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:

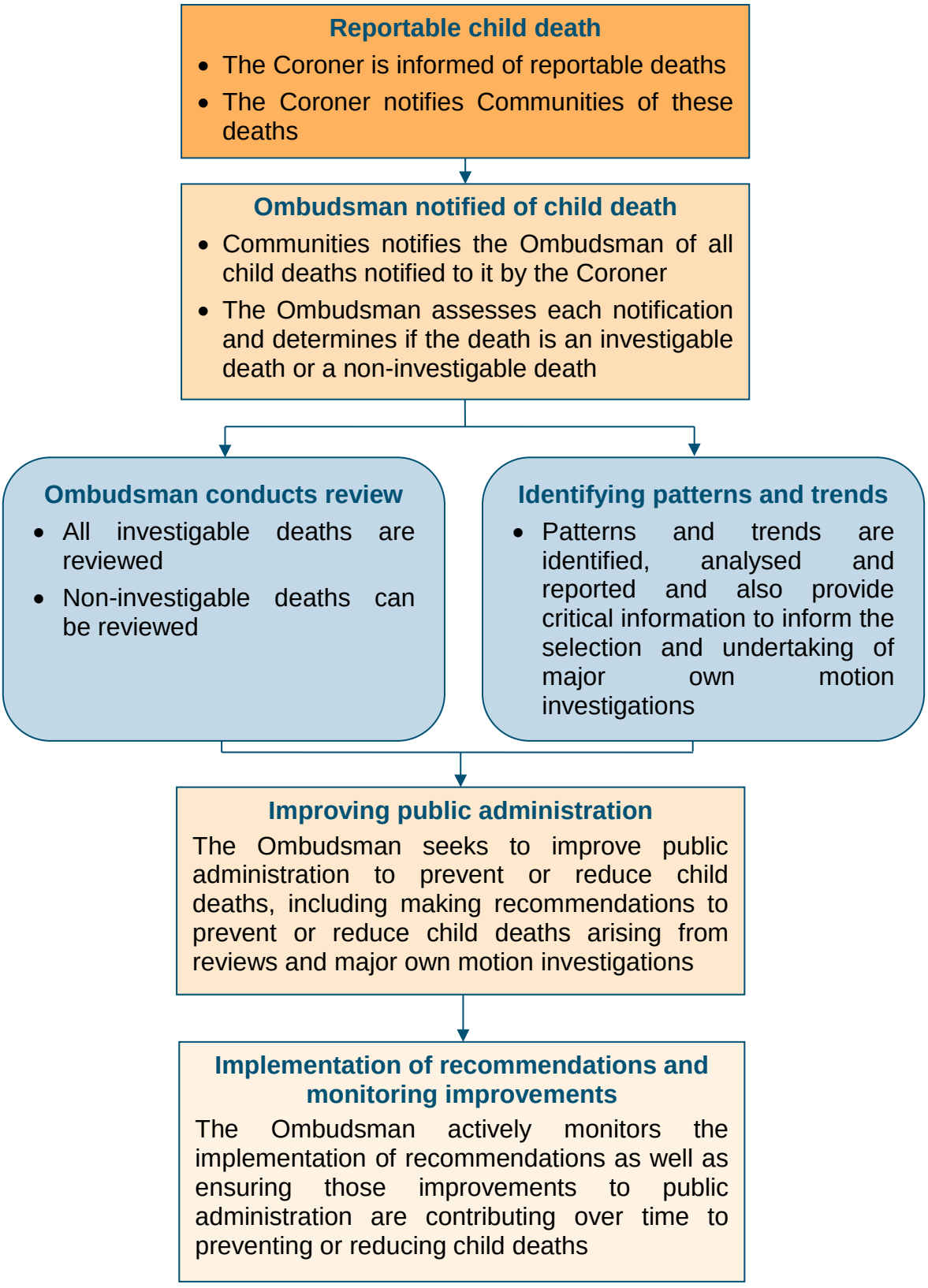
- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children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

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

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

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

The Child Death Review Process



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

Communities 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 Communities by the Coroner about the circumstances of the child's death together with a summary outlining the past involvement of Communities with the child and the child's family.

The Ombudsman assesses all child death notifications received to determine if the death is, or is not, an investigable death. If the death is an investigable death, it must be reviewed. If the death is a non-investigable death, it can be reviewed. The extent of a review depends on a number of factors, including the circumstances surrounding the child's death and the level of involvement of Communities or other public authorities in the child's life. Confidentiality of the child, family members and other persons involved with the case is strictly observed.

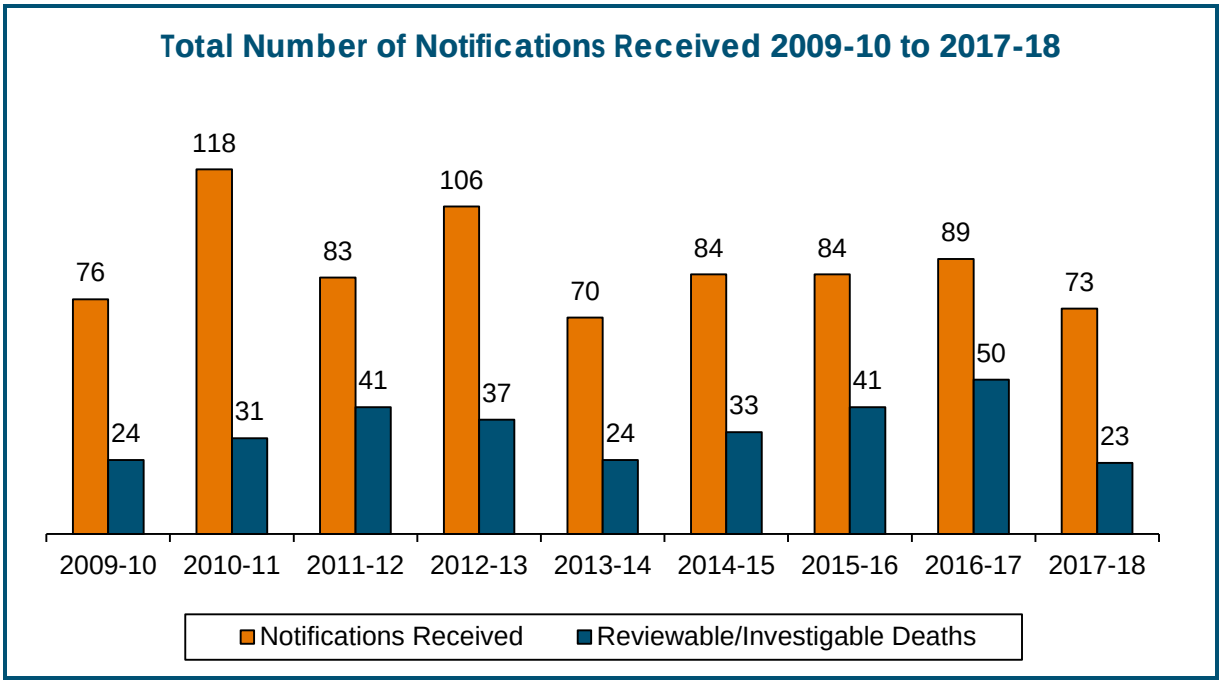
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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 2017-18, there were 23 child deaths that were investigable and subject to review from a total of 73 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 15 years from 2003-04 to 2017-18. It is important to note that an investigable death is one which meets the legislative criteria and does not necessarily mean that the death was preventable, or that there has been any failure of the responsibilities of Communities.

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

Year	A	B	C	D
	Total WA child deaths (excluding stillbirths) (See Note 1)	Child deaths reported to the Coroner (See Note 2)	Child deaths where the child or a relative of the child was known to Communities (See Note 3)	Reviewable/ investigable child deaths (See Note 4 and Note 5)
2003-04	177	92	42	19
2004-05	212	105	52	19
2005-06	210	96	55	14
2006-07	165	84	37	17
2007-08	187	102	58	30
2008-09	167	84	48	25
2009-10	201	93	52	24
2010-11	203	118	60	31
2011-12	150	76	49	41
2012-13	193	121	62	37
2013-14	156	75	40	24
2014-15	170	93	48	33
2015-16	178	92	61	41
2016-17	181	91	60	50
2017-18	135	81	37	23

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. The data in Column A is subject to updating and may vary from data published in previous Annual Reports.
2. The data in Column B has been provided by the Office of the State Coroner. Reportable child deaths received by the Coroner are deaths reported to the Coroner of children under the age of 18 years pursuant to the provisions of the *Coroners Act 1996*. The data in this section is based on the number of deaths of children that were reported to the Coroner during the year.
3. 'Communities' refers to the Department of Communities from 2017-18, Department for Child Protection and Family Support for the year 2012-13 to 2016-17, Department for Child Protection for the years 2006-07 to 2011-12 and Department for Community Development (**DCD**) prior to 2006-07. The data in Column C has been provided by Communities and is based on the date the notification was received by Communities. For 2003-04 to 2007-08 this information is the same as that included in the CDRC Annual Reports for the relevant year. In the 2005-06 to 2007-08 Annual Reports, the CDRC counted 'Child death notifications where any form of contact had previously occurred with Communities: recent, historical, significant or otherwise'. In the 2003-04 and 2004-05 Annual Reports, the CDRC counted 'Coroner notifications where the families had some form of contact with DCD'.

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

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

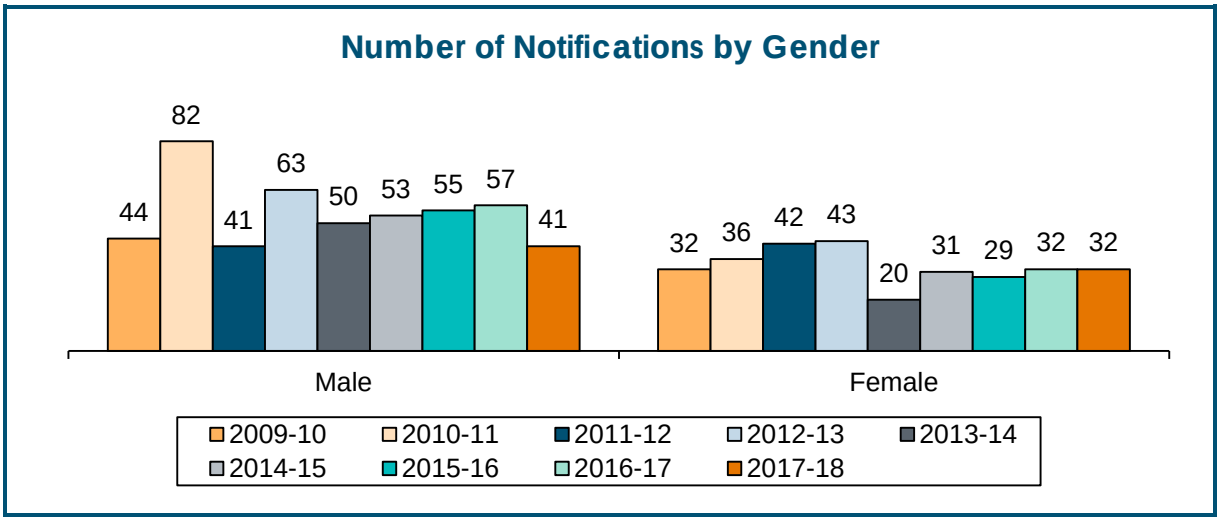
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

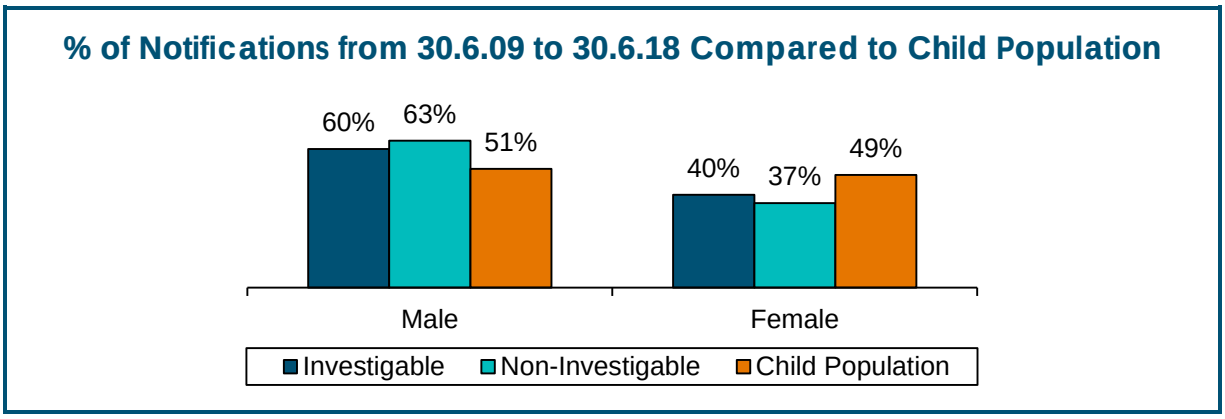
The following charts show:

- The number of children in each group for each year from 2009-10 to 2017-18; and
- For the period from 30 June 2009 to 30 June 2018, 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 nine years, male children are over-represented compared to the population for both investigable and non-investigable deaths.

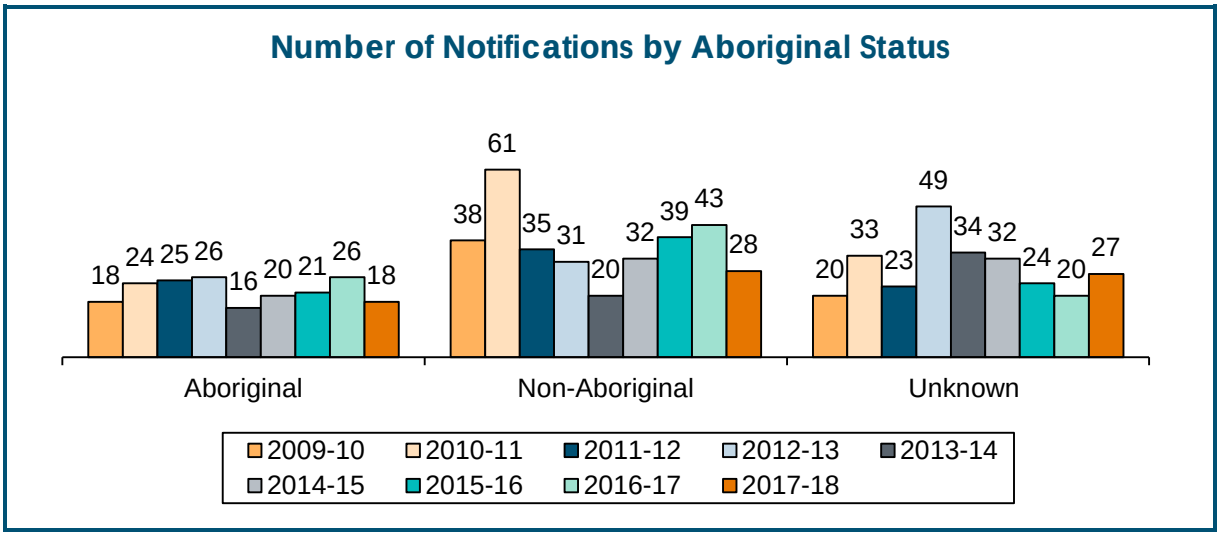


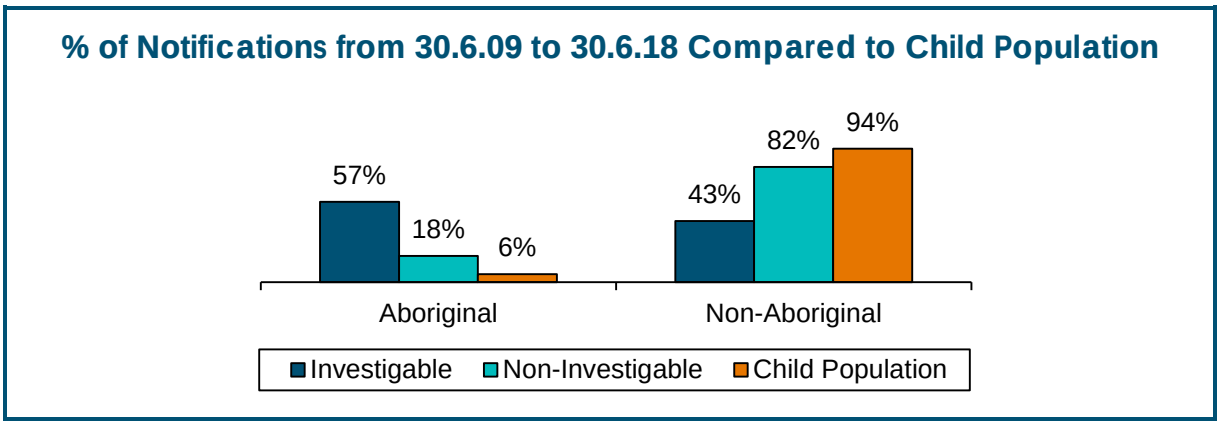


Further analysis of the data shows that, considering all nine years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

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.





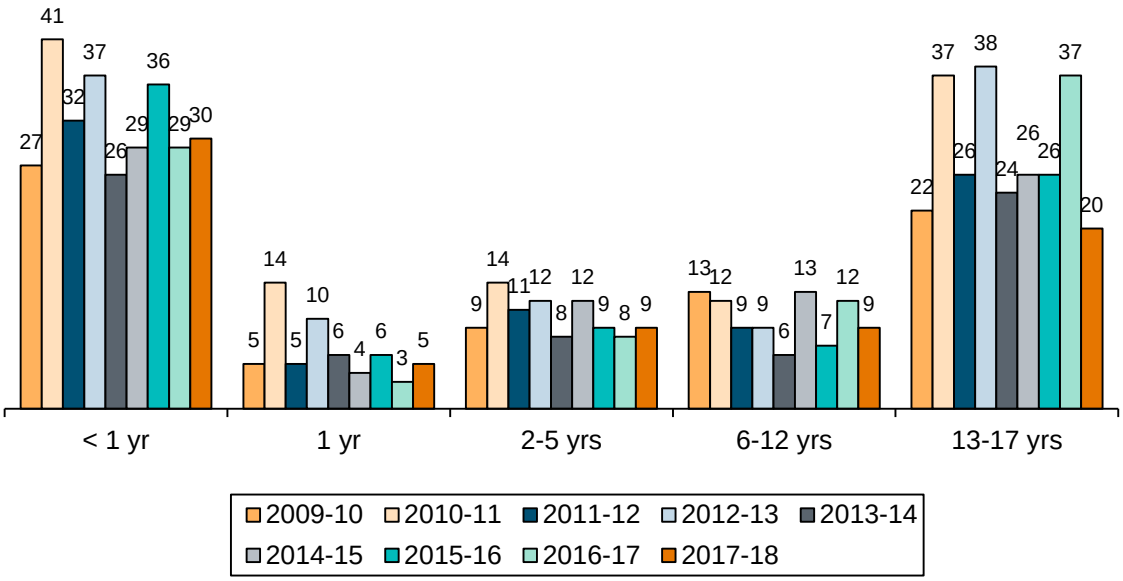
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

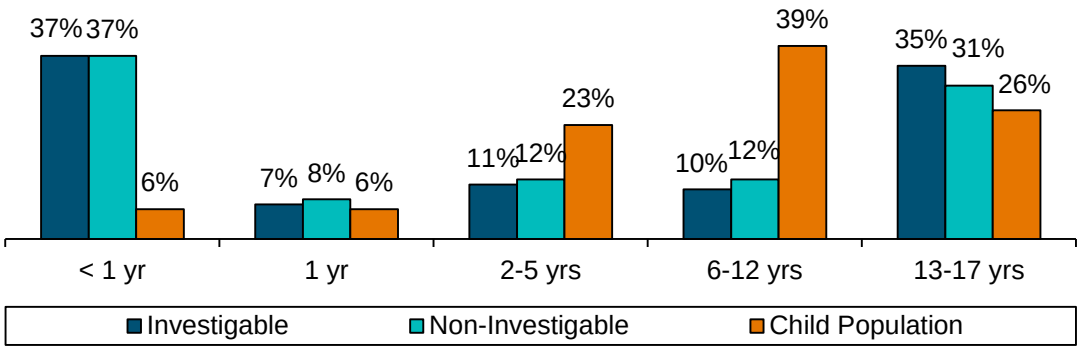
Age groups

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

Number of Notifications by Age of Child



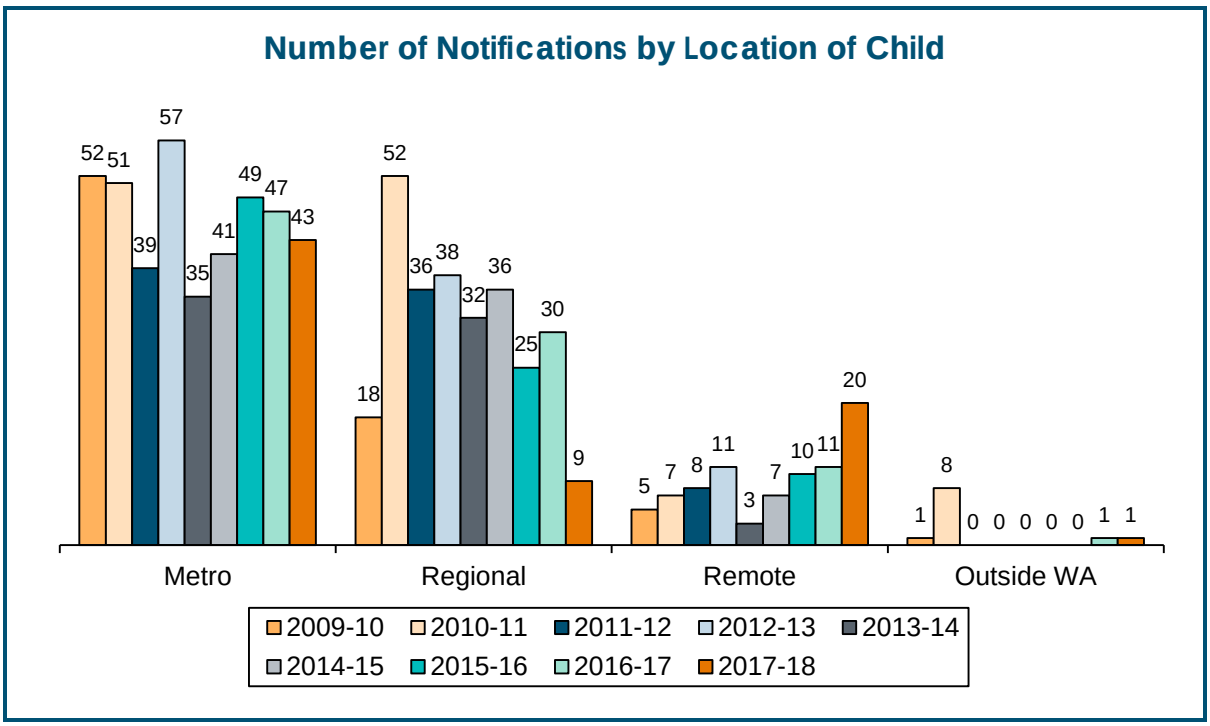
% of Notifications from 30.6.09 to 30.6.18 Compared to Child Population



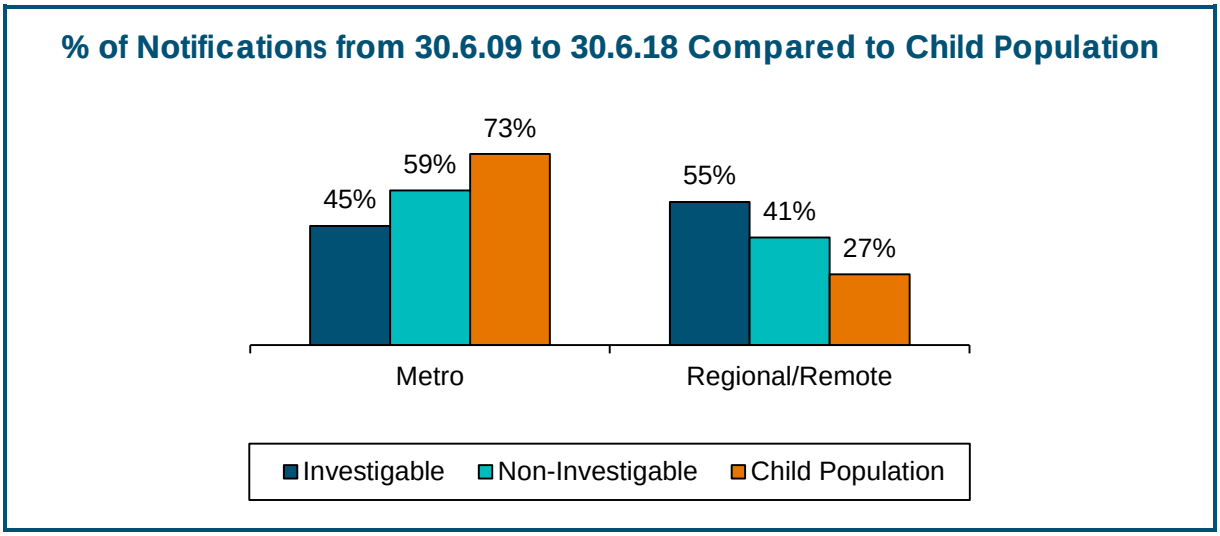
A more detailed analysis by age group is provided later in this section.

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 79% 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

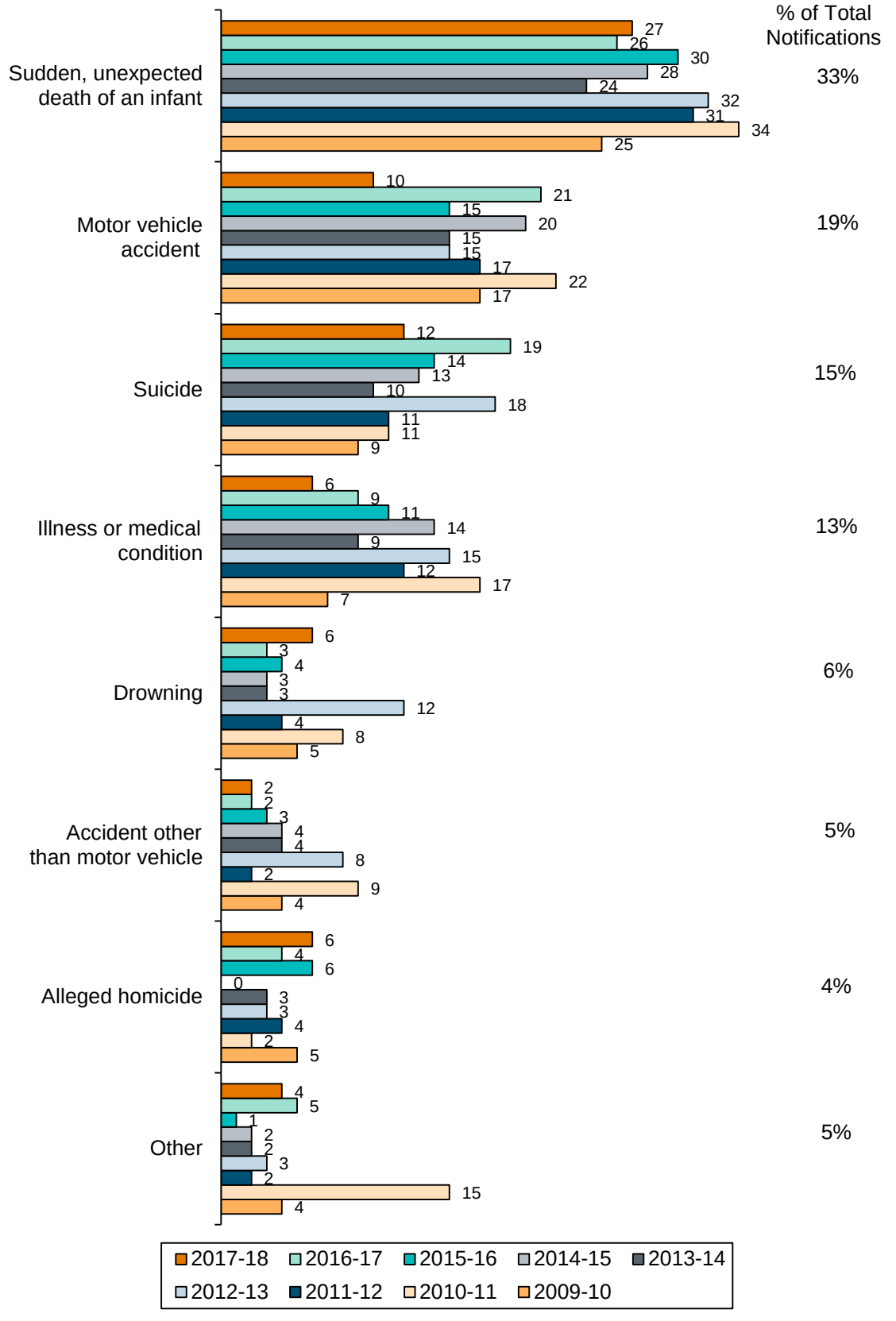
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally 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 2018.

Circumstances of Child Deaths



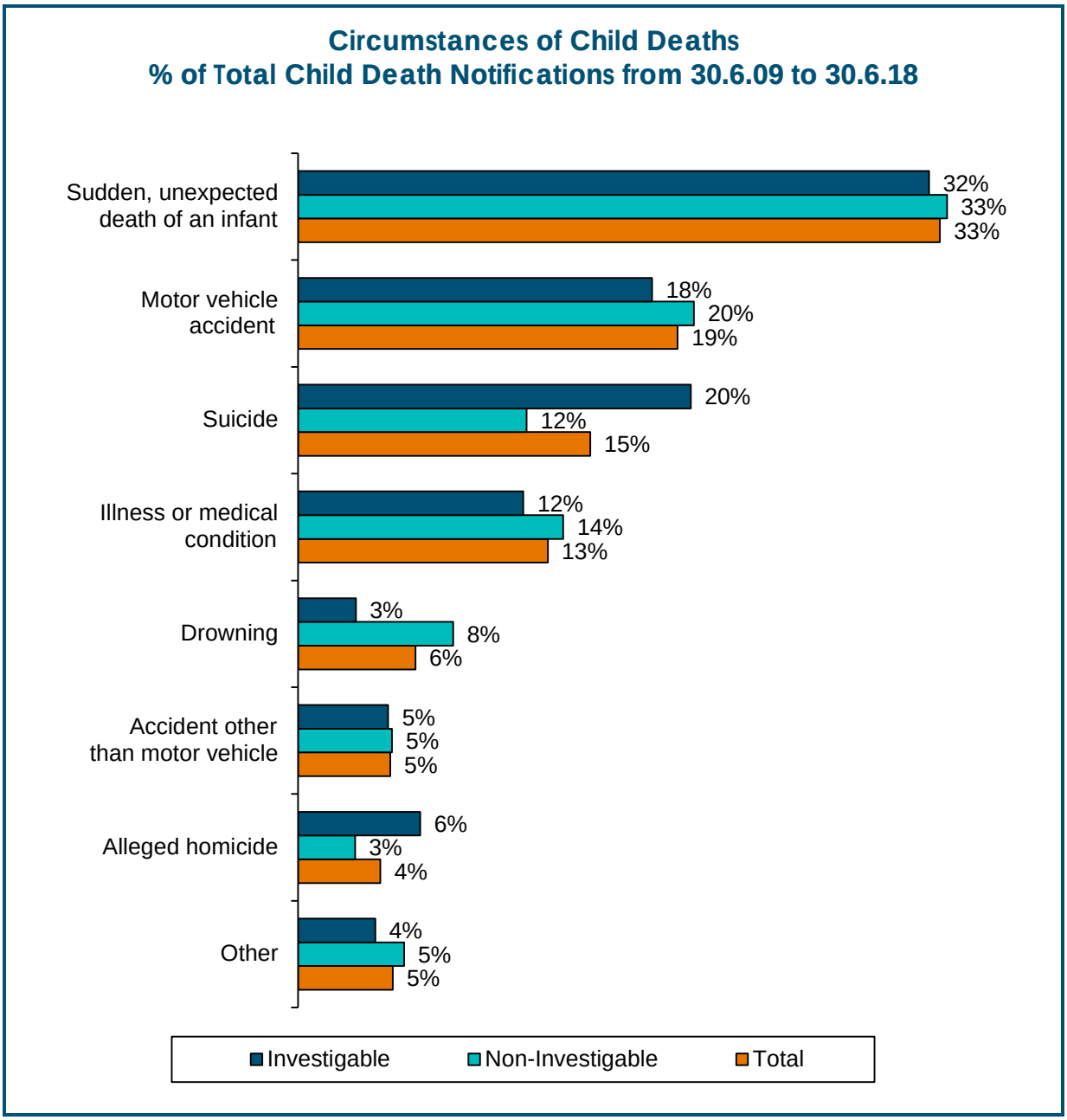
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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

The two main circumstances of death for the 783 child death notifications received in the nine years from 30 June 2009 to 30 June 2018 are:

- Sudden, unexpected deaths of infants, representing 33% of the total child death notifications from 30 June 2009 to 30 June 2018 (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, 29% in 2016-17 and 37% in 2017-18); and
- Motor vehicle accidents, representing 19% of the total child death notifications from 30 June 2009 to 30 June 2018 (22% of the child death notifications received in 2009-10, 19% in 2010-11, 20% in 2011-12, 14% in 2012-13, 21% in 2013-14, 24% in 2014-15, 18% in 2015-16, 24% in 2016-17 and 14% in 2017-18).

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 Communities. These figures are much larger than previous years as the CDRC only reported on the circumstances of death for the cases that were reviewable and that were finalised during the financial year.

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
2017-18	2	10	6		6	6	27	12	4

* 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 Communities 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 2018.

Social or Environmental Factor	% of Finalised Reviews from 30.6.09 to 30.6.18
Family and domestic violence	73%
Parenting	59%
Alcohol use	45%
Drug or substance use	45%
Homelessness	24%
Parental mental health issues	26%

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 nearly a third of the cases.
- Where alcohol use was present:
  - Parenting was a co-existing factor in 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 Communities

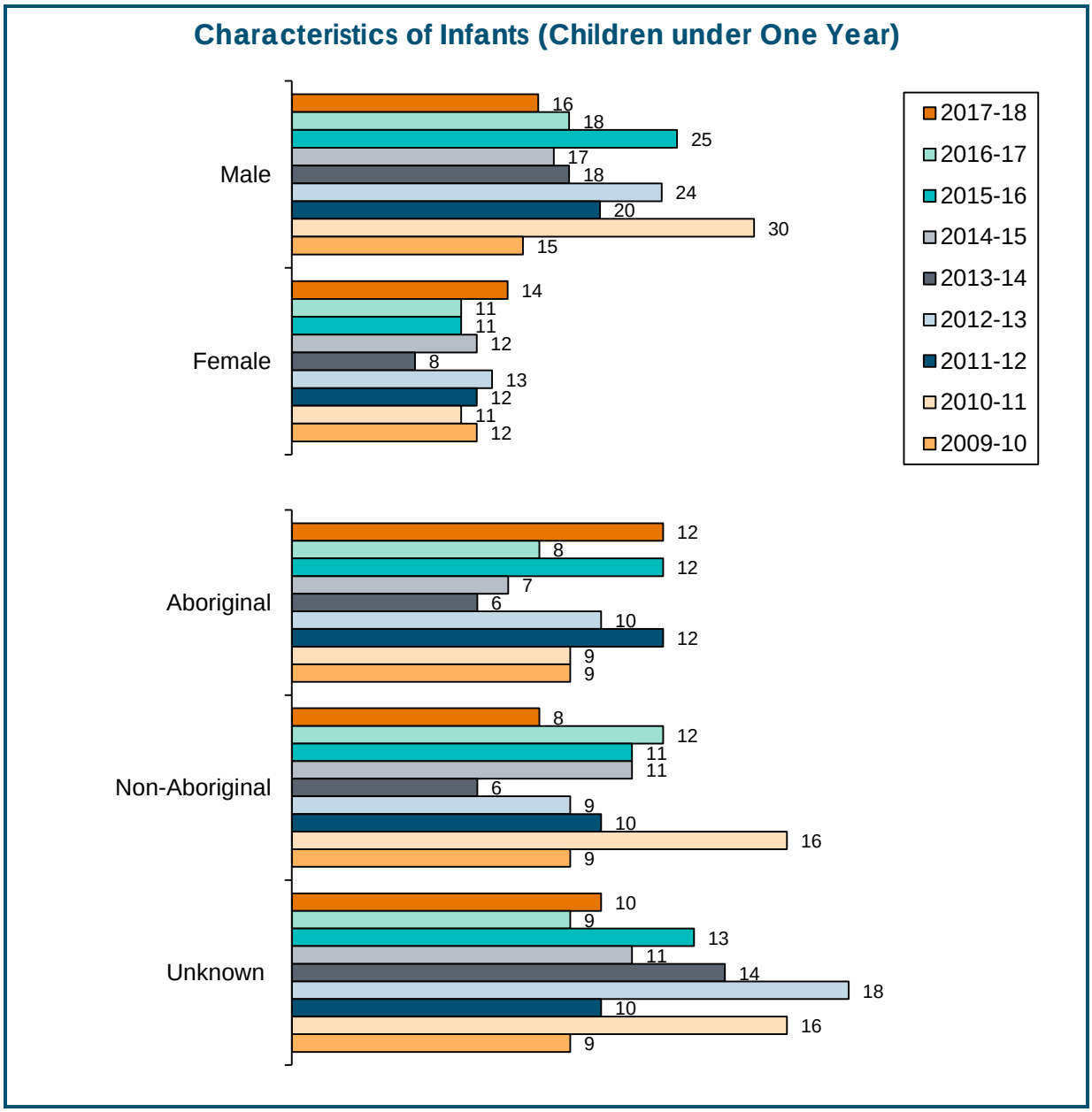
In child deaths notified to the Ombudsman in 2017-18, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

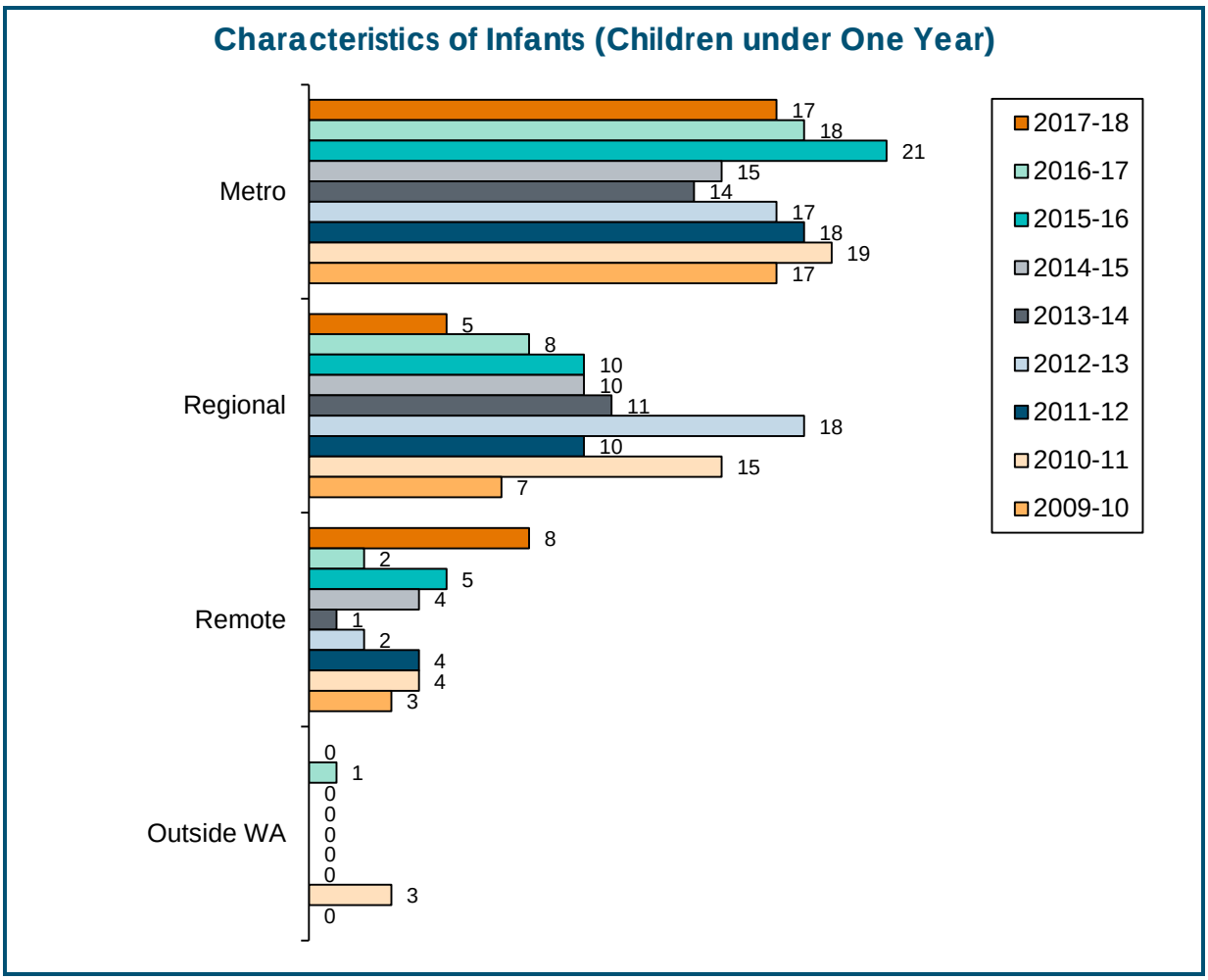
Analysis of children in particular age groups

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

Deaths of infants

Of the 783 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2018, there were 287 (37%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.



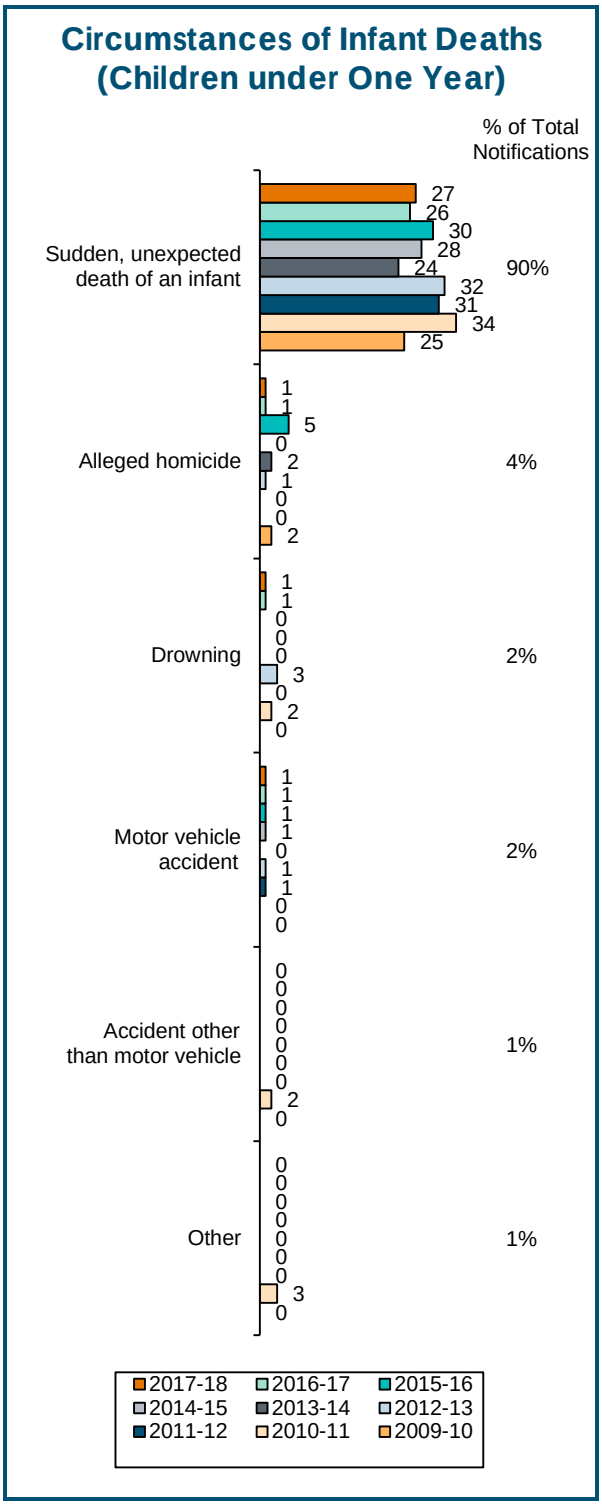


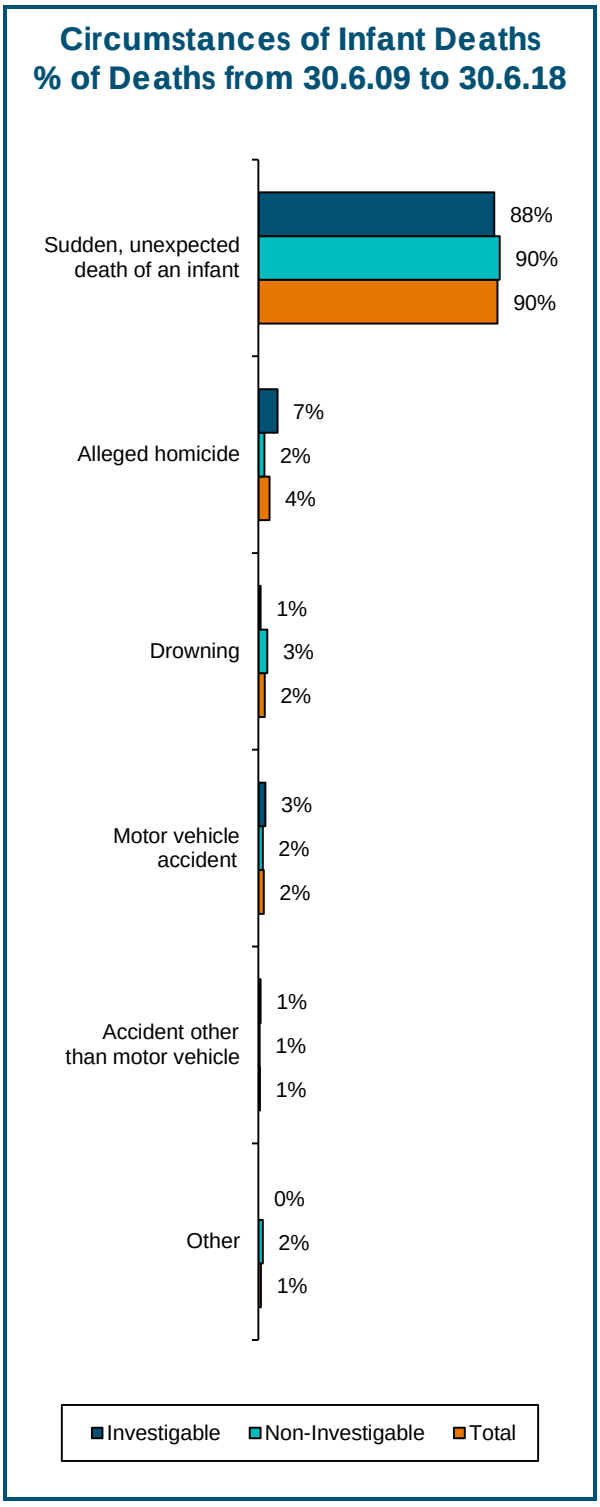
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 68% of investigable infant deaths and 61% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 66% of investigable deaths and 32% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 52% of investigable infant deaths and 40% of non-investigable deaths of infants, living in Western Australia, were children living in regional or remote locations compared to 27% in the child population.

An examination of the patterns and trends of the circumstances of infant deaths showed that of the 287 infant deaths, 257 (90%) were categorised as sudden, unexpected deaths of an infant and the majority of these (164) 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.





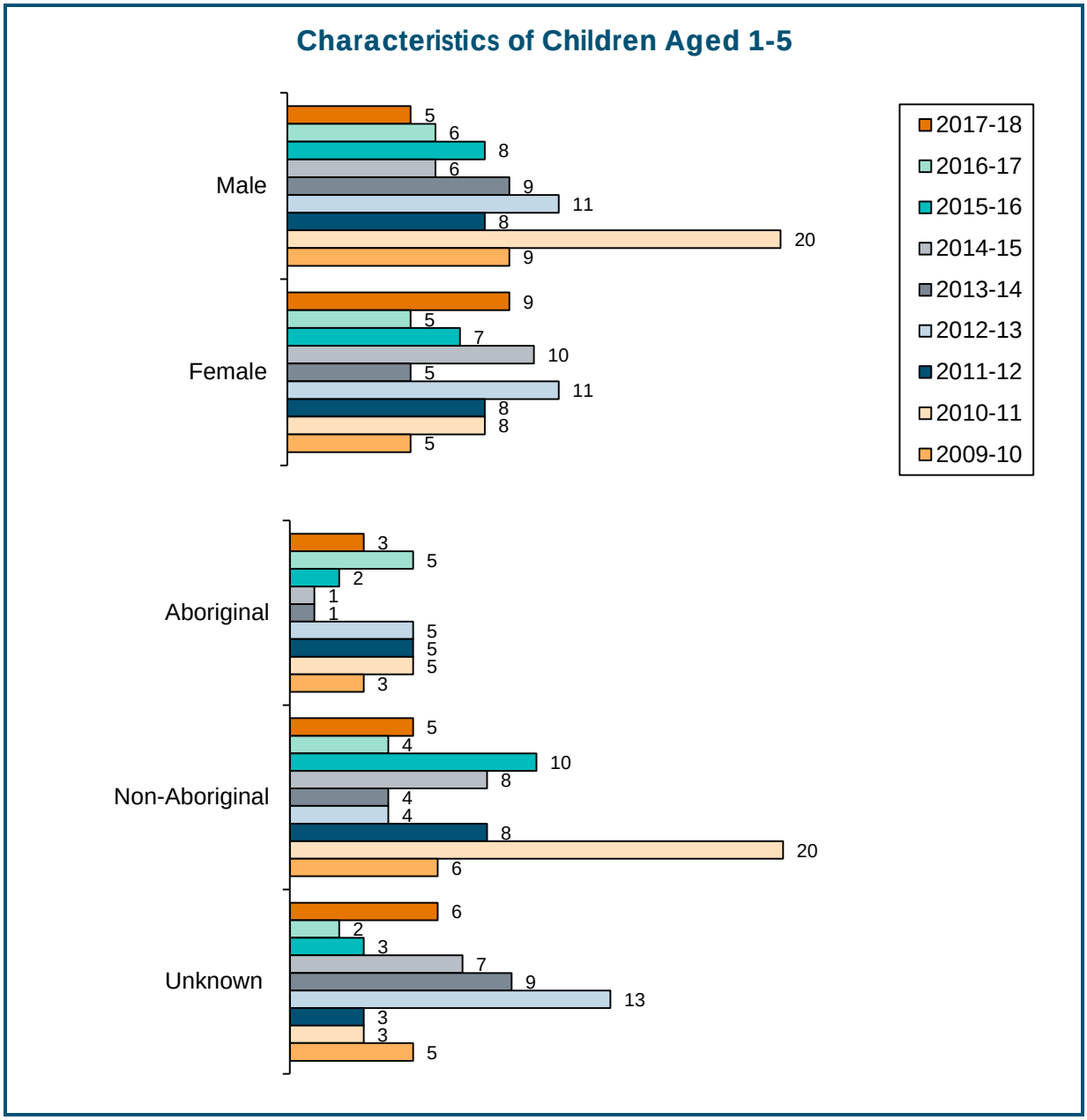
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

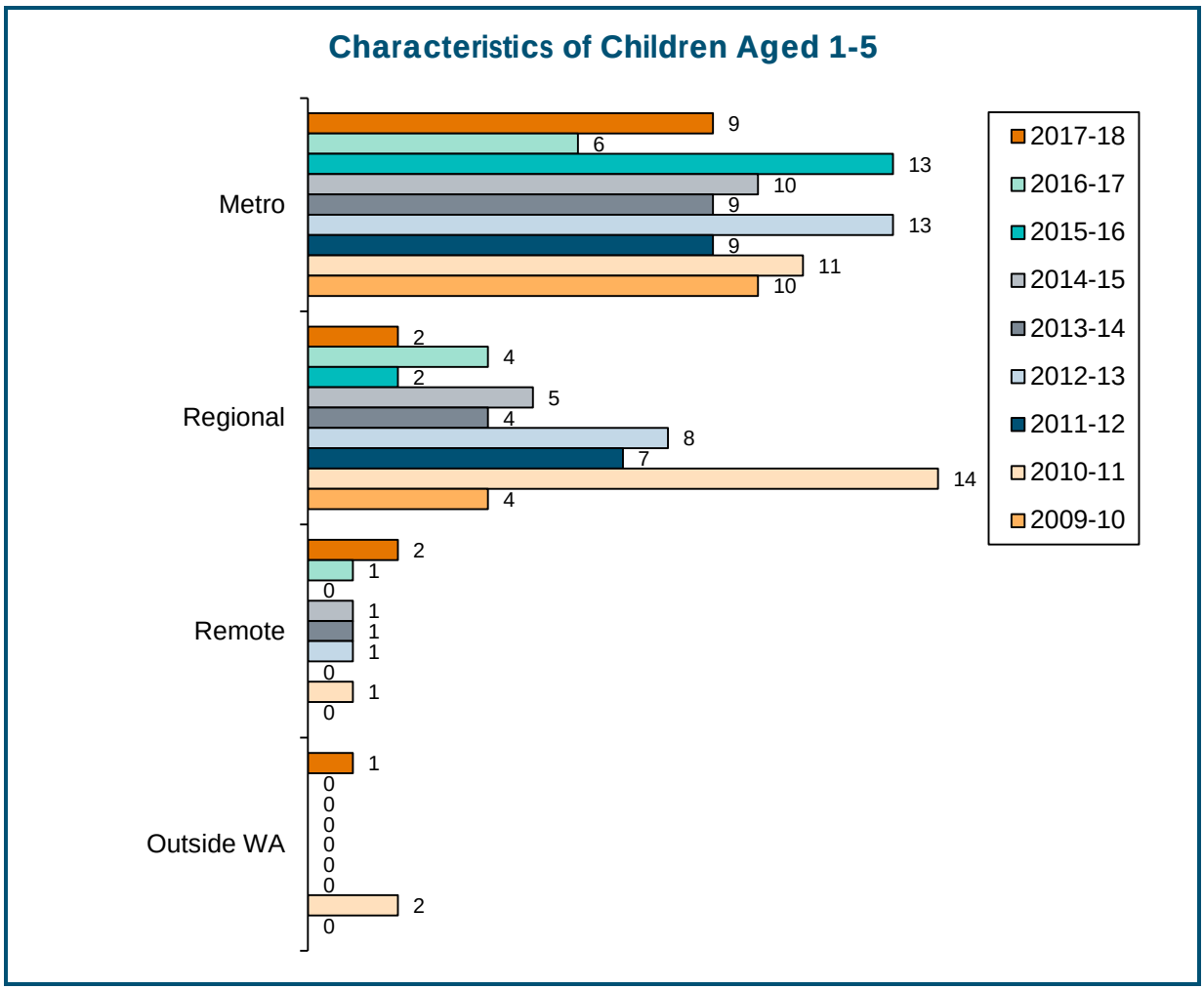
One hundred and eleven deaths of infants were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 783 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2018, there were 150 (19%) related to children aged from 1 to 5 years.

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



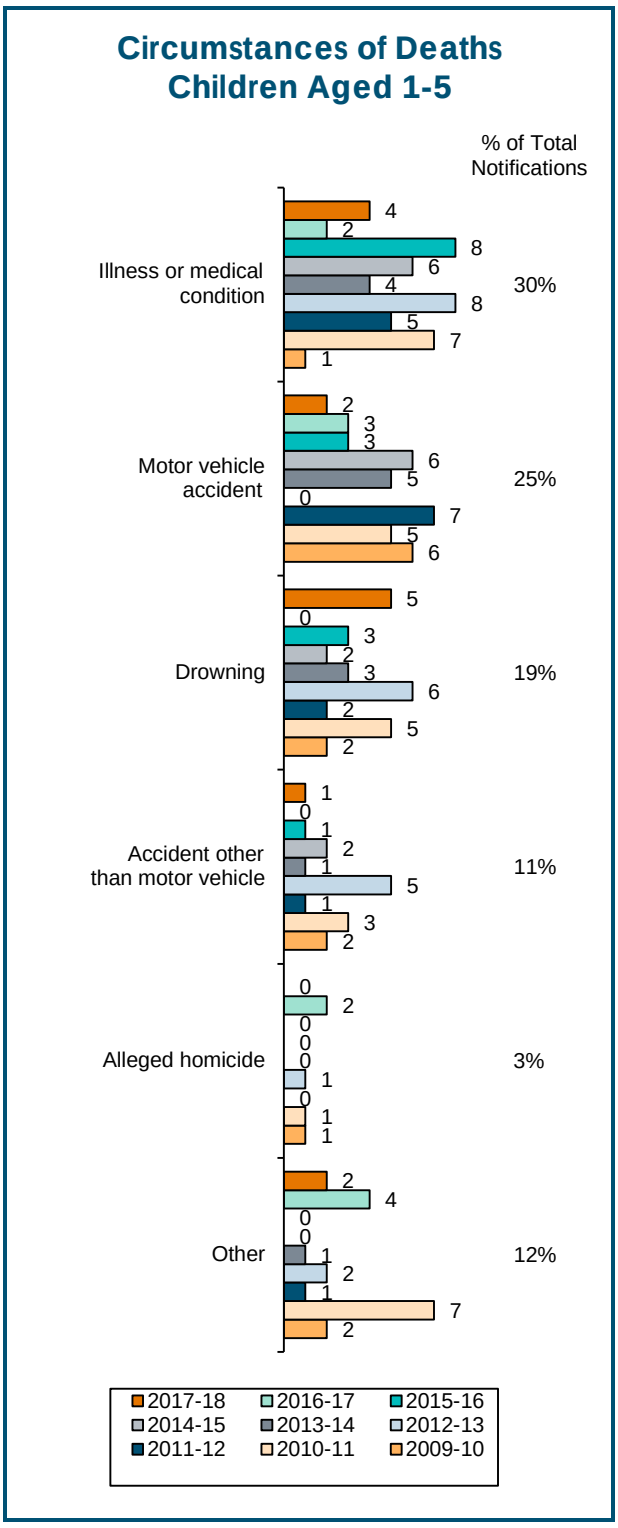


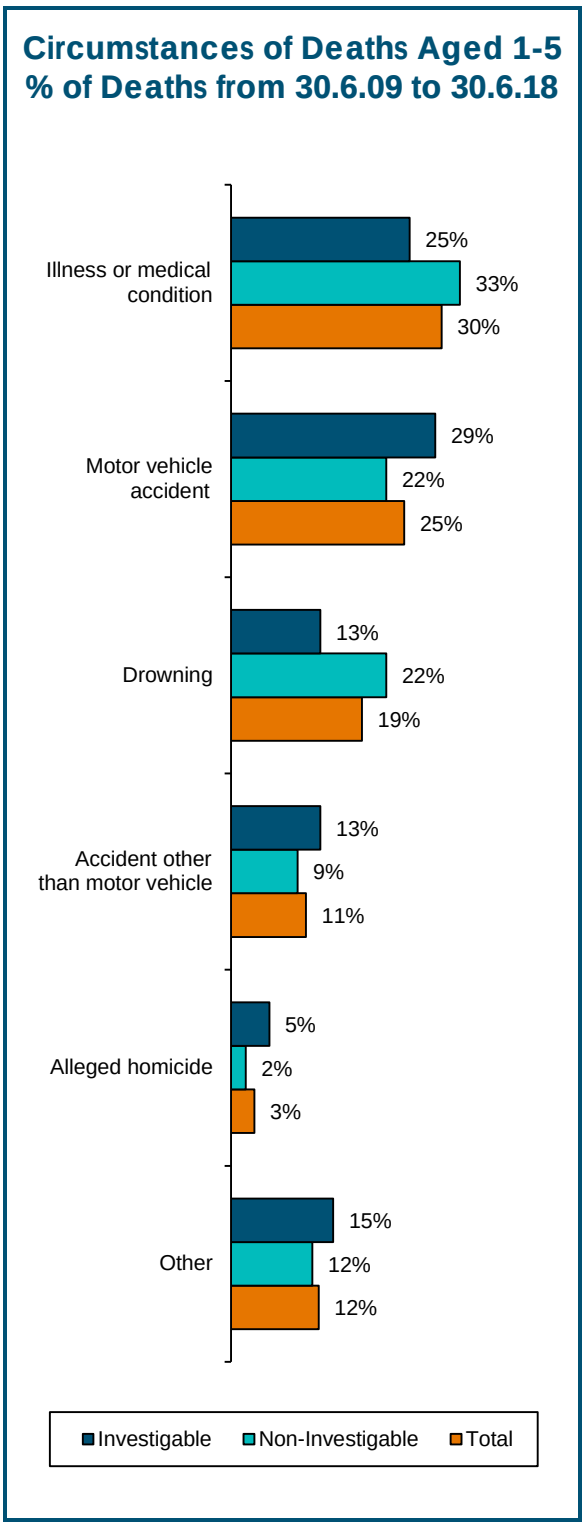
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 55% 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 – 53% 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 – 40% of investigable deaths and 38% 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 (19%).





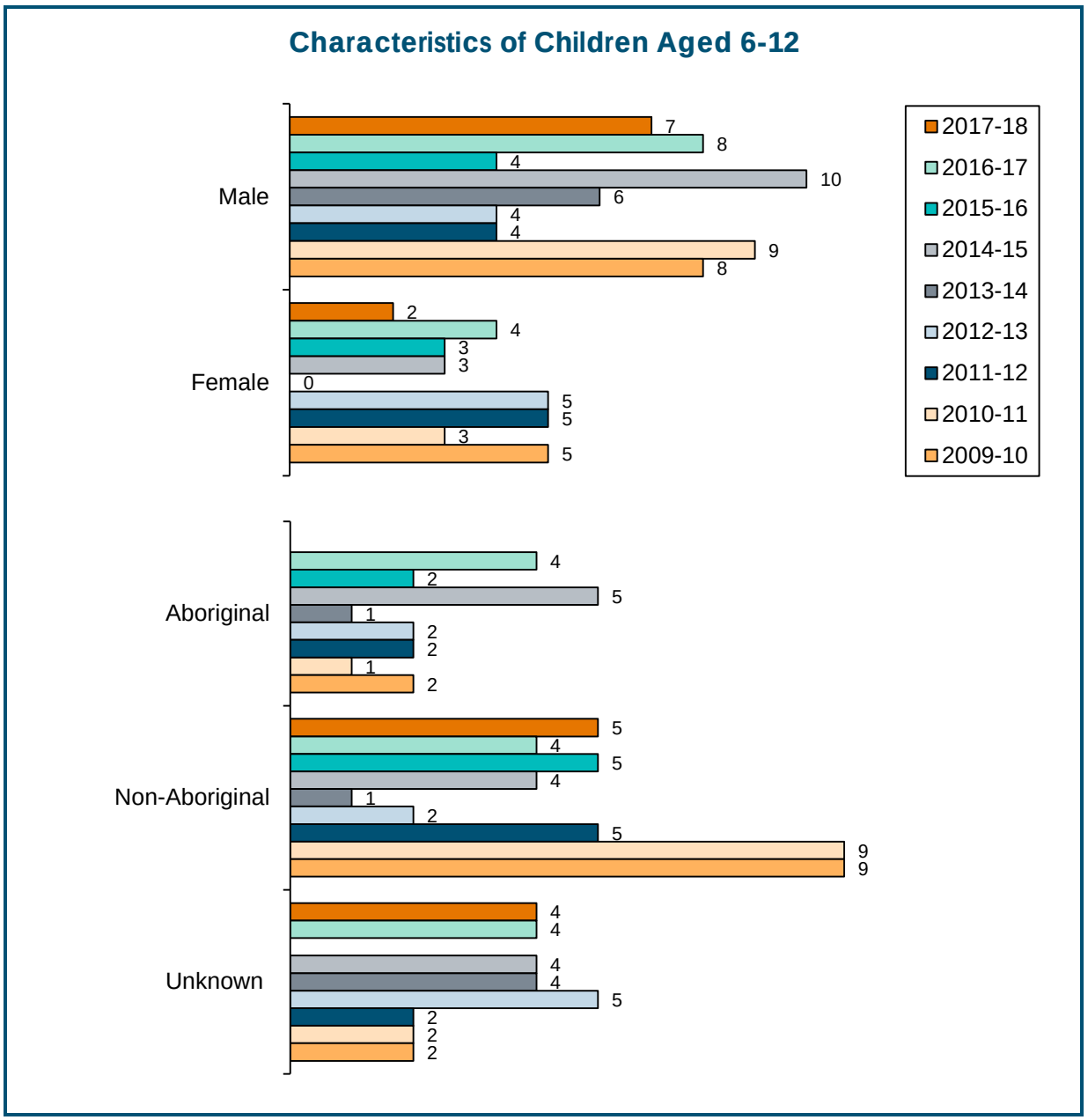
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

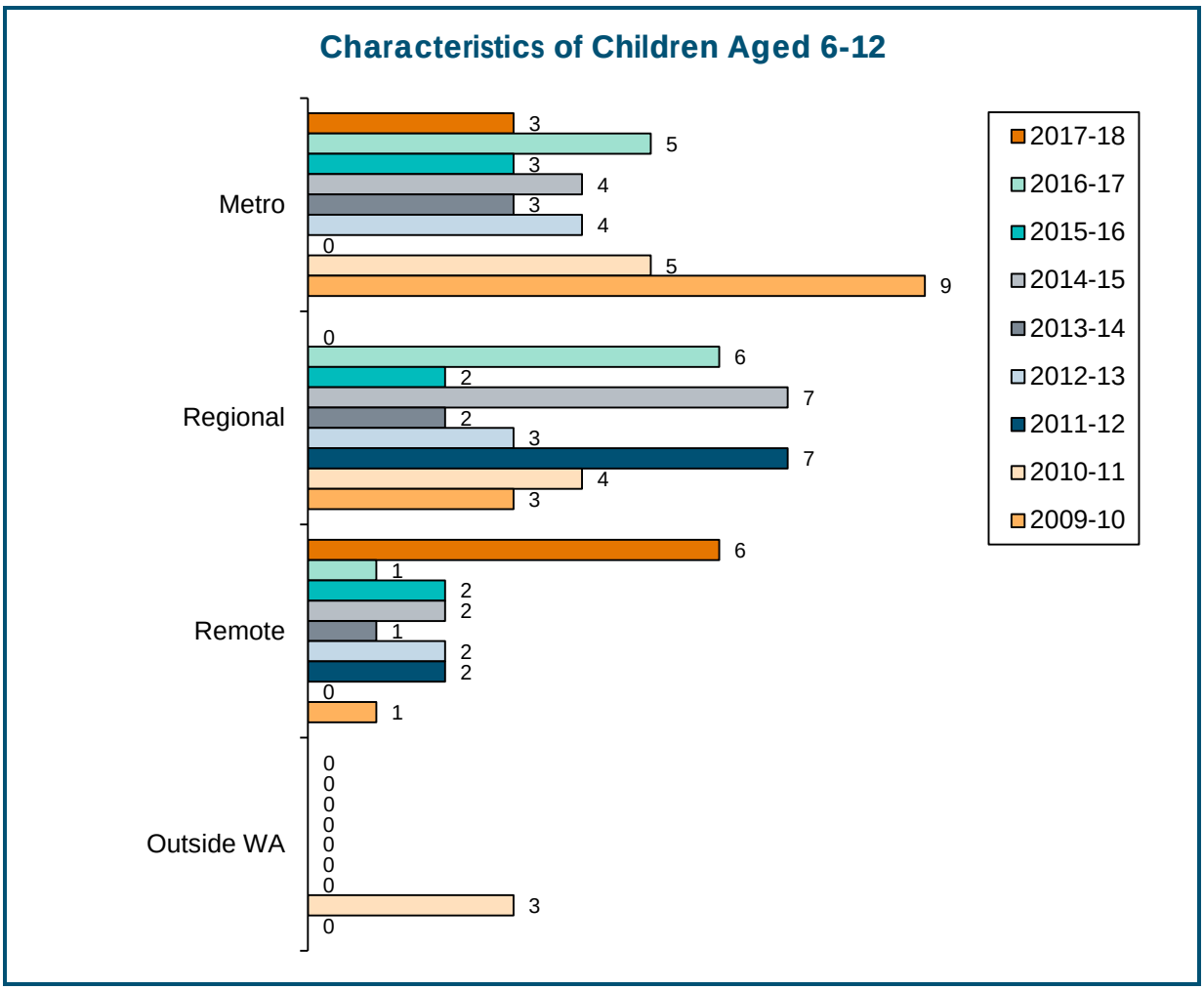
Fifty five deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of children aged 6 to 12 years

Of the 783 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2018, there were 90 (11%) related to children aged from 6 to 12 years.

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



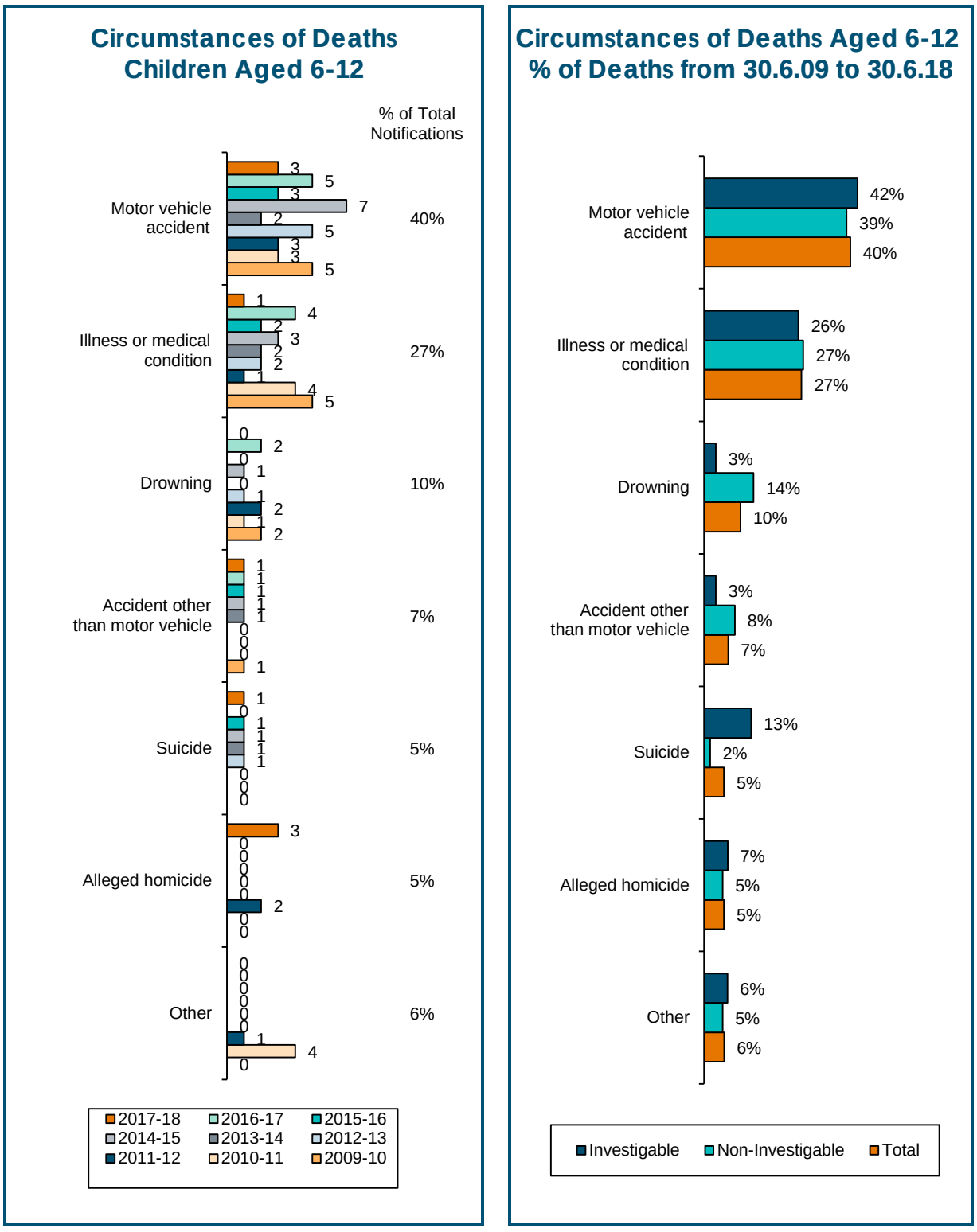


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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 75% 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 11% 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 50% 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 (40%), followed by illness or medical condition (27%) and drowning (10%).



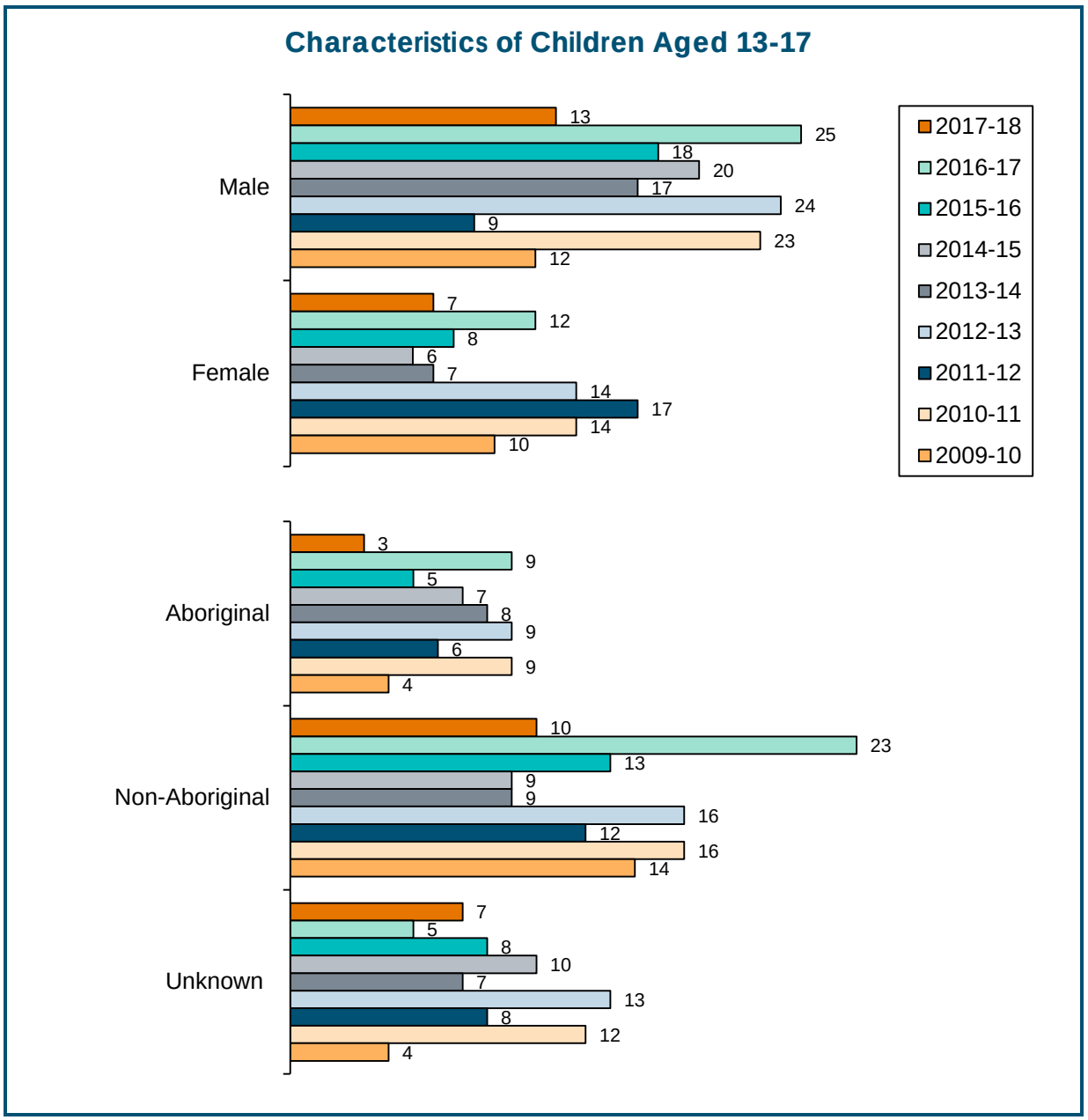
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

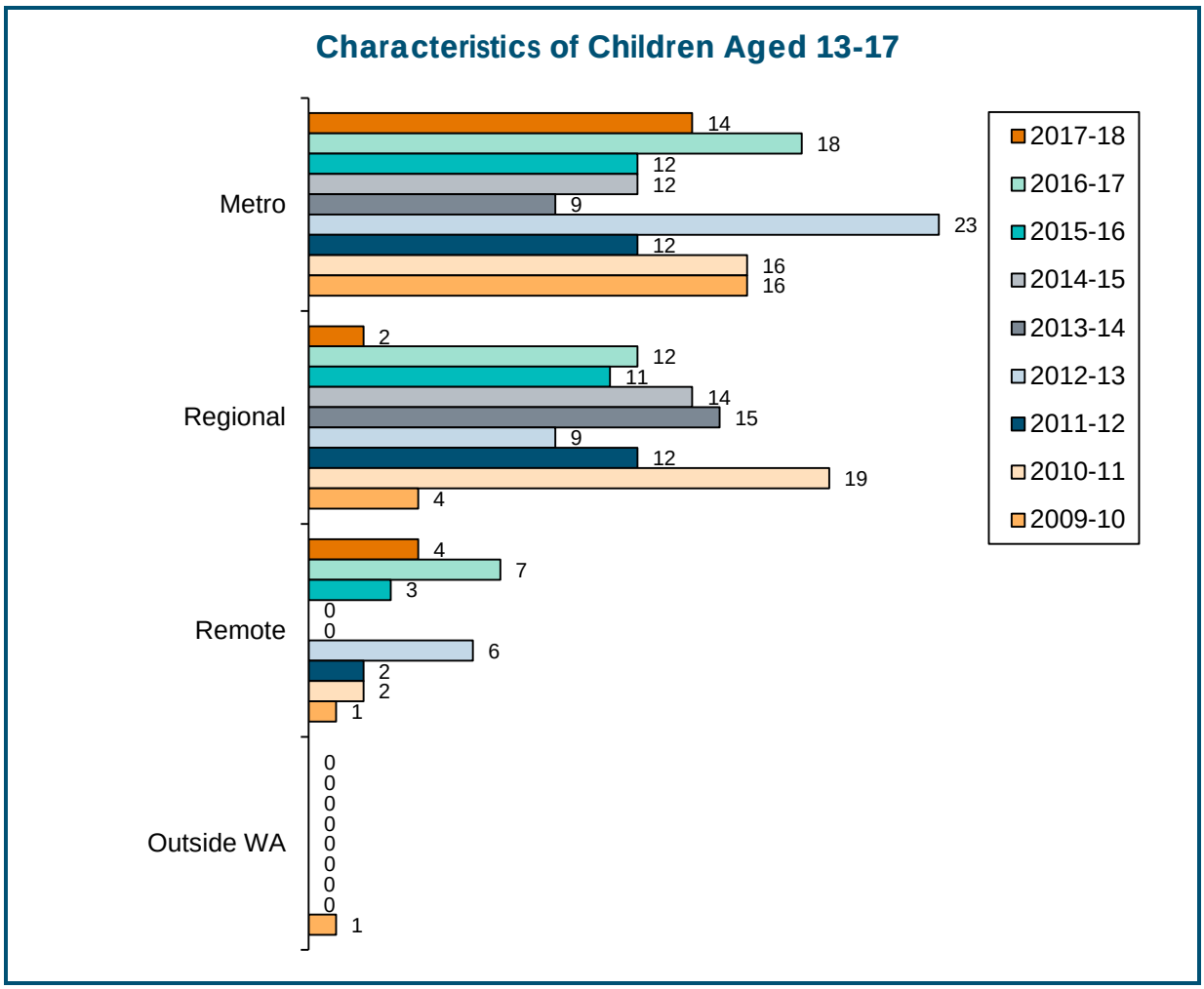
Thirty one deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of children aged 13 – 17 years

Of the 783 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2018, there were 256 (33%) related to children aged from 13 to 17 years.

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



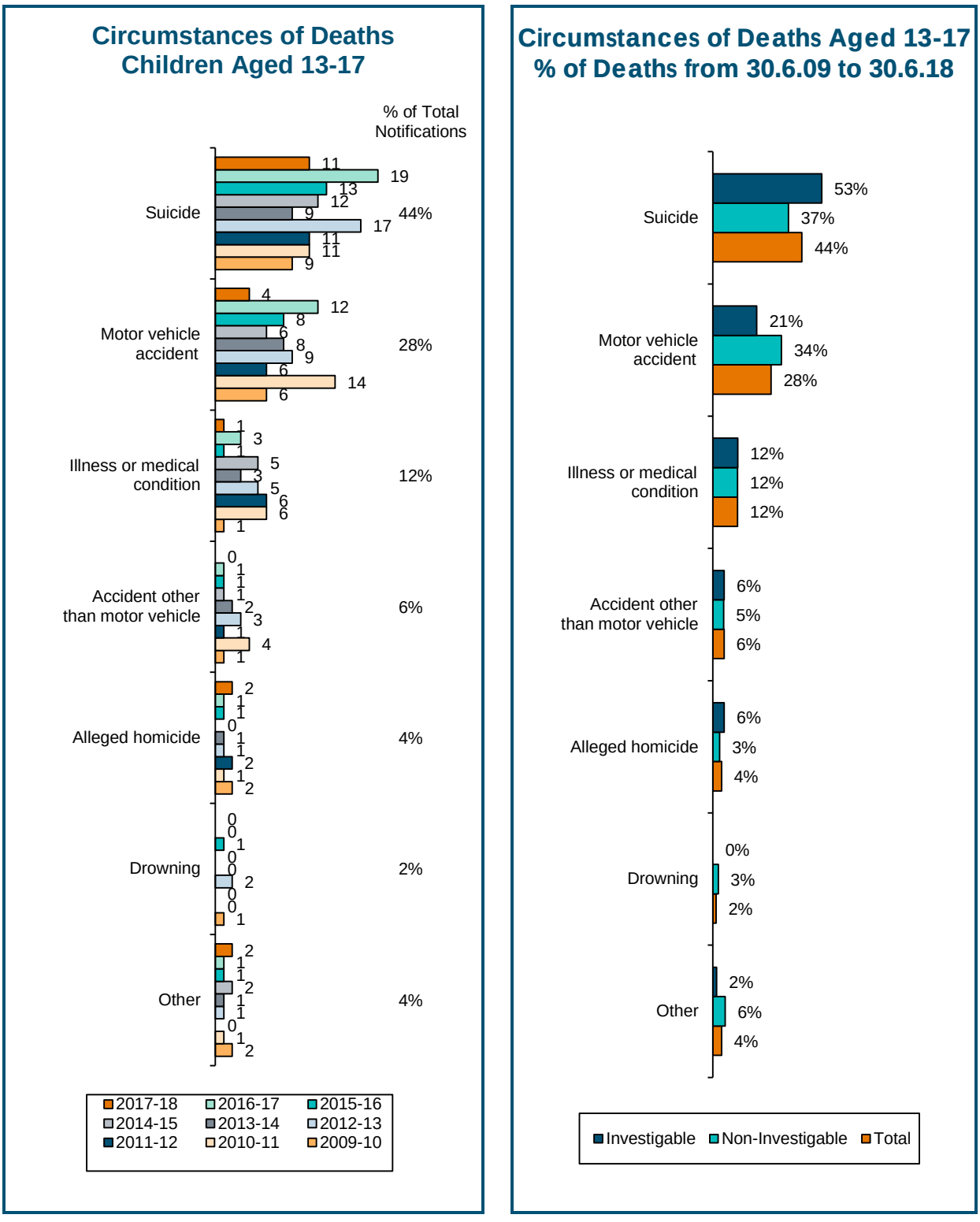


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 57% of investigable deaths and 67% of non-investigable deaths of children aged 13 to 17 were male compared to 51% in the child population;
- Aboriginal children – 52% of investigable deaths and 13% 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 – 59% 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 (44%), particularly for investigable deaths, followed by motor vehicle accidents (28%) and illness or medical condition (12%).



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.

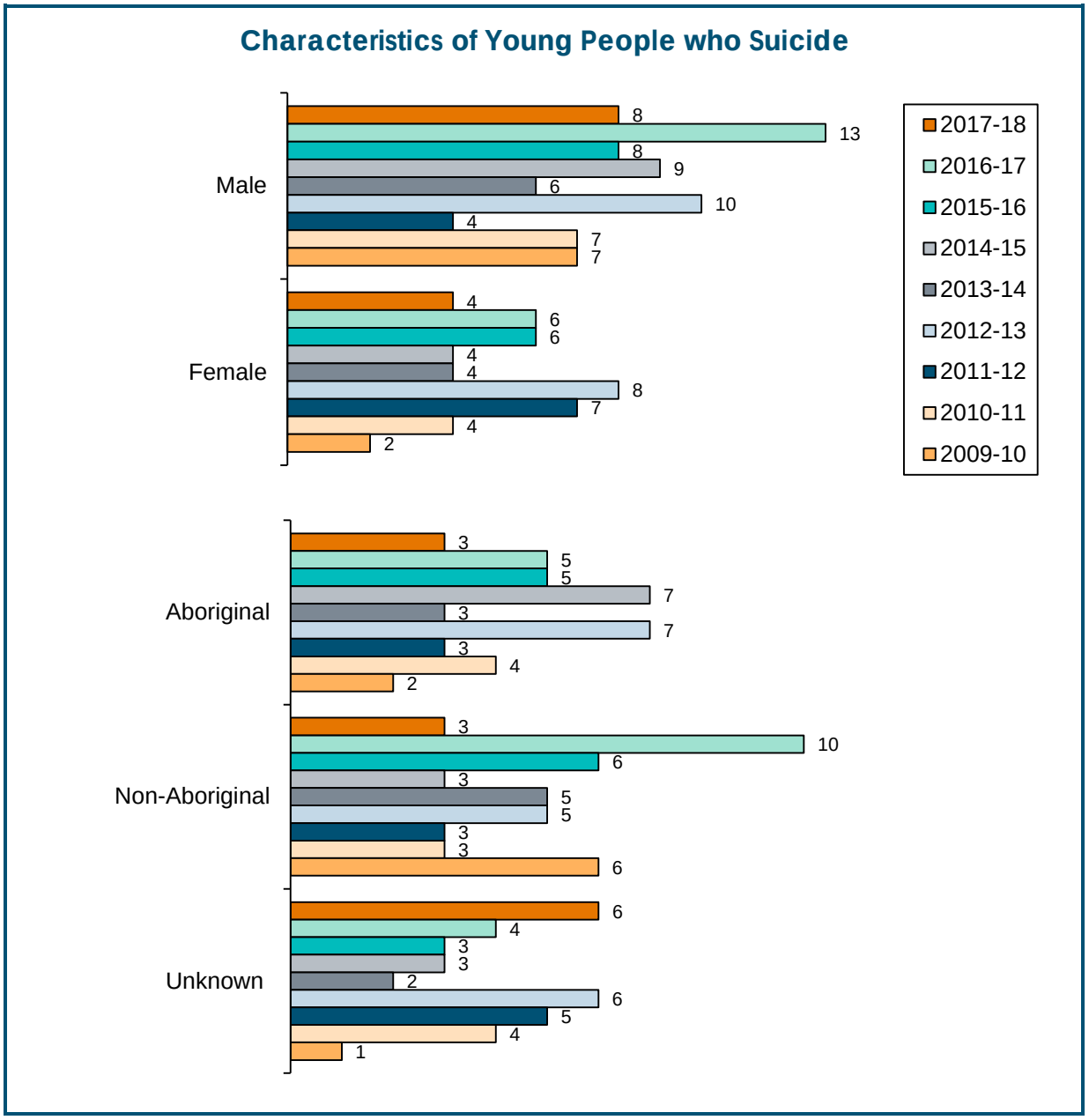
One hundred and seven deaths of children aged 13 to 17 years were determined to be investigable deaths.

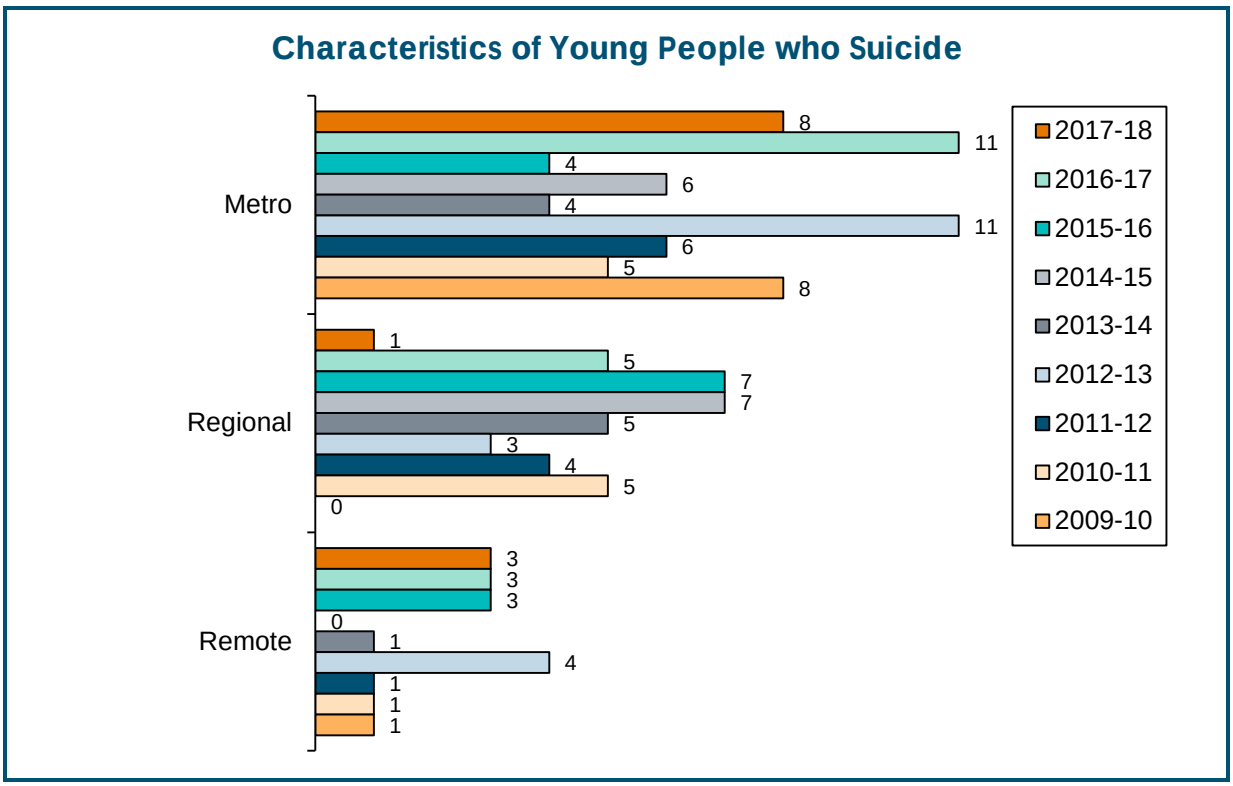
Suicide by young people

Of the 117 young people who apparently took their own lives from 30 June 2009 to 30 June 2018:

- Five were under 13 years old;
- Six were 13 years old;
- Eleven were 14 years old;
- Twenty six were 15 years old;
- Twenty nine were 16 years old; and
- Forty were 17 years old.

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





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

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

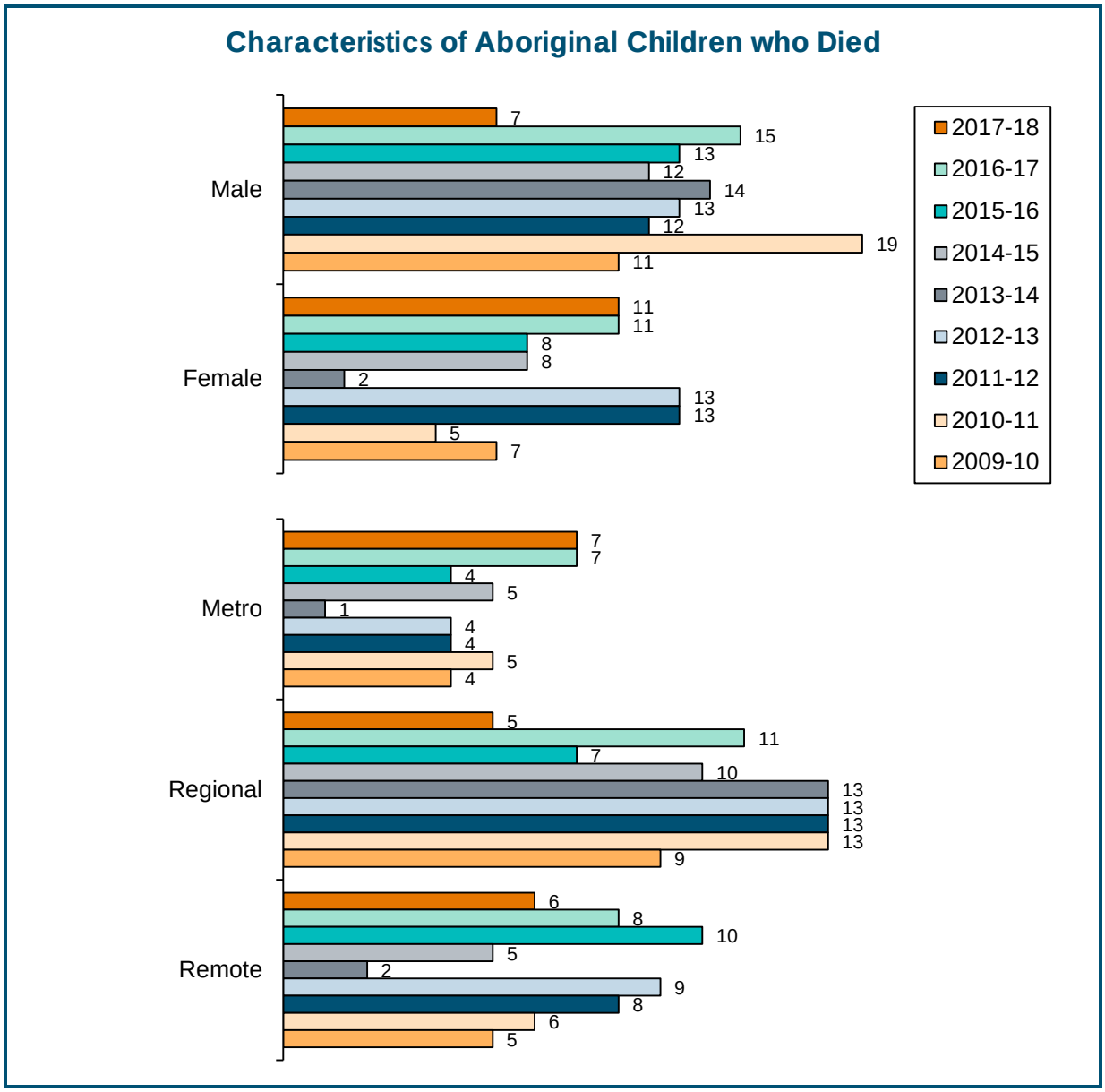
- Males – 52% of investigable deaths and 71% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 83 apparent suicides by young people where information on the Aboriginal status of the young person was available, 66% of the investigable deaths and 13% 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 61% of investigable suicides by young people and 30% 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

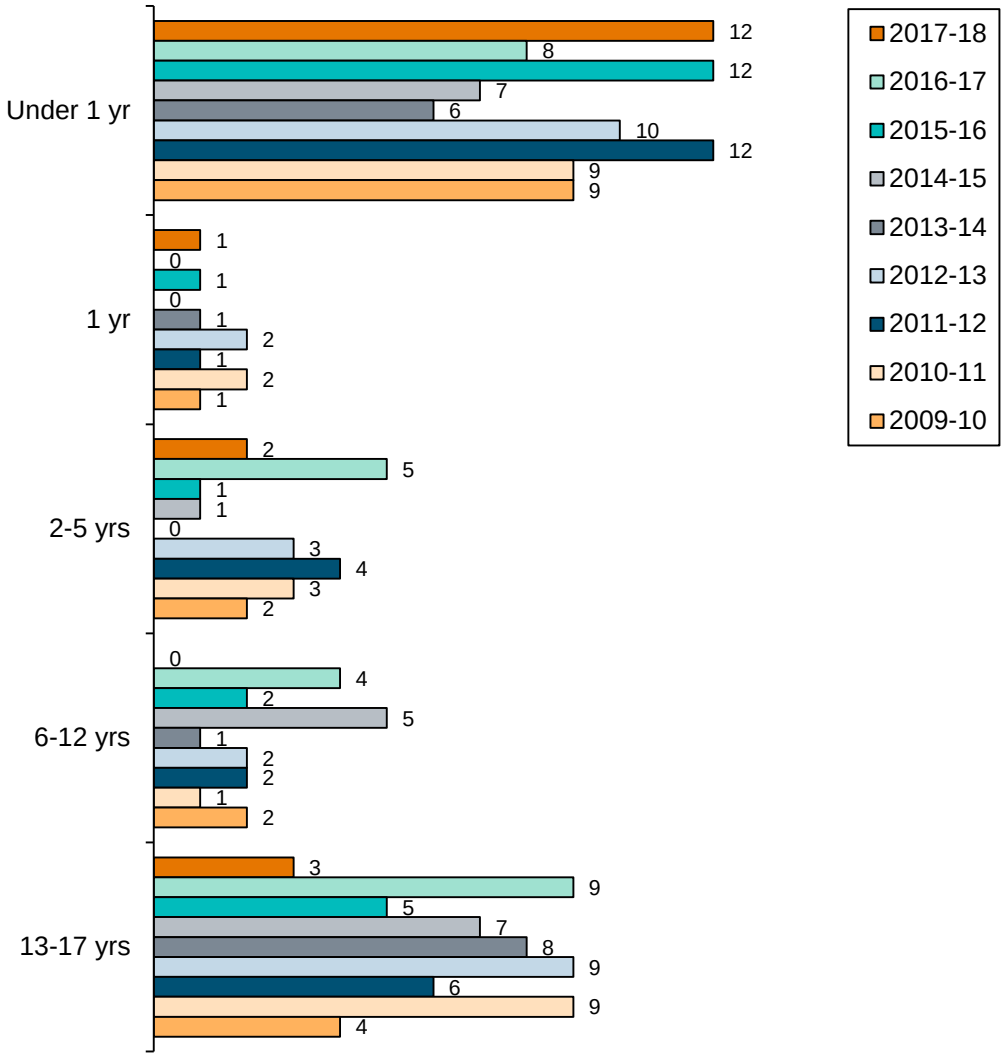
Of the 521 child death notifications received from 30 June 2009 to 30 June 2018, where the Aboriginal status of the child was known, 194 (37%) of the children were identified as Aboriginal.

For the notifications received, the following chart demonstrates:

- Over the nine year period from 30 June 2009 to 30 June 2018, the majority of Aboriginal children who died were male (60%). For 2017-18, 39% 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 nine year period, 79% of Aboriginal children who died lived in regional or remote communities.

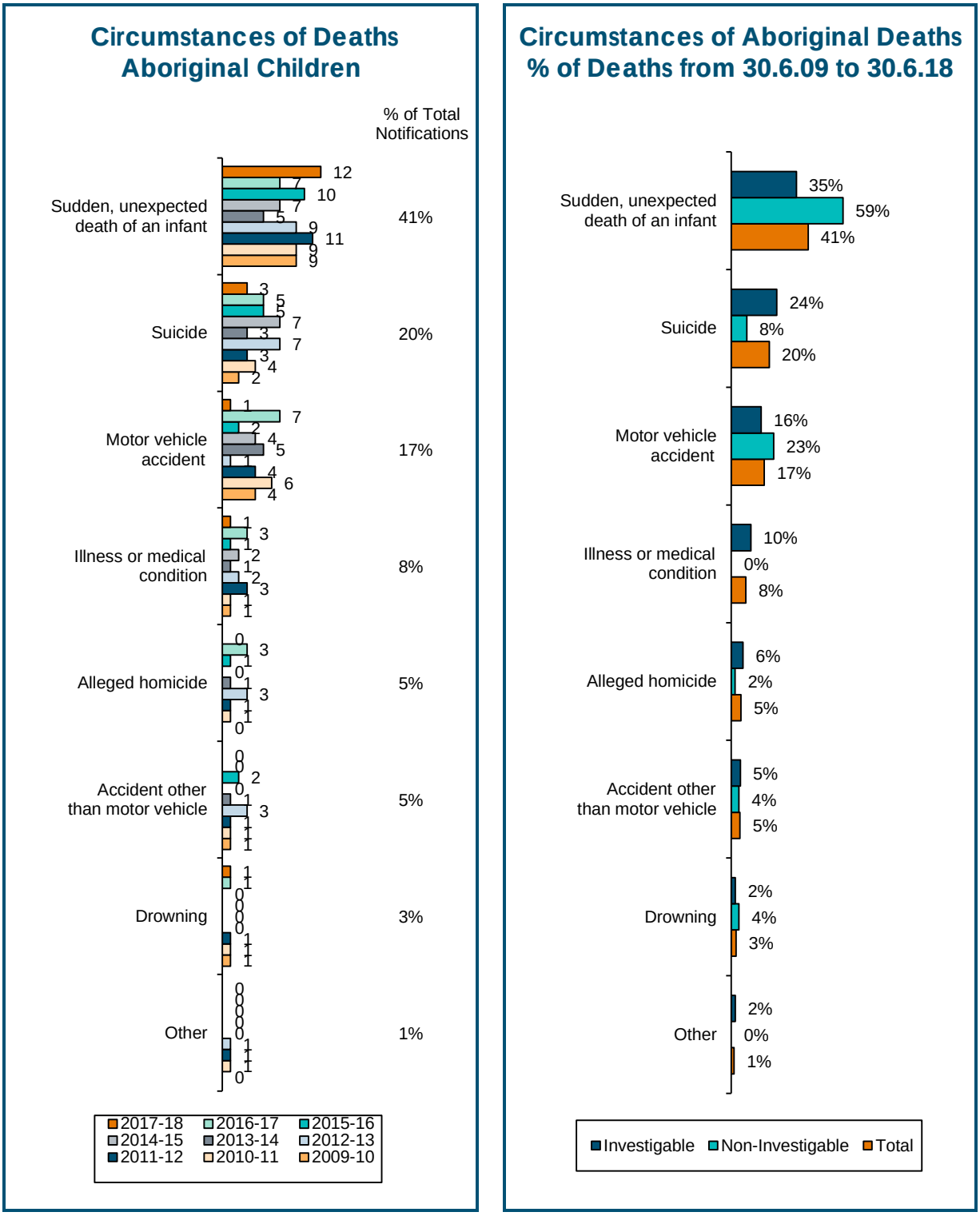


Characteristics of Aboriginal Children who Died



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 (41%), suicide (20%), and motor vehicle accidents (17%) are the largest circumstance of death categories for the 194 Aboriginal child death notifications received in the nine years from 30 June 2009 to 30 June 2018.



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.

LINKING RECOMMENDATIONS TO THEMES IDENTIFIED

During 2017-18, the Ombudsman made 19 recommendations in reviews of infant deaths, including two recommendations relating to the provision of safe infant sleeping information, two recommendations relating to undertaking pre-birth planning for the unborn child to promote their living circumstances at birth, two recommendations to improve intra-agency and inter-agency sharing of risk related information, and eight recommendations relating to timely assessment and safety planning to promote the infant's safety and wellbeing.

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. Communities considers the findings of this review in the circumstances of the current development and implementation of '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)*' and incorporates in the 'evidence based practice guidance' appropriate practice guidance associated with the investigation of infant injury, including in consultation with health services where medical review is indicated or has occurred.
2. Communities clarifies the requirements outlined in the *Casework Practice Manual* associated with the appropriate restriction of infants, not in the Chief Executive Officer's care, from being placed on the Monitored List.
3. Communities considers the findings of this review and whether mandatory safe infant sleeping training (such as completion of the Department of Health's *Safe Sleeping E-Learning Package*) is indicated to achieve informed compliance with Communities policy and practice requirements regarding provision of safe infant sleeping information as detailed in *Chapter 1.2 Safe infant sleeping* of the *Casework Practice Manual*.
4. Communities provides the Ombudsman with a report on actions taken to give effect to recommendations one to three, including a status report on the development and implementation of '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)*' within six months of the finalisation of this child death review.
5. The relevant WA Country Health Service (**WACHS**) Regional District considers the findings of this review to determine whether further action is required to ensure the appropriate:
    - Inclusion of all risk-relevant information in referrals to Communities from relevant WACHS Regional District maternity hospitals; and
    - Administration of the *Special Referral to Child Health Services* in accordance with *Operational Directive OD 0617/15* including the transfer of all risk-relevant information from relevant WACHS Regional District maternity hospitals to WACHS child health services.
6. WACHS considers the findings of this review to determine whether further action is required to ensure the appropriate implementation of a *Child Injury Surveillance Program* in all WACHS EDs that treat children in accordance with *Operational Directive OD 0606/15* and the associated *Guidelines for Protecting Children*.

Case Study *continued*

7. WACHS considers the findings of this review, including in collaboration with the Statewide Protection of Children Coordination Unit, to determine whether further action is required to ensure the appropriate administration of the *Guidelines for Protecting Children* by WACHS child health nurses in the circumstances of responding to infant injury and whether a *Child Injury Surveillance Program* equivalent, specific for WACHS child health services, is indicated.
8. WACHS provides a report to the Ombudsman within six months of the finalisation of this child death review outlining the results of WACHS consideration with respect to recommendations five to seven including a status report on the implementation of a *Child Injury Surveillance Program* in all WACHS EDs that treat children.

Deaths of children aged 1 to 5 years

Deaths from drowning

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

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

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

Further details of *Investigation into ways to prevent or reduce child deaths by drowning* are provided in the Own Motion Investigations and Administrative Improvement section.

Deaths of children aged 6 to 12 years

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

Case Study

Child B

Child B died in an accident, while playing without adult supervision. Following a review of Child B's death, the Ombudsman made the following recommendations:

1. Communities provides the Ombudsman within six months of the finalisation of this child death review:

    - An update on the review of the *Aboriginal Services and Practice Framework 2016-2018*, to include the status of progress of the 'strategies for change' documented in the Implementation Plan and how their effectiveness is being evaluated; and
    - Clarification of where Aboriginal leadership is placed in Communities' organisational structure, to lead the implementation of the *Aboriginal Services and Practice Framework 2016-2018* and Communities' responsibilities to promote the wellbeing of Aboriginal children and families as required by the *Children and Community Services Act 2004*.

2. The relevant DOE Regional School reviews its actions in this case, from a culturally informed perspective, to identify any learnings to guide its staff in promoting the attendance of Aboriginal students, particularly when there are multiple enrolled children from the same family with 'persistent student absence' and documented challenges impacting on attendance, and provides a report on the outcome to the Ombudsman within six months of the finalisation of this child death review.

Care planning for children in the CEO's care

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

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

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

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

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

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

Deaths of primary school aged children from motor vehicle accidents

In 2017-18, the Ombudsman received three notifications of the deaths of children aged six to 12 years in the circumstances of motor vehicle accidents. Two out of the three 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 44% 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 2017-18, 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 2018.

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.

Issues Identified in Child Death Reviews

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

It is important to note that:

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

- Not undertaking sufficient inter-agency communication to enable effective case management and collaborative responses.
- Not including sufficient cultural consideration in child protection assessment, planning and intervention.
- Missed opportunities to improve agency culturally informed practice and provide cultural leadership.
- 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.
- Not adequately administering the Monitored List in accordance with policies and procedures.
- Not assessing infant injury in accordance with the *Guidelines for Protecting Children, Child Injury Surveillance Program*.

- Missed opportunities to promote infant safe sleeping by providing appropriate information.
- 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.
- Not adequately meeting policy and procedures relating to the assessment of parental mental health, to provide support to the parenting capacity.
- Not adequately meeting policies and procedures relating to the assessment of alleged physical abuse and neglect.
- Not adequately meeting policy and procedures to address poor school attendance.
- Missed opportunity to identify child wellbeing concerns associated with poor school attendance.
- Not including sufficient cultural consideration in addressing poor school attendance.
- Missed opportunity to adopt a trauma informed approach and to assess cumulative harm to address factors associated with suicide risk.
- Missed opportunities to recognise and respond to child and adolescent drug and alcohol use.
- Not adequately meeting policies and procedures relating to the provision of staff supervision and governance processes in approving Safety and Wellbeing Assessments and safety planning.
- 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 2017-18 arising from child death reviews (certain recommendations may be de-identified to ensure confidentiality).

1. As Communities implements the 'consistent intake' process, as set out in the Organisational Reform Briefing, Communities considers, in view of the findings of this child death review and Recommendation 1 [*Annual Report 2016-17*] arising from this office's review of the death of [Infant A], whether any further steps are required to ensure this 'consistent intake' process appropriately responds to hospital social worker referrals regarding infant safety and wellbeing concerns and supports interagency communication and collaboration.

2. Communities assists the relevant Communities Metropolitan District to develop and implement an action plan to:

    - Address the ‘areas of learning opportunities requiring further consideration’ listed in Communities’ response; and

- Identify and address factors adversely impacting upon compliance with Communities' practice requirements related to assessment and investigation processes, safety planning and use of the *Signs of Safety Child Protection Practice Framework* when administering Communities' legislative responsibilities associated with determining whether a child is in need of protection and/or whether action is warranted to safeguard a child's wellbeing.

3. Communities evaluates the Standards Monitoring Unit processes to determine whether further action is required in response to the receipt of Required Action progress reports to ensure that timely and appropriate action is undertaken by Communities Districts to sustainably address the issues identified by the Standards Monitoring Unit and improve compliance with Communities' legislative responsibilities, Standards and practice requirements.

4. Communities provides a report to the Ombudsman within six months of the finalisation of this child death review outlining actions taken by the Department to give effect to recommendations 2 and 3.

5. Communities provides a report to the Ombudsman, within six months of the finalisation of this child death review, outlining the steps taken by the relevant Communities Metropolitan District to address the six 'areas and learning opportunities' as identified in Communities' response.

6. Communities takes steps to reiterate to its staff the practice requirements in Communities' *Casework Practice Manual* Chapter 1.2 *Family Support and Earlier Intervention*, *Safe infant sleeping*, and ensure staff are aware that these practice requirements are supplementary to the responsibilities of health service providers in informing parents and caregivers of safe infant sleeping information.

7. Communities provides the Ombudsman within six months of the finalisation of this child death review:

   - An update on the review of the *Aboriginal Services and Practice Framework 2016-2018*, to include the status of progress of the 'strategies for change' documented in the Implementation Plan and how their effectiveness is being evaluated; and

   - Clarification of where Aboriginal leadership is placed in Communities' organisational structure, to lead the implementation of the *Aboriginal Services and Practice Framework 2016-2018* and Communities' responsibilities to promote the wellbeing of Aboriginal children and families as required by the *Children and Community Services Act 2004*.

8. The relevant DOE Regional School reviews its actions in this case, from a culturally informed perspective, to identify any learnings to guide its staff in promoting the attendance of Aboriginal students, particularly when there are multiple enrolled children from the same family with 'persistent student absence' and documented challenges impacting on attendance, and provides a report on the outcome to the Ombudsman by [nominated date].

9. The relevant Communities Regional District considers the findings of the Ombudsman's child death reviews of [Child B] and [Child C] to determine if any action is required to ensure that where Communities receives reports of concern for a child/or subset of children of a family group, that the safety and wellbeing of

all children of that family group are considered in initial inquires or Safety and Wellbeing Assessments.

10. Communities takes all necessary steps to ensure that administrative processes associated with the completion of Safety and Wellbeing Assessments do not restrict the capacity of Communities in considering the safety and wellbeing of all the children in a family group.

11. Communities provides an outline of the actions taken to address the challenges outlined in the Communities' response.

12. Communities provides the Ombudsman with a report within six months of the finalisation of this child death review on actions taken to give effect to recommendations 9, 10 and 11.

13. The relevant DOE Regional School reviews its actions in this case, from a culturally informed perspective, to identify any learnings to guide its staff in promoting the attendance of Aboriginal students, particularly when there are multiple enrolled children from the same family with 'persistent student absence' and documented challenges impacting on attendance, and provides a report on the outcome to the Ombudsman by [nominated date].

14. Communities considers the findings of this child death review in the development of strategies associated with the implementation of the proposed revised *Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby Is Identified as at Risk of Abuse and/or Neglec*t to ensure that pre-birth safety planning is commenced by Communities where indicated in accordance with Chapter 2.2 *Assessment and Investigation Processes* of the *Casework Practice Manual*.

15. Communities provides the Ombudsman with a copy of the report arising from the Communities 2017 analysis of pre-birth safety planning by [nominated date] and an outline of Communities' plans for the ongoing implementation and evaluation of pre-birth safety planning.

16. Communities provides the Ombudsman an outline of Communities' plans to address the issues identified by the Australian Centre for Child Protection in the 'Signs of Safety Reloaded Project Phase Two'.

17. Communities clarifies the requirements outlined in the *Casework Practice Manual* associated with the appropriate restriction of infants, not in the Chief Executive Officer's care, from being placed on the Monitored List.

18. Communities provides the Ombudsman with a report on actions taken to give effect to recommendations 14, 15, 16 and 17, by [a nominated date] including a status report on the implementation of the revised *Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby Is Identified as at Risk of Abuse and/or Neglect* and 'Signs of Safety Reloaded Project Phase Two'.

19. The relevant WACHS Regional District considers the findings of this review to determine whether further action is required to ensure the appropriate:

    - Inclusion of all risk-relevant information in referrals to Communities from relevant WACHS Regional District maternity hospitals; and

- Administration of the *Special Referral to Child Health Services* in accordance with Operational Directive OD 0617/15 including the transfer of all risk-relevant information from relevant WACHS Regional District maternity hospitals to WACHS child health services.

20. WACHS considers the findings of this review to determine whether further action is required to ensure the appropriate implementation of a *Child Injury Surveillance Program* in all WACHS Emergency Departments that treat children in accordance with Operational Directive OD 0606/15 and the associated *Guidelines for Protecting Children*.

21. WACHS provides a report to the Ombudsman within six months of the finalisation of this child death review outlining the results of WACHS consideration with respect to recommendations 19 and 20 including a status report on the implementation of a *Child Injury Surveillance Program* in all WACHS Emergency Departments that treat children.

22. Communities considers the findings of this review in the circumstances of the current development and implementation of '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)*' and incorporates in the 'evidence based practice guidance' appropriate practice guidance associated with the investigation of infant injury, including in consultation with health services where medical review is indicated or has occurred.

23. Communities clarifies the requirements outlined in the *Casework Practice Manual* associated with the appropriate restriction of infants, not in the Chief Executive Officer's care, from being placed on the Monitored List.

24. Communities considers the findings of this review and whether mandatory safe infant sleeping training (such as completion of the Department of Health's *Safe Sleeping E-Learning Package*) is indicated to achieve informed compliance with Communities policy and practice requirements regarding provision of safe infant sleeping information as detailed in Chapter 1.2 *Safe infant sleeping* of the *Casework Practice Manual*.

25. Communities provides the Ombudsman with a report on actions taken to give effect to recommendations 22, 23 and 24, including a status report on the development and implementation of '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)*' within six months of the finalisation of this child death review.

26. The relevant WACHS Regional District considers the findings of this review to determine whether further action is required to ensure the appropriate: inclusion of all risk-relevant information in referrals to Communities from relevant WACHS Regional District maternity hospitals; and administration of the *Special Referral to Child Health Services* in accordance with Operational Directive OD 0617/15 including the transfer of all risk-relevant information from relevant WACHS Regional District maternity hospitals to WACHS child health services.

27. WACHS considers the findings of this review to determine whether further action is required to ensure the appropriate implementation of a *Child Injury Surveillance Program* in all WACHS Emergency Departments that treat children in accordance with Operational Directive OD 0606/15 and the associated *Guidelines for Protecting Children*.

28. WACHS considers the findings of this review, including in collaboration with the Statewide Protection of Children Coordination Unit, to determine whether further action is required to ensure the appropriate administration of the *Guidelines for Protecting Children* by WACHS child health nurses in the circumstances of responding to infant injury and whether a *Child Injury Surveillance Program* equivalent, specific for WACHS child health services, is indicated.

29. WACHS provides a report to the Ombudsman within six months of the finalisation of this child death review outlining the results of WACHS consideration with respect to recommendations 26, 27 and 28, including a status report on the implementation of a *Child Injury Surveillance Program* in all WACHS Emergency Departments that treat children.

30. That Communities, in developing the *Action Plan for At Risk Youth* and any action plan associated with the *Western Australian Alcohol and Drug Interagency Strategy 2017-2021*, considers whether there is a need for developing detailed guidelines for undertaking assessment when children and young people are identified as using alcohol and/or drugs, and guidelines for developing associated safety plans and treatment referrals.

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 19 recommendations about ways to prevent or reduce child deaths in 2015-16. The Office has requested that the relevant public authorities[1] 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.

[1] In this section, Department refers to, prior to 1 July 2017, the Department for Child Protection and Family Support, and subsequent to 1 July 2017, Communities.

Recommendation 1: That the Department takes all reasonable steps to achieve timely compliance with the Department's assessment policies and practice requirements in implementing and monitoring safety planning to promote the wellbeing of an unborn child/infant.

Steps taken to give effect to the recommendation

The Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 17 May 2017, containing a report prepared by the Department (**the Department's 2017 report**). Additional information was provided by the Department on 19 July 2018, containing a report prepared by the Department (**the Department's 2018 report**).

In the Department's 2018 report, the Department relevantly informed the Office that:

> **High Risk Infant – *Casework Practice Manual***
>
> The Department continues to focus on case practice and strategies to improve Signs of Safety Pre-birth planning and assessment with consideration of enhanced practice guidelines, additional monitoring and data analysis, and promoting learning, development of staff.
>
> The *Casework Practice Manual* will include an entry titled 'High Risk Infant' to guide departmental staff to respond to the specific considerations of infants within a child protection context. The *Casework Practice Manual* entry has been drafted and is due to be discussed with Perth Children's Hospital in early August 2018, following which time it will be considered by the Department's Joint Service Delivery Management Meeting to update the *Casework Practice Manual*.
>
> The new High Risk Infant *Casework Practice Manual* entry will incorporate risk factors for infants including Safe Sleeping practices. The Department is due to meet with the Perth Children's Hospital in early August 2018, to finalise information to be published in the *Casework Practice Manual*.
>
> The practice requirements of the High Risk Infant *Casework Practice Manual* entry will be incorporated into the Department's compulsory Orientation training program 1 and 3, once finalised.
>
> **Bilateral Schedule – Interagency Collaborative Processes when an Unborn or Newborn Baby is identified as at risk of abuse and/or neglect (2013)**
>
> In December 2017 the Professional Practice Unit (formerly known as Service Delivery and Practice Unit) completed a report titled, Interagency Pre-Birth Protocol Position Paper ('the paper'). The purpose of the paper was to review the history and current process regarding the facilitation of Pre-birth planning meetings and provide recommendations on how the current process can be improved.
>
> The recommendations include managing an increased demand for Pre-birth planning, skilful and consistent facilitation of Pre-birth meetings, recording and data collection.
>
> The implementation of recommendations are ongoing, due completion at the end of August 2018. The process includes consultation with key stakeholders including the Department of Health, various Aboriginal health organisations, Aboriginal Legal Service, Aboriginal Family Law Service and others.
>
> The Bilateral Schedule (the Schedule) between the Department and the Department of Health remains subject to review. It was envisaged that an updated Schedule will

be approved and operation by mid-2018 however the review process has been impacted by the machinery of government changes.

The existing Schedule remains fully functional, pending the outcome of the joint review. In line with the Schedule, local protocols have been developed in conjunction with external agencies (maternity hospitals and Aboriginal health services), to improve local strategies to respond to unborn or newborn children.

Signs of Safety Reloaded – Knowledge Bank

To promote excellence in practice and to best assist workers to view completed work in Signs of Safety, a collection of completed work has been compiled on line in the Knowledge Bank.

The Knowledge Bank is a contribution from districts of exemplary work, quality assured by the Professional Practice Unit. Additional context and reflections are included for each piece of work under the following headings, noting those highlighted that support the Ombudsman recommendation;

- **Best Beginnings Plus**
- Cultural Tools
- Danger Statements
- Family Finding
- Harm Statements
- **Mappings**
- Parent Support
- Safe and Together Model
- Safety Goals
- **Safety Plans**
- Trajectories
- Words and Pictures.

The website has been completed. Documents to be included in the Knowledge Bank website continue to be gathered and quality assured. The Knowledge Bank is due to 'go live' on 23 July 2018. A Communication strategy will be implemented at this time to ensure that workers are aware of the Knowledge Bank and its purpose.

Signs of Safety Reloaded – Capability Matrix

The Capability Matrix (the Matrix) focuses on child protection workers attitudes, behaviours, skill and knowledge in regards to Signs of Safety child protection practice. The Matrix will support the continuous improvement through case practice guidance, learning and development strategies and quality assurance in Signs of Safety practice application to achieve greater consistency with staff, children, parents including their networks and stakeholders. Furthermore, the capability matrixes will support self-reflection and supervision processes for staff.

The Matrix is due to be available for caseworkers, team leaders and management by 31 August 2018.

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

Recommendation 2: That the Department undertakes a home visit, where appropriate and possible, to assess infant sleeping arrangements and provide parents with safe infant sleeping information, in accordance with the Department's *Casework Practice Manual*, *Chapter 3.2 Safe Infant Sleeping* [Chapter 1.2 at July 2018], when working with parents who smoke tobacco or are alleged to have a history of alcohol or drug abuse or illegal drug use is alleged to be occurring currently.

Steps taken to give effect to the recommendation

The Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 17 May 2017, containing a report prepared by the Department. Additional information was provided by the Department on 19 July 2018, containing a second report prepared by the Department.

In the Department's 2017 report, the Department relevantly informed the Office that:

> Practice requirements outlined in the *Casework Practice Manual* Chapter 3.2 [Chapter 1.2 at July 2018] include resources, guidelines and tools to reflect Health's Safe Infant Sleeping statement/framework.

The Department provided a copy of Chapter 3.2, with the following paragraph highlighted:

> When working with a family with an infant, child protection workers and Best Beginnings home visitors advise about co-sleeping and factors that increase or reduce this risk. Child protection workers and Best Beginnings home visitors must do this in the first four weeks of the baby's birth (where involved), and, where appropriate, provide information and the following resources:
>
> - Women and Newborn Health Service of WA: Safe Infant Sleeping Information for Parents, Carers and Families
> - SIDS and Kids WA: Reducing the Risk of SUDI in Aboriginal Communities
> - SIDS and Kids webpage: Safe Sleeping in Other Languages, and
> - Quitnow webpage: Pregnancy and Quitting for information on:
>   - the impact of smoking during pregnancy
>   - the effects of second-hand smoke on infants, and
>   - smoking and SIDS.

In the Department's 2018 report, the Department relevantly informed the Office that:

> ***Casework Practice Manual***
>
> The *Casework Practice Manual* has been modified with new chapter references and entries ensuring cross referencing of 'Safe Infant Sleep', throughout Chapter 1, prompting workers for a specific response to this significant risk factor.
>
> - 1.2 Family Support and Earlier Intervention
> - 1.2.2 Best Beginnings Plus
> - 1.4 Mental Health and Alcohol and Other Drugs
>
> Additional related resources are also included and cross referenced.

Learning and Development/Training

Infant, Child and Family Mental Wellbeing

Participants learn to observe infants and young children in interaction with their parents to inform assessment and to plan appropriate supportive interventions.

The online program aims to reduce the risk of sudden unexpected deaths in infants, including the risk that can occur when babies co-sleep. It provides professionals working with families with infants, current evidence based information on safe sleeping practices.

All Best Beginnings officers are required to complete this package. It is also recommended for child protection workers engaging with families and infants.

The training provides links to Safe Sleeping Pamphlets, the Review of Safe Infant Sleeping Policy and Framework 2013, access to the website for newborn and child health website (Department of Health) and to view the safe infant sleeping website.

The Learning outcomes are:

- Develop an understanding of safe sleeping practices.
- Recommend and ensure the safest possible environment for mothers and babies.
- Reduce the risk of sudden unexpected infant death associated with co-sleeping.
- Provide parents with adequate information to make an informed decision.
- Understand and show sensitivity to the emotional, cultural and physical needs of the mother and her family.

Safe Sleeping

The module was developed in 2013 by SIDS and KIDS and WA Health and includes information on background, risks, benefits, cultural considerations and harm minimisation.

Alcohol and Other Drugs

Provides a fundamental understanding of the issues associated with problematic Alcohol and Other Drug (**AOD**) Use. Topics include drug use in perspective, models of alcohol and drug use, drug classification, intoxication and withdrawal effects, responding to drug overdose, AOD agencies and services. Information and learnings promote further consideration of the impact of substance misuse with regards to the impact of children, including the newborn.

In March 2017, Learning and Development Unit provided a one day training, 'Recognising and Responding to Amphetamine Intoxication/Toxicity and Opioid Overdose' delivered by the Mental Health Organisation.

It is noted that the Department has taken steps to improve training relating to safe infant sleeping, and that the relevant sections of the Department's *Casework Practice Manual* outline when safe infant sleeping information must be provided, and that it is anticipated that 'Best Beginning home visitors' can provide safe infant sleeping information while undertaking a 'home visit'.

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

Recommendation 3: That the Department considers, in accordance with the definition of 'at risk' youth as outlined in the *At Risk Youth Strategy 2015-2018*, the development of guidelines to recognise alleged alcohol and drug use by children and adolescents as an indicator of cumulative safety and wellbeing concerns warranting assessment and action where appropriate.

Steps taken to give effect to the recommendation

The Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 17 May 2017, containing a report prepared by the Department.

In the Department's 2017 report, the Department relevantly informed the Office that:

> Updated practice requirement [now Chapter 2.2 *Assessment and Investigation, Assessment and investigation processes*], of the *Casework Practice Manual:*
>
> Where a young person's alcohol and drug use has been reported to the Department as a safety and wellbeing concern, the duty officer should look at the behaviour in the context of the young person's circumstances as a whole. Where drug and alcohol use co-exists with other issues such as isolation, disengagement from education, family and domestic violence and/or other youth at-risk issues, these should be considered as part of the assessment. In addition, a referral to Parent Support should be considered.

It is noted that Recommendation 3 required the Department to consider the development of guidelines to recognise alleged alcohol and drug use by children and adolescents as an indicator of cumulative safety and wellbeing concerns warranting assessment and action where appropriate. The Department's response indicates that, at the time of the response, the development of such guidelines was not intended. The updated practice requirement directs, where 'a young person's alcohol and drug use has been reported' that this issue 'should be considered as part of the assessment'.

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

Recommendation 4: That the Department takes all reasonable steps to recognise where poor school attendance may be a cumulative indicator of child safety and wellbeing concerns.

Steps taken to give effect to the recommendation

The Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 17 May 2017, containing a report prepared by the Department.

In the Department's 2017 report, the Department relevantly informed the Office that:

> Education is an area covered in the Signs of Safety Prompts for neglect.

This Office reviewed the *Signs of Safety Prompts for neglect* which, under the heading of 'education' states:

- Does the child attend school?
- What age appropriate educational stimulation does the child receive?
- Are the parents interested in the child's schooling?

The Office also considered the Department:

- *Casework Practice Manual Chapter 1.1 At Risk Youth*; and
- *At Risk Youth Strategy 2015-18*.

Chapter 1.1 states, consistent with the *At Risk Youth Strategy 2015-18*:

> 'At risk' can mean:
>
> - Behavioural indicators - truancy, emotionally unstable, disruptive behaviour, displaying suicidal intent or self-harm, antisocial behaviour, violent or aggressive in the community, social isolation, juvenile offending, vandalism, drug and/or alcohol abuse, rejecting parental support, low self-esteem, lack of social and communication skills
> - Situational indicators - unemployed, homeless, socially disadvantaged, family and domestic violence, alcohol and other drug use in the home, family breakdown, transient families, lower socio-economic families, abused children, and
> - Educational indicators – underachieving academically, not coping in classroom situations, poor literacy and numeracy skills, suspended from school or excluded.

Chapter 1.1 and the *At Risk Youth Strategy* identifies that poor school attendance and associated poor academic performance can indicate 'risk' to a young person's safety and wellbeing. It is noted that current Department policy identifies poor school attendance and/or academic performance may indicate child wellbeing risk.

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

Recommendation 5: That the Department continues to improve interagency communication and collaboration associated with the management of the Department of Education's (DOE) *Students Whose Whereabouts is Unknown list* (SWU List) in the context of child safety and wellbeing concerns.

Steps taken to give effect to the recommendation

The Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 17 May 2017, containing a report prepared by the Department. Additional information was provided by the Department on 19 July 2018, containing a second report prepared by the Department .

In the Department's 2017 report, the Department relevantly informed the Office that:

> The Department focusses on those children on the *Student's Whose Whereabouts is Unknown List* (SWU) for whom it has guardianship responsibility.
>
> The SWU list is matched against children in care in week five of each academic/school term in accordance with the Memorandum of Understanding (**MOU**) with DOE/ the Department.
>
> The Department's Principal Education Officer and Student Tracking Coordinator meet

in week six of each academic/school term.

The Department's Principal Education Officer sends a courtesy email to the child's case manager, Assistant District Director and district Education Officer to enquire as to why the child is not attending the school, and where possible provide updated information to DOE (i.e. child changed enrolment to private school and original school not notified).

The Department and DOE have been rolling out Collaborative Practice/MOU key messages workshops over the last three years (and continuing into the future). These workshops place the Department and local school principals in the same room. They provide an opportunity for the Department to provide detail to schools about child protection processes as well as an opportunity to consider and plan for how at risk children are responded to by each agency.

In the Department's 2018 report, the Department relevantly informed the Office that:

Joint Meeting – Department of Education (DoE) and Department of Communities Students Whose Whereabouts are Unknown

- The joint meeting between Departments focusses on those children on the *Student's Whose Whereabouts is Unknown List* (the list) who are in the care of the CEO of the Department. The meeting looks at each matched child and the reasons for their non-engagement and/or possible engagement in alternative mainstream options.

- The Department's Principal Education Officer and Student Tracking Coordinator from DoE meet four times a year, in week six of each academic/school term. The meeting looks at process (for example removing a child in care that is engaged in alternative to mainstream education from the SWU list) and reasons for non-attendance – such as children becoming parents or severe mental health concerns.

- When schools identify additional concerns for the safety and wellbeing of a child they can refer to the Department, in accordance with the Reciprocal Memorandum of Understanding that exists between Departments to respond to child protection concerns.

- Where poor or non-school attendance is an indicator of child safety and wellbeing concerns, it is assessed by the Department within the investigation of neglect/child protection concerns. Schools can also engage their local Regional Education Offices to consider attendance interventions such as Assessment Panels.

- The Department's Principal Education Officer remains available to district Education Officers and case management teams to provide additional advice and support for those children in the care of the CEO, who are not attending school, usually due to very complex reasons. Specialist programs for educationally at risk students, intervention programs for older students, such as the Participation Program and tutoring, and other support services such as occupational therapy, are incorporated into individual Education Plans.

- The Department and DoE have maintained Collaborative Practice/MOU key messages workshops over the last three years (and continuing into the future). These workshops provide the opportunities for agencies to work together at a local level. They provide an opportunity for the Department to provide detail to schools about child protection processes as well as an opportunity to consider and plan for how at risk children are responded to by each agency.

Children at Risk/Youth at Risk Meetings

Districts convene 'Children at Risk Meetings' and 'Youth at Risk Meetings' that invite local key stakeholders, including DoE, to contribute information to assist in the identification of children considered at risk in the community. These local forums provide additional contextual information to assist the Department and other agencies respond to the needs of individual students. DoE will share information with the Department when children are not attending school including those on the Whereabouts Unknown Lists.

When a school has made efforts to locate an absent child, including raising concerns for this child at local 'Children at Risk' or 'Youth at Risk' meetings convened by the Department (as outlined above), the student's name is placed on the centrally managed SWU List. This Office has been informed that DOE provides the Department with a copy of the updated SWU List on a monthly basis. On the information provided by the Department in the May 2017 and July 2018 reports, the Department currently considers those names on the SWU List where the Department has 'guardianship responsibility' (i.e in the Chief Executive Officer's care).

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

Recommendation 6: That the DOE review of the *Child Protection* policy includes consideration of poor school attendance as a cumulative indicator of safety and wellbeing concerns warranting consideration of consultation with and/or referral to the Department

Steps taken to give effect to the recommendation

The Office requested that DOE inform the Office of the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 22 June 2017, containing a report prepared by DOE (**the DOE report**).

In the DOE report, DOE relevantly informed the Office that the DOE's:

- …revised *Child Protection* policy and procedures and updated supporting documents highlight issues relating to ongoing student absence and school avoidance as a possible indicator of emotional abuse, neglect, sexual abuse and family or domestic violence.
- Amended procedures for a principal's response when a student is at immediate risk of harm state that the principal must call the Department District Office. Principals are advised that if these calls receive no response, they can escalate the request for support to the Department Team Leader or the relevant Assistant District Director or District Director.

In its report, DOE further relevantly informed the Office that:

> The revised *Child Protection* policy is scheduled for release in June 2017. Supporting documents, including *Child Protection and Abuse Prevention: A resource for schools*, will be released to support the policy. On release of the policy both documents will be available online.

This Office has reviewed the above documentation, which was effective from 25 July 2017 and is currently available at http://www.det.wa.edu.au/policies. 'School

attendance issues' are mentioned in the associated DOE document *Fact sheet – possible indicators of abuse*, which guides schools in identifying 'types of abuse' (that is, physical abuse, emotional abuse, family and domestic violence, neglect and sexual abuse).

The *Child Protection* policy directs that 'Principals must refer all child protection concerns received which relate to physical abuse, emotional abuse, family and domestic violence, or neglect to the local the Department District Office'.

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

Recommendation 7: That DOE takes all reasonable steps to achieve compliance with the *Student Attendance* policy and *Case management of persistent absences* policy.

Steps taken to give effect to the recommendation

The Office requested that DOE inform the Office of the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 22 June 2017, containing a report prepared by DOE.

In the DOE report, DOE relevantly informed the Office that:

> As part of its response to similar recommendations in the *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, the Department:
>
> - reviewed and clarified the *Student Attendance* policy;
> - reviewed and improved access for users to web based information regarding policy, guidelines and procedures for school staff and parents;
> - published policy information and resources on the Student Attendance website;
> - established a *Connect* e-community for sharing of information and resources by school and regional staff;
> - provided training to assist regional staff (including members of the School Psychology Service and other complimentary services) on the implementation and compliance of the revised *Student Attendance* policy;
> - undertook an internal audit of compliance with *Student Attendance* policy; and
> - strategically focused on the increased use of measures available in relevant legislation to manage attendance, such as attendance panels and responsible parenting agreements (RPAs). A train the trainer program, resource package, and RPA guidelines were developed.
>
> In addition to these measures, a *Student Attendance Toolkit* (the *Toolkit*) was developed in 2016. The *Toolkit* provides schools comprehensive guidance for:
>
> - planning for improved student attendance; including target setting;
> - adopting practices that lead to improved student, parent and community engagement in school; and
> - selecting and implementing targeted strategies that address the causes of absence.
>
> The *Toolkit* consists of five modules to assist leadership teams to build attendance

into strategic, operational and classroom planning and aligns to the *School Improvement and Accountability* framework.

The *Toolkit* contains over 100 resources and strategies to support schools to strengthen student and parent engagement and reduce barriers to attendance. Resources for schools include:

- Student engagement;
- Teaching and Learning;
- Parent engagement;
- Community engagement;
- Health;
- School culture;
- Special Education Needs;
- Complex cases; and
- Others.

DOE's compliance with the *Student Attendance* policy and *Case management of persistent absences* policy was examined in the Office's major own motion investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people. 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 and made a number of recommendation in this area, specifically Recommendations 15-21. During 2017-2018, 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 2018-19, which will further examine the implementation and effectiveness of the steps identified in DOE's response

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

Recommendation 8: That DOE takes all reasonable steps to ensure that, prior to placing a student on the SWU List, child safety and wellbeing concerns are recognised, responded to and relevant interagency communication and collaboration occurs.

Steps taken to give effect to the recommendation

The Office requested that DOE inform the Office of the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 22 June 2017, containing a report prepared by DOE.

In the DOE report, DOE relevantly informed the Office that:

The Department's delegations register has been reviewed, and Regional Executive Directors have now been delegated:

- responsibility for ensuring that schools have taken all reasonable measures to locate students suspected of being missing; and

- powers for confirming a student as whereabouts unknown.

This ensures that Department and non-Department service providers involved in supporting the student are aware that the student is suspected missing and are able to participate in attempts to locate the student prior to the student being placed on the *Students Whose Whereabouts are Unknown* [SWU] list.

Once a student has been verified as whereabouts unknown, Statewide Services ensures that student information is verified and then communicated to any identified agencies, such as the Department, Department of Corrective Services, Department of Education Services, Catholic Education Western Australia, Association of Independent Schools Western Australia, that have had contact with the student during the students educational career.

A measure taken by the Department to minimise risk is to audit the SWU list against enrolment information held by the School Curriculum and Standards Authority. This ensures that for any student previously identified as at risk, the student's prior school is notified of the student's new enrolment, thereby assisting with the transfer of information to the new school.

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

Recommendation 9: That DOH considers the development of procedural guidelines for assessing and responding to the safety and wellbeing of children and adolescents presenting to health services where alcohol and drug use issues have been identified.

Steps taken to give effect to the recommendation

The Office requested that DOH inform the Office of the steps taken to give effect to the recommendation. In response, the WA Country Health Service (**WACHS**) and the Child and Adolescent Health Service (**CAHS**) provided a range of information in letters to this Office dated 15 June 2017 and 7 July 2017, respectively, containing reports prepared by WACHS (**the WACHS report**) and CAHS (**the CAHS report**).

In the WACHS report, WACHS relevantly informed the Office that:

- A Clinical Nurse Specialist for Community Health has recently been employed in a regional position within the Wheatbelt. This role has a responsibility in consulting and providing clinical leadership to the multi-disciplinary health teams in assisting to coordinate care for children and families identified as vulnerable within the community setting. A major focus of the role is to support community nurses in the case management of identified vulnerable clients and families within the child and school health environment. The role also supports the implementation of Community Health policy's and guidelines as well as establishing local processes and procedures.

- The Wheatbelt Population Health Team has implemented a system for monitoring clients of concern as per the recommendations outlined in the WA Health Neglect Protocol. This document guides staff in the use and management of this monitoring tool. Community nursing staff have received training on the WA Health Protection of Children Policy and attend regular updates on the accompanying framework – Guidelines for Protecting Children 2015. Wheatbelt flow-charts guide staff in the process of completing and reporting Child Protection Concern.

- The Education and Health Department work collaboratively to complete annual

SLA [Service Level Agreements] agreements across the schools in the Wheatbelt. Specifically in relation to drug and alcohol related issues in schools, school staff actions are guided by the School Drug Policy which remains the responsibility of the Education Department. The main role for the school health nurses in relation to this area is health counselling which is guided by using the HEADSS psychosocial assessment tool. Nurses work within their scope of practice which is guided by the 'working with youth guide'. Referral pathways guide Wheatbelt staff to access Holyoake for drug and alcohol counselling services. Staff from Wheatbelt Population Health have established links with this organisation. School Drug Education and Road Awareness (SDERA) continues to provide education to schools and is a community resource for students and parents.

- The management of first aid within the school environment remains the responsibility of the Education Department. A MOU exists between Education and the Health Department to outline this relationship. It is however well understood that school health nurses are a resource to be utilised within the school in the event of an emergency first aid situation. In these situations nurses are guided by their scope of practice.

In the CAHS report, CAHS relevantly informed the Office that:

> Statewide child protection guidelines are already in effect to address children at risk. These guidelines have been developed for use across agencies working with children and their families. The identification of drug and alcohol use issues triggers the use of these child protection guidelines.

This Office notes that the *DOH Guidelines for Protecting Children (2015)* was in place when this recommendation was made. This document, and the version revised May 2017, have been examined and, in this Office's opinion, does not appear to provide direction regarding responding to child/adolescent alcohol and drug use issues.

In the CAHS report, CAHS further relevantly informed the Office that:

> There are school health services tailored for adolescent students. They provide an easy access point to health care for students. The school health service may carry out health assessment and provide information, advice, referrals and support for students. Students can seek information, guidance and support about a range of issues including (but not limited to) smoking, alcohol and drug use.

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

Recommendation 10: That DOH continues to work with DOE to develop opportunities for interagency communication and collaboration to identify children on the SWU List.

Steps taken to give effect to the recommendation

The Office requested that DOH inform the Office of the steps taken to give effect to the recommendation. In response, WACHS and CAHS provided a range of information in letters to this Office dated 15 June 2017 and 7 July 2017, respectively, containing reports prepared by WACHS and CAHS.

In the WACHS report, WACHS relevantly informed the Office that:

> There is no standardised and approved system for sharing information between the Education Department and the Health Department in relation to the 'student's whose whereabouts are unknown list'. Locating student's whereabouts remains the responsibility of the Education Department. Current barriers to implementing a system involve issues around confidentiality. However a forum for raising students of concern forms part of the role of the 'Student Services Meeting'.

In the CAHS report, CAHS relevantly informed the Office that:

> There is close collaboration between CAHS and Department of Education already in place particularly with the presence of CAHS School Health Nurses working within the public school system.
>
> There are ongoing efforts to improve lines of communication and sharing of appropriate information for at risk children between CAHS and Department of Education.
>
> The management of '*students whose whereabouts is unknown*' is challenging and requires the development of an agreed notification system. This would be best managed through the Department. This would provide an avenue for Schools/Department of Education to notify the Department of the name and relevant details for '*students whose whereabouts is unknown*' who are then able to notify the Police, Department of Health and CAHS to alert them to the situation and enable an alert to be posted on the relevant health patient management system. If the child presented to a health service then the Department would be notified.

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

Recommendation 11: That the Department, in consultation with the Department's Aboriginal Engagement and Coordination Directorate, undertakes a review of this case to determine whether any additional action is required in the Regional District to facilitate culturally informed assessment, planning and intervention when working with Aboriginal families.

Steps taken to give effect to the recommendation

The Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 17 May 2017, containing a report prepared by the Department.

In the Department's 2017 report, the Department relevantly informed the Office that:

> The case was reviewed by the Aboriginal Practice Leader in consultation with the District Director and Executive Director Aboriginal Engagement and Coordination. The review concluded that although consultation occurred in the assessment phase, the Aboriginal Practice Leader could have been included in an ongoing manner.
>
> An Aboriginal Practice Leader is now assigned to the centralised intake team and oversees and provides consultation to all new intakes.
>
> Pilbara staff undergo mandatory cultural awareness training in the District. The District is working with the Martu people to gain further cultural competence and bring an elected Martu representative to work alongside Pilbara office staff to provide not only cultural advice and to support families but also walk alongside staff and families to strengthen this relationship and hopefully reduce the need for child protection services. The Memorandum of Understanding is nearing completion.

In its report, the Department further relevantly informed the Office that:

> Pilbara District has implemented an Elder Engagement strategy for the Newman team. The District has identified two Elders who are consulted in relation to child protection matters (new work) and existing children in care (around placements and reunification work).

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

Recommendation 12: That the Department considers the appropriateness of any further strategies and actions and their implementation for the Regional District, which considers the challenges in undertaking pre-birth planning in remote communities and engages with Aboriginal health service providers in the Regional District, to ensure the requirements of DOH's *Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby is Identified as at Risk of Abuse and/or Neglect (2014)* can be implemented across the Regional District.

Steps taken to give effect to the recommendation

The Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 17 May 2017, containing a report prepared by the Department.

In the Department's 2017 report, the Department relevantly informed the Office that:

> An MOU involving two out of three Aboriginal Medical Services in the Pilbara and the Ngaanyatjarra Health women's group based in the Northern Territory has been developed and signed off.

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

Recommendation 13: That the Department takes all reasonable steps to ensure that engagement with families is not focussed on 'single events' but adopts a 'holistic' child-centred approach to assessments of child safety and wellbeing concerns.

Steps taken to give effect to the recommendation

The Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 17 May 2017, containing a report prepared by the Department.

In the Department's 2017 report, the Department relevantly informed the Office that:

> Practice requirements require staff to document and update a chronology of events to inform current and future assessment, and to recognise cumulative harm. There is a comprehensive focus on Cumulative Harm in the three-day training available to staff on Assessing Child Abuse and Neglect using Signs of Safety features.

This recommendation was made in the context of a child death review where the Department reported to this Office that:

> …a total of nine interactions were recorded between October 2014 and February 2015 for this family. Staff have responded to single events rather than assessing and responding in a holistic manner … It is evident that during this timeframe there was escalation in reported concerns and domestic violence. The likelihood of future violence combined with other risk factors including mental health and drug issues was not subject to rigorous assessment.

The Office also notes that the Department has, in July 2017, commenced operation of the new metropolitan Central Intake team which the Department has informed this office 'will create a consistent approach to managing work coming into the Department'. The Department has provided this Office with a presentation on the Central Intake process and associated risk assessment tool, and it is noted that this process requires consideration of all prior information documented in the Department's files, in assessing risk of harm.

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

Recommendation 14: That the Department takes all reasonable steps to achieve compliance with the administration of Safety and Wellbeing Assessments and use of the *Signs of Safety Child Protection Practice Framework* when investigating allegations of neglect and assessing whether a child and/or unborn child is in need of protection within the meaning of sections 28 and 33A of the *Children and Community Services Act 2004*.

Steps taken to give effect to the recommendation

The Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 17 May 2017, containing a report prepared by the Department. Additional information was provided by the Department on 19 July 2018, containing a report prepared by the Department.

In the Department's 2018 report, the Department relevantly informed the Office that:

> **Compliance and Monitoring**
>
> Standards Monitoring Unit (SMU) assess, at regular intervals, whether the Districts are meeting standards, identify excellence in service provision and highlight required actions and opportunities for service improvement. Cycle 6 has commenced for the next two year period with the elevated priority of monitoring of Safety and Wellbeing Assessments (SWAs). Standards Monitoring Reports are regularly provided to the Ombudsman.
>
> **Signs of Safety (SoS) Reloaded**
>
> In 2016 the Signs of Safety (SoS) Reloaded Project commenced the aim to strengthen Western Australia's Sos child protection practice approach across all service delivery units through integrating contemporary child protection knowledge and learning and development initiatives. The project seeks to address the gaps in the Department implementation of SoS as well as refocus attention on consistency in the application of core child protection practice.
>
> ***Casework Practice Manual* (CPM)**
>
> On 2 May 2018 the Department's new CPM entry 'Neglect' was updated to align information with new Intensive Family Support, Best Beginnings Plus and Parent Support CPM entries.
>
> On 6 June 2017 information was inserted to check Family and Domestic Violence triage application in Duty Interaction.
>
> Related resources include Signs of Safety prompts for neglect.
>
> On 4 May 2018 CPM 2.2.2 [*Assessment and investigation processes*] was updated to include working with other agencies, memorandum of understanding and information sharing.
>
> **CPM Review Project**
>
> The Department is revising the presentation and accessibility of the information in the CPM, given the complexity and breadth of information. Presently the review is at the consultative phase. Approval of the Action Plan is listed for the week ending 31 August 2018. KPMG have been contracted to assist the Department and are currently due to present the Interim Findings Report. KPMG are scheduled to deliver the report

to the Department on 18 July 2018. Next steps are:

- KPMG to develop the new structure of the revised CPM which is comprised of two stages:
    - Map compliance requirements and develop a skeleton framework. This will then be tested at a workshop with key stakeholders.
    - Following the workshop, KPMG will design the structure of the CPM Framework, index and template. These will be provided to us for review and feedback and then this will [be] incorporated into the final document.

Learning and Development/Training

Orientation Training Program 1, 2, 3 and 4 ('the Programs')

Throughout the Department's compulsory training for caseworkers, information about the *Children and Community Services Act 2004* (CCSA 2004), underpinning the Department's policy and practice, is highlighted. All workers are required to complete the Programs during the first six months of their employment, after a district induction period of 4 to 6 weeks during which time they complete an online induction course. After completion of Orientation 1 and 2 workers can be allocated a half caseload, respectful of the learners' need to continue their professional learning and development.

During their learning journey, workers must demonstrate their skill in the application of their knowledge to a scenario that remains a theme across the program areas; with continuous additional information to challenge the participants: for example, medical neglect of a baby is one of the concerns played out in the scenario to test workers application of their learning. During Program 4 the scenario includes a pregnancy and tests workers on their knowledge and application to respond via Pre-birth planning. Safety planning, with a trajectory of six months, is required as they work the scenario from duty, intake, safety and wellbeing assessment and intensive family support.

Perth Children's Hospital present information regarding physical, sexual abuse and neglect during Orientation Program One. Invited professionals from other agencies provide extension programs on specific topics such as Alcohol and Other Drugs.

Assessing Child Abuse and Neglect Using Signs of Safety

Workers learn to use the *Signs of Safety Child Protection Practice Framework* to enhance their ability to apply policies and procedures when responding to allegations of significant harm.

The Assessing Child Abuse and Neglect is divided into two sessions. The first two sessions focus on applying trauma sensitive practices in child protection work and the last three days focus on Assessing the Safety and Wellbeing of children using Signs of Safety.

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

Recommendation 15: That the Department takes all reasonable steps to achieve compliance with the administration of Safety and Wellbeing Assessments and use of *the Signs of Safety Child Protection Practice Framework* when investigating allegations of physical abuse and assessing whether a child is in need of protection within the meaning of section 28 of the *Children and Community Services Act 2004*.

Steps taken to give effect to the recommendation

The Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 17 May 2017, containing a report prepared by the Department. Additional information was provided by the Department on 19 July 2018, containing a report prepared by the Department.

In the Department's 2018 report, the Department relevantly informed the Office that:

> **Critical Incident Collaborative Inquiry**
>
> On 15 December 2015 the Department implemented the Signs of Safety Critical Incident Collaborative Inquiry to assess the tragic death of [a young person], which invited key agencies to examine practice and other considerations alongside the Department, with the aim of reflective learnings.
>
> The Department participates in Department of Health, 'Root Cause Analysis' meetings with the WA Country Health Services when these are convened to examine child deaths or major incidents.
>
> **Safety and Wellbeing Assessment ('SWA') Review Project**
>
> - The SWA Project will focus on revisiting and resetting the purpose of a SWA to ensure that changes promote better critical thinking and analysis of information concerning allegations of harm against a child, and to bring about better clarity and consistencies of SWA's across Western Australia.
> - The aims of the project are:
>   - Staff to have a better understanding of the purpose of conducting a SWA inclusive of its intersection with policy, frameworks and legislation,
>   - Staff to develop knowledge, assessment and analysis skills in assessments,
>   - All staff to have access to training and professional development opportunities in relation to conducting a SWA,
>   - To develop, integrate and strengthen consistency of practice and recording across the state in relation to SWA's.
> - Currently in the pre-implementation and consultation phase
>   - consults have occurred with District Staff – Country and Metro inclusive of District Directors, Senior Practice Development Officers, Psychological Services; Policy
>   - consults pending with Legal; Client Applications; Duty of Care Unit, Complaints Management Unit and Information Research and Evaluation
> - Research of the National Landscape has occurred with feedback received from all Jurisdictions
> - Review of other developmental projects and reviews has occurred to assess any

intersection with SWA project such as the Royal Commission into Institutional Response to Child Sexual Abuse; Legislative Review; Signs of Safety Reloaded Project; District Structural Review; Centralised Intake and the Interaction Tool; Pre-Birth Planning Project.

- Project timeframe expectation is end of June 2018.

Phase 1, the consultative phase, of the SWA Review has been completed. Phase 2 to reset, review and develop the process, has commenced, due for completion at the end of October 2018. Phase 3, the implementation phase, will include revised training modules and state-wide rollout due to commence in December 2018.

Keeping Children Front and Centre – Workbook and Video

The Department's workbook and training video released November 2017 is available internally and for external agencies (via YouTube).

The film and workbook was developed by staff in the former Department for Child Protection and Family Support. The film features professional actors and over 30 departmental and partner agency staff in a variety of employment roles, enacting scenes encountered by staff on a daily basis. Accompanying the story is commentary by senior staff, highlights key messages about issues and good practice while implementing the Department's Signs of Safety Framework.

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

Recommendation 16: That the Department considers, where appropriate, the provision of interim support to Districts where it is identified that workload management issues are preventing the management and allocation of cases on the Monitored List.

Steps taken to give effect to the recommendation

The Office requested that the Department inform the Office of the steps taken to give effect to the recommendation. In response, the Department provided a range of information in a letter to this Office dated 17 May 2017, containing a report prepared by the Department.

In the Department's 2017 report, the Department relevantly informed the Office that:

> The Monitored List is not a list of children considered at risk waiting to be assessed. New or existing cases that cannot be allocated to a caseworker are allocated to the Team Leader and monitored regularly by the Team Leader on a case by case basis. The 'Monitored List' refers to these cases.
>
> Children aged five years and younger may only be placed on the Monitored List after a Safety and Wellbeing Assessment has commenced and the children are not considered at risk of harm.
>
> The Department has guidelines in place to ensure that children aged five years and younger are not on the Monitored List without approval by the District Director. If concerns are received for any child on the Monitored List, then an urgent review occurs and immediate allocation is required.
>
> The Department actively scrutinises the Monitored List on a regular basis and provides monthly reports on the numbers to both the Union and Corporate Executive.

In its report, the Department further relevantly informed the Office that:

> A Statewide Relieving Team is now available to provide support to districts experiencing unusually high workload demands or where workers can come in to target a particular area of practice.
>
> Staff are available for country and metropolitan deployment for up to two weeks at a time. The team is staffed by specified callings level 2 workers who have capacity to work within child safety teams, care teams and intensive family support.

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

Recommendation 17: That DOE takes all reasonable steps to achieve compliance with the development and implementation of documented attendance, behaviour management and education plans in accordance with procedural requirements included in the *Student Attendance* policy, *Behaviour Management in Schools* policy and *Documented Plans. Supporting Education for All. Guidelines for Implementing Documented Plans in Public Schools* policy.

Steps taken to give effect to the recommendation

The Office requested that DOE inform the Office of the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 22 June 2017, containing a report prepared by DOE.

In the DOE report, DOE relevantly informed the Office that:

> The previous guideline *Documented Plans, Supporting Education for All. Guidelines for Implementing Documented Plans for Government Schools* has been revised and will be replaced with new guidelines on personalised learning and support. A new resource, currently undergoing consultative review, is under development to assist schools with implementation of the new guideline.
>
> Procedures for monitoring Documented Educational Plans (DEP) for Children in the Care of the CEO of the Department have been significantly strengthened in the revised *Child Protection* policy. Principals must:
>
> - verify a DEP is developed within 30 working days of receiving information from the Department that a child is in care:
> - record on Integris the date when the DEP was forwarded to the Department and the due date for review;
> - review the DEP at the start of every school year to ensure the child remains in care;
> - review the DEP at least twice a year:
> - review details on Integris as required;
> - review the DEP twice yearly; and
> - review details for the child in care monthly.
>
> The Student Support Services Directorate in the Department monitors accuracy of information every month.

In its report, DOE further relevantly informed the Office that:

> The revised *Child Protection* policy is scheduled for release in June 2017 and includes improved procedures for compliance with [this recommendation], including:
>
> - principals must review the DEP at least twice yearly and review details for a child in care monthly in Integris; and
> - the level of compliance by schools on children in care must be reported in the Department's Annual Report.

DOE's compliance with the development and implementation of documented attendance, behaviour management and education plans was examined in the Office's major own motion investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people. 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 and made a number of recommendation in this area, specifically Recommendations 15-21. During 2017-2018, 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 2018-19, which will further examine the implementation and effectiveness of the steps identified in DOE's response

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

Recommendation 18: That DOE takes all reasonable steps to achieve compliance with the relevant guidelines related to attendance, learning, behaviour management and continuity of service provision.

Steps taken to give effect to the recommendation

The Office requested that DOE inform the Office of the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 22 June 2017, containing a report prepared by DOE.

In the DOE report, DOE relevantly informed the Office that:

> Explicit mention has been made of professional practice guidelines in newsletters to all School Psychology Service staff:
>
> - February 2016: An article about all professional practice guidelines;
> - March 2016: Student Learning;
> - June 2016: Updates about School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-Injury;
> - September 2016: Spotlight on professional practice guideline – Behaviour;
> - December 2016: Handover of Psychology Cases to Another School Psychologist.
>
> Professional Practice Guidelines have been an ongoing discussion topic at teleconferences among Lead School Psychologists. This included:
>
> - 21 March 2016: Suicide Prevention and NSSI [Non suicidal self-injury] Guidelines;
> - 13 June 2016: Suicide and NSSI Guidelines;
> - 24 October 2016: Suicide and NSSI Guidelines; and
> - 28 November 2016: Behaviour, Attendance, Mental Health and Handover of Student Files were explicitly discussed with reminders to all staff.

The School Psychology Service contributed to the Department's *Student Attendance Toolkit*, which included awareness for all about the Professional Practice Guideline for school psychologists relating to student attendance.

Professional learning (PL) for school psychologists about assessment of students with specific learning disorders has been rolled out across the state. The PL refers specifically to the professional practice guideline in learning.

An additional professional practice guideline dealing with specific learning disorders has been developed and is currently pending approval.

All graduate school psychologists and new school psychologists participate in the School Psychology Service Graduate Induction Program. In the Orientation sessions, all professional practice guidelines are introduced to the new graduates.

DOE's compliance with the relevant guidelines related to attendance, learning, behaviour management and continuity of service provision was examined in the Office's major own motion investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people. 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 and made a number of recommendation in this area, specifically Recommendations 15-21. During 2017-2018, 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 2018-19, which will further examine the implementation and effectiveness of the steps identified in DOE's response

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

Recommendation 19: That DOE considers the development of guidelines and staff education related to recognising and responding to alleged drug and alcohol use by children as an indicator of cumulative harm associated with potential abuse and or/neglect warranting consultation with and/or referral to the Department.

Steps taken to give effect to the recommendation

The Office requested that DOE inform the Office of the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 22 June 2017, containing a report prepared by DOE.

In the DOE report, DOE relevantly informed the Office that:

New requirements related to the *Student Behaviour* policy were introduced in 2016. These include requirements related to students suspected of being intoxicated on school sites, which were developed in consultation with *School Drug Education and Road Aware*. The overarching *Student Behaviour* procedures require that risks associated with cumulative harm be taken into consideration when implementing all student behaviour-related requirements.

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

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

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of child deaths. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2017-18, 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. During the year, the Ombudsman tabled in Parliament a report, *Investigation into ways to prevent or reduce deaths of children by drowning*. The report of this major own motion investigation was tabled in Parliament in November 2017.

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 of Communities

Efficient and effective liaison has been established with Communities to support the child death review process and objectives. Regular liaison occurs between the Ombudsman and the Director General of Communities, 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 Communities' 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 2017-18 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);
- Dr Michael Wright (Health Sciences, Curtin University);
- Mr Ralph Mogridge (Consultant); and

- Associate Professor Carolyn Johnson (Consultant).

Observers from Communities, the Department of Health, the Department of Aboriginal Affairs, the Department of Education, the Department of Justice, the Mental Health Commission and Western Australia Police also attended the meetings in 2017-18.

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 2017-18 as part of the child death review jurisdiction include:

- The Coroner;
- Public authorities that have involvement with children and their families including:
  - Department of Communities;
  - Department of Health and Health Service Providers;
  - Department of Education;
  - Department of Justice;
  - 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, complaint resolution involving Aboriginal people and own motion investigations; and
- Raise awareness of and accessibility to the Ombudsman's roles and services to Aboriginal communities and support cross cultural communication between Ombudsman staff and Aboriginal people.

A Senior Aboriginal Advisor was appointed in January 2018 to assist the Principal Aboriginal Liaison Officer in this important work. With the leadership and support of the Principal Aboriginal Liaison Officer and Senior Aboriginal Advisor, significant work was undertaken throughout 2017-18 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, Communities and community advocates.