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.

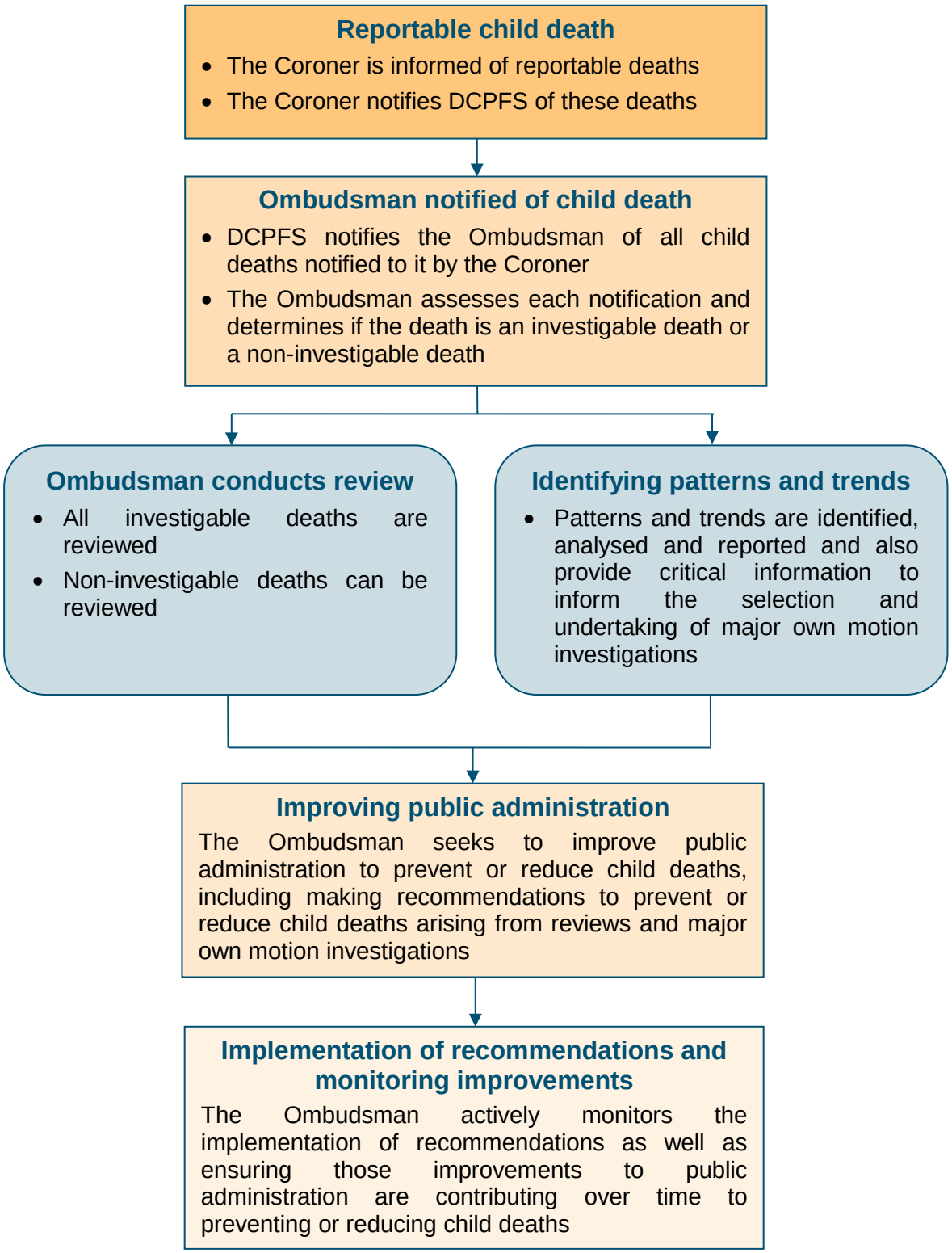
In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

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.

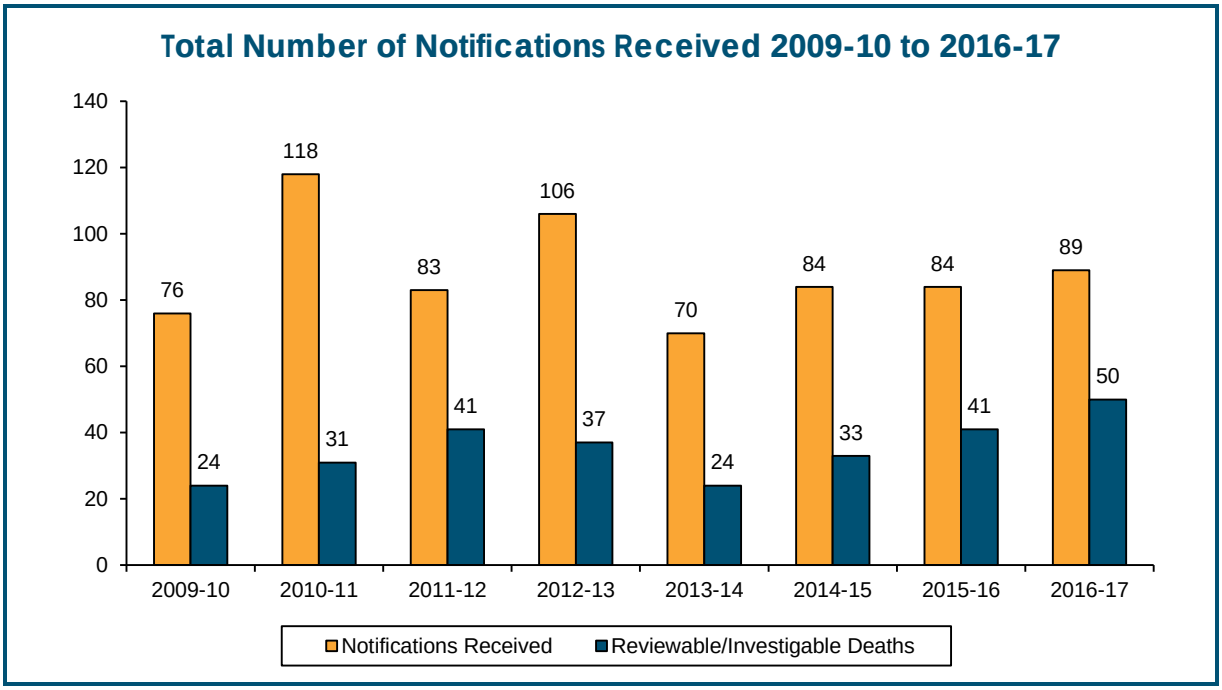
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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

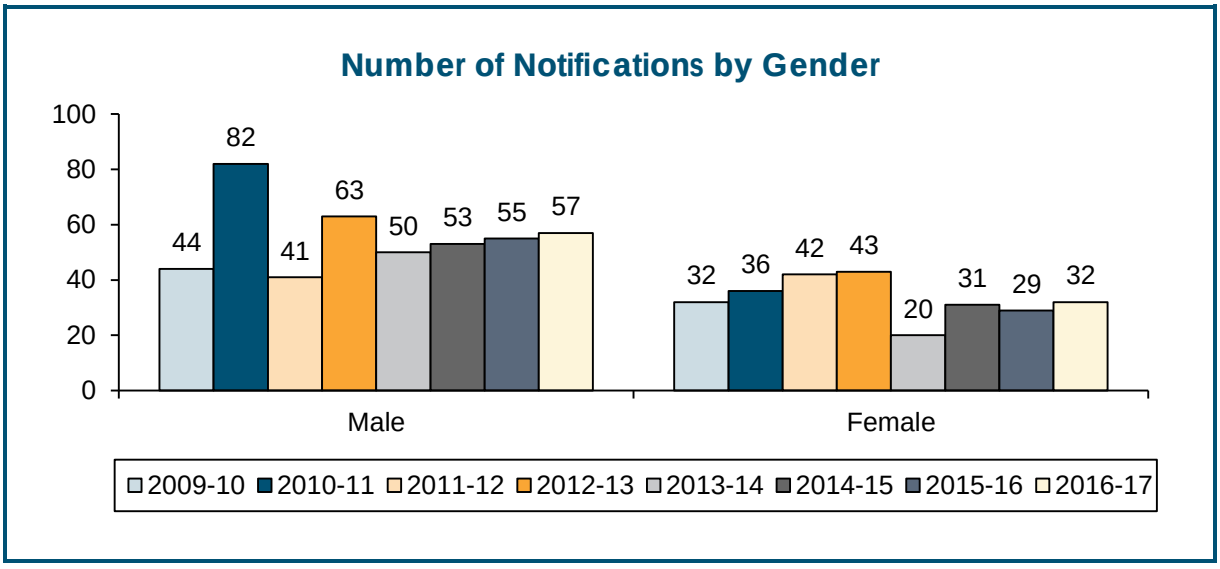
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

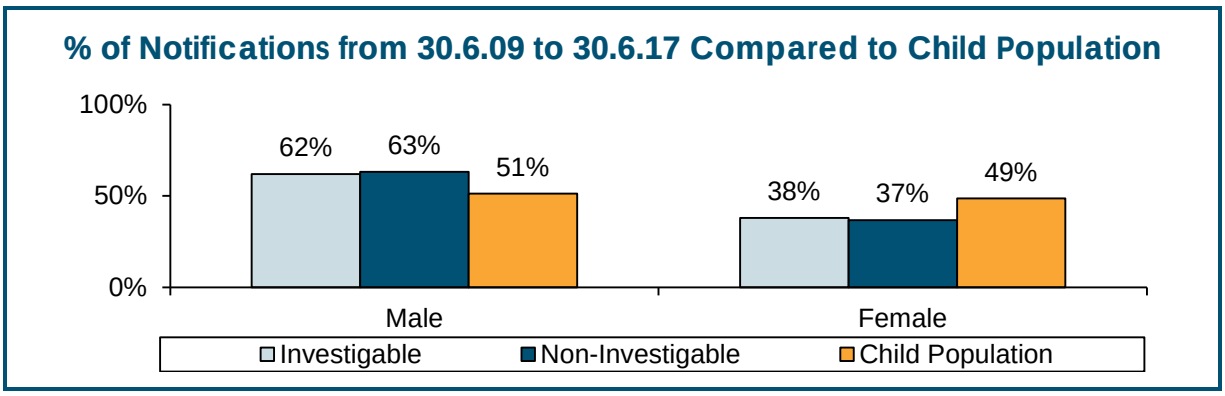
The following charts show:

- 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.

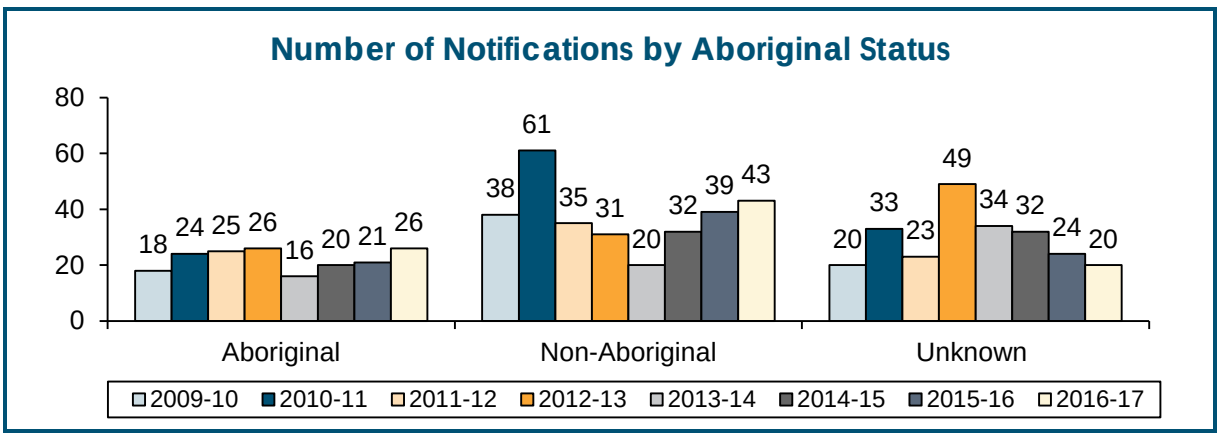


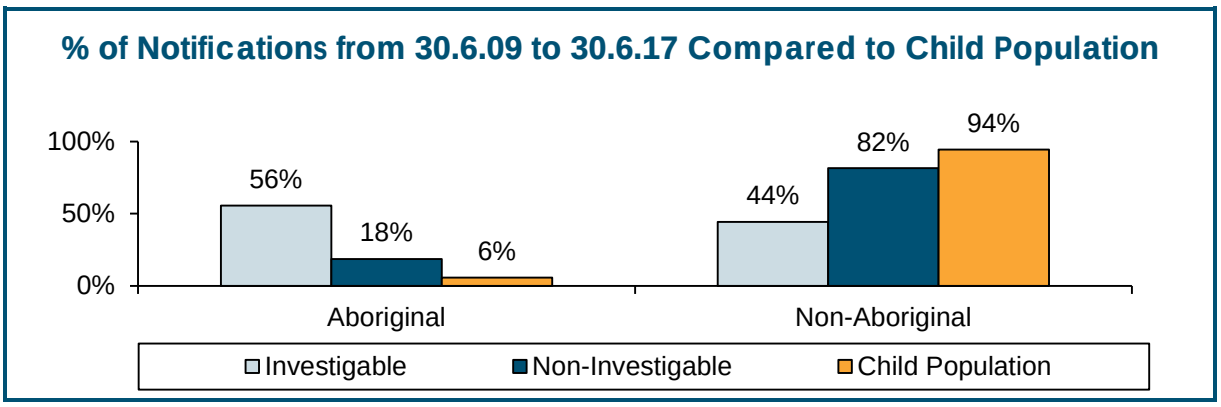


Further analysis of the data shows that, considering all eight years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

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.



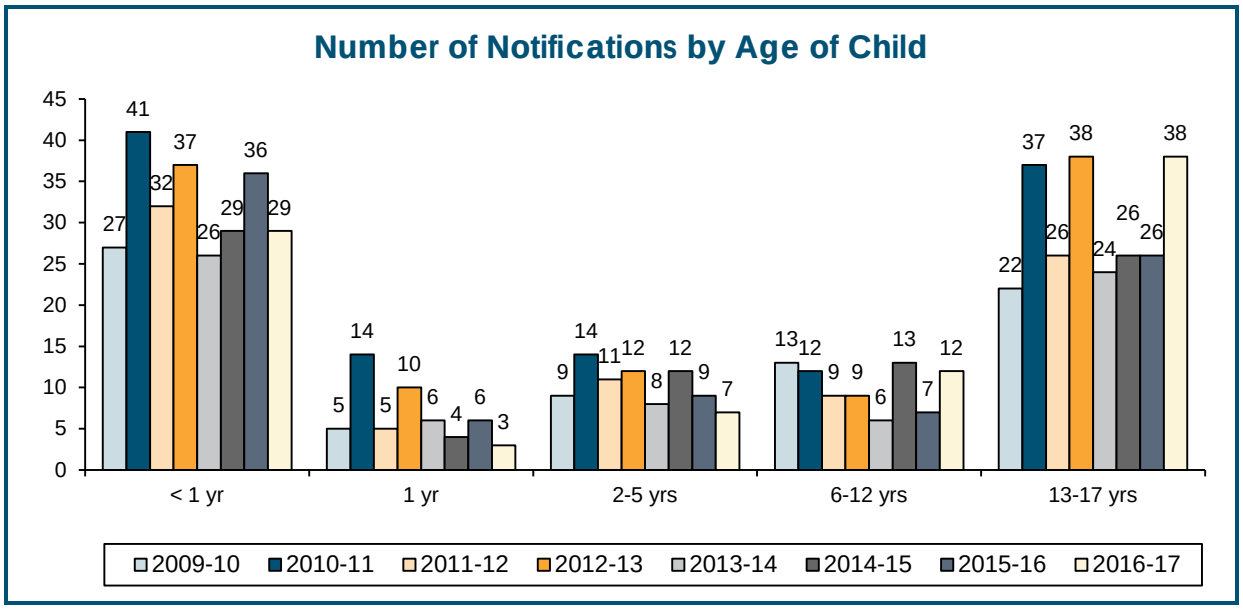


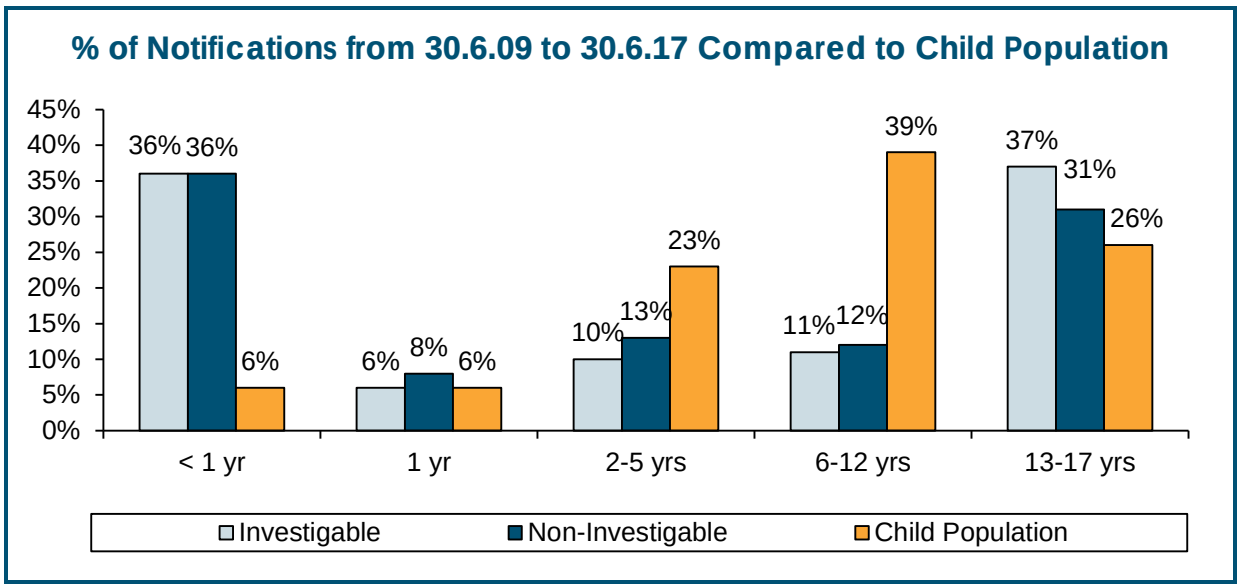
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

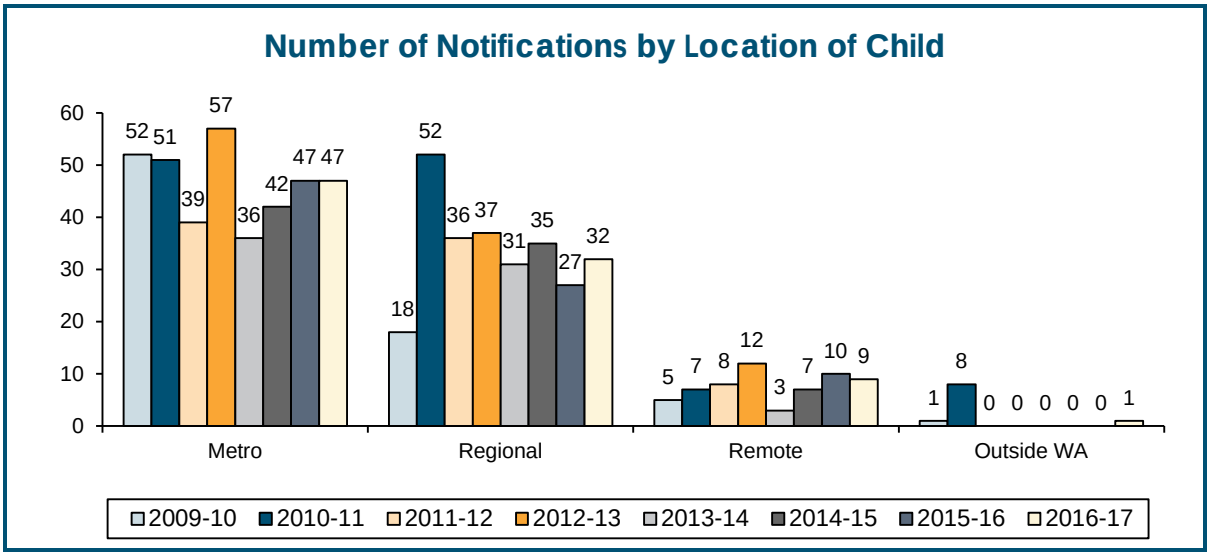




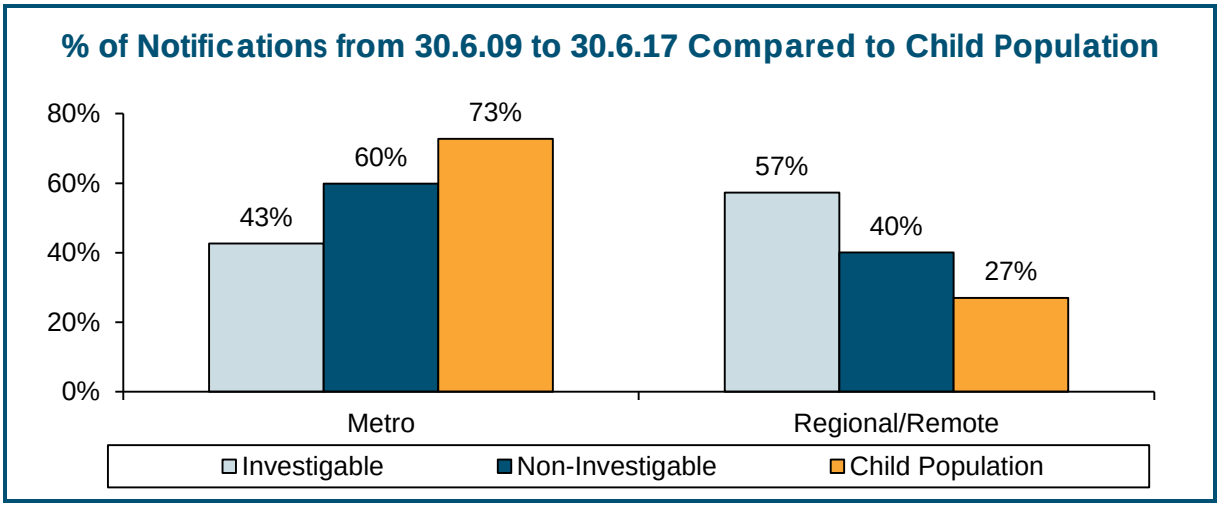
A more detailed analysis by age group is provided later in this section.

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

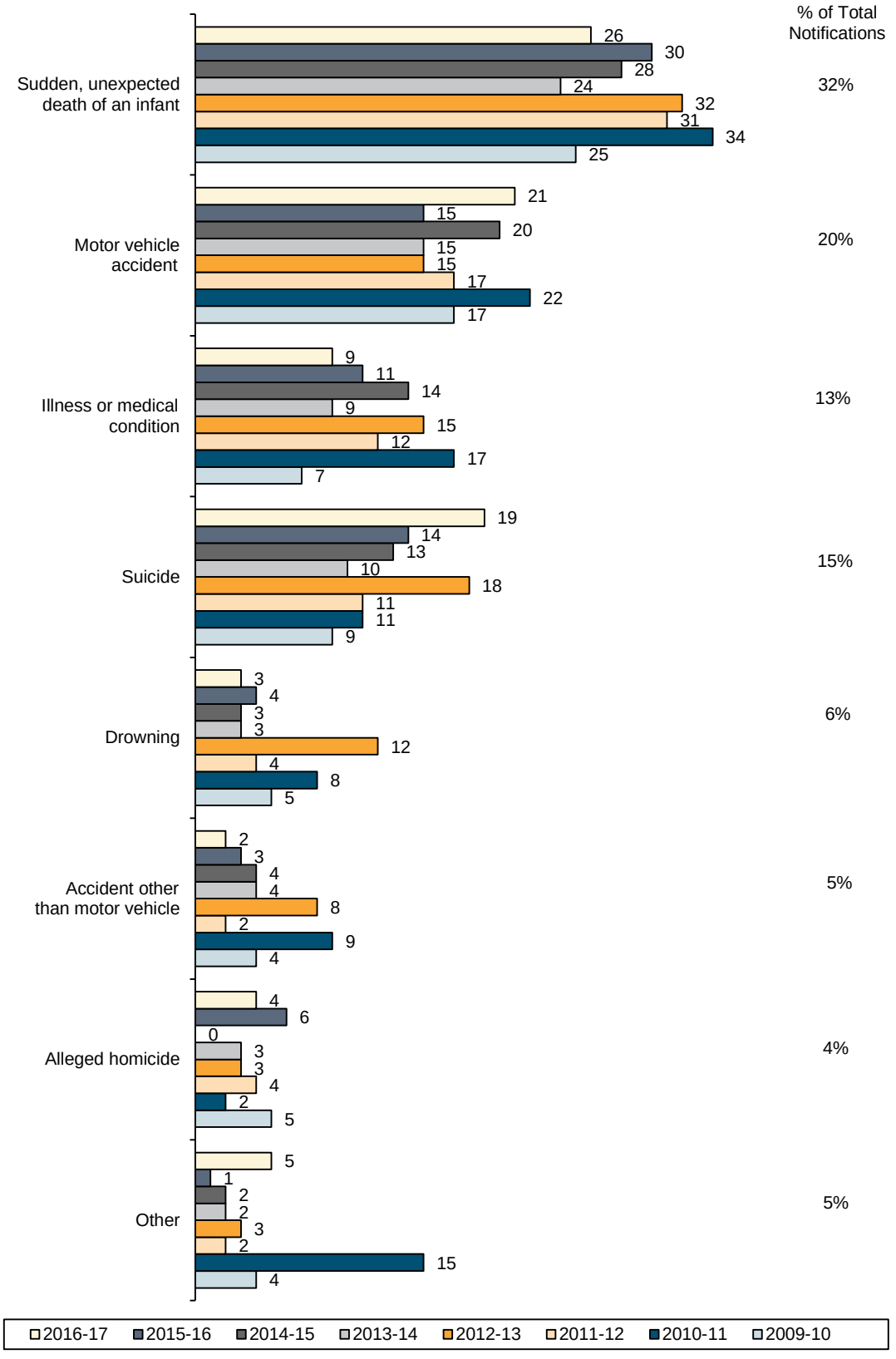
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally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



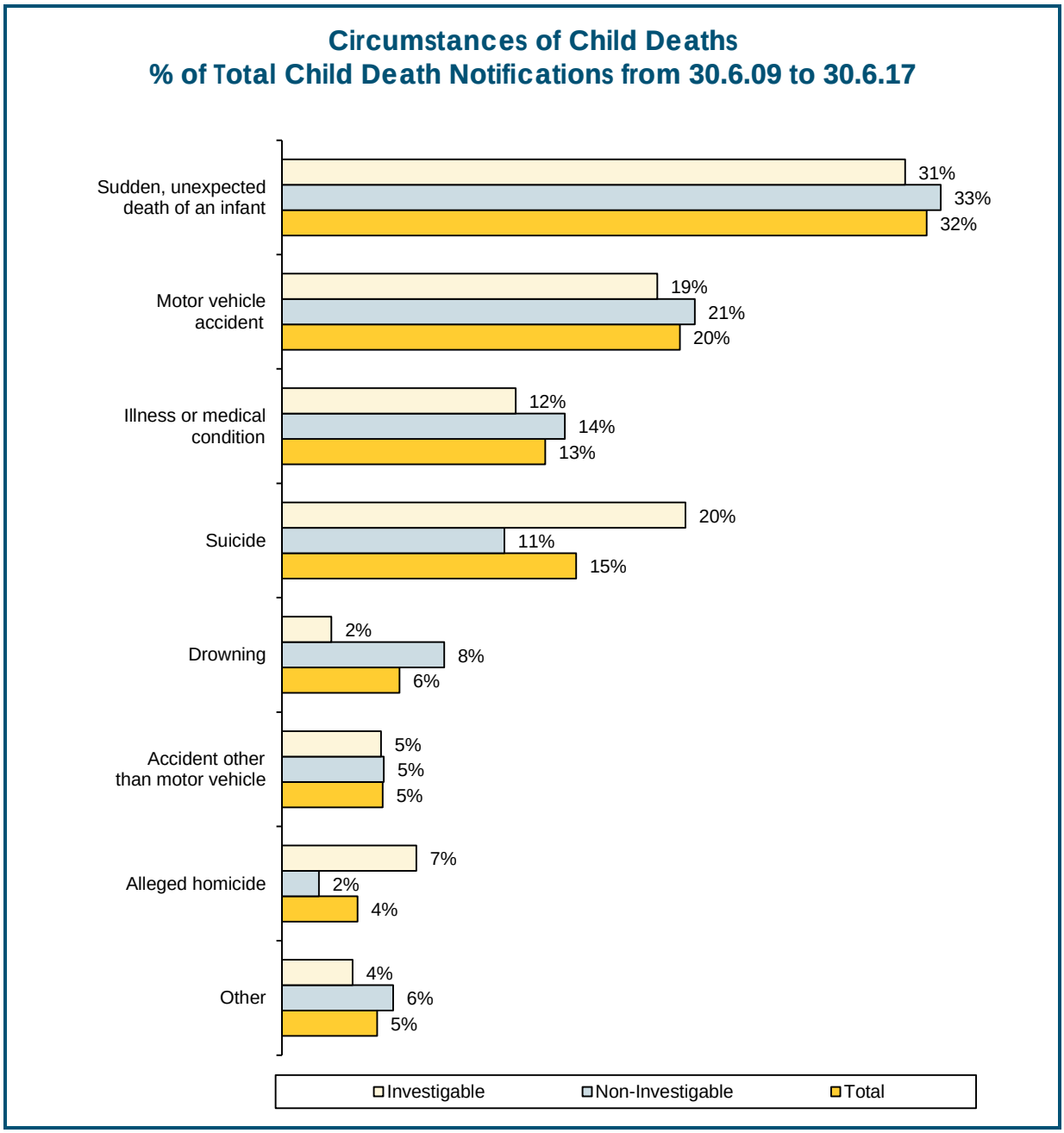
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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

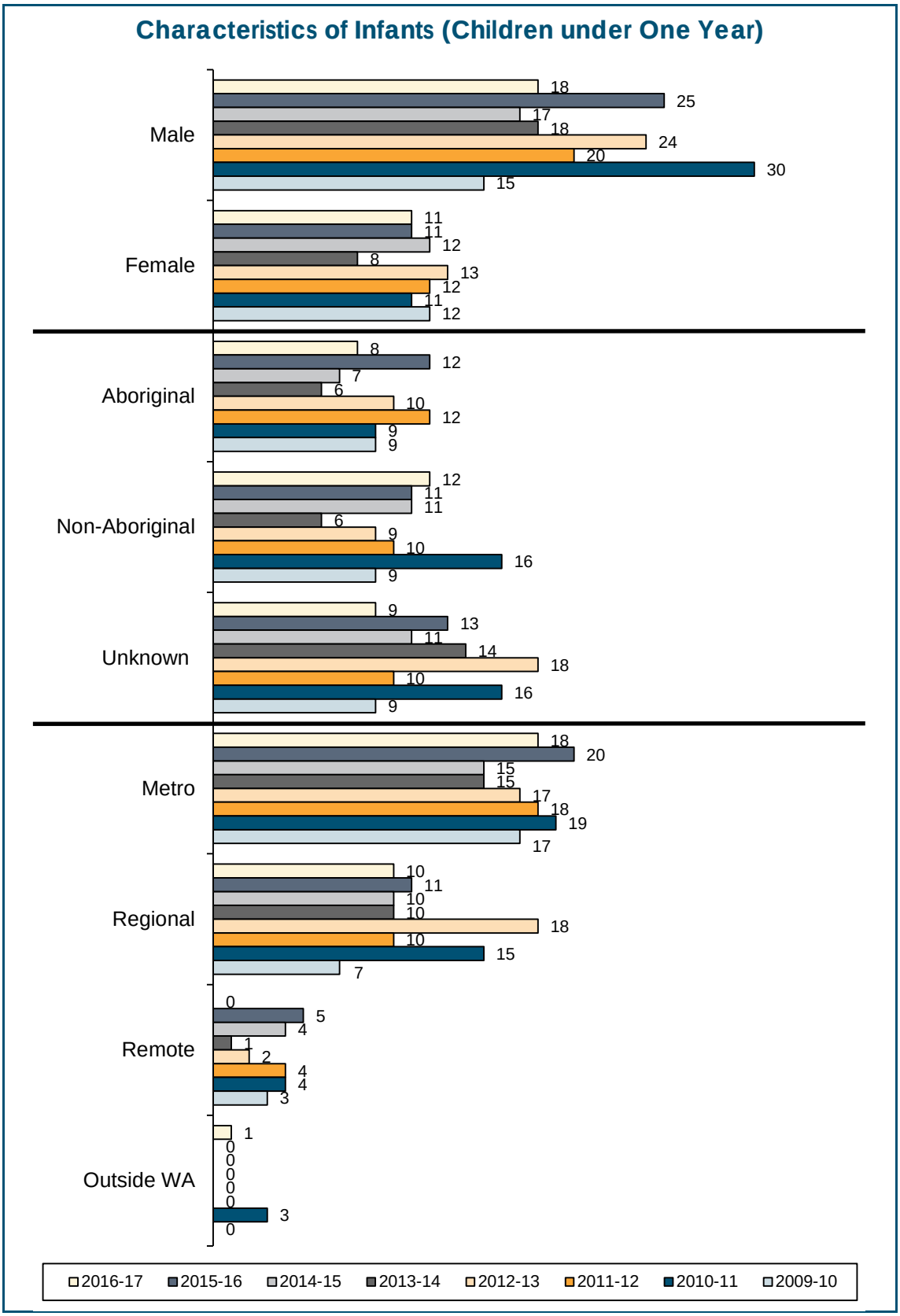
In child deaths notified to the Ombudsman in 2016-17, the majority of children who were known to DCPFS were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

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.

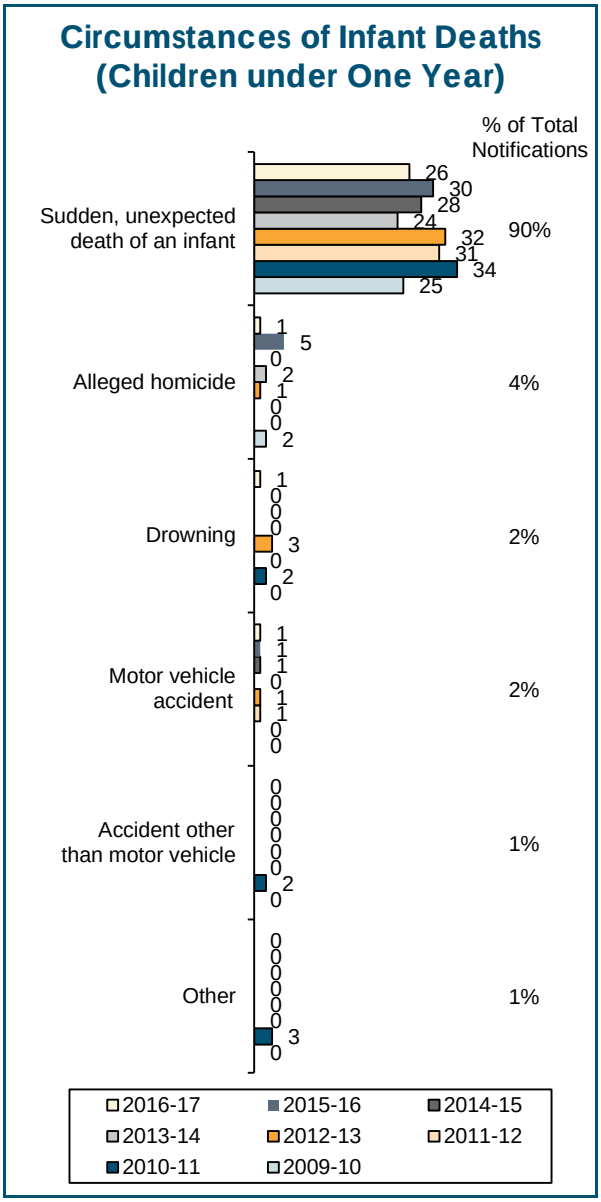


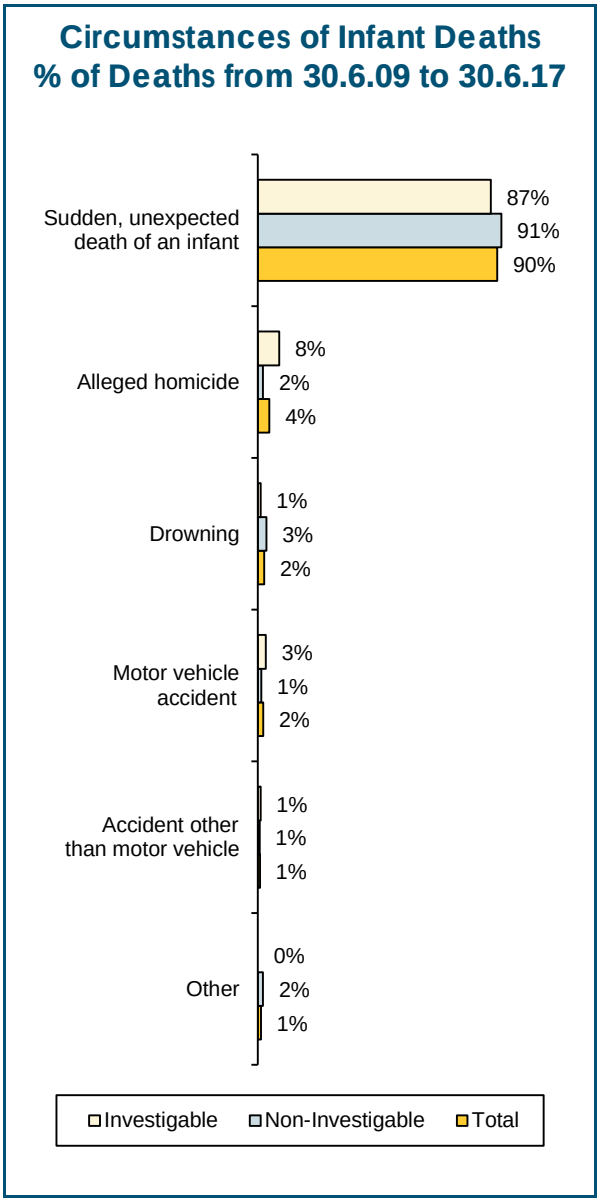
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.





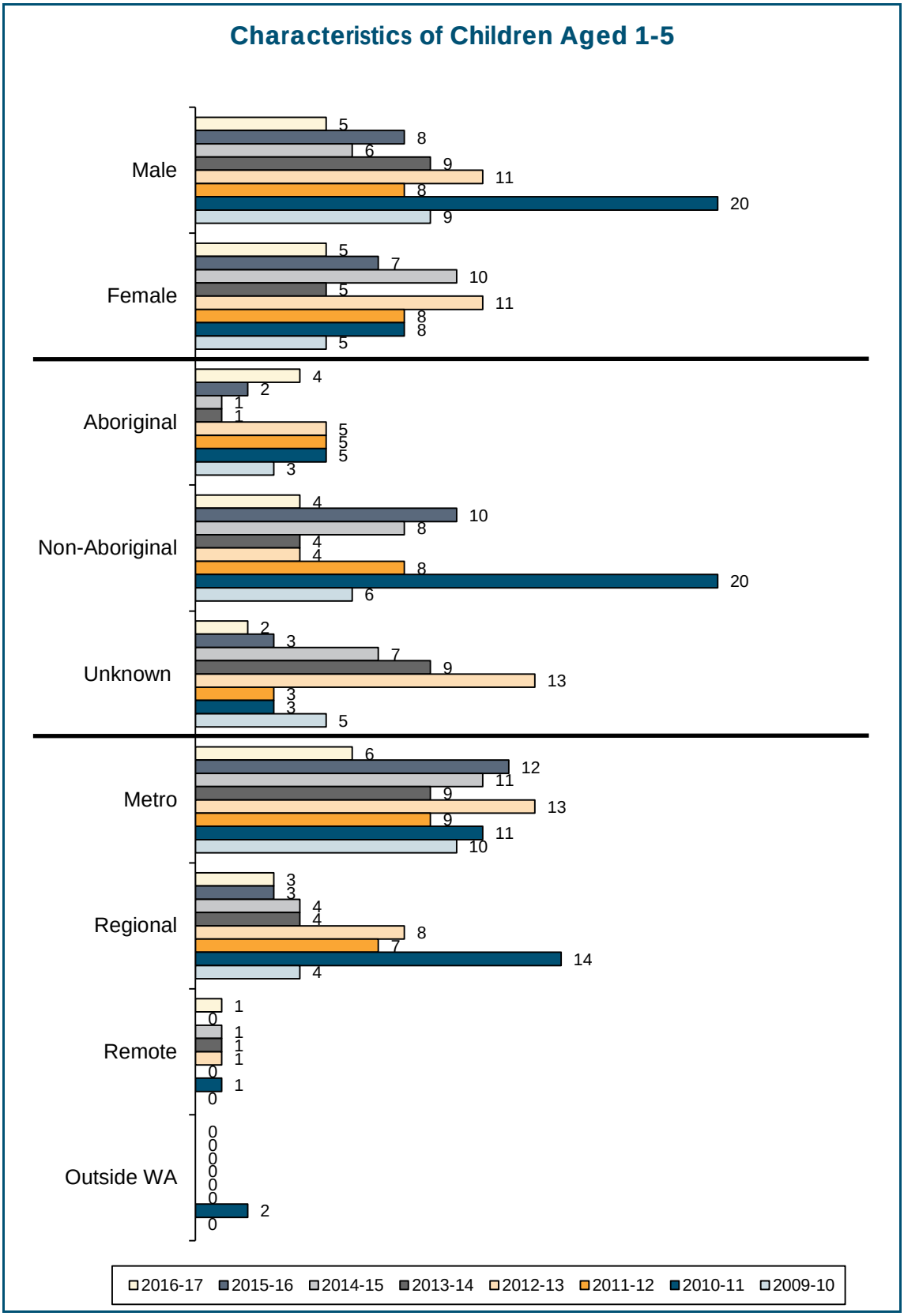
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

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.

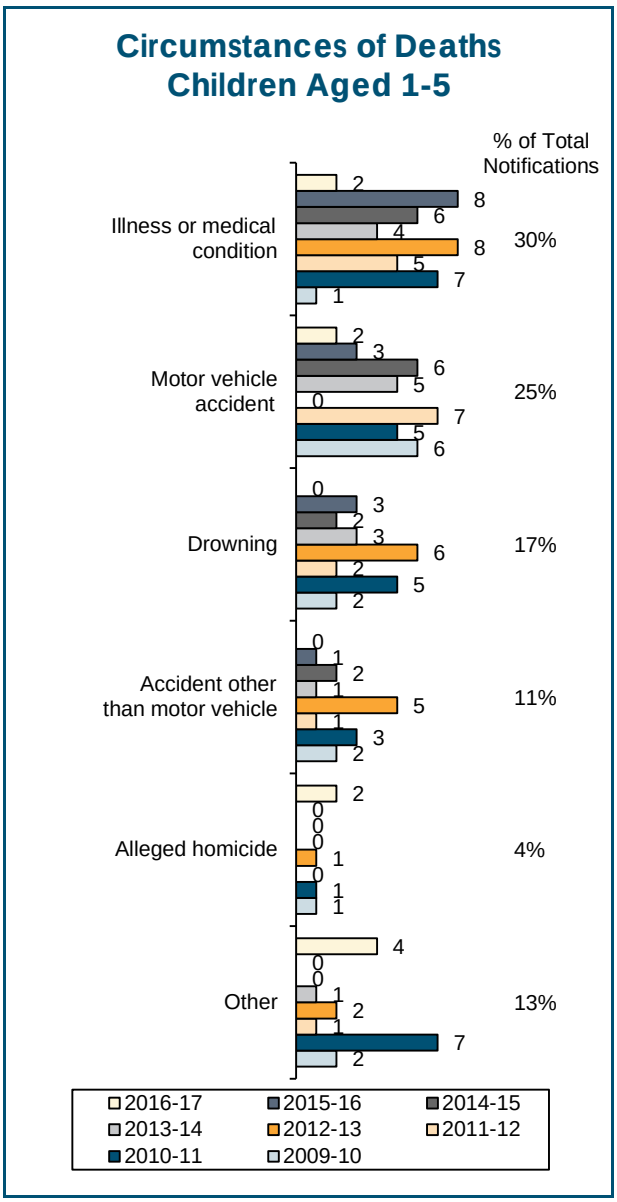


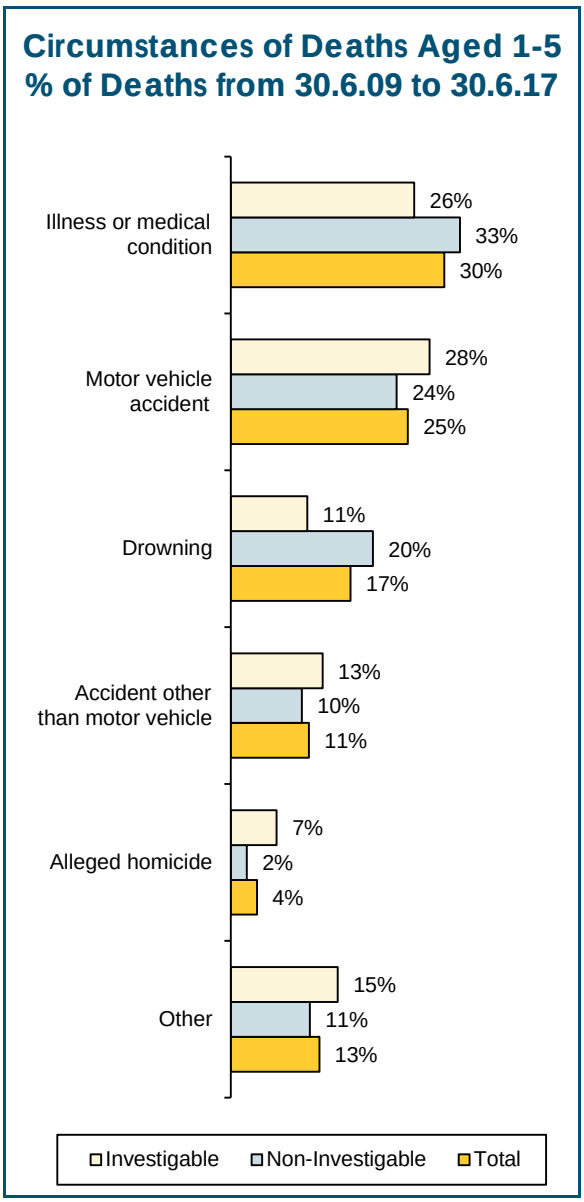
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).





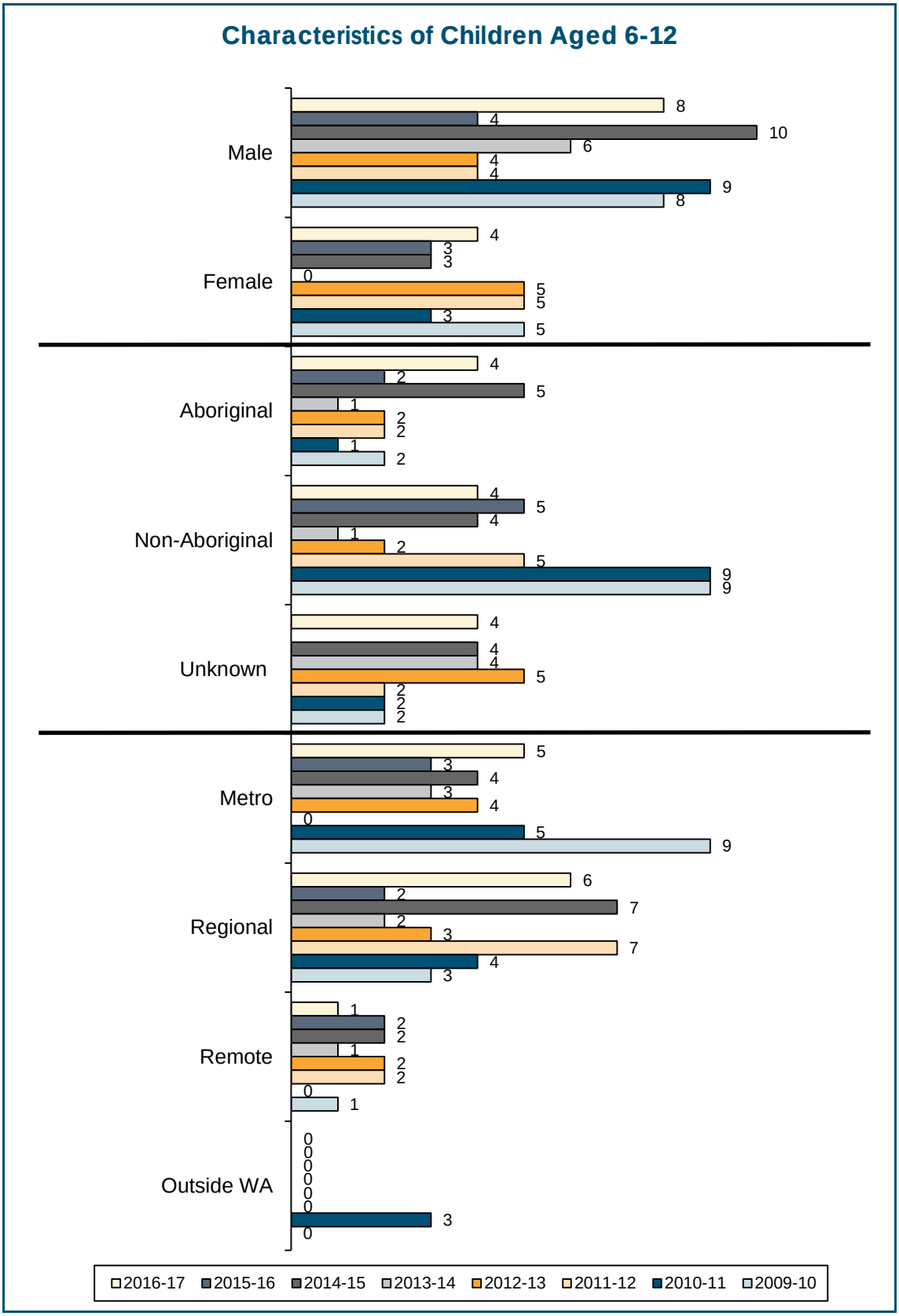
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

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.

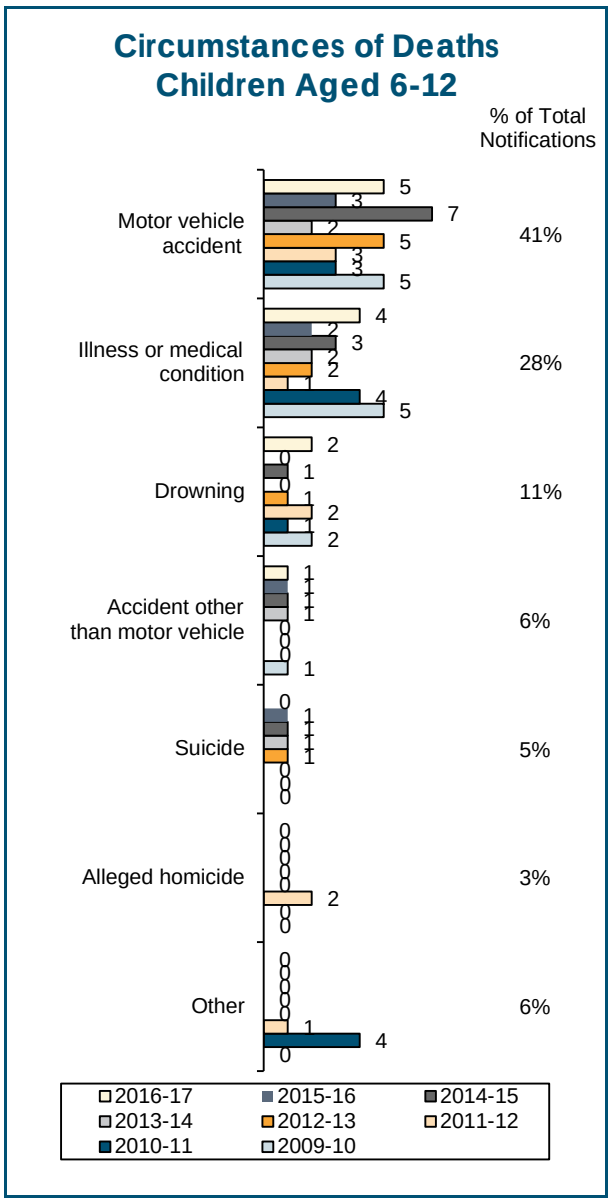


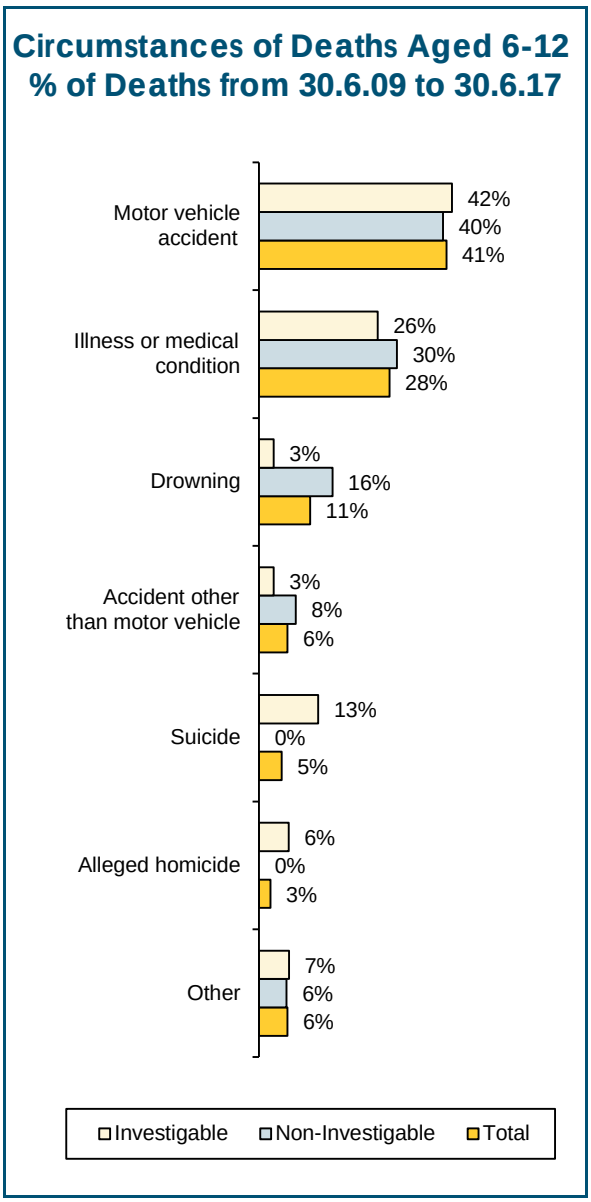
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).





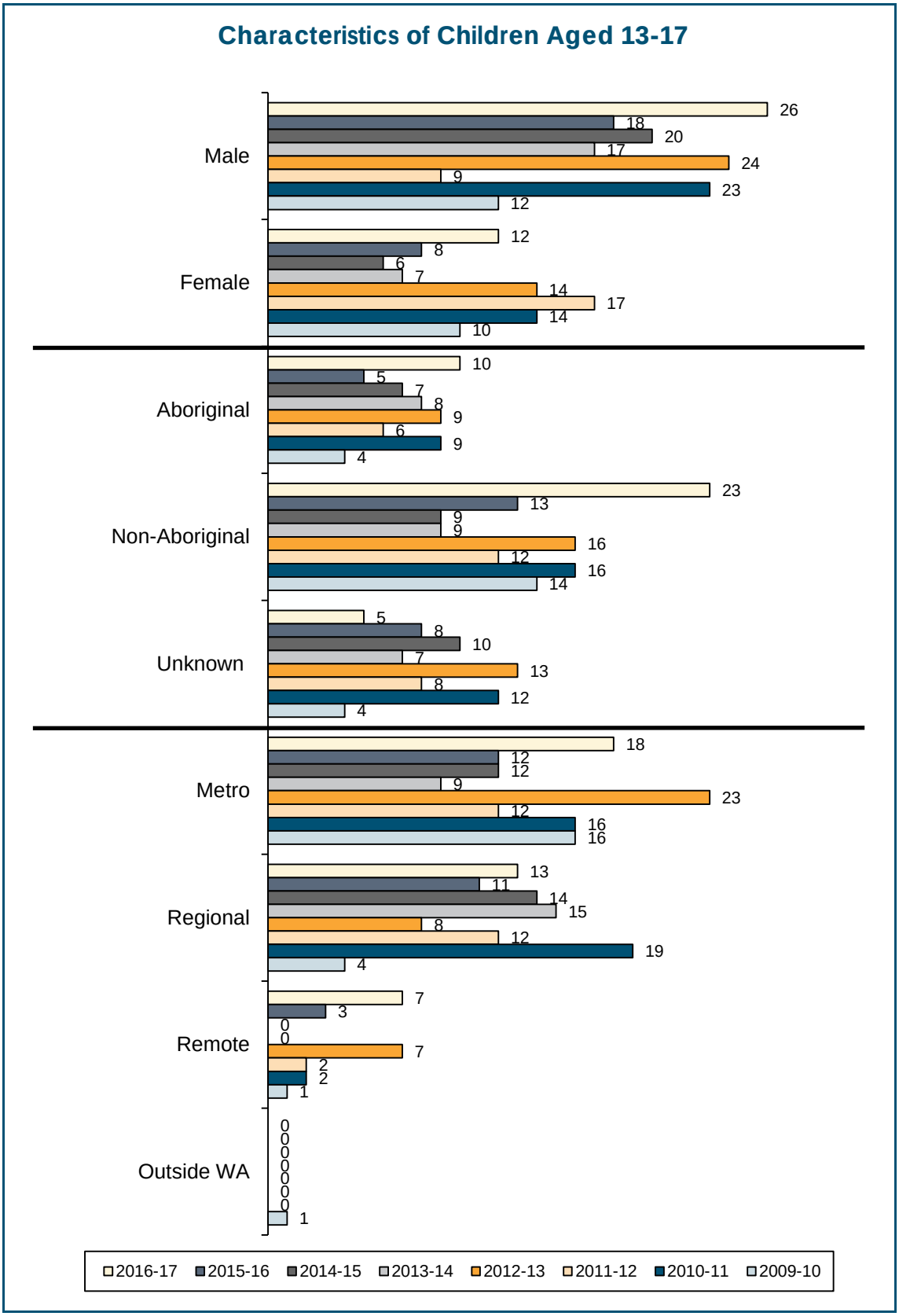
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

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.

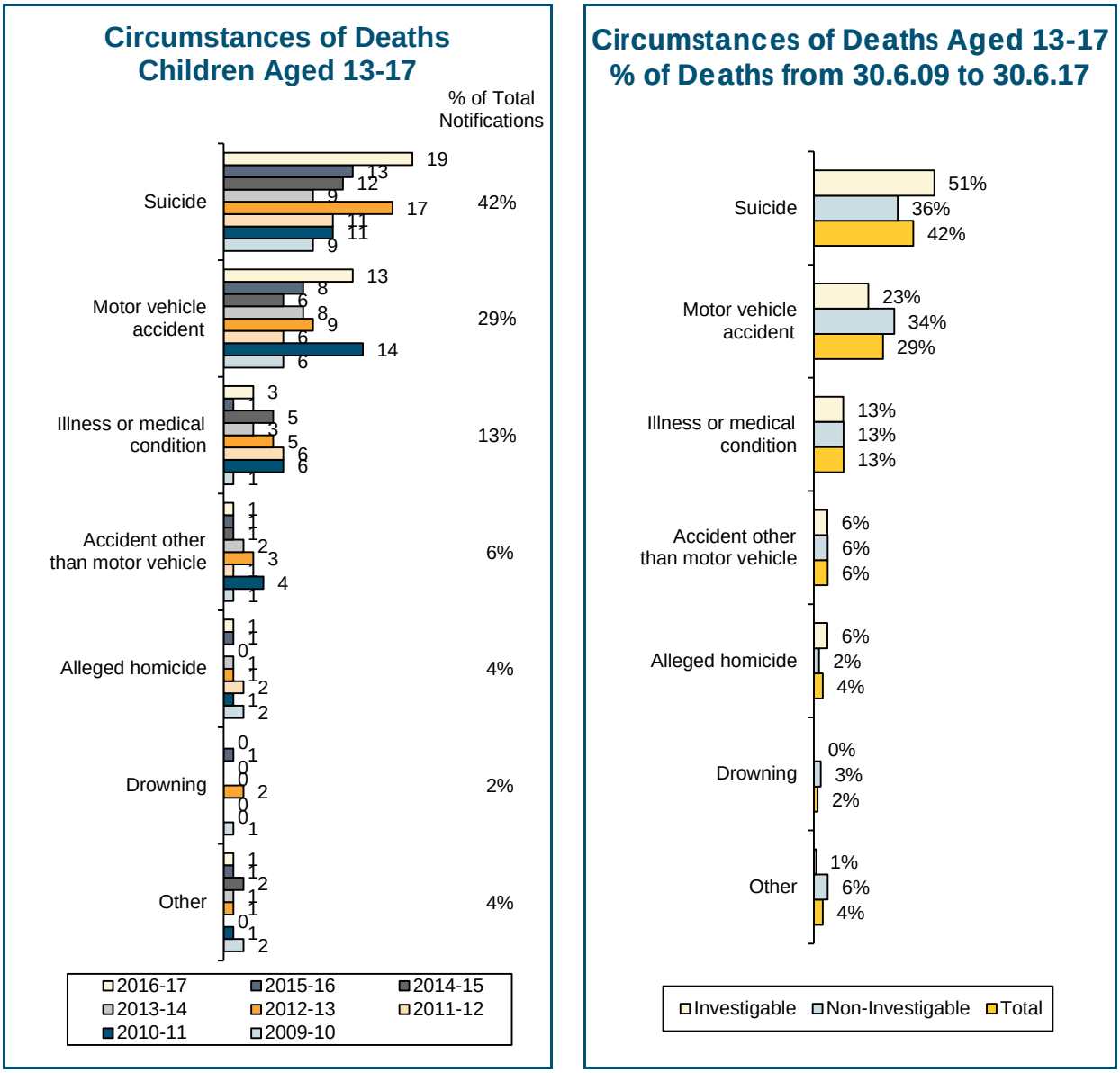


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.

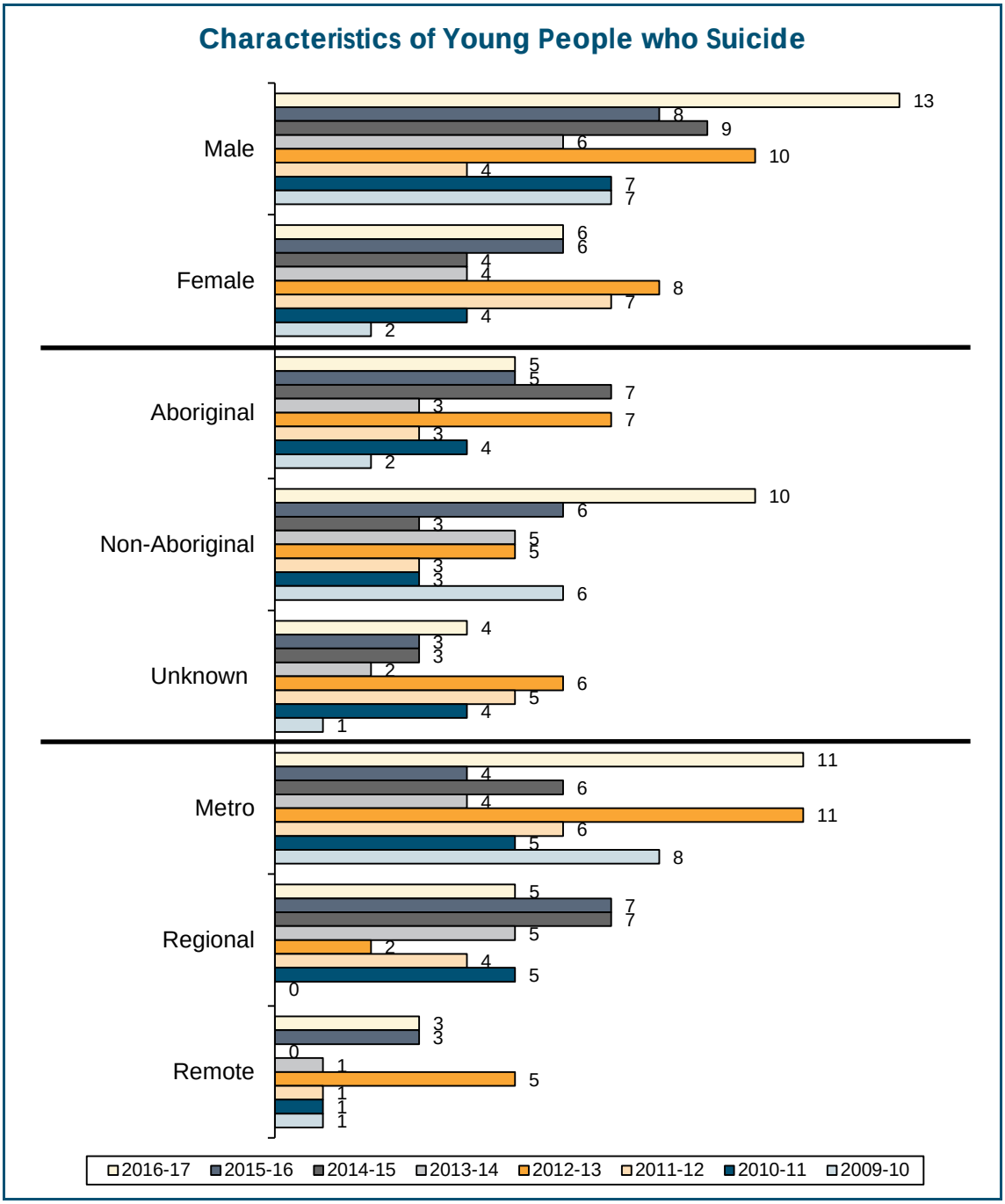
One hundred and three deaths of children aged 13 to 17 years were determined to be investigable deaths.

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.

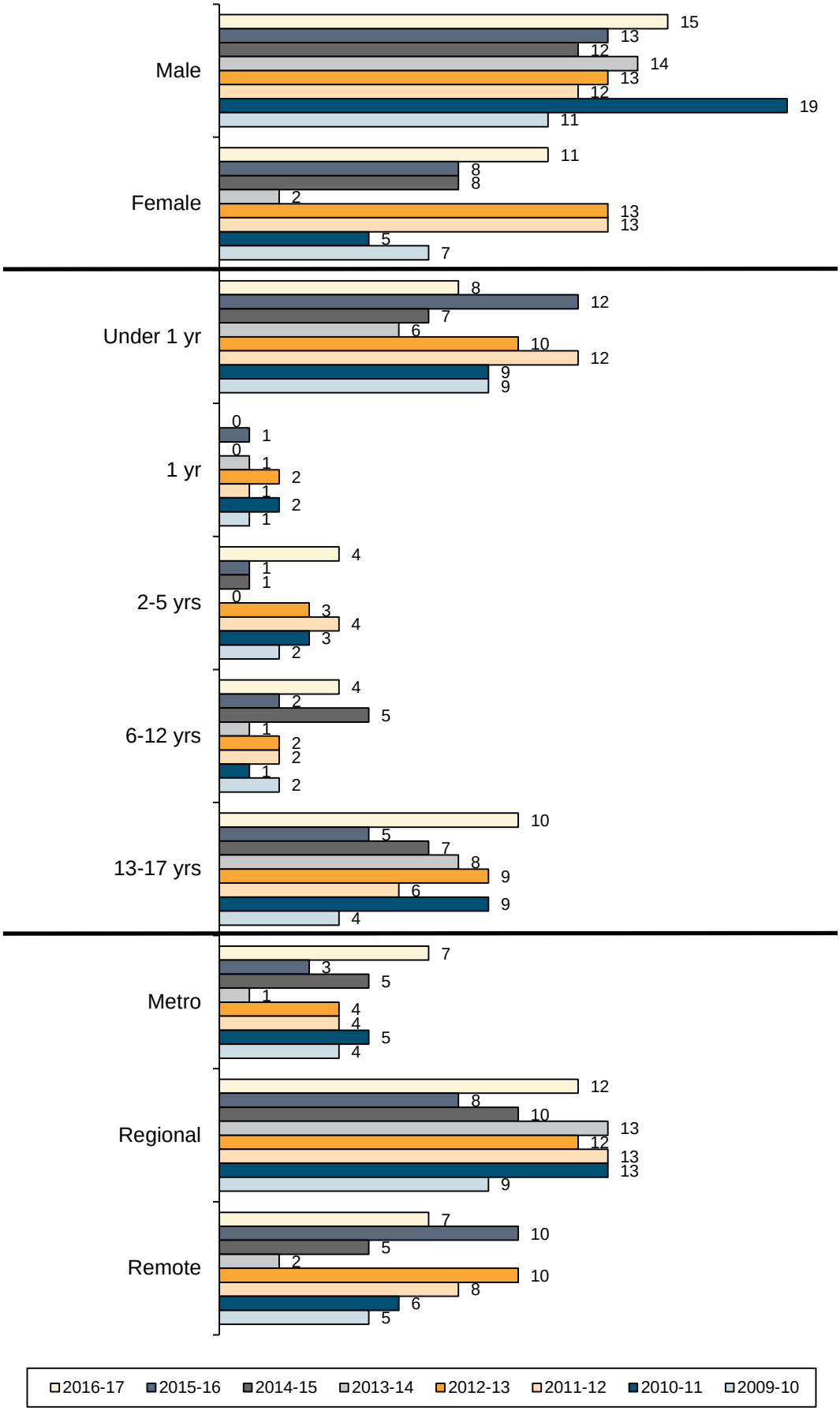
Deaths of Aboriginal children

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:

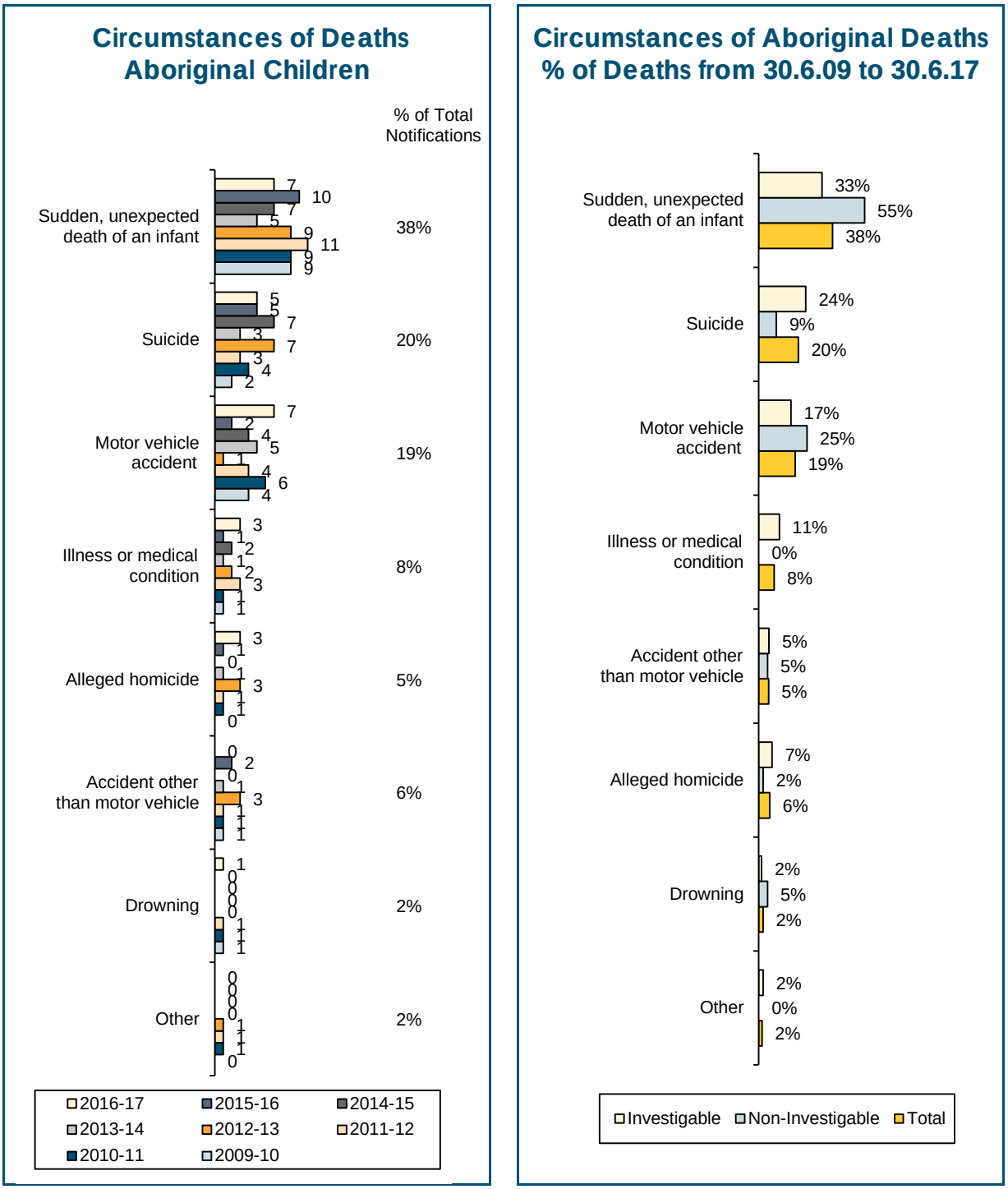
- Over the eight year period from 30 June 2009 to 30 June 2017, the majority of Aboriginal children who died were male (62%). For 2016-17, 58% of Aboriginal children who died were male;
- Most of the Aboriginal children who died were under the age of one or aged 13-17; and
- The deaths of Aboriginal 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.