The following case study provides an example of action taken by a public sector agency as a result of the involvement of the Ombudsman.

Case Study

Maintenance issues resolved

A tenant of a public authority contacted the public authority's maintenance line and lodged an urgent request for repairs to their plumbing. The tradesperson arrived a day later than expected and only temporarily fixed the problem. The tenant complained to the Office about the ongoing plumbing issues.

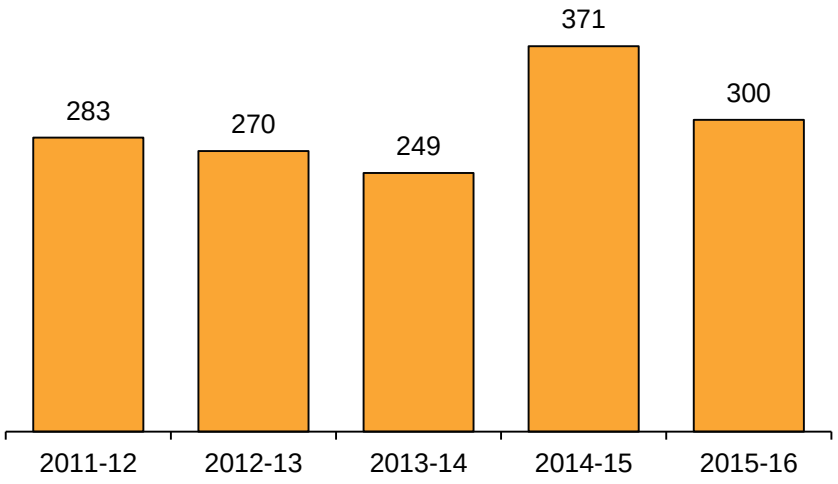
Following enquiries by the Office, the public authority made enquiries internally and agreed that the standard of maintenance service was not acceptable. It wrote to the tenant to apologise, ensured the maintenance works were resolved, and offered a two week rent concession to compensate.

The Local Government Sector

The following section provides further details about the issues and outcomes of complaints for the local government sector.

Local Government

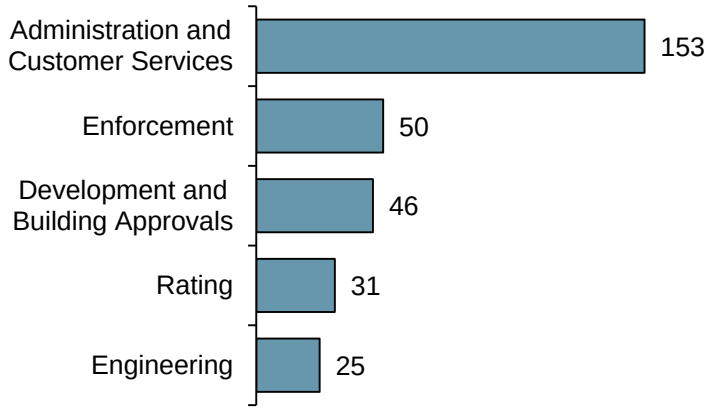
Complaints received



The fluctuation in the numbers in 2014-15 is partly due to complaints where identical or similar complaints were made by different people about the same issue.

Local Government

Most common allegations



Other types of allegations

- Environmental health;
- Community facilities; and
- Planning.

Outcomes achieved

- Reversal or significant variation of original decision;
- Monetary charge or infringement refunded or withdrawn;
- Apology given;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Change to business systems or practices;
- Update to website; and
- Staff training.

Case Study

Improved procedures for feedback to residents

A resident asked their local government to repair the crossover at the front of their property. The person raised their concerns with the local government a number of times, over several months, but received no information about if, and when, the repairs would be carried out. The resident then complained to the Office.

Following enquiries by the Office, the local government explained that it had received a large number of similar requests at the time and acknowledged that, although it had recorded the requests and was taking steps to repair affected properties, there were issues with providing satisfactory feedback and information to residents.

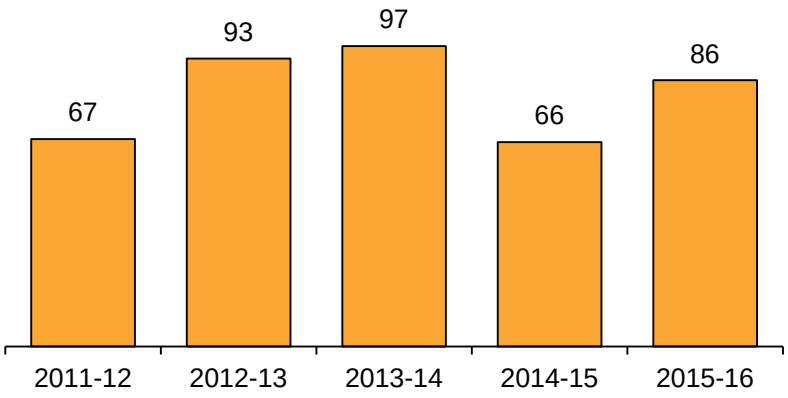
The local government undertook the repairs to the resident's crossover and informed them when the repairs were completed. It also reviewed and amended its procedures for dealing with requests from residents, in particular the level of feedback provided to residents on the progress of their requests.

The University Sector

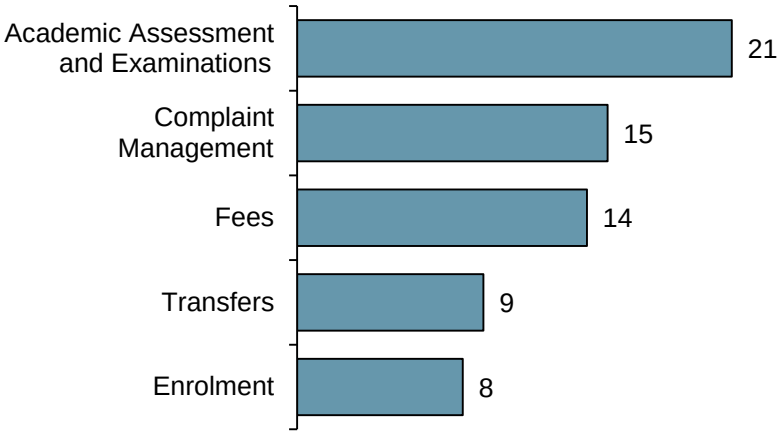
The following section provides further details about the issues and outcomes of complaints for the university sector.

Universities

Complaints received



Most common allegations



These figures include appeals by overseas students under the *National Code of Practice for Registration Authorities and Providers of Education and Training to Overseas Students 2007.* Further details on these appeals are included later in this section.

Other types of allegations

- Termination of enrolment;
- Staff conduct; and
- Scholarships and prizes.

Outcomes Achieved

- Reversal or significant variation of original decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Change to business systems or practices; and
- Staff training.

Case Study

Assistance to enable thesis to be resubmitted

An international student was studying for their PhD at a Western Australian university. Unfortunately, the student's thesis supervisor was hospitalised and then unable to return before the student was due to submit their thesis. After the thesis was submitted the university appointed a replacement supervisor and thesis panel and, subsequently, the student was required to amend and resubmit their thesis. The student could not do this as they had to return to their home overseas because their sponsorship had ended.

The student complained to the Office that the university had unreasonably delayed the appointment of a new supervisor and thesis panel which meant the student had to submit their thesis without feedback from a supervisor. The student also alleged that the thesis reviewer was not appropriate to conduct the review.

Following enquiries by the Office, the university decided that, as the thesis had not been failed by the reviewer, the most appropriate course of action would be for the student to amend and resubmit their thesis. The university provided assistance to the student to enable them to resubmit the thesis, including appointing an appropriate supervisor and providing additional sponsorship.

Other Complaint Related Functions

Reviewing appeals by overseas students

The *National Code of Practice for Registration Authorities and Providers of Education and Training to Overseas Students 2007* (**the National Code**) sets out standards required of registered providers who deliver education and training to overseas students studying in Australian universities, TAFE colleges and other public education agencies. It provides overseas students with rights of appeal to external, independent bodies if the student is not satisfied with the result or conduct of the internal complaint handling and appeals process.

Overseas students studying with both public and private education providers have access to an Ombudsman who:

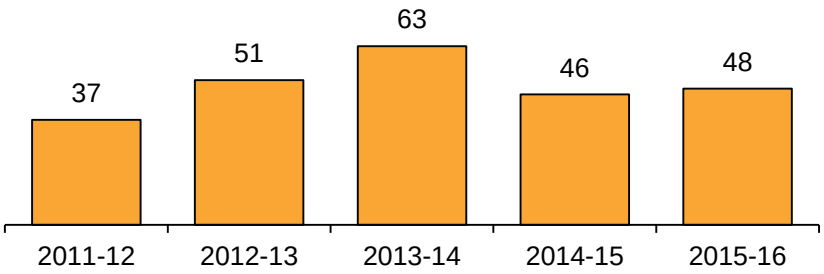
- Provides a free complaint resolution service;
- Is independent and impartial and does not represent either the overseas students or education and training providers; and
- Can make recommendations arising out of investigations.

In Western Australia, the Ombudsman is the external appeals body for overseas students studying in Western Australian public education and training organisations. The Overseas Students Ombudsman is the external appeals body for overseas students studying in private education and training organisations.

Complaints lodged with the Office under the National Code

Education and training providers are required to comply with 15 standards under the National Code. In dealing with these complaints, the Ombudsman considers whether the decisions or actions of the agency complained about comply with the requirements of the National Code and if they are fair and reasonable in the circumstances.

Complaints Received from Overseas Students under the National Code between 2011-12 and 2015-16



During 2015-16, the Office received 48 complaints about public education and training providers from overseas students. Twenty nine complaints were about universities, three were about TAFE colleges and eight were about other public education agencies. The Office also received eight complaints that, after initial assessment, were found to be about a private education provider. The Office referred these complainants to the Overseas Students Ombudsman.

The most common issues raised by overseas students were decisions about:

- Fees (17);
- Transfers between education and training providers (11);
- Termination of enrolment (9); and
- Academic assessment (6).

During the year, the Office finalised 45 complaints about 51 issues.

Case Study

Course information corrected and costs paid

A student obtained information about a qualification from a tertiary education provider and, based on this information, travelled with their family to Perth to commence study. After the student arrived they were told that the course would not provide the qualifications they were expecting and the student and their family then returned home overseas. The student complained to the Office that they had received incorrect information from the tertiary education provider about the qualification.

Following enquiries by the Office, the tertiary education provider agreed that the information on the relevant course was not clear and would be corrected. The education provider also agreed to pay the costs of travel, accommodation and other costs incurred by the student.

Public Interest Disclosures

Section 5(3) of the *Public Interest Disclosure Act 2003* allows any person to make a disclosure to the Ombudsman about particular types of 'public interest information'. The information provided must relate to matters that can be investigated by the Ombudsman, such as the administrative actions and practices of public authorities, or relate to the conduct of public officers.

Key members of staff have been authorised to deal with disclosures made to the Ombudsman and have received appropriate training. They assess the information provided to determine whether the matter requires investigation, having regard to the *Public Interest Disclosure Act 2003*, the *Parliamentary Commissioner Act 1971* and relevant guidelines. If a decision is made to investigate, subject to certain additional requirements regarding confidentiality, the process for investigation of a disclosure is the same as that applied to the investigation of complaints received under the *Parliamentary Commissioner Act 1971*.

During the year, three disclosures were received.

Indian Ocean Territories

Under a service delivery arrangement between the Ombudsman and the Australian Government, the Ombudsman handles complaints about State Government departments and authorities delivering services in the Indian Ocean Territories and about local governments in the Indian Ocean Territories. There were 15 complaints received during the year.

Terrorism

The Ombudsman can receive complaints from a person detained under the *Terrorism (Preventative Detention) Act 2006*, about administrative matters connected with his or her detention. There were no complaints received during the year.

Requests for Review

Occasionally, the Ombudsman is asked to review or re-open a complaint that was investigated by the Office. The Ombudsman is committed to providing complainants with a service that reflects best practice administration and, therefore, offers complainants who are dissatisfied with a decision made by the Office an opportunity to request a review of that decision.

Eleven requests for review were received in 2015-16, representing less than one per cent of the total number of complaints received by the Office. In all cases where a review was undertaken, the original decision was upheld and, in one case, a complaint was reopened due to the provision of new information.

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;
- Issues identified in child death reviews;
- Recommendations;
- 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) 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.

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:

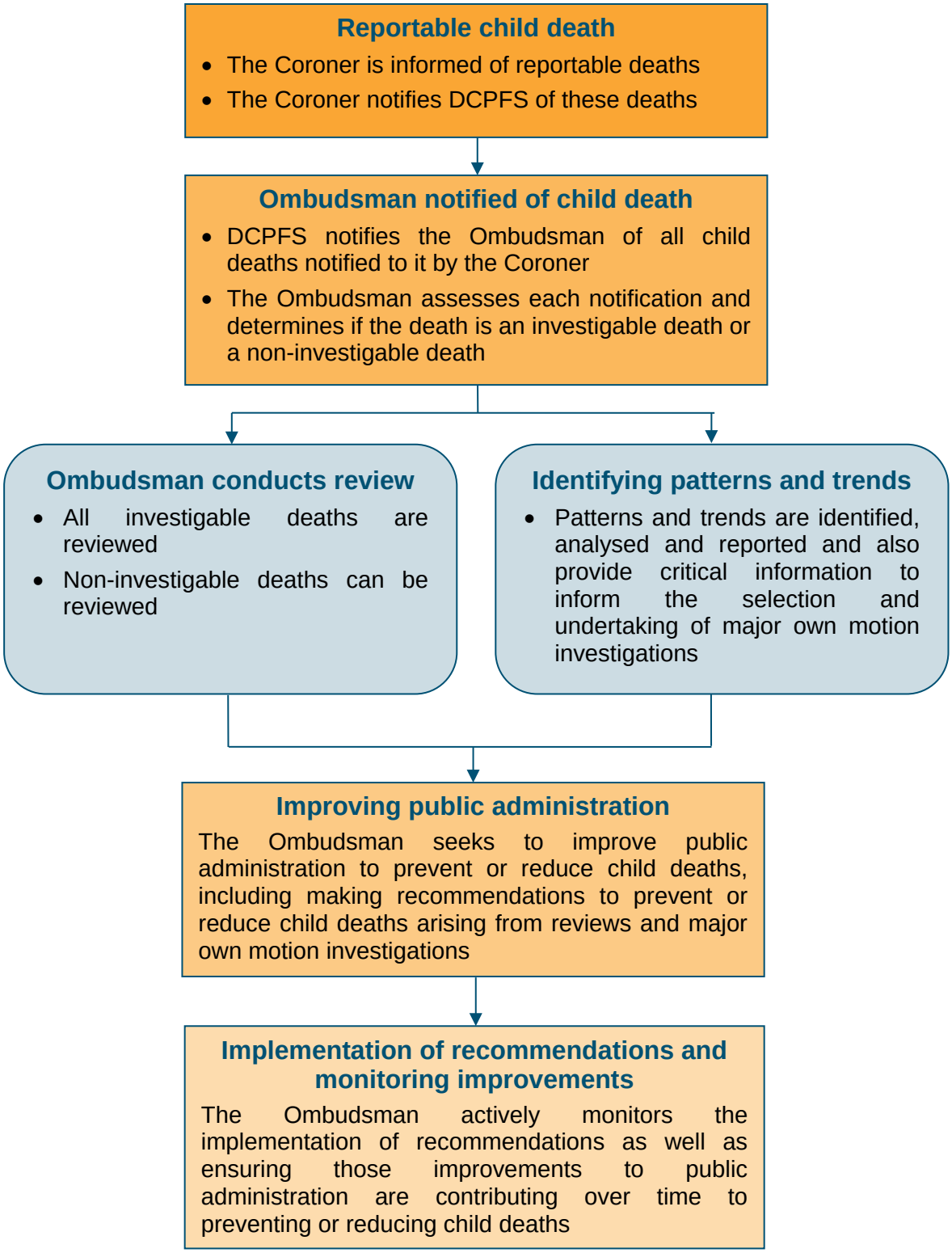
- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department for Child Protection and Family Support (**DCPFS**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 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 particular, 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.

In addition to reviewing investigable deaths, the Ombudsman can review other notified deaths. The Ombudsman also undertakes major own motion investigations arising from child death reviews.

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 Child Death Review Process



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 reviews;
- 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

DCPFS receives information from the Coroner on reportable deaths of children and notifies the Ombudsman of these deaths. The notification provides the Ombudsman with a copy of the information provided to DCPFS by the Coroner about the circumstances of the child's death together with a summary outlining the past involvement of DCPFS with the child.

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 extent of a review depends on a number of factors, including the circumstances surrounding the child's death and the level of involvement of DCPFS 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.

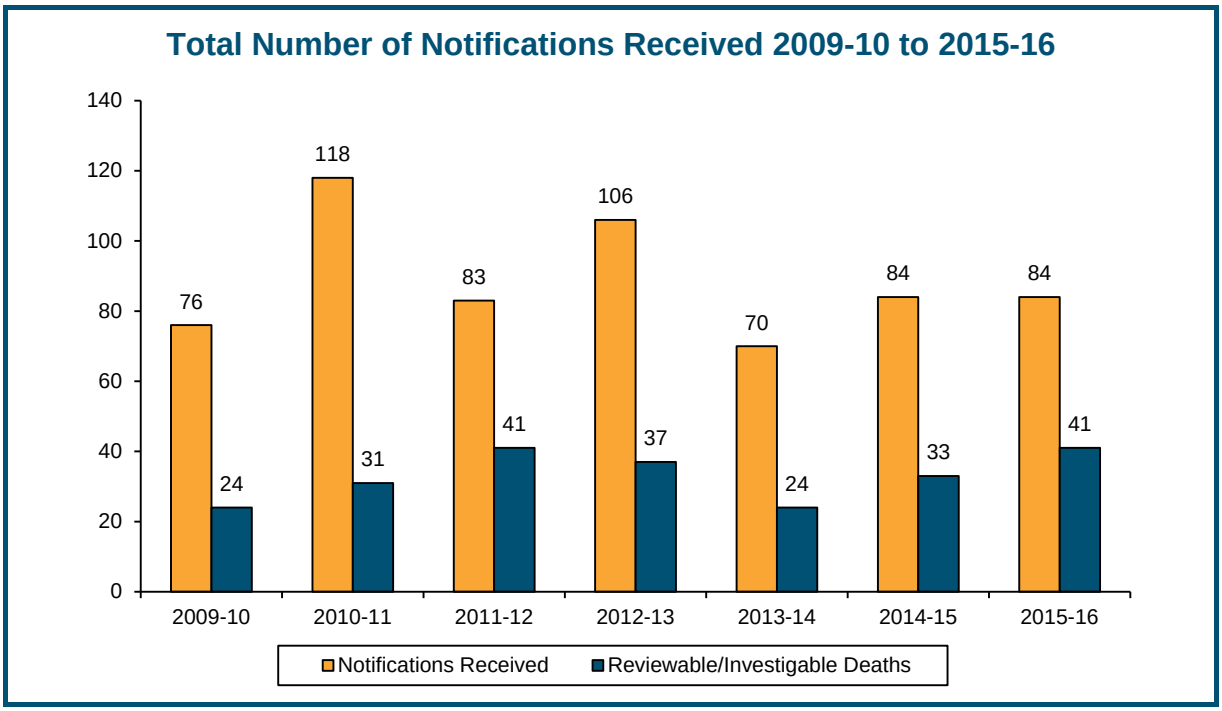
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

Child death review cases prior to 30 June 2009

At the commencement of the child death review jurisdiction on 30 June 2009, 73 cases were transferred to the Ombudsman from the CDRC. These cases related to child deaths prior to 30 June 2009 that were reviewable by the CDRC and covered a range of years from 2005 to 2009. Almost all (67 or 92%) of the transferred cases were finalised in 2009-10 and six cases were carried over. Three of these transferred cases were finalised during 2010-11 and the remaining three were finalised in 2011-12.

Number of child death notifications and reviews

During 2015-16, there were 41 child deaths that were investigable and subject to review from a total of 84 child death notifications received.



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 12 years from 2003-04 to 2014-15. 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 DCPFS.

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 DCPFS. It should be noted that children or their relatives may be known to DCPFS 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 DCPFS (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	199	118	60	31
2011-12	144	76	49	41
2012-13	189	121	62	37
2013-14	151	75	40	24
2014-15	157	93	48	33
2015-16	165	92	61	41

Abbreviations

DCPFS: Department for Child Protection and Family Support from 2012-13, Department for Child Protection for the years 2006-07 to 2011-12 and Department for Community Development (**DCD**) prior to 2006-07.

Notes

1. The data in Column A has been provided by the Registry of 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.
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. The data in Column C has been provided by DCPFS and is based on the date the notification was received by DCPFS. 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 DCPFS: 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. Since the commencement of the child death review function this has occurred on one occasion resulting in the 2009-10 number of investigable deaths being revised from 23 to 24.

Demographic information identified from child death reviews

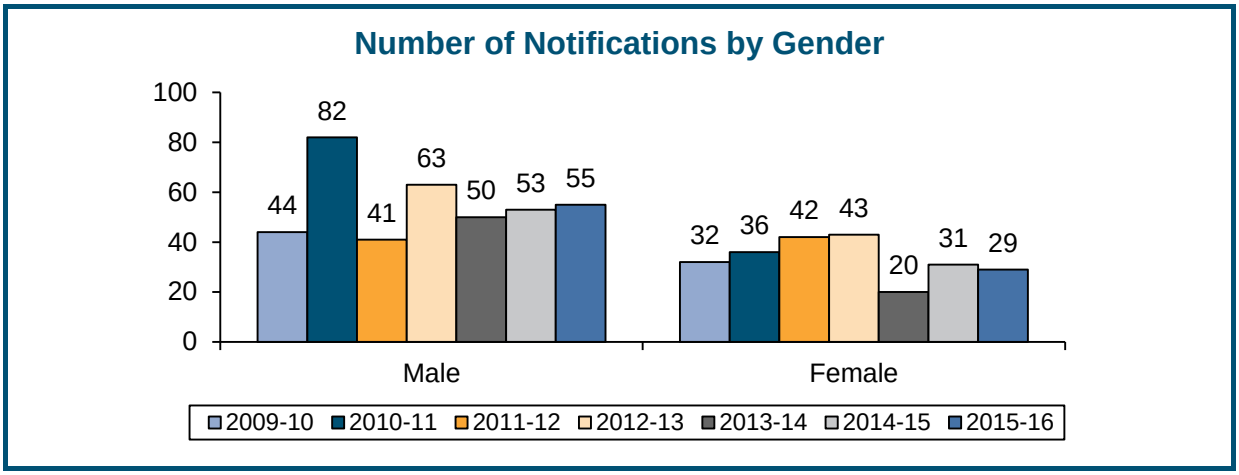
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

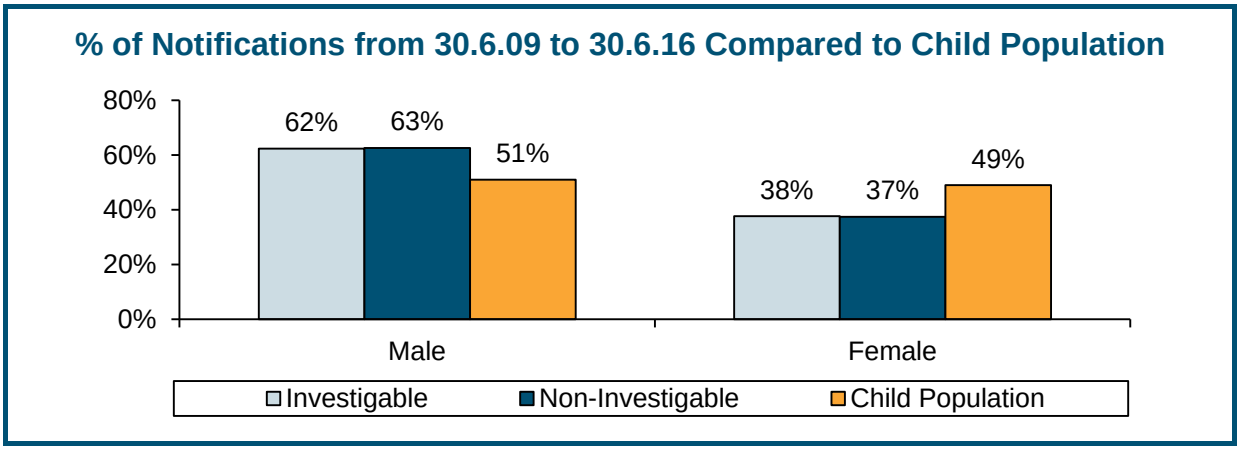
The following charts show:

- The number of children in each group for each year from 2009-10 to 2015-16; and
- For the period from 30 June 2009 to 30 June 2016, 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

As shown in the following charts, considering all seven years, male children are over-represented compared to the population for both investigable and non-investigable deaths.

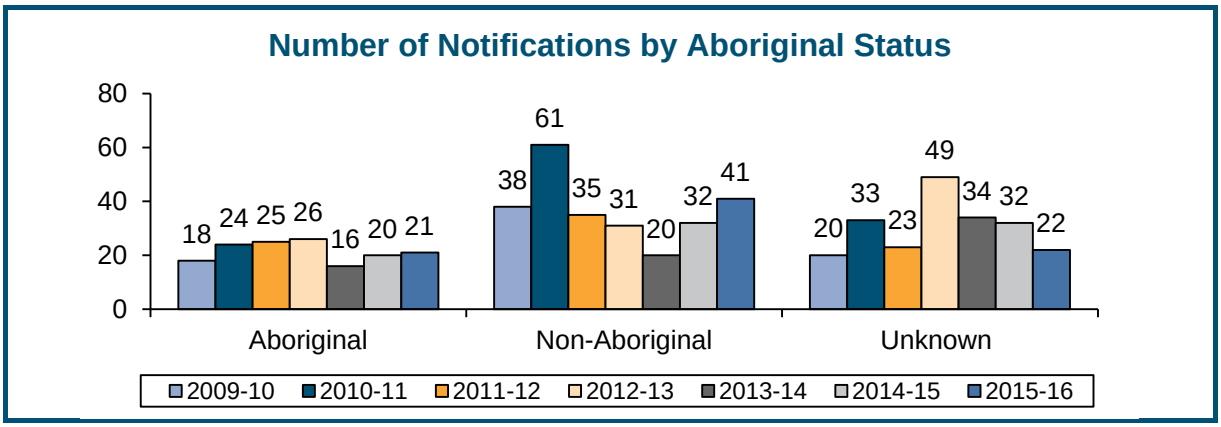


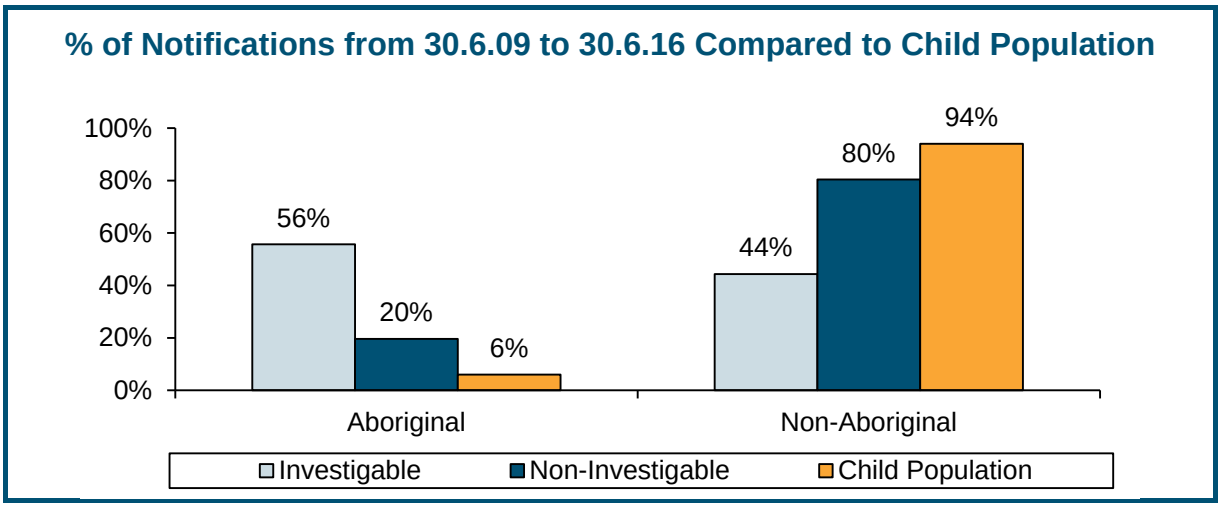


Further analysis of the data shows that, considering all seven years, male children are over-represented for all age groups, but particularly for children under the age of one and children aged between six and 12 years.

Aboriginal status

As shown in the following charts, Aboriginal children are over-represented compared to the population in all deaths and more so for investigable deaths.



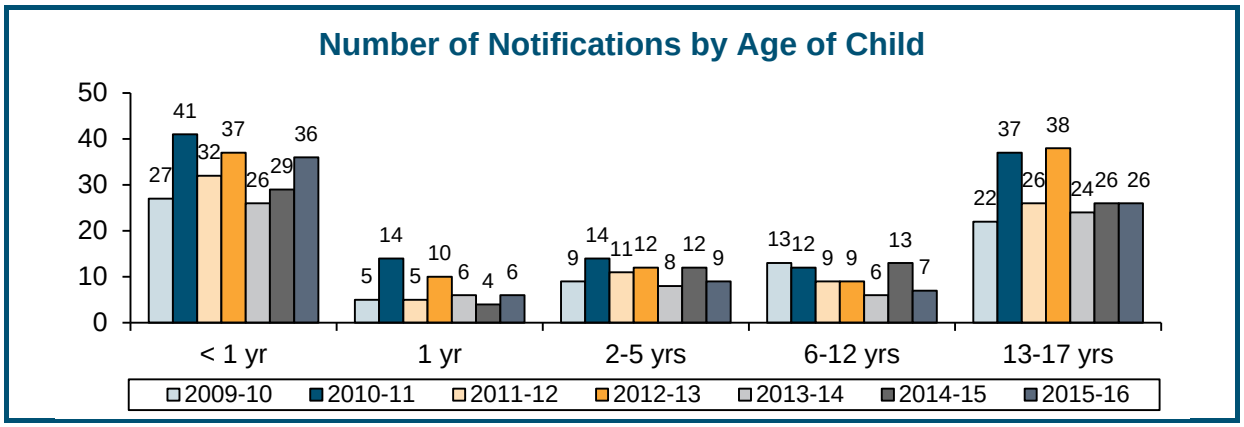


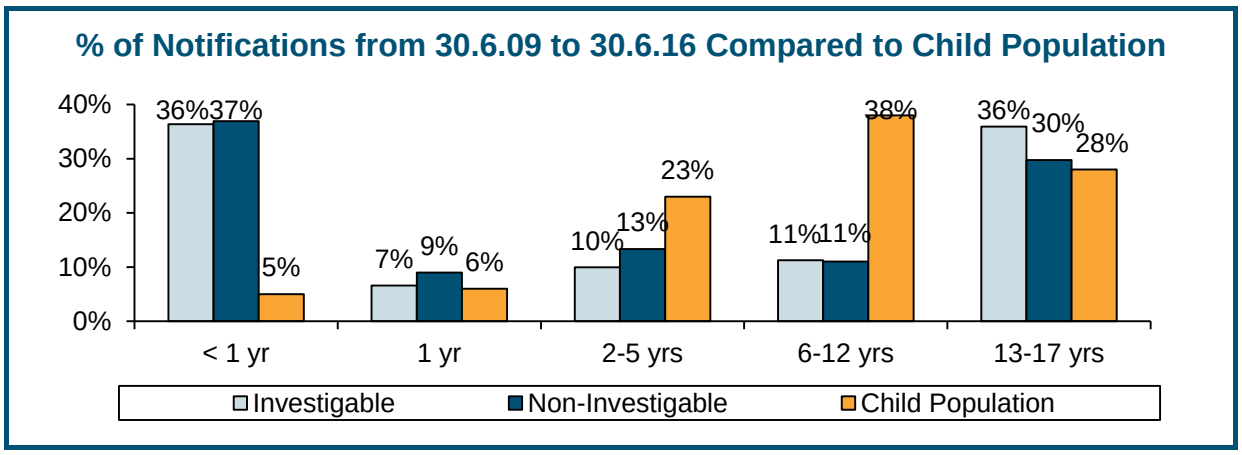
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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 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.

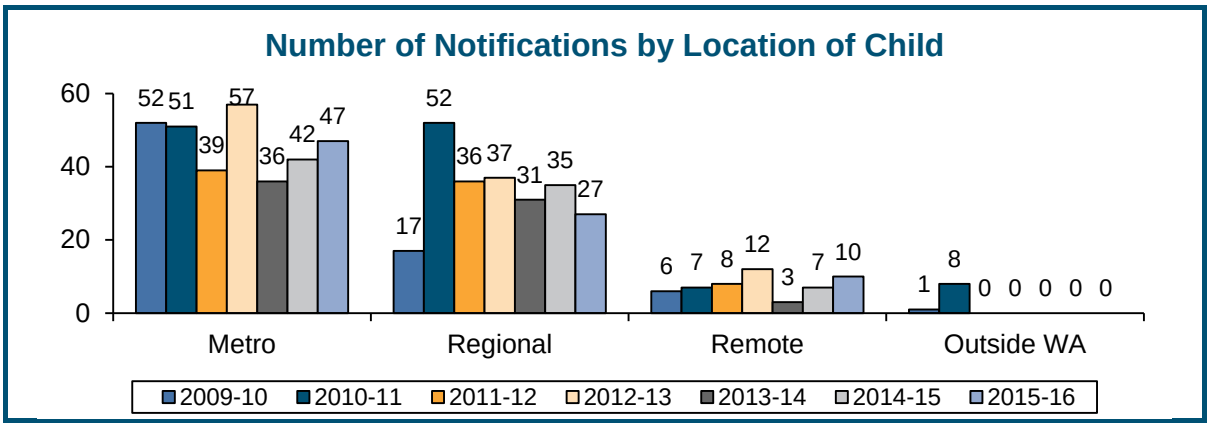




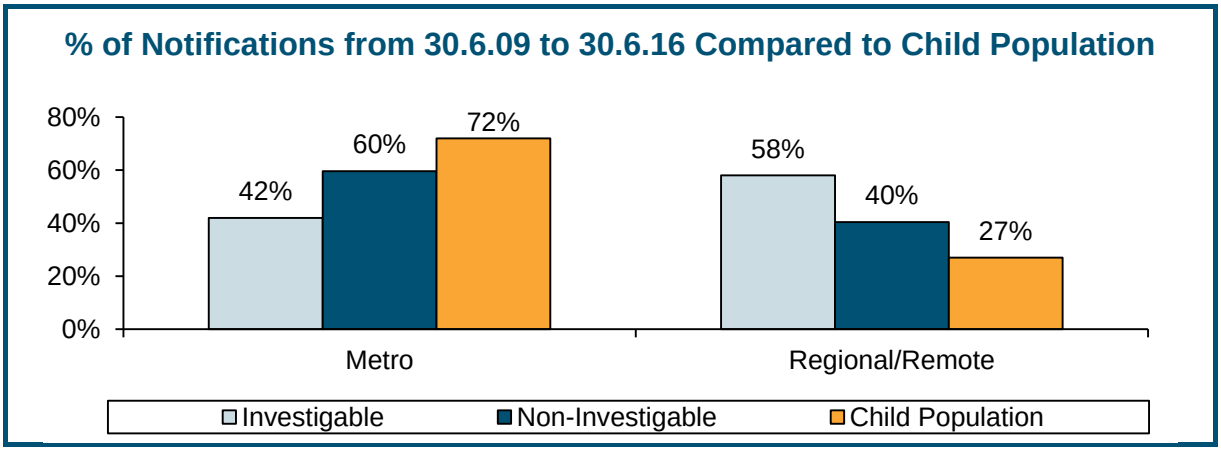
Further analysis of the data shows that Aboriginal children are more likely to be under the age of one than non-Aboriginal children. A more detailed analysis by age group is provided later in this section.

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: 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.



Further analysis of the data shows that 83% 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 is higher than would be expected based on the child population.

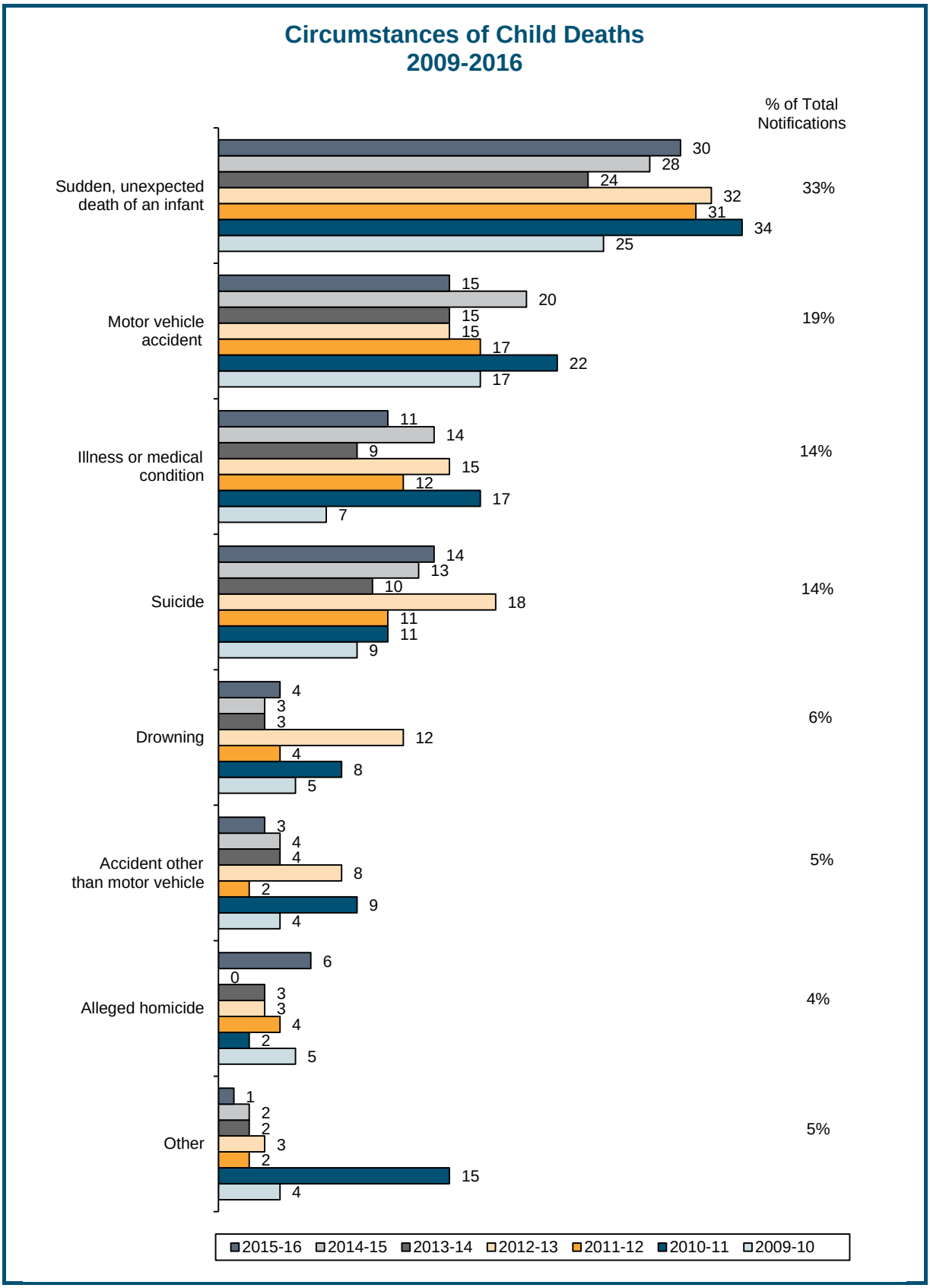
Circumstances in which child deaths have occurred

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 2016.



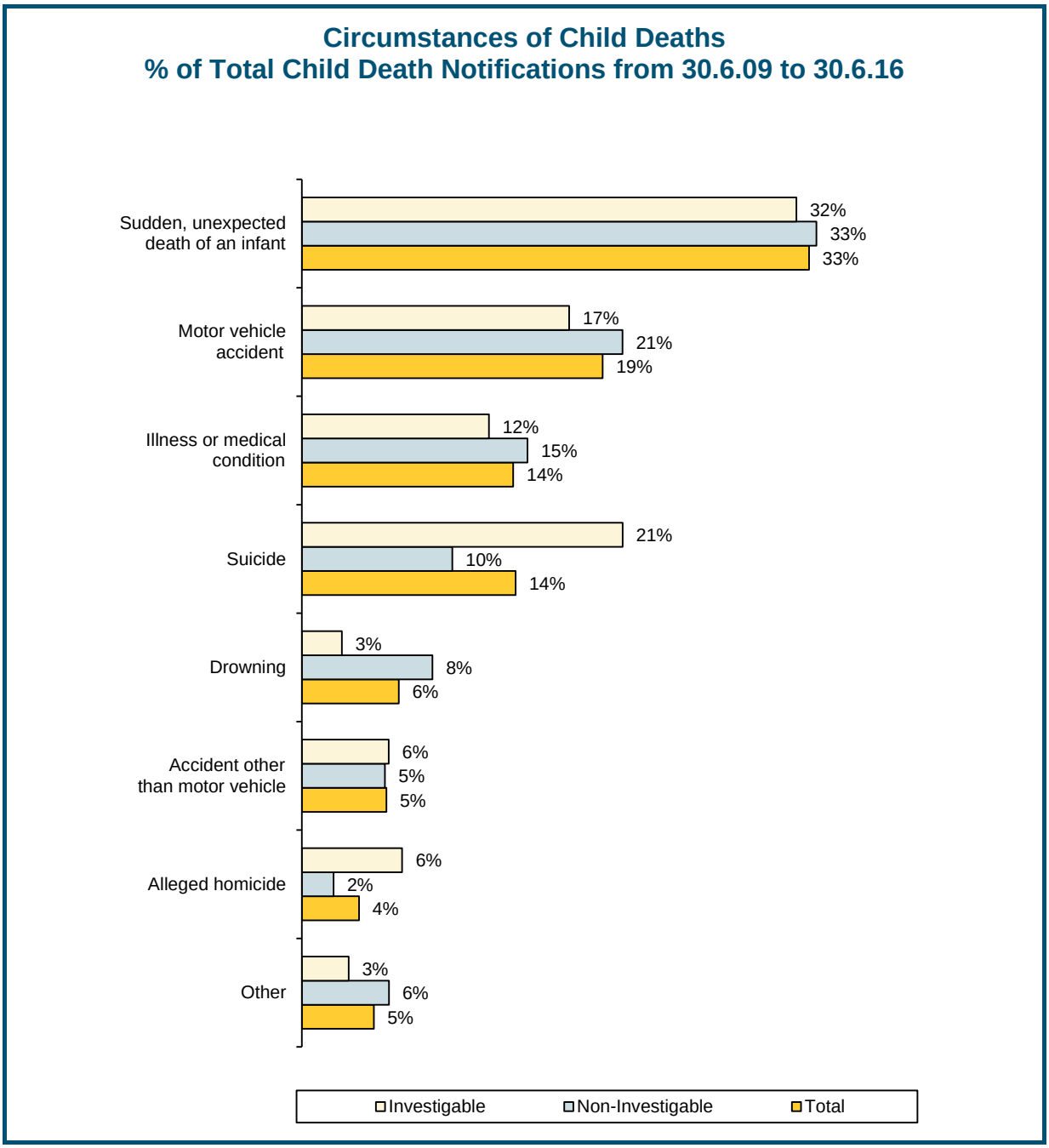
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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.

The two main circumstances of death for the 621 child death notifications received in the seven years from 30 June 2009 to 30 June 2016 are:

- Sudden, unexpected deaths of infants, representing 33% of the total child death notifications from 30 June 2009 to 30 June 2016 (33% of the child death notifications received in 2009-10, 29% in 2010-11, 37% in 2011-12, 30% in 2012-13, 34% in 2013-14, 33% in 2014-15 and 36% in 2015-16); and
- Motor vehicle accidents, representing 19% of the total child death notifications from 30 June 2009 to 30 June 2016 (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, and 18% in 2015-16).

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



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
- Accident other than motor vehicle.

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.

Child Death Review Committee up to 30 June 2009 – see Note 1

The figures on the circumstances of death for 2003-04 to 2008-09 relate to cases where the review was finalised by the CDRC during the financial year.

Year	Accident – Non-vehicle	Accident - Vehicle	Acquired Illness	Asphyxiation /Suffocation	Alleged Homicide (lawful or unlawful)	Immersion/ Drowning	SUDI *	Suicide	Other
2003-04	1	1	1	1	2	3	1		
2004-05		2	1	1	3	1	2		
2005-06	1	5			2	3	13		
2006-07	1	2	2				4	1	
2007-08	2	1			1	1	2	3	4
2008-09						1	6	1	

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

Ombudsman from 30 June 2009 – see Note 2

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 DCPFS. 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.

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			3	28	13	2
2015-16	3	15	11		6	4	30	14	1

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

Note 1: The source of the CDRC's data is the CDRC's Annual Reports for the relevant year. For 2007-08, only partial data is included in the Annual Report. The remainder of the data for 2007-08 and all data for 2008-09 has been obtained from the CDRC's records transferred to the Ombudsman. Types of circumstances are as used in the CDRC's Annual Reports.

Note 2: 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.

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 DCPFS or another public authority.

The following table shows the percentage of child death reviews associated with particular social and environmental factors for the period 30 June 2009 to 30 June 2016.

Social or Environmental Factor	% of Finalised Reviews from 30.6.09 to 30.6.16
Family and domestic violence	55%
Parenting	51%
Alcohol use	37%
Drug or substance use	33%
Homelessness	21%
Parental mental health issues	20%

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 nearly half of the cases;
  - Homelessness was a co-existing factor in nearly a third of the cases; and
  - Parental mental health issues were a co-existing factor in over a quarter 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 over three quarters of the cases;
  - Drug or substance use was a co-existing factor in over half of the cases; and
  - Homelessness was a co-existing factor in over a third of the cases.

Reasons for contact with DCPFS

In 2015-16, the majority of children who were known to DCPFS 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, access, fostering or adoption enquiries and homelessness.

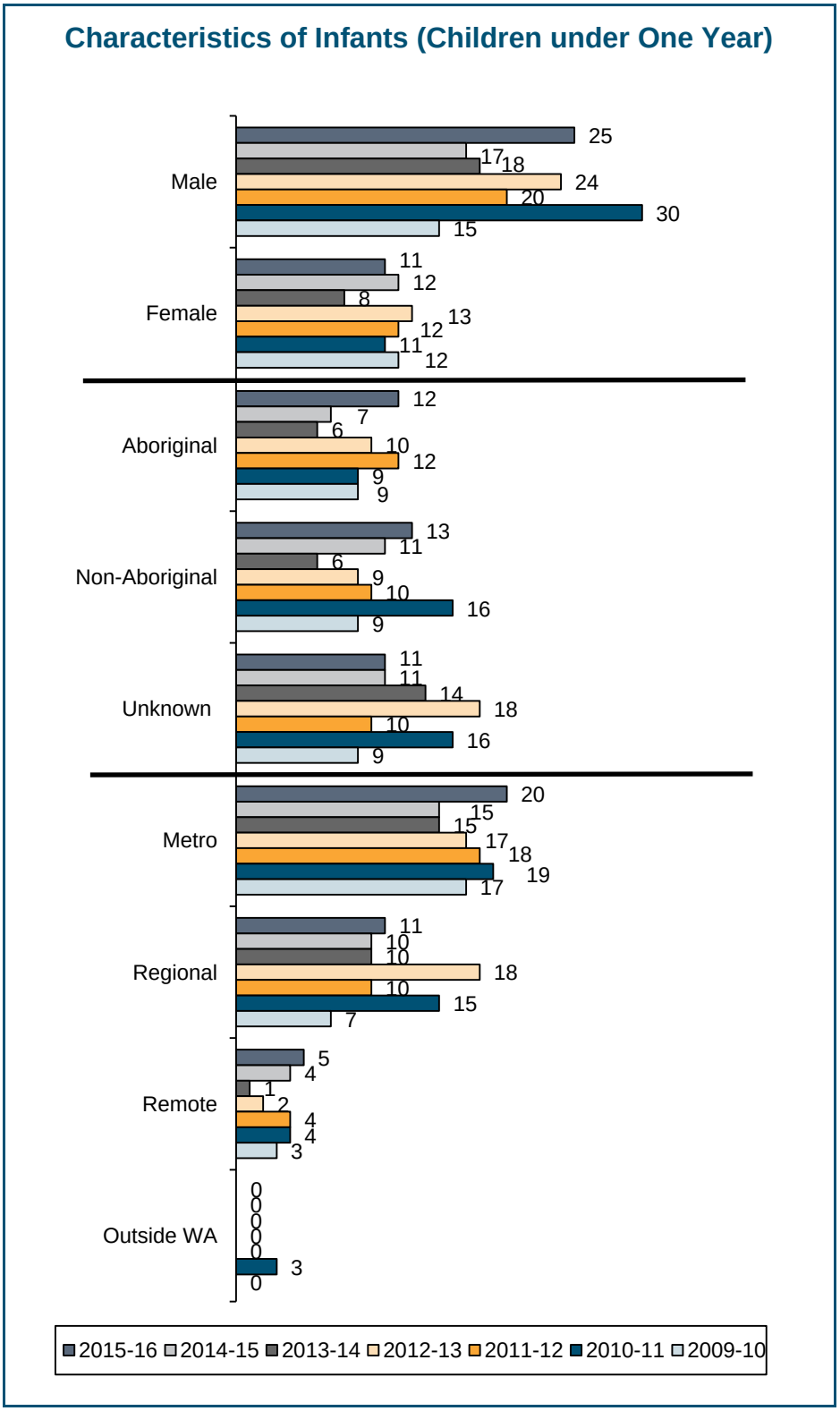
Analysis of children in particular age groups

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 621 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2016, there were 228 (37%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.

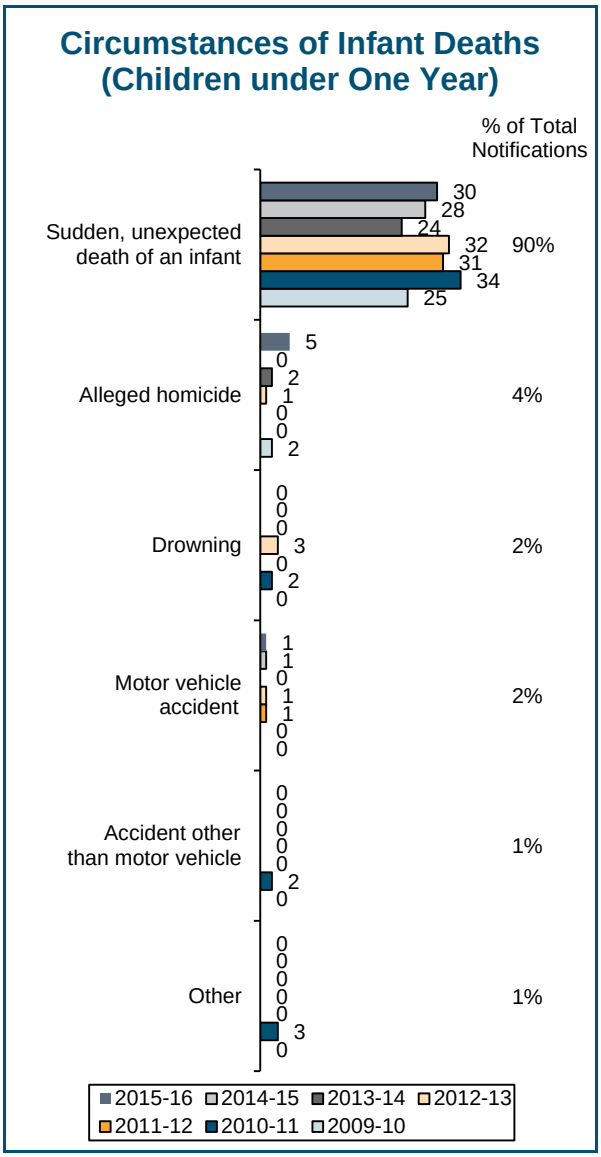


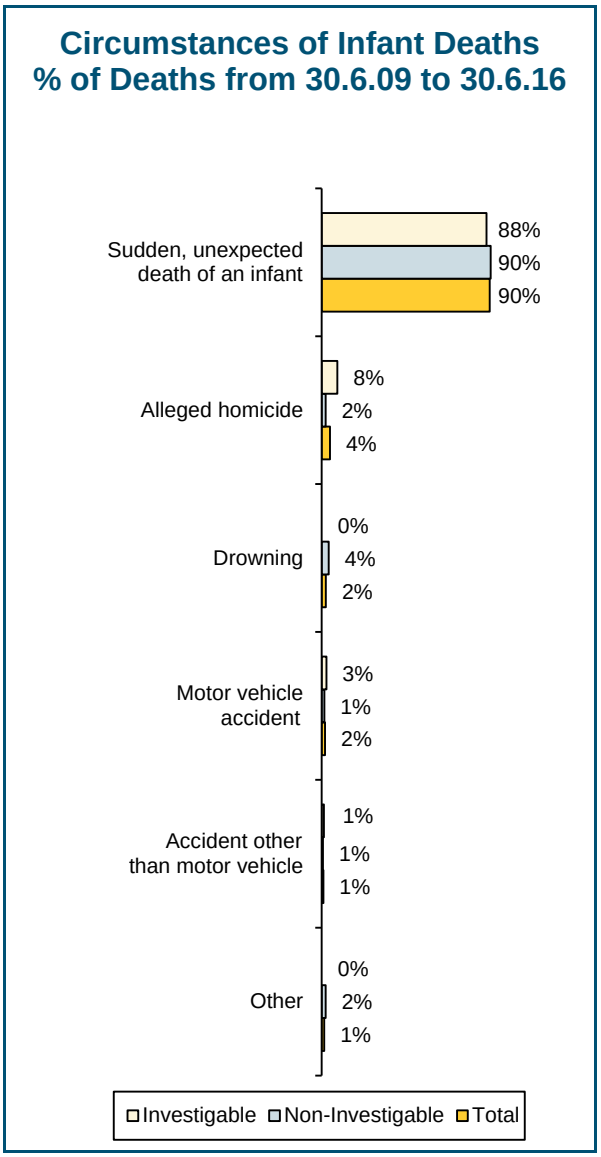
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 73% of investigable infant deaths and 61% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 65% of investigable deaths and 32% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 56% of investigable infant deaths and 40% of non-investigable deaths of infants, living in Western Australia, were children living in regional or remote locations compared to 27% in the child population.

An examination of the patterns and trends of the circumstances of infant deaths showed that of the 228 infant deaths, 204 (89%) were categorised as sudden, unexpected deaths of an infant and the majority of these (136) appear to have occurred while the infant had been placed for sleep. There were a small number of other deaths as shown in the following charts.





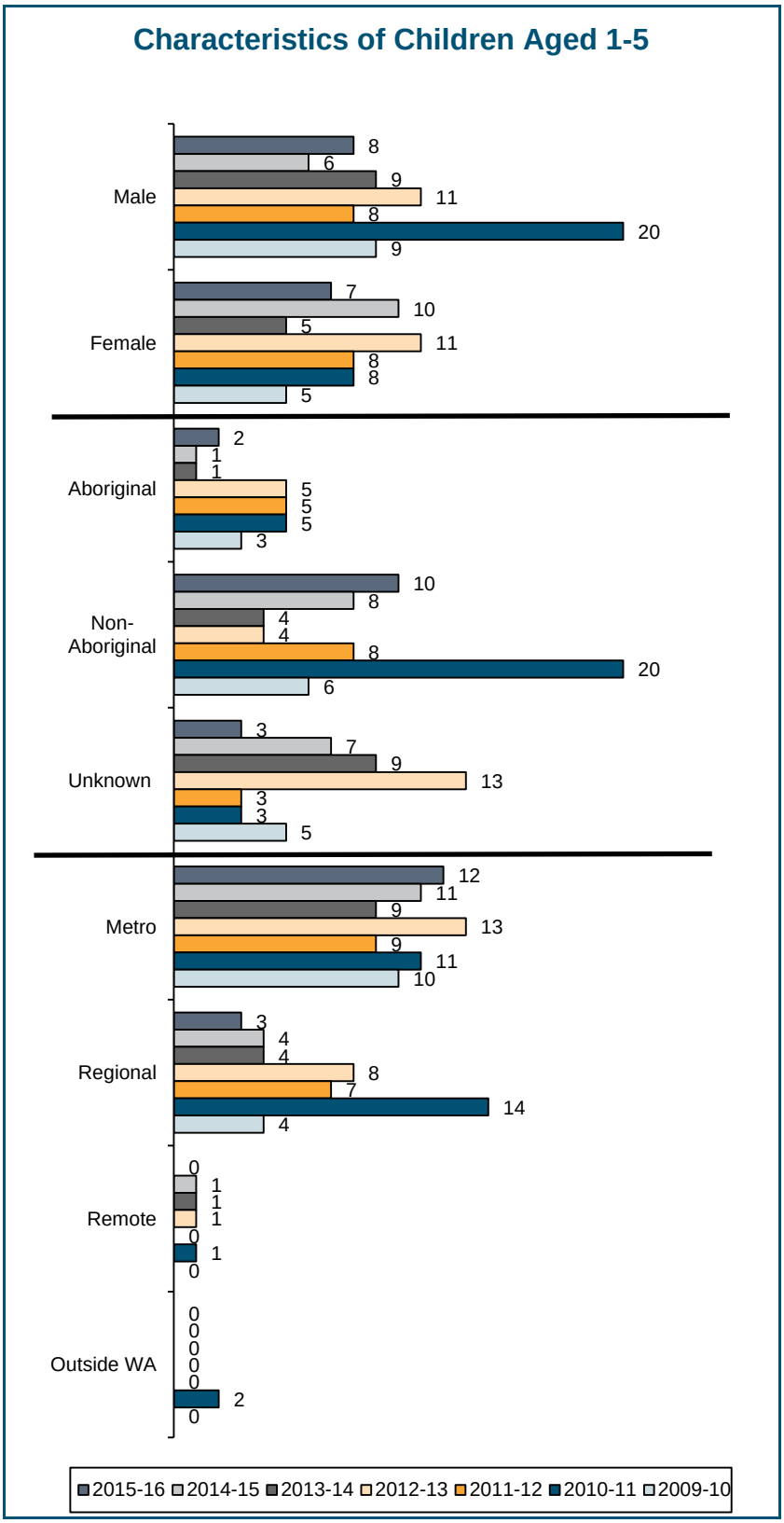
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Eighty four deaths of infants were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 621 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2016, there were 125 (20%) related to children aged from 1 to 5 years.

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

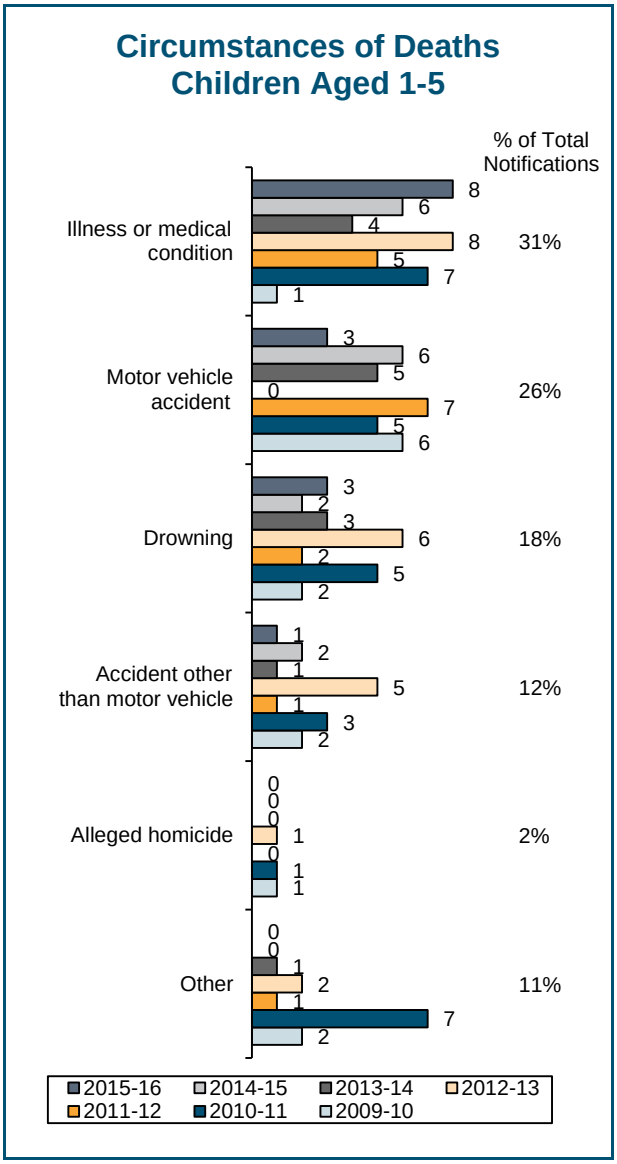


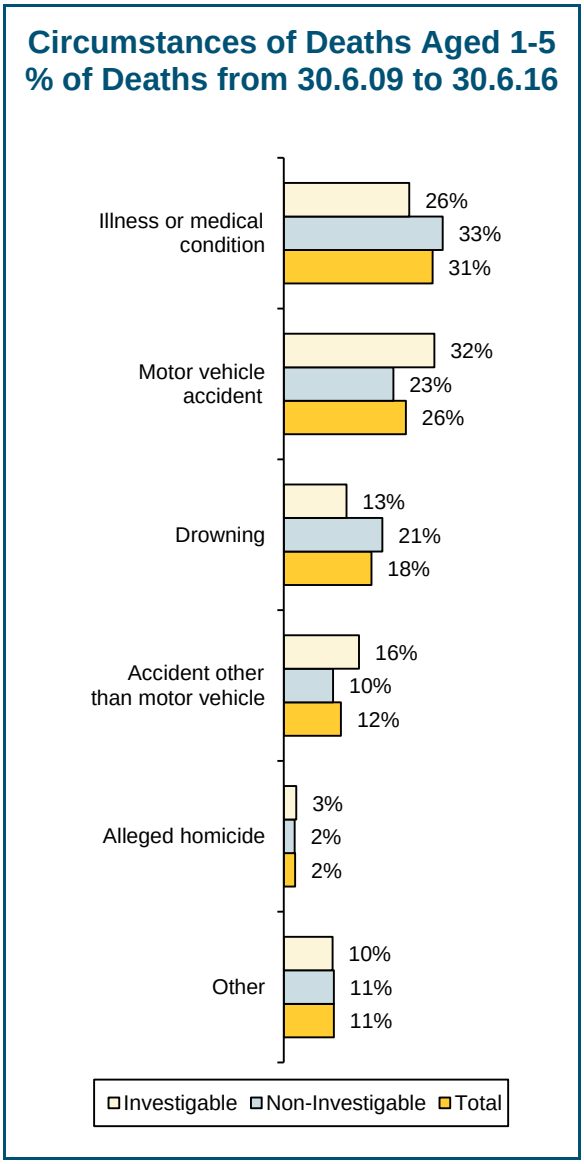
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 63% of investigable deaths and 54% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Aboriginal children – 50% of investigable deaths and 10% 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 37% of non-investigable deaths of children aged 1 to 5, living in Western Australia, were children living in regional or remote locations compared to 27% 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 (31%), followed by motor vehicle accidents (26%) and drowning (18%).





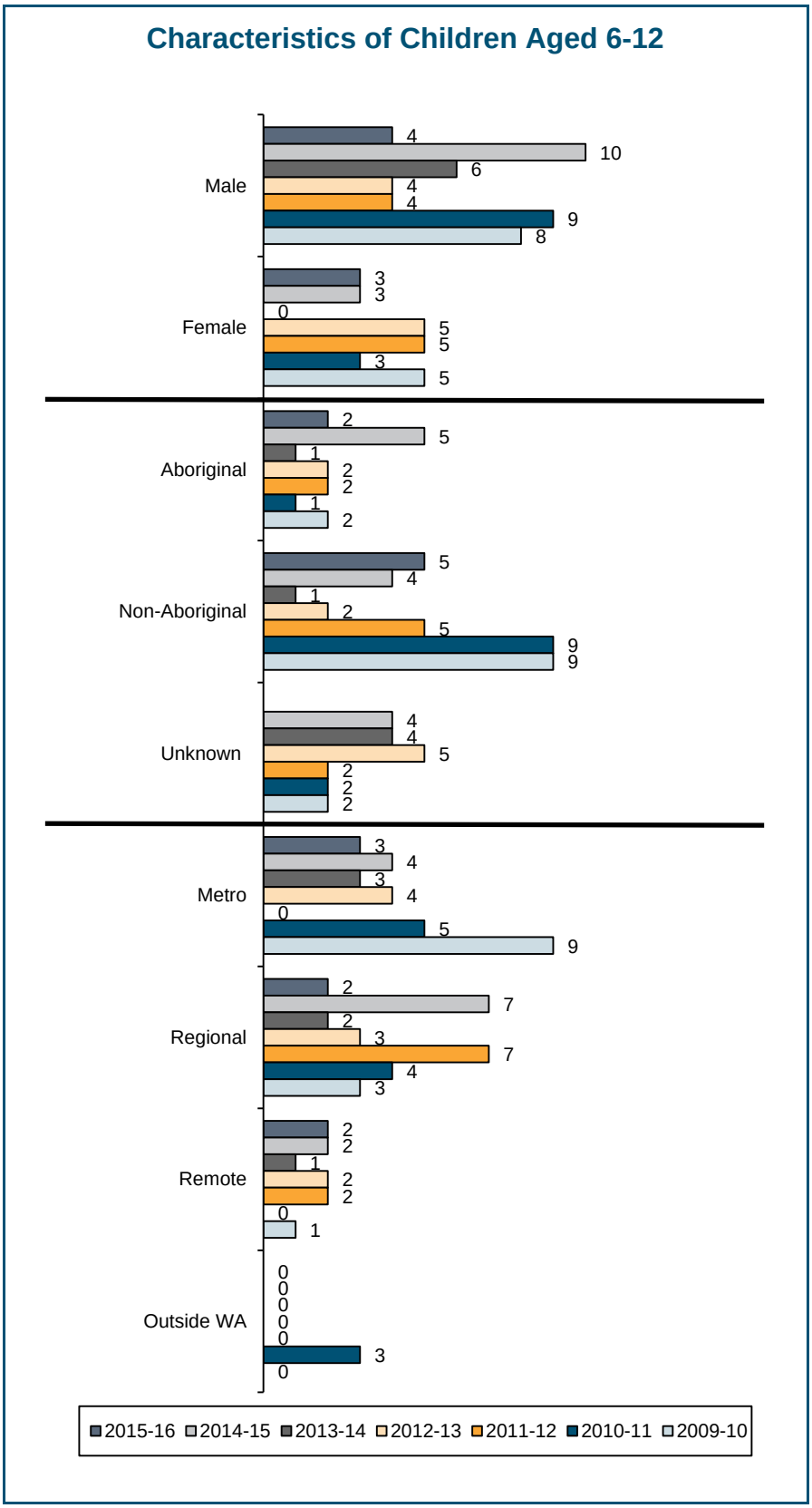
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Thirty eight deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of children aged 6 to 12 years

Of the 621 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2016, there were 69 (11%) related to children aged from 6 to 12 years.

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

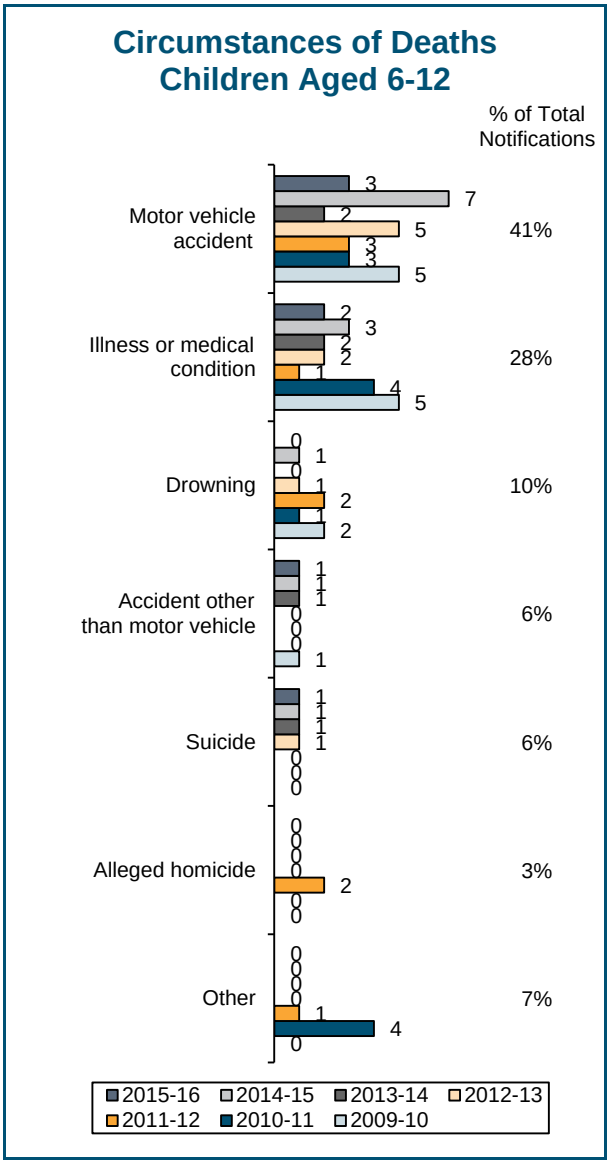


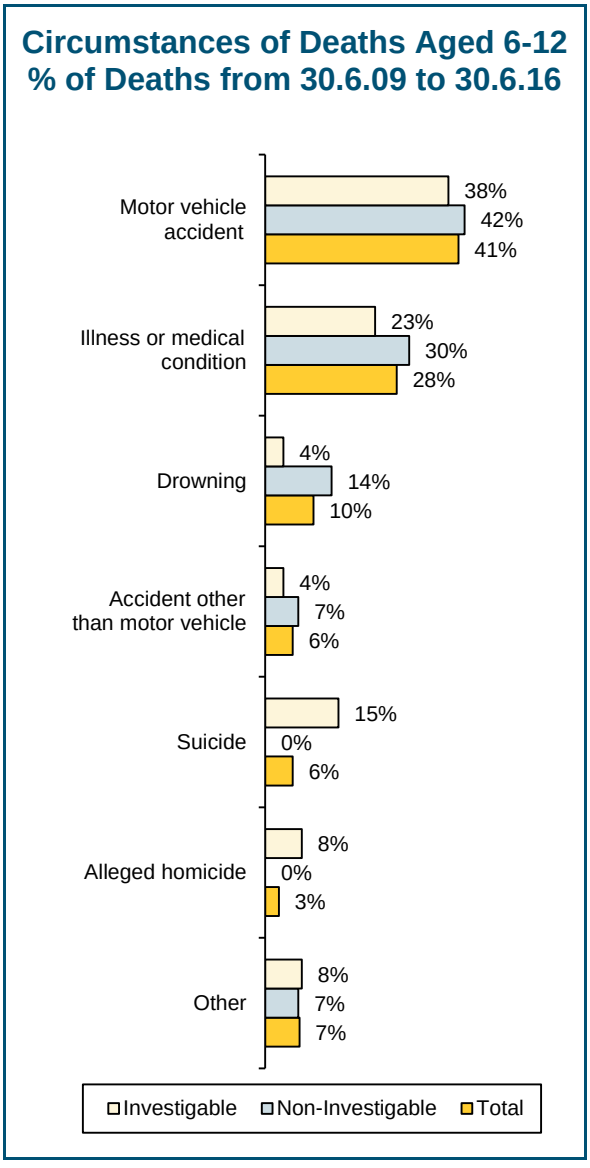
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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 72% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population;
- Aboriginal children – 50% of investigable deaths and 12% 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 – 73% of investigable deaths and 44% of non-investigable deaths of children aged 6 to 12, living in Western Australia, were children living in regional or remote locations compared to 27% in the child population.

As shown in the following chart, motor vehicle accidents are the most common circumstance of death for this age group (41%), followed by illness or medical condition (28%) and drowning (10%).





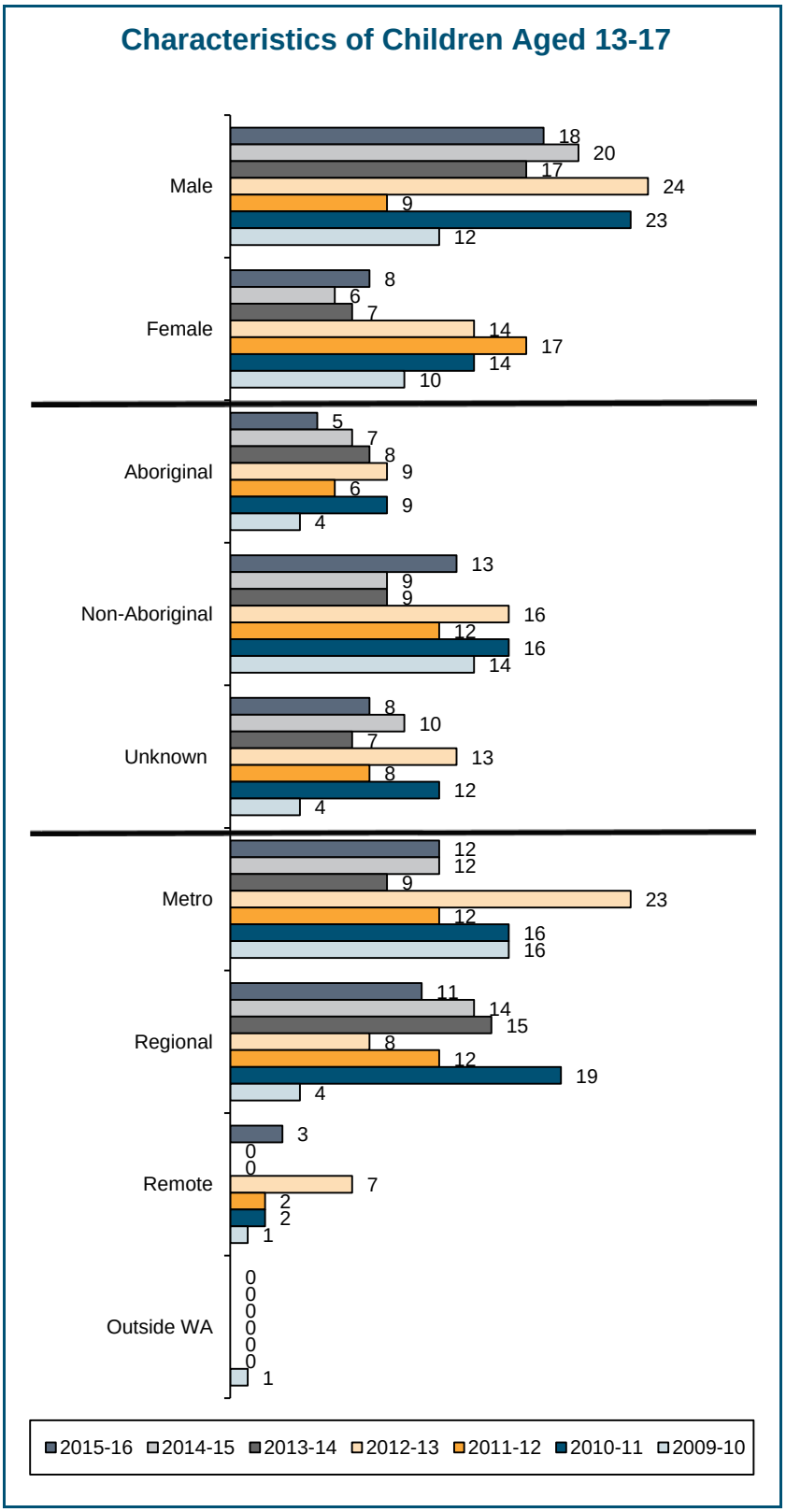
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Twenty six deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of children aged 13 – 17 years

Of the 621 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2016, there were 199 (32%) related to children aged from 13 to 17 years.

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

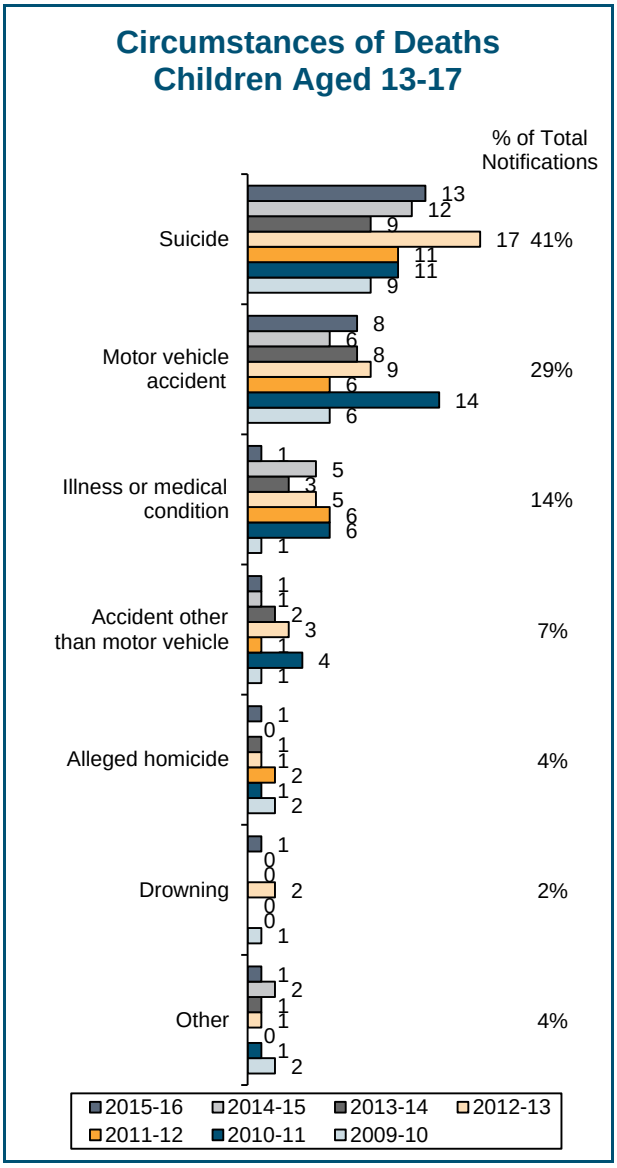


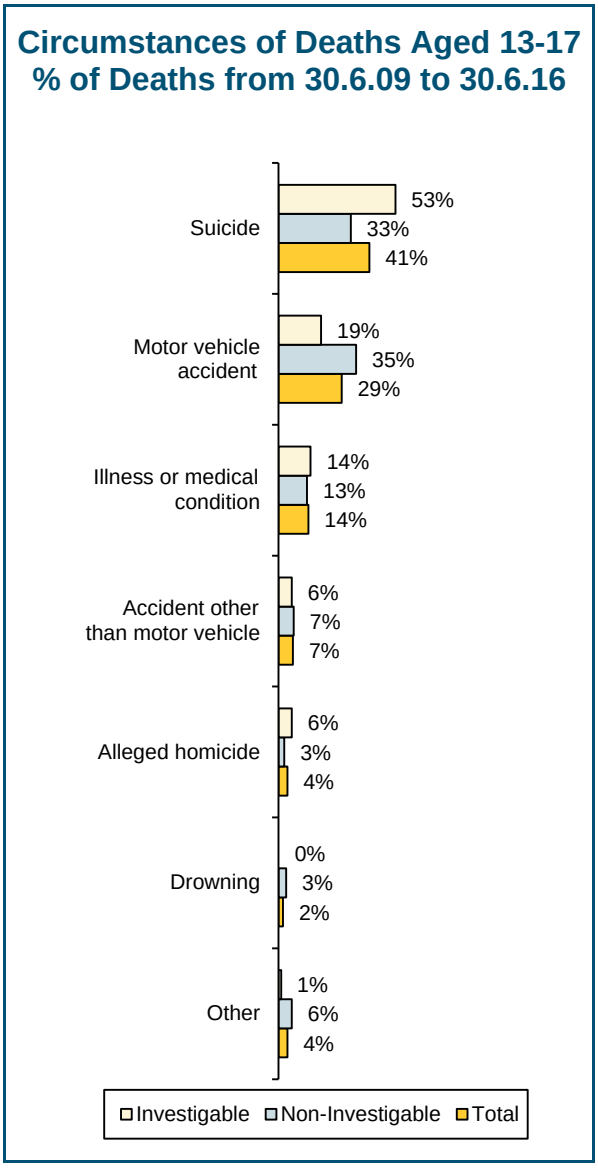
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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 67% of non-investigable deaths of children aged 13 to 17 were male compared to 51% in the child population;
- Aboriginal children – 52% of investigable deaths and 16% 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 – 61% of investigable deaths and 41% of non-investigable deaths of children aged 13 to 17, living in Western Australia, were living in regional or remote locations compared to 27% in the child population.

As shown in the following chart, suicide is the most common circumstance of death for this age group (41%), particularly for investigable deaths, followed by motor vehicle accidents (29%) and illness or medical condition (14%).





Note: 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.

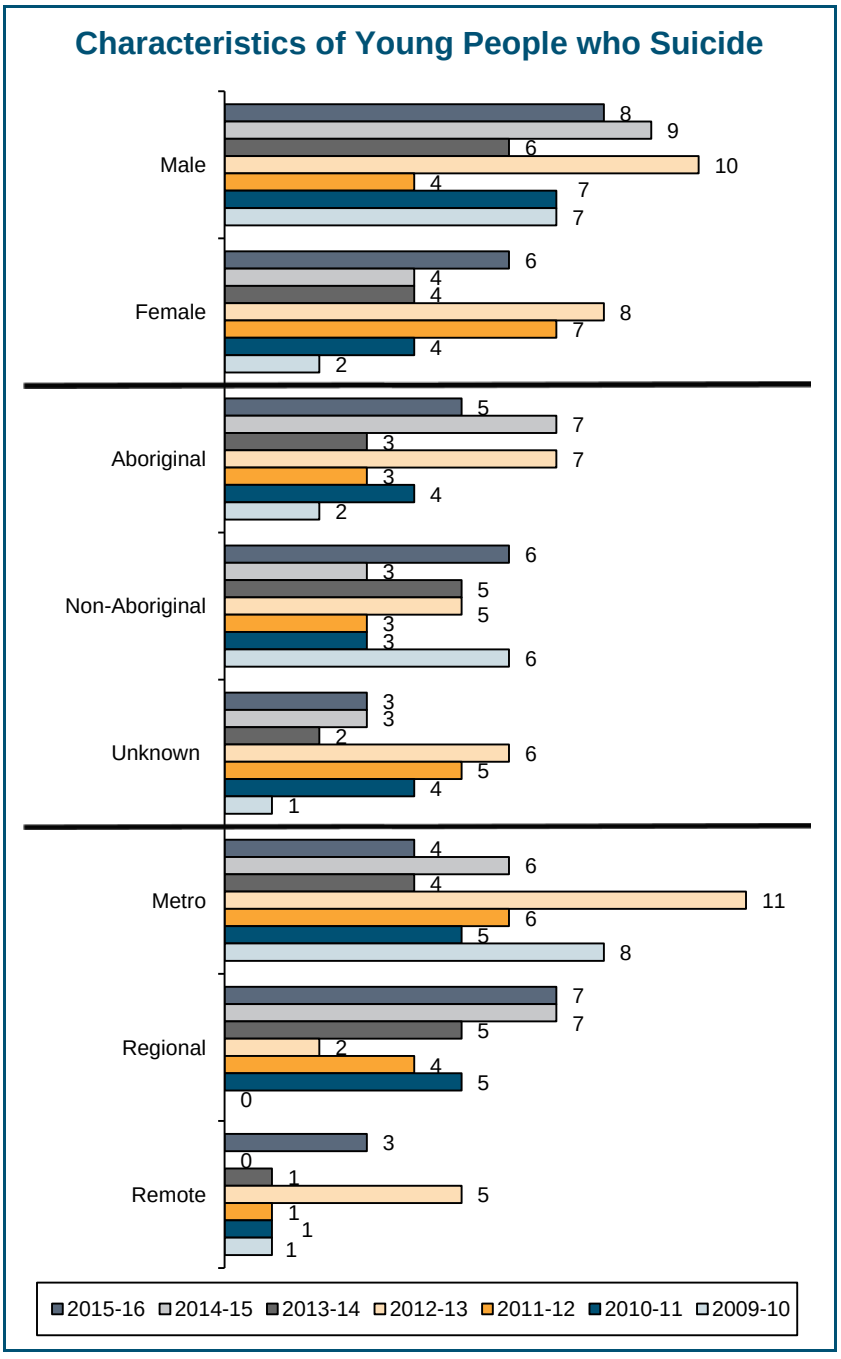
Eighty three deaths of children aged 13 to 17 years were determined to be investigable deaths.

Suicide by young people

Of the 86 young people who apparently took their own lives from 30 June 2009 to 30 June 2016:

- Four were under 13 years old;
- Four were 13 years old;
- Nine were 14 years old;
- Twenty were 15 years old;
- Twenty were 16 years old; and
- Twenty nine were 17 years old.

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



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

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

- Males – 52% of investigable deaths and 68% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 62 apparent suicides by young people where information on the Aboriginal status of the young person was available, 67% of the investigable deaths and 15% 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 65% of investigable suicides by young people and 29% of non-investigable suicides by young people were young people who were living in regional or remote locations compared to 27% in the child population.

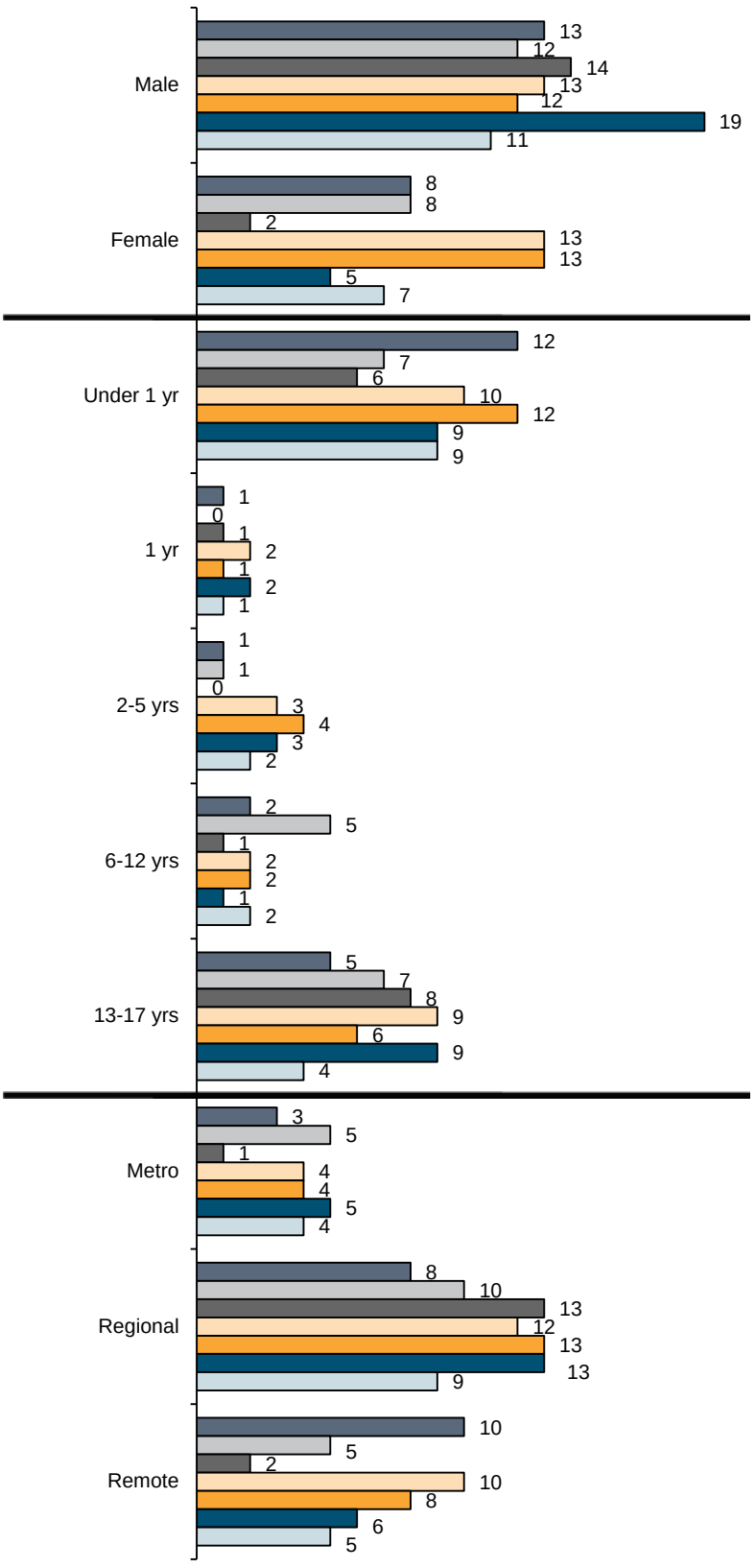
Deaths of Aboriginal children

Of the 408 child death notifications received from 30 June 2009 to 30 June 2016, where the Aboriginal status of the child was known, 150 (37%) of the children were identified as Aboriginal.

For the notifications received, the following chart demonstrates:

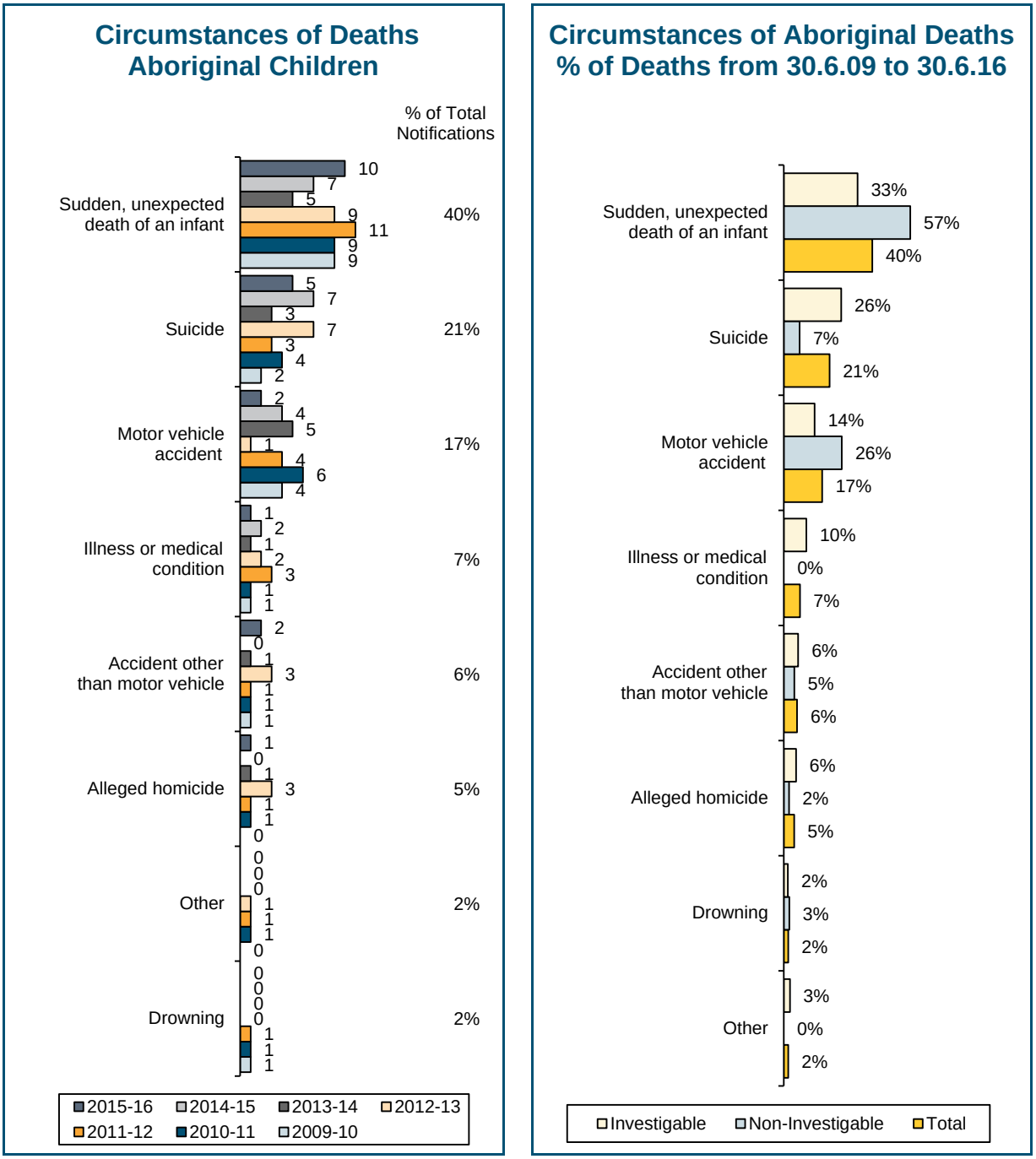
- Over the seven year period from 30 June 2009 to 30 June 2016, the majority of Aboriginal children who died were male (63%). For 2015-16, 62% of Aboriginal children who died were male;
- Most of the Aboriginal children who died were under the age of one or aged 13-17; and
- The deaths of Aboriginal children living in regional communities far outnumber the deaths of Aboriginal children living in the metropolitan area. Over the seven year period, 83% of Aboriginal children who died lived in regional or remote communities.

Characteristics of Aboriginal Children who Died



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

As shown in the following chart, sudden, unexpected deaths of infants (40%), suicide (21%), and motor vehicle accidents (17%) are the largest circumstance of death categories for the 150 Aboriginal child death notifications received in the seven years from 30 June 2009 to 30 June 2016.



Note: 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.

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 (**DOH**) 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 DOH 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

Infant A

Infant A died at the age of three weeks in the circumstance of co-sleeping. Prior to Infant A's birth, concerns were reported to DCPFS relating to alleged family and domestic violence and alleged parental illicit drug and alcohol use. DCPFS also became aware that Infant A's mother smoked. DCPFS worked with Infant A's parents to undertake a Safety and Wellbeing Assessment and to develop a safety plan for Infant A who was then discharged to home after birth.

DCPFS's *Casework Practice Manual Chapter 3.2 Safe Infant Sleeping* (**the Manual**) identifies that there is an increased risk of sleep-related infant death when co-sleeping occurs with a parent/carer who has consumed alcohol or used illicit drugs, taken medication which may alter consciousness or cause drowsiness, or is a smoker. The Manual directs that where these risk factors are identified, child protection workers must, in the first four weeks of the infant's life, provide the parents/carers with information on the risks of co-sleeping. However, there had been a missed opportunity to visit Infant A at home to assess the sleep arrangements and discuss the increased risk of sleep-related infant death when co-sleeping, in the context of the concerns relating to the parents' alleged illicit drug and alcohol use, and that Infant A's mother smoked.

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).

Major Own Motion Investigation

Through the undertaking of child death reviews, including the prevalence of drowning as a circumstance of death for children under one year of age and children between one and five years of age, the Office identified a need to commence a major own motion investigation into ways to prevent or reduce child deaths by drowning. In 2015-16, the Office undertook significant work on this major own motion investigation. The report of this major own motion investigation will be tabled in Parliament in 2016-17.

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 DCPFS, the DOH and the Department of Education (**DOE**) in care planning is necessary to ensure the child's health and education needs are met.

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 DOH and the 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 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 2015-16, the Ombudsman received three notifications of the deaths of children aged six to 12 years in the circumstances of motor vehicle accidents. All of these deaths occurred in regional Western Australia.

The Road Safety Commission's Fact Sheet *Seat Belts* (available at www.rsc.wa.gov.au/) states that:

> *Drivers and passengers travelling unrestrained in a car are at least 10 times more likely to be killed in a road crash than those wearing a seat belt.*
>
> *Wearing a seat belt may reduce the chance of being killed in a road accident by up to 50%.*
>
> *…In rural areas 14% of those [killed or seriously injured] were unrestrained, compared to 5% of those [killed or seriously injured] in the Metropolitan area* (page 1).

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 third related to children aged 13 to 17 years old. Of these children, suicide was the most common circumstance of death, accounting for over 40% 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 report made 22 recommendations about ways to prevent or reduce suicide by young people, all of which were accepted by the agencies involved.

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

Identification of good practice

Child death reviews may identify examples of good practice by agencies as shown in the following case study.

Case Study

Child B

Child B was born with complex health care needs. While attending primary school, Child B received support from the school (DOE), the school nurse (DOH), the hospital medical team (DOH) and the Disability Services Commission (**DSC**) Local Area Coordinator. Support for this child was discussed at an inter-agency meeting and a decision was made to make a referral to DCPFS for assessment and support. While DCPFS assessed these concerns and developed a safety plan, DOE, DOH and DSC continued to work collaboratively to support Child B and the child's family.

Child B subsequently died due to his medical condition.

The Ombudsman's review of this case identified good practice related to inter-agency collaboration and support to Child B and the child's family.

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 inter-agency communication to enable effective case management and collaborative responses.
- Not adequately meeting policies and procedures relating to case allocation.
- Not including sufficient cultural consideration in child protection assessment, planning and intervention.
- Not adequately meeting policies and procedures relating to Safety and Wellbeing Assessments.
- Not adequately meeting policies and procedures relating to the Signs of Safety Framework.
- Not adequately meeting policies and procedures in relation to pre-birth planning.

- Missed opportunities to promote infant safe sleeping by providing appropriate information, including risks of co-sleeping associated with parental alcohol use and/or drug use.
- Not adequately meeting policies and procedures in relation to family and domestic violence.
- Not adequately meeting policies and procedures in relation to the assessment of parental drug and alcohol use.
- Missed opportunities to recognise and respond to child and adolescent drug and alcohol use.
- Missed opportunities to recognise poor school attendance as a cumulative indicator of child safety and wellbeing concerns.
- Not undertaking sufficient inter-agency communication to enable effective case management and collaborative responses to students whose whereabouts are unknown.
- Not adequately meeting policies and procedures in relation to student attendance and behaviour management.
- Missed opportunity to provide information relating to pool fencing requirements.
- Not meeting recordkeeping requirements.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce child deaths. The following recommendations were made by the Ombudsman in 2015-16 arising from child death reviews (certain recommendations may be de-identified to ensure confidentiality).

- That DCPFS takes all reasonable steps to achieve timely compliance with the Department's assessment policies and practice requirements in implementing and monitoring safety planning to promote the wellbeing of an unborn child/infant.
- That DCPFS undertakes a home visit, where appropriate and possible, to assess infant sleeping arrangements and provide parents with safe infant sleeping information, in accordance with the Department's Casework Practice Manual, *Chapter 3.2 Safe Infant Sleeping*, when working with parents who smoke tobacco or are alleged to have a history of alcohol or drug abuse or illegal drug use is alleged to be occurring currently.
- That DCPFS considers, in accordance with the definition of 'at risk' youth as outlined in the *At Risk Youth Strategy 2015-2018*, the development of guidelines to recognise alleged alcohol and drug use by children and adolescents as an indicator of cumulative safety and wellbeing concerns warranting assessment and action where appropriate.
- That DCPFS takes all reasonable steps to recognise where poor school attendance may be a cumulative indicator of child safety and wellbeing concerns.

- That DCPFS continues to improve interagency communication and collaboration associated with the management of the DOE's *Students Whose Whereabouts is Unknown list* (**SWU List**) in the context of child safety and wellbeing concerns.
- That the DOE review of the *Child Protection* policy includes consideration of poor school attendance as a cumulative indicator of safety and wellbeing concerns warranting consideration of consultation with and/or referral to DCPFS.
- That DOE takes all reasonable steps to achieve compliance with the *Student Attendance* policy and *Case management of persistent absences* policy.
- That DOE takes all reasonable steps to ensure that, prior to placing a student on the SWU List, child safety and wellbeing concerns are recognised, responded to and relevant interagency communication and collaboration occurs.
- That DOH considers the development of procedural guidelines for assessing and responding to the safety and wellbeing of children and adolescents presenting to health services where alcohol and drug use issues have been identified.
- That DOH continues to work with DOE to develop opportunities for interagency communication and collaboration to identify children on the SWU List.
- That DCPFS, in consultation with the Department's Aboriginal Engagement and Coordination Directorate, undertakes a review of this case to determine whether any additional action is required in the Regional District to facilitate culturally informed assessment, planning and intervention when working with Aboriginal families.
- That DCPFS considers the appropriateness of any further strategies and actions and their implementation for the Regional District, which considers the challenges in undertaking pre-birth planning in remote communities and engages with Aboriginal health service providers in the Regional District, to ensure the requirements of DOH's *Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby is Identified as at Risk of Abuse and/or Neglect (2014)* can be implemented across the Regional District.
- That DCPFS takes all reasonable steps to ensure that engagement with families is not focussed on 'single events' but adopts a 'holistic' child-centred approach to assessments of child safety and wellbeing concerns.
- That DCPFS takes all reasonable steps to achieve compliance with the administration of Safety and Wellbeing Assessments and use of the *Signs of Safety Child Protection Framework* when investigating allegations of neglect and assessing whether a child and/or unborn child is in need of protection within the meaning of sections 28 and 33A of the *Children and Community Services Act 2004*.
- That DCPFS takes all reasonable steps to achieve compliance with the administration of Safety and Wellbeing Assessments and use of *the Signs of Safety Child Protection Framework* when investigating allegations of physical abuse and assessing whether a child is in need of protection within the meaning of section 28 of the *Children and Community Services Act 2004*.

- That DCPFS considers, where appropriate, the provision of interim support to Districts where it is identified that workload management issues are preventing the management and allocation of cases on the Monitored List.
- That DOE takes all reasonable steps to achieve compliance with the development and implementation of documented attendance, behaviour management and education plans in accordance with procedural requirements included in the *Student Attendance* policy, *Behaviour Management in Schools* policy and *Documented Plans. Supporting Education for All. Guidelines for Implementing Documented Plans in Public Schools* policy.
- That DOE takes all reasonable steps to achieve compliance with the relevant guidelines related to attendance, learning, behaviour management and continuity of service provision.
- That DOE considers the development of guidelines and staff education related to recognising and responding to alleged drug and alcohol use by children as an indicator of cumulative harm associated with potential abuse and or/neglect warranting consultation with and/or referral to DCPFS.

The Ombudsman will actively monitor what steps have been taken to give effect to these recommendations. The results of this monitoring will be reported in the 2016-17 Annual Report.

Further improvements in public administration arising from Ombudsman's reviews

During the investigations of child death reviews, public authorities may, and do, voluntarily undertake to make improvements to public administration. The following is a summary of the voluntary actions by public authorities in 2015-16 arising from child death reviews (certain improvements may be de-identified to ensure strict confidentiality of the Ombudsman's review process).

- Improve communication with, and education to, pool owners and builders about legislated pool fencing requirements.
- Improve building permit approval processes to increase compliance with legislated pool fencing requirements.
- Improve communication with, and education to, parents of infants on Safe Infant Sleeping practices and risks associated with sleep-related infant deaths.
- Improve guidance and training for staff to promote compliance with Safe Infant Sleeping policy requirements.
- Improve policy compliance to promote school participation.

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 2015-16, timely review processes have resulted in nearly three-quarters 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. In 2015-16, the Office undertook significant work on a major own motion investigation into ways to prevent or reduce child deaths by drowning. The report of this major own motion investigation will be tabled in Parliament in 2016-17.

The Office also actively monitors the implementation of recommendations from completed 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; and
- *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.

Details of own motion investigations are provided in the Own Motion Investigations and Administrative 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 the Ombudsman's Advisory Panel (**the Panel**), and other mechanisms, 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; and
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of child deaths.

Stakeholder Liaison

The Department for Child Protection and Family Support

Efficient and effective liaison has been established with DCPFS to support the child death review process and objectives. Regular liaison occurs between the Ombudsman and the Director General of DCPFS, together with regular liaison at senior executive level, to discuss issues raised in child death reviews and how positive change can be achieved. Since the jurisdiction commenced, meetings with DCPFS's staff have been held in all districts in the metropolitan area, and in regional and remote areas.

The Ombudsman's Advisory Panel

The Panel is an advisory body established to provide independent advice to the Ombudsman on:

- Issues and trends that fall within the scope of the child death review function;
- Contemporary professional practice relating to the wellbeing of children and their families; and
- Issues that impact on the capacity of public sector agencies to ensure the safety and wellbeing of children.

The Panel met four times in 2015-16 and during the year, the following members provided a range of expertise:

- Professor Steve Allsop (Director, National Drug Research Institute of Curtin University);
- Ms Jocelyn Jones (Health Sciences, Curtin University);
- Professor Donna Chung (Head of the Department of Social Work, Curtin University);
- Ms Dorinda Cox (Consultant);
- Ms Angela Hartwig (Women's Council for Domestic and Family Violence Services WA);
- Ms Victoria Hovane (Consultant); and
- Associate Professor Carolyn Johnson (School of Population Health, University of Western Australia).

Observers from the Department for Child Protection and Family Support, the Department of Health, the Department of Aboriginal Affairs, the Department of Education, the Department of Corrective Services, the Department of the Attorney General, the Mental Health Commission and Western Australia Police also attended the meetings.

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 liaises as part of the child death review jurisdiction include:

- The Coroner;

- Public authorities that have involvement with children and their families including:
  - Department of Housing;
  - Department of Health;
  - Department of Education;
  - Department of Corrective Services;
  - Department of Aboriginal Affairs;
  - The Mental Health Commission;
  - Western Australia Police; and
  - Other accountability and similar agencies including the Commissioner for Children and Young People;
- 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 appointed a Principal Aboriginal Liaison Officer 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, complaints 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.

With the leadership and support of the Principal Aboriginal Liaison Officer significant work continued throughout the year 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 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.

As part of this work, Office staff liaise with Aboriginal community leaders, Aboriginal Health Services, local governments, regional offices of Western Australia Police, DCPFS and community advocates.

Family and Domestic Violence Fatality Review

Overview

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

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

Background

The *National Plan to Reduce Violence against Women and their Children 2010-2022* (**the National Plan**) identifies six key national outcomes:

- Communities are safe and free from violence;
- Relationships are respectful;
- Indigenous communities are strengthened;
- Services meet the needs of women and their children experiencing violence;
- Justice responses are effective; and
- Perpetrators stop their violence and are held to account.

The National Plan is endorsed by the Council of Australian Governments and supported by the *First Action Plan: Building a Strong Foundation 2010-2013* (available at www.dss.gov.au), which established the 'groundwork for the National Plan', and the *Second Action Plan: Moving Ahead 2013-2016* (available at www.dss.gov.au), which builds upon this work.

The *WA Strategic Plan for Family and Domestic Violence 2009-13* (**WA Strategic Plan**) and *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating safer communities* (**the State Strategy)**, available at www.dcp.wa.gov.au, include the following principles:

1. *Family and domestic violence and abuse is a fundamental violation of human rights and will not be tolerated in any community or culture.*
2. *Preventing family and domestic violence and abuse is the responsibility of the whole community and requires a shared understanding that it must not be tolerated under any circumstance.*
3. *The safety and wellbeing of those affected by family and domestic violence and abuse will be the first priority of any response.*
4. *Children have unique vulnerabilities in family and domestic violence situations, and all efforts must be made to protect them from short and long term harm.*
5. *Perpetrators of family and domestic violence and abuse will be held accountable for their behaviour and acts that constitute a criminal offence will be dealt with accordingly.*
6. *Responses to family and domestic violence and abuse can be improved through the development of an all-inclusive approach in which responses are integrated and specifically designed to address safety and accountability.*
7. *An effective system will acknowledge that to achieve substantive equality, partnerships must be developed in consultation with specific communities of interest including people with a disability, people from diverse sexualities and/or gender, people from Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds.*
8. *Victims of family and domestic violence and abuse will not be held responsible for the perpetrator's behaviour.*

The associated *Annual Action Plan 2009-10* identified a range of strategies including a 'capacity to systematically review family and domestic violence deaths and improve the response system as a result' (page 2). The *Annual Action Plan 2009-10* sets out 10 key actions to progress the development and implementation of the integrated response in 2009-10, including the need to '[r]esearch models of operation for family and domestic violence fatality review committees to determine an appropriate model for Western Australia' (page 2).

Following a Government working group process examining models for a family and domestic violence fatality review process, the Government requested that the Ombudsman undertake responsibility for the establishment of a family and domestic violence fatality review function.

On 1 July 2012, the Office commenced its family and domestic violence fatality review function.

It was essential to the success of the establishment of the family and domestic violence fatality review role that the Office identified and engaged with a range of key stakeholders in the implementation and ongoing operation of the role. It was important that stakeholders understood the role of the Ombudsman, and the Office was able to understand the critical work of all key stakeholders.

Working arrangements were established to support implementation of the role with Western Australia Police (**WAPOL**) and the Department for Child Protection and Family Support (**DCPFS**) and with other agencies, such as the Department of Corrective Services (**DCS**) and the Department of the Attorney General (**DOTAG**), and relevant courts.

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

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

The Role of the Ombudsman in relation to Family and Domestic Violence Fatality Reviews

Information regarding the use of terms

Information in relation to those fatalities that are suspected by WAPOL to have occurred in circumstances of family and domestic violence are described in this report as family and domestic violence fatalities. For the purposes of this report the person who has died due to suspected family and domestic violence will be referred to as 'the person who died' and the person whose actions are suspected of causing the death will be referred to as the 'suspected perpetrator' or, if the person has been convicted of causing the death, 'the perpetrator'.

Additionally, following Coronial and criminal proceedings, it may be necessary to adjust relevant previously reported information if the outcome of such proceedings is that the death did not occur in the context of a family and domestic relationship.

WAPOL informs the Office of all family and domestic violence fatalities and provides information about the circumstances of the death together with any relevant information of prior WAPOL contact with the person who died and the suspected perpetrator. A family and domestic violence fatality involves persons apparently in a 'family and domestic relationship' as defined by section 4 of the *Restraining Orders Act 1997*.

More specifically, the relationship between the person who died and the suspected perpetrator is a relationship between two people:

(a) Who are, or were, married to each other; or

(b) Who are, or were, in a de facto relationship with each other; or

(c) Who are, or were, related to each other; or

(d) One of whom is a child who —

(i) Ordinarily resides, or resided, with the other person; or

(ii) Regularly resides or stays, or resided or stayed, with the other person;

or

(e) One of whom is, or was, a child of whom the other person is a guardian; or

(f) Who have, or had, an intimate personal relationship, or other personal relationship, with each other.

'Other personal relationship' means a personal relationship of a domestic nature in which the lives of the persons are, or were, interrelated and the actions of one person affects, or affected the other person.

'Related', in relation to a person, means a person who —

(a) Is related to that person taking into consideration the cultural, social or religious backgrounds of the two people; or

(b) Is related to the person's —

(i) Spouse or former spouse; or

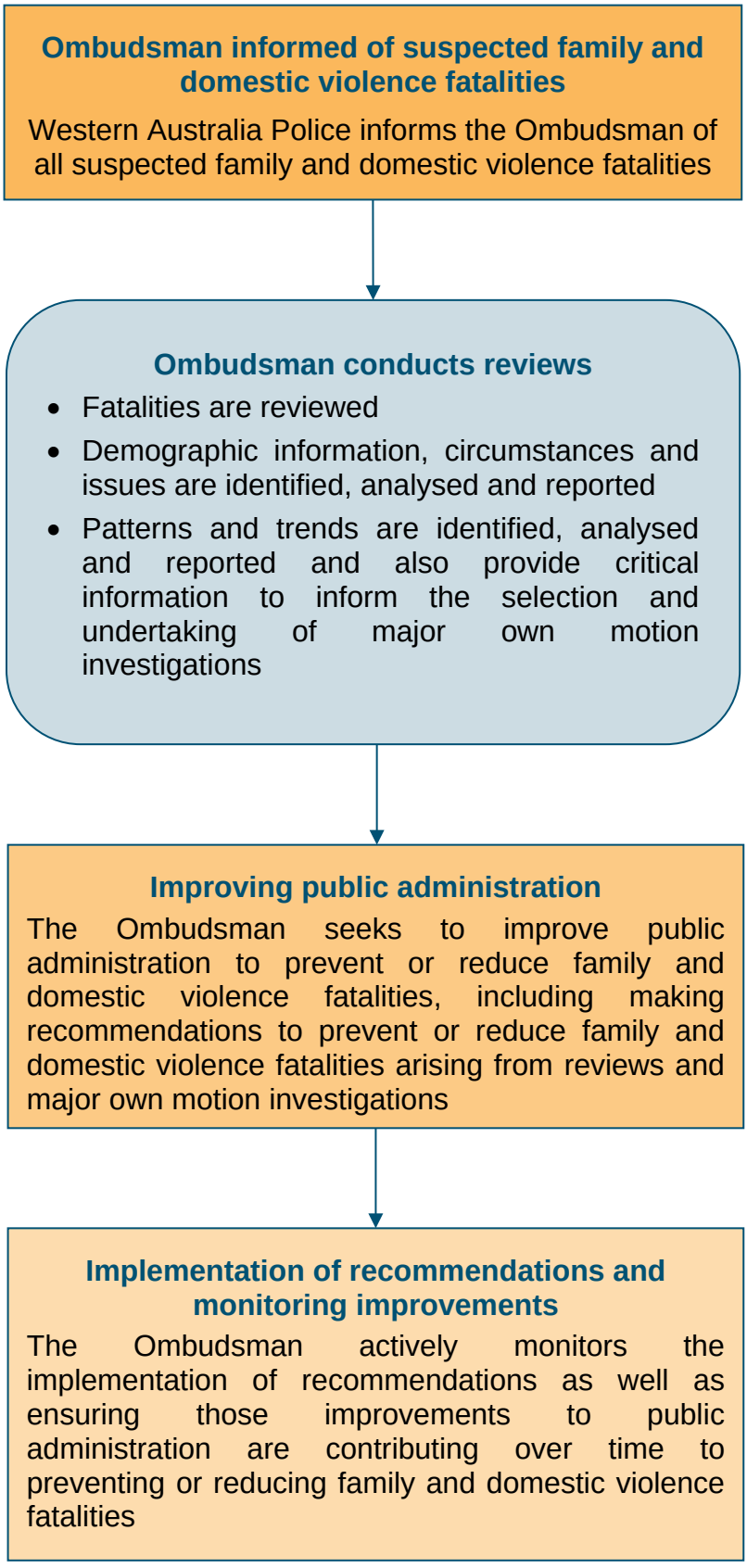
(ii) De facto partner or former de facto partner.

If the relationship meets these criteria, a review is undertaken.

The extent of a review depends on a number of factors, including the circumstances surrounding the death and the level of involvement of relevant public authorities in the life of the person who died or other relevant people in a family and domestic relationship with the person who died, including the suspected perpetrator. Confidentiality of all parties involved with the case is strictly observed.

The family and domestic violence fatality review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce family and domestic violence fatalities. The review does not set out to establish the cause of death of the person who died; this is properly the role of the Coroner. Nor does the review seek to determine whether a suspected perpetrator has committed a criminal offence; this is only a role for a relevant court.

The Family and Domestic Violence Fatality Review Process



Analysis of Family and Domestic Violence Fatality Reviews

Information on interpretation of data

Information in this section is derived from the 73 reviewable family and domestic violence fatalities received from 2012-13 to 2015-16. As the information in the following charts is based on four years of data, care should be undertaken in interpreting the data.

By reviewing family and domestic violence fatalities, the Ombudsman is able to identify, record and report on a range of information and analysis, including:

- The number of family and domestic violence fatality reviews;
- Demographic information identified from family and domestic violence fatality reviews;
- Circumstances in which family and domestic violence fatalities have occurred; and
- Patterns, trends and case studies relating to family and domestic violence fatality reviews.

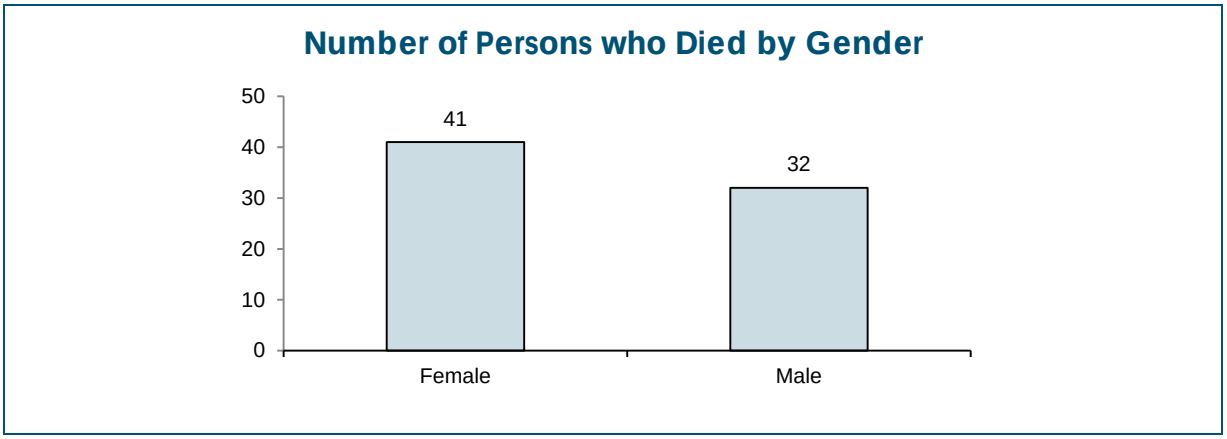
Number of family and domestic violence fatality reviews

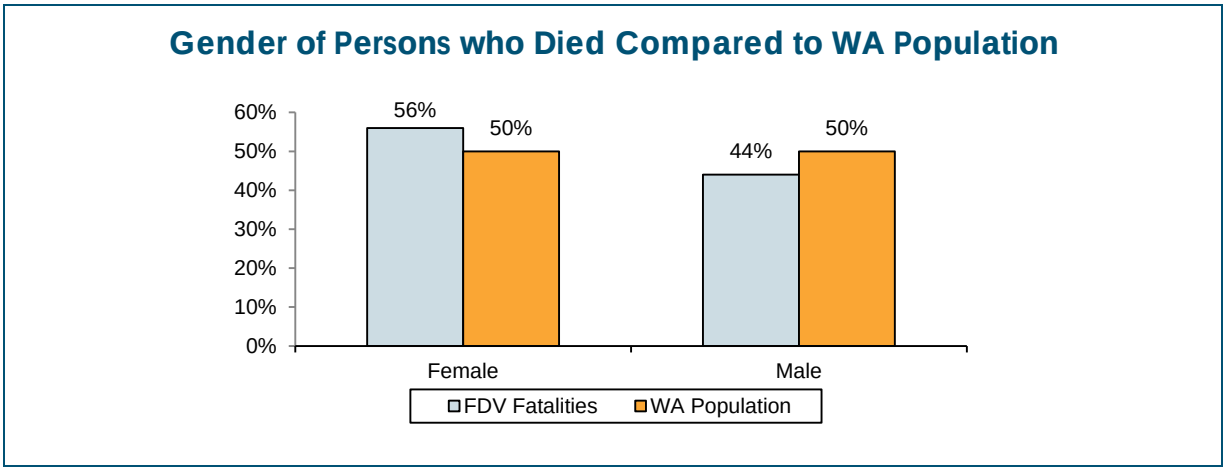
In 2015-16, the number of reviewable family and domestic violence fatalities received was 22, compared to 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

Demographic information identified from family and domestic violence fatality reviews

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

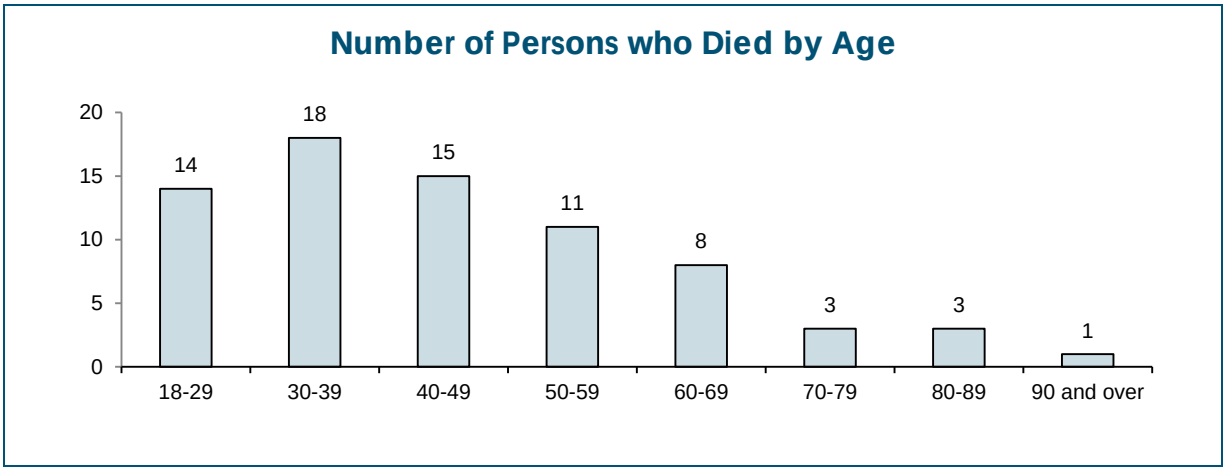
The following charts show characteristics of the persons who died for the 73 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2016. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

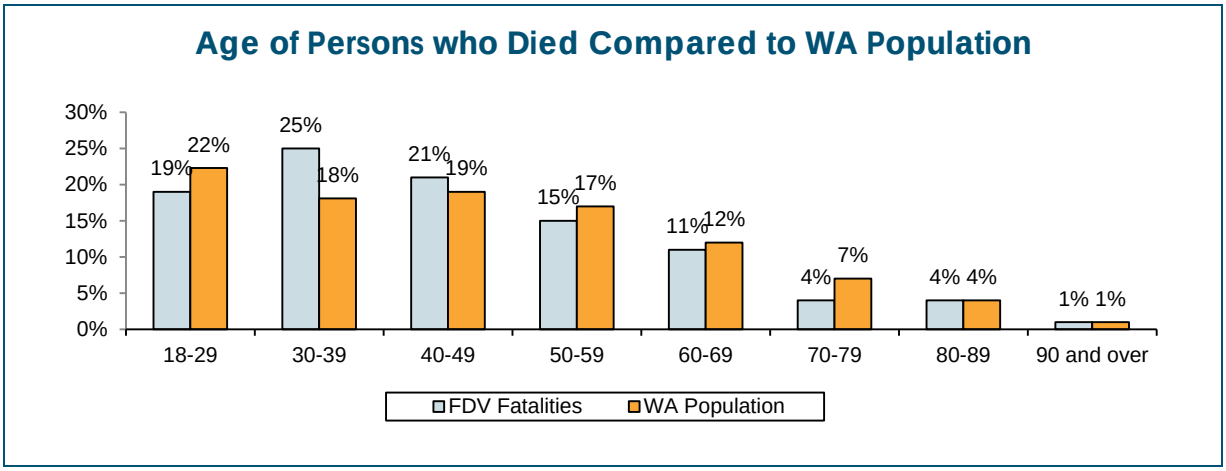




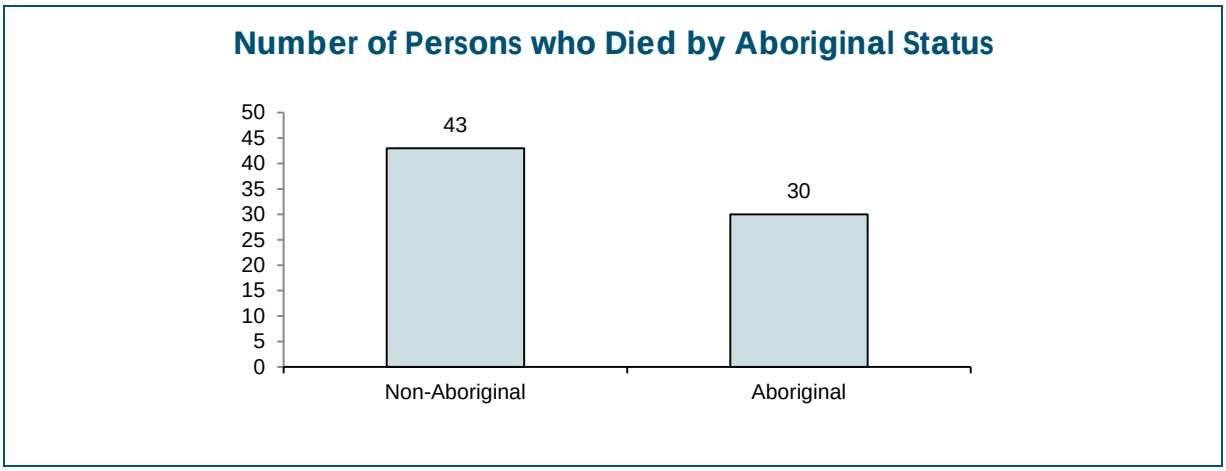
Compared to the Western Australian population, females who died in the four years from 1 July 2012 to 30 June 2016, were over-represented, with 56% of persons who died being female compared to 50% in the population.

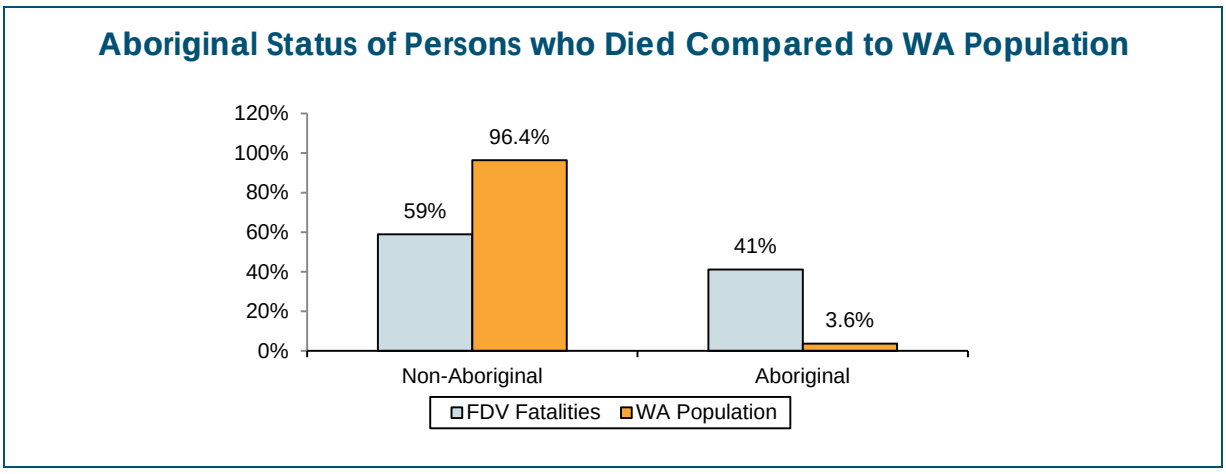
In relation to the 41 females who died, 39 involved a male suspected perpetrator and two involved a female suspected perpetrator. Of the 32 men who died, six were apparent suicides, 15 involved a female suspected perpetrator, nine involved a male suspected perpetrator and two involved multiple suspected perpetrators of both genders.





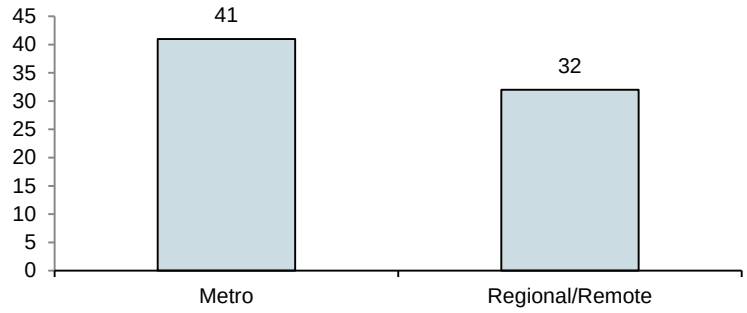
Compared to the Western Australian population, the age group 30-39 is over-represented, with 25% of persons who died, compared to 18% of the population.



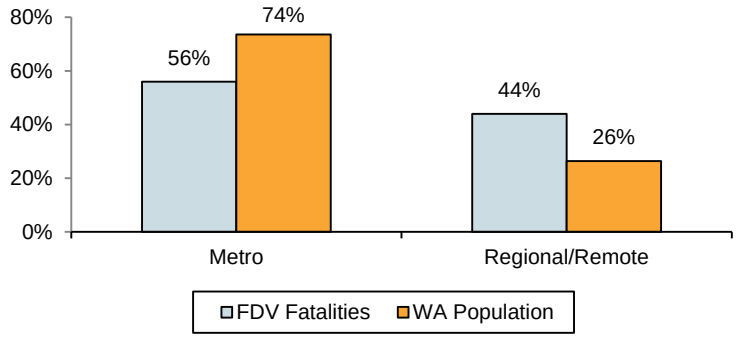


Compared to the Western Australian population, Aboriginal people who died were over-represented, with 41% of people who died in the four years from 1 July 2012 to 30 June 2016 being Aboriginal compared to 3.6% in the population. Of the 30 Aboriginal people who died, 18 were female and 12 were male.

Number of Persons who Died by Location of Fatal Incident



Location of Fatal Incident Compared to WA Population



Compared to the Western Australian population, incidents in regional or remote locations were over-represented, with 44% of fatal incidents in the four years from 1 July 2012 to 30 June 2016 occurring in regional or remote locations, compared to 26% of the population living in those locations.

The WA Strategic Plan notes that:

> *While there has been debate about the reliability of research that quantifies the incidence of family and domestic violence, there is general agreement that …*
>
> - *[A]n overwhelming majority of people who experience family and domestic violence are women, and*
> - *Aboriginal women are more likely than non-Aboriginal women to be victims of family violence* (page 4).

More specifically, with respect to the impact on Aboriginal women in Western Australia, the WA Strategic Plan notes that:

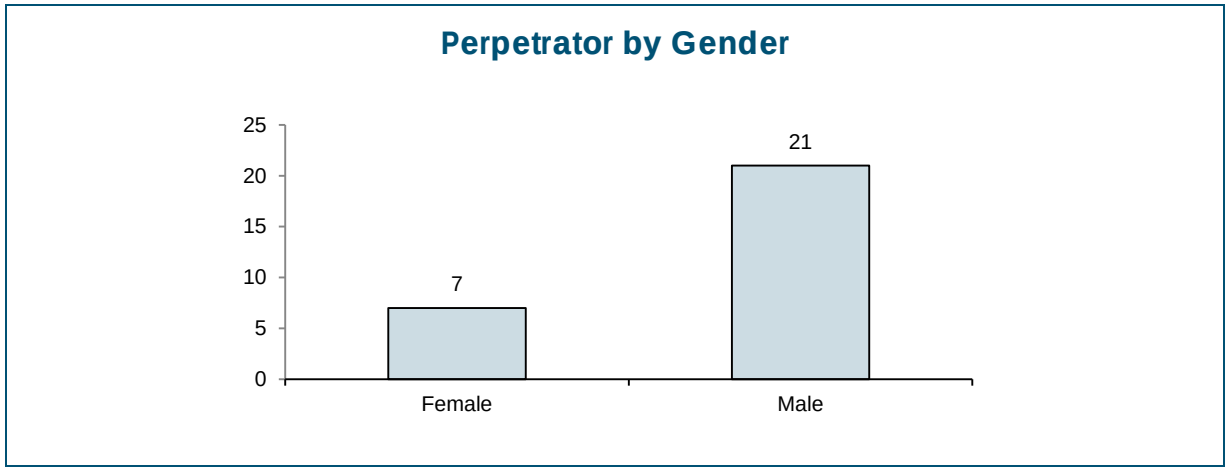
> *Family and domestic violence is particularly acute in Aboriginal communities. In Western Australia, it is estimated that Aboriginal women are 45 times more likely to be the victim of family violence than non-Aboriginal women, accounting for almost 50 per cent of all victims* (page 4).

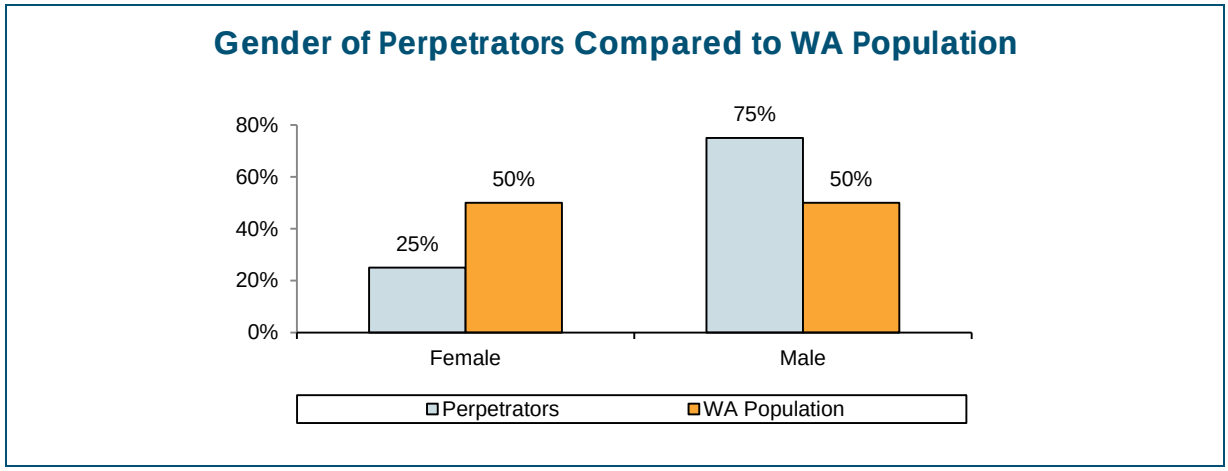
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2016 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2016.

Of the 73 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2016, coronial and criminal proceedings were finalised in 28 cases.

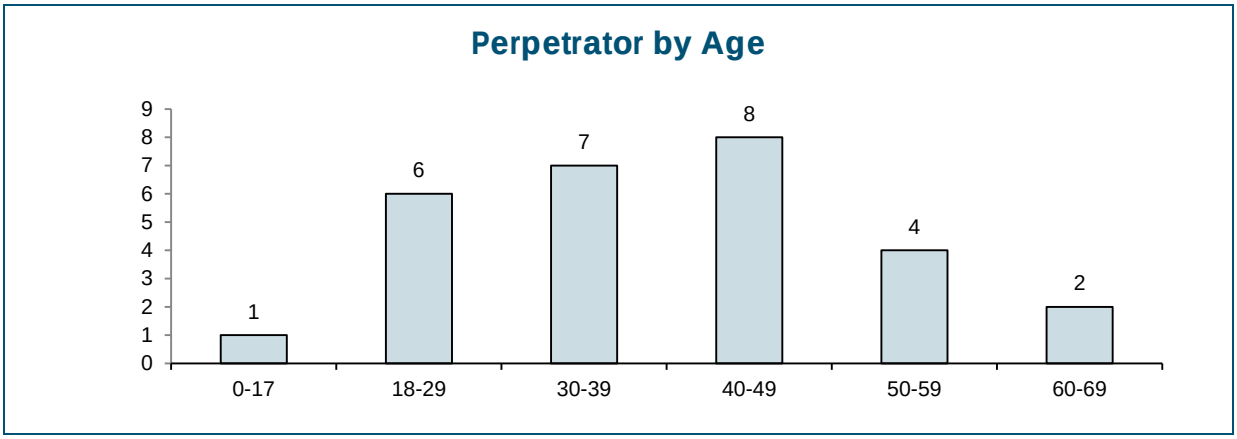
Information is obtained on a range of characteristics of the perpetrator including gender, age group and Aboriginal status. The following charts show characteristics for the 28 perpetrators where both the coronial process and the criminal proceedings have been finalised.

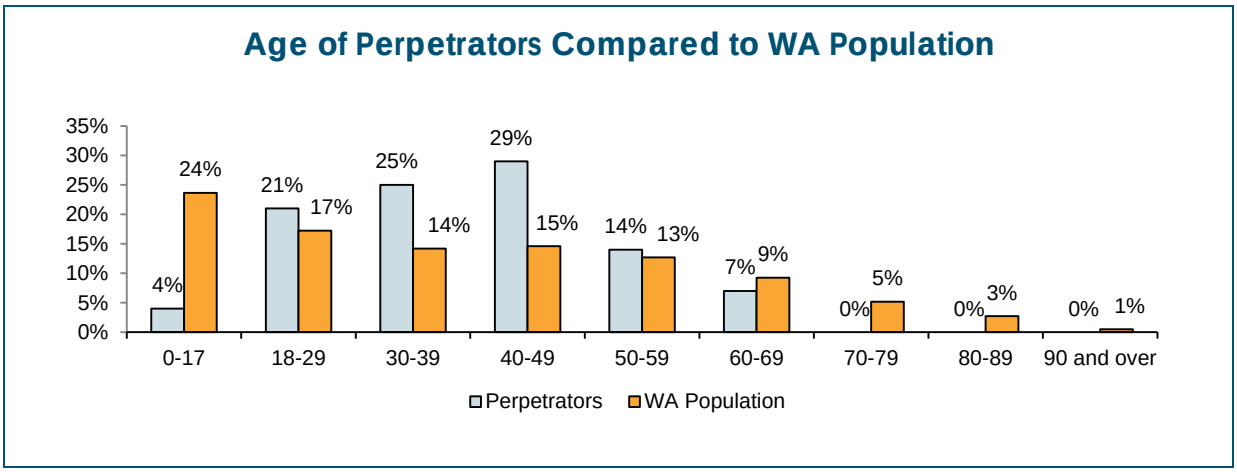




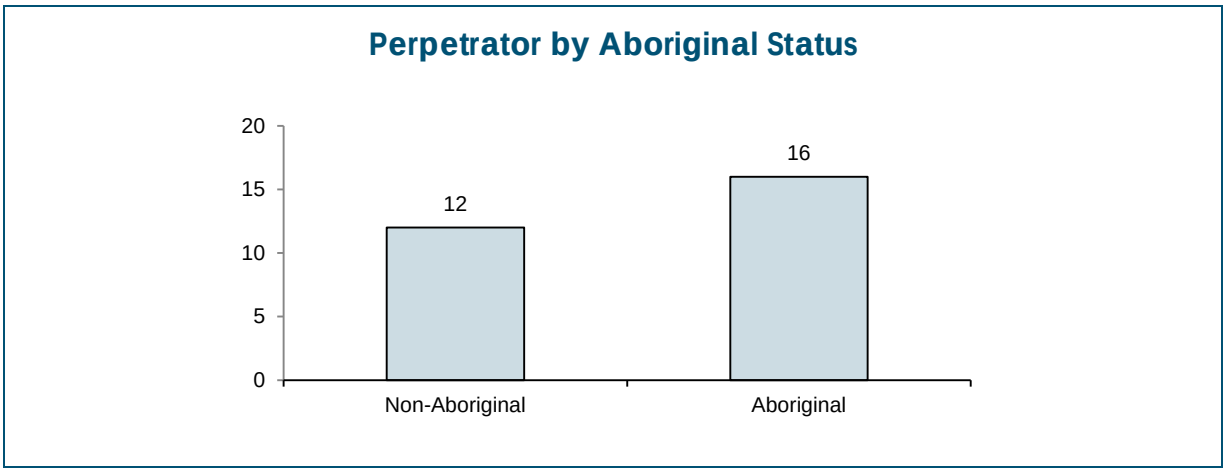
Compared to the Western Australian population, male perpetrators of fatalities in the years from 1 July 2012 to 30 June 2016 were over-represented, with 75% of perpetrators being male compared to 50% in the population.

Nine males were convicted of manslaughter and 12 males were convicted of murder. Five females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death and one female was convicted of murder.

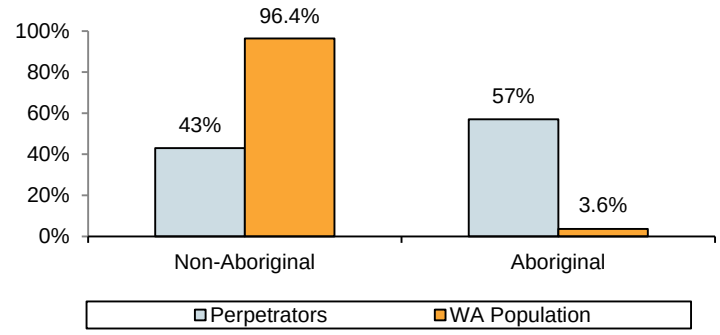




Compared to the Western Australian population, perpetrators of fatalities in the four years from 1 July 2012 to 30 June 2016 in the age groups 30-39 and 40-49 were over-represented, with 25% of perpetrators being in the 30-39 age group compared to 14% in the population, and 29% of perpetrators being in the 40-49 age group compared to 15% in the population.



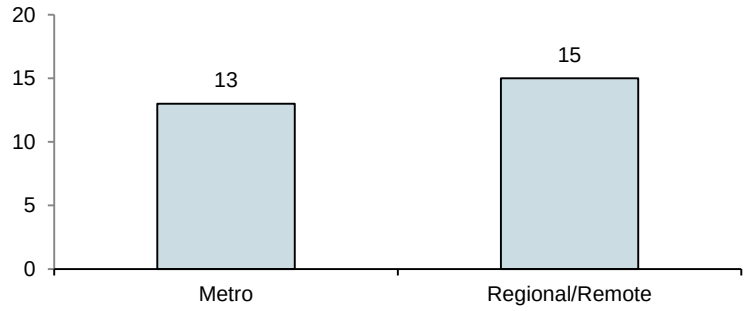
Aboriginal Status of Perpetrators Compared to WA Population



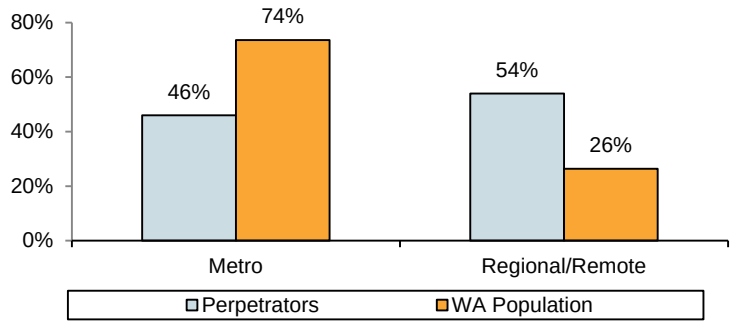
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the four years from 1 July 2012 to 30 June 2016 were over-represented with 57% of perpetrators being Aboriginal compared to 3.6% in the population.

In 14 of the 16 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location of Fatal Incident



Perpetrators by Location of Fatal Incident Compared to WA Population



The majority of fatal incidents occured in regional or remote areas.

Compared to the Western Australian population, perpetrators of fatalities that occurred in regional or remote locations in the four years from 1 July 2012 to 30 June 2016 were over-represented, with 54% of perpetrators in regional or remote locations compared to 26% of the population living in those locations.

Circumstances in which family and domestic violence fatalities have occurred

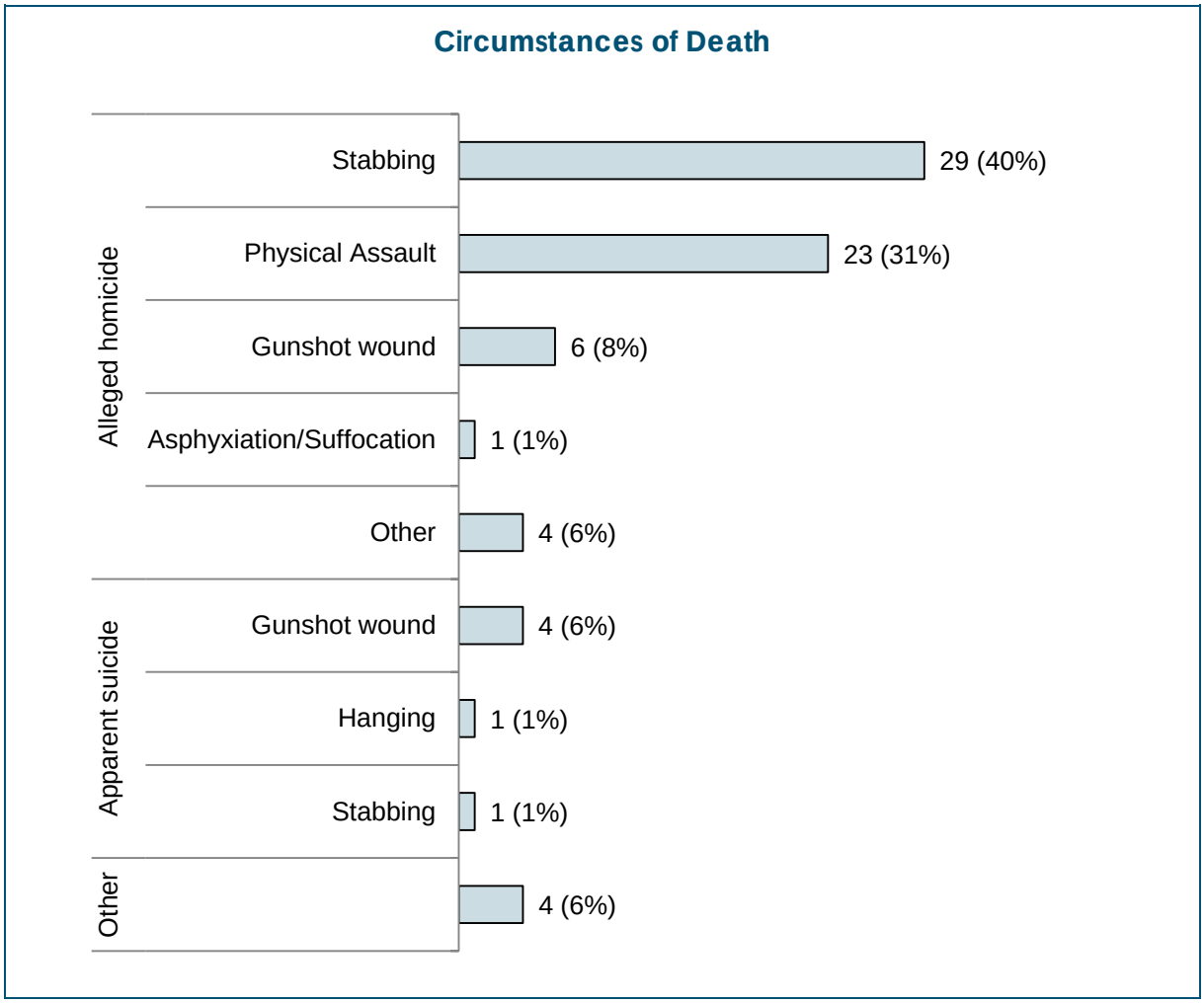
Information provided to the Office by WAPOL about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

Family and domestic violence fatalities may occur through alleged homicide or apparent suicide and the circumstances of death are categorised by the Ombudsman as:

- Alleged homicide, including:
  - Stabbing;
  - Physical assault;
  - Gunshot wound;
  - Asphyxiation/suffocation;
  - Drowning; and
  - Other.
- Apparent suicide, including:
  - Gunshot wound;
  - Overdose of prescription or other drugs;
  - Stabbing;
  - Motor vehicle accident;
  - Hanging;
  - Drowning; and
  - Other.
- Other, including fatalities where it is not clear whether the circumstances of death are alleged homicide or apparent suicide.

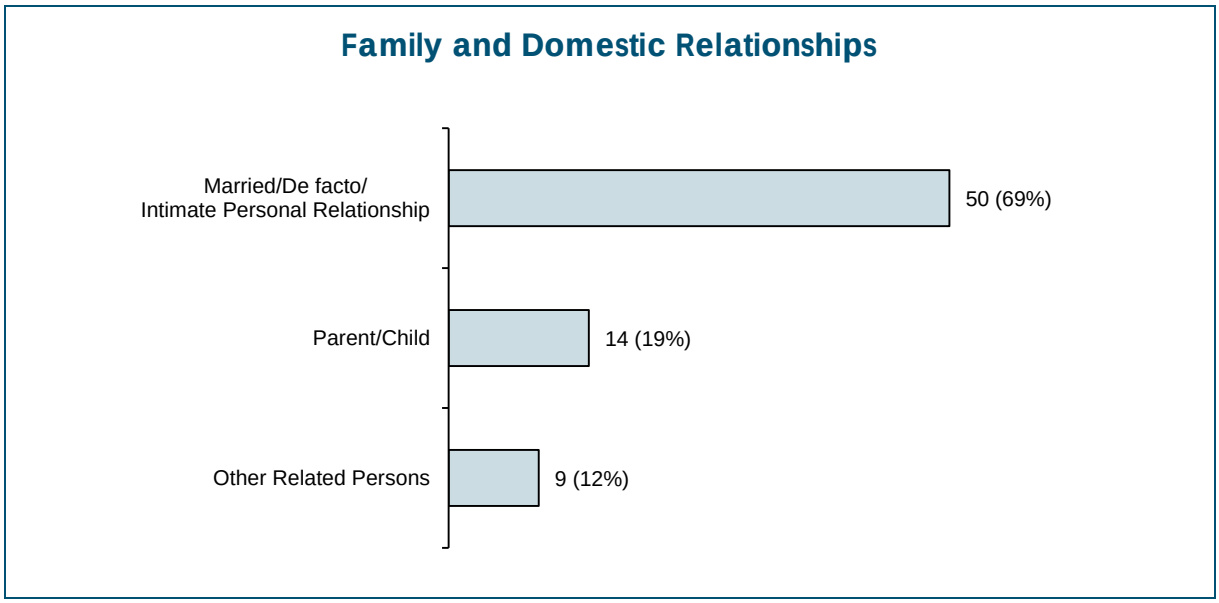
The principal circumstances of death in 2015-16 were alleged homicide by stabbing and physical assault.

The following chart shows the circumstance of death as categorised by the Ombudsman for the 73 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2016.



Family and domestic relationships

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



Of the 73 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2016:

- 50 fatalities (69%) involved a married, de facto or intimate personal relationship, of which there were 44 alleged homicides and six apparent suicides. The 50 fatalities included 10 deaths that occurred in five cases of alleged homicide/suicide and, in all five cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. The sixth apparent suicide involved a male. Of the remaining 39 alleged homicides, 25 (64%) of the people who died were female and 14 (36%) were male;
- There were 14 people who died (19%) who were either the parent or adult child of the suspected perpetrator. Of these, seven (50%) were female and seven (50%) were male. In 10 cases (71%) the person who died was the parent or step-parent and in four cases (29%) the person who died was the adult child or step-child; and
- There were nine people who died (12%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, four (44%) were female and five (56%) were male.

Patterns, Trends and Case Studies Relating to Family and Domestic Violence Fatality Reviews

State policy and planning to reduce family and domestic violence fatalities

The State Strategy**,** released in 2012, sets out the State Government's commitment to reducing family and domestic violence, identifying that it 'builds on reforms already undertaken through the [WA Strategic Plan]…' (page 3).

The DCPFS website *Family and Domestic Violence Strategic Planning* page (available at www.dcp.wa.gov.au) states DCPFS is the lead agency responsible for family and domestic violence strategic planning in Western Australia. This includes development, implementation and monitoring of the State Strategy and contribution to the National Plan. Strategic planning is overseen by the FDV Governance Council, comprising senior representatives from State and Commonwealth Government agencies and the Women's Council for Domestic and Family Violence Services (WA), with input from the FDV Advisory Network.

The Ombudsman's family and domestic violence fatality reviews and the Ombudsman's own motion investigation and associated report, titled *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* (**the FDV investigation report**), have identified that there is scope for State Government departments and authorities to improve the ways in which they respond to family and domestic violence. The Ombudsman has recommended that in the development of Action Plans under the State Strategy identify in more detail actions for achieving the State Strategy's Primary State Outcomes, priorities among these actions, and allocation of responsibilities for these actions to specific State Government departments and authorities, as occurs with the National Plan. The findings and recommendations of the Law Reform Commission of Western Australia's *Enhancing Family and Domestic Violence Laws Final Report* June 2014 (available at www.lrc.justice.wa.gov.au) and of the Ombudsman's FDV investigation report, could inform this work.

Type of relationships

The Ombudsman finalised 58 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2016.

For 40 (69%) of the finalised reviews of family and domestic violence fatalities, the fatality occurred between persons who, either at the time of death or at some earlier time, had been involved in a married, de facto or other intimate personal relationship. For the remaining 18 (31%) of the finalised family and domestic violence fatality reviews, the fatality occurred between persons where the relationship was between a parent and their adult child or persons otherwise related (such as siblings and extended family relationships).

These two groups will be referred to as 'intimate partner fatalities' and 'non-intimate partner fatalities'.

For the 58 finalised reviews, the circumstances of the fatality were as follows:

- For the 40 intimate partner fatalities, 35 were alleged homicides and five were apparent suicides; and
- For the 18 non-intimate partner fatalities, all were alleged homicides.

Intimate partner relationships

Of the 35 intimate partner relationship fatalities involving alleged homicide:

- There were 24 fatalities where the person who died was female and the suspected perpetrator was male, 10 where the person who died was male and the suspected perpetrator was female, and one where the person who died was male and there were multiple suspected perpetrators of both genders;
- There were 16 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In nine of these fatalities the person who died was female and in seven the person who died was male;
- There were 19 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, five at the residence of the person who died or the residence of the suspected perpetrator, five at the residence of family or friends, and six at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 18 fatalities that occurred in regional and remote areas, and in 14 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 18 non-intimate partner fatalities, there were 12 fatalities involving a parent and adult child and six fatalities where the parties were otherwise related.

Of the 18 non-intimate partner fatalities, all of which involved alleged homicide:

- In eight fatalities the person who died was female and the suspected perpetrator was male. In the remaining 10 fatalities where the person who died was male, seven of the suspected perpetrators were male and three were female;
- There were five non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were seven fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, eight at the residence of the person who died or the residence of the suspected perpetrator, and three at the residence of family or friends or in a public place; and
- There were six fatalities that occurred in regional and remote areas.

Prior reports of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reports of alleged family and domestic violence between the parties. In 23 (66%) of the 35 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2016, alleged family and domestic violence between the parties had been reported to WAPOL and/or to other public authorities. In six (33%) of the 18 non-intimate partner fatalities finalised between 1 July 2012 and 30 June 2016, alleged family and domestic violence between the parties had been reported to WAPOL and/or other public authorities.

Collation of data to build our understanding about communities who are over-represented in family and domestic violence

Principle 7 of the State Strategy states that:

> *An effective system will acknowledge that to achieve substantive equality, partnerships must be developed in consultation with specific communities of interest including people with a disability, people from diverse sexualities and/or gender, people from Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds* (page 5).

The Ombudsman's FDV investigation report found that the research literature identifies that there are higher rates of family and domestic violence among certain communities in Western Australia. However, there are limitations to the supporting data, resulting in varying estimates of the numbers of people in these communities who experience family and domestic violence and a limited understanding of their experiences.

Of the 29 family and domestic violence fatalities where there had been prior reports of alleged family and domestic violence between the parties, from the records available:

- One fatality involved a deceased person with a disability;
- None of the fatalities involved a deceased person who identified as lesbian, gay, bisexual, trans or intersex;

- Seventeen fatalities involved a deceased Aboriginal person; and
- Seventeen fatalities had occurred in regional/remote Western Australia.

Examination of the family and domestic violence fatality review data provides some insight into the issues relevant to these communities. However, these numbers are limited and greater insight is only possible through consideration of all reported family and domestic violence, not just where this results in a fatality. The Ombudsman's FDV investigation report found that neither the State Strategy nor the *Achievement Report to 2013* identify any actions to improve the collection of data relating to different communities experiencing higher rates of family and domestic violence, for example through the collection of cultural, demographic and socioeconomic data. The Ombudsman has recommended that in developing and implementing future phases of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, DCPFS collaborates with WAPOL, DOTAG and other relevant agencies to identify and incorporate actions to be taken by State Government departments and authorities to collect data about communities who are over-represented in family and domestic violence, to inform evidence-based strategies tailored to addressing family and domestic violence in these communities.

Identification of family and domestic violence incidents

Of the 29 family and domestic violence fatalities where there had been prior reports of alleged family and domestic violence between the parties, WAPOL was the agency to receive the majority of these reports. The Ombudsman's FDV investigation report also noted that DCPFS may become aware of family and domestic violence through a referral to DCPFS and subsequent assessment through the duty interaction process. Identification of family and domestic violence is integral to the agency being in a position to implement its family and domestic violence policy and processes to address perpetrator accountability and promote victim safety and support. However, the Ombudsman's reviews and own motion investigations have identified missed opportunities to identify family and domestic violence in interactions. In 2015-16, the Ombudsman has made recommendations that public authorities ensure all reported family and domestic violence is correctly identified.

Provision of agency support to obtain a violence restraining order

As identified above, WAPOL is likely to receive the majority of reports of family and domestic violence. WAPOL is not currently required by legislation or policy to provide victims with information and advice about violence restraining orders when attending the scene of acts of family and domestic violence. However, its attendance at the scene affords WAPOL with the opportunity to provide victims with information and advice about:

- What a violence restraining order is and how it can enhance their safety;
- How to apply for a violence restraining order; and
- What support services are available to provide further advice and assistance with obtaining a violence restraining order, and how to access these support services.

The Ombudsman's FDV investigation report examined WAPOL's response to FDV incidents through the review of 75 Domestic Violence Incident Reports (associated with 30 fatalities). The FDV investigation report found that WAPOL recorded the provision of information and advice about violence restraining orders in 19 of the 75 (25%) instances. The Ombudsman has recommended that WAPOL amends the *Commissioner's Operations and Procedures Manual* to require that victims of family

and domestic violence are provided with verbal information and advice about violence restraining orders in all reported instances of family and domestic violence. Further, the Ombudsman has recommended that WAPOL collaborates with DCPFS and DOTAG to develop an 'aide memoire' that sets out the key information and advice about violence restraining orders that WAPOL should provide to victims of all reported instances of family and domestic violence, and that this 'aide memoire' is also developed in consultation with Aboriginal people to ensure its appropriateness for family violence incidents involving Aboriginal people.

The Ombudsman's FDV investigation report also examined the response by DCPFS to prior reports of family and domestic violence involving 30 children who experienced family and domestic violence associated with the 30 fatalities. The FDV investigation report found that DCPFS did not provide any active referrals for legal advice or help from an appropriate service to obtain a violence restraining order for any of the children involved in the 30 fatalities. The Ombudsman has recommended that DCPFS complies with the requirements of its *Family and Domestic Violence Practice Guidance*, in particular, that:

> *[w]here a violence restraining order is considered desirable or necessary but a decision is made for the Department not to apply for the order, the non-abusive adult victim should be given an active referral for legal advice and help from an appropriate service.*

Further, the Ombudsman's FDV investigation report has noted DCPFS's *Family and Domestic Violence Practice Guidance* also identifies that taking out a violence restraining order on behalf of a child 'can assist in the protection of that child without the need for removal (intervention action) from his or her family home', and can serve to assist adult victims of violence when it would decrease risk to the adult victim if the Department was the applicant. The Ombudsman has made three recommendations relating to DCPFS's improved compliance with the provisions of its *Family and Domestic Violence Practice Guidance* in seeking violence restraining orders on behalf of children, including that in its implementation of section 18(2) of the *Restraining Orders Act 1997*, DCPFS complies with its *Family and Domestic Violence Practice Guidance* which identifies that DCPFS officers should consider seeking a violence restraining order on behalf of a child if the violence is likely to escalate and the children are at risk of further abuse, and/or it would decrease risk to the adult victim if the Department was the applicant for the violence restraining order.

The Ombudsman's FDV investigation report also identified the importance of opportunities for victims to seek help and for perpetrators to be held to account at other points in the process for obtaining a violence restraining order, and that these opportunities are acted upon, not just by WAPOL but by all State Government departments and authorities. The Ombudsman has recommended that in developing and implementing future phases of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities,* DCPFS specifically identifies and incorporates opportunities for State Government departments and authorities to deliver information and advice about violence restraining orders, beyond the initial response by WAPOL.

The Ombudsman's FDV investigation report examined a sample of 41,229 hearings regarding violence restraining orders and identified that an application for a violence restraining order was dismissed or not granted as an outcome of 6,988 hearings (17%) in the investigation period. In cases where an application for a violence restraining order has been dismissed it may still be appropriate to provide safety

planning assistance. The Ombudsman has recommended that DOTAG, in collaboration with DCPFS, identifies and incorporates into *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, ways of ensuring that, in cases where an application for a violence restraining order has been dismissed, if appropriate, victims are provided with referrals to appropriate safety planning assistance.

Provision of support to victims experiencing family and domestic violence

In November 2015, DCPFS launched the *Western Australia Family and Domestic Violence Common Risk Assessment and Risk Management Framework (Second edition)* (available at www.dcp.wa.gov.au). This across government framework states that:

> *The purpose of risk assessment is to determine the risk and safety for the adult victim and children, taking into consideration the range of victim and perpetrator risk factors that affect the likelihood and severity of future violence.*
>
> *Risk assessment must be undertaken when family and domestic violence has been identified…*
>
> *Risk assessment is conducted for a number of reasons including:*
>
> - *evaluating the risk of re-assault for a victim;*
> - *evaluating the risk of homicide;*
> - *informing service system and justice responses;*
> - *supporting women to understand their own level of risk and the risk to children and/or to validate a woman's own assessment of her level of safety; and*
> - *establishing a basis from which a case can be monitored* (pages 36-37).

The Ombudsman's reviews and FDV investigation report have noted that, where agencies become aware of family and domestic violence, they do not always undertake a comprehensive assessment of the associated risk of harm and provide support and safety planning.

In 2015-16, the Ombudsman has made recommendations to public authorities that they ensure compliance with their family and domestic violence policy requirements, including assessing risk of future harm and providing support to address the impact of experiencing family and domestic violence.

Fatalities with no prior reported family and domestic violence

In 12 (34%) of the 35 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2016, the fatal incident was the only family and domestic violence between the parties that had been reported, on the information available to the Office, to WAPOL and/or other public authorities. It is important to note, however, research indicating under-reporting of family and domestic violence. The Australian Bureau of Statistics' *Personal Safety Survey 2012* 'collected information about a person's help seeking behaviours in relation to their experience of partner violence'.

For example, this research found that:

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

The Ombudsman's reviews provide information on family and domestic violence fatalities where there is no previous reported history of family and domestic violence, including cases where information becomes available after the death to confirm a history of unreported family and domestic violence, as shown in the following case study.

Case Study

Case study A

Mr F and Ms G were in an intimate partner relationship. Mr F died in the context of family and domestic violence.

The Ombudsman's review of the fatality found that there had been no prior reports of family and domestic violence to any public authority. Information became available after the fatality that indicated that there had been a long history of unreported alleged family and domestic violence, where Mr F was the alleged primary aggressor and Ms G was the alleged primary victim.

The Ombudsman will continue to collate information on family and domestic violence fatalities where there is no reported history of family and domestic violence, to identify patterns and trends and consider improvements that may increase reporting of family and domestic violence and access to supports.

Family violence involving Aboriginal people

Of the 58 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2016, Aboriginal Western Australians were over-represented, with 21 persons who died being Aboriginal. In each case, the suspected perpetrator was also Aboriginal. There were 17 of these fatalities that occurred in a regional or remote area of Western Australia, of which 14 were intimate partner fatalities.

The Ombudsman's reviews and FDV investigation report identify the over-representation of Aboriginal people in family and domestic violence fatalities. This is consistent with the research literature that Aboriginal people are 'more likely to be victims of violence than any other section of Australian society' (Cripps, K and Davis, M, *Communities working to reduce Indigenous family violence*, Brief 12, June 2012, Indigenous Justice Clearinghouse, New South Wales, 2012, p. 1) and that Aboriginal people experience family and domestic violence at 'significantly higher rates than other Australians.' (Aboriginal and Torres Strait Islander Social Justice Commissioner, *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities – Key Issues, An overview paper of research and findings by*

the Human Rights and Equal Opportunity Commission, *2001 - 2006*, Human Rights and Equal Opportunity Commission, June 2006, p. 6).

As discussed in the Ombudsman's FDV investigation report, the research literature suggests that there are a number of contextual factors contributing to the prevalence and seriousness of family violence in Aboriginal communities and that:

> *…violence against women within the Indigenous Australian communities need[s] to be understood within the specific historical and cultural context of colonisation and systemic disadvantage. Any discussion of violence in contemporary Indigenous communities must be located within this historical context. Similarly, any discussion of "causes" of violence within the community must recognise and reflect the impact of colonialism and the indelible impact of violence perpetrated by white colonialists against Indigenous peoples…A meta-evaluation of literature…identified many "causes" of family violence in Indigenous Australian communities, including historical factors such as: collective dispossession; the loss of land and traditional culture; the fragmentation of kinship systems and Aboriginal law; poverty and unemployment; structural racism; drug and alcohol misuse; institutionalisation; and the decline of traditional Aboriginal men's role and status - while "powerless" in relation to mainstream society, Indigenous men may seek compensation by exerting power over women and children*...(Blagg, H, Bluett-Boyd, N, and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 3).

The Ombudsman's FDV investigation report notes that, in addition to the challenges faced by all victims in reporting family and domestic violence, the research literature identifies additional disincentives to reporting family and domestic violence faced by Aboriginal people:

> *Indigenous women continuously balance off the desire to stop the violence by reporting to the police with the potential consequences for themselves and other family members that may result from approaching the police; often concluding that the negatives outweigh the positives. Synthesizing the literature on the topic reveals a number of consistent themes, including: a reluctance to report because of fear of the police, the perpetrator and perpetrator's kin; fear of "payback" by the offender's family if he is jailed; concerns the offender might become "a death in custody"; a cultural reluctance to become involved with non-Indigenous justice systems, particularly a system viewed as an instrument of dispossession by many people in the Indigenous community; a degree of normalisation of violence in some families and a degree of fatalism about change; the impact of "lateral violence" … which makes victims subject to intimidation and community denunciation for reporting offenders, in Indigenous communities; negative experiences of contact with the police when previously attempting to report violence (such as being arrested on outstanding warrants); fears that their children will be removed if they are seen as being part of an abusive house-hold; lack of transport on rural and remote communities; and a general lack of culturally secure services* (Blagg, H, Bluett-Boyd, N and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 13).

The Ombudsman's reviews and FDV investigation report have identified that Aboriginal victims want the violence to end, but not necessarily always through the use of violence restraining orders.

A separate strategy to prevent and reduce Aboriginal family violence

In examining the family and domestic violence fatalities involving Aboriginal people, the research literature and stakeholder perspectives, the FDV investigation report identified a gap in that there is no strategy solely aimed at addressing family violence experienced by Aboriginal people and in Aboriginal communities.

The findings of the Ombudsman's FDV investigation report strongly support the development of a separate strategy (linked to the State Strategy and consistent with, and supported by, the State Strategy) that is specifically tailored to preventing and reducing Aboriginal family violence. This can be summarised as three key points.

Firstly, the findings set out in Chapters 4 and 5 of the FDV investigation report identify that Aboriginal people are over-represented, both as victims of family and domestic violence and victims of fatalities arising from this violence.

Secondly, the research literature, discussed in Chapter 6 of the FDV investigation report suggests a distinctive '…nature, history and context of family violence in Aboriginal and Torres Strait Islander communities.' (National Aboriginal and Torres Strait Islander Women's Alliance, *Submission to the Finance and Public Administration Committee Inquiry into Domestic Violence in Australia*, National Aboriginal and Torres Strait Islander Women's Alliance, New South Wales, 31 July 2014, p. 5). The research literature further suggests that combating violence is likely to require approaches that are informed by and respond to this experience of family violence.

Thirdly, the findings set out in the FDV investigation report demonstrate how the unique factors associated with Aboriginal family violence have resulted in important aspects of the use of violence restraining orders by Aboriginal people which are different from those of non-Aboriginal people.

The Ombudsman recommended that DCPFS, as the lead agency responsible for family and domestic violence strategic planning in Western Australia, develops a strategy that is specifically tailored to preventing and reducing Aboriginal family violence, and is linked to, consistent with, and supported by *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities.* The FDV investigation report identified that development of the strategy must include and encourage the involvement of Aboriginal people in a full and active way, at each stage and level of the development of the strategy, and be comprehensively informed by Aboriginal culture. Doing so would mean that an Aboriginal family violence strategy would be developed with, and by, Aboriginal people. The Ombudsman has recommended that DCPFS, in developing a strategy tailored to preventing and reducing Aboriginal family violence, actively invites and encourages the involvement of Aboriginal people in a full and active way at each stage and level of the process, and be comprehensively informed by Aboriginal culture.

Limited use of violence restraining orders

The FDV investigation report identified that while Aboriginal people are significantly over-represented as victims of family and domestic violence, they are less likely than non-Aboriginal people to seek a violence restraining order. The FDV investigation report examined the research literature and views of stakeholders on the possible reasons for this lower use of violence restraining orders by Aboriginal people, identifying that the process for obtaining a violence restraining order is not necessarily always culturally appropriate for Aboriginal victims and that Aboriginal people in regional and remote locations face additional logistical and structural barriers in the process of obtaining a violence restraining order. The Ombudsman has recommended that DOTAG, in collaboration with key stakeholders, considers opportunities to address the cultural, logistical and structural barriers to Aboriginal victims seeking a violence restraining order, and ensures that Aboriginal people are involved in a full and active way at each stage and level of this process, and that this process is comprehensively informed by Aboriginal culture.

The FDV investigation report noted that data examined by the Office concerning the use of police orders and violence restraining orders by Aboriginal people in Western Australia indicates that Aboriginal victims are more likely to be protected by a police order than a violence restraining order. This data is consistent with information examined in the Ombudsman's reviews of family and domestic violence fatalities involving Aboriginal people. The Ombudsman has made a number of recommendations, set out in the FDV investigation report, to improve the use of violence restraining orders to prevent or reduce family and domestic violence fatalities, including that DCPFS considers the findings of the Ombudsman's investigation regarding the link between the use of police orders and violence restraining orders by Aboriginal people in developing and implementing the Aboriginal family violence strategy.

Strategies to recognise and address the co-occurrence of alcohol consumption and Aboriginal family violence

The Ombudsman's reviews of the family and domestic violence fatalities of Aboriginal people and prior reported family violence between the parties, identify a high co-occurrence of alcohol consumption and family violence. The FDV investigation report examined the research literature on the relationship between alcohol use and family and domestic violence and found that the research literature regularly identifies alcohol as 'a significant risk factor associated with intimate partner and family violence in Aboriginal communities'. (Mitchell, L, *Domestic violence in Australia – an overview of the issues*, Parliament of Australia, 2011, Canberra, accessed 16 October 2014, pp. 6-7). As with family and domestic violence in non-Aboriginal communities, the research literature suggests that 'while alcohol consumption [is] a common contributing factor … it should be viewed as an important situational factor that exacerbates the seriousness of conflict, rather than a cause of violence'. (Buzawa, E, Buzawa, C and Stark, E, *Responding to Domestic Violence*, Sage Publications, 4th Edition, 2012, Los Angeles, p. 99; Morgan, A. and McAtamney, A. 'Key issues in alcohol-related violence,' *Australian Institute of Criminology*, Canberra, 2009, viewed 27 March 2015, p. 3). The Ombudsman has recommended that DCPFS, in developing the Aboriginal family violence strategy referred to at Recommendation 4, incorporates strategies that recognise and address the co-occurrence of alcohol use and Aboriginal family violence.

Strategies to address the over-representation of family violence involving Aboriginal people in regional WA

Of the 21 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2016 involving Aboriginal people, 17 of these fatalities occurred in a regional or remote area of Western Australia. Ten of these fatalities occurred in the Kimberley region, which is home to 1.6 per cent of people in the Western Australian population.

Building on the work of the State Strategy, the *Freedom from Fear: Working towards the elimination of family and domestic violence in Western Australia Action Plan 2015* was launched in September 2015. This Action Plan includes the priority to 'Target communities and populations at greatest risk' and 'Develop and implement a plan for the Kimberley region' identifying that:

> *In comparison to other regional and metropolitan locations in Western Australia the Kimberley region has the highest rates, per head of population, of reported family and domestic violence and hospitalisations for domestic assault...* (page 10).

In identifying the Kimberley as a region of priority for an improved response to family and domestic violence, *Safer Families, Safer Communities Kimberley Family Violence Regional Plan 2015-2020* (**the Kimberley Plan**) (available at www.dcp.wa.gov.au) was launched in October 2015. The Kimberley Plan aims to:

> *…increase the health, safety and wellbeing of women, children and men living in the Kimberley region by working towards a reduction in family violence. The Kimberley Plan which sets out a framework for responding to family violence, includes strategies that will benefit all members of the Kimberley community as well as priority areas targeted at responding to Aboriginal family violence* (page 4).
>
> *… This will be achieved through a whole of community approach that promotes:*
>
> 1. *shared responsibility for the safety and wellbeing of children, individuals and families;*
> 2. *developing culture and community based responses to family violence;*
> 3. *building strong and safe communities; and*
> 4. *developing services and a service system that is integrated, culturally secure, client centered, accessible and effective* (page 10).

The Ombudsman has recommended that DCPFS, as the lead agency responsible for family and domestic violence strategic planning in Western Australia, develops a strategy that is specifically tailored to preventing and reducing Aboriginal family violence, and is linked to, consistent with, and supported by *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities* that would encompass all regions of Western Australia.

Factors co-occurring with family and domestic violence

Where family and domestic violence co-occurs with alcohol use, drug use and/or mental health issues, a collaborative, across service approach is needed. Treatment services may not always identify the risk of family and domestic violence and provide an appropriate response.

Case Study

Case study B

Mr G was killed by his relative, Mr H. Mr H pleaded guilty to Manslaughter and was sentenced to a period of imprisonment.

The Ombudsman's review identified that both Mr G and Mr H had involvement with public authorities in regards to mental health issues and alcohol/drug use.

Co-occurrence with alcohol and other drug use

Consistent with the research literature discussed relating to the co-occurrence between alcohol consumption and/or drug use and incidents of family and domestic violence (as outlined in the Ombudsman's FDV investigation report), the National Plan (available at www.dss.gov.au) observes that:

> *Alcohol is usually seen as a trigger, or a feature, of violence against women and their children rather than a cause. Research shows that addressing alcohol in isolation will not automatically reduce violence against women and their children. This is because alcohol does not, of itself, create the underlying attitudes that lead to controlling or violent behaviour* (page 29).

The National Plan and the *National Drug Strategy 2010-2015* identify initiatives to address alcohol and drug use, and the co-occurrence with family and domestic violence. The Foundation for Alcohol Research and Education's *National framework for action to prevent alcohol-related family violence* (available at www.fare.org.au/preventalcfv/) states:

> *Integrated and coordinated service models within the AOD [alcohol and other drug] and family violence sectors in Australia are rare. Historically, the sectors have worked independently of each other despite the long-recognised association between alcohol and family violence. Part of the reason is that models of treatment for alcohol use disorders have traditionally been focused towards the needs of individuals and in particular, men* (page 36).

On the information available, relating to the 53 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2016, the Ombudsman's reviews identify where alcohol use and/or drug use are factors associated with the fatality, and where there may be a history of alcohol use and/or drug use.

	ALCOHOL USE		DRUG USE	
	Associated with fatal event	Prior history	Associated with fatal event	Prior history
Person who died only	1	0	2	5
Suspected perpetrator only	3	13	7	10
Both person who died and suspected perpetrator	19	19	3	6
Total	**23**	**32**	**12**	**21**

The Ombudsman's reviews and FDV investigation report have identified that in Western Australia, the State Strategy does not mention or address alcohol and its relationship with family and domestic violence. However, the goal of the Drug and Alcohol Office's *Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015* (**the Framework**) is to 'prevent and reduce the adverse impacts of alcohol and other drugs in the Western Australian community' (page 5).

As one of these adverse impacts, the Framework highlights 'violence and family and relationship breakdown' as a result of 'problematic drug and alcohol use' (page 94). Stakeholders have suggested to the Ombudsman that programs and services for victims and perpetrators of violence in Western Australia, including family and domestic violence, do not address its co-occurrence with alcohol and other drug abuse. Specifically, this means that programs and services addressing family and domestic violence:

- May deny victims or perpetrators access to their services, particularly if they are under the influence of alcohol and other drugs; and
- Frequently do not address victims' or perpetrators' alcohol and other drug abuse issues.

Conversely, stakeholders have suggested programs and services which focus on alcohol and other drug use generally do not necessarily:

- Address perpetrators' violent behaviour; or
- Respond to the needs of victims resulting from their experience of family and domestic violence.

The concerns of stakeholders are consistent with the research literature as outlined in the Ombudsman's FDV investigation report. Given the level of recorded alcohol use associated with the Ombudsman's reviews, the Ombudsman has recommended that DCPFS and the Mental Health Commission collaborate to include initiatives in Action Plans under the State Strategy which recognise and address the co-occurrence of alcohol use and family and domestic violence.

Co-occurrence of mental health issues

As with alcohol and drug use, it is noted that the State Strategy does not mention mental health issues and the relationship with family and domestic violence. Though it is noted that in screening for family and domestic violence, the *Western Australia Family and Domestic Violence Common Risk Assessment and Risk Management Framework (second edition)* (available at www.dcp.wa.gov.au) states that:

> *Perpetrators often present with issues that coexist with their use of violence, for example, alcohol and drug misuse or **mental health concerns**. These coexisting issues are not to be blamed for the violence, but they may exacerbate the violence or act as a barrier to accessing the service system or making behavioural change.*
>
> *The primary focus of referral for perpetrators of family and domestic violence should be the violence itself. Coexisting issues may be addressed simultaneously, where appropriate* (page 53, our emphasis).

and

> *Family and domestic violence may be present, but undisclosed when a woman presents at a service for assistance with other issues such as health concerns, financial crisis, legal difficulties, parenting problems, **mental health concerns**, drug and/or alcohol misuse or homelessness* (page 29, our emphasis).

The DCPFS's *Western Australia Family and Domestic Violence Common Risk Assessment and Risk Management Framework* identifies mental health as a potential risk factor for family and domestic violence, and indicates that screening should be undertaken by mental health services (page 29).

On the information available, relating to the 53 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2016, the Ombudsman's reviews identify where mental health is potentially associated with the fatality, and where there may be a history of a mental health diagnosis.

Issues identified in Family and Domestic Violence Fatality Reviews

The following are the types of issues identified when undertaking family and domestic violence fatality reviews.

It is important to note that:

- Issues are not identified in every family and domestic violence fatality review; and
- When an issue has been identified, it does not necessarily mean that the issue is related to the death.

- Not identifying incidents as related to family and domestic violence.
- Not adequately informing staff of family and domestic violence policies and procedures.
- Not adequately implementing family and domestic violence policies and procedures.

- Not adequately implementing family and domestic violence policies and procedures.
- Not adequately progressing family and domestic violence investigations in a timely manner.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities to address family and domestic violence victim safety.
- Missed opportunities to utilise data management systems in responding to threats of family and domestic violence.
- Inaccurate recordkeeping.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following recommendations were made by the Ombudsman in 2015-16 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

- WAPOL considers whether action is required to strengthen processes associated with the receipt, assessment and verification of intelligence related to threats to kill made in family and domestic relationships, to ensure the prioritisation of victim safety and perpetrator accountability.
- WAPOL considers whether action is required to strengthen processes and procedures to promote that the interrogation of data systems identifies contemporaneous and relevant information upon which to inform the allocation of matters to the appropriate WAPOL division for action.
- WAPOL considers current procedures to determine whether action is required to strengthen the timely provision of intelligence to WAPOL prosecutors to inform bail applications and associated bail conditions.
- The Department of Health (**DOH**) considers amending and/or supplementing DOH's *Guideline for Responding to Family and Domestic Violence 2014*, to provide its staff with guidance on implementing the outlined procedures associated with identifying and responding to family and domestic violence in circumstances where a patient presents as intoxicated.
- DOH liaises with the relevant community service and DCPFS to clarify information relating to the criteria for referral and services available from the relevant community service, and updates the family and domestic violence Local Service Information sheet accordingly.
- DOH ensures the knowledge and views of clinicians, and other health services throughout the Region, are incorporated in current planning to address the issues of family and domestic violence in the Region.

- WAPOL takes all reasonable steps to ensure that actions allocated to WAPOL arising from the Family and Domestic Violence Response Team (**FDVRT**) triage meetings are undertaken in a timely manner and consistent with the FDVRT Operating Procedures and WAPOL's Family and Domestic Violence Policy.
- WAPOL takes all reasonable steps to ensure its cumulative knowledge associated with the circumstances of recidivist family and domestic violence offending, in addition to perpetrator offending histories, is utilised at FDVRT triage meetings to inform the identification of high risk cases for referral and management via multi-agency case management.

The Ombudsman will actively monitor what steps have been taken to give effect to these recommendations. The results of this monitoring will be reported in the 2016-17 Annual Report.

Timely handling of notifications and reviews

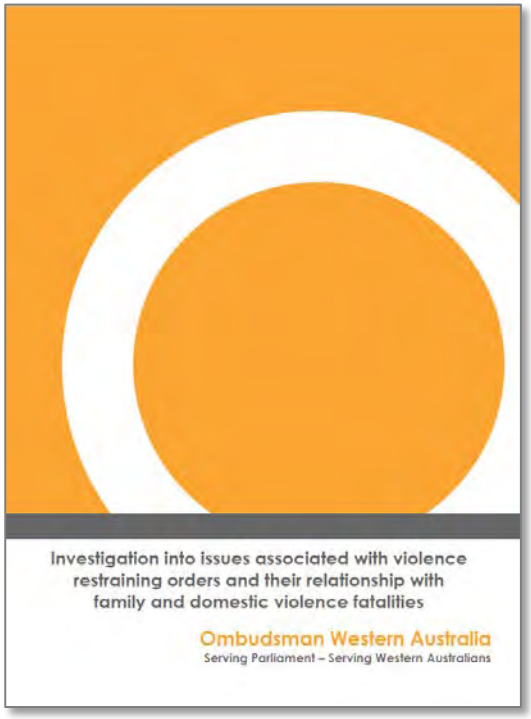
The Office places a strong emphasis on the timely review of family and domestic violence fatalities. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2015-16, timely review processes have resulted in one third of reviews being completed within three months and 80% of reviews completed within 12 months.

Major own motion investigations arising from family and domestic violence fatality reviews

In addition to investigations of individual family and domestic violence fatalities, the Office identifies patterns and trends arising out of reviews to inform major own motion investigations that examine the practice of public authorities that provide services to children, their families and their communities.

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

In November 2015, the Ombudsman tabled in Parliament a report of a major own motion investigation entitled *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*. The report is available on the Ombudsman's website.



About the investigation

Through the review of family and domestic violence fatalities, the Ombudsman identified a pattern of cases in which violence restraining orders were, or had been, in place between the person who was killed and the suspected perpetrator, or between the person who was

killed or the suspected perpetrator and other parties. The Ombudsman also identified a pattern of cases in which violence restraining orders were not used, although family and domestic violence had been, or had been recorded as, occurring and State Government departments and authorities had been contacted.

Accordingly, the Ombudsman decided to undertake an investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, with a view to determining whether it may be appropriate to make recommendations to any State Government department or authority about ways to prevent or reduce family and domestic violence fatalities.

The investigation had two aims. Firstly, arising from the work of the Ombudsman in reviewing family and domestic violence fatalities, the investigation aimed to set out a comprehensive understanding of family and domestic violence in Western Australia. Secondly, informed by this comprehensive understanding, the investigation aimed to examine the actions of State Government departments and authorities in administering their relevant legislative responsibilities, including particularly the *Restraining Orders Act 1997*, with a focus on violence restraining orders.

Throughout the investigation, the Office also considered if, and if so how, family and domestic violence affects different people and groups of people, in particular Aboriginal people (given the significant over-representation of Aboriginal Western Australians in family and domestic violence fatalities).

Methodology

- The Office examined 30 family and domestic violence fatalities (**the 30 fatalities**) notified to the Ombudsman over a defined 18 month period (**the investigation period**).
- The Office also collected and analysed a comprehensive set of de-identified state-wide data for the investigation period (**the state-wide data**), regarding:
  - All family and domestic violence incidents attended, and all violence restraining orders served, by WAPOL;
  - All applications for violence restraining orders lodged in, and all violence restraining orders issued by, the Magistrates Court and the Children's Court; and
  - All court hearings and outcomes for charges relating to breaches of violence restraining orders.
- The investigation also included an extensive literature review and stakeholder engagement.

Key findings: Family and domestic violence in Western Australia

- In the investigation period, WAPOL reported that they responded to 1,055,414 calls for assistance from the public and that 688,998 of these calls required police to attend to provide assistance.
- Of the 688,998 incidents attended by WAPOL, 75,983 incidents (11%) were recorded by WAPOL as family and domestic violence incidents.
- In 20,480 of these 75,983 incidents, an offence against the person was detected. For these 20,480 incidents, the Office found that:

- 12,962 of these incidents occurred in Metropolitan Police Districts (63%) and 7,518 in Regional Police Districts (37%); and
- Despite having the lowest population of all of the regions in Western Australia, the Kimberley Police District had the third highest number of domestic violence incidents (and domestic violence offences).

- At the 20,480 incidents, police officers detected a total of 26,023 offences against the person.
- WAPOL recorded 24,479 victims for these 26,023 offences.
- Of the 24,479 victims:
  - 17,539 (72%) were recorded as being female; and
  - 8,150 (33%) were recorded as being Indigenous.

Key findings: Family and domestic fatalities notified to the Ombudsman

During the investigation period, WAPOL notified the Ombudsman of 30 family and domestic violence fatalities.

The Office's analysis of the 30 fatalities identified that:

- 15 (50%) of the 30 people who were killed were Aboriginal;
- 15 (50%) of the 30 people who were killed were residing in a regional, remote, or very remote region of Western Australia, with remote and very remote regions significantly over-represented;
- In 16 fatalities (53%), there was a recorded prior history of family and domestic violence involving the person who was killed and the suspected perpetrator;
- In 17 of the 30 fatalities (57%), violence restraining orders involving at least one of the people involved in the fatality were granted at some point in time (a total of 48 violence restraining orders);
- The average age of the people who were killed was 36 years, with over a third between 35 and 44;
- 14 of the 30 suspected perpetrators (47%) had been held in custody for criminal offences at some point prior to the time when a person was killed and 18 (60%) had contact with the justice system; and
- In 19 of the 30 fatalities (63%) the records of State Government departments and authorities and the courts indicated that alcohol and/or other drugs had been used by the perpetrator immediately prior to the fatal incident.

Key findings: Key principles for administering the *Restraining Orders Act 1997*

The investigation identified nine key principles for State Government departments and authorities to apply when responding to family and domestic violence and administering the *Restraining Orders Act 1997*. Applying these principles will enable State Government departments and authorities to have the greatest impact on preventing and reducing family and domestic violence and related fatalities:

i. Perpetrators use family and domestic violence to exercise power and control over victims;

ii. Victims of family and domestic violence will resist the violence and try to protect themselves;

iii. Victims may seek help to resist the violence and protect themselves, including help from State Government departments and authorities;

iv. When victims seek help, positive and consistent responses by State Government departments and authorities can prevent and reduce further violence;

v. Victims' decisions about how they will resist violence and protect themselves may not always align with the expectations of State Government departments and authorities; this does not mean that victims do not need, want, or are less deserving of, help;

vi. Perpetrators of family and domestic violence make a decision to behave violently towards their victims;

vii. Perpetrators avoid taking responsibility for their behaviour and being held accountable for this behaviour by others;

viii. By responding decisively and holding perpetrators accountable for their behaviour, State Government departments and authorities can prevent and reduce further violence; and

ix. Perpetrators may seek to manipulate State Government departments and authorities, in order to maintain power and control over their victims and avoid being held accountable; State Government departments and authorities need to be alert to this.

Key findings: WAPOL's initial response to reports of family and domestic violence

- In the 16 fatalities where WAPOL recorded a history of family and domestic violence between the person who was killed and the suspected perpetrator, WAPOL recorded 133 family and domestic violence incidents.
- WAPOL complied with requirements to attend the scene in 96 per cent of incidents.
- A Domestic Violence Incident Report (**DVIR**) was submitted for 87 (65%) of the 133 family and domestic violence incidents between the person who was killed and the suspected perpetrator. For the remaining 46, a general incident report or Computer Aided Dispatch system recording was made.
- 75 DVIRs were submitted relating to these 87 recorded incidents (**the 75 DVIRs**).

Key findings: Providing advice and assistance and sharing information regarding violence restraining orders

- For the 30 fatalities it was recorded that:
  - WAPOL provided information and advice about violence restraining orders, and sought consent to share information with support services, in a quarter of instances where WAPOL investigated a report of family and domestic violence relating to the 30 fatalities (19 of 75 DVIRs).
  - WAPOL did not make any applications for violence restraining orders on behalf of the person who was killed or the suspected perpetrator in the 30 fatalities.
  - There were 22 instances (31%) in which WAPOL issued a police order (of the 71 applicable DVIRs).

- In 56% of incidents related to the 30 fatalities no order was made or sought and a written reason was provided.
- In 77% of instances where 'no consent and no safety concerns' were recorded as the reason, this was inconsistent with other information recorded at the scene.
- The number of police orders issued has increased from 10,312 in 2009-10 to 17,761 in 2013-14.

Key findings: Applying for a violence restraining order

- In the investigation period, 21,237 applications for a violence restraining order were made in Western Australia.
- In 12,393 (58%) of these applications, the applicant identified that the person seeking to be protected was in a family and domestic relationship with the respondent. Of these 12,393 applications:
  - 9,533 (77%) persons seeking to be protected were female;
  - 8,620 (70%) applicants identified that the person seeking to be protected was, or had been, in an intimate partner relationship with the respondent; and
  - 1,340 (11%) persons seeking to be protected identified themselves as Aboriginal or Aboriginal and Torres Strait Islander.

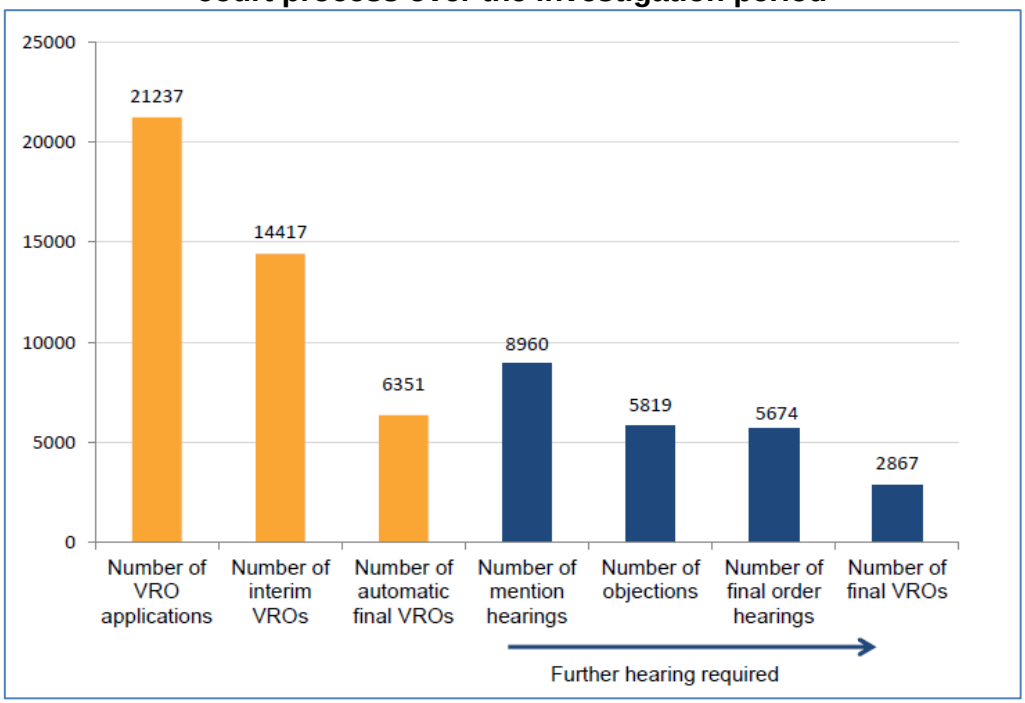
Key findings: Aboriginal family violence

- Aboriginal Western Australians are significantly over-represented as victims of family violence, yet under-represented in the use of violence restraining orders. More particularly:
  - 33% of all victims of domestic violence offences against the person were recorded by WAPOL as being Aboriginal;
  - Half of the people who were killed in the 30 fatalities were Aboriginal; and
  - 11% of all persons seeking to be protected by a violence restraining order, who were in a family and domestic relationship with the respondent identified themselves as Aboriginal or Aboriginal and Torres Strait Islander.

Key findings: Obtaining a violence restraining order

- Applications for an interim violence restraining order frequently did not progress to a final violence restraining order in the investigation period:
  - 14,417 interim violence restraining orders were made by the courts;
  - 6,351 interim violence restraining orders automatically became final violence restraining orders without returning to court; and
  - A final violence restraining order was granted as an outcome of 2,867 hearings.
- Considered collectively, this indicates that a total of approximately 43% of all applications for violence restraining orders go on to become final orders.

Patterns in violence restraining order hearings and outcomes across the court process over the investigation period



Source: Ombudsman Western Australia

Key findings: Serving violence restraining orders

- The Office identified that, in the investigation period, 13,378 violence restraining orders were served.
- 13,014 of these violence restraining orders were served personally, with 12,032 (92%) served personally by police officers.

Comparison of time taken to serve violence restraining orders

	Ombudsman's finding for the investigation period	Office of the Auditor General's finding (using data for the period 1999 to 2001)
Percentage of all violence restraining orders issued that were served within 4 days	42%	58%
Average time to serve all violence restraining orders issued	29 days	44 days
Average time to serve, without including outliers	14 days	18 days

Source: Ombudsman Western Australia and Office of the Auditor General

Note: The Auditor General noted that 'the average is impacted by a minority of orders where there is significant delay in service. A clearer estimate of service timeliness may be gained by looking only at orders served in 100 days' or less. To enable this comparison, the Office has also excluded orders served on day 101 or after.

- The Office also identified that 6,300 violence restraining orders were served by WAPOL more than five days after the violence restraining order was granted.
- The Office modelled the implementation of the Law Reform Commission's recommendation that, 'if a family and domestic violence protection order has not been served on the person bound within 72 hours, [WAPOL] are to apply to a registrar of the court within 24 hours'.
- If this had been applicable during the investigation period, WAPOL would have been required to apply for oral service for 63 per cent of served violence restraining orders, resulting in 8,450 applications to do so to the registrar of the court.

Key findings: Responding to breaches of violence restraining orders

- During the investigation period, there were 8,767 alleged breaches of violence restraining orders reported to, and recorded by, WAPOL, with 3,753 alleged offenders recorded.
- During the investigation period, 3,099 of the 3,753 (83%) alleged offenders were charged with the offence of 'breach of violence restraining order'.
- Of the 3,099 alleged offenders who were charged:
    - 2,481 (80%) were arrested;
    - 581 (19%) were summonsed to appear in court; and
    - A warrant was issued for the remaining 37 (1%) alleged offenders.
- WAPOL arrested and charged 75 per cent of people alleged to have breached a violence restraining order in the 75 DVIRs relating to the 30 fatalities.
- In the investigation period, the Magistrates and Children's Courts held 11,352 hearings relating to 8,147 charges of breach of a violence restraining order, and 2,676 alleged offenders.
- Of the 8,147 charges, 6,087 were finalised during the investigation period. The alleged offender was found guilty and a sentence imposed in 5,519 (91%) of the 6,087 finalised charges.
- The most frequent sentence imposed for breaching a violence restraining order was a fine (ranging from $10 to $3000), with 6,004 fines issued (64% of 9,378 sentencing outcomes). The second most frequent was imprisonment (879 occasions).
- Violence restraining orders are more likely to be breached, and less likely to be effective in high risk cases.
- Several factors increase the risk of a violence restraining order being breached, including separation, history of violence or crime by the perpetrator, or non-compliance with court conditions by a perpetrator.
- In the 30 fatalities:
    - 8 people who were killed in the 30 fatalities intended to separate, or had recently separated, from the suspected perpetrator;
    - 18 of the 30 suspected perpetrators had contact with the justice system at some point prior to the time when a person was killed; and

- WAPOL recorded a suspected perpetrator as being in breach of an order or other protective conditions imposed by the court in 17 per cent of the 75 DVIRs relating to the 30 fatalities.

- The Office's analysis identified that, in high risk cases, violence restraining orders may be insufficient if used alone and additional strategies may be useful.
- One such additional strategy is the consideration of deferral of bail or, in high risk cases in certain circumstances, a presumption against bail.

Key findings: Investigating if an act of family and domestic violence is a criminal offence

- Violence restraining orders are not a substitute for criminal charges where an offence has been committed.
- WAPOL's policy, in its *Commissioner's Operations and Procedures (COPS) Manual* 'is pro-charge, pro-arrest and pro-prosecution; where evidence exists that a criminal offence has been committed' (DV 1.1.2).
- The Office's examination of the 75 DVIRs found that:
  - WAPOL detected an offence in 51 of the 75 DVIRs (68%);
  - An offender was processed (arrested or summonsed) on 29 of these 51 occasions (57%); and
  - The victim was most likely to be interviewed (92%), followed by the suspect/person of interest (73%), with other significant witnesses least likely to be interviewed (48% of 46 incidents where potential significant witnesses were recorded).

Key findings: The use of violence restraining orders to protect children from family and domestic violence

- Research identifies that family and domestic violence causes harm to children.
- The Office identified that there were 30 children (aged less than 18 years) who experienced family and domestic violence associated with the 30 fatalities.
- Of these 30 children:
  - 18 (60%) were male and 12 were female; and
  - 21 (70%) were Aboriginal and nine were non-Aboriginal.
- The Office also identified children regarding whom the state-wide data indicated that:
  - A violence restraining order was applied for in the Magistrates Court in the investigation period;
  - The grounds selected by the applicant in applying for a violence restraining order included 'exposing a child to an act of family and domestic violence'; and
  - The applicant also submitted a DVIR number as evidence in support of the violence restraining order application.

- This identified a pool of 141 children. A random sample of 70 of the 141 children was selected, and these 70 children are referred to as the **70 children in the violence restraining order sample**. Twelve (17%) of these children were Aboriginal.
- For the 70 children in the violence restraining order sample, DCPFS recorded a total of 686 referrals (recorded by DCPFS as 'duty interactions').
- The Office identified family and domestic violence in 467 (68%) of duty interactions. DCPFS identified family and domestic violence in 290 (42%) of duty interactions.
- The Office's analysis of the 290 interactions identified that:
    - For 129 (44%) duty interactions where DCPFS identified family and domestic violence, DCPFS concluded that this was 'not departmental business'; and
    - DCPFS did not proceed with further action in 271 (93%) of duty interactions where DCPFS identified family and domestic violence as an issue.
- For each of the 686 duty interactions about the 70 children in the violence restraining order sample, the Office examined whether DCPFS provided the adult victims associated with these children with an active referral for legal advice or help from an appropriate service. The Office identified that:
    - In 154 (22%) of the 686 duty interactions, violence restraining orders were mentioned in information provided to DCPFS by the referrer, or in DCPFS's assessment of the information; and
    - DCPFS assisted with two violence restraining order applications and provided one referral for help regarding the 70 children in the violence restraining order sample.

The Office also examined all records relating to the children involved in the 30 fatalities. The Office identified that DCPFS did not provide any active referrals for legal advice or help from an appropriate service to obtain a violence restraining order for any of the children involved in the 30 fatalities.

- DCPFS's *Family and Domestic Violence Practice Guidance* specifies that 'Child Protection workers should consider seeking a violence restraining order on behalf of a child if the violence is likely to escalate and the children are at risk of further abuse; and/or it would decrease the risk to the adult victim if the Department was the applicant for the violence restraining order'.
- The Office analysed the 12,393 applications where the applicant identified that the person seeking to be protected was in a family and domestic relationship with the respondent; 6,813 (55%) of applicants cited grounds relating to children for seeking a violence restraining order.
- The Office found that DCPFS applied for 12 violence restraining orders on behalf of eight children in Western Australia during the investigation period.

Key findings: Actions by DCPFS to engage with adult victims and perpetrators of family and domestic violence in order to protect children

- During the 290 duty interactions where DCPFS identified family and domestic violence, DCPFS did not use the Common Screening Tool to screen for family and domestic violence, or assess the risks posed by family and domestic violence against Key Risk Indicators identified in *The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework*.
- The Office reviewed all duty interactions and associated documents concerning the children involved in the 30 fatalities and the 70 children in the violence restraining order sample to determine whether DCPFS undertook safety planning. The Office did not identify any instances where DCPFS undertook safety planning with adult victims of family and domestic violence.
- The Office reviewed all of the duty interactions concerning the children involved in the 30 fatalities and the violence restraining order sample to determine whether DCPFS engaged with perpetrators of family and domestic violence. The Office did not identify any instances where DCPFS utilised any forms of engagement identified in its Perpetrator Accountability resource materials.

Summary of recommendations

Arising from the findings of the investigation, the Ombudsman made 54 recommendations about ways to prevent or reduce family and domestic violence fatalities:

- 26 recommendations directed to DCPFS;
- 22 recommendations directed to WAPOL; and
- 6 recommendations directed to DOTAG.

- Recommendation 1: DCPFS, as the lead agency responsible for family and domestic violence strategic planning in Western Australia, in the development of Action Plans under *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, identifies actions for achieving its agreed Primary State Outcomes, priorities among these actions, and allocation of responsibilities for these actions to specific State Government departments and authorities.
- Recommendation 2: In developing and implementing future phases of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities,* DCPFS collaborates with WAPOL, DOTAG and other relevant agencies to identify and incorporate actions to be taken by State Government departments and authorities to collect data about communities who are over-represented in family and domestic violence, to inform evidence based strategies tailored to addressing family and domestic violence in these communities.
- Recommendation 3: DCPFS, in collaboration with the Mental Health Commission and other key stakeholders, includes initiatives in Action Plans developed under the *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, which recognise and address the co-occurrence of alcohol use and family and domestic violence.

- Recommendation 4: DCPFS, as the lead agency responsible for family and domestic violence strategic planning in Western Australia, develops a strategy that is specifically tailored to preventing and reducing Aboriginal family violence, and is linked to, consistent with, and supported by *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*.
- Recommendation 5: DCPFS, in developing the Aboriginal family violence strategy referred to at Recommendation 4, incorporates strategies that recognise and address the co-occurrence of alcohol use and Aboriginal family violence.
- Recommendation 6: In developing a strategy tailored to preventing and reducing Aboriginal family violence, referred to at Recommendation 4, DCPFS actively invites and encourages the involvement of Aboriginal people in a full and active way at each stage and level of the process, and be comprehensively informed by Aboriginal culture.
- Recommendation 7: WAPOL ensures that all family and domestic violence incidents are correctly identified, recorded and submitted in accordance with the *Commissioner's Operations and Procedures Manual.*
- Recommendation 8: In implementing Recommendation 7, WAPOL considers its amended definition of family and domestic relationship, in terms of its consistency with the *Restraining Orders Act 1997*, and giving particular consideration to the identification of, and responses to, Aboriginal family violence.
- Recommendation 9: WAPOL amends the *Commissioner's Operations and Procedures Manual* to require that victims of family and domestic violence are provided with verbal information and advice about violence restraining orders in all reported instances of family and domestic violence.
- Recommendation 10: WAPOL collaborates with DCPFS and DOTAG to develop an 'aide memoire' that sets out the key information and advice about violence restraining orders that WAPOL should provide to victims of all reported instances of family and domestic violence.
- Recommendation 11: WAPOL collaborates with DCPFS and DOTAG to ensure that the 'aide memoire', discussed at Recommendation 10, is developed in consultation with Aboriginal people to ensure its appropriateness for family violence incidents involving Aboriginal people.
- Recommendation 12: WAPOL ensures that both victims and perpetrators are asked if they consent to share their information with support and referral agencies, in accordance with the *Commissioner's Operations and Procedures Manual.*
- Recommendation 13: WAPOL amends the *Commissioner's Operations and Procedures Manual* to require that, if a police order is issued, it is explained to the victim that the order is intended to provide them with time to seek a violence restraining order, and also that victims are provided with information and advice about violence restraining orders in accordance with Recommendation 9.

- Recommendation 14: In developing and implementing future phases of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, DCPFS specifically identifies and incorporates opportunities for state government departments and authorities to deliver information and advice about violence restraining orders, beyond the initial response by WAPOL.
- Recommendation 15: In considering whether legislation should provide that, with the consent of the victim, a police order can be filed at court as an initiating application by police for an interim family and domestic violence protection order, DOTAG should involve Aboriginal people in a full and active way at each stage and level of the process, and should seek to have the process of consideration comprehensively informed by Aboriginal culture.
- Recommendation 16: DCPFS considers the findings of the Ombudsman's investigation regarding the link between the use of police orders and violence restraining orders by Aboriginal people in developing and implementing the Aboriginal family violence strategy referred to at Recommendation 4.
- Recommendation 17: Taking into account the findings of this investigation, WAPOL reviews the *Commissioner's Operations and Procedures Manual* to ensure its consistency with section 62C of the *Restraining Orders Act 1997*.
- Recommendation 18: Following the implementation of Recommendation 17, WAPOL complies with the requirements of the *Commissioner's Operations and Procedures Manual.*
- Recommendation 19: WAPOL ensures that where an application for a violence restraining order has not been made, or a police order has not been issued, written records of the reasons why are recorded on each occasion.
- Recommendation 20: WAPOL ensures that if 'no consent and no safety concerns of involved persons' is recorded as a reason for not making an application for a violence restraining order or making a police order, this is consistent with other information recorded in the associated Domestic Violence Incident Report.
- Recommendation 21: WAPOL considers establishing a Key Performance Indicator that relates to the quality of service as well as the timeliness of responding to family and domestic violence incidents to ensure a balanced approach is achieved.
- Recommendation 22: As part of the implementation of Frontline 2020, WAPOL ensures that the creation of Response Teams continues to provide an appropriate opportunity for frontline police officers to provide critical initial response and support to victims.
- Recommendation 23: DOTAG, in collaboration with key stakeholders, considers opportunities to address the cultural, logistical and structural barriers to Aboriginal victims seeking a violence restraining order, and ensures that Aboriginal people are involved in a full and active way at each stage and level of this process, and that this process is comprehensively informed by Aboriginal culture.

- Recommendation 24: DCPFS, in collaboration with DOTAG, ensures that the development of the Aboriginal family violence strategy referred to at Recommendation 4 incorporates the opportunities to address the cultural, logistical and structural barriers to Aboriginal victims seeking a violence restraining order identified through the implementation of Recommendation 23.
- Recommendation 25: DOTAG, in collaboration with DCPFS, identifies and incorporates into *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, ways of ensuring that, in cases where an application for a violence restraining order has been dismissed, if appropriate, victims are provided with referrals to appropriate safety planning assistance.
- Recommendation 26: DOTAG collaborates with WAPOL to consider whether it may be appropriate to pursue amendments to the *Restraining Orders Act 1997* so that, where a violence restraining order has not been served on the person bound within 72 hours, and reasonable efforts have been made to serve the order personally, the violence restraining order is deemed to be authorised for oral service, including considering establishing legislative and administrative arrangements to ensure WAPOL keeps records that demonstrate that reasonable efforts had been made to serve the order personally prior to oral service.
- Recommendation 27: DOTAG collaborates with WAPOL to establish a process for providing WAPOL with the following information, together with the violence restraining order for service:
  - the relationship between the respondent and the protected person (particularly if they are in a family and domestic relationship);
  - the grounds for the violence restraining order;
  - identifying particulars (full name, address, date of birth, telephone contact details) of both parties, as recorded by the protected person; and
  - any relevant information regarding the history of family and domestic violence disclosed by the applicant when seeking a violence restraining order.
- Recommendation 28: Taking into account the findings of this investigation, DCPFS consults with key stakeholders to explore issues associated with the provision of information to respondents to violence restraining orders, whether these issues require a state-wide response, and the appropriate form of this response, for potential incorporation into future Action Plans.
- Recommendation 29: WAPOL amend its Incident Management System to ensure all information relevant to a violence restraining order can be included on its associated running sheet.
- Recommendation 30: WAPOL ensures that all reports of alleged breaches of a violence restraining order are recorded and investigated in accordance with the *Restraining Orders Act 1997* and the *Commissioner's Operations and Procedures Manual*.

- Recommendation 31: WAPOL ensures that it does not inform victims to withdraw a violence restraining order on the basis that alleged breaches are consensual.
- Recommendation 32: DOTAG reviews the effectiveness of national and international models of deferral of bail, or in high risk cases in certain circumstances, a presumption against bail, having consideration to:
  - perpetrator accountability;
  - promoting victim safety;
  - the rights of defendants; and
  - makes recommendations for implementing any changes that arise from the review.
- Recommendation 33: WAPOL ensures that, when undertaking investigations in accordance with section 62A of the *Restraining Orders Act 1997*, and where required by the *Commissioner's Operations and Procedures Manual* and the *WA Police Investigation Doctrine*, police officers interview all witnesses, including victims, suspects/persons of interest, eye witnesses and other significant witnesses, and, should a decision be made not to interview a person of interest, the reasons should be fully explained and recorded on the running sheet.
- Recommendation 34: WAPOL ensures that, when undertaking investigations in accordance with section 62A of the *Restraining Orders Act 1997*, and where required by the *Commissioner's Operations and Procedures Manual* and the *WA Police Investigation Doctrine*, police officers take photographs of any arising injuries to the victim, with their consent, in accordance with the *Commissioner's Operations and Procedures Manual* and the *WA Police Investigation Doctrine*.
- Recommendation 35: WAPOL ensures that responses to family and domestic violence incidents record all offences disclosed in accordance with the *Commissioner's Operations and Procedures Manual* (including offences disclosed prior to attendance).
- Recommendation 36: WAPOL ensures that it takes ownership of the decision to prefer a charge and does not place the responsibility with the victim, in accordance with the *Commissioner's Operations and Procedures Manual*.
- Recommendation 37: WAPOL ensures that all offences detected at family and domestic violence incidents are cleared in accordance with the *Commissioner's Operations and Procedures Manual*.
- Recommendation 38: WAPOL complies with the *Commissioner's Operations and Procedures Manual*, in particular, that for all children who are present or usually reside with parties to a family and domestic violence incident, police officers:
  - ensure that all children are sighted and their welfare checked;
  - record the details of the children; and
  - where children are exposed to, or involved in, a serious incident of family violence, contact DCPFS.

- Recommendation 39: DCPFS, in accordance with its Casework Practice Manual and *Family and Domestic Violence Policy 2012*, instructs child protection workers to review information provided for each referral to DCPFS, to identify if family and domestic violence indicators are present and record when family and domestic violence has been identified.
- Recommendation 40: When family and domestic violence has been identified during duty interactions, DCPFS complies with its *Family and Domestic Violence Practice Guidance*, which identifies 'the outcome of option of 'Not Departmental Business' should rarely be used in [family and domestic violence] cases as [family and domestic violence] is the Department's business'.
- Recommendation 41: When family and domestic violence has been identified during duty interactions, DCPFS complies with the Casework Practice Manual in providing 'Family Support', in particular that the provision of 'Family Support' involves the provision of information to referrers or families on available support services such as those listed in the Casework Practice Manual.
- Recommendation 42: Where family and domestic violence is identified, DCPFS, if required, takes action to assess and safeguard the wellbeing of children, including, where appropriate, progressing to intake, initial inquiries and safety and wellbeing assessments.
- Recommendation 43: DCPFS monitors the percentage of duty interactions relating to family and domestic violence resulting in an outcome of 'concern for child' and progression to initial inquiries and safety and wellbeing assessments, in quarterly reports to its Corporate Executive, taking any appropriate action in relation to performance.
- Recommendation 44: DCPFS complies with the requirements of the *Family and Domestic Violence Practice Guidance*, in particular, that '[w]here a violence restraining order is considered desirable or necessary but a decision is made for the Department not to apply for the order, the non-abusive adult victim should be given an active referral for legal advice and help from an appropriate service'.
- Recommendation 45: In its implementation of section 18(2) of the *Restraining Orders Act 1997*, DCPFS complies with its *Family and Domestic Violence Practice Guidance* which identifies that DCPFS officers should consider seeking a violence restraining order on behalf of a child if the violence is likely to escalate and the children are at risk of further abuse, and/or it would decrease risk to the adult victim if the Department was the applicant for the violence restraining order.
- Recommendation 46: DCPFS instructs officers providing legal advice to child protection workers to provide advice that is consistent with the practice guidance regarding applications for violence restraining orders on behalf of children, in particular that 'child protection workers should consider seeking a violence restraining order on behalf of a child if the violence is likely to escalate and the children are at risk of further abuse and/or it would decrease the risk to the adult victim if the Department was the applicant for the violence restraining order'.
- Recommendation 47: DCPFS, through case reviews and case consultations, monitors, on an ongoing basis, compliance with the practice guidance regarding applications for violence restraining orders on behalf of children.

- Recommendation 48: DCPFS ensures that its Casework Practice Manual requirements for screening for family and domestic violence are both internally consistent and consistent with the 'Minimum Standards of Practice for Screening' in *The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework*.
- Recommendation 49: Following the implementation of Recommendation 48, DCPFS complies with the requirements for family and domestic violence screening and risk assessment.
- Recommendation 50: Following the implementation of Recommendation 48, DCPFS undertakes safety planning in accordance with the Casework Practice Manual.
- Recommendation 51: DCPFS incorporates the minimum forms of engagement with perpetrators of family and domestic violence into the Casework Practice Manual, so that child protection workers are required to engage with perpetrators when it has been assessed as safe to do so.
- Recommendation 52: DCPFS ensures that, following the implementation of Recommendation 51, DCPFS provides appropriate training in relation to the amended Casework Practice Manual.
- Recommendation 53: DCPFS sets out in the Casework Practice Manual, *Family and Domestic Violence Policy 2012*, and *Family and Domestic Violence Practice Guidance* how DCPFS responds to Aboriginal family violence and how Aboriginal children may best be protected from harm arising from family violence, within DCPFS frameworks developed to respond to Aboriginal families.
- Recommendation 54: Taking into account the findings of this investigation, DCPFS:
  - conducts a review to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance;
  - develops an associated action plan to overcome identified barriers; and
  - provides the resulting review report and action plan to this Office within 12 months of the tabling in the Western Australian Parliament of the report of this investigation.

The Ombudsman will actively monitor what steps have been taken to give effect to these recommendations. The results of this monitoring will be reported to Parliament in November 2016.

Other mechanisms to prevent or reduce family and domestic violence fatalities

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

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through the Panel, and other mechanisms, working with public authorities and communities where individuals may be at risk of family and domestic violence to consider safety issues and potential areas for improvement, and to highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information, where appropriate, with other accountability and oversight agencies including Ombudsmen and family and domestic violence fatality review bodies in other States to facilitate consistent approaches and shared learning;
- Engaging with other family and domestic violence fatality review bodies in Australia and New Zealand through meetings with the Australian Domestic and Family Violence Death Review Network;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

Efficient and effective liaison has been established with WAPOL to develop and support the implementation of the process to inform the Ombudsman of family and domestic violence fatalities. Regular liaison occurs at senior officer level between the Office and WAPOL.

The Ombudsman's Advisory Panel

The Panel is an advisory body established to provide independent advice to the Ombudsman on:

- Issues and trends that fall within the scope of the family and domestic violence fatality review function;
- Contemporary professional practice relating to the safety and wellbeing of people impacted by family and domestic violence; and
- Issues that impact on the capacity of public authorities to ensure the safety and wellbeing of individuals and families.

The Panel met four times in 2015-16 and during the year the following members provided a range of expertise:

- Professor Steve Allsop (Director, National Drug Research Institute, Curtin University);
- Ms Jocelyn Jones (Health Sciences, Curtin University);
- Professor Donna Chung (Head of the Department of Social Work, Curtin University);
- Ms Dorinda Cox (Consultant);
- Ms Angela Hartwig (Women's Council for Domestic and Family Violence Services WA);
- Ms Victoria Hovane (Consultant); and
- Associate Professor Carolyn Johnson (School of Population Health, University of Western Australia).

Observers from Western Australia Police, the Department for Child Protection and Family Support, the Department of Health, the Department of Education, the Department of Corrective Services, the Department of the Attorney General, the Mental Health Commission and the Department of Aboriginal Affairs also attended the meetings.

In 2015-16, among other things, the Panel provided advice to the Ombudsman regarding the first major own motion investigation in relation to family and domestic violence fatalities.

Key stakeholder relationships

There are a number of public authorities and other bodies that interact with or deliver services to those who are at risk of family and domestic violence or who have experienced family and domestic violence. Important stakeholders, with which the Office liaises as part of the family and domestic violence fatality review function, include:

- The Coroner;
- Relevant public authorities including:
  - Western Australia Police;
  - The Department of Health;

- The Department of Education;
- The Department of Corrective Services;
- The Department for Child Protection and Family Support;
- The Department of Housing;
- The Department of the Attorney General;
- The Department of Aboriginal Affairs;
- The Mental Health Commission; and
- Other accountability and similar agencies including the Commissioner for Children and Young People;

- The Women's Council for Domestic and Family Violence Services WA and relevant non-government organisations; and
- Research institutions including universities.

Aboriginal and regional communities

In 2016, the Ombudsman appointed a Principal Aboriginal Liaison Officer 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, complaints resolution involving Aboriginal people and own motion investigations.
- 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.

Through the Principal Aboriginal Liaison Officer, the Panel and outreach activities, work was undertaken through the year to build relationships relating to the family and domestic violence fatality review function with Aboriginal and regional communities, including by communicating with:

- Key public authorities that work in metropolitan and regional areas;
- Non-government organisations that provide key services such as health services to Aboriginal people; and
- Aboriginal community leaders to increase the awareness of the family and domestic violence fatality review function and its purpose.

Building on the work already undertaken by the Office, as part of its other functions, including its child death review function, networks and contacts have been established to support effective and efficient family and domestic violence fatality reviews.

Own Motion Investigations and Administrative Improvement

A key function of the Office is to improve the standard of public administration. The Office achieves positive outcomes in this area in a number of ways including:

- Improvements to public administration as a result of:
  - The investigation of complaints;
  - Reviews of child deaths and family and domestic violence fatalities; and
  - Undertaking own motion investigations that are based on the patterns, trends and themes that arise from the investigation of complaints, and the review of certain child deaths and family and domestic violence fatalities;
- Providing guidance to public authorities on good decision making and practices and complaint handling through continuous liaison, publications, presentations and workshops;
- Working collaboratively with other integrity and accountability agencies to encourage best practice and leadership in public authorities; and
- Undertaking inspection and monitoring functions.

Improvements from Complaints and Reviews

In addition to outcomes which result in some form of assistance for the complainant, the Ombudsman also achieves outcomes which are aimed at improving public administration. Among other things, this reduces the likelihood of the same or similar issues which gave rise to the complaint occurring again in the future. Further details of the improvements arising from complaint resolution are shown in the Complaint Resolution section.

Child death and family and domestic violence fatality reviews also result in improvements to public administration as a result of the review of individual child deaths and family and domestic violence fatalities. Further details of the improvements arising from reviews are shown in the Child Death Review section and the Family and Domestic Violence Fatality Review section.

Own Motion Investigations

One of the ways that the Office endeavours to improve public administration is to undertake investigations of systemic and thematic patterns and trends arising from complaints made to the Ombudsman and from child death and family and domestic violence fatality reviews. These investigations are referred to as own motion investigations.

Own motion investigations are intended to result in improvements to public administration that are evidence-based, proportionate, practical and where the benefits of the improvements outweigh the costs of their implementation.

Own motion investigations that arise out of child death and family and domestic violence fatality reviews focus on the practices of agencies that interact with children

and families and aim to improve the administration of these services to prevent or reduce child deaths and family and domestic violence fatalities.

Selecting topics for own motion investigations

Topics for own motion investigations are selected based on a number of criteria that include:

- The number and nature of complaints, child death and family and domestic violence fatality reviews, and other issues brought to the attention of the Ombudsman;
- The likely public interest in the identified issue of concern;
- The number of people likely to be affected;
- Whether reviews of the issue have been done recently or are in progress by the Office or other organisations;
- The potential for the Ombudsman's investigation to improve administration across public authorities; and
- Whether investigation of the chosen topic is the best and most efficient use of the Office's resources.

Having identified a topic, extensive preliminary research is carried out to assist in planning the scope and objectives of the investigation. A public authority selected to be part of an own motion investigation is informed when the project commences and Ombudsman staff consult regularly with staff at all levels to ensure that the facts and understanding of the issues are correct and findings are evidence-based. The public authority is given regular progress reports on findings together with the opportunity to comment on draft conclusions and any recommendations.

Monitoring the implementation of recommendations

Recommendations for administrative improvements are based closely on evidence gathered during investigations and are designed to be a proportionate response to the number and type of administrative issues identified. Each of the recommendations arising from own motion investigations is actively monitored by the Office to ensure its implementation and effectiveness in relation to the observations made in the investigation.

In addition, significant work was undertaken during the year on a report in relation to the implementation of Ombudsman recommendations arising from own motion investigations.

Own Motion Investigations in 2015-16

In 2015-16, a report of a major own motion investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities was finalised and tabled in Parliament, and significant work was undertaken on an own motion investigation, into ways to prevent or reduce child deaths by drowning.

Major investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities

In November 2015, the Ombudsman tabled in Parliament the report of a major own motion investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities.

The Ombudsman undertakes an important responsibility to review family and domestic violence fatalities. Arising from this work, the Ombudsman identified the need to undertake a major own motion investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities.

To undertake the investigation, in addition to an extensive literature review and stakeholder engagement, the Office collected and analysed a comprehensive set of de-identified state-wide data relevant to family and domestic violence and examined 30 family and domestic violence fatalities notified to the Ombudsman.

The Ombudsman found that a range of work has been undertaken by State Government departments and authorities to administer their relevant legislative responsibilities, including their responsibilities arising from the *Restraining Orders Act 1997*. However, there is important further work that should be done. This work, detailed in the findings of the report, includes a range of important opportunities for improvement for State Government departments and authorities, working individually and collectively, across all stages of the violence restraining order process.

The Ombudsman also found that Aboriginal Western Australians are significantly over-represented as victims of family violence, yet under-represented in the use of violence restraining orders. Following from this, the Ombudsman identified that a separate strategy, specifically tailored to preventing and reducing Aboriginal family violence, should be developed. This strategy should actively invite and encourage the full involvement of Aboriginal people in its development and be comprehensively informed by Aboriginal culture.

Furthermore, the Ombudsman identified nine key principles for State Government departments and authorities to apply when responding to family and domestic violence and in administering the *Restraining Orders Act 1997*. Applying these principles will enable State Government departments and authorities to have the greatest impact on preventing and reducing family and domestic violence and related fatalities.

Arising from the findings, the Ombudsman made 54 recommendations to four State Government agencies about ways to prevent or reduce family and domestic violence fatalities. Further details of the report's findings and recommendations are included in the Family and Domestic Violence Fatality Review section.

The full report, *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* is available at www.ombudsman.wa.gov.au/familydomesticviolencereport.

Significant work has been undertaken in the 2015-16 year on a report by the Office on the implementation of the 54 recommendations arising from the findings of the investigation. The report will be tabled in Parliament in November 2016.

Major investigation into ways to prevent or reduce deaths of children by drowning

Through the review of the circumstances in which, and why, child deaths occurred, the Ombudsman identified a pattern of cases in which children appeared to have died by drowning. The Ombudsman decided to undertake an investigation into these deaths with a view to determining whether it may be appropriate to make recommendations to any local government or State Government department or authority about ways to prevent or reduce deaths of children by drowning.

During 2015-16, significant work was undertaken on this own motion investigation. The report of the investigation will be tabled in Parliament in 2016-17.

Continuous Administrative Improvement

The Office maintains regular contact with staff from public authorities to inform them of trends and issues identified in individual complaints and the Ombudsman's own motion investigations with a view to assisting them to improve their administrative practices. This contact seeks to encourage thinking around the foundations of good administration and to identify opportunities for administrative improvements.

Where relevant, these discussions concern internal investigations and complaint processes that authorities have conducted themselves. The information gathered demonstrates to the Ombudsman whether these internal investigations have been conducted appropriately and in a manner that is consistent with the standards and practices of the Ombudsman's own investigations.

Guidance for public authorities

The Office provides publications, workshops, assistance and advice to public authorities regarding their decision making and administrative practices and their complaint handling systems. This educative function assists with building the capacity of public authorities and subsequently improving the standard of administration.

Publications

The Ombudsman has a range of guidelines available for public authorities in the areas of effective complaint handling, conducting administrative investigations and administrative decision making. These guidelines aim to assist public authorities in strengthening their administrative and decision making practices. For a full listing of the Office's publications, see Appendix 3.

Workshops for public authorities

During the year, the Office continued to proactively engage with public authorities through presentations and workshops.

Workshops are targeted at people responsible for making decisions or handling complaints as well as customer service staff. The workshops are also relevant for supervisors, managers, senior decision and policy makers as well as integrity and

governance officers who are responsible for implementing and maintaining complaint handling systems or making key decisions within a public authority.

The workshops are tailored to the organisation or sector by using case studies and practical exercises. Details of workshops conducted during the year are provided in the Collaboration and Access to Services section.

Working collaboratively

The Office works collaboratively with other integrity and accountability agencies to encourage best practice and leadership in public authorities. Improvements to public administration are supported by the collaborative development of products and forums to promote integrity in decision making, practices and conduct. Details are provided in the Collaboration and Access to Services section.

Inspection and Monitoring Functions

Telecommunications interception records

The *Telecommunications (Interception and Access) Western Australia Act 1996*, the *Telecommunications (Interception and Access) Western Australia Regulations 1996* and the *Telecommunications (Interception and Access) Act 1979* (Commonwealth) permit designated 'eligible authorities' to carry out telecommunications interceptions. The Western Australia Police (**WAPOL**) and the Corruption and Crime Commission are eligible authorities in Western Australia. The Ombudsman is appointed as the Principal Inspector to inspect and report on the extent of compliance with the legislation.

Infringement notices

The *Criminal Code Amendment (Infringement Notices) Act 2011* amended *The Criminal Code* to introduce a new scheme into Western Australia for the issue of infringement notices by WAPOL for certain offences.

The *Criminal Code Amendment (Infringement Notices) Act 2011* amended *The Criminal Code* to include Chapter LXXIII – Infringement notices (**the Infringement Notices provisions**). Regulations may be made pursuant to section 721 of *The Criminal Code* to allow infringement notices to be issued for Code offences, being the *Criminal Code (Infringement Notices) Regulations 2015* (**the Regulations**), and that *The Criminal Code* is to be taken as a prescribed Act for the purposes of Part 2 of the *Criminal Procedure Act 2004*.

Together, *The Criminal Code*, the *Criminal Procedure Act 2004* and the Regulations allow authorised officers to issue Criminal Code infringement notices with a modified penalty for prescribed offences. The Infringement Notices provisions and the Regulations came into operation on 4 March 2015.

The Ombudsman has an important function to keep under scrutiny the operation of the Infringement Notices provisions. Under section 723 of *The Criminal Code*:

> *(1) For the period of 12 months after the commencement of this section, the Ombudsman is to keep under scrutiny the operation of the provisions of this Chapter and the regulations made under this Chapter and the Criminal Investigation (Identifying People) Act 2002 Part 7 and section 67.*

(2) *The scrutiny referred to in subsection (1) is to include review of the impact of the operation of the provisions referred to in that subsection on Aboriginal and Torres Strait Islander communities.*

(3) *For that purpose, the Ombudsman may require the Commissioner of Police or any public authority to provide information about police or the public authority's participation in the operation of the provisions referred to in subsection (1).*

(4) *The Ombudsman must, as soon as practicable after the expiration of that 12 month period, prepare a report on the Ombudsman's work and activities under this section and furnish a copy of the report to the Minister for Police and the Commissioner of Police.*

(5) *The Ombudsman may identify, and include recommendations in the report to be considered by the Minister about, amendments that might appropriately be made to this Act with respect to the operation of the provisions referred to in subsection (1).*

(6) *The Minister is to lay (or cause to be laid) a copy of the report furnished to the Minister under this section before both Houses of Parliament as soon as practicable after the Minister receives the report.*

The period of 12 months referred to in Section 723(1) of *The Criminal Code* commenced on 5 March 2015.

The Ombudsman is undertaking a range of work as part of this monitoring role, including critically, a wide range of consultative activities regarding the operation of the Infringement Notices provisions. An important part of these consultative activities is that the Ombudsman has consulted members of the community who have had experience with the operation of Criminal Code infringement notices. In particular, the Ombudsman has consulted Aboriginal and Torres Strait Islander communities.

This included the development of a Consultation Paper, which was placed prominently on our website as well as being distributed to relevant State Government agencies, non-government organisations and community groups, for their response. The Consultation Paper was also advertised in *The West Australian* newspaper, community newspapers, the *Koori Mail* and on Aboriginal radio stations. In addition, a Community Consultation Forum, specifically focused on consultation with Aboriginal and Torres Strait Islander Communities, will be undertaken in August 2016.

In accordance with section 723 of *The Criminal Code*, the report on the Ombudsman's work and activities will be completed and provided to the Minister for Police and the Commissioner of Police in 2016-17.

Criminal organisations control

Under the *Criminal Organisations Control Act 2012*, the Ombudsman scrutinises and reports on the exercise of certain powers by WAPOL, for a five year period commencing in November 2013.

In accordance with the *Criminal Organisations Control Act 2012*, a report was prepared by the Ombudsman for the monitoring period ending 1 November 2015. A copy of this report was provided to the Minister for Police and the Commissioner of Police on 20 November 2015 and was tabled in Parliament on 16 February 2016.

Collaboration and Access to Services

Engagement with key stakeholders is essential to the Office's achievement of the most efficient and effective outcomes. The Office does this through:

- Working collaboratively with other integrity and accountability bodies – locally, nationally and internationally – to encourage best practice, efficiency and leadership;
- Ensuring ongoing accountability to Parliament as well as accessibility to its services for public authorities and the community; and
- Developing, maintaining and supporting relationships with public authorities and community groups.

Working Collaboratively

The Office works collaboratively with local, national and international integrity and accountability bodies to promote best practice, efficiency and leadership. Working collaboratively also provides an opportunity for the Office to benchmark its performance and stakeholder communication activities against other similar agencies, and to identify areas for improvement through the experiences of others.

Integrity Coordinating Group

Members:

Western Australian Ombudsman

Public Sector Commissioner

Corruption and Crime Commissioner

Auditor General

Information Commissioner

Background:

The Integrity Coordinating Group (**ICG**) was formed to promote and strengthen integrity in Western Australian public bodies.

The Office's involvement:

The Ombudsman participates as a member of the ICG and the Office has nominated senior representatives who sit on the ICG's joint working party.

2015-16 initiatives:

The ICG met three times in 2015-16.

The Office was involved in the review and update of *Gifts, benefits and hospitality – A guide to good practice,* available on the ICG's website, and the ICG's graduate program, which involves a graduate working in each of the member agencies over a two year period in total.

Public Sector Commission's Induction Seminars	**Background:** As part of the induction process for all new public officers, the Public Sector Commission holds a half-day induction seminar. Staff from the Public Sector Commission, the Office of the Ombudsman and the Office of the Information Commissioner present at these sessions. **2015-16 initiatives:** The Office presented on four occasions during the year. The Office provides information on *The Role of the Ombudsman* and how the Office may be able to assist new public officers in their work. This program will continue into 2016-17.
International Ombudsman Institute	**Background:** The International Ombudsman Institute (**IOI**), established in 1978, is the only global organisation for the cooperation of more than 170 Ombudsman institutions. **The Office's involvement:** The Office is a member of the IOI. The Ombudsman was elected to the position of IOI Treasurer and as a member of the Executive Committee of the Board of Directors of the IOI in March 2014. The Ombudsman previously served as the President of the Australasian and Pacific Ombudsman Region (**APOR**) of the IOI from November 2012 until March 2014. **2015-16 initiatives:** On 3 May 2016, the Ombudsman launched *a Starter kit for new ombudsmen and developing or expanding offices* (**Starter Kit)** at the 2016 APOR Conference held in Melbourne. The Starter Kit is a project funded by the IOI and jointly undertaken by the offices of the Western Australian Ombudsman and New South Wales Ombudsman. The objective of the project is to provide a highly accessible, web-based induction tool for newly appointed Ombudsmen, utilising the knowledge and experience of existing Ombudsmen, and a resource for those offices who are undergoing an expansion of functions or dealing with novel or challenging issues.
Information sharing with Ombudsmen from other jurisdictions	**Background:** Where appropriate, the Office shares information and insights about its work with Ombudsmen from other jurisdictions, as well as with other accountability and integrity bodies. **2015-16 initiatives:** The Office exchanged information with a number of Parliamentary Ombudsmen and industry-based Ombudsmen during the year.

Australia and New Zealand Ombudsman Association **Members:** Parliamentary and industry-based Ombudsmen from Australia and New Zealand	**Background:** The Australia and New Zealand Ombudsman Association (**ANZOA**) is the peak body for Parliamentary and industry-based Ombudsmen from Australia and New Zealand **The Office's involvement:** The Office is a member of ANZOA. The Office periodically provides general updates on its activities and also has nominated representatives who participate in interest groups in the areas of Aboriginal complaints handling, first contact, business improvement and policy and research. **2015-16 initiatives:** The Ombudsman participated in the ANZOA Joint Executive Committee and Members meeting in May 2016.
Indonesian/ Australian Ombudsman Linkages and Strengthening Program **Members:** Western Australian Ombudsman Commonwealth Ombudsman New South Wales Ombudsman Ombudsman Republik Indonesia	**Background:** The Indonesian/Australian Ombudsman Linkages and Strengthening Program (**the Linkages Program**) aims to provide greater access across Indonesia to more effective and sustainable Ombudsman services. **The Office's involvement:** The Office has been involved with the Linkages Program since 2005 and supports the Linkages Program through staff placements in Indonesia and Australia. **2015-16 initiatives:** In September 2015, the Office hosted a senior delegation from the office of the Ombudsman Republik Indonesia. The delegates met with senior Ombudsman staff during the two day visit. Following the successful internship program in December 2014, the Office once again hosted two staff from the office of the Ombudsman Republik Indonesia for a one week internship in December 2015. The interns met with senior Ombudsman staff and received training in the Office's complaint handling processes.

Providing Access to the Community

Communicating with complainants

The Office provides a range of information and services to assist specific groups, and the public more generally, to understand the role of the Ombudsman and the complaint process. Many people find the Office's enquiry service and complaint clinics held during regional visits assist them to make their complaint. Other initiatives in 2015-16 include:

- Regular updating and simplification of the Ombudsman's publications and website to provide easy access to information for people wishing to make a complaint and those undertaking the complaint process;
- Ongoing promotion of the role of the Office and the type of complaints the Office handles through 'Ask the Ombudsman' on 6PR's Nightline Program; and
- The Office's Youth Awareness and Accessibility Program and Prison Program.

Access to the Ombudsman's services

The Office continues to implement a number of strategies to ensure its complaint services are accessible to all Western Australians. These include access through online facilities as well as more traditional approaches by letter and through visits to the Office. The Office also holds complaints clinics and delivers presentations to community groups, particularly through the Regional Awareness and Accessibility Program. Initiatives to make services accessible include:

- Access to the Office through a toll free number for country callers;
- Access to the Office through email and online services. The importance of email and online access is demonstrated by its further increased use this year from 65% to 66% of all complaints received;
- Information on how to make a complaint to the Ombudsman is available in 15 languages and features on the homepage of the Ombudsman's website. People may also contact the Office with the assistance of an interpreter by using the Translating and Interpreting Service;
- The Office's accommodation, building and facilities provide access for people with disabilities, including lifts that accommodate wheelchairs and feature braille on the access buttons and people with hearing and speech impairments can contact the Office using the National Relay Service;
- The Office's Regional Awareness and Accessibility Program and Youth Awareness and Accessibility Program target awareness and accessibility for regional and Aboriginal Western Australians as well as children and young people;
- The Office attends events to raise community awareness of, and access to, its service, such as the Financial Counsellors' Association conference in October 2015, and Homeless Connect in November 2015; and
- The Office's visits to adult prisons and juvenile custodial facilities provide an opportunity for adult prisoners and juvenile detainees to meet with representatives of the Office and lodge complaints in person.

Ombudsman website

The Ombudsman's website provides a wide range of information and resources for:

- Members of the public on the complaint handling services provided by the Office as well as links to other complaint bodies for issues outside the Ombudsman's jurisdiction;

- Public authorities on decision making, complaint handling and conducting investigations;
- Children and young people as well as information for non-government organisations and government agencies that assist children and young people;
- Access to the Ombudsman's investigation reports such as the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*;
- The latest news on events and collaborative initiatives such as the Regional Awareness and Accessibility Program; and
- Links to other key functions undertaken by the Office such as the Energy and Water Ombudsman website and other related bodies including other Ombudsmen and other Western Australian accountability agencies;

The website continues to be a valuable resource for the community and public sector as shown by the increased use of the website this year. In 2015-16:

- The total number of visits to the website has increased by 20% to 96,526 page visits compared to 80,445 page visits in 2014-15;
- The top two most visited pages (besides the homepage and the Contact Us page) on the site were *The role of the Ombudsman* and *How to make a complaint*; and
- The Office's *Guidelines on Complaint Handling* and *Procedural Fairness Guidelines* were the two most viewed documents.

The website content and functionality are continually reviewed and improved to ensure there is maximum accessibility to all members of the diverse Western Australian community. The site provides information in a wide range of community languages and is accessible to people with disabilities.

Dedicated youth space for children and young people

In June 2016, the Office launched a new, dedicated youth space on the Ombudsman's website. The new pages provide information about the Office specifically tailored for children and young people, as well as information for non-government organisations and government agencies that assist children and young people. The pages also have downloadable print material tailored for children and young people.

The youth pages can be accessed at www.ombudsman.wa.gov.au/youth.

‘Ask the Ombudsman’ on Nightline

The Office continues to provide access to its services through the Ombudsman’s regular appearances on Radio 6PR’s *Nightline* program. Listeners who have complaints about public authorities or want to make enquiries have the opportunity to call in and speak with the Ombudsman live on air. The segment allows the public to communicate a range of concerns with the Ombudsman. The segment also allows the Office to communicate key messages about the State Ombudsman and Energy and Water Ombudsman jurisdictions, the outcomes that can be achieved for members of the public and how public administration can be improved. The Ombudsman appeared on the ‘Ask the Ombudsman’ segment in August and November 2015 and May 2016.

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2015-16. Three regional visits were conducted, to the Indian Ocean Territories in May 2016, South Hedland, Roebourne and Karratha in the Pilbara in June 2016 and Broome in the Kimberley in June 2016, including such activities as:

- Complaints clinics, which provided an opportunity for members of the local community to raise their concerns face-to-face with the staff of the Office. The Office resolved many of the complaints made during the time of the visits;
- Meetings with Aboriginal community members in the Pilbara and Kimberley regions and meetings with local communities in the Indian Ocean Territories to discuss government service delivery and where the agencies may be able to assist;
- Liaison with community, advocacy and consumer groups; and
- Liaison with public authorities, including prison visits and visits to out-of-home care facilities.

The Program is an important way for the Office to raise awareness of, access to, and use of, its services for regional and Aboriginal Western Australians.

The Program enables the Office to:

- Deliver key services directly to regional communities, particularly through complaints clinics;
- Increase awareness and accessibility among regional and Aboriginal Western Australians (who were historically under-represented in complaints to the Office); and
- Deliver key messages about the Office’s work and services.

The Program also provides a valuable opportunity for staff to strengthen their understanding of the issues affecting people in regional and Aboriginal communities.

Youth Awareness and Accessibility Program

Building on a number of systems already in place, the Office began significantly improving systems to enhance access to the Office for children and young people in 2015-16, including a proactive visiting program to vulnerable groups of children in the child protection system.

In November 2015, the Office conducted a youth focus group to listen directly to young people and their representatives, in collaboration with the office of the Commissioner for Children and Young People. The youth focus group provided an opportunity for young people to be heard on ways the Ombudsman can enhance awareness and accessibility for children and young people.

Following from this youth focus group, and a range of other consultation, the Office has developed a new, dedicated youth space on the Ombudsman Western Australia website with information about the Office specifically tailored for children and young people, as well as information for non-government organisations and government agencies that assist children and young people, and a suite of new promotional materials targeted at, and tailored for, children and young people.

This year, the Office also commenced a major new visiting program to vulnerable groups of children and young people in the child protection system. This included visits to:

- The Kath French Secure Care Centre in February 2016;
- Two residential group homes in the Perth metropolitan area in May 2016;
- Two residential group homes and one family group home in the Pilbara region in June 2016; and
- One residential group home in the Kimberley region in June 2016.

The Ombudsman has also increased regular visits to the Banksia Hill Detention Centre and engagement with the community sector in the metropolitan area and regional Western Australia under the Ombudsman's Regional Awareness and Accessibility Program.

The children and young people section of the Ombudsman's website can be found at www.ombudsman.wa.gov.au/youth.

Prison Program

The Office continued the Prison Program during 2015-16. Four visits were made to prisons and juvenile detention centres to raise awareness of the role of the Ombudsman and enhance accessibility to the Office for adult prisoners and juvenile detainees in Western Australia.

Speeches and Presentations

The Ombudsman and other staff delivered speeches and presentations throughout the year at local, national and international conferences and events.

Ombudsman's speeches and presentations

- *The Role of the Ombudsman* to University of Western Australia Administrative Law Students in October 2015;
- Presented and chaired sessions at the *Government Accountability: Law and Practice Unit* at the Faculty of Law, University of Western Australia in February 2016;

- The *Role of the Ombudsman* at the Legal Aid Summer Series Law Day in February 2016;
- *Starter Kit for New Ombudsmen and Developing or Expanding Offices* at the Australasian and Pacific Ombudsman Region Conference in May 2016; and
- *My Leadership Journey* at the Public Sector Commission Leadership Essentials Program in May 2016.

Speeches by the Ombudsman are available on the Ombudsman's website.

Speeches and presentations by other staff

- Presentations on the Ombudsman's report, *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* to a range of government agencies and non-government organisations;
- Presentation on the Ombudsman's report, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* to an Australasian Evaluation Society Seminar in August 2015;
- *Managing Unreasonable Complainant Conduct* to senior staff at the Department of Education in August 2015;
- *The Role and Functions of the Ombudsman* to staff at Banksia Hill Detention Centre in December 2015 and staff at Bandyup Women's Prison in March 2016;
- *The Role and Functions of the Ombudsman* to staff and visitors at the Lorikeet Centre, a rehabilitation centre for adults with a diagnosed mental illness, in Janurary 2016;
- *Keeping Accountability Agencies Accountable* and *The Role and Functions of the Ombudsman* to University of Western Australia Administrative Law Students in January and February 2016;
- *The Role and Functions of the Ombudsman* to Edith Cowan University Administrative Law Students in March 2016;
- *The Role and Functions of the Ombudsman* to Aboriginal Practice Leaders at the Department for Child Protection and Family Support in March 2016;
- *Effective Complaint Handling* to staff at the Department of Education in March 2016; and
- *The Role and Functions of the Ombudsman* to staff at Western Australian Police in May 2016.

Staff of the Office also regularly present on the role of the Ombudsman at the Public Sector Commission's *Induction to the Western Australian Public Sector* seminars for public sector employees.

Liaison with Public Authorities

Liaison relating to complaint resolution

The Office liaised with a range of bodies in relation to complaint resolution in 2015-16, including:

- The Department of Corrective Services;

- The Department of Housing;
- The Department of Transport;
- The Department of Education;
- The Department for Child Protection and Family Support;
- Western Australia Police;
- The Office of the Inspector of Custodial Services;
- The Commissioner for Children and Young People;
- The Corruption and Crime Commission;
- Various universities; and
- Various local governments.

Liaison relating to reviews and own motion investigations

The Office undertook a range of liaison activities in relation to its reviews of child deaths and family and domestic violence fatalities and its own motion investigations.

See further details in the Child Death Review section, the Family and Domestic Violence Fatality Review section, and the Own Motion Investigations and Administrative Improvements section.

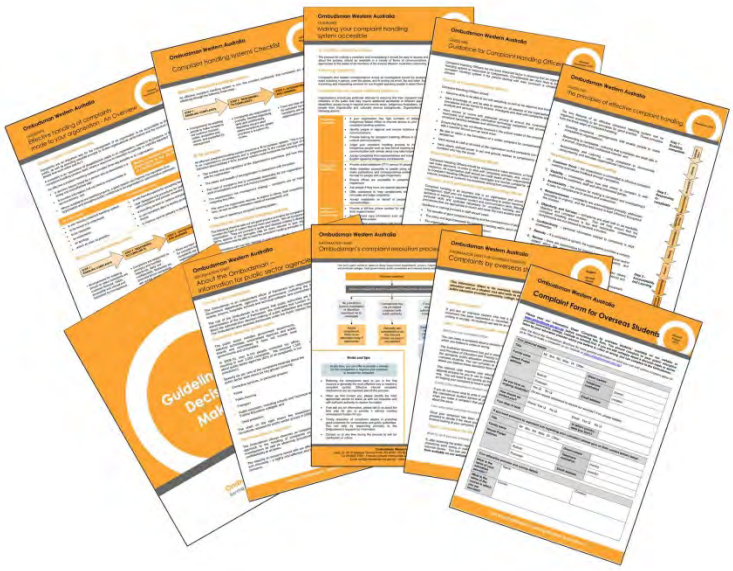
Liaison relating to inspection and monitoring functions

The Office undertook a range of liaison activities in relation to its inspection and monitoring functions.

See further details in the Own Motion Investigations and Administrative Improvements section.

Publications

The Office has a comprehensive range of publications about the role of the Ombudsman to assist complainants and public authorities, which are available on the Ombudsman's website. For a full listing of the Office's publications, see Appendix 3.



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