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	2015-16 Actual	2016-17 Target	2016-17 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	156	100	**109**	+9

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 2016-17, there were 270 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 2016-17 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 2016-17 actual number of improvements to practices and procedures of public authorities as a result of Ombudsman action (109) has exceeded the 2016-17 target (100). There may, however, be fluctuations from year to year, related to the number and nature of investigations 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	2015-16 Actual	2016-17 Target	2016-17 Actual	Variance from Target
Percentage of allegations finalised within three months	95%	95%	94%	-1%
Percentage of allegations finalised within 12 months	100%	100%	100%	Nil
Percentage of allegations on hand at 30 June less than three months old	93%	90%	94%	+4%
Percentage of allegations on hand at 30 June less than 12 months old	100%	100%	100%	Nil
Average cost per finalised allegation	$1,886	$1,890	$1,889	-$1
Average cost per finalised notification of death	$18,597	$18,950	$16,731	-$2,219
Cost to monitor the Infringement Notices provisions of *The Criminal Code*	$851,068	$557,000	$549,267	-$7,733
Cost of monitoring and inspection functions	$413,821	$415,000	$412,129	-$2,871

Comparison of Actual Results and Budget Targets

The 2016-17 actual results for the Key Efficiency Indicators met, or were comparable to, the 2016-17 target. Overall, 2016-17 actual results represent sustained improvement in the efficiency of complaint resolution over the last five years.

The average cost per finalised allegation in 2016-17 ($1,889) met the 2016-17 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 $1,889 in 2016-17.

The average cost per finalised notification of death ($16,731) improved on the 2016-17 target ($18,950) and the 2015-16 actual result ($18,597), reflecting continuous improvement of the finalisation of notifications.

The cost to monitor the Infringement Notices provisions of *The Criminal Code* ($549,267) met the 2016-17 target ($557,000). The 2016-17 actual result is lower than the 2015-16 actual result ($851,068), reflecting the final year of funding for this function.

The cost of monitoring and inspection functions ($412,129) met the 2016-17 target ($415,000).

For further details, see the Key Performance Indicator section.

Summary of Financial Performance

The majority of expenses for the Office (76%) relate to staffing costs. The remainder is primarily for accommodation, communications and office equipment.

Financial Performance	2015-16 Actual	2016-17 Target ('000s)	2016-17 Actual ('000s)	Variance from Target ('000s)
Total cost of services (sourced from Statement of Comprehensive Income)	$10,663	$10,595	$11,106	+$511
Income other than income from State Government (sourced from Statement of Comprehensive Income)	$2,048	$1,989	$2,055	+$66
Net cost of services (sourced from Statement of Comprehensive Income)	$8,615	$8,606	$9,051	+$445
Total equity (sourced from Statement of Financial Position)	$2,837	$2,302	$2,436	+$134
Net increase in cash held (sourced from Statement of Cash Flows)	$395	$20	-$458	-$478
Staff Numbers	**Number**	**Number**	**Number**	**Number**
Full time equivalent (FTE) staff level at 30 June	65	67	69	+2

Comparison of Actual Results and Budget Targets

The variation between the 2016-17 actual results and the targets for the Office's total cost of services and net cost of services and the decrease in cash held is primarily due to the staffing required to monitor the Infringement Notices provisions of *The Criminal Code*, as a result of a change in the timing of the commencement of the function in 2014-15 and, as a consequence, a change in the completion date in 2016-17. The decrease in cash held also included asset purchases committed in 2015-16 but paid in 2016-17.

For further details see Note 29 'Explanatory Statement' in the Financial Statements section.

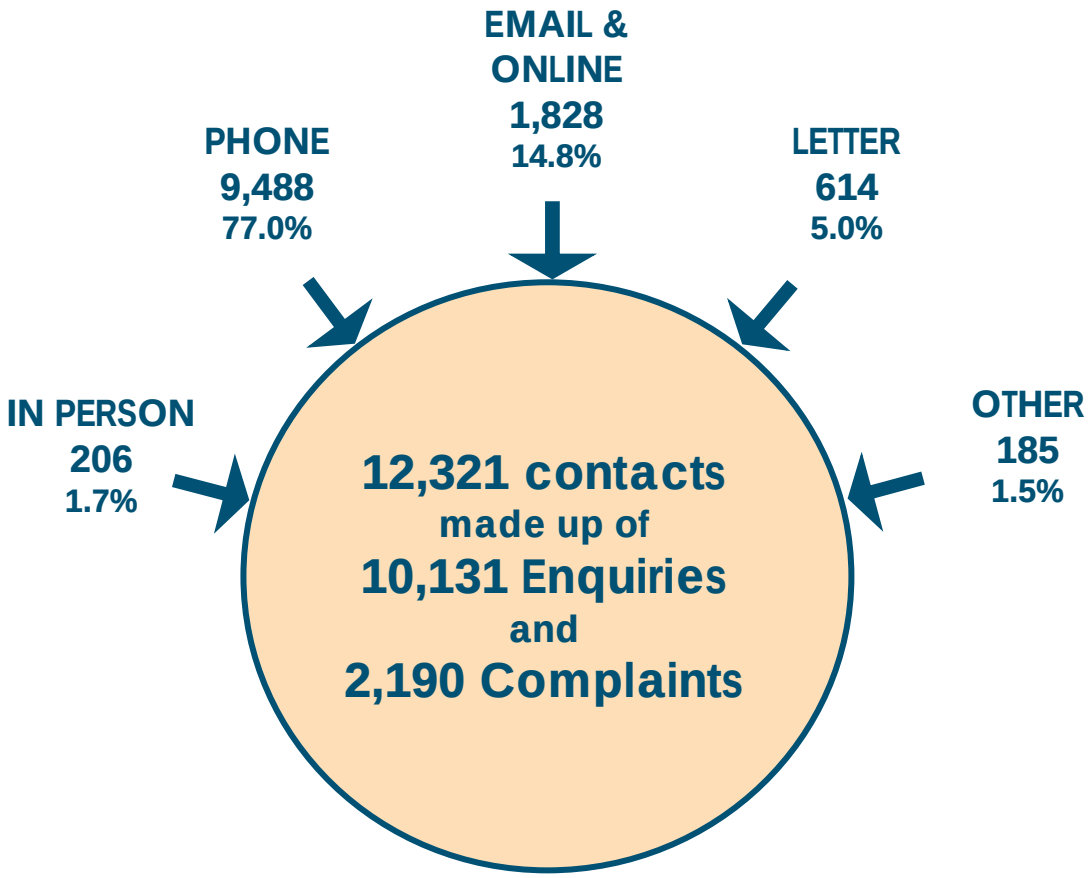
Complaint Resolution

A core function of the Ombudsman 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 2016-17, the Office received 12,321 contacts from members of the public consisting of:

- 10,131 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 2,190 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

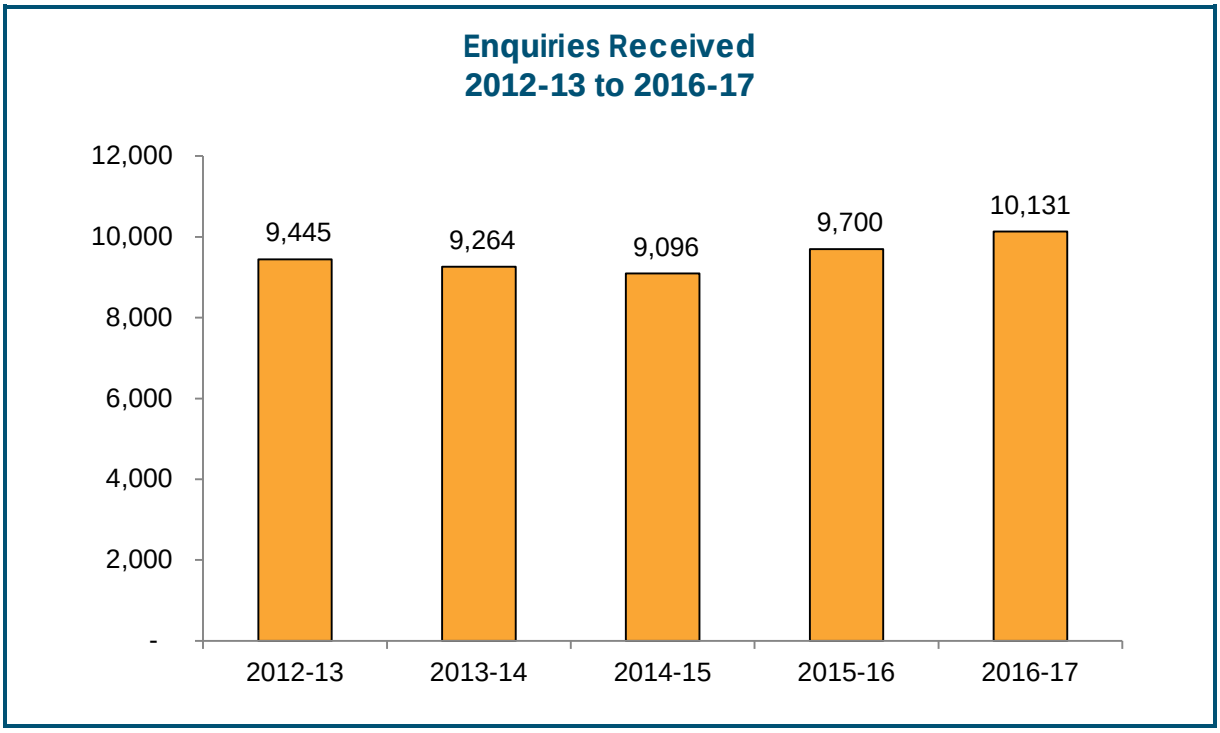


Enquiries Received

There were 10,131 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.

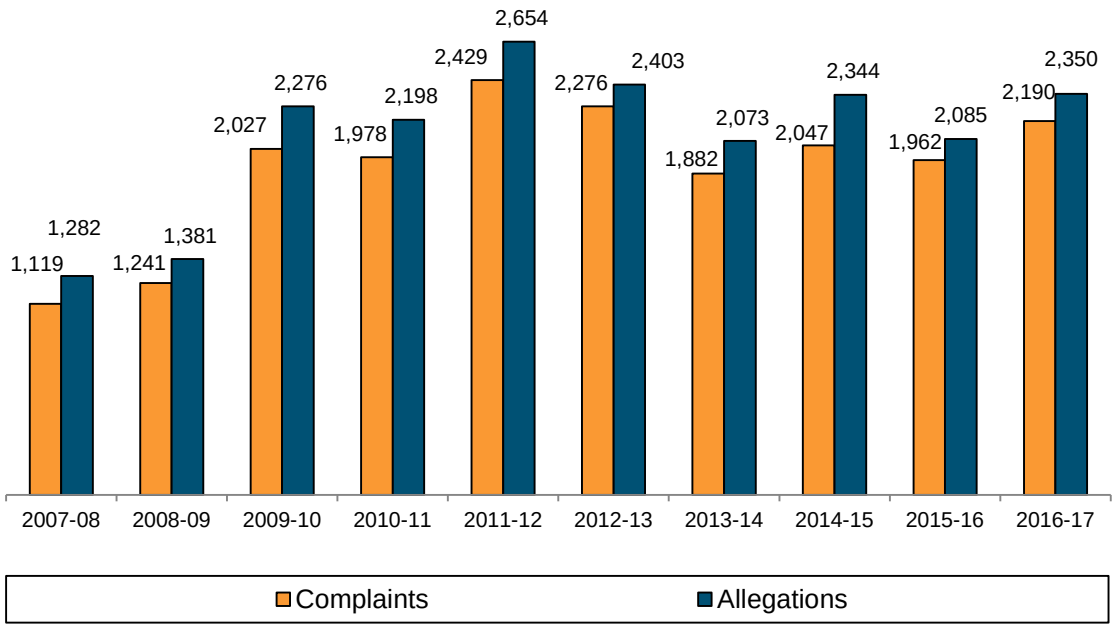


Enquirers are encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

Complaints Received

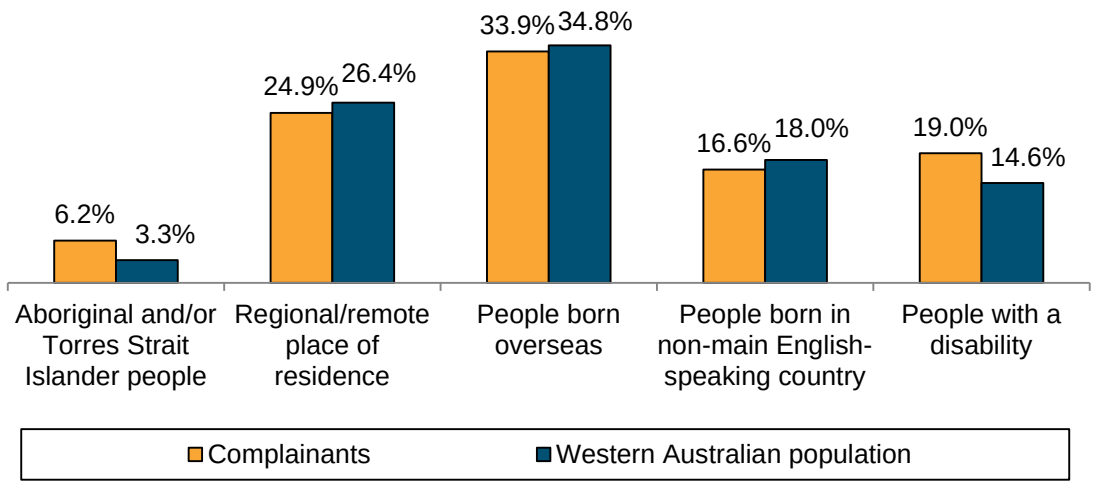
In 2016-17, the Office received 2,190 complaints, with 2,350 separate allegations, and finalised 2,169 complaints. There are more allegations than complaints because one complaint may cover more than one issue.

Total Number of Complaints and Allegations Received 2007-08 to 2016-17



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

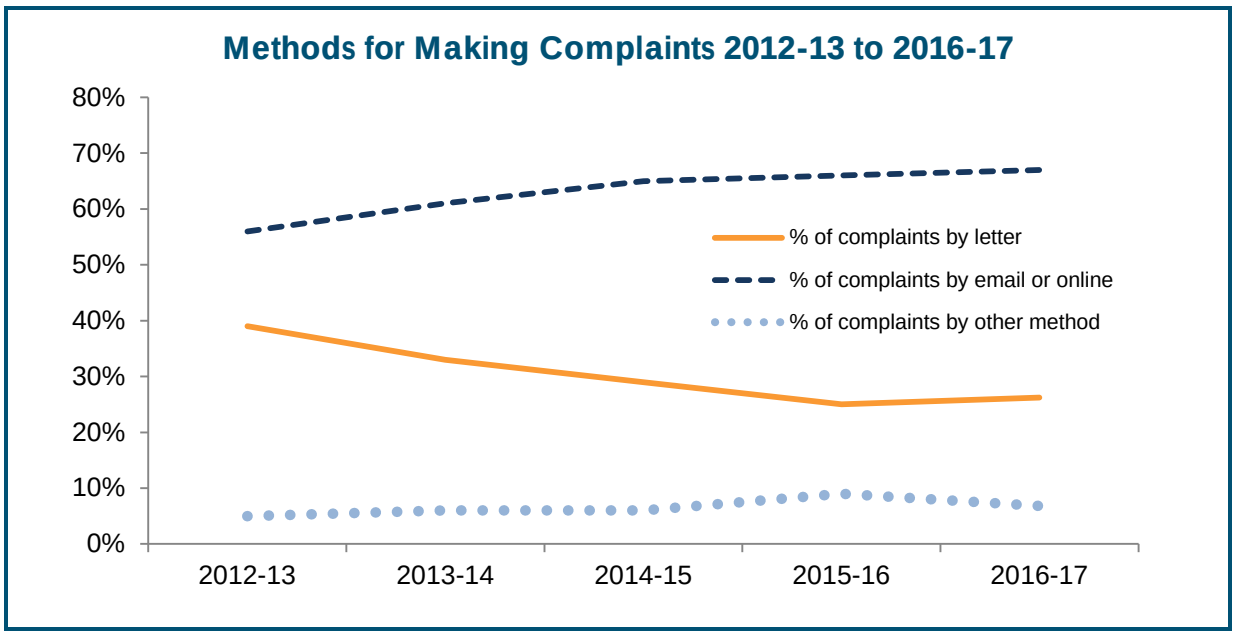


NOTE: Non-main English-speaking countries as defined by the Australian Bureau of Statistics are countries other than Australia, the United Kingdom, the Republic of Ireland, New Zealand, Canada, South Africa and the United States of America. Being from a non-main English-speaking country does not imply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

How Complaints Were Made

The use of email and online facilities to lodge complaints has continued to increase in 2016-17. The number of people using email and online facilities to lodge complaints has increased from 1,278 to 1,467 (15%) since 2012-13.

During the same period, the proportion of people who lodge complaints by letter has concomitantly reduced. 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 2016-17, 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 2016-17:

- The percentage of allegations finalised within 3 months was 94%; and
- The percentage of allegations on hand at 30 June less than 3 months old was 94%.

94% 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 32 days; and
- Complaints older than 6 months have decreased from 40 to 2.

Complaints Finalised in 2016-17

There were 2,169 complaints finalised during the year and, of these, 1,533 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 841 were finalised at initial assessment, 658 were finalised after an Ombudsman investigation and 34 were withdrawn.

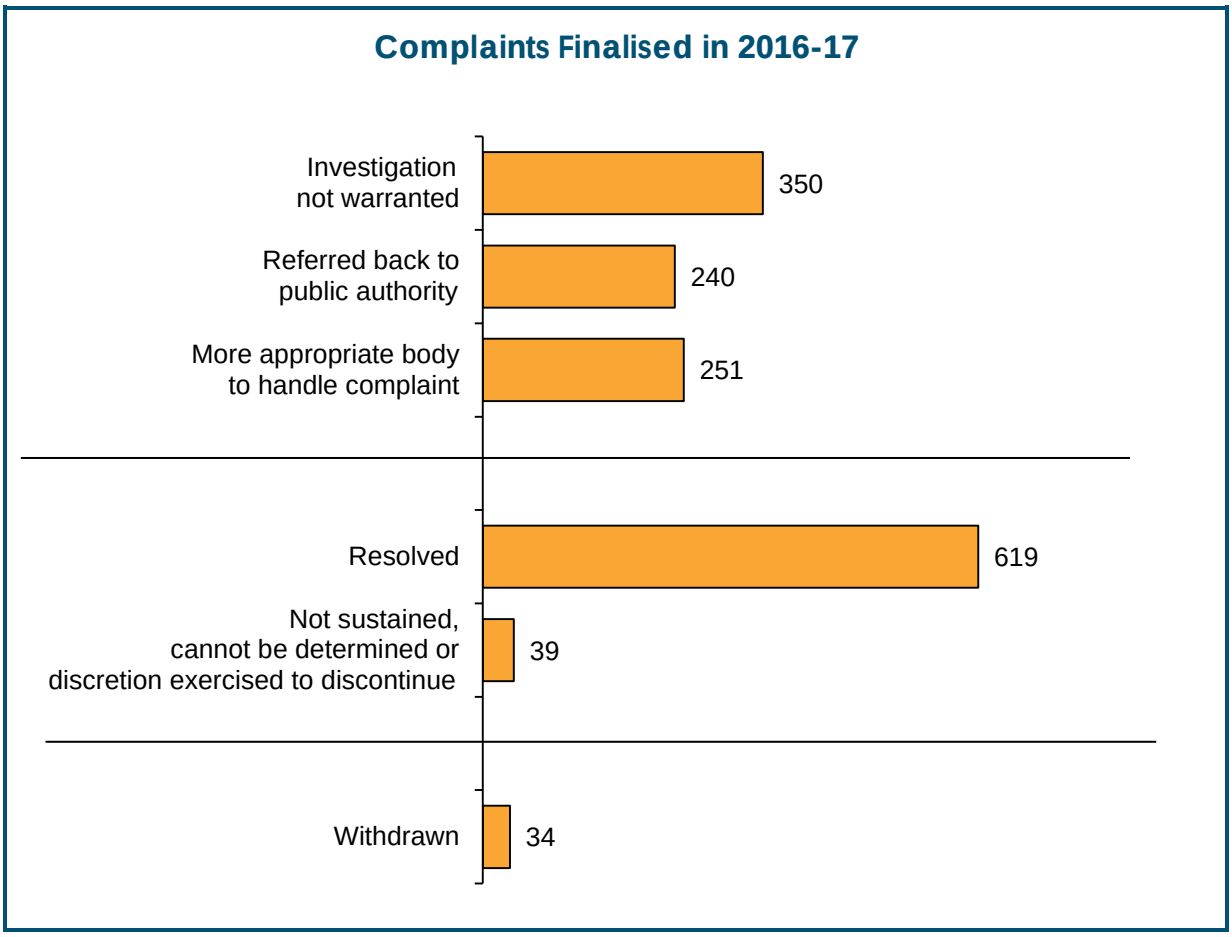
Complaints finalised at initial assessment

Nearly a third (29%) of the 841 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 251 (30%) 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 658 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.

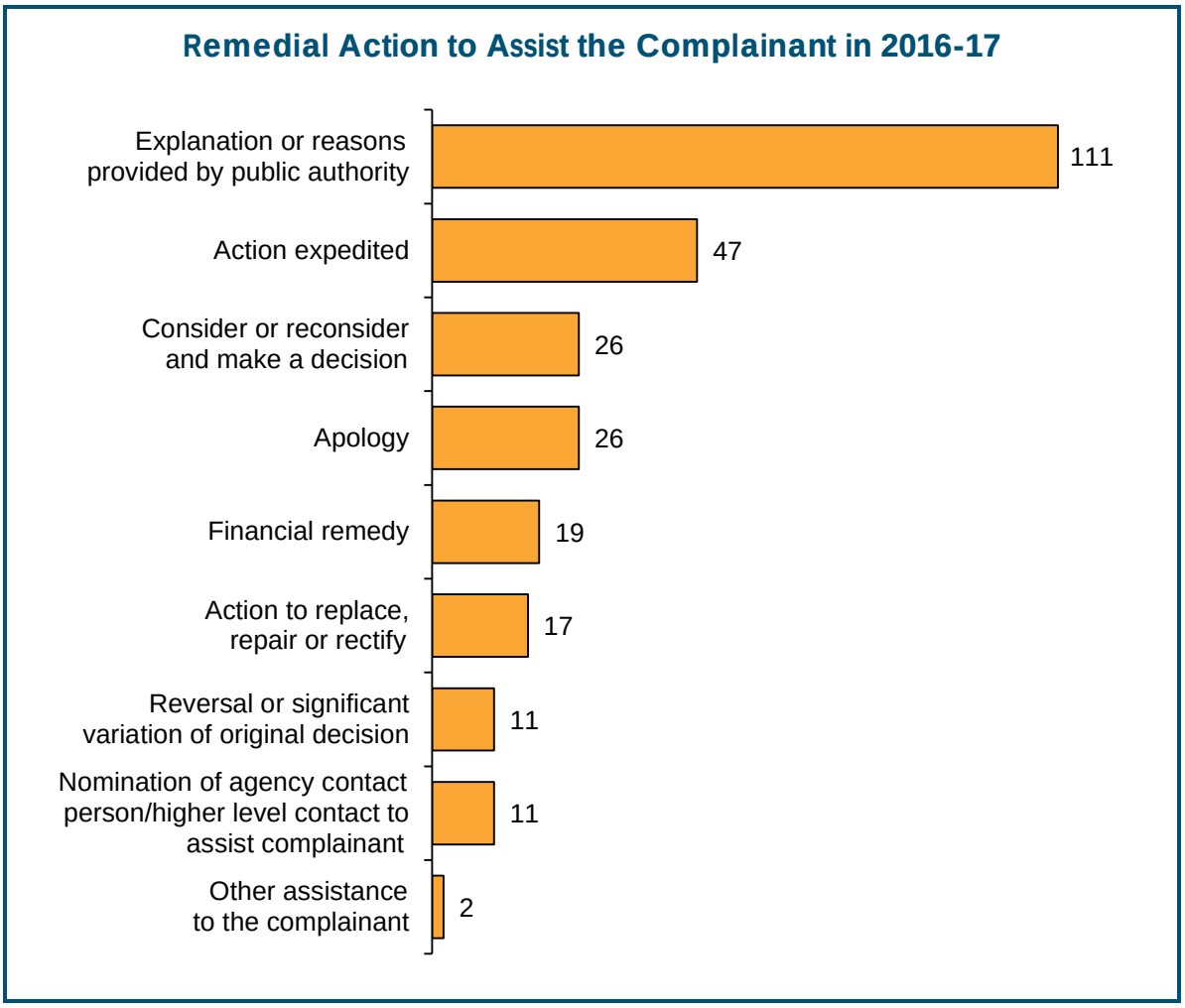


Note: Investigation not warranted includes complaints where the matter is not in the Ombudsman's jurisdiction.

Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2016-17, there were 270 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman, an increase of 10% from 245 in 2015-16. 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 159 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.



Case Study

Decision reconsidered for a victim of domestic violence

A woman was forced to move out of her home into a refuge due to domestic violence. As a result, the woman was not aware that her vehicle registration papers had been sent to her home address. The woman became aware that the vehicle was no longer registered when paying her driver's licence and she was required to pay for a temporary vehicle movement permit, a vehicle inspection fee and a fine for not returning the number plates. The woman complained to the Office about the fees and fine.

Following enquiries by the Office, the public authority agreed to reconsider the matter taking into account the woman's particular circumstances. After giving further consideration, the public authority agreed to refund the fees and withdraw the fine.

Outcomes to improve public administration

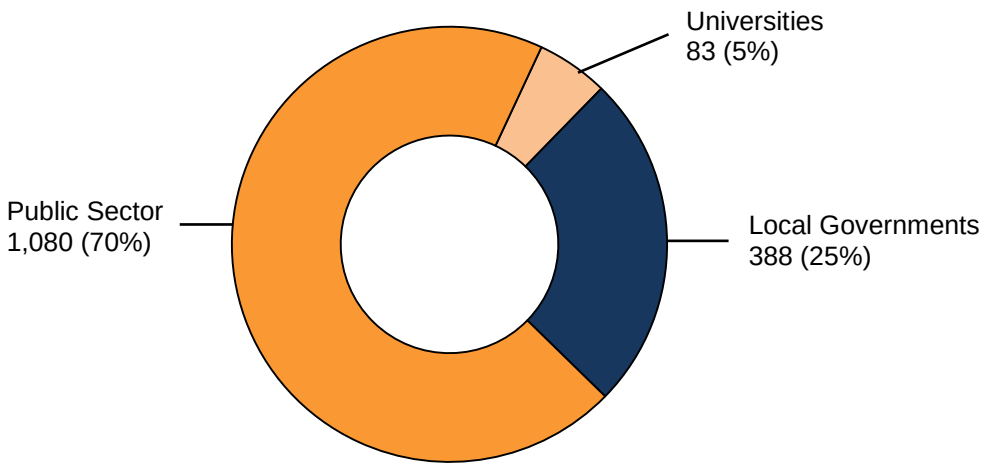
In addition to providing individual remedies, complaint resolution can also result in improved public administration. This occurs when the public authority takes action to improve its decision making and practices in order to address systemic issues and prevent similar complaints in the future. Administrative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

About the Complaints

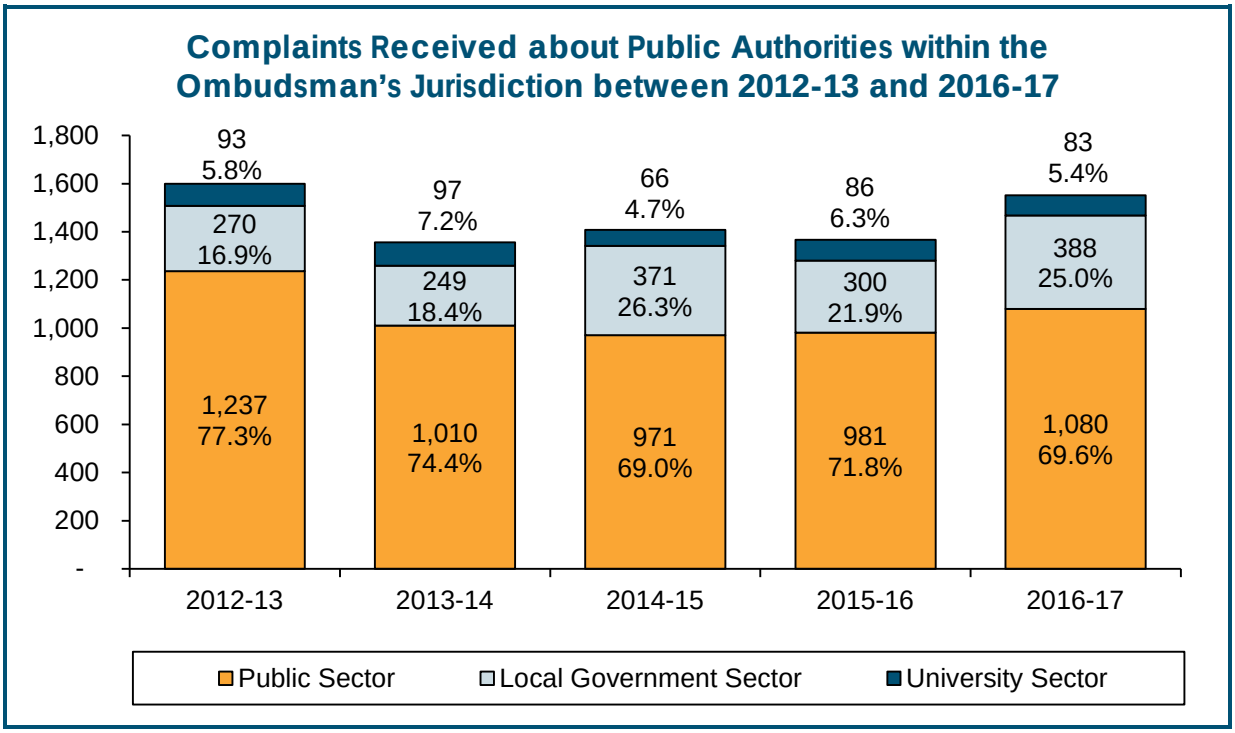
Of the 2,190 complaints received, 1,551 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 639 complaints were about bodies outside the Ombudsman's jurisdiction. In these cases, Ombudsman staff provided assistance to enable the people making the complaint to take the complaint to a more appropriate body.

Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (1,080 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (388 complaints); and the university sector (83 complaints).

Complaints Received about Public Authorities within the Ombudsman's Jurisdiction in 2016-17

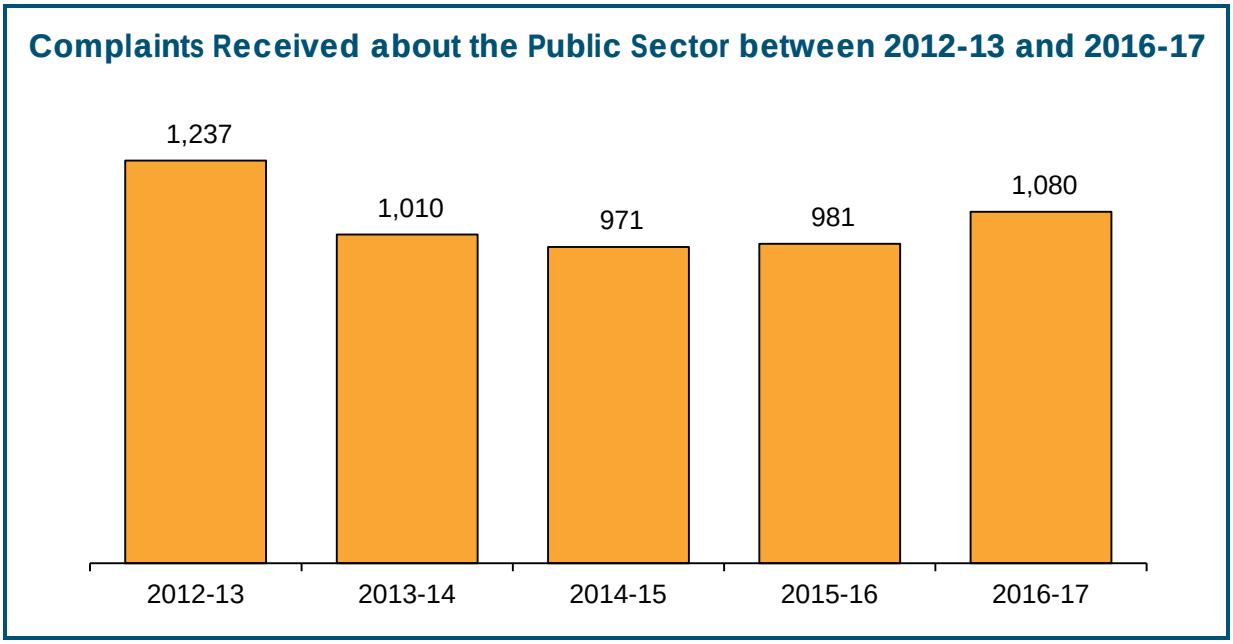


The proportion of complaints about each sector in the last five years is shown in the following chart.



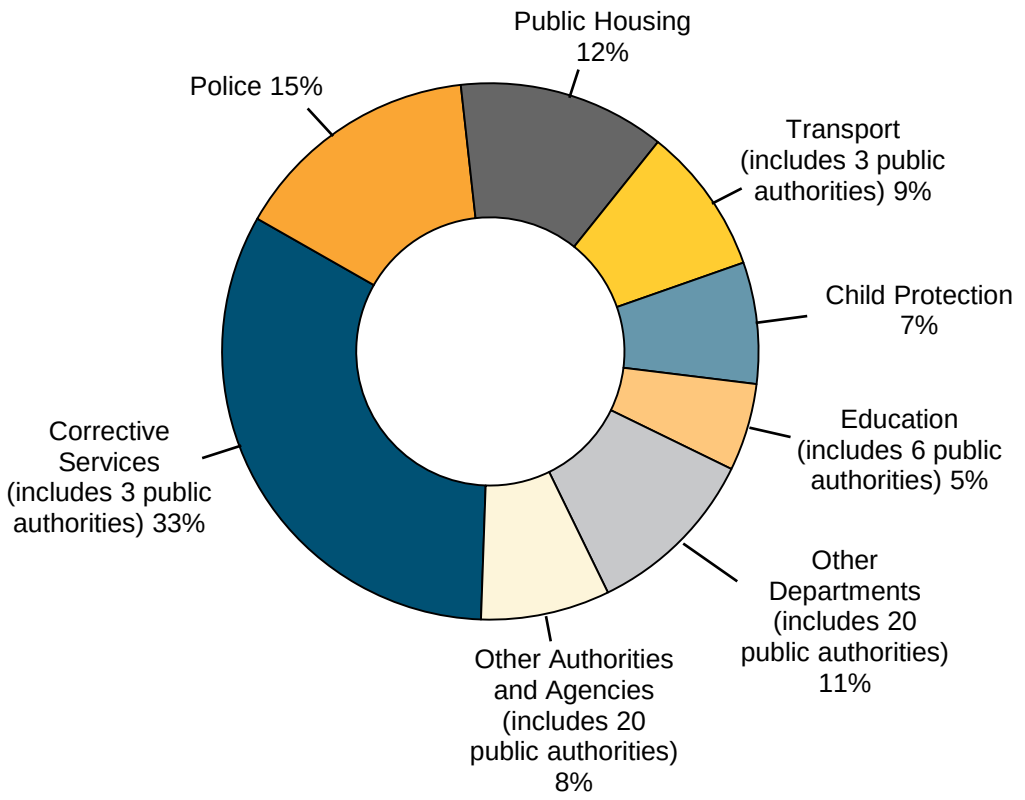
The Public Sector

In 2016-17, there were 1,080 complaints received about the public sector and 1,068 complaints were finalised. The number of complaints about the public sector as a whole since 2012-13 is shown in the chart below.



Public sector agencies are very diverse. In 2016-17, complaints were received about 55 agencies as shown in the following chart.

Complaints Received about the Public Sector in 2016-17



Of the 1,080 complaints received about the public sector in 2016-17, 81% were about six key areas covering:

- Corrective services, in particular prisons (353 or 33%);
- Police (162 or 15%);
- Public housing (135 or 12%);
- Transport (96 or 9%);
- Child protection (79 or 7%); and
- Education – public schools and TAFE colleges (57 or 5%). Information about universities is shown separately under the University Sector.

The remaining complaints about the public sector (198) were about 40 other State Government departments, statutory authorities and boards. For 29 (73%) of these agencies, the Office received five complaints or less.

Outcomes of complaints about the public sector

In 2016-17, there were 251 actions taken by public sector bodies as a result of Ombudsman action following a complaint. These resulted in 215 remedies being provided to complainants and 36 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

Application reinstated after Ombudsman involvement

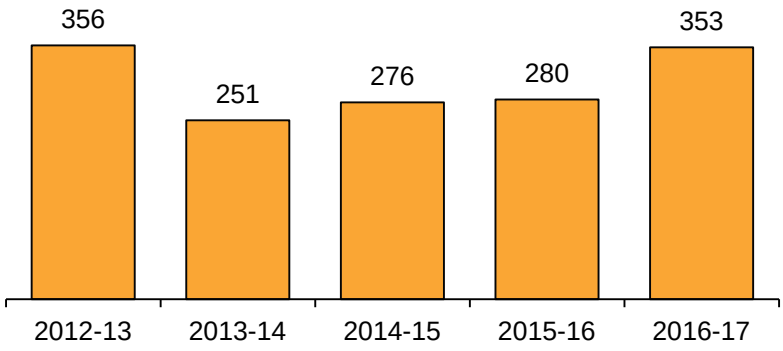
A person submitted an application to a public authority. The public authority requested additional information from the person to support their application and specified the timeframe for providing this information. Although the person provided the additional information within the required timeframe, the public authority withdrew the person's application when the timeframe elapsed. The person complained to the Office about the withdrawal of the application.

Following enquiries by the Office, the public authority reviewed the person's file and found that the person had provided the information within the specified timeframe but the public authority had not placed the information on the person's file until after the application was withdrawn. The public authority wrote to the person and reinstated their application, acknowledged the information had been received but had not been filed, apologised for any inconvenience caused and undertook actions to reduce the risk of such an error occurring again.

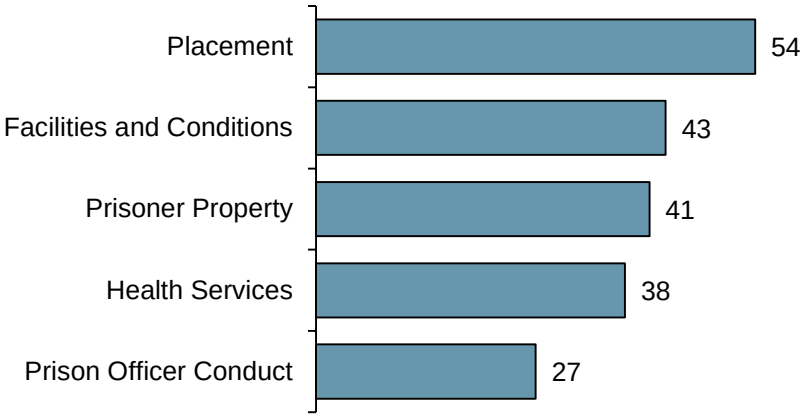
Public Sector Complaint Issues and Outcomes

Corrective Services

Complaints received



Most common allegations



Other types of allegations

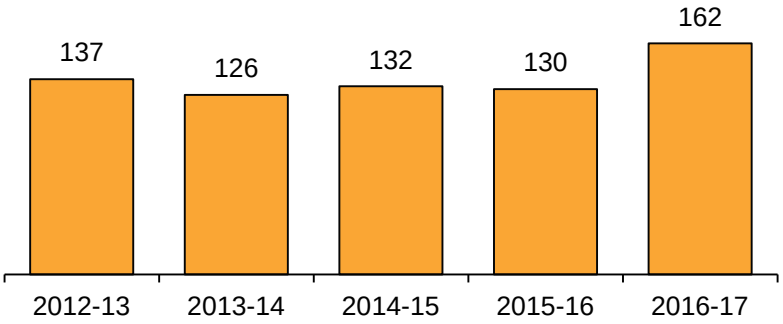
- Visits;
- Communication;
- Education courses and facilities;
- Discipline; and
- Sentencing, parole and reintegration issues.

Outcomes achieved

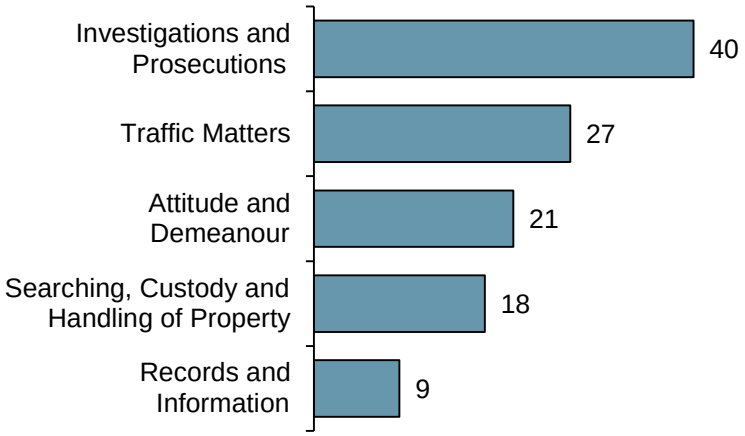
- Act of grace payment;
- Monetary charge reduced or refunded;
- Action to replace, repair or rectify a matter;
- Reversal or variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to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

Police

Complaints received



Most common allegations



Other types of allegations

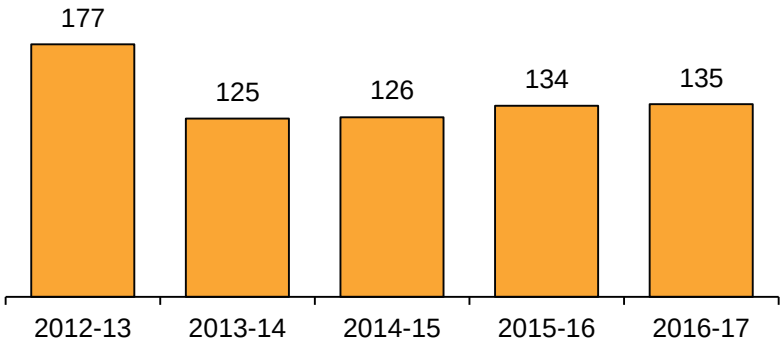
- Officer conduct;
- Complaints management;
- Management of warrants and licences; and
- Arrest and detention issues.

Outcomes achieved

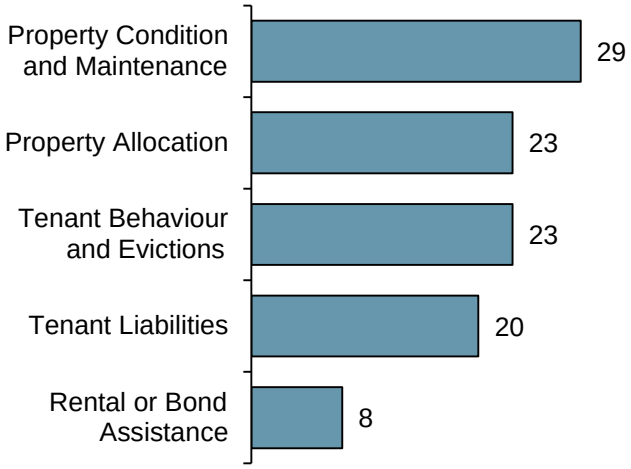
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to business system or practice;
- Update to publications or website;
- Conduct an audit or review; and
- Staff training.

Public Housing

Complaints received



Most common allegations



Other types of allegations

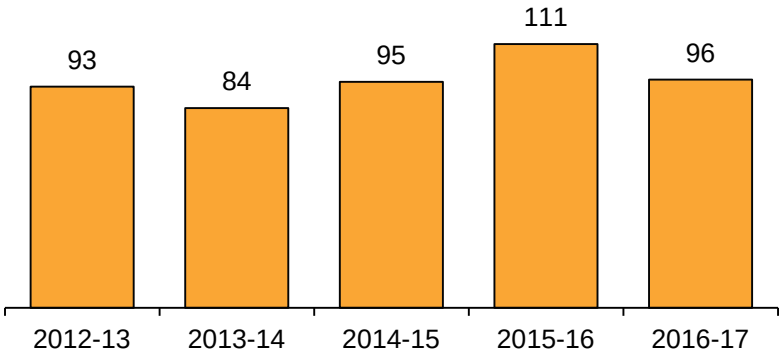
- Fencing;
- Property transfers;
- Tenants' personal property; and
- Construction and development.

Outcomes achieved

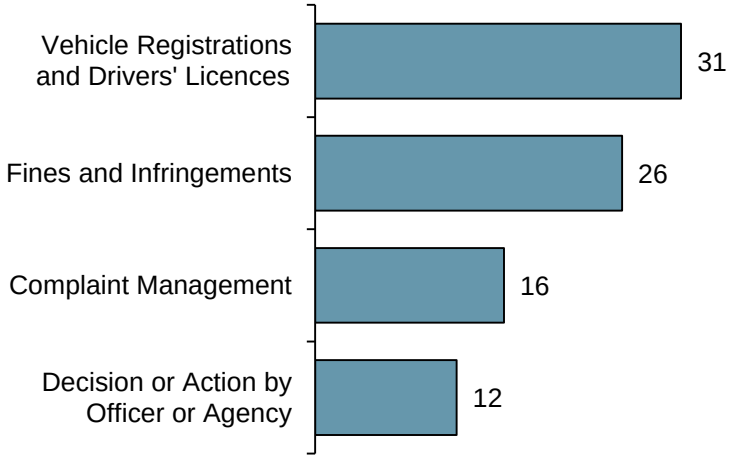
- Monetary charge reduced;
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Senior officer nominated to handle the matter;
- Explanation given or reasons provided;
- Improved recordkeeping; and
- Staff training.

Transport

Complaints received



Most common allegations



Other types of allegations

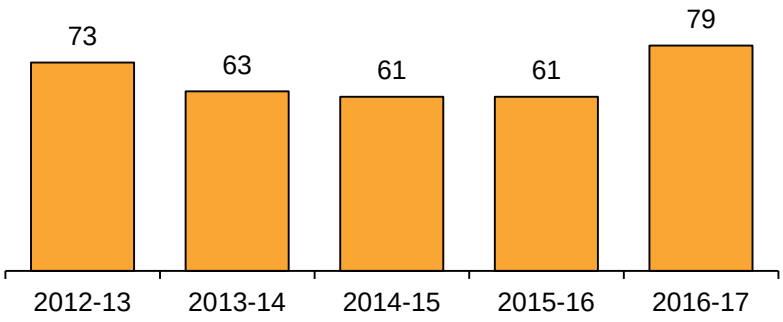
- Policies or procedures of the agency; and
- Personal information and privacy issues.

Outcomes achieved

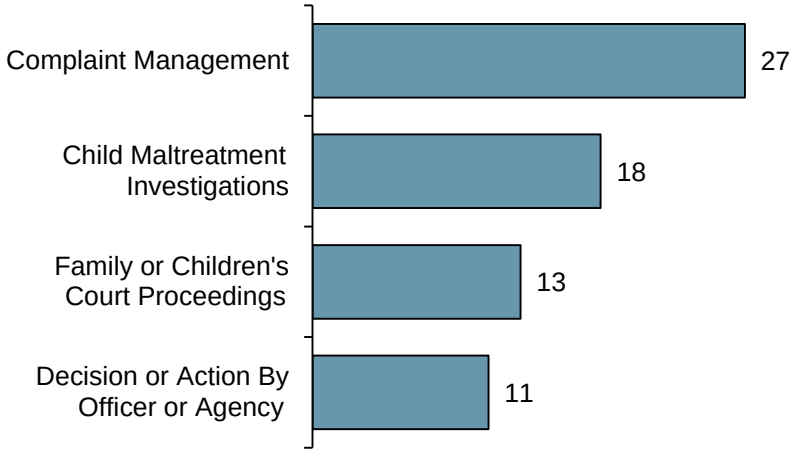
- Monetary charge withdrawn or refunded;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Change to business systems or practices;
- Update to publications or website; and
- Staff training.

Child Protection

Complaints received



Most common allegations



Other types of allegations

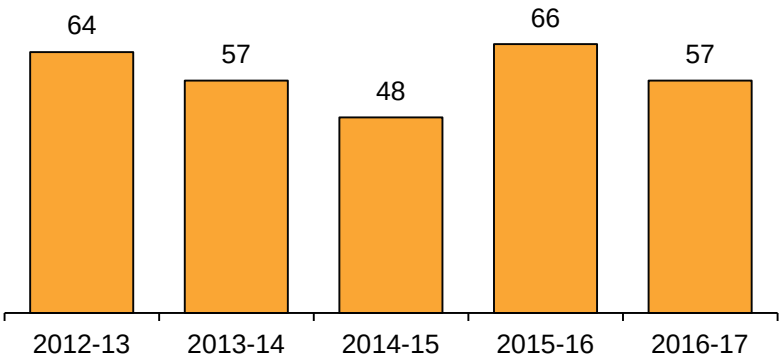
- Out of home care and foster care:
- Personal information and privacy issues; and
- Special assistance.

Outcomes achieved

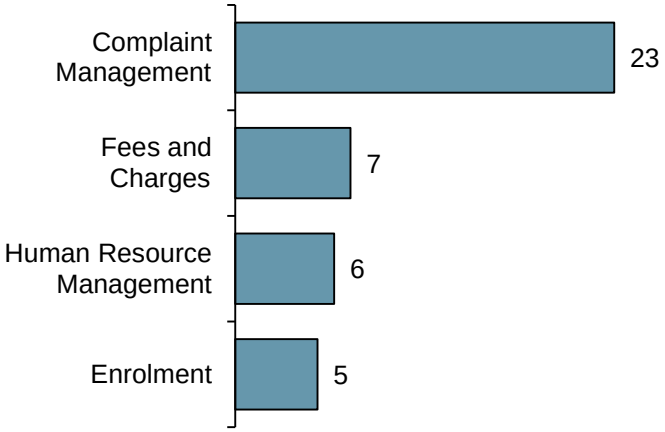
- Action to replace, repair or rectify;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter; and
- Staff training.

Education

Complaints received



Most common allegations



These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2017* relating to TAFE colleges and other public education agencies. Further details on these appeals are included later in this section.

Other types of allegations

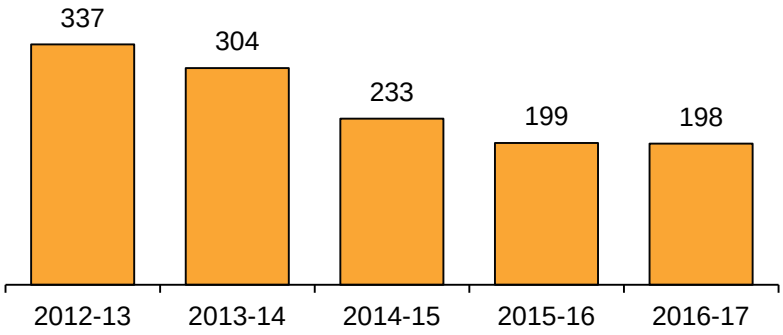
- Student care;
- Personal information and privacy issues; and
- Examinations, assessments, prizes and awards.

Outcomes achieved

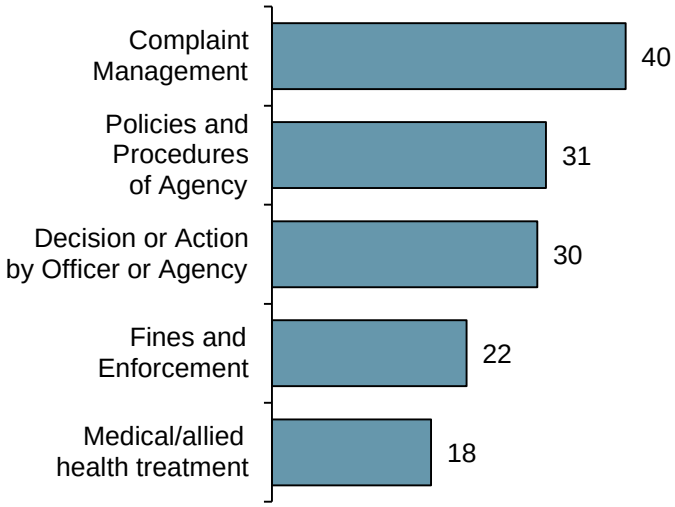
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to policy or procedure;
- Change to business systems or practices; and
- Conduct an audit or review.

Other Public Sector Agencies

Complaints received



Most common allegations



Other types of allegations

- Conduct of officer or agency;
- Court or Tribunal proceedings;
- Patient's property; and
- Human resource issues.

Outcomes achieved

- Monetary charge reduced, withdrawn or refunded;
- Action to replace, repair or rectify;
- Reversal or significant variation of original decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to business system or practice;
- Update to website;
- Conduct an audit or review; and
- Staff training.

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

Delays in sending correct approval

A person submitted an application to a public authority for installation of a device at their property. The public authority's approval of the request used an incorrect surname and the person wrote to the public authority twice asking that the approval be given in the correct name. When the correction did not occur the person telephoned the public authority's complaints line and the public authority provided the correct written approval the next day, two months after the original incorrect approval was sent. The person complained to the Office about the time taken and the process required to get the correct name on the approval.

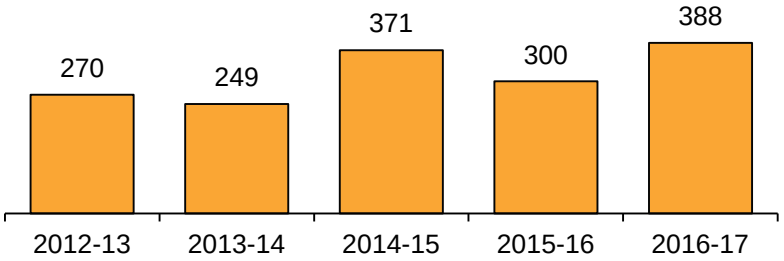
The public authority reviewed the matter, acknowledged the delay in providing the correct approval, expressed its sincere regret for any distress the delay caused, and undertook appropriate actions to reduce the risk of such an error occurring again.

The Local Government Sector

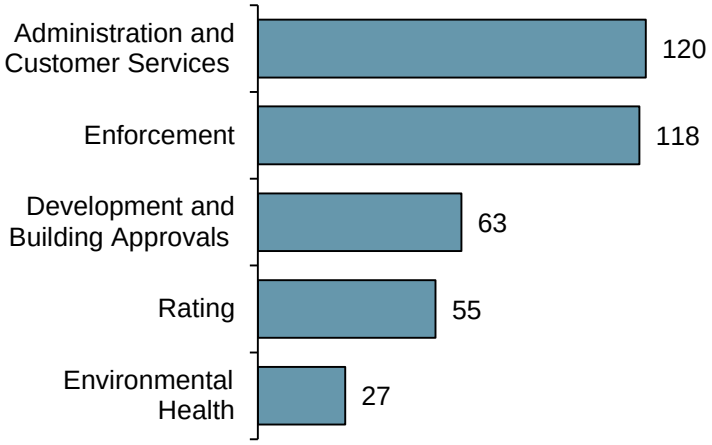
The following section provides further details about the issues and outcomes of complaints for the local government sector.

Local Government

Complaints received



Most common allegations



Other types of allegations

- Engineering;
- Community facilities;
- Planning; and
- Contracts and property management.

Outcomes achieved

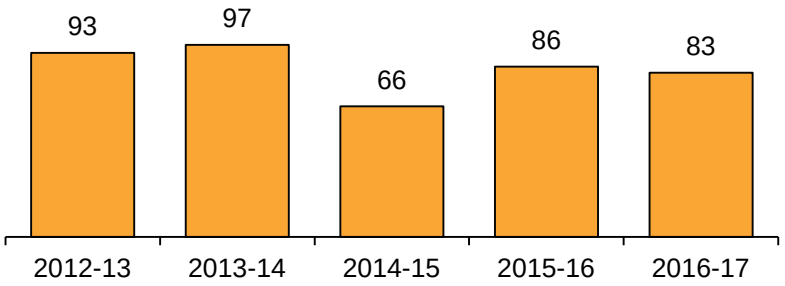
- Act of grace payment;
- Monetary charge refunded or withdrawn;
- Action to replace, repair or rectify;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Senior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

The University Sector

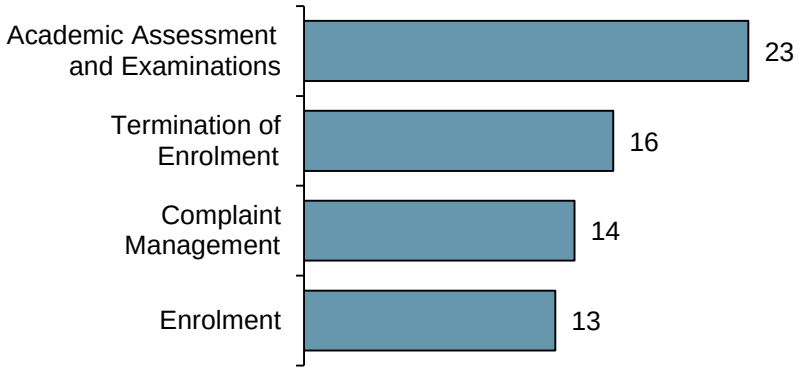
The following section provides further details about the issues and outcomes of complaints for the university sector.

Universities

Complaints received



Most common allegations



These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2017.* Further details on these appeals are included later in this section.

Other types of allegations

- Management of academic misconduct;
- Fees;
- Transfers;
- Parking infringements; and
- Human resource issues.

Outcomes Achieved

- Monetary charge reduced, withdrawn or refunded;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to policy or procedure;
- Change to business systems or practices;
- Update to publications or website;
- Conduct an audit or review;
- Improved recordkeeping; and
- Staff training.

Case Study

Student enrolment

A student had enrolled in a master's degree at a Western Australian university and paid a deposit for the fees but the enrolment was subject to the successful completion of a pre-requisite unit. When they were unable to meet these requirements, the student was 'released' from the university, however the university withheld $1,000 of the fees already paid on the basis that it was a non-refundable deposit. After the university's decision was confirmed on appeal, the student complained to the Office that the university had unreasonably withheld the fees.

The university re-considered its decision and refunded the fees in full. The university also undertook appropriate actions to address issues of this nature in the future.

Other Complaint Related Functions

Reviewing appeals by overseas students

The *National Code of Practice for Providers of Education and Training to Overseas Students 2017* (**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:

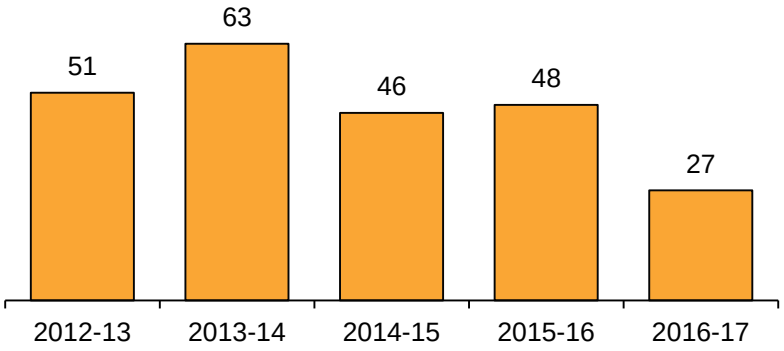
- Provides a free complaint resolution service;
- Is independent and impartial and does not represent either the overseas students or education and training providers; and
- Can make recommendations arising out of investigations.

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 2012-13 and 2016-17



During 2016-17, the Office received 27 complaints about public education and training providers from overseas students. Twenty five complaints were about universities and two were about TAFE colleges. The Office also received seven 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:

- Termination of enrolment (13);
- Academic assessment (4);
- Transfers between education and training providers (3);
- Management of academic misconduct (3); and
- Fees (2).

During the year, the Office finalised 30 complaints about 34 issues.

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, four 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 two 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.

Fourteen reviews were undertaken in 2016-17, representing less than one per cent of the total number of complaints finalised by the Office. In all cases where a review was undertaken, the original decision was upheld.

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**),[1] 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.

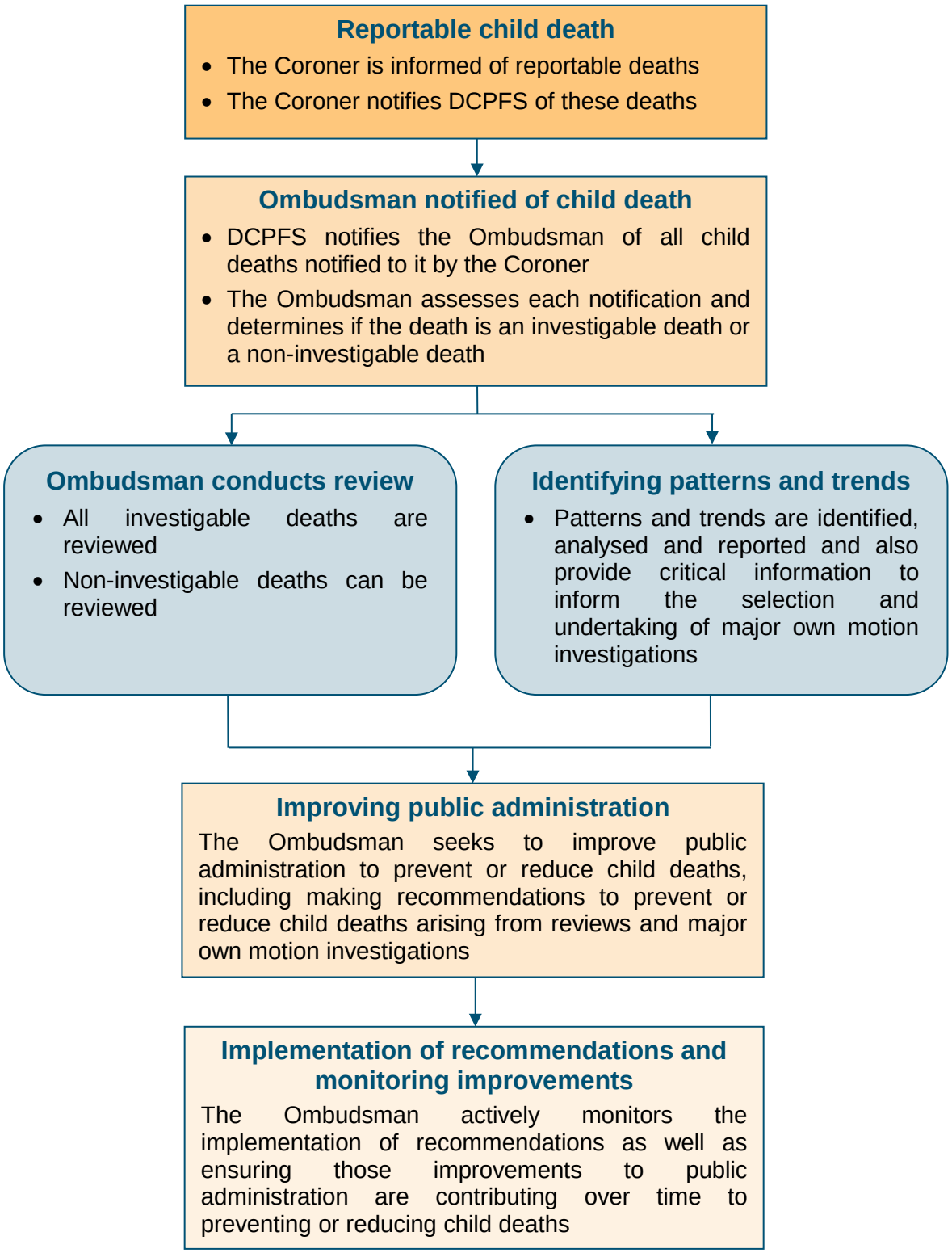
In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

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.

[1] As of 1 July 2017, DCPFS became part of the new Department of Communities.

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 and the child's family.

The Ombudsman assesses all child death notifications received to determine if the death is, or is not, an investigable death. If the death is an investigable death, it must be reviewed. If the death is a non-investigable death, it can be reviewed. The 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.

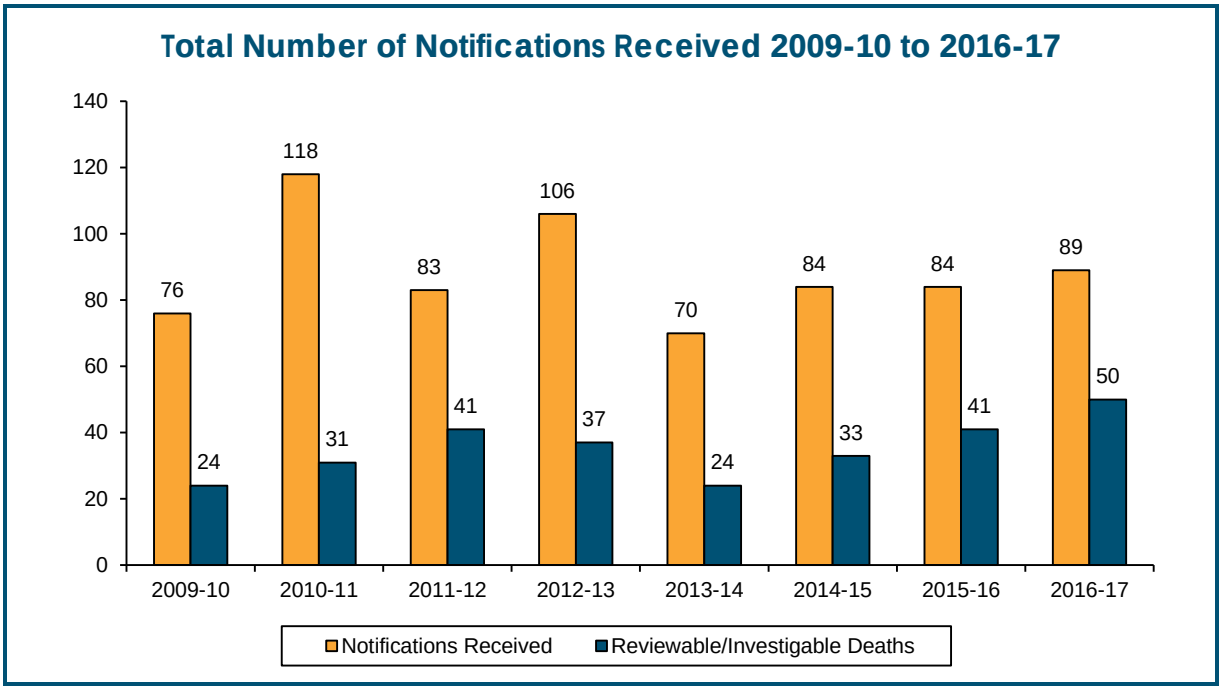
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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 2016-17, there were 50 child deaths that were investigable and subject to review from a total of 89 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 14 years from 2003-04 to 2016-17. 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
2016-17	177	91	60	50

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

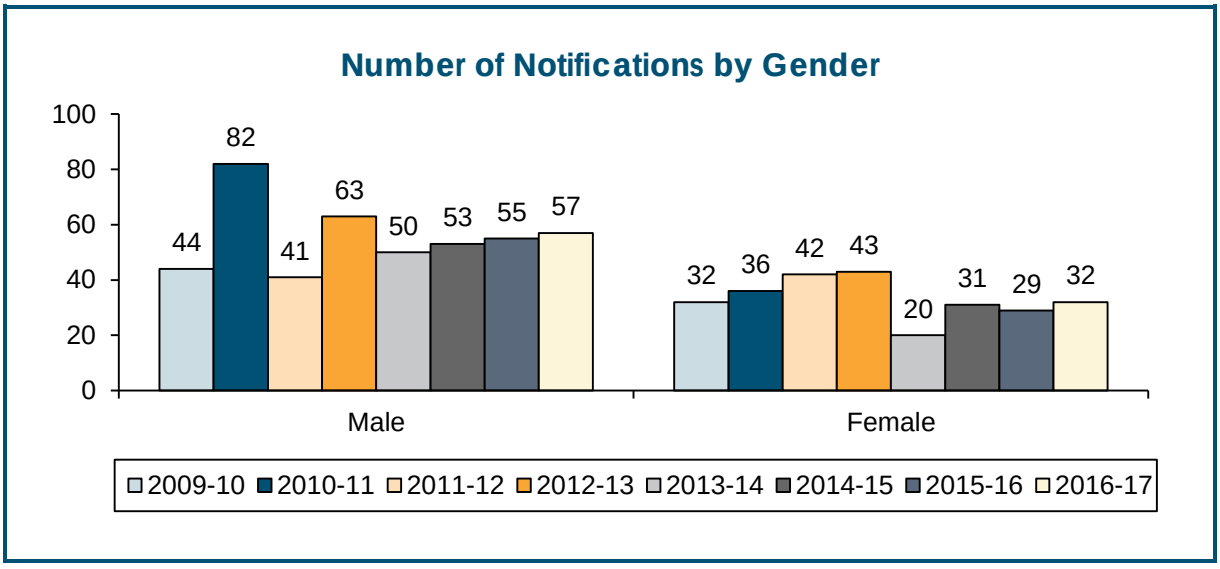
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

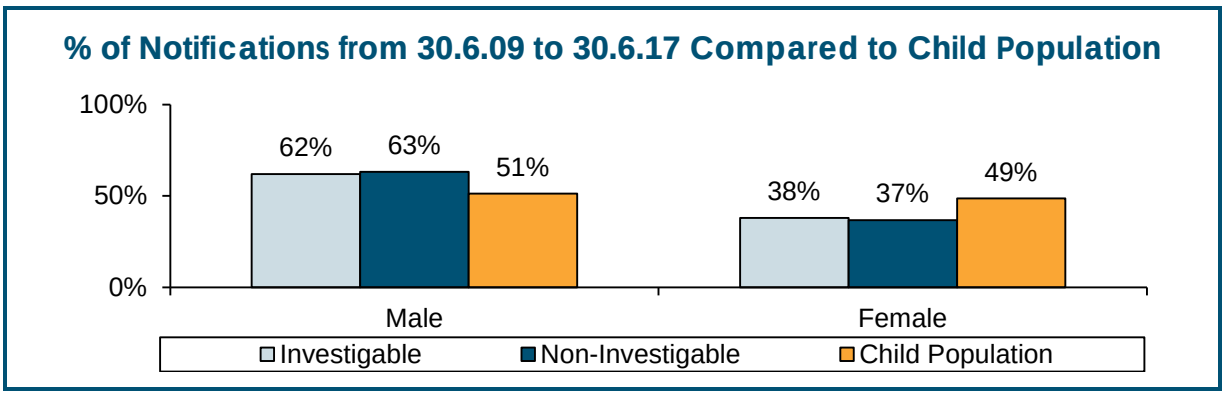
The following charts show:

- The number of children in each group for each year from 2009-10 to 2016-17; and
- For the period from 30 June 2009 to 30 June 2017, 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 eight years, male children are over-represented compared to the population for both investigable and non-investigable deaths.

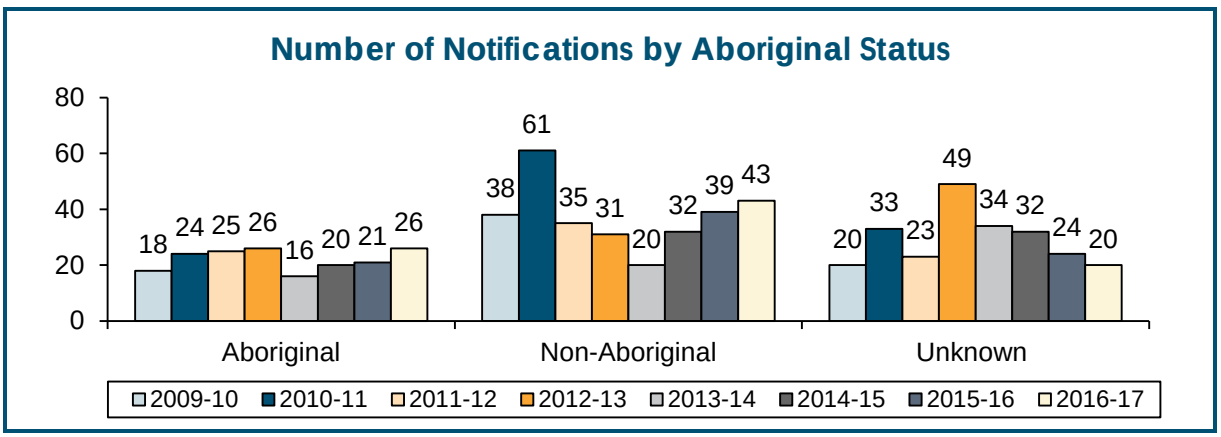


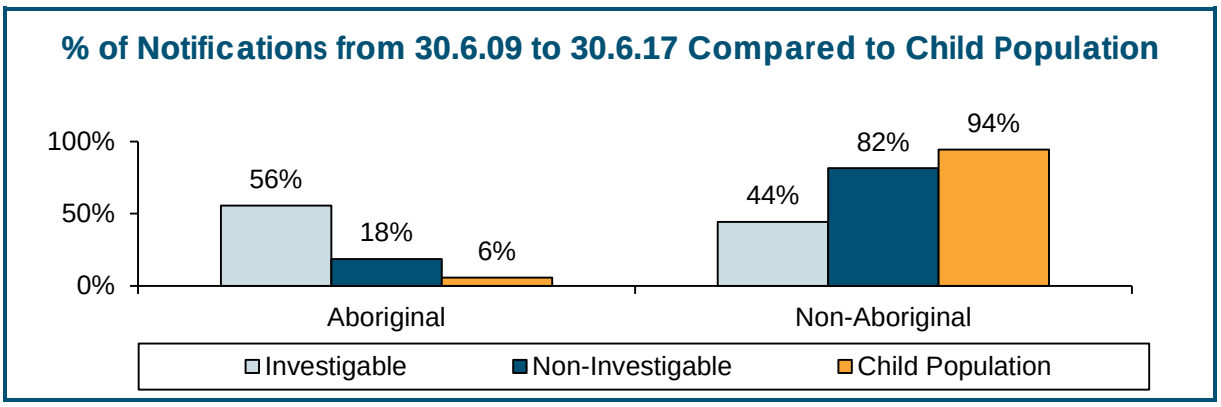


Further analysis of the data shows that, considering all eight years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

Aboriginal status

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



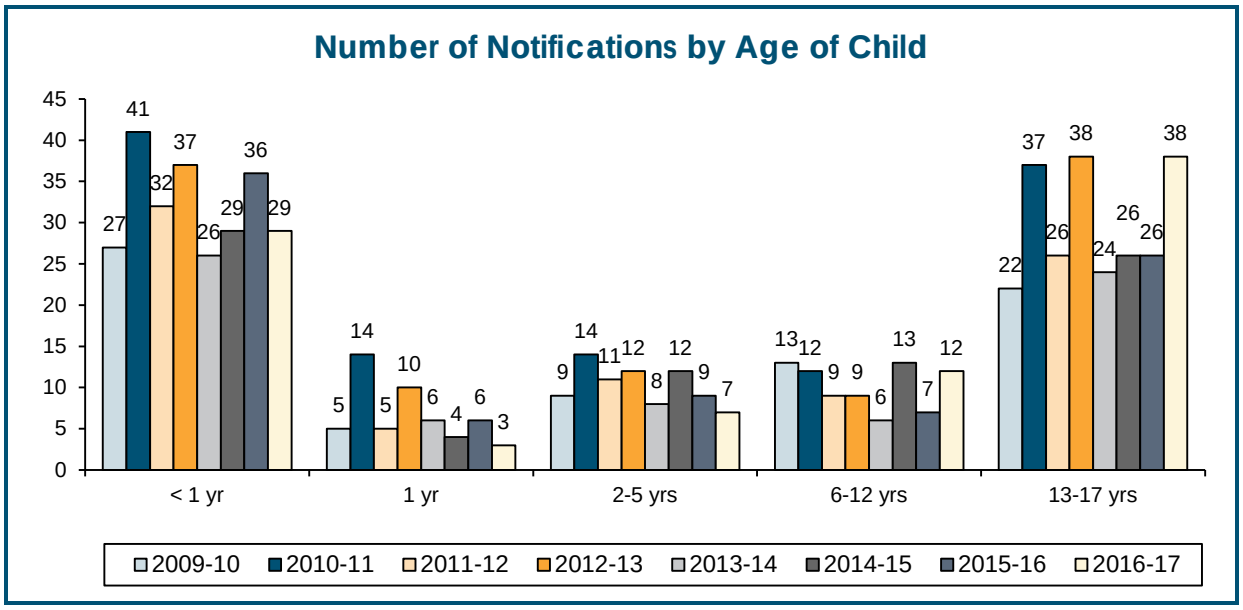


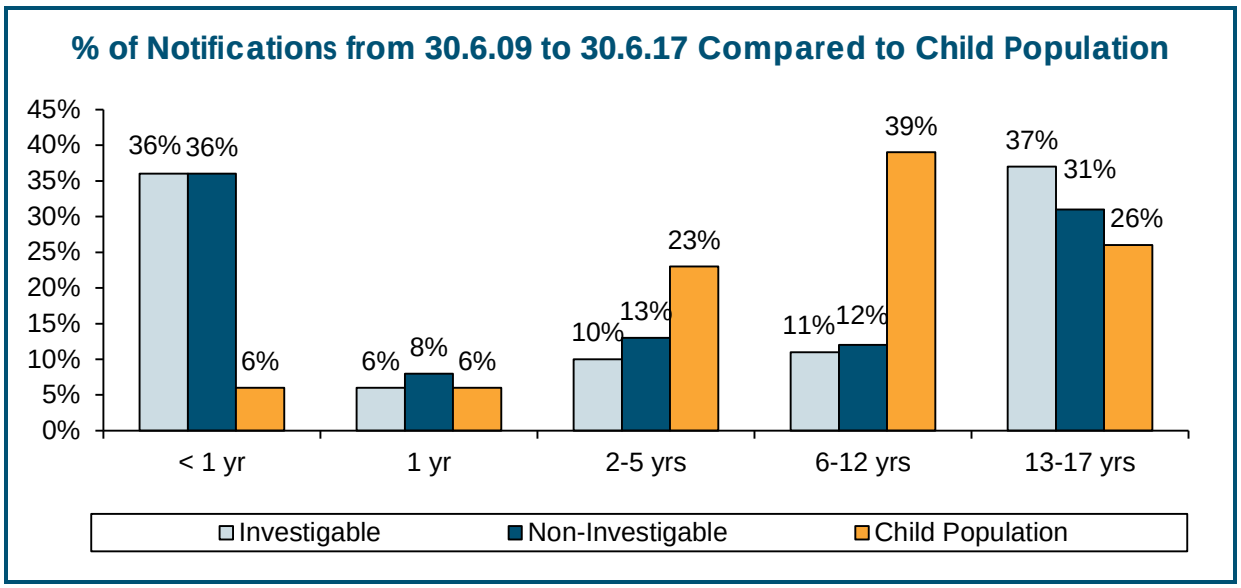
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

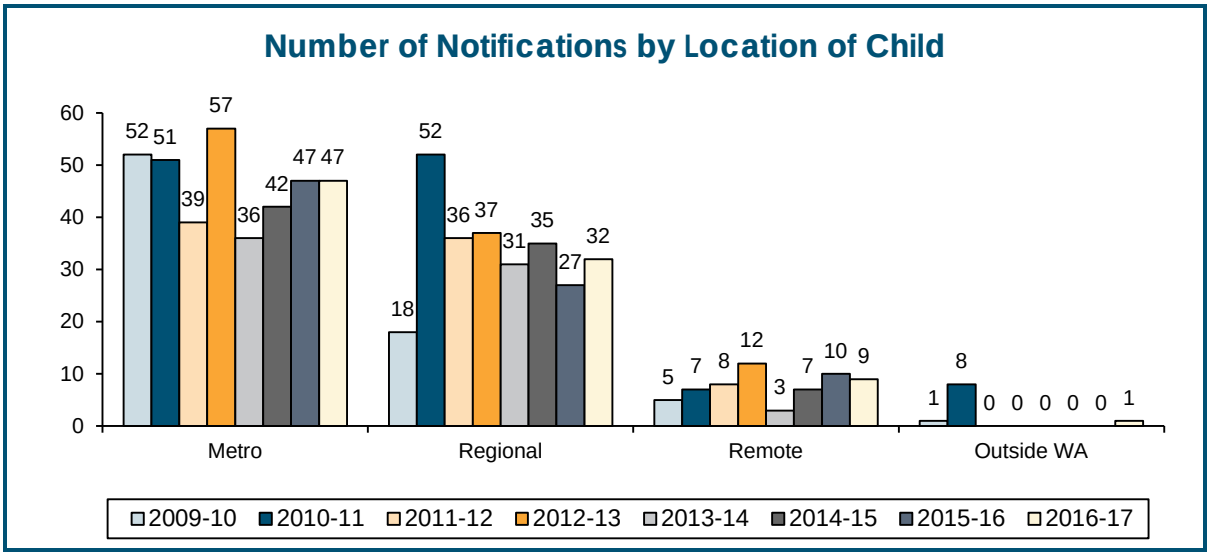




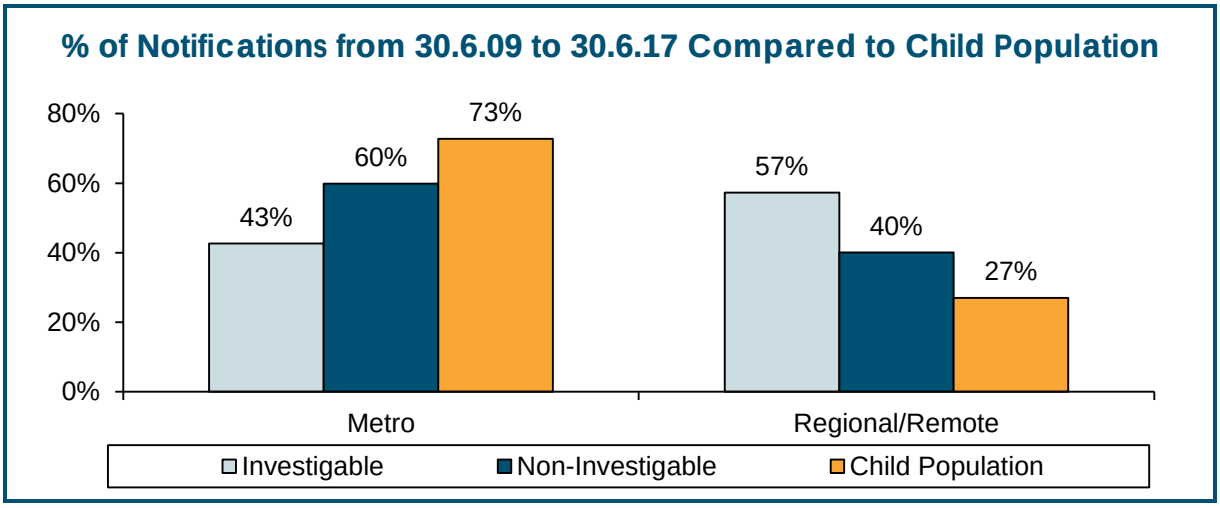
A more detailed analysis by age group is provided later in this section.

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 81% 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

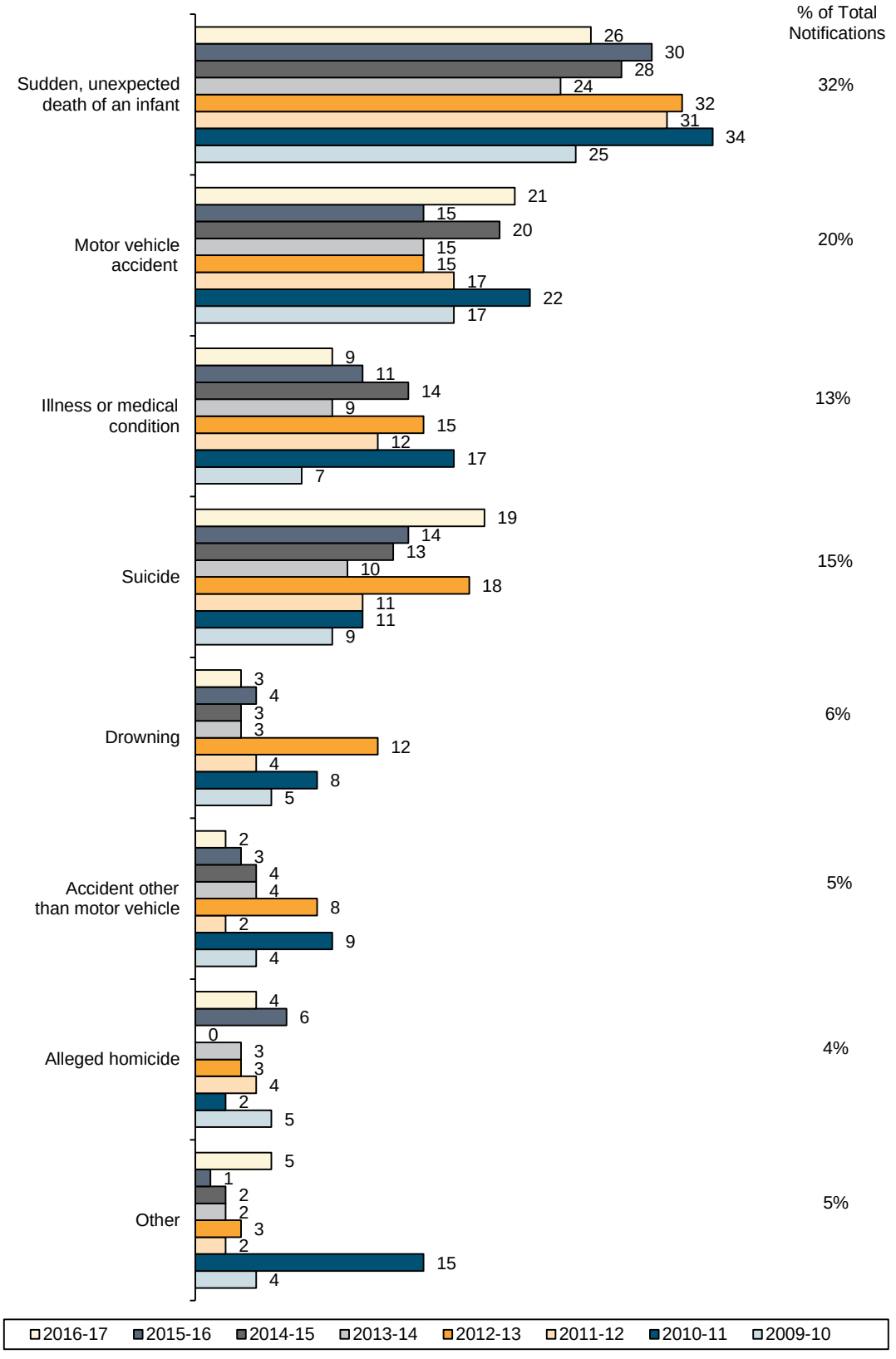
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally 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 2017.

Circumstances of Child Deaths 2009-2017



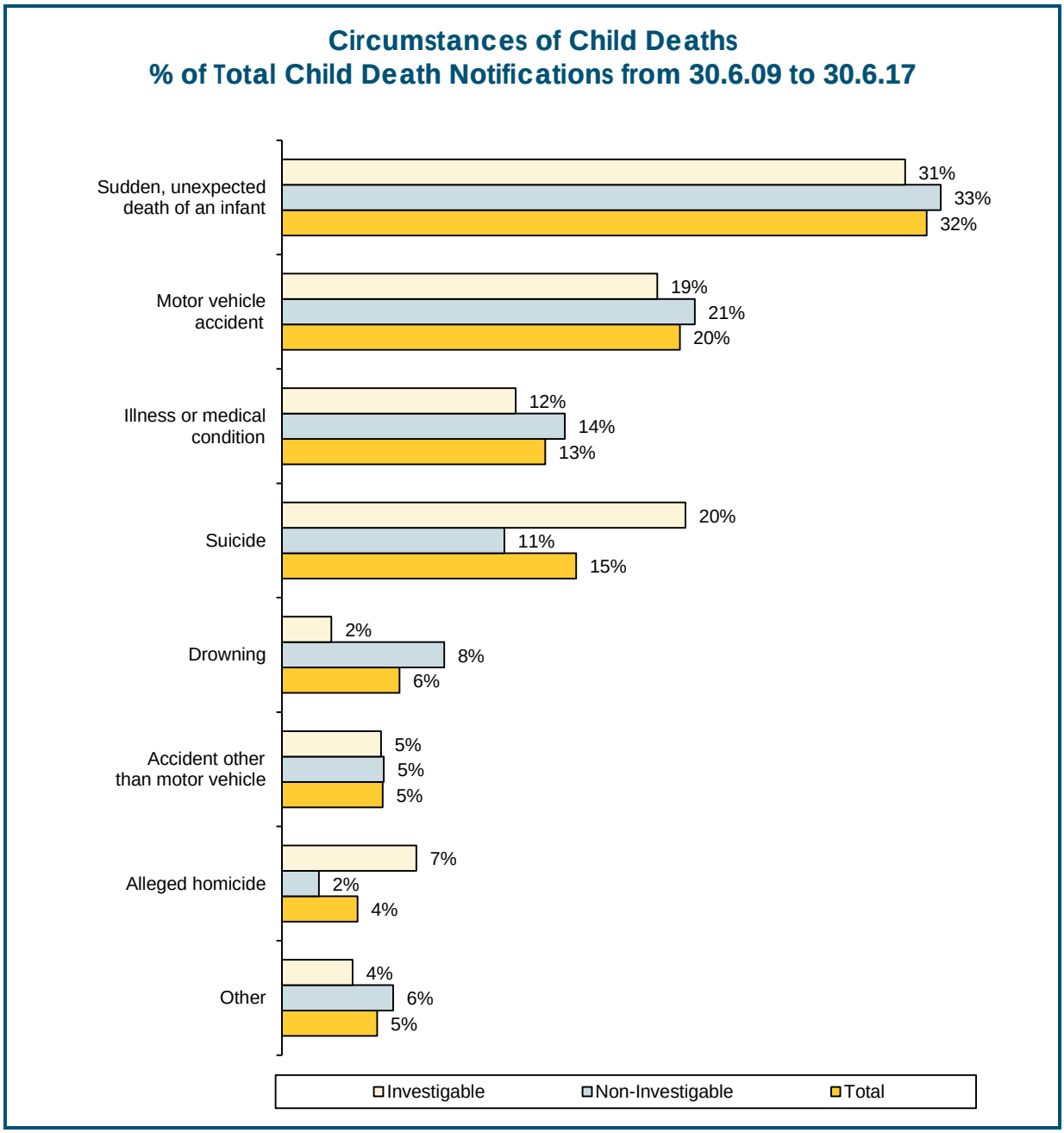
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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 710 child death notifications received in the eight years from 30 June 2009 to 30 June 2017 are:

- Sudden, unexpected deaths of infants, representing 32% of the total child death notifications from 30 June 2009 to 30 June 2017 (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, 36% in 2015-16 and 29% in 2016-17); and
- Motor vehicle accidents, representing 20% of the total child death notifications from 30 June 2009 to 30 June 2017 (22% of the child death notifications received in 2009-10, 19% in 2010-11, 20% in 2011-12, 14% in 2012-13, 21% in 2013-14, 24% in 2014-15, 18% in 2015-16, and 24% in 2016-17).

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



There are two areas where the circumstance of death shows a higher proportion for investigable deaths than for deaths that are not investigable. These are:

- Suicide; and
- Alleged homicide.

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
2016-17	2	21	9		4	3	26	19	5

* 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 2017.

Social or Environmental Factor	% of Finalised Reviews from 30.6.09 to 30.6.17
Family and domestic violence	70%
Parenting	60%
Alcohol use	45%
Drug or substance use	43%
Homelessness	24%
Parental mental health issues	25%

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 nearly two-thirds of the cases;
  - Alcohol use was a co-existing factor in over half of the cases;
  - Drug or substance use was a co-existing factor in over half of the cases;
  - Homelessness was a co-existing factor in over a quarter of the cases; and
  - Parental mental health issues were a co-existing factor in over a 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

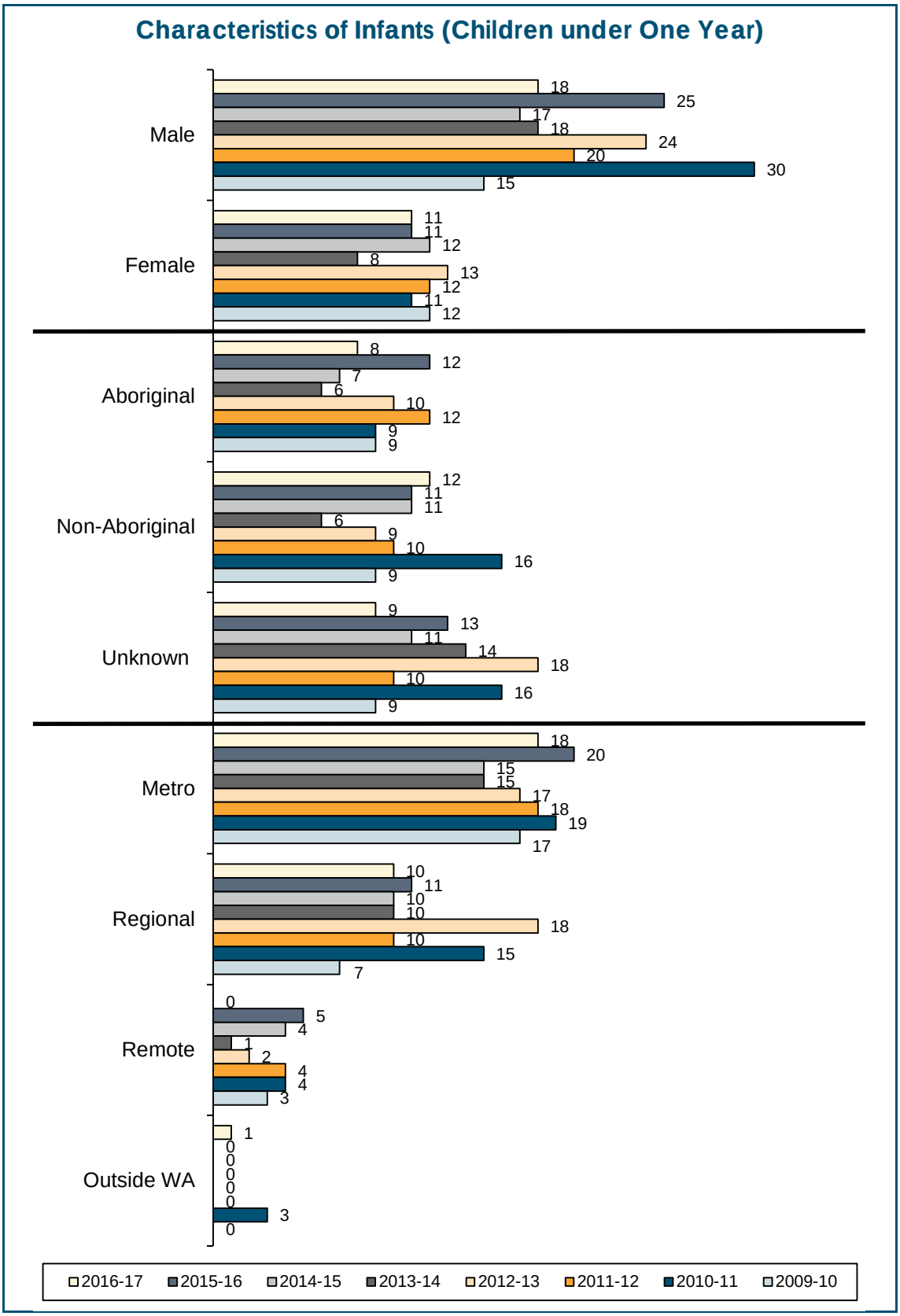
In child deaths notified to the Ombudsman in 2016-17, the majority of children who were known to DCPFS were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

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 710 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2017, there were 257 (36%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.

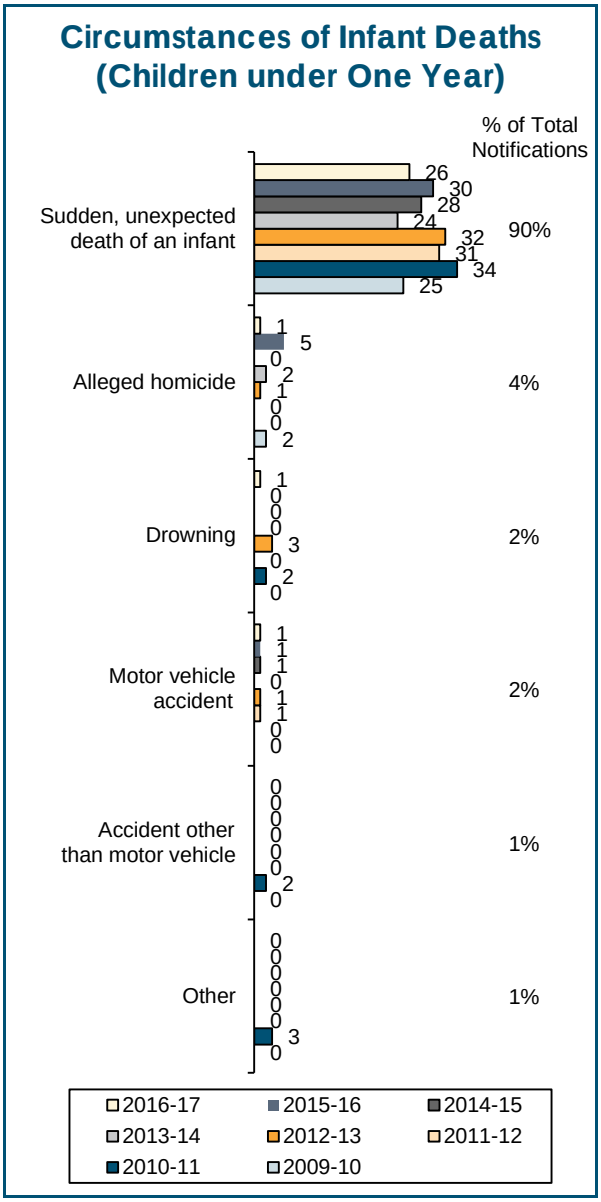


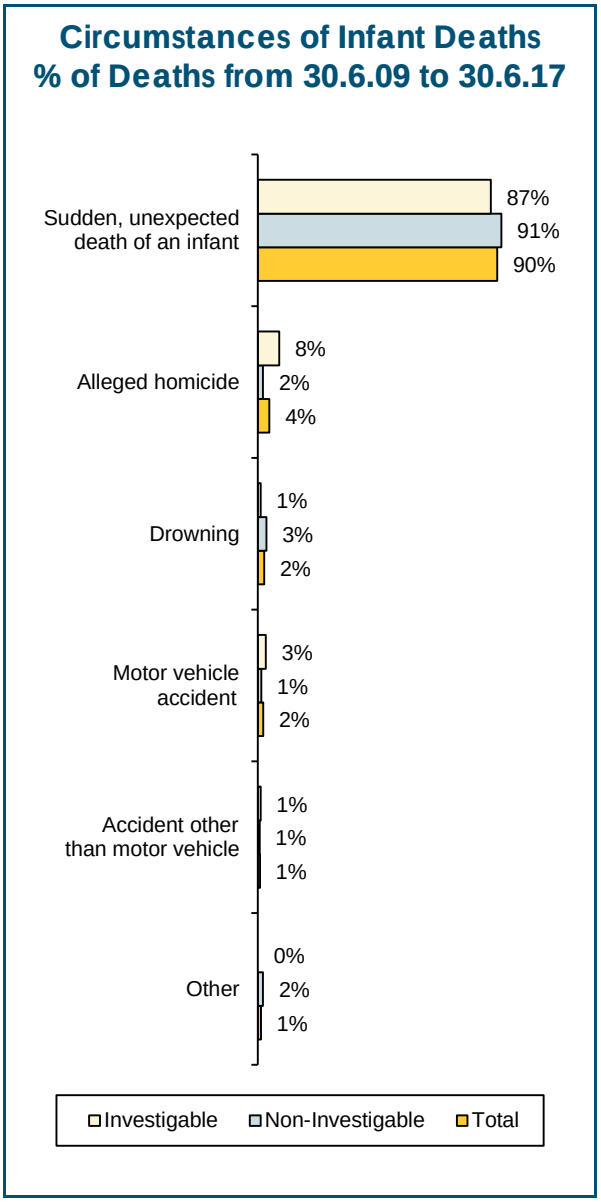
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 70% of investigable infant deaths and 62% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 64% of investigable deaths and 30% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 54% of investigable infant deaths and 39% 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 257 infant deaths, 230 (89%) were categorised as sudden, unexpected deaths of an infant and the majority of these (151) 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.





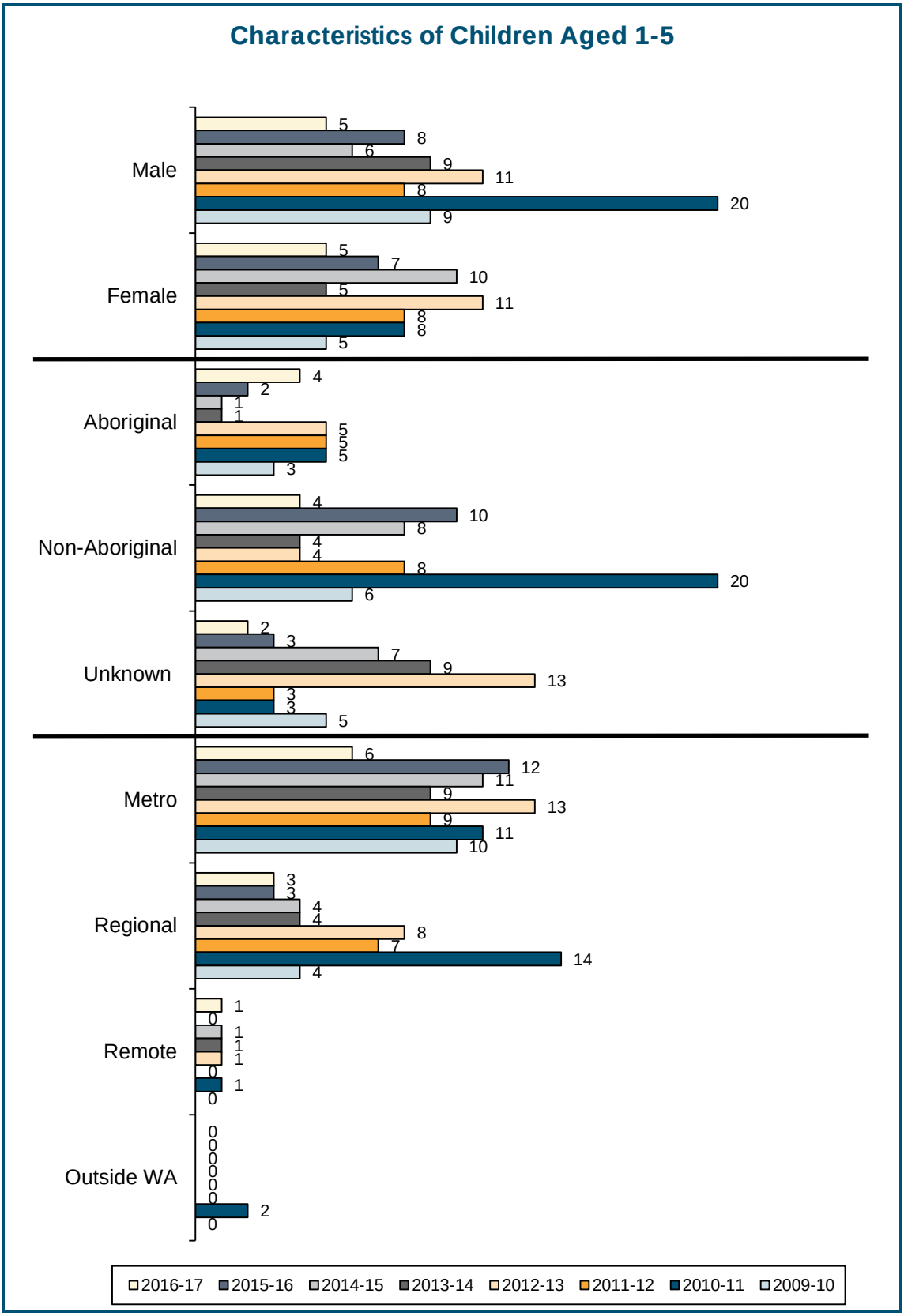
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

One hundred and one deaths of infants were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 710 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2017, there were 135 (19%) related to children aged from 1 to 5 years.

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

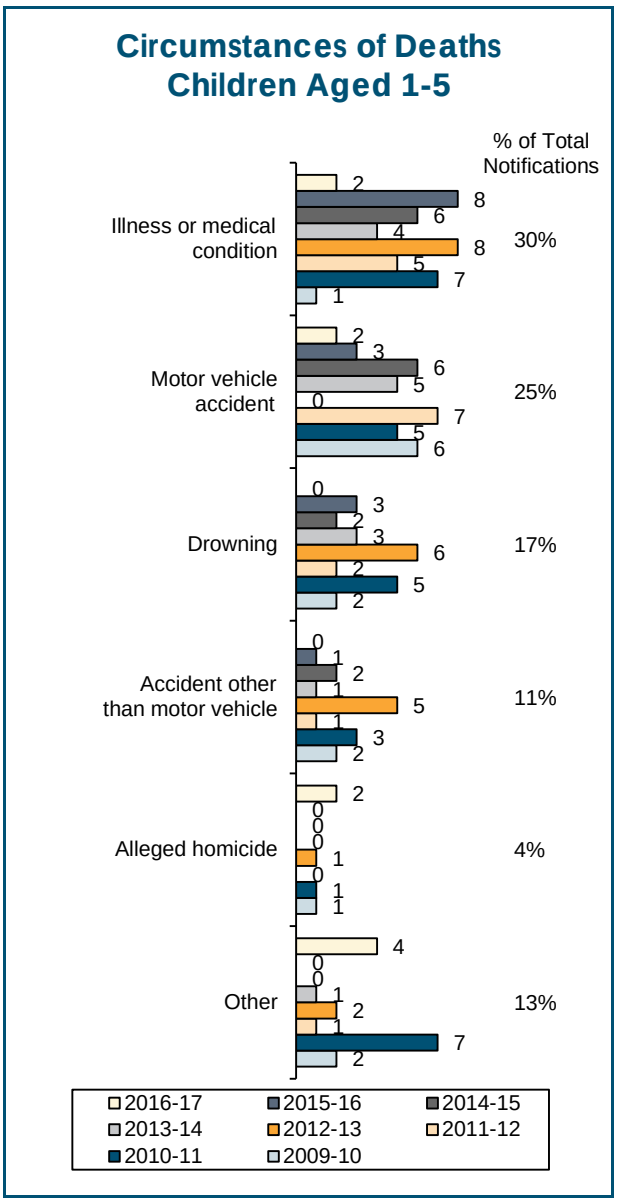


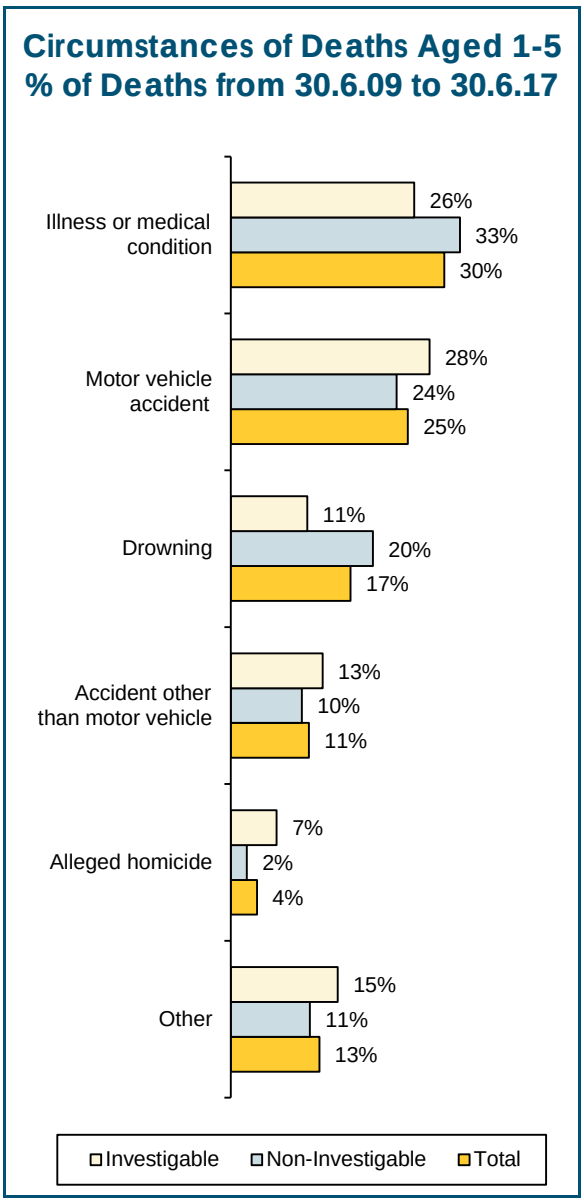
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 59% of investigable deaths and 55% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Aboriginal children – 52% 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 – 43% 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 (30%), followed by motor vehicle accidents (25%) and drowning (17%).





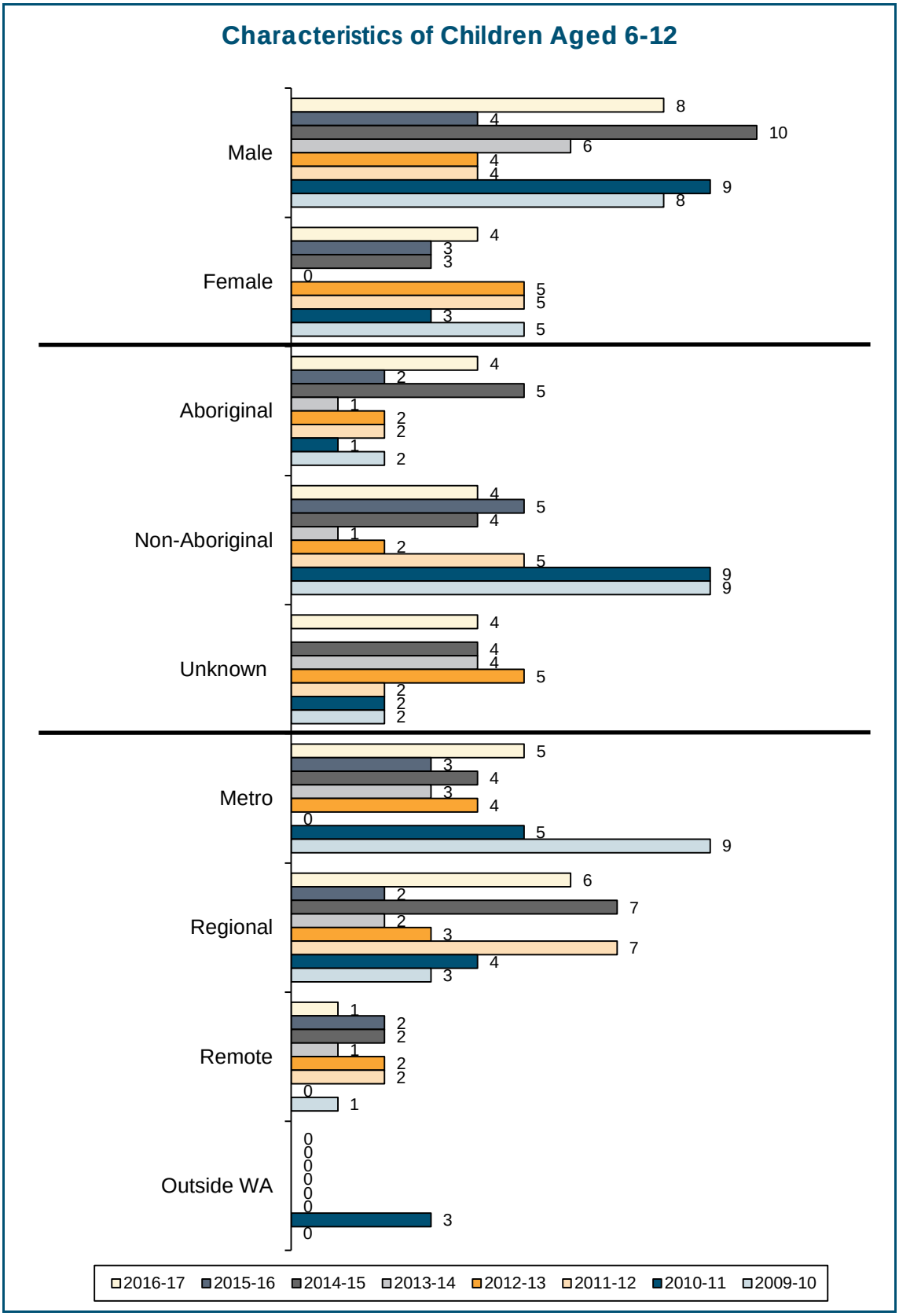
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Forty six deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of children aged 6 to 12 years

Of the 710 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2017, there were 81 (11%) related to children aged from 6 to 12 years.

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

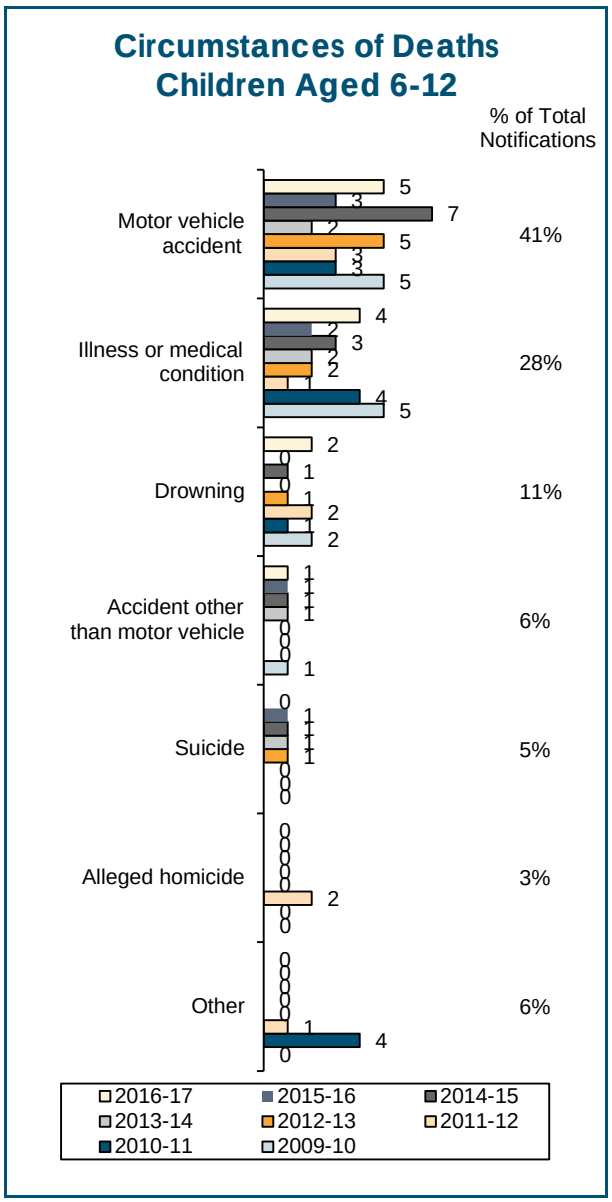


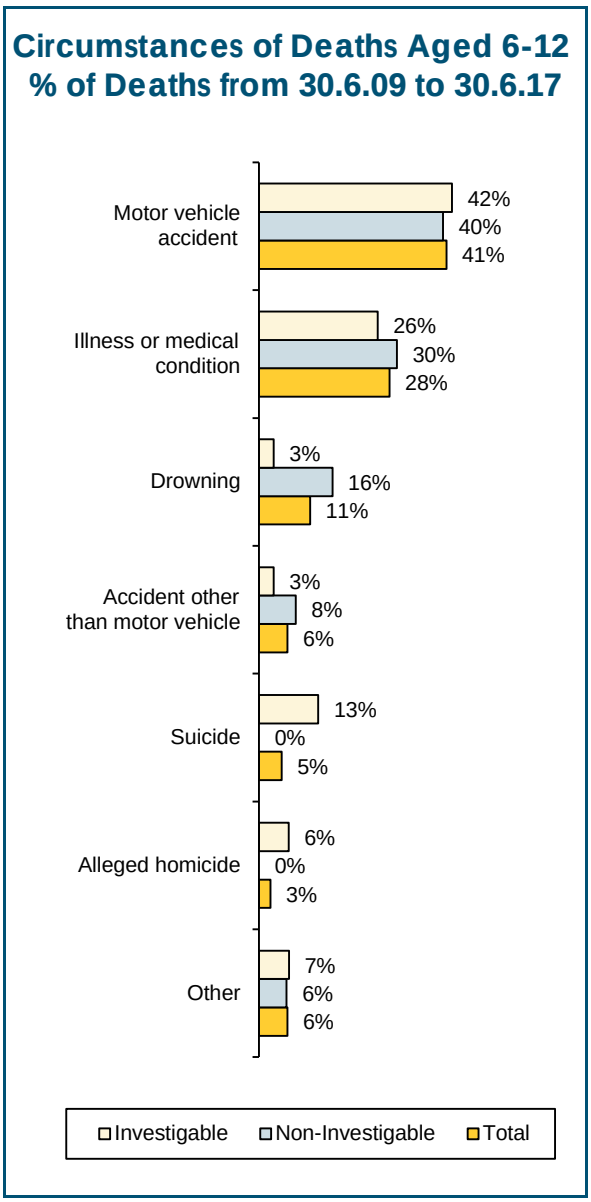
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 52% of investigable deaths and 74% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population;
- Aboriginal children – 54% of investigable deaths and 13% 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 – 74% of investigable deaths and 47% 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 (11%).





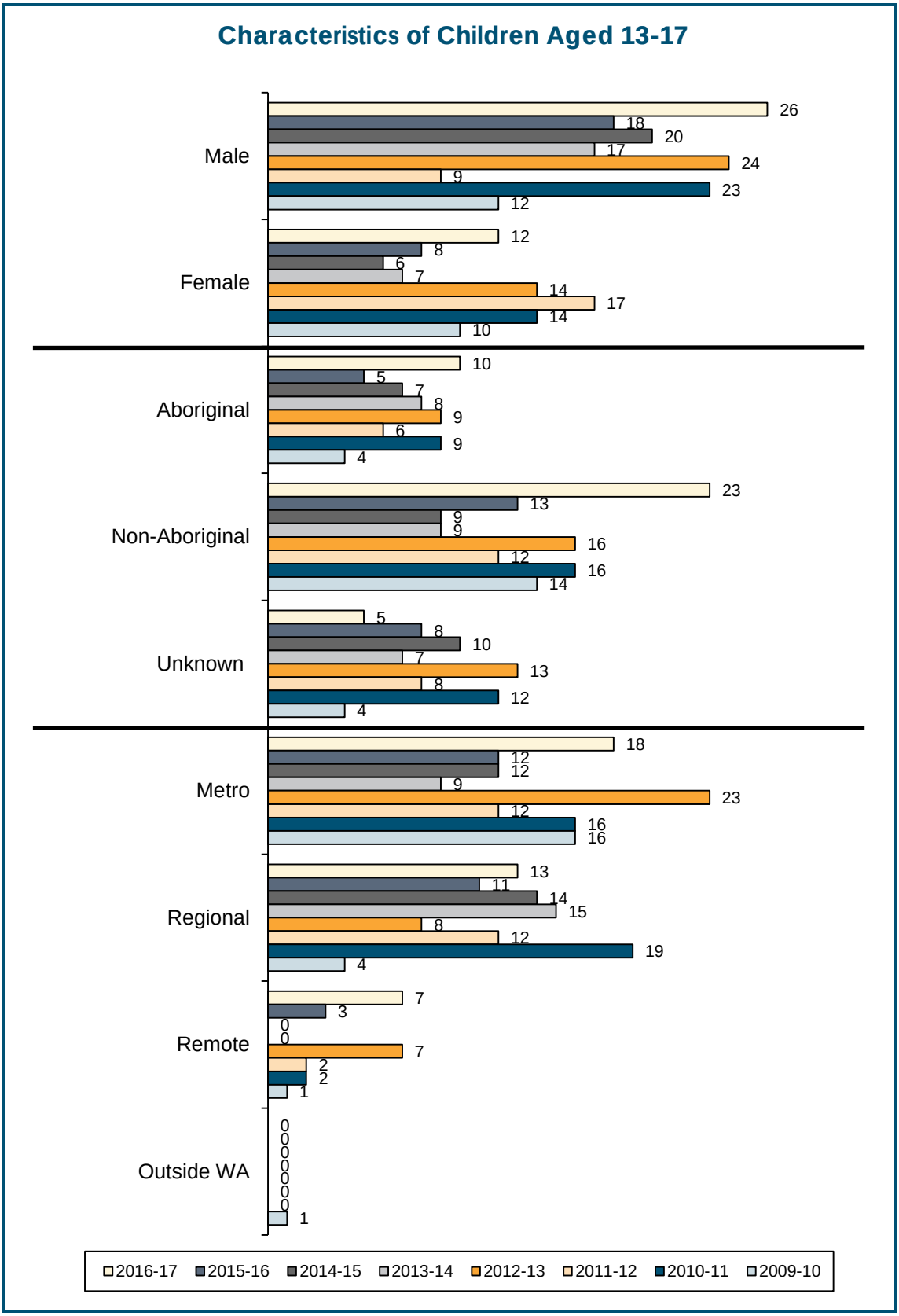
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Thirty one deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of children aged 13 – 17 years

Of the 710 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2017, there were 237 (33%) related to children aged from 13 to 17 years.

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

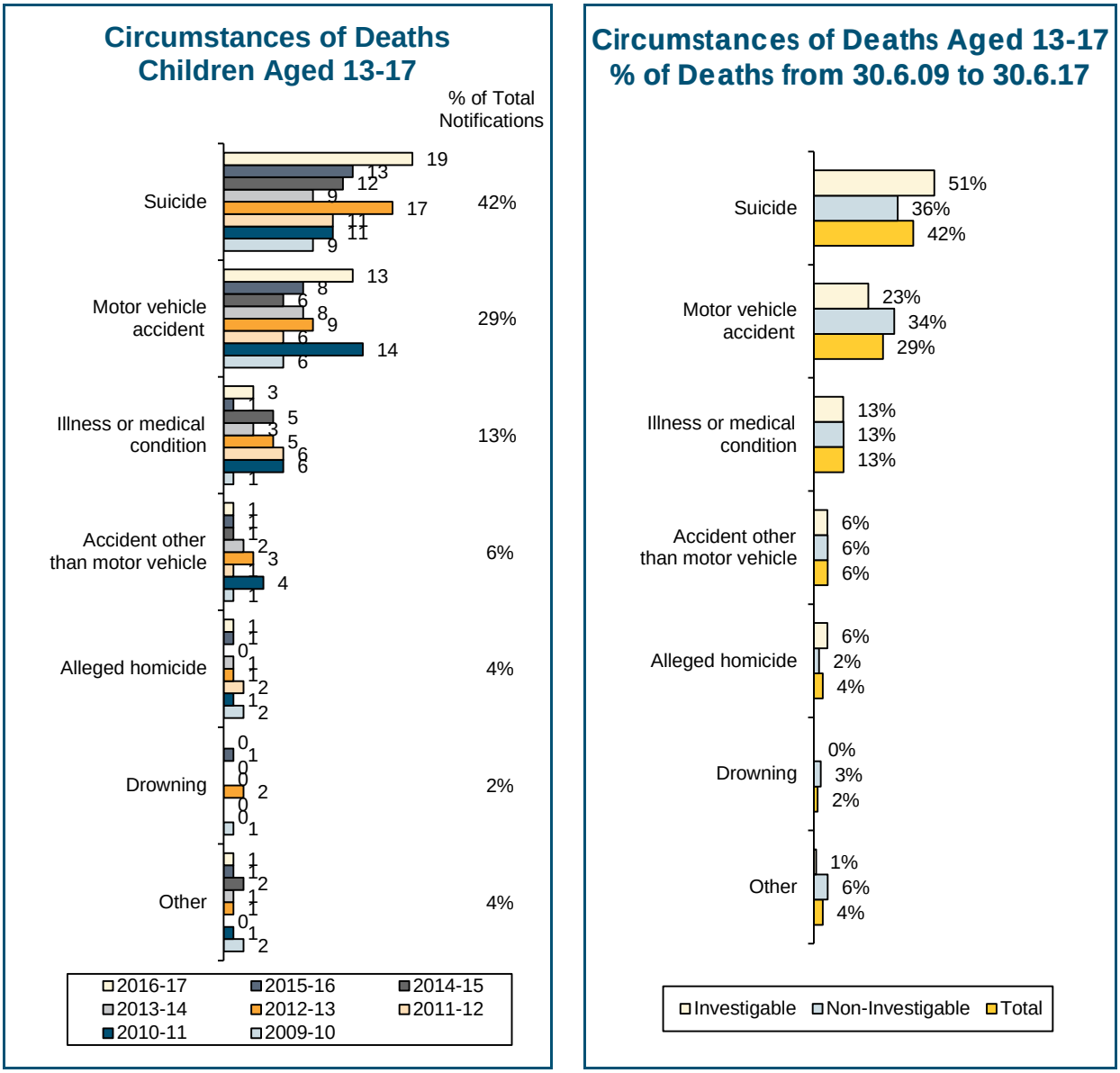


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 58% of investigable deaths and 66% of non-investigable deaths of children aged 13 to 17 were male compared to 51% in the child population;
- Aboriginal children – 51% of investigable deaths and 14% 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 (42%), particularly for investigable deaths, followed by motor vehicle accidents (29%) and illness or medical condition (13%).



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.

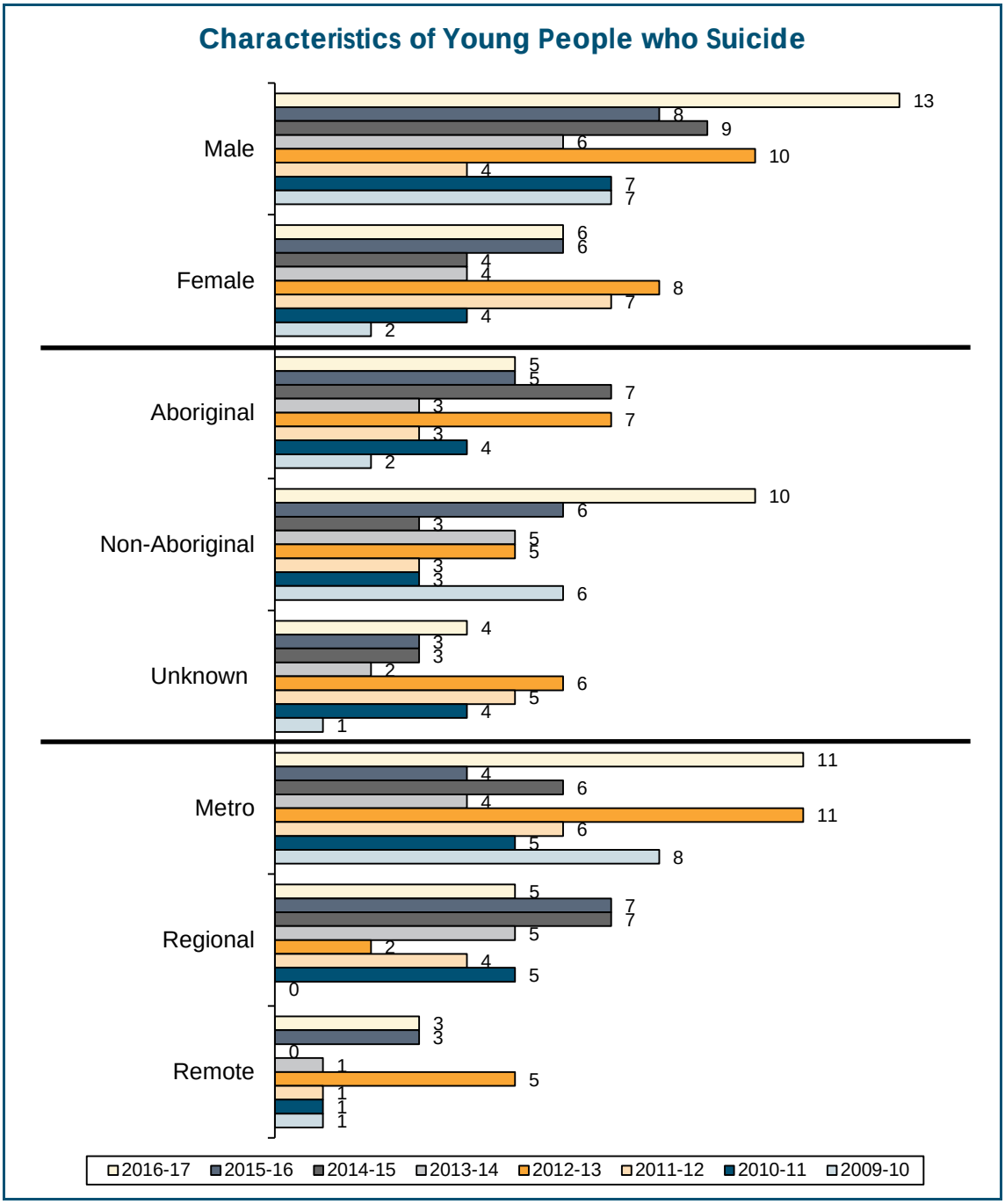
One hundred and three deaths of children aged 13 to 17 years were determined to be investigable deaths.

Suicide by young people

Of the 105 young people who apparently took their own lives from 30 June 2009 to 30 June 2017:

- Four were under 13 years old;
- Five were 13 years old;
- Eleven were 14 years old;
- Twenty five were 15 years old;
- Twenty four were 16 years old; and
- Thirty six 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 – 53% of investigable deaths and 71% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 77 apparent suicides by young people where information on the Aboriginal status of the young person was available, 64% 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 63% 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.

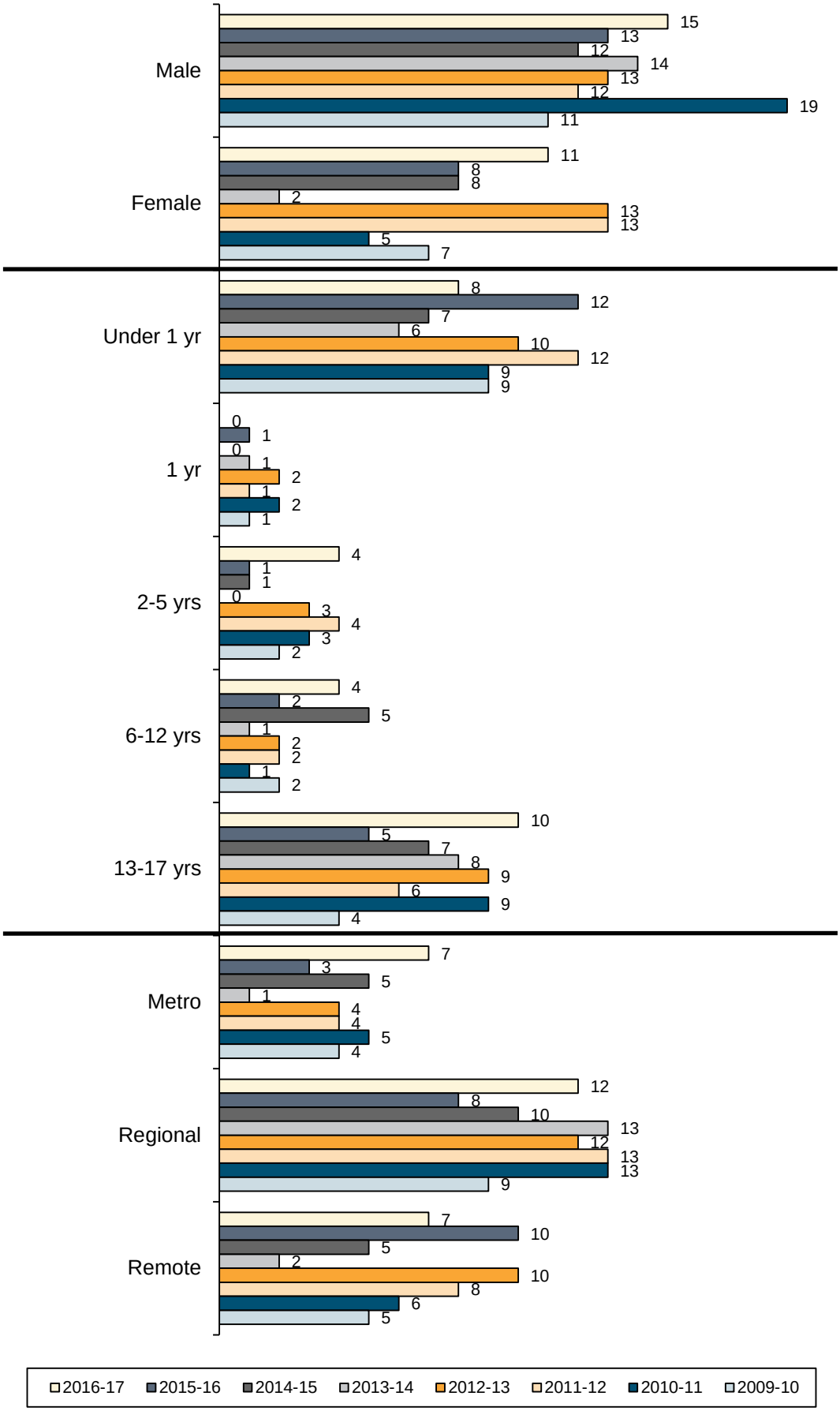
Deaths of Aboriginal children

Of the 475 child death notifications received from 30 June 2009 to 30 June 2017, where the Aboriginal status of the child was known, 176 (37%) of the children were identified as Aboriginal.

For the notifications received, the following chart demonstrates:

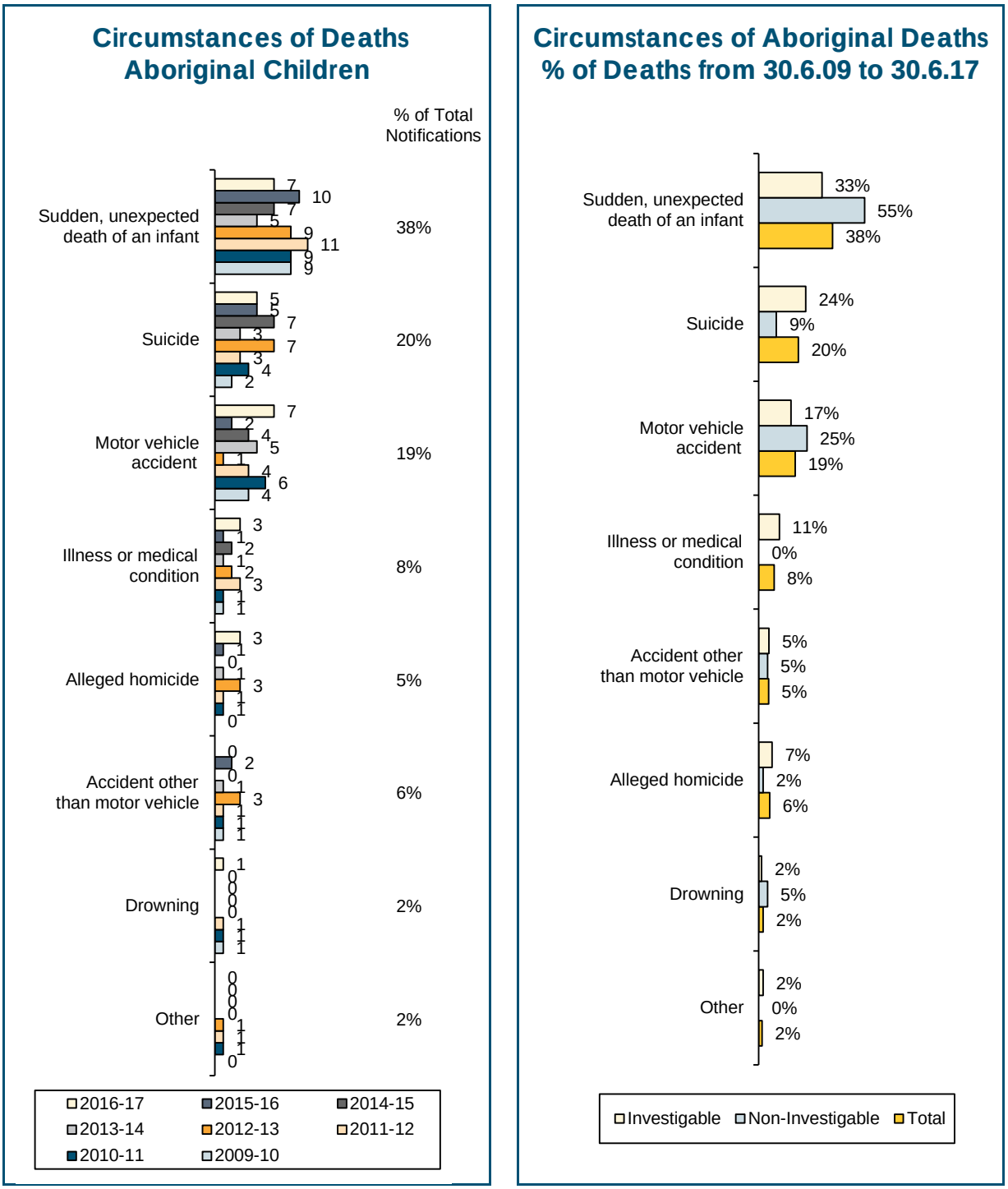
- Over the eight year period from 30 June 2009 to 30 June 2017, the majority of Aboriginal children who died were male (62%). For 2016-17, 58% of Aboriginal children who died were male;
- Most of the Aboriginal children who died were under the age of one or aged 13-17; and
- The deaths of Aboriginal children living in regional communities far outnumber the deaths of Aboriginal children living in the metropolitan area. Over the eight year period, 81% 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 (39%), suicide (20%), and motor vehicle accidents (18%) are the largest circumstance of death categories for the 176 Aboriginal child death notifications received in the eight years from 30 June 2009 to 30 June 2017.



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 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

Baby A

Baby A died as a result of the actions of a parent. Following a review of Baby A's death, the Ombudsman made the following recommendations:

1. That DCPFS develops and implements evidence based practice guidelines associated with identifying and responding to infants at high risk of emotional abuse (including exposure to family and domestic violence), harm and/or neglect within the meaning of section 28 of the *Children and Community Services Act 2004*.
2. That DCPFS provides a report to the Ombudsman within six months of the finalisation of this child death review outlining actions taken by DCPFS to give effect to Recommendation 1.

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 2016-17, 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 2017-18.

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.

Case Study

Child B

Child B was in the care of the CEO of DCPFS and placed with foster carers. Child B died from a medical condition.

Following a review of Child B's death, the Ombudsman made the following recommendations:

1. That DCPFS takes all reasonable steps to ensure compliance with the practice requirements outlined in Chapter 9.3 Placement with a Relative or Significant Other of the *Casework Practice Manual*.
2. That DCPFS takes all reasonable steps to ensure compliance with documented plans to monitor the health, safety and wellbeing of children in Provisional Protection and Care of DCPFS.
3. That DCPFS takes all reasonable steps to ensure compliance with the practice requirements outlined in Chapter 10.6 Health Care Planning of DCPFS's *Casework Practice Manual*.

Deaths of primary school aged children from motor vehicle accidents

In 2016-17, the Ombudsman received five notifications of the deaths of children aged six to 12 years in the circumstances of motor vehicle accidents. Four out of the five deaths occurred in regional Western Australia.

Deaths of children aged 13 to 17 years

Suicide by young people

Of the child death notifications received by the Office since the commencement of the Office's child death review responsibility, 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 42% 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.

During 2016-2017 significant work was undertaken to determine the steps taken to give effect to the recommendations arising from this investigation. A report on the findings of this work will be tabled in Parliament in 2017-18.

Further details of *A report on giving effect to the recommendations arising from the Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* are provided in the Own Motion Investigations and Administrative Improvement section.

Identification of good practice

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

Case Study

Baby C

Baby C died in circumstances of co-sleeping with a parent.

The Office's review of the case identified that health service providers, in accordance with the *WA Health Safe Infant Sleeping Policy and Framework 2013* had provided information to both parents to promote safe infant sleeping practices at the antenatal care stage, in hospital following Baby C's birth, and in the community through child health nurse contact. The Office's review also noted that this information had been provided, on all occasions, by nursing staff who had completed the required training module (WA Health's *Safe Sleeping E-learning Package*) and the health service providers had complied with the *WA Health Safe Infant Sleeping Policy and Framework 2013.*

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.
- Missed opportunities to obtain information from interstate child protection services to inform child wellbeing assessments.
- 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 Child Protection Practice Framework.
- Not adequately meeting policies and procedures relating to pre-birth planning.
- Missed opportunities to identify risk of harm and progress to a Safety and Wellbeing Assessment, to determine whether an infant was in need of protection within the meaning of section 28 of the *Children and Community Services Act 2004*.
- Not adequately meeting policies and procedures relating to Safety and Wellbeing Assessments for an infant, in a timely manner.
- 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 relating to family and domestic violence.
- Not adequately meeting policies and procedures relating to the assessment of parental drug and alcohol use.
- Missed opportunities to recognise and respond to child and adolescent mental health issues, and drug and alcohol use.
- Not adequately meeting policies and procedures relating to child and adolescent mental health.
- Not adequately meeting policies and procedures relating to care planning.
- Not adequately meeting policies and procedures relating to Relative Carer Assessments.
- Missed opportunities to support relative carers.
- Not adequately implementing governance processes for approving Safety and Wellbeing Assessments or case closure, to promote compliance with policy and practice requirements in this critical decision-making.
- Not adequately meeting policies and procedures relating to the provision of staff supervision and training.
- 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 2016-17 arising from child death reviews (certain recommendations may be de-identified to ensure confidentiality).

1. DCPFS develops and implements evidence based practice guidelines associated with identifying and responding to infants at high risk of emotional abuse (including exposure to family and domestic violence), harm and/or neglect within the meaning of section 28 of the *Children and Community Services Act 2004*.
2. DCPFS provides a report to the Ombudsman within six months of the finalisation of this child death review outlining actions taken by DCPFS to give effect to Recommendation 1.
3. DCPFS considers its compliance with its record keeping obligations in the context of this case and provides a report to the Ombudsman within six months of the finalisation of this child death review outlining the results of this consideration.
4. Having agreed to implement Recommendation 1 arising from this office's review of the death of [Child A] DCPFS reviews [Child B's] case to determine if CCU staff require specific guidelines to support timely responses to safety and wellbeing concerns for infants.
5. DCPFS continues to take all reasonable steps to achieve compliance with DCPFS's policy and practice requirements regarding the provision of safe infant sleeping information as detailed in DCPFS's *Casework Practice Manual* Chapter 3.2 *Safe Infant Sleeping*.
6. DCPFS takes all reasonable steps to ensure compliance with the practice requirements outlined in Chapter 9.3 Placement with a Relative or Significant Other of the *Casework Practice Manual*.
7. DCPFS takes all reasonable steps to ensure compliance with documented plans to monitor the health, safety and wellbeing of children in the Provisional Protection and Care of DCPFS.
8. DCPFS takes all reasonable steps to ensure compliance with the practice requirements outlined in Chapter 10.6 Health Care Planning of the *Casework Practice Manual*.
9. The relevant DCPFS Metropolitan District reiterates to staff with the delegated responsibility to approve critical decisions for the child's best interests, including but not limited to approvals of SWA and case closure, what their responsibilities are in providing such approvals.
10. DCPFS is to provide a report to the Ombudsman, within six months of the finalisation of this child death review, outlining the outcomes of DCPFS's three-month project to analyse pre-birth planning data and activity (in accordance with the *Bilateral Schedule: Interagency Collaborative Processes when an Unborn or Newborn Baby is Identified as at Risk of Abuse and/or Neglect (2013)*) across each of DCPFS's seventeen Districts.

11. The relevant DCPFS Regional District reiterates to staff with the delegated responsibility to approve critical decisions for the child's best interests, including but not limited to approvals of SWA and case closure, what their responsibilities are in providing such approvals.
12. That DSCPFS reviews this case and determines what actions should have been taken by the District to continue to engage with this family to 'effectively assess risks and respond to the needs of the child/family', between 23 November 2015 and [Child C's] death in February 2016, to provide guidance in working with future cases where there are similar circumstances of 'highly mobile and/or transient children and families'.
13. DCPFS is to provide a report to the Ombudsman, by 31 December 2017, outlining:
    - Actions taken by the relevant Regional District to address the identified areas and learning opportunities requiring consideration, and inform of their effectiveness; and
    - Outcomes of the review of the Safety and Wellbeing Assessment approved on 10 November 2015.
14. DCPFS develops the necessary strategies to assist the relevant Regional District Office in providing 'formal individual supervision' in accordance with Chapter 4.1 *Accountability, Governance and Conduct, Supervision in case practice/service delivery* of the Department's *Casework Practice Manual*.
15. In developing the next Learning and Development Centre's 'Learning Pathways Map', DCPFS documents what core Learning and Development Centre training programs are mandatory, across the specific positions (i.e. Case Worker, Team Leader etc) and the timeframe in which they must be completed following commencement to this position.
16. DCPFS develops the necessary strategies to assist the relevant Regional District Office to ensure that every staff member completes Orientation Programs 1, 2 and 3 (or equivalent).
17. That WA Country Health Service (**WACHS**) provides the Ombudsman with a report, by 31 December 2017, to outline what steps have been taken by the relevant regional hospital, in the context of the issue identified by this child death review, to ensure compliance with the *Memorandum of Understanding Pilbara District Pre-Birth Planning, Addendum to: Bilateral Schedule between CPFS and WA Health "Interagency collaborative processes when an unborn or newborn is identified as at risk of abuse and/or neglect."* (2016).
18. The relevant DCPFS Regional District takes all reasonable steps to ensure Child Centred Family Support is provided in accordance with the requirements of the *Family Support (Responsible Parenting) Framework (2013)* and Chapter 3.1 *Family Support* of the *Casework Practice Manual*.
19. The relevant DCPFS Regional District takes all reasonable steps to complete Provisional Care Plans and associated health care plans in accordance with the requirements of section 39 of the *Children and Community Services Act (2004)*, the *Care Planning Policy (2016)* and Chapters 10.2 *Provisional Care Plans* and 10.6 *Health Care Planning* of the *Casework Practice Manual*.
20. The relevant DCPFS Regional District takes all reasonable steps to ensure that assessments of relative carers are completed in accordance with Chapter 9.3 *Care Arrangements with a Family or Significant Other Carer* of the *Casework Practice Manual*.

21. The relevant DCPFS Regional District takes all reasonable steps to ensure that Care Plans are reviewed in the circumstances of a change in placement and include comprehensive cultural plans for Aboriginal children placed with non-Aboriginal carers.
22. DCPFS, in collaboration with a non-government organisation, reviews the support and education provided to the non-government organisation's carers in this case to identify any opportunities for improvement in the future interagency management of children with complex health and care needs placed in out of home care.
23. The relevant DCPFS Regional District takes all reasonable steps to provide staff supervision in accordance with Chapter 2.4 *Supervision in Case Practice/Service Delivery* of the *Casework Practice Manual* to promote staff compliance with Departmental policies and practice requirements.
24. DCPFS takes all reasonable steps to promote compliance with the Department's *Casework Practice Manual Chapter 14.3 Alcohol and Other Drug Issues*.
25. DCPFS ensures that when approving Safety and Wellbeing Assessments, DCPFS confirms that:
    - The Signs of Safety Framework and associated practice requirements have been implemented;
    - Family and domestic violence (**FDV**) assessment, where appropriate, has been undertaken in accordance with DCPFS's FDV policy; and
    - Drug and alcohol use assessment, where appropriate, has been undertaken in accordance with DCPFS's *Casework Practice Manual Chapter 14.3 Alcohol and Other Drug Issues.*
26. DCPFS takes all reasonable steps to achieve compliance with the administration of the Signs of Safety Child Protection Framework and the practice requirements outlined in Chapter 4.1 *Assessment and Investigation Processes* of the *Casework Practice Manual* in response to referrals associated with young people at risk of suicide.
27. DOH develops and implements an appropriate policy associated with the discharge of adolescents from WA Country Health Service (**WACHS**) Child and Adolescent Mental Health Service.
28. DOH takes all reasonable steps to ensure compliance with the WACHS *Missing or Suspected Missing Inpatient Procedure*.
29. DOH takes all reasonable and appropriate steps to involve an adolescent's family/community in promoting engagement with mental health services, risk assessment, safety planning and discharge planning.
30. DOH takes all reasonable steps to recognise and respond to factors impacting upon an adolescent's mental health and safety and wellbeing in a child protection context including consultation with and/or referral to DCPFS where indicated.
31. DCPFS is to provide a report to the Ombudsman within six months of the finalisation of this child death review outlining action taken by a Regional District to address the identified areas and learning opportunities requiring further consideration.

The Ombudsman will table a report in Parliament in 2018-19 on the steps taken to give effect to the 31 recommendations made about ways to prevent or reduce child deaths in 2016-17.

Steps taken to give effect to recommendations

The steps taken to give effect to the recommendations arising from child death reviews in 2015-16

The Ombudsman made nineteen recommendations about ways to prevent or reduce child deaths in 2015-16. In 2016-17, the Office has requested that the relevant public authorities notify the Ombudsman regarding:

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

The Ombudsman will table a report in Parliament in 2017-18 on the steps taken to give effect to the 19 recommendations made about ways to prevent or reduce child deaths in 2015-16.

The steps taken to give effect to the recommendations arising from major own motion investigations

During 2016-17 significant work was undertaken to determine the steps taken to give effect to the 22 recommendations arising from the *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, tabled in Parliament on 9 April 2014. The Ombudsman will table a report in Parliament in 2017-18 on the steps taken to give effect to the 22 recommendations made in the report about ways to prevent or reduce child deaths.

Case Study

Monitoring provision of safe infant sleeping information

The Ombudsman's major own motion investigation report, *Investigation into ways that State Government departments and authorities can prevent or reduce sleep-related infant deaths,* tabled in Parliament in November 2012, included the following recommendation:

> **Recommendation 1:** It is recommended that the Department of Health establishes a statement on safe sleeping, either by expanding its existing Policy on co-sleeping, or by establishing an additional statement on safe sleeping, which:
>
> - Takes into account and complements existing information available from non-government organisations including SIDS and Kids WA, as appropriate;
> - Forms the basis for safe sleeping advice provided to parents and carers;
> - Forms the basis for strategies across State Government hospitals and health services to assist parents and carers understand and apply this advice; and
> - Is a guide for policies and strategies by other State Government departments and authorities aimed at achieving the same objective.

The Department of Health subsequently released the *WA Health Safe Infant Sleeping Policy and Framework 2013* (**the SIS Framework**), which aims to:

> …reduce the risk and incidence, and raise awareness, of Sudden Unexpected Deaths in Infancy in Western Australia through consistent:
>
> - Education of parents, carers, families and communities using evidence-based best practice;
> - Training and education of health professionals and social service providers using evidence-based best practice; and
> - Implementation of safe infant sleeping messages to meet health professionals and social service providers requirements. (at page 5, www.health.wa.gov.au)

In undertaking reviews of sleep related infant deaths, the Office considers health services' implementation of the SIS Framework, and the recommendations made by the Ombudsman as set out in the *Investigation into ways that State Government departments and authorities can prevent or reduce sleep-related infant deaths*.

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 2016-17, timely review processes have resulted in over two-thirds 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 2016-17, the Office undertook significant work on a report 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 2017-18.

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

- *Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004*, which was tabled in Parliament in November 2011;
- *Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths*, which was tabled in Parliament in November 2012; 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 2016-17 and during the year, the following members provided a range of expertise:

- Professor Steve Allsop (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 (Consultant).

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 in 2016-17.

Key stakeholder relationships

There are a number of public authorities and other bodies that interact with, or deliver services to, children and their families. Important stakeholders with which the Office liaised in 2016-17 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 2016-17 to continue to build relationships relating to the child death review jurisdiction with Aboriginal and regional communities, for example by communicating with:

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

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

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.

In 2016-17, the Principal Aboriginal Liaison Officer and the Assistant Ombudsman Reviews met with Aboriginal community members, and government and non-government service providers in Geraldton, to hear from them about what they believe is working well, what is not working well, and what they believe needs to

happen in relation to preventing and reducing Aboriginal child deaths. Key messages given to the Office by stakeholders in these meetings were the need for Aboriginal leadership and involvement of Aboriginal people in service planning and decision-making, the need for the direct funding to local Aboriginal community controlled services and the need for improved collaboration between service providers. The learnings from these meetings will inform the Office's understanding of child death reviews. Further regional visits to listen to, and engage with, the Aboriginal community about ways to prevent or reduce Aboriginal child deaths will be undertaken by the Office in 2017-18.

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 2010-2013: Building a Strong Foundation* (available at www.dss.gov.au), which established the 'groundwork for the National Plan', and the *Second Action Plan 2013-2016: Moving Ahead* (available at www.dss.gov.au) and the *Third Action Plan 2016-2019* (available at www.dss.gov.au), which build 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. *Victims of family and domestic violence and abuse will not be held responsible for the perpetrator's behaviour.*
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. *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.*

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**)[2] and with other agencies, such as the Department of Corrective Services (**DCS**) and the Department of the Attorney General (**DOTAG**),[3] and relevant courts.

[2] As of 1 July 2017, DCPFS became part of the new Department of Communities.
[3] As of 1 July 2017, DCS and DOTAG became part of the new Department of Justice.

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

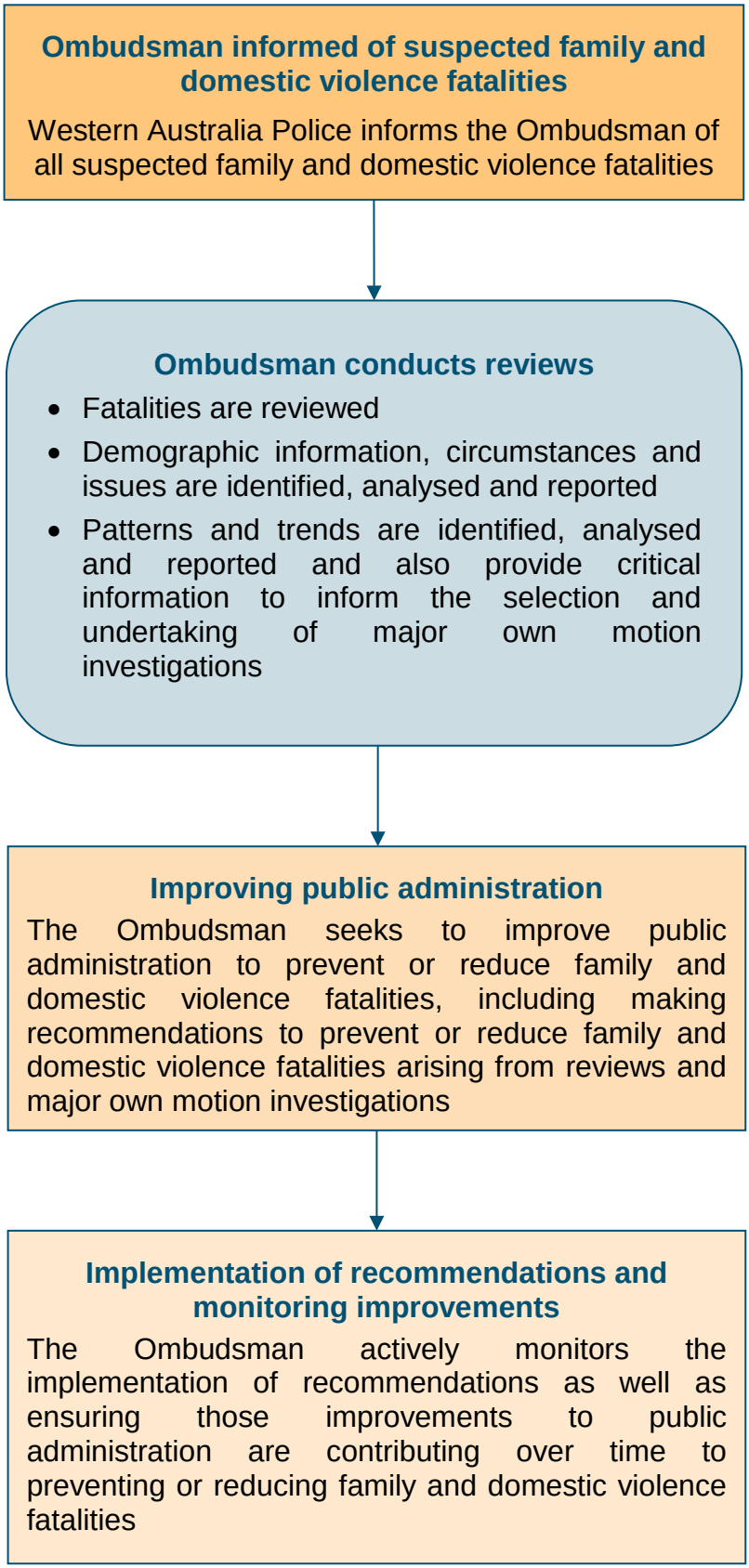
(ii) De facto partner or former de facto partner.

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 88 reviewable family and domestic violence fatalities received from 2012-13 to 2016-17. As the information in the following charts is based on five 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.

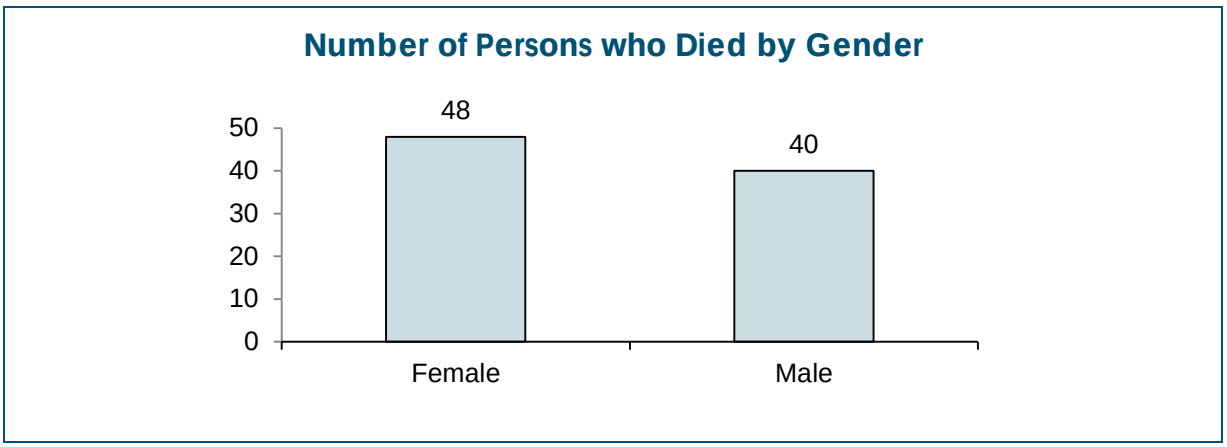
Number of family and domestic violence fatality reviews

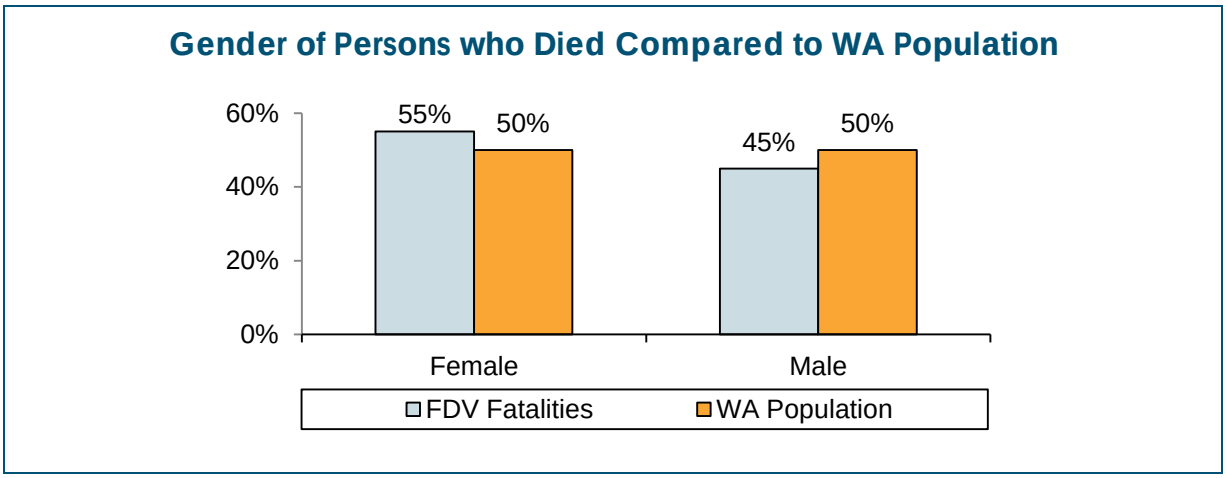
In 2016-17, the number of reviewable family and domestic violence fatalities received was 15, compared to 22 in 2015-16, 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

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.

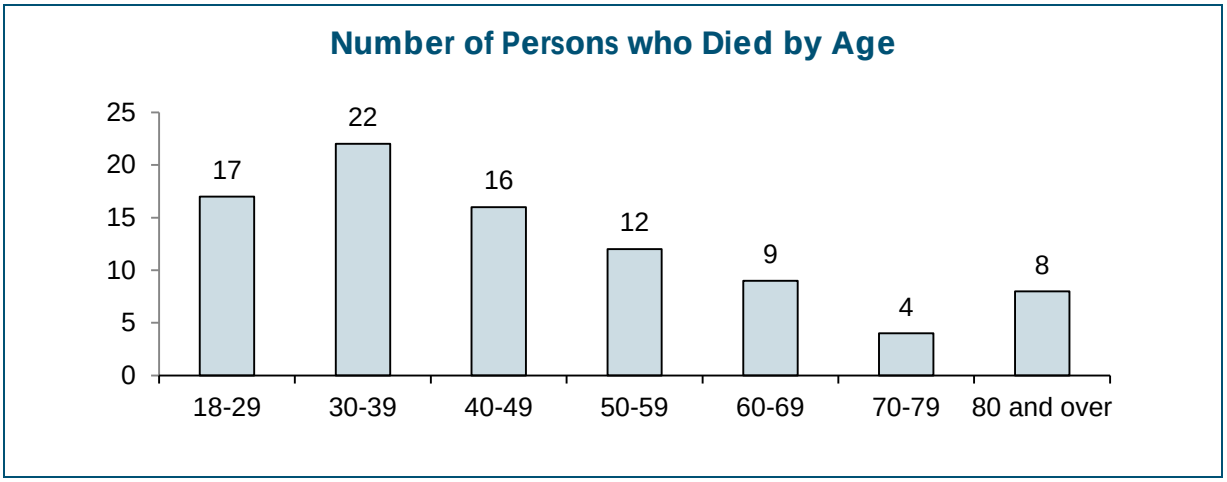
The following charts show characteristics of the persons who died for the 88 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2017. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

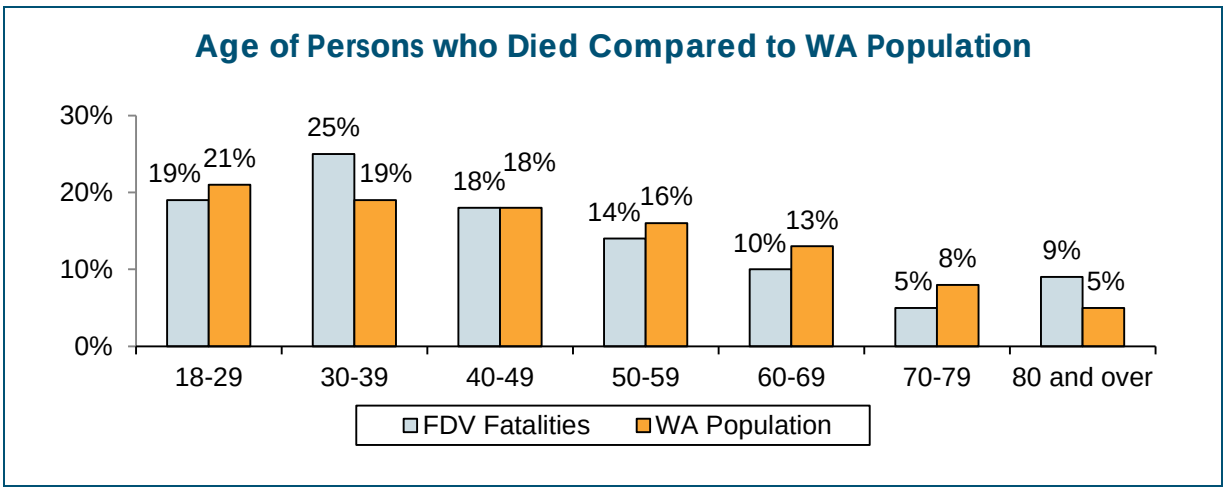




Compared to the Western Australian population, females who died in the five years from 1 July 2012 to 30 June 2017, were over-represented, with 55% of persons who died being female compared to 50% in the population.

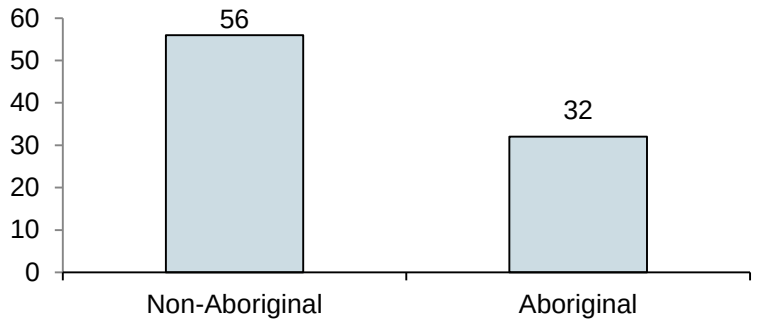
In relation to the 48 females who died, 44 involved a male suspected perpetrator, three involved a female suspected perpetrator, and one involved multiple suspected perpetrators of both genders. Of the 40 men who died, seven were apparent suicides, 18 involved a female suspected perpetrator, 13 involved a male suspected perpetrator and two involved multiple suspected perpetrators of both genders.



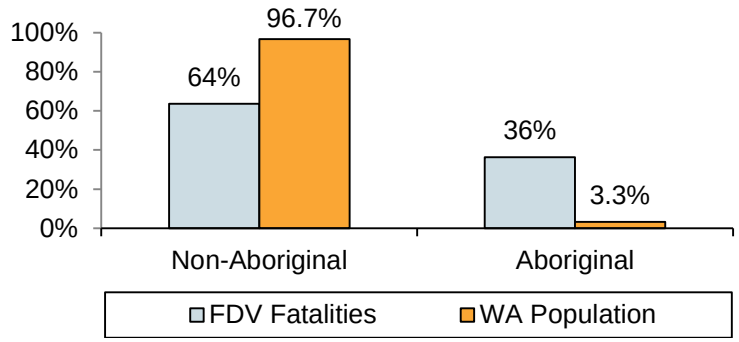


Compared to the Western Australian population, the age groups 30-39 and 80 and over are over-represented, with 25% of persons who died being in the 30-39 age group compared to 19% of the population, and nine percent of persons who died being in the 80 and over age group compared to five percent of the population.

Number of Persons who Died by Aboriginal Status

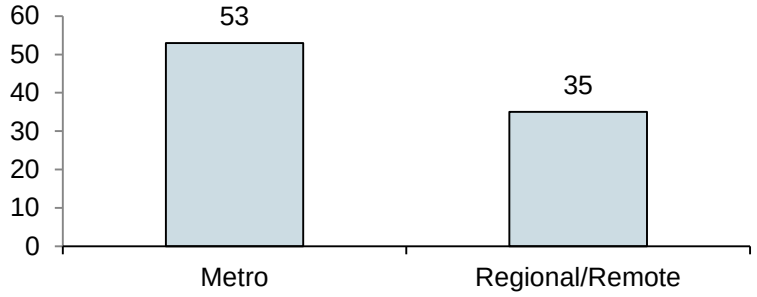


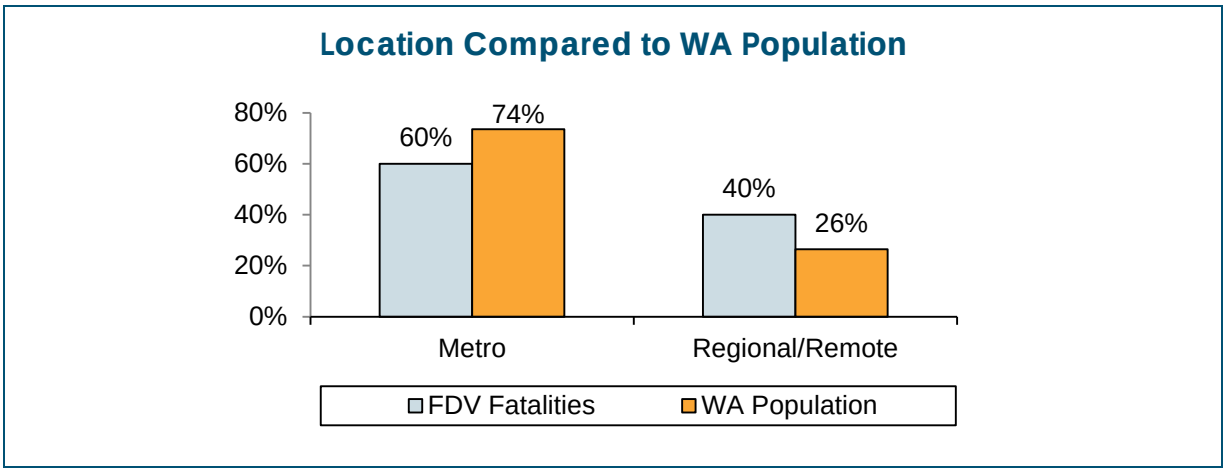
Aboriginal Status of Persons who Died Compared to WA Population



Compared to the Western Australian population, Aboriginal people who died were over-represented, with 36% of people who died in the five years from 1 July 2012 to 30 June 2017 being Aboriginal compared to 3.3% in the population. Of the 32 Aboriginal people who died, 19 were female and 13 were male.

Number of Persons who Died by Location





Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 40% of the people who died in the five years from 1 July 2012 to 30 June 2017 living 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:

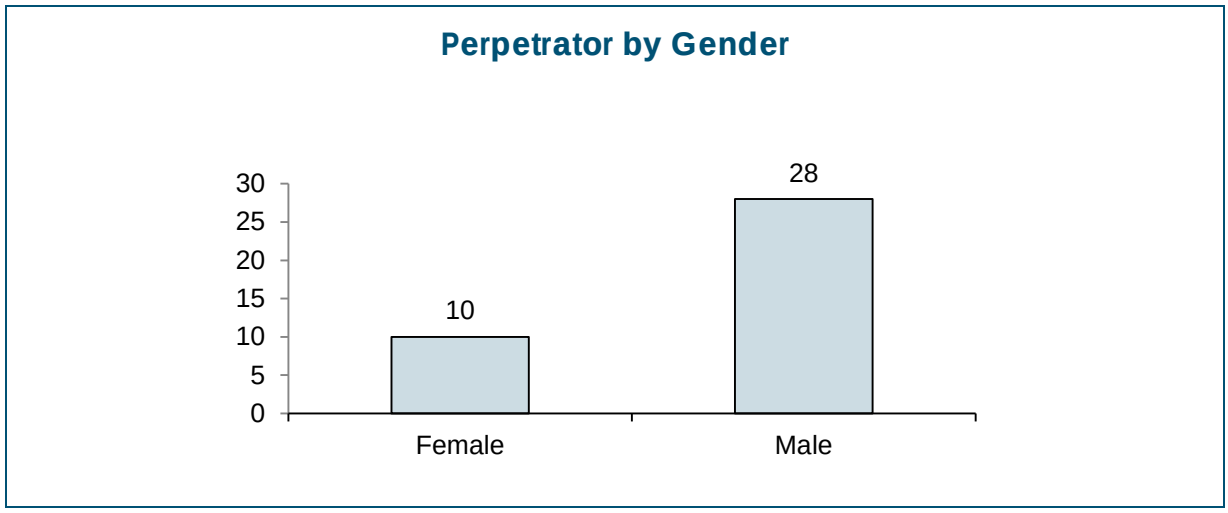
> *Family and domestic violence is particularly acute in Aboriginal communities. In Western Australia, it is estimated that Aboriginal women are 45 times more likely to be the victim of family violence than non-Aboriginal women, accounting for almost 50 per cent of all victims* (page 4).

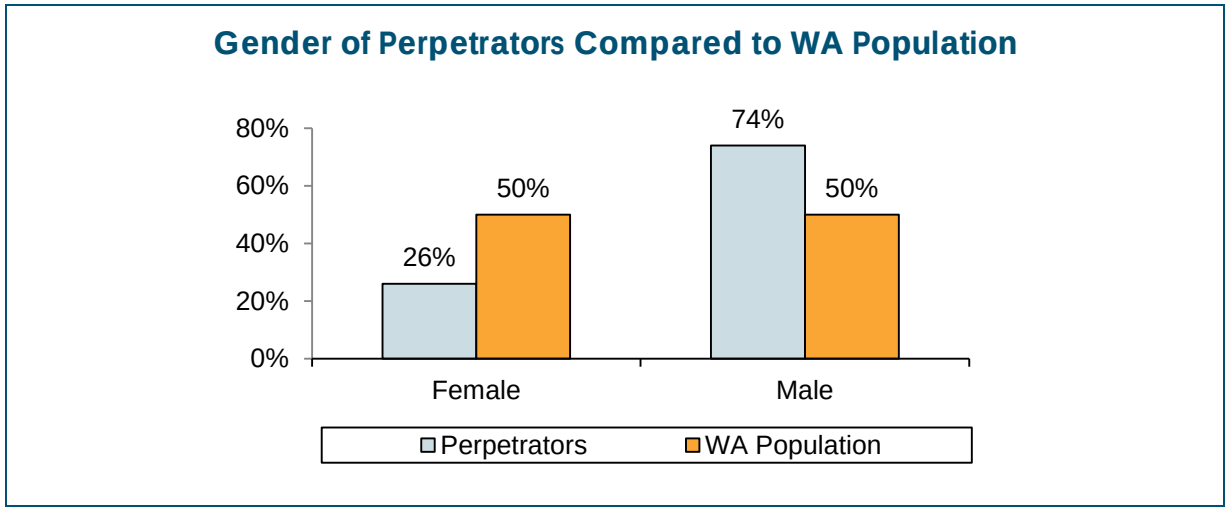
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2017 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2017.

Of the 88 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2017, coronial and criminal proceedings were finalised in 38 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 38 perpetrators where both the coronial process and the criminal proceedings have been finalised.

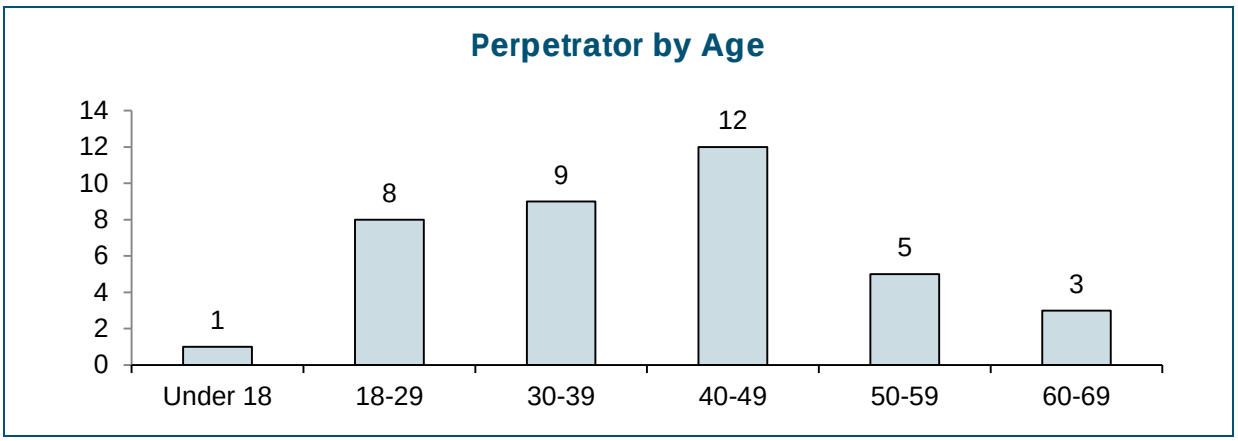


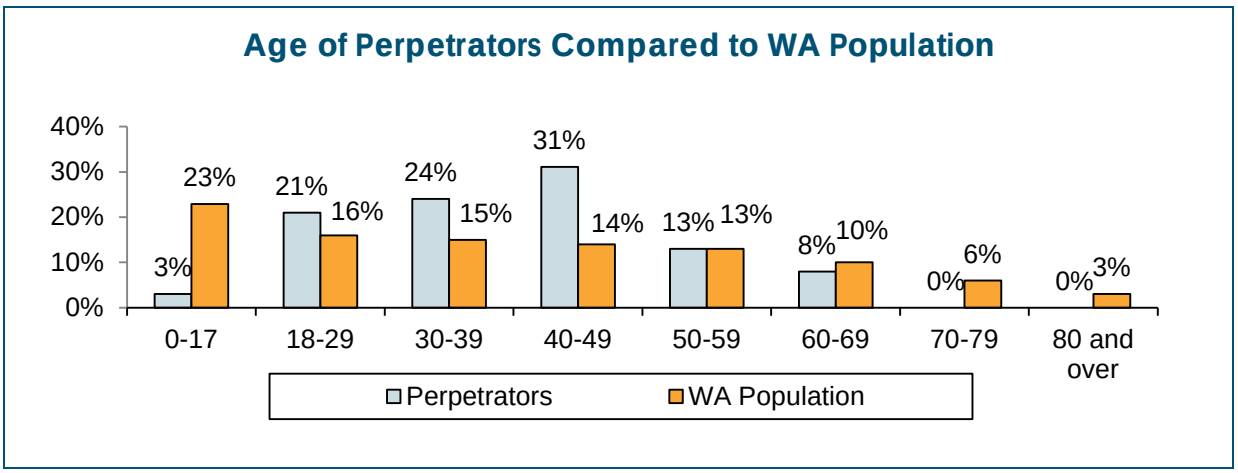


Compared to the Western Australian population, male perpetrators of fatalities in the five years from 1 July 2012 to 30 June 2017 were over-represented, with 74% of perpetrators being male compared to 50% in the population.

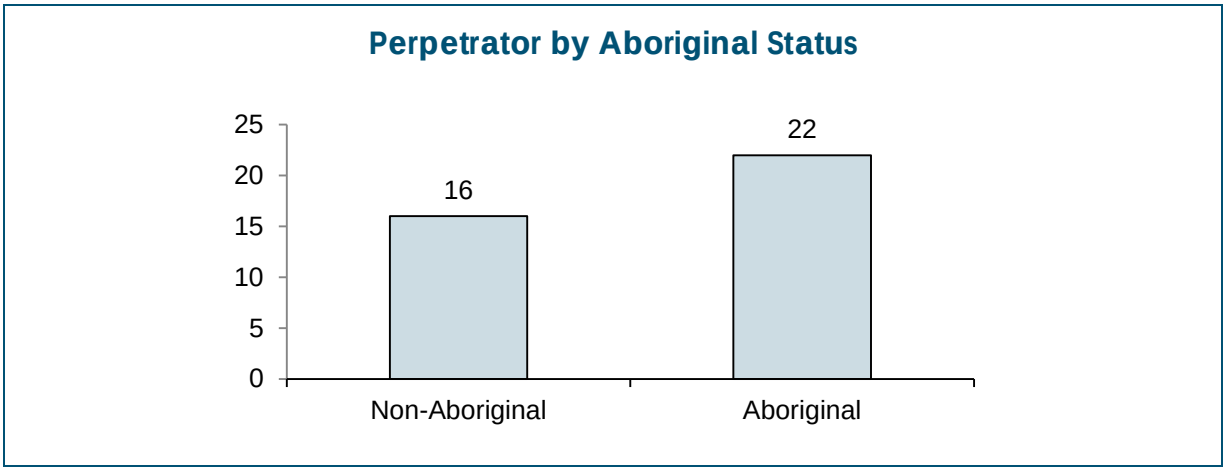
Nine males were convicted of manslaughter and 19 males were convicted of murder. Seven females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death and two females were convicted of murder.

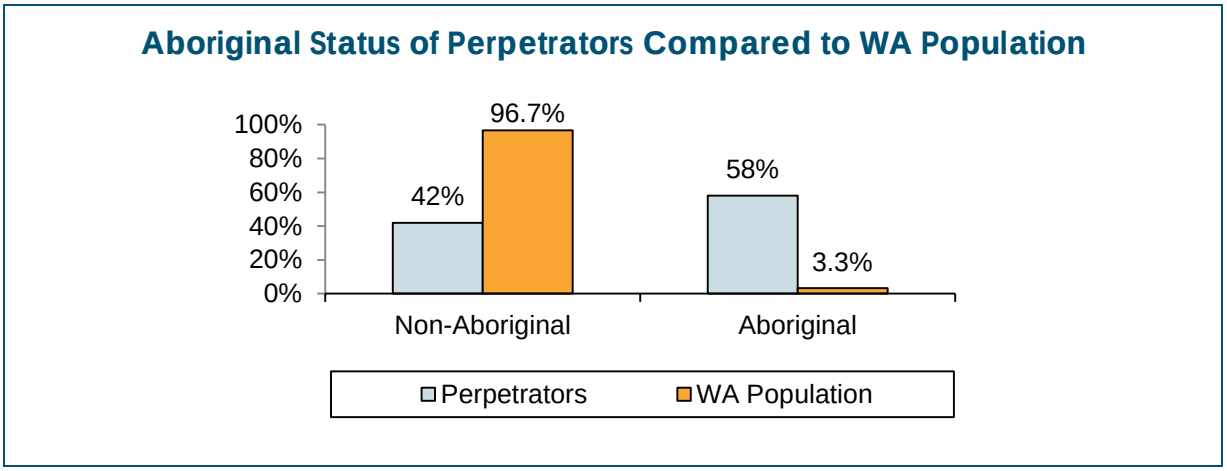
In the 10 fatalities where the perpetrator was female, the person who died was male. Of the 28 fatalities where the perpetrator was male, in 22 fatalities the person who died was female, and in six fatalities the person who died was male.





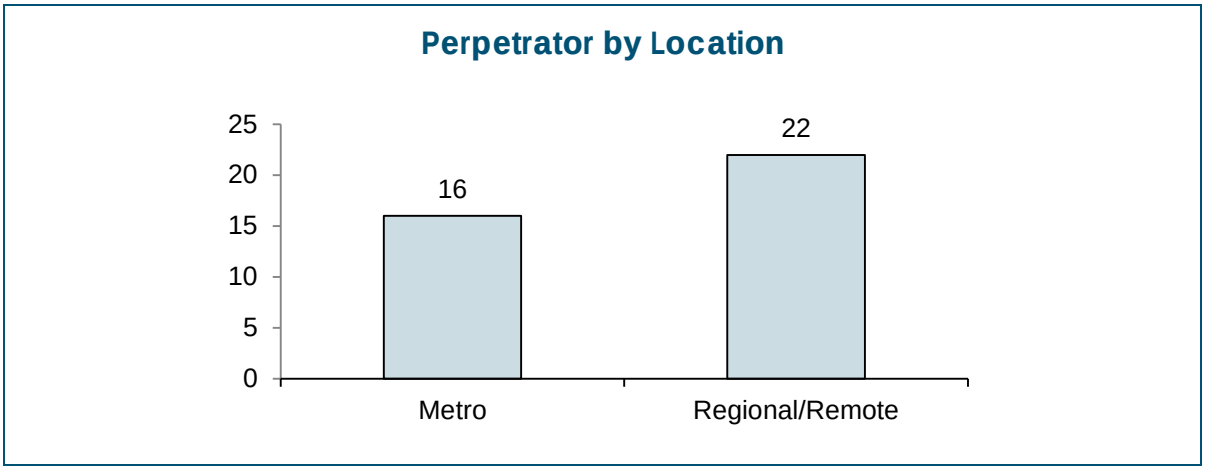
Compared to the Western Australian population, perpetrators of fatalities in the five years from 1 July 2012 to 30 June 2017 in the 40-49 age group were over-represented, with 31% of perpetrators being in the 40-49 age group compared to 14% in the population.

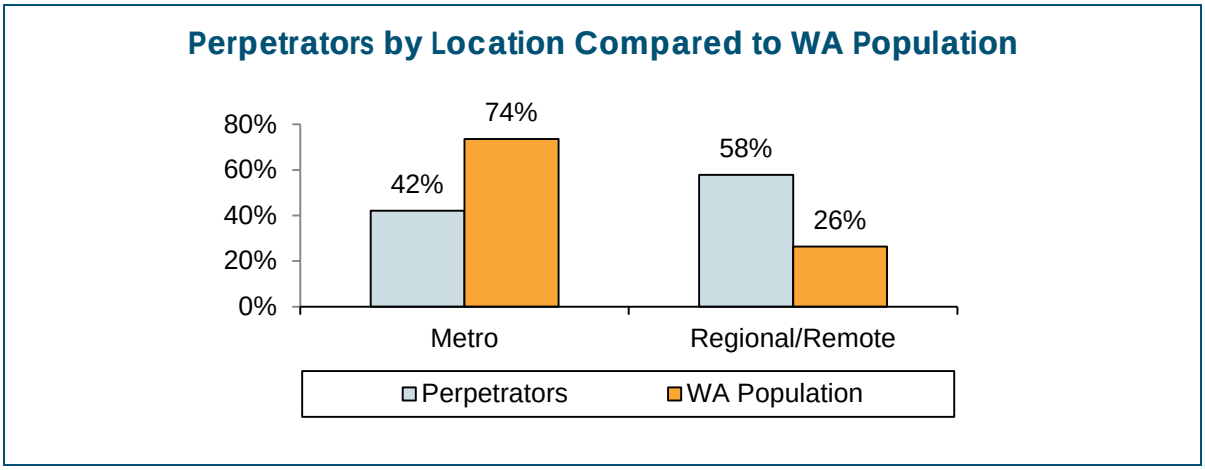




Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the five years from 1 July 2012 to 30 June 2017 were over-represented with 58% of perpetrators being Aboriginal compared to 3.3% in the population.

In 20 of the 22 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.





The majority of people who died lived in regional or remote areas.

Compared to the Western Australian population, the people who died in the five years from 1 July 2012 to 30 June 2017, who were living in regional or remote locations, were over-represented, with 58% of the people who died living 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

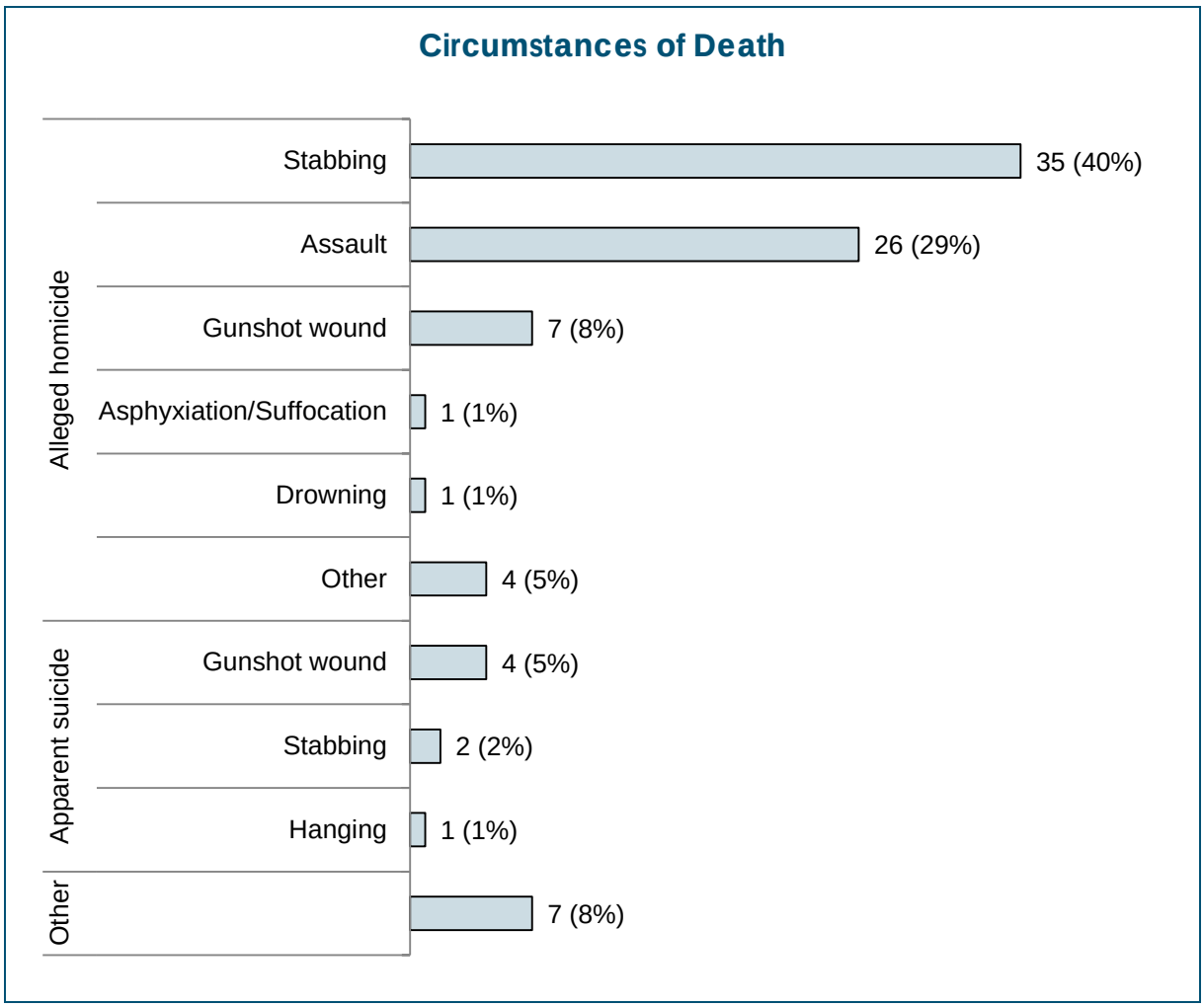
Information provided to the Office by WAPOL about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

Family and domestic violence fatalities may occur through alleged homicide, apparent suicide or other circumstances:

- Alleged homicide includes:
  - Stabbing;
  - Physical assault;
  - Gunshot wound;
  - Asphyxiation/suffocation;
  - Drowning; and
  - Other.
- Apparent suicide includes:
  - Gunshot wound;
  - Overdose of prescription or other drugs;
  - Stabbing;
  - Motor vehicle accident;
  - Hanging;
  - Drowning; and
  - Other.
- Other circumstances includes fatalities not in the circumstances of death of either alleged homicide or apparent suicide.

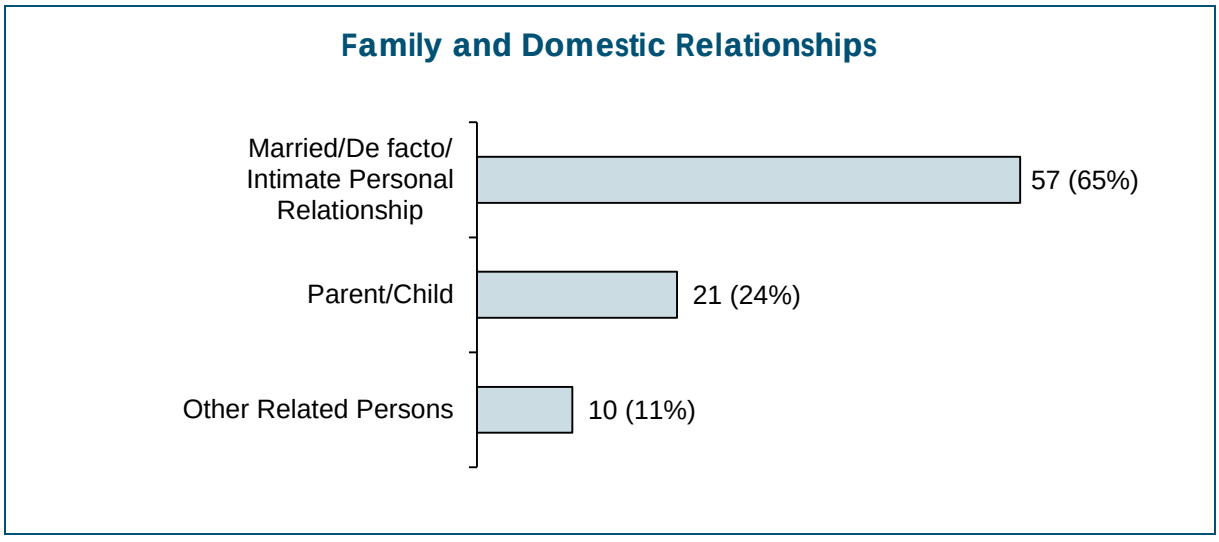
The principal circumstances of death in 2016-17 were alleged homicide by stabbing and physical assault.

The following chart shows the circumstance of death as categorised by the Ombudsman for the 88 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2017.



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 88 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2017:

- 57 fatalities (65%) involved a married, de facto or intimate personal relationship, of which there were 49 alleged homicides, six apparent suicides and two in other circumstances. The 57 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 44 alleged homicides, 30 (68%) of the people who died were female and 14 (32%) were male;
- 21 fatalities (24%) involved a relationship between a parent and adult child, of which there were 16 alleged homicides, one apparent suicide and four in other circumstances. Of the 16 alleged homicides, five (31%) of the people who died were female and 11 (69%) were male. Of these 16 fatalities, in 10 cases (63%) the person who died was the parent or step-parent and in six cases (37%) the person who died was the adult child or step-child; and
- There were 10 people who died (11%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, four (40%) were female and six (60%) 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 major own motion investigation *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities,* November 2015, 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. In the report, the Ombudsman recommended that, consistent with the National Plan:

> *Recommendation 1: DCPFS, as the lead agency responsible for family and domestic violence strategy planning in Western Australia, in the development of Action Plans under [the State Strategy], identifies actions for achieving [the State Strategy's] agreed Primary State Outcomes, priorities among these actions, and allocation of responsibilities for these actions to specific state government departments and authorities*.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that steps have been taken to give effect to the Ombudsman's recommendation.

Type of relationships

The Ombudsman finalised 78 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2017.

For 51 (65%) 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 27 (35%) 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 78 finalised reviews, the circumstances of the fatality were as follows:

- For the 51 intimate partner fatalities, 43 were alleged homicides, six were apparent suicides, and two were other circumstances; and
- For the 27 non-intimate partner fatalities, 21 were alleged homicides, one was an apparent suicide, and five were other circumstances.

Intimate partner relationships

Of the 43 intimate partner relationship fatalities involving alleged homicide:

- There were 28 fatalities where the person who died was female and the suspected perpetrator was male, one where the person who died was female and there were multiple suspected perpetrators of both genders, 11 where the person who died was male and the suspected perpetrator was female, one where the person who died was male and the suspected perpetrator was male, and two where the person who died was male and there were multiple suspected perpetrators of both genders;
- There were 18 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In ten of these fatalities the person who died was female and in eight the person who died was male;
- There were 21 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, five at the residence of family or friends, and nine at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 21 fatalities where the person who died lived in regional and remote areas, and in 16 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 27 non-intimate partner fatalities, there were 18 fatalities involving a parent and adult child and nine fatalities where the parties were otherwise related.

Of the 21 non-intimate partner fatalities involving alleged homicide:

- There were five fatalities where the person who died was female and the suspected perpetrator was male, two where the person who died was female and the suspected perpetrator was female, 10 where the person who died was male and the suspected perpetrator was male, and four where the person who died was male and the suspected perpetrator was female;
- There were five non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 10 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 where the person who died lived 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 26 (60%) of the 43 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2017, alleged family and domestic violence between the parties had been reported to WAPOL and/or to other public authorities. In five (24%) of the 21 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2017, 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 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities,* November 2015, 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 31 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, from the records available:

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

- 19 fatalities involved a deceased Aboriginal person; and
- 18 of the people who died lived 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 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. In the report, the Ombudsman recommended that:

> Recommendation 2: *In developing and implementing future phases of [the State Strategy], 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.*

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that steps have been taken, and are proposed to be taken, to give effect to this recommendation. The Office will continue to monitor, and report on the steps being taken to implement this recommendation.

Identification of family and domestic violence incidents

Of the 31 family and domestic violence fatalities involving alleged homicide 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 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, 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 the report, the Ombudsman made two recommendations (Recommendations 7 and 39) that WAPOL and DCPFS ensure all reported family and domestic violence is correctly identified and recorded. *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that WAPOL and DCPFS had proposed steps to be taken to give effect to these recommendations. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

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.

Support to victims in reported incidences of family and domestic violence

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, examined WAPOL's response to FDV incidents through the review of 75 Domestic Violence Incident Reports (associated with 30 fatalities). The report found that WAPOL recorded the provision of information and advice about violence restraining orders in 19 of the 75 (25%) instances. In the report, the Ombudsman recommended that:

> *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;* and
>
> 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.*

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that WAPOL had taken steps and/or proposed steps to be taken to give effect to these recommendations. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Support to obtain a violence restraining order on behalf of children

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, 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 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. In the report, the Ombudsman recommended that:

> *Recommendation 44: 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 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. In the report the Ombudsman 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 (Recommendations 45, 46 and 47), including:

> *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.*

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that in relation to Recommendations 44, 45, 46 and 47 DCPFS had taken steps and proposed steps to be taken to give effect to all these recommendations. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Support during the process of obtaining a violence restraining order

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identified the importance of opportunities for victims to seek help and for perpetrators to be held to account throughout 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. In the report the Ombudsman recommended that:

> *Recommendation 14: In developing and implementing future phases of [the State Strategy], 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.*

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps to give effect to this recommendation. The Office will continue to monitor, and report on, the steps being taken to implement this recommendation.

Support when a violence restraining order has not been granted

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, 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. In the report, the Ombudsman recommended that:

> *Recommendation 25: DOTAG, in collaboration with DCPFS, identifies and incorporates into [the State Strategy], 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.*

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DOTAG and DCPFS had proposed steps to be taken to give effect to this recommendation. The Office will continue to monitor, and report on, the steps being taken to implement this recommendation.

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 family and domestic violence fatality reviews and the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, 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 the report, the Ombudsman made eight recommendations (Recommendations 40 – 44 and 48 – 50) 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.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to all these recommendations. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

In 2016-17, through the reviews of family and domestic violence fatalities, the Office has continued to examine compliance with family and domestic violence policy, in relation to promoting victim safety, and has made recommendations to agencies to improve family and domestic violence policy compliance.

Case Study

Case Study A

DCPFS received information regarding nine alleged family and domestic violence incidents involving Mr and Ms A including seven incidents where their children were present.

The Office recommended that:

- The Department takes all reasonable steps to ensure that DCPFS's Family and Domestic Violence Response Team triage assessments align with DCPFS's policies and practice requirements associated with responding to family and domestic violence and child safety and wellbeing concerns.

Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 26 (60%) of the 43 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2017, prior family and domestic violence between the parties had been reported to WAPOL and/or other public authorities. The Ombudsman's reviews identify where perpetrators have a history of reported violence, with one or more partners, and examines steps taken to hold perpetrators to account for their actions and support them to cease their violent behaviors, in accordance with the intent of the State Strategy.

Fatalities with no prior reported family and domestic violence

Based on the information available to the Office, in 17 (40%) of the 43 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2017, the fatal incident was the only family and domestic violence between the parties that had been reported 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, drug or alcohol use, or mental health issues that may be relevant to the circumstances of the fatality.

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 78 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2017, Aboriginal Western Australians were over-represented, with 25 (32%) persons who died being Aboriginal. In each case, the suspected perpetrator was also Aboriginal. There were 20 of these fatalities where the person who died lived in a regional or remote area of Western Australia, of which 16 were intimate partner fatalities.

The Ombudsman's family and domestic violence fatality reviews and the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, 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).

Contextual Factors for family violence involving Aboriginal people

As discussed in the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, 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 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 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 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, 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 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 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 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 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 report also 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. In the report, the Ombudsman recommended that:

> *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 [the State Strategy];* and
>
> *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.*

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to these recommendations. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Case Study

Case Study B

The Ombudsman's review of this fatality identified WAPOL attendance at multiple alleged family violence incidents relating to Ms B and her family between July 2014 and June 2015, participation in the associated Family and Domestic Violence Response Team (**FDVRT**) triage meetings and provision of follow-up by the Local Policing Team.

The Office made the following recommendations:

- That WAPOL's Metropolitan District, Aboriginal and Community Diversity Unit, and State Family Violence Unit review WAPOL's response to this Aboriginal family violence from July 2014 to June 2015, to identify any learnings to guide Districts in working with Aboriginal family violence, and provides a report on the outcome to the Ombudsman by 31 December 2017.
- That WAPOL reviews, considers and, if appropriate, amends the current WAPOL FDV Policy, to include strategies that are specifically tailored to preventing and reducing Aboriginal family violence.

Limited use of violence restraining orders

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, 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 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.

In the report, the Ombudsman recommended that:

> *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.*

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DOTAG had taken steps and proposed steps to be taken to give effect to this recommendation. The Office will continue to monitor, and report on, the steps being taken to implement this recommendation.

The November 2015 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. In the report, the Ombudsman recommended that:

> *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 in Recommendation 4.*

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to this recommendation. The Office will continue to monitor, and report on, the steps being taken to implement this recommendation.

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 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, 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).

In the report, the Ombudsman recommended that:

> *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.*

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to this recommendation. The Office will continue to monitor, and report on, the steps being taken to implement this recommendation.

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

Of the 25 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2017 involving Aboriginal people, 20 (80%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Eleven (44%) of the Aboriginal people who died lived in the Kimberley region, which is home to 1.4 per cent of all people and 19 per cent of Aboriginal 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).

As outlined above, *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to Recommendations 4 and 6 of the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015. These recommendations related to DCPFS developing 'a strategy that is specifically tailored to preventing and reducing Aboriginal family violence' that would encompass all regions of Western Australia and DCPFS actively inviting and encouraging 'the involvement of Aboriginal people in a full and active way at each stage and level of the process' and being 'comprehensively informed by Aboriginal culture'.

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.

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 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015), 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 64 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2017, the Office'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	2	3	2	7
Suspected perpetrator only	3	12	6	9
Both person who died and suspected perpetrator	19	20	5	8
Total	**24**	**35**	**13**	**24**

The Ombudsman's reviews and *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, 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 Mental Health Commission'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). This Framework is currently being revised by the Mental Health Commission, in consultation with the Drug and Alcohol Strategic Senior Officers Group, as stated at www.mhc.wa.gov.au.

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 3). 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 report. Given the level of recorded alcohol use associated with the Ombudsman's reviews, in the report the Ombudsman recommended that:

> *Recommendation 3: DCPFS, in collaboration with the Mental Health Commission and other key stakeholders, includes initiatives in Action Plans developed under [the State Strategy] which recognise and address the co-occurrence of alcohol use and family and domestic violence.*

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that in relation to Recommendation 3, the Mental Health Commission and DCPFS had taken steps and proposed steps to be taken to give effect to this recommendation. The Office will continue to monitor, and report on, the steps being taken to implement this recommendation.

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).

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 adequately informing staff of family and domestic violence policies and procedures.
- Not providing culturally informed practice guidance for responding to Aboriginal family violence.
- Not adequately implementing family and domestic violence policies and procedures.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities to address family and domestic violence victim safety.
- Not undertaking sufficient inter-agency communication to enable effective case management and collaborative responses.
- Missed opportunities to seek cultural consultation to enable effective case management and collaborative processes in the context of ongoing reported Aboriginal family 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 nine recommendations were made by the Ombudsman in 2016-17 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. DCPFS reiterates to Metropolitan District Team Leaders, Assistant District Director and District Director that, consistent with Chapter 4.1 *Assessment and Investigation Processes* and Chapter 1.2 *Signs of Safety – Child Protection Practice Framework* of the *Casework Practice Manual*, approval of Safety and Wellbeing Assessments requires documented evidence that key decisions have been informed by the administration of the *Signs of Safety Child Protection Framework* and compliance with Safety and Wellbeing Assessment practice requirements.

2. DCPFS reviews this family and domestic violence fatality and the findings of the Standards Monitoring Unit's Metropolitan District Final Reports of 2012, 2014 and 2016 with a view to considering whether ongoing improvements can be made to policy and practice that would promote the effective administration of DCPFS's assessment and investigation processes and *Signs of Safety Child Protection Framework* consistent with practice requirements.

3. DCPFS provides a report to the Ombudsman within six months of the finalisation of this review outlining actions taken by the Metropolitan District to give effect to Recommendation 2.

4. That the WA Country Health Service (**WACHS**) regional hospital develops strategies to ensure emergency department staff are able to comply with the *Department of Health Family and Domestic Violence Policy February 2014* and *Guideline for Responding to Family and Domestic Violence 2014*, and that WACHS provides a report to the Ombudsman by 31 December 2017 setting out the strategies that have been developed.

5. That the WACHS regional hospital consults with DCPFS (the lead agency responsible for family and domestic violence strategic planning in WA) to complete and maintain the *Local Service Information* list included in the *Guideline for Responding to Family and Domestic Violence 2014* to ensure WACHS regional hospital staff can provide current information on family and domestic violence support service options to all family and domestic violence victims and perpetrators as relevant.

6. DCPFS takes all reasonable steps to ensure that DCPFS's Family and Domestic Violence Response Team triage assessments align with DCPFS's policies and practice requirements associated with responding to family and domestic violence and child safety and wellbeing concerns.

7. WAPOL takes all reasonable steps to ensure that identified child safety and wellbeing concerns are reported to DCPFS consistent with procedural requirements included in the Commissioner's Operations and Procedures Manual.

8. That WAPOL's Metropolitan District, Aboriginal and Community Diversity Unit, and State Family Violence Unit review WAPOL's response to this Aboriginal family violence from July 2014 to June 2015, to identify any learnings to guide Districts in working with Aboriginal family violence, and provides a report on the outcome to the Ombudsman by 31 December 2017.

9. That WAPOL reviews, considers and, if appropriate, amends the current WAPOL FDV Policy, to include strategies that are specifically tailored to preventing and reducing Aboriginal family violence.

The Ombudsman will table a report in Parliament in 2018-19 on the steps taken to give effect to the nine recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2016-17.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2015-16

The Ombudsman made eight recommendations about ways to prevent or reduce family and domestic violence fatalities in 2015-16. In 2016-17, the Office has requested that the relevant public authorities notify the Ombudsman regarding:

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

The Ombudsman will table a report in Parliament in 2017-18 on the steps taken to give effect to the eight recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2015-16.

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 2016-17, timely review processes have resulted in one half of reviews being completed within three months and 75% 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.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities

On 10 November 2016, the Ombudsman tabled in Parliament *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*. The report is available at: www.ombudsman.wa.gov.au/familydomesticviolencereport.

About the report

On 19 November 2015, the Ombudsman tabled the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* in the Western Australian Parliament. Through that investigation, the Ombudsman found that a range of work had been undertaken by state government departments and authorities to administer their relevant legislative responsibilities, including their responsibilities arising from the *Restraining Orders Act 1997*. The Ombudsman also found, however, that 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.

Arising from the findings in the report, the Ombudsman made 54 recommendations to four government agencies about ways to prevent or reduce family and domestic violence fatalities. Each agency agreed to these recommendations.

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

Objectives

- The objectives of the November 2016 report were to consider (in accordance with the *Parliamentary Commissioner Act 1971*):
  - The steps that have been taken to give effect to the recommendations;
  - The steps that are proposed to be taken to give effect to the recommendations; or
  - If no such steps have been, or are proposed to be taken, the reasons therefor.

Methodology

- First, the Office sought from the relevant agencies a report on the steps taken to give effect to the recommendations, such report to include evidence regarding the steps taken. The relevant agencies being:
  - Department for Child Protection and Family Support;
  - Department of the Attorney General;
  - Mental Health Commission; and

- Western Australia Police.

- Second, where further information, clarification or validation was required, the Office met with the relevant agencies;
- Third, for a number of recommendations, the Office conducted fieldwork to collect further information regarding the steps taken to give effect to the recommendations;
- Fourth, the Office reviewed all information it obtained and made draft findings;
- Fifth, the Office developed a draft report;
- Sixth, the Office provided the draft report to the relevant agencies; and
- Seventh, the Office developed a final report.

Summary of findings

- The Ombudsman is pleased that in relation to all of the recommendations in the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, the relevant agencies have either taken steps, or propose to take steps (or, in some cases, both) to give effect to the recommendations.
- In no instances did the Office find that no steps had been taken to give effect to the recommendations.
- It is particularly pleasing that, in giving effect to the recommendations, important improvements have been achieved when compared to the findings identified in the report.

Giving effect to the recommendations

- In the report, 22 recommendations were directed to WAPOL.
  - Steps have been taken (and, in some cases, are also proposed to be taken) to give effect to nine recommendations; and
  - Steps are proposed to be taken to give effect to 13 recommendations.
- In the report, 26 recommendations were directed to DCPFS.
  - Steps have been taken (and, in some cases, are also proposed to be taken) to give effect to 17 recommendations;
  - Steps are proposed to be taken to give effect to seven recommendations; and
  - The steps taken to give effect to two recommendations, Recommendations 5 and 6, are contingent on giving effect to Recommendation 4.
- In the report, six recommendations were directed to DOTAG.
  - Steps have been taken (and, in some cases, are also proposed to be taken) to give effect to four recommendations; and
  - Steps are proposed to be taken to give effect to two recommendations.

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

Identifying and overcoming barriers to the effective implementation of family and domestic violence policies and practice guidance

In the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, the Ombudsman recommended that:

> *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.*

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that:

> *The review report and action plan have been provided to the Office within 12 months of the tabling of the* [*Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*]*, and will be reviewed by the Office and the results of this review reported on in the Office's 2016-17 Annual Report.*

In 2016-17, the review report and action plan were comprehensively reviewed by the Office. The Office's analysis and findings will be the subject of a report on the steps taken to give effect to the recommendations arising from child death reviews and family and domestic violence fatality reviews to be tabled in Parliament in 2017-18.

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 2016-17 and during the year the following members provided a range of expertise:

- Professor Steve Allsop (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 (Consultant).

In 2016-17, 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.

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 liaised as part of the family and domestic violence fatality review function in 2016-17, included:

- 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 continue 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 members and 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.

In 2016-17, the Principal Aboriginal Liaison Officer and the Assistant Ombudsman Reviews met with Aboriginal community members, and government and non-government service providers in Geraldton, to hear from them about what they believe is working well, what is not working well, and what they believe needs to happen in relation to preventing and reducing Aboriginal family and domestic violence fatalities. Key messages given to the Office by stakeholders in these meetings were the need for Aboriginal leadership and involvement of Aboriginal people in service planning and decision-making, the need for the direct funding to local Aboriginal community controlled services and the need for improved collaboration between service providers. The learnings from these meetings will inform the Office's understanding of family and domestic violence reviews. Further regional visits to listen to, and engage with, the Aboriginal community about ways to prevent or reduce Aboriginal child deaths will be undertaken by the Office in 2017-18.

Own Motion Investigations and Administrative Improvements

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 two reports in relation to the steps taken to giving effect to the recommendations arising from own motion investigations.

Own Motion Investigations in 2016-17

In 2016-17, significant work was undertaken on:

- A report on a major investigation into ways to prevent or reduce child deaths by drowning, to be tabled in Parliament in 2017-18;
- *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, tabled in Parliament on 10 November 2016; and

- *A report on giving effect to the recommendations arising from the Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, to be tabled in Parliament in 2017-18.

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 2016-17, significant work was undertaken on a report by the Office on this own motion investigation. The report of the investigation will be tabled in Parliament in 2017-18.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities

In November 2015, the Office tabled in Parliament the report of a major own motion investigation, *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*. Through that investigation, the Office found that a range of work had been undertaken by State Government departments and authorities to administer their relevant legislative responsibilities, including their responsibilities arising from the *Restraining Orders Act 1997*. The Office also found, however, that 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 Office also found that Aboriginal Western Australians are significantly overrepresented as victims of family violence, yet underrepresented in the use of violence restraining orders. Following from this, the Office 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 report 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 in the report, the Office made 54 recommendations to four State Government agencies about ways to prevent or reduce family and domestic violence fatalities. Each agency agreed to these recommendations.

Importantly, the Office committed to the active monitoring of the implementation of these recommendations and report to Parliament on the results of this monitoring.

Accordingly, on 10 November 2016 the Office tabled in Parliament *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*. The report sets out the steps taken, or proposed to be taken, to give effect to the recommendations arising from the November 2015 report.

The Office found that the relevant State Government departments and authorities have either taken steps, or propose to take steps (or, in some cases, both) to give effect to the recommendations. In no instance did the Office find that no steps had been taken, or were proposed to be taken, to give effect to the recommendations.

The Office further found that important improvements had been achieved when compared to the findings identified in the report.

The full report, *A report on giving effect to the recommendations arising from the 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.

Further details of the report's findings and recommendations are included in the Family and Domestic Violence Fatality Review section.

A report on giving effect to the recommendations arising from the Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people

Through the review of the circumstances in which and why child deaths occurred, the Ombudsman identified a pattern of cases in which young people appeared to have died by suicide. Of the child death notifications received by the Office since the child death review function commenced, 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 nearly forty per cent 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 Ombudsman 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 report of the findings and recommendations arising from that investigation, titled *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, was tabled in Parliament on 9 April 2014. The report made 22 recommendations to four government agencies about ways to prevent or reduce suicide by young people. Each agency agreed to these recommendations.

During 2016-17, significant work was undertaken on a report by the Office on the steps taken to give effect to the 22 recommendations arising from the findings of this report. The report will be tabled in Parliament in 2017-18.

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 has undertaken 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.

In 2015-16, the Office developed 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 2016-17, further consultation was undertaken including a Community Consultation Forum, specifically focused on consultation with Aboriginal and Torres Strait Islander Communities. This year, the Office also undertook significant work on a major report on the monitoring of the Infringement Notices provisions of *The Criminal Code*. In accordance with section 723 of *The Criminal Code*, the completed report on the Ombudsman's work and activities will be provided to the Minister for Police and the Commissioner of Police in 2017-18.

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 2016. A copy of this report was provided to the Minister for Police and the Commissioner of Police in accordance with the *Criminal Organisations Control Act 2012.*

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	**Background:**
Members: Western Australian Ombudsman Public Sector Commissioner Corruption and Crime Commissioner Auditor General Information Commissioner	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. **2016-17 initiatives:** The ICG met twice in 2016-17. The Office was involved in 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. **2016-17 initiatives:** The Office presented on three 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.
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 from over 90 countries. **The Office's involvement:** The Office is a member of the IOI. The Ombudsman was elected 2nd Vice-President of the IOI in November 2016. The Ombudsman previously served as the Treasurer of the IOI from March 2014 to November 2016 and President of the Australasian and Pacific Ombudsman Region (**APOR**) of the IOI from November 2012 until March 2014. **2016-17 initiatives:** In November 2016, the Ombudsman attended the 11th IOI World Conference held in Bangkok, Thailand. The Ombudsman gave a speech, *The evolution of the Ombudsman* in the opening plenary session and in a separate plenary session presented an IOI-funded project jointly undertaken by the offices of the Western Australian and New South Wales Ombudsman, the *Starter Kit for New Ombudsman and Developing or Expanding Offices*. The objective of the project is to provide a highly accessible and practical web-based induction tool for newly appointed Ombudsmen, utilising the knowledge and experience of existing Ombudsmen, and a resource for those offices undergoing an expansion of functions or dealing with novel or challenging issues. Alongside of the Conference, the Ombudsman attended meetings of the Executive Committee of the Board of the IOI, meetings of the Board of the IOI, a meeting of the Australasian and Pacific Ombudsman Region of the IOI, a civil society dialogue hosted by the Austrian Ambassador to Thailand and the General Assembly of the IOI. In April 2017, the Ombudsman attended a meeting of the Board of the IOI in Vienna.

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. **2016-17 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, policy and research, and public relations and communications. **2016-17 initiatives:** The Ombudsman attended the Annual General Meeting and Members meeting of ANZOA in November 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. **2016-17 initiatives:** The Office hosted three staff from Ombudsman Republik Indonesia for a four day internship in December 2016. 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 2016-17 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 *Perth Tonight* 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 Freecall number, which is free from landline phones;
- 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 66% to 67% 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 Youth Affairs Council of WA (YACWA) conference in July 2016, the Financial Counsellors' Association of WA conference in October 2016, and Homeless Connect in November 2016; and
- The Office's visits to adult prisons and juvenile custodial facility 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 reports such as *A report on giving effect to the recommendations arising from 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 2016-17:

- The total number of visits to the website has increased by 91% to 184,221 page visits compared to 96,526 page visits in 2015-16;
- The top two most visited pages (besides the homepage and the Contact Us page) on the site were *The role of the Ombudsman* and *What you can complain about*; and
- The Office's *Guidelines on Complaint Handling* and *Procedural Fairness Guidelines* were the two most viewed documents. The Office's three most recent major investigation reports also regularly featured in the top 10 most downloaded documents each month.

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 6PR's *Perth Tonight*

The Office continues to provide access to its services through the Ombudsman's regular appearances on Radio 6PR's *Perth Tonight* 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 2016 and May 2017.

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2016-17. Two regional visits were conducted to Broome in the Kimberley in July 2016 and Carnarvon in the Gascoyne in June 2017, 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;
- Meetings with the Aboriginal community 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 meetings with senior officers and workshops for public officers on *Good Decision Making* and *Effective Complaint Handling*.

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

The Office has a 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 promotional materials targeted at, and tailored for, children and young people. In 2016-17, the Office expanded the range of publications available on the youth space.

The Office continued its proactive visiting program to vulnerable groups of children in the child protection system. During 2016-17, the Office visited:

- The Kath French Secure Care Centre in October 2016;
- Four residential group homes in the Perth metropolitan area in October and November 2016, and June 2017; and
- One residential group home in the Mid West Region in June 2017.

The Ombudsman has also increased regular visits to the Banksia Hill Detention Centre and engagement with the community sector in the 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 2016-17. Three 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

- *Consumer Law and Economics Workshop*, University of Western Australia in August 2016;
- *The Ombudsman*, University of Western Australia Administrative Law Students in October 2016;
- Speech to the *Asia Pacific Coroners Society (APCS) Annual Conference* in November 2016;
- *The evolution of the Ombudsman*, a speech to the opening plenary session of the 11th World Conference of the International Ombudsman Institute in November 2016;
- *Starter Kit for New Ombudsman and Developing or Expanding Offices*, A presentation to the 11th World Conference of the International Ombudsman Institute in November 2016;
- *The Ombudsman*, to the Treasury Coffee Shop Forum in December 2016; and
- Panel discussion titled *Don't Silence the Violence*, hosted by the Aboriginal Family Law Service in February 2017.

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 non-government organisations;
- *Operationalising KPIs – Improving Performance and Accountability* to the Institute of Internal Auditors' Australian Public Sector Internal Auditors Conference in July 2016 and the Western Australia Internal Auditor Conference in September 2016;
- *Conducting an Investigation* to staff at Murdoch University, in October 2016;
- *The Energy and Water Ombudsman* to the Water Regulatory Managers Forum in October 2016;
- *The Western Australian Ombudsman* to members of the community at the Glyde-in Community Resource Centre East Fremantle, in a session titled 'Integrity in government' in collaboration with the Public Sector Commission and the Office of the Information Commissioner, in October 2016;

- *The Role and Functions of the Ombudsman* to staff at Hakea Prison in November 2016 and staff at Banksia Hill Detention Centre in March 2016;
- *The Role and Functions of the Ombudsman* to Edith Cowan University Administrative Law Students in March 2017;
- *The Role and Functions of the Ombudsman* to staff and visitors at the Lorikeet Centre in May 2017; and
- *Ombudsman Western Australia* to a delegation from the Botswana High Commission Directorate on Corruption and Economic Crime in June 2017.

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 2016-17, 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 Improvement section.

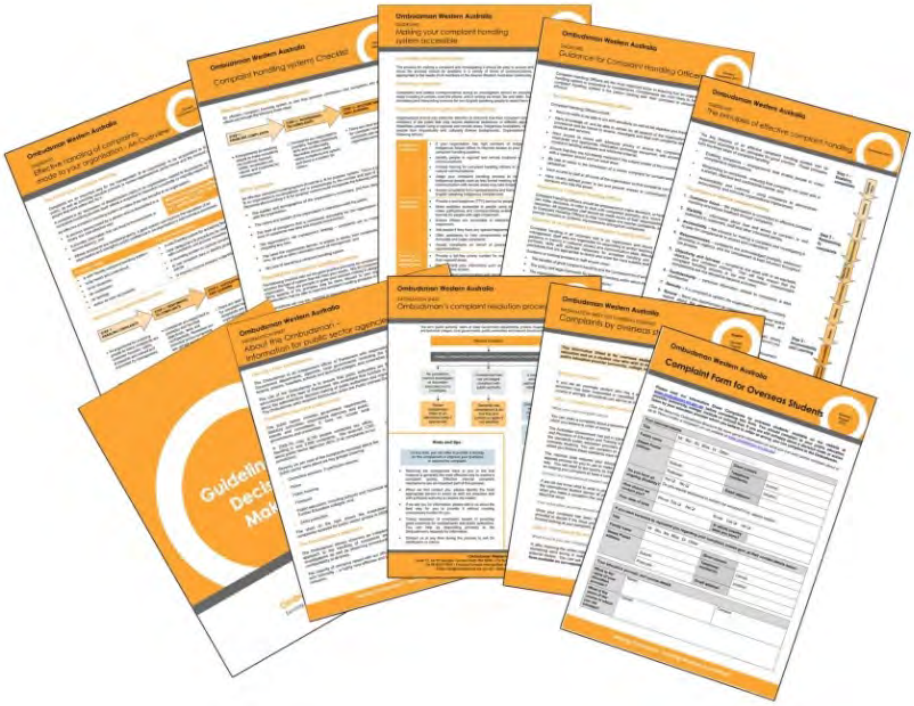
Liaison relating to inspection and monitoring functions

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 Improvement 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.



This page has been intentionally left blank.