Our Performance in 2017-18

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

- Summary of Performance
  - Key Performance Indicators
  - Summary of Financial Performance
- Complaint Resolution
- Child Death Reviews
- Family and Domestic Violence Fatality Review
- Administrative Improvement
- Collaboration and Access to Services

Summary of Performance

Key Performance Indicators

Key Effectiveness Indicators

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

Key Effectiveness Indicators	2016-17 Actual	2017-18 Target	2017-18 Actual	Variance from Target
Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies	100%	100%	**100%**	Nil
Number of improvements to practices or procedures as a result of Ombudsman action	109	100	**173**	+73

Another important role of the Ombudsman is to enable remedies to be provided to people who make complaints to the Office where service delivery by a public authority may have been inadequate. The remedies may include reconsideration of decisions, more timely decisions or action, financial remedies, better explanations and apologies. In 2017-18, there were 236 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman.

Comparison of Actual Results and Budget Targets

Public authorities have accepted every recommendation made by the Ombudsman, matching the actual results of the past four years and meeting the 2017-18 target.

In 2007-08, the Office commenced a program to ensure that its work increasingly contributed to improvements to public administration. Consistent with this program, the 2017-18 actual number of improvements to practices and procedures of public authorities as a result of Ombudsman action (173) has exceeded the 2017-18 target (100). This is the highest number of improvements achieved since this target has

been recorded. There may, however, be fluctuations from year to year, related to the number and nature of investigations finalised by the Office in any given year.

Key Efficiency Indicators

The Key Efficiency Indicators relate to timeliness of complaint handling, the cost per finalised allegation about public authorities, the cost per finalised notification of child deaths and family and domestic violence fatalities, and the cost of monitoring and inspection functions.

Key Efficiency Indicators	2016-17 Actual	2017-18 Target	2017-18 Actual	Variance from Target
Percentage of allegations finalised within three months	94%	95%	**94%**	-1%
Percentage of allegations finalised within 12 months	100%	100%	**100%**	Nil
Percentage of allegations on hand at 30 June less than three months old	94%	90%	**92%**	+2%
Percentage of allegations on hand at 30 June less than 12 months old	100%	100%	**100%**	Nil
Average cost per finalised allegation	$1,889	$1,890	**$1,879**	-$11
Average cost per finalised notification of death	$16,731	$17,500	**$17,438**	-$62
Cost of monitoring and inspection functions	$412,129	$415,000	**$414,311**	-$689

Comparison of Actual Results and Budget Targets

The 2017-18 actual results for the Key Efficiency Indicators met, or were comparable to, the 2017-18 target. Overall, 2017-18 actual results represent sustained efficiency of complaint resolution over the last five years.

The average cost per finalised allegation in 2017-18 ($1,879) met the 2017-18 target ($1,890). Since 2007-08, the efficiency of complaint resolution has improved significantly with the average cost per finalised allegation reduced by a total of 36% from $2,941 in 2007-08 to $1,879 in 2017-18.

The average cost per finalised notification of death ($17,438) met the 2017-18 target ($17,500), reflecting continuous improvement of the finalisation of notifications.

The cost of monitoring and inspection functions ($414,311) met the 2017-18 target ($415,000).

For further details, see the Key Performance Indicator section.

Summary of Financial Performance

The majority of expenses for the Office (77%) relate to staffing costs. The remainder is primarily for accommodation, communications and office equipment.

Financial Performance	2016-17 Actual	2017-18 Target ('000s)	2017-18 Actual ('000s)	Variance from Target ('000s)
Total cost of services (sourced from Statement of Comprehensive Income)	$11,106	$10,148	**$11,931**	+$1,783
Income other than income from State Government (sourced from Statement of Comprehensive Income)	$2,055	$1,989	**$2,214**	+$225
Net cost of services (sourced from Statement of Comprehensive Income)	$9,051	$8,159	**$9,717**	+$1,558
Total equity (sourced from Statement of Financial Position)	$2,436	$2,528	**$1,031**	-$1,497
Net increase/decrease in cash held (sourced from Statement of Cash Flows)	-$458	$20	**-$1,351**	-$1,371
Staff Numbers	**Number**	**Number**	**Number**	**Number**
Full time equivalent (FTE) staff level at 30 June	69	65	**61**	-4

Comparison of Actual Results and Budget Targets

The variation between the 2017-18 actual results and the targets for the Office's total cost of services and net cost of services and the decrease in cash held is primarily due to additional staffing required to enable the Office to manage the workload associated with an increase in complaints to the Ombudsman and one-off costs associated with voluntary separations to enable changes to further enhance the efficiency of complaint resolution services.

The variation between the 2017-18 actual results and the target for the Office's revenue is primarily due to additional funding approved by the Board of the Energy and Water Ombudsman (Western Australia) to enable the Office to meet the workload associated with an increase in complaints to the Energy and Water Ombudsman and to provide further capacity for activities such as building awareness.

For further details see Note 9.9 'Explanatory Statement' in the Financial Statements section.

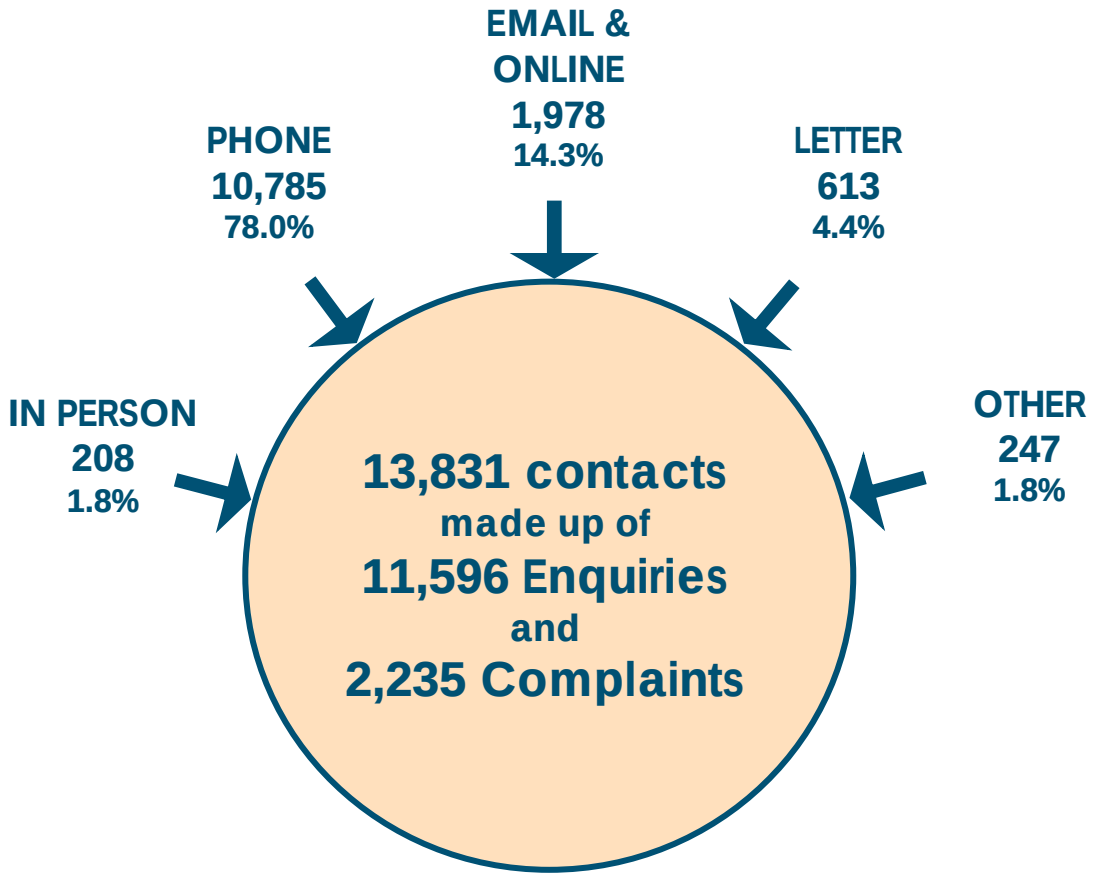
Complaint Resolution

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

Contacts

In 2017-18, the Office received 13,831 contacts from members of the public consisting of:

- 11,596 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 2,235 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

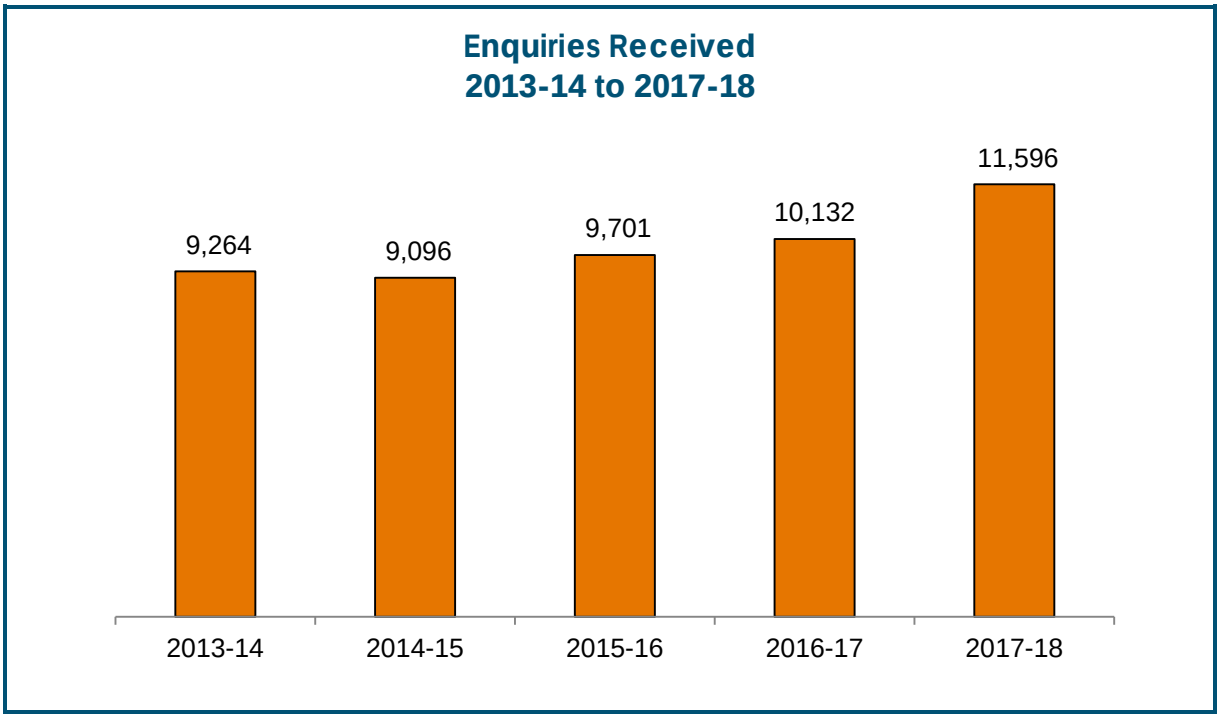


Enquiries Received

There were 11,596 enquiries received during the year.

For enquiries about matters that are within the Ombudsman's jurisdiction, staff provide information about the role of the Office and how to make a complaint. For over 40% of these enquiries, the enquirer is referred back to the public authority in the first instance to give it the opportunity to hear about and deal with the issue. This is often the quickest and most effective way to deal with the issue. Enquirers are advised that if their issues are not resolved by the public authority, they can make a complaint to the Ombudsman.

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

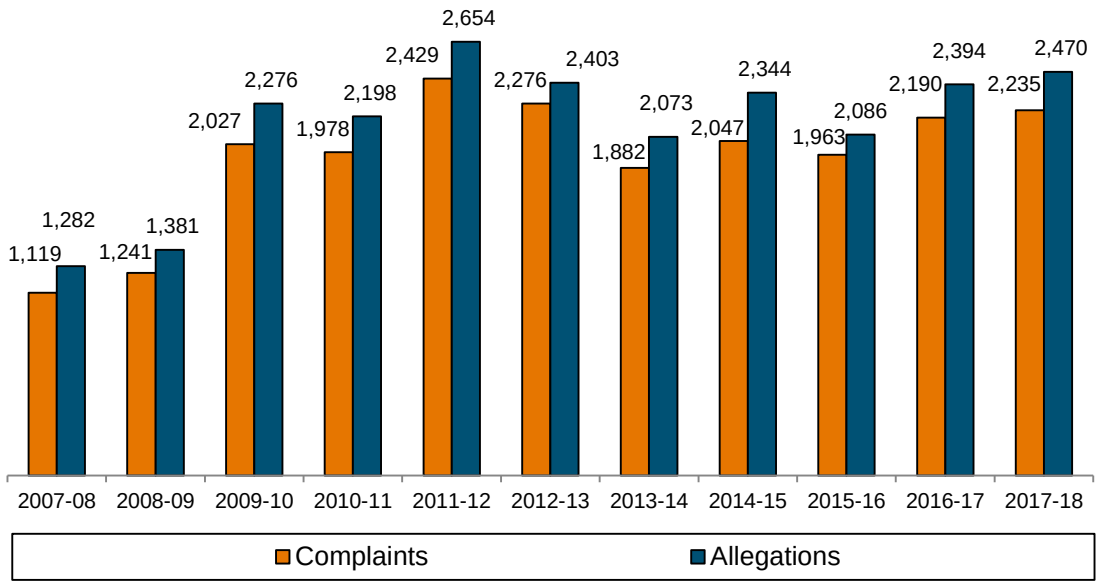


Enquirers are encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

Complaints Received

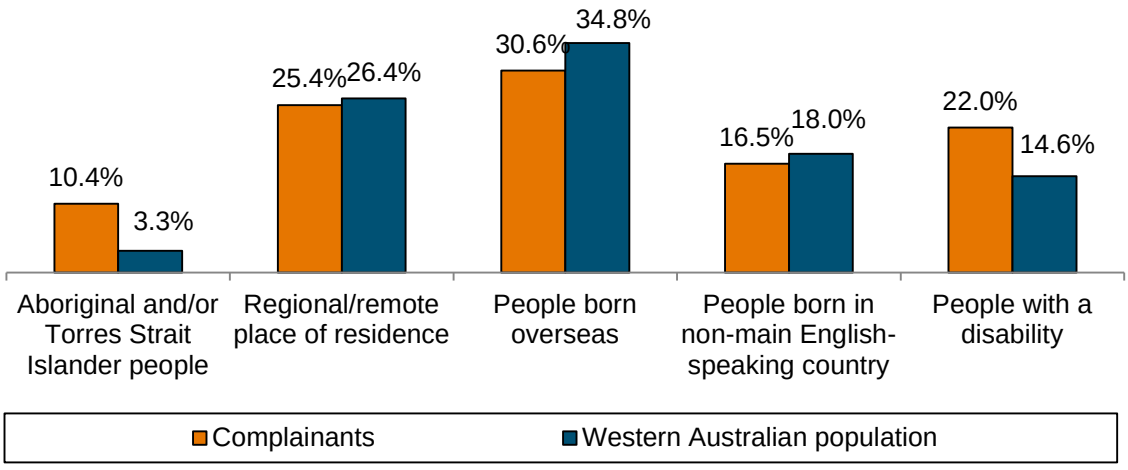
In 2017-18, the Office received 2,235 complaints, with 2,470 separate allegations, and finalised 2,212 complaints. There are more allegations than complaints because one complaint may cover more than one issue.

Total Number of Complaints and Allegations Received 2007-08 to 2017-18



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

Characteristics of Complainants in 2017-18

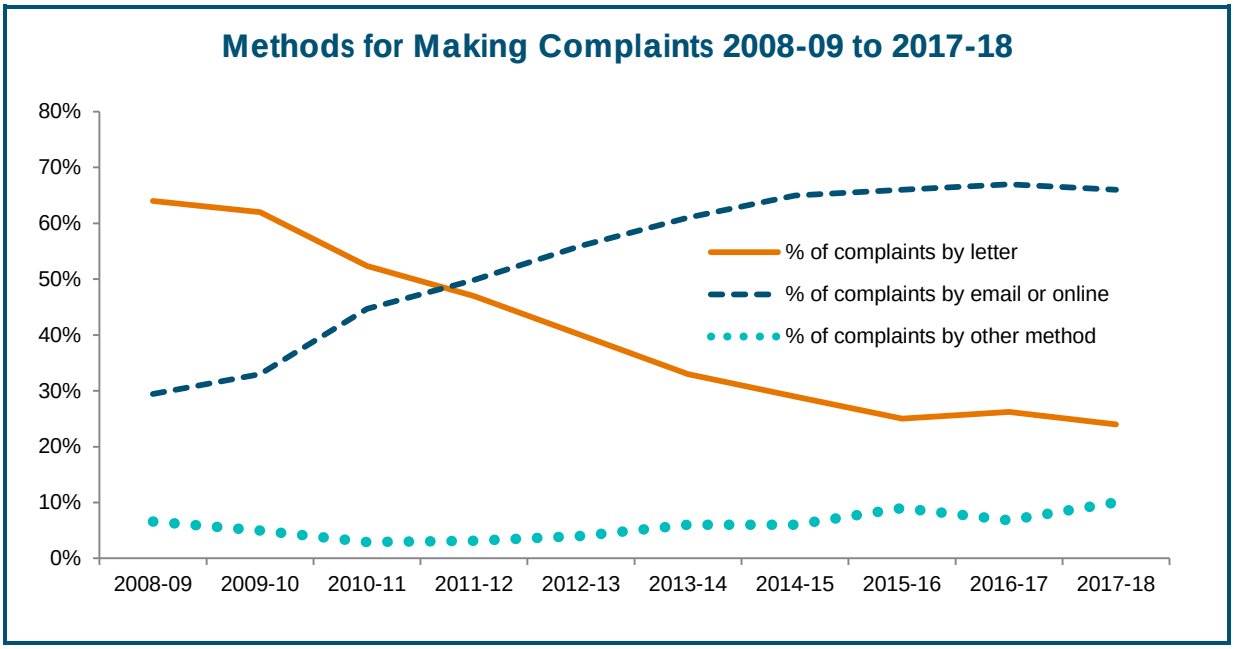


NOTE: Non-main English-speaking countries as defined by the Australian Bureau of Statistics are countries other than Australia, the United Kingdom, the Republic of Ireland, New Zealand, Canada, South Africa and the United States of America. Being from a non-main English-speaking country does not imply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

How Complaints Were Made

Over the last 10 years, the use of email and online facilities to lodge complaints has increased and the proportion of people who lodge complaints by letter has declined.

In 2017-18, 66% of complaints were lodged by email or online, compared to 24% by letter and 10% by other methods including during regional visits and in person.



Resolving Complaints

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

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

Time Taken to Resolve Complaints

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

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

Building on the program, the Office developed and commenced a new organisational structure and processes in 2011-12 to promote and support early resolution of complaints. There have been further enhancements to complaint handling processes in 2017-18, in particular in relation to the early resolution of complaints.

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

In 2017-18:

- The percentage of allegations finalised within 3 months was 94%; and
- The percentage of allegations on hand at 30 June less than 3 months old was 92%.

94% of allegations were finalised within 3 months.

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

- The average age of complaints has decreased from 173 days to 33 days; and
- Complaints older than 6 months have decreased from 40 to 7.

Complaints Finalised in 2017-18

There were 2,212 complaints finalised during the year and, of these, 1,693 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 953 were finalised at initial assessment, 692 were finalised after an Ombudsman investigation and 48 were withdrawn.

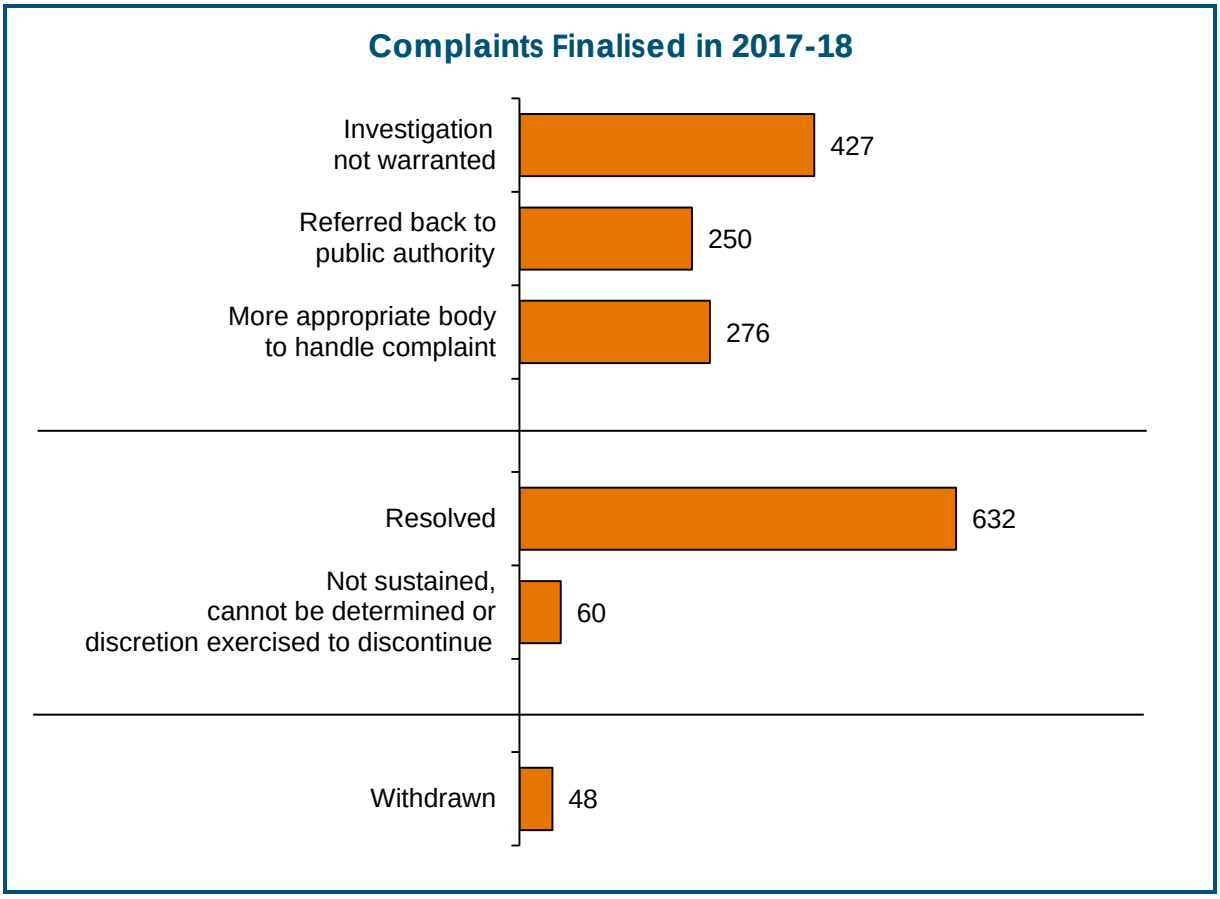
Complaints finalised at initial assessment

Over a quarter (26%) of the 953 complaints finalised at initial assessment were referred back to the public authority to provide it with an opportunity to resolve the matter before investigation by the Ombudsman. This is a common and timely approach and often results in resolution of the matter. The person making the complaint is asked to contact the Office again if their complaint remains unresolved. In a further 276 (29%) complaints finalised at the initial assessment, it was determined that there was a more appropriate body to handle the complaint. In these cases, complainants are provided with contact details of the relevant body to assist them.

Complaints finalised after investigation

Of the 692 complaints finalised after investigation, 88% were resolved through the Office's early resolution approach. This involves Ombudsman staff contacting the public authority to progress a timely resolution of complaints that appear to be able to be resolved quickly and easily. Public authorities have shown a strong willingness to resolve complaints using this approach and frequently offer practical and timely remedies to resolve matters in dispute, together with information about administrative improvements to be put in place to avoid similar complaints in the future.

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

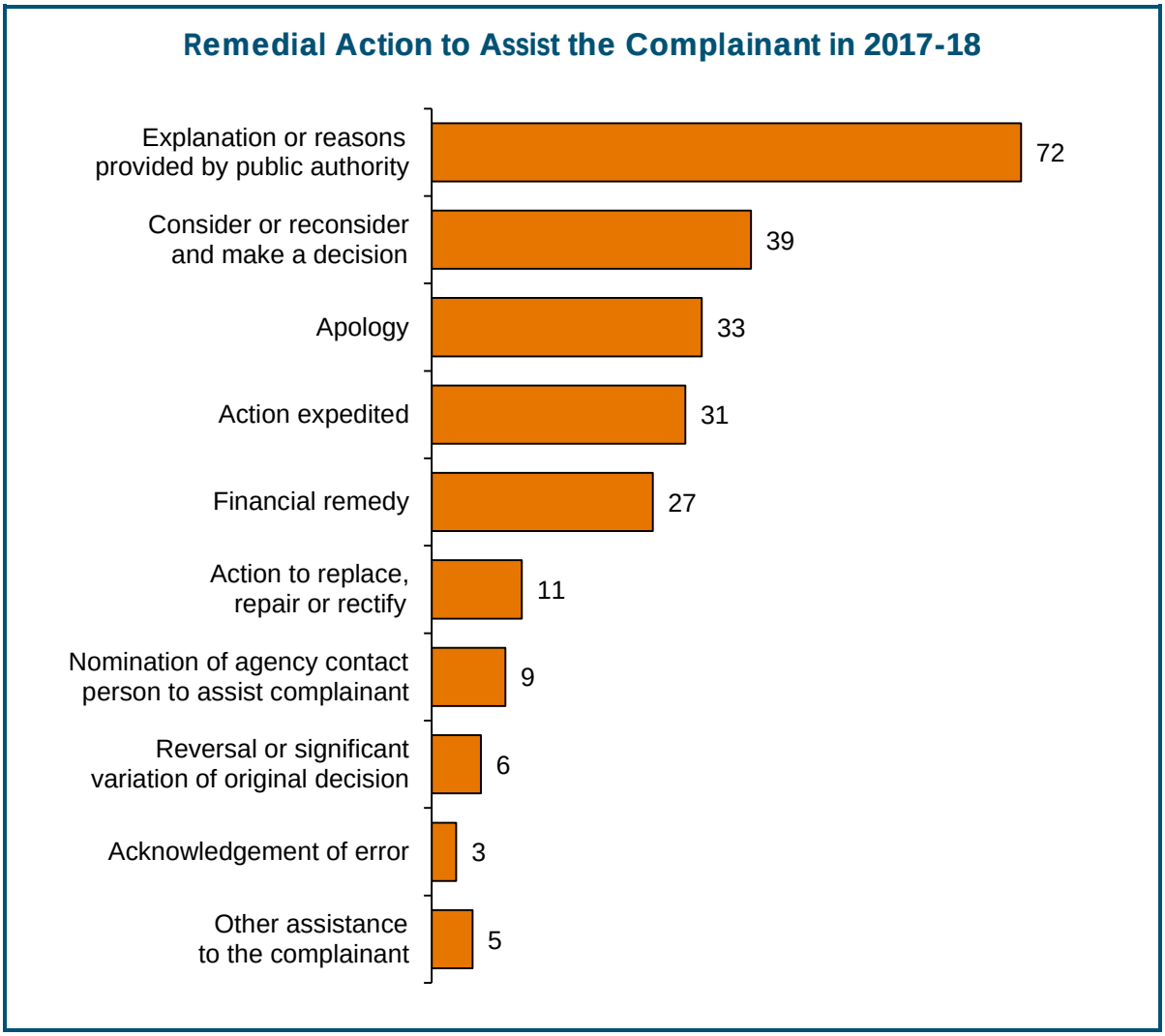


Note: Investigation not warranted includes complaints where the matter is not in the Ombudsman's jurisdiction.

Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2017-18, there were 236 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman. In some cases, there is more than one action to resolve a complaint. For example, the public authority may apologise and reverse their original decision. In a further 46 instances, the Office referred the complaint to the public authority following its agreement to expedite examination of the issues and to deal directly with the person to resolve their complaint. In these cases, the Office follows up with the public authority to confirm the outcome and any further action the public authority has taken to assist the individual or to improve their administrative practices.

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



Case Study

Exercise of discretion reconsidered

A couple who were tenants were charged for maintenance work and agreed to pay the charges in instalments. When one of the couple passed away, the remaining tenant's circumstances made it difficult for them to make the payments and they lodged an appeal to the public authority to review its decision relating to the charges. When the public authority informed the tenant the appeal was ineligible on the basis that more than 12 months had passed since the decision to charge the tenant, the tenant complained to the Office.

Following enquiries by the Office, which considered the provisions in the public authority's policies that enabled the exercise of discretion, the public authority reconsidered its position and agreed to waive the charges.

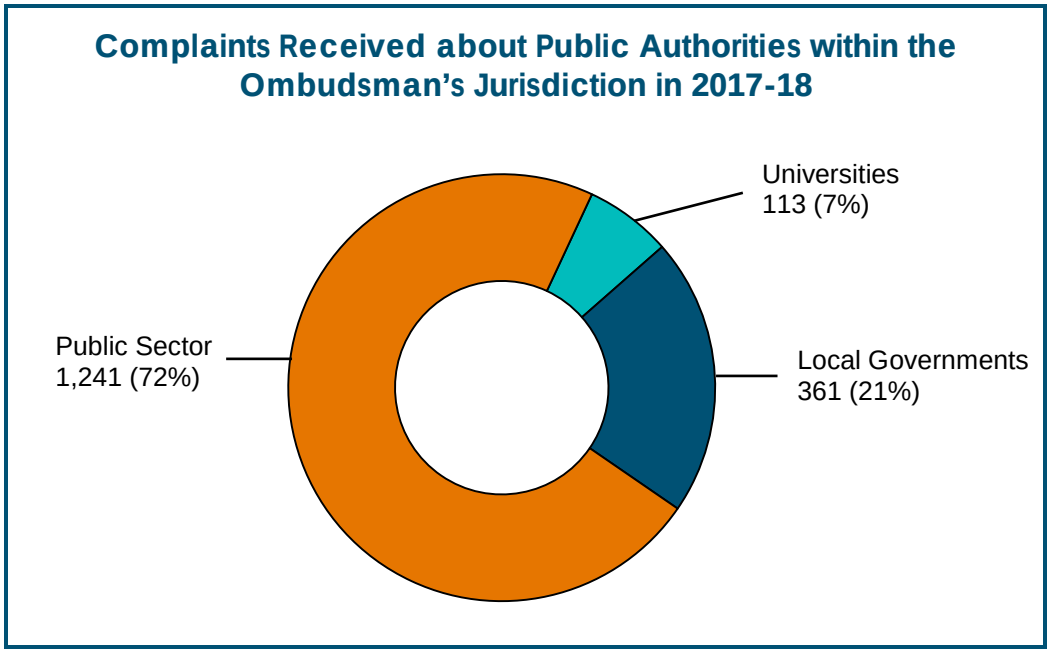
Outcomes to improve public administration

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

About the Complaints

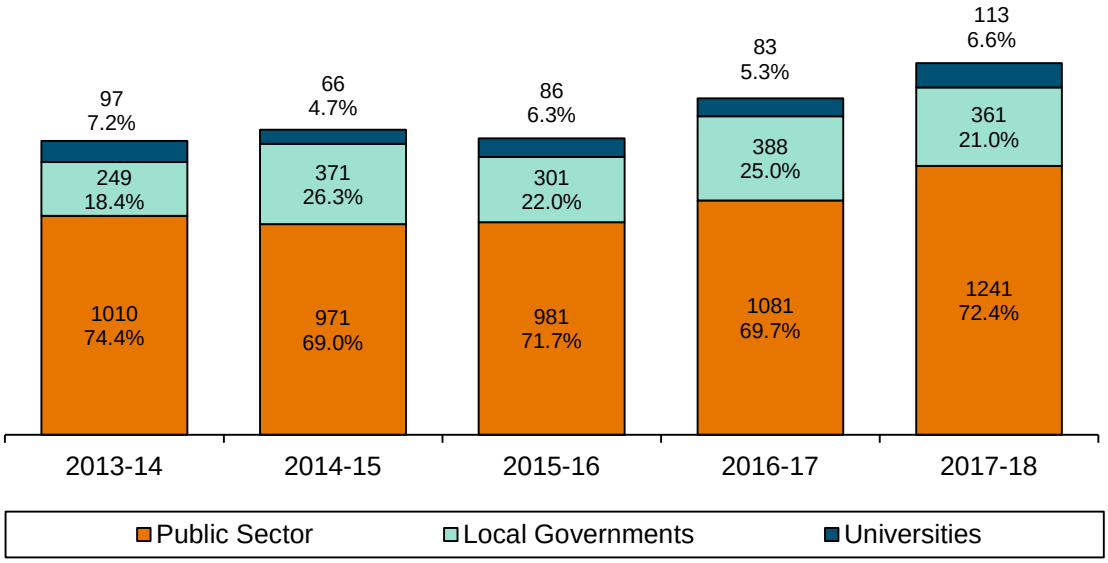
Of the 2,235 complaints received, 1,715 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 520 complaints were about bodies outside the Ombudsman's jurisdiction. In these cases, Ombudsman staff provided assistance to enable the people making the complaint to take the complaint to a more appropriate body.

Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (1,241 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (361 complaints); and the university sector (113 complaints).



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

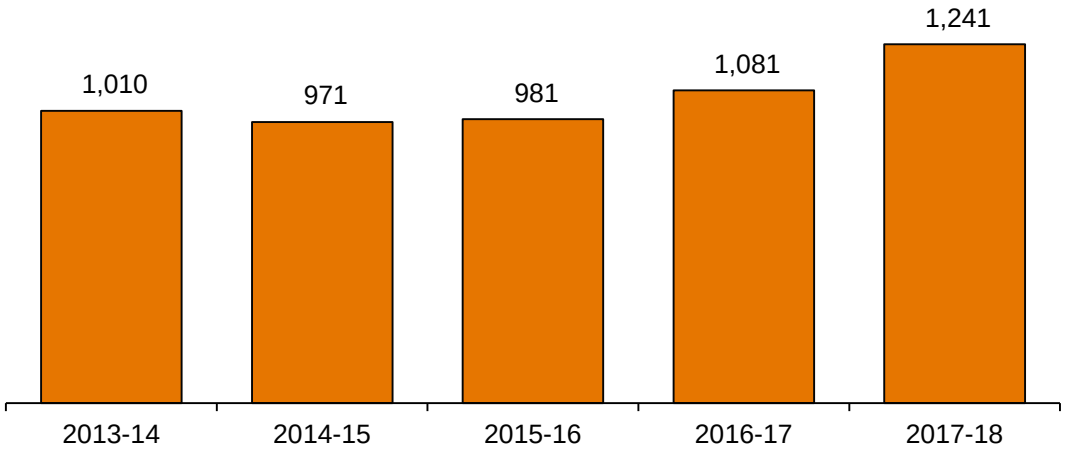
Complaints Received about Public Authorities within the Ombudsman's Jurisdiction between 2013-14 and 2017-18



The Public Sector

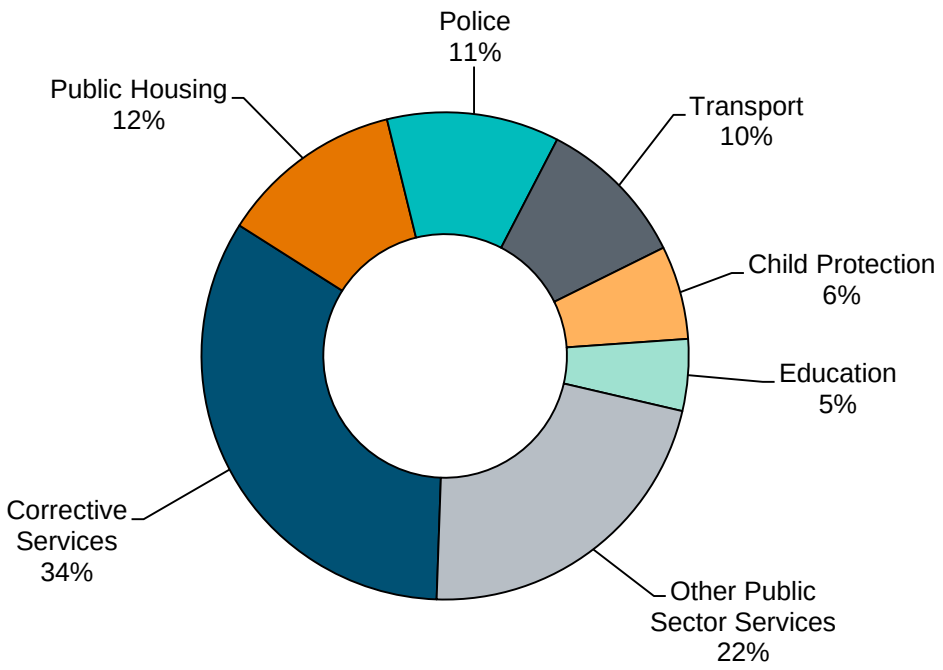
In 2017-18, there were 1,241 complaints received about the public sector and 1,219 complaints were finalised. The number of complaints about the public sector as a whole since 2013-14 is shown in the chart below.

Complaints Received about the Public Sector between 2013-14 and 2017-18



Public sector agencies deliver a very diverse range of services to the Western Australian community. In 2017-18, complaints were received about key services as shown in the following chart.

Complaints Received about the Public Sector in 2017-18



Of the 1,241 complaints received about the public sector in 2017-18, 78% were about six key service areas covering:

- Corrective services, in particular prisons (415 or 34%);
- Public housing (151 or 12%);
- Police (142 or 11%);
- Transport (125 or 10%);
- Child protection (77 or 6%); and
- Education, including public schools and TAFE colleges (59 or 5%). Information about universities is shown separately under the University Sector.

For further details about the number of complaints received and finalised about individual public sector agencies and authorities, see Appendix 1.

Outcomes of complaints about the public sector

In 2017-18, there were 225 actions taken by public sector bodies as a result of Ombudsman action following a complaint. These resulted in 175 remedies being provided to complainants and 50 improvements to public sector practices.

The following case study illustrates the outcomes arising from complaints about the public sector. Further information about the issues raised in complaints and the

outcomes of complaints is shown in the following tables for each of the six key areas and for the other public sector services as a group.

Case Study

Reconsideration of decision and improved governance

A person complained to the Office about the process used by a public authority when making a decision which affected their ability to undertake their work. Following an investigation by the Office, the public authority, in a very positive way, agreed to (among other things):

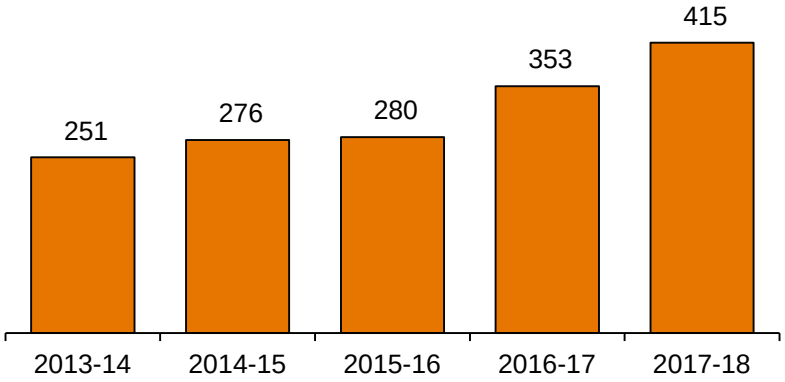
- Write to the person and outline its concerns about their suitability to undertake their work; and
- Propose a pathway forward to resolve the matter.

Further the public authority informed the Office that it had commenced a project to identify and progress a range of administrative improvements to strengthen its ability to govern bodies and persons carrying out the work on its behalf, including consideration of amendments to relevant regulations.

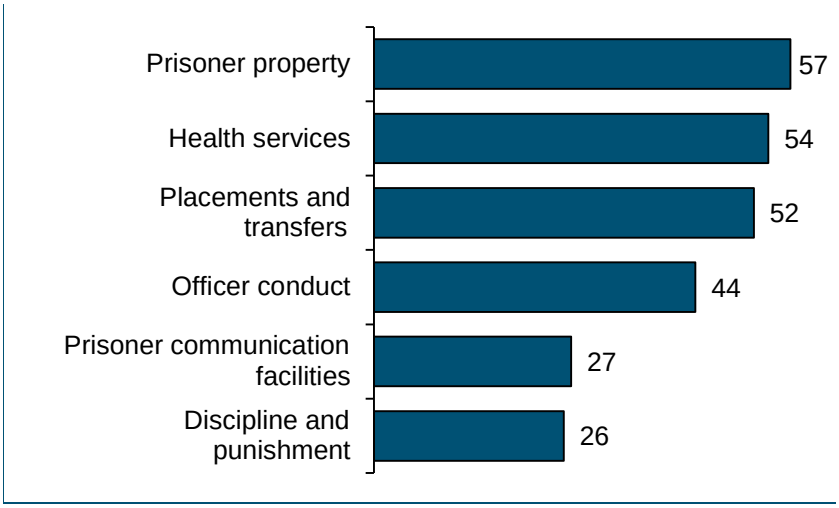
Public sector complaint issues and outcomes

Corrective Services

Complaints received



Most common allegations



Other types of allegations

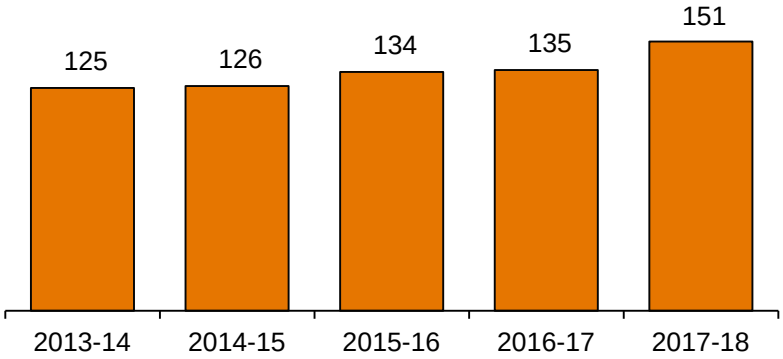
- Prisoner employment;
- Facilities and conditions;
- Canteen and prisoner allowance issues;
- Individual Management Plans; and
- Visits.

Outcomes achieved

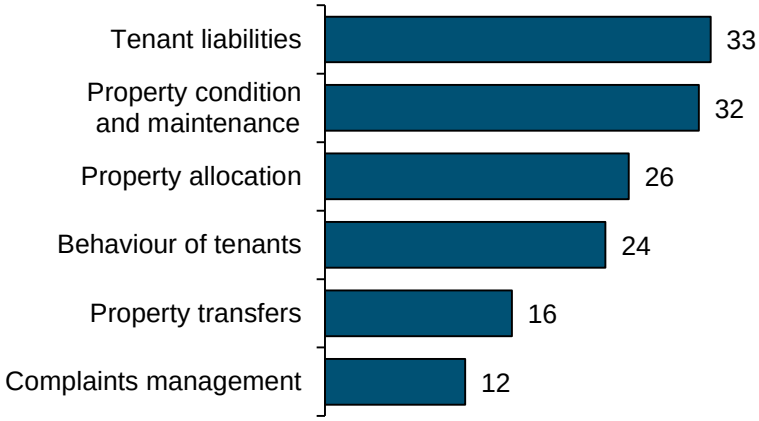
- 'Act of grace' payment or monetary charge reduced/refunded;
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy, procedure, business systems or practices;
- Update to publications or website;
- Conduct audit or review; and
- Staff training.

Public Housing

Complaints received



Most common allegations



Other types of allegations

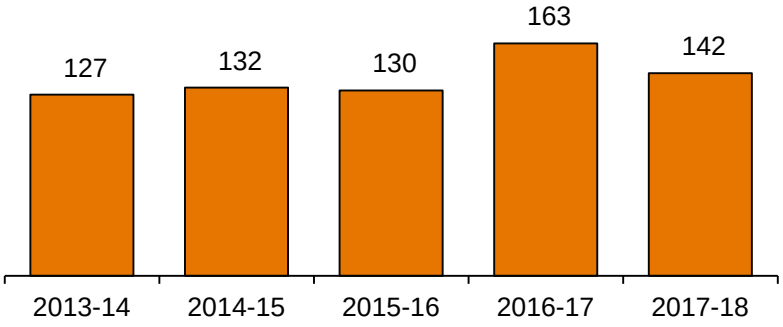
- Rent or bond assistance;
- Debt repayments;
- Tenant's personal property;
- General communication and provision of information;
- Dividing fence issues; and
- Termination of tenancy.

Outcomes achieved

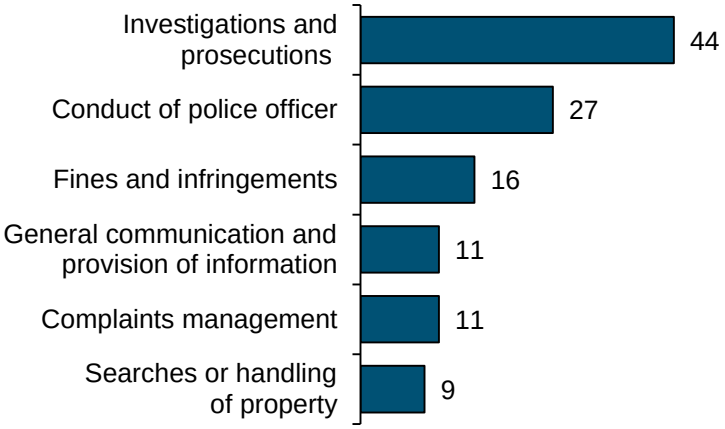
- Monetary charge reduced or withdrawn;
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated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

Police

Complaints received



Most common allegations



Other types of allegations

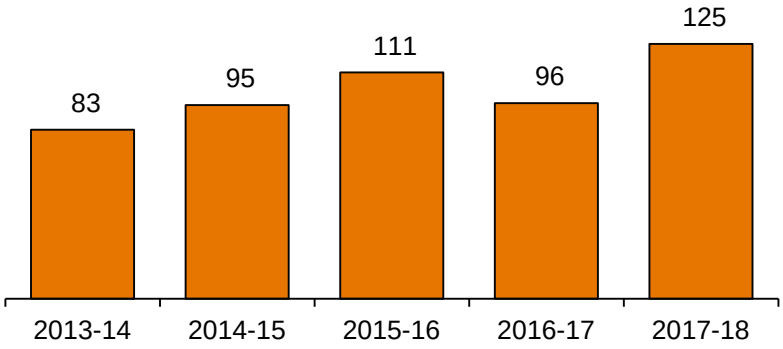
- Traffic matters;
- Arrest and detention issues;
- Permits and licences;
- Personal information and privacy issues; and
- Human resource management issues.

Outcomes achieved

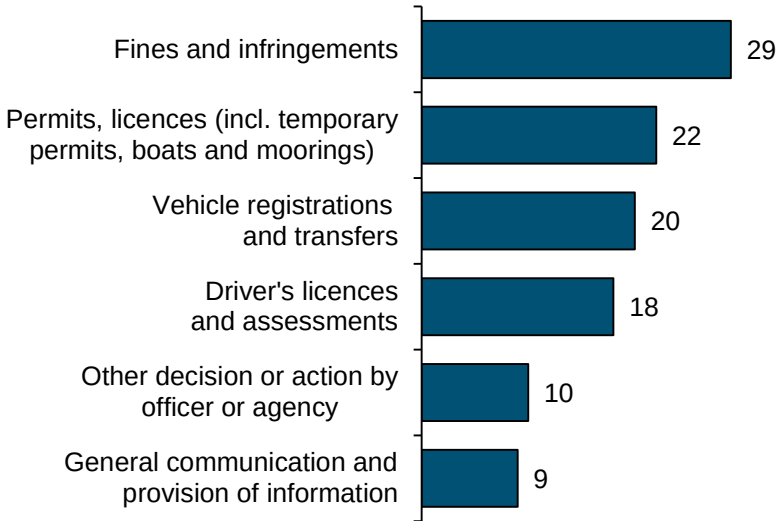
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Update to publications or website; and
- Staff training.

Transport

Complaints received



Most common allegations



Other types of allegations

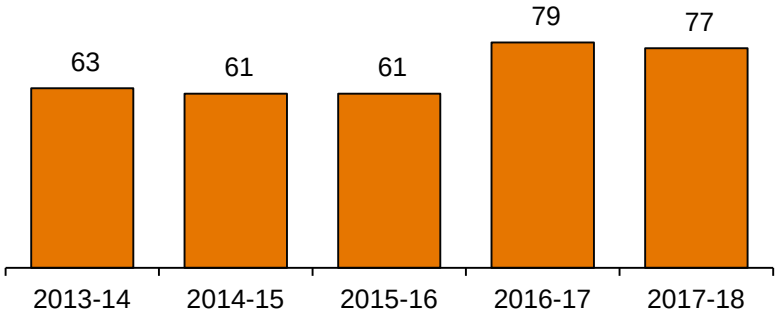
- Policies and procedures of the agency;
- Public transport ticketing (other than infringements); and
- Human resource management issues.

Outcomes achieved

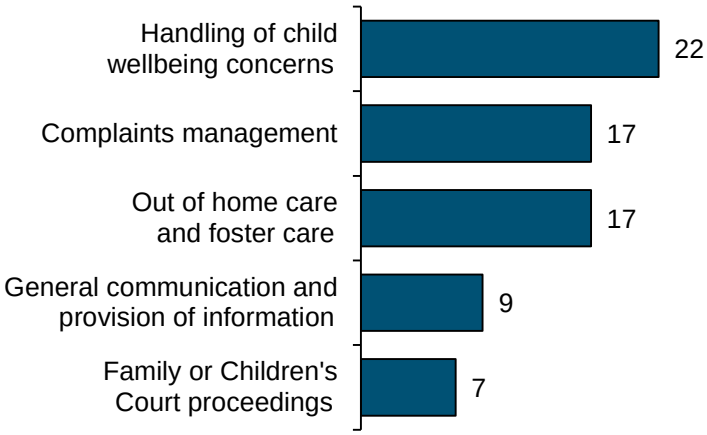
- Consider or reconsider a matter and make a decision;
- Apology given;
- Acknowledgement of error;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to legislation;
- Change to policy, procedure, business systems or practices;
- Update to publications or website;
- Conduct audit or review; and
- Staff training.

Child Protection

Complaints received



Most common allegations



Other types of allegations

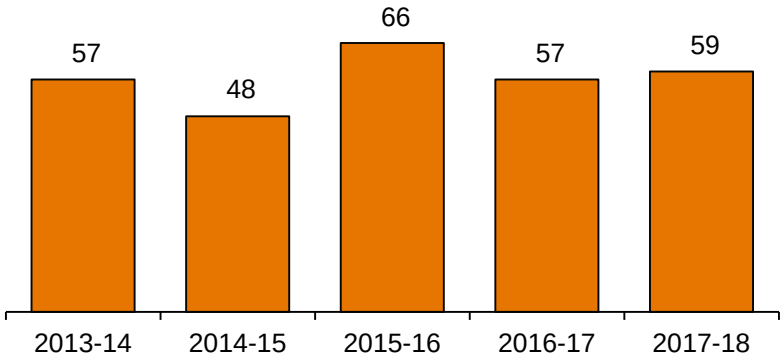
- Policies and procedures of the agency;
- Human resource management issues;
- Personal information and privacy issues; and
- Special assistance and grants.

Outcomes achieved

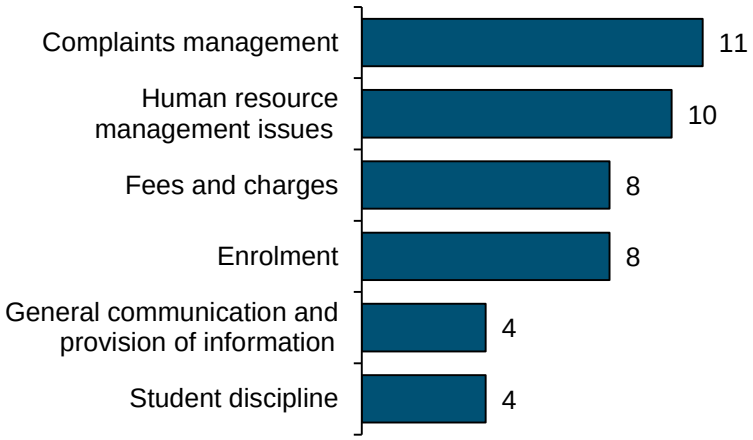
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to policy or procedure; and
- Staff training.

Education

Complaints received



Most common allegations



These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2018* relating to TAFE colleges and other public education agencies. Further details on these appeals are included later in this section.

Other types of allegations

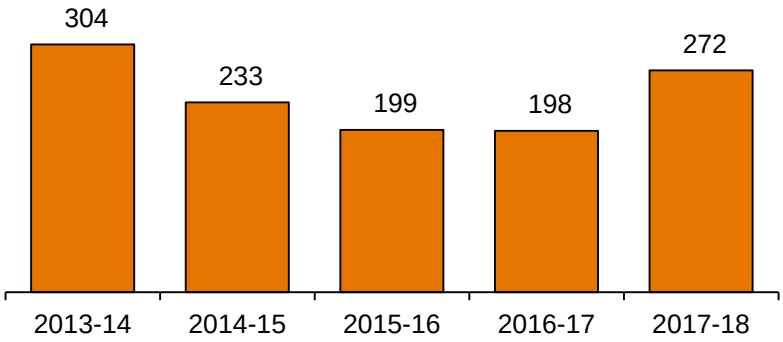
- Transfers between education providers;
- Termination of enrolment;
- Student care; and
- Examinations and assessments.

Outcomes achieved

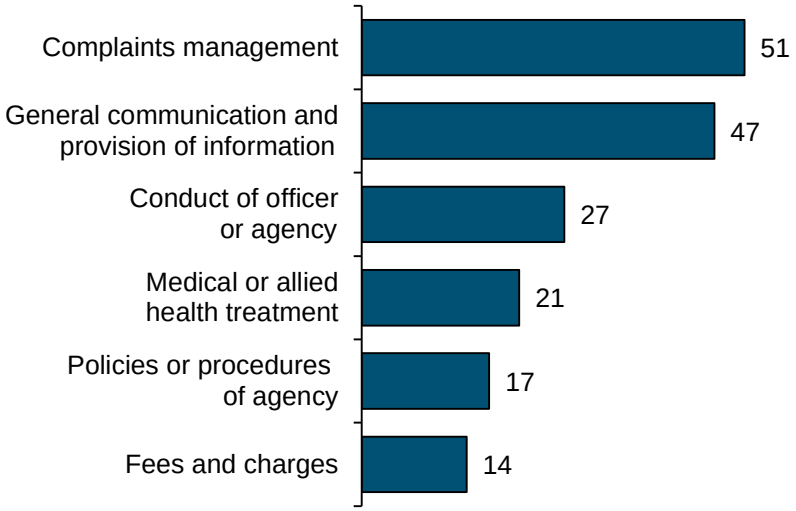
- Monetary charge reduced, withdrawn or refund given;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to business systems or practices; and
- Update to publications or website.

Other Public Sector Services

Complaints received



Most common allegations



Other types of allegations

- Enforcement action;
- Service quality;
- Patient's property;
- Board or committee proceedings;
- Personal information and privacy issues; and
- Human resource management issues.

Outcomes achieved

- 'Act of grace' payment or monetary charge reduced, withdrawn or refunded;
- Consider or reconsider and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to policy, procedure, business systems or practices;
- Update to publications or website; and
- Conduct audit or review.

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

Case Study

Decision reconsidered due to misunderstanding

A student informed an educational institution of a planned absence during the semester. Prior to the absence, the educational institution informed the student that there was a scheduled assessment during their absence and it would look at what could be done about the assessment on their return. Subsequently, the student received a zero grade for the assessment. The student complained to the Office about the alleged change in the position of the educational institution.

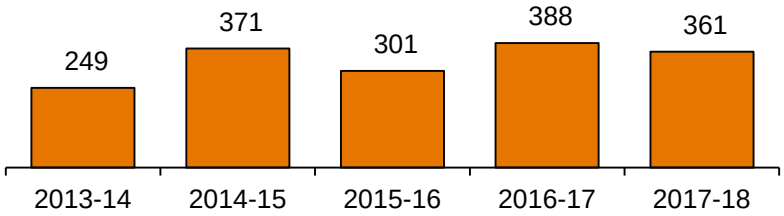
Following enquiries by the Office, the educational institution agreed to provide the student with a score for the assessment based on their performance in previous assessments.

The local government sector

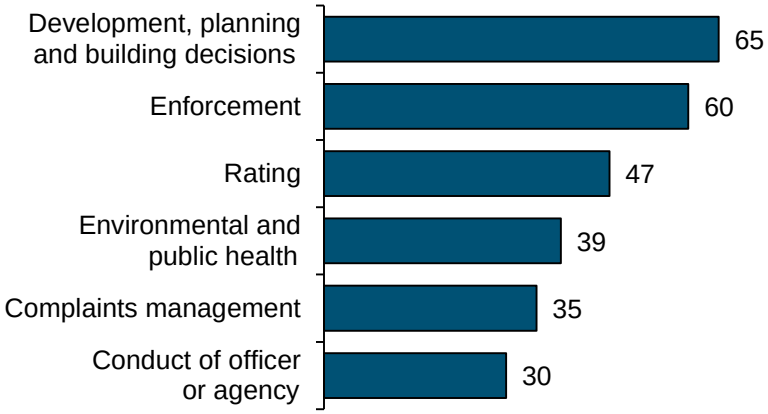
The following section provides further details about the issues and outcomes of complaints for the local government sector.

Local Government

Complaints received



Most common allegations



Other types of allegations

- General communication and provision of information;
- Fines and infringements;
- Liability claims;
- Engineering;
- Approvals and licences (other than development, planning and building); and
- Community facilities.

Outcomes achieved

- 'Act of grace' payment or monetary charge refunded or withdrawn;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy, procedure, business systems or practices;
- Update to publications or website;
- Conduct audit or review;
- Improved recordkeeping; and
- Staff training.

Case Study

Request for additional rates payment withdrawn

A resident visited their local government office to pay their annual rates with cash and was issued a receipt by the customer service officer. Sometime later, the local government contacted the resident informing them of an operator error that resulted in an incorrect receipt being issued for the full rates instead of a lower payment option. As a result, the local government said the resident still owed an amount for their rates and requested payment. The resident believed that they had paid the full amount as shown on the receipt and complained to the Office about the local government's request for further payment.

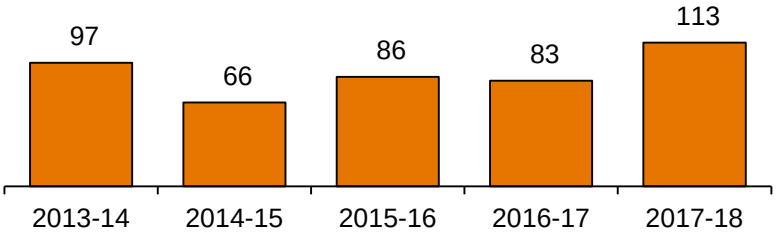
Following enquiries by the Office, the local government reviewed the circumstances surrounding the incident. As a result of that review, the local government informed the resident that it had decided not to pursue the payment further and would adjust the rate record to reflect that the rates had been paid in full and apologised for any inconvenience and misunderstanding that may have arisen. Further, the local government implemented multiple operational changes to prevent a similar situation occurring in the future.

The university sector

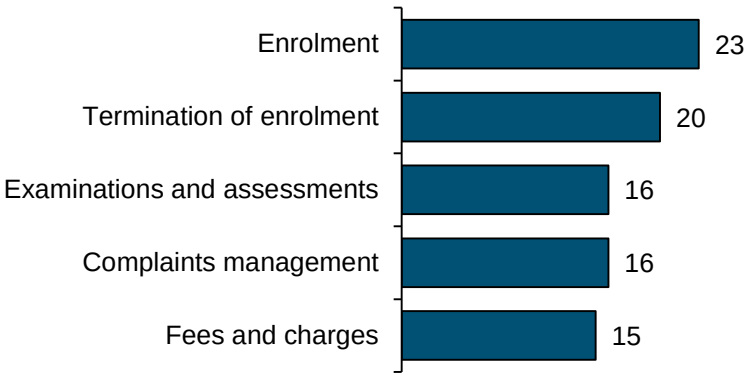
The following section provides further details about the issues and outcomes of complaints for the university sector.

Universities

Complaints received



Most common allegations



These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2018.* Further details on these appeals are included later in this section.

Other types of allegations

- Management of academic misconduct;
- General communication and provision of information;
- Prizes, awards and scholarships;
- Human resource management issues; and
- Transfers.

Outcomes Achieved

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

Case Study

Refund of fees and improved refund processes

A prospective student made an application to study a course at a Western Australian university. The student paid the course fees but was later unsuccessful in meeting a pre-requisite for the course and requested a refund of the fees. When the student did not receive a response from the university, they complained to the Office about the university's delay in refunding the fees.

Following enquiries by the Office, the university informed the Office that there was an oversight in the processing of the refund and that it would refund the fees and undertake a review to understand why the refund was not actioned. Following the review, the university informed the Office that, in addition to the request for the refund occurring at a busy time and human error, there was an administrative process step that needed to be addressed. This was already under review by the university with an estimated completion by the next admission period.

Other Complaint Related Functions

Reviewing appeals by overseas students

The *National Code of Practice for Providers of Education and Training to Overseas Students 2018* (**the National Code**) sets out standards required of registered providers who deliver education and training to overseas students studying in Australian universities, TAFE colleges and other public education agencies. It provides overseas students with rights of appeal to external, independent bodies if the student is not satisfied with the result or conduct of the internal complaint handling and appeals process.

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

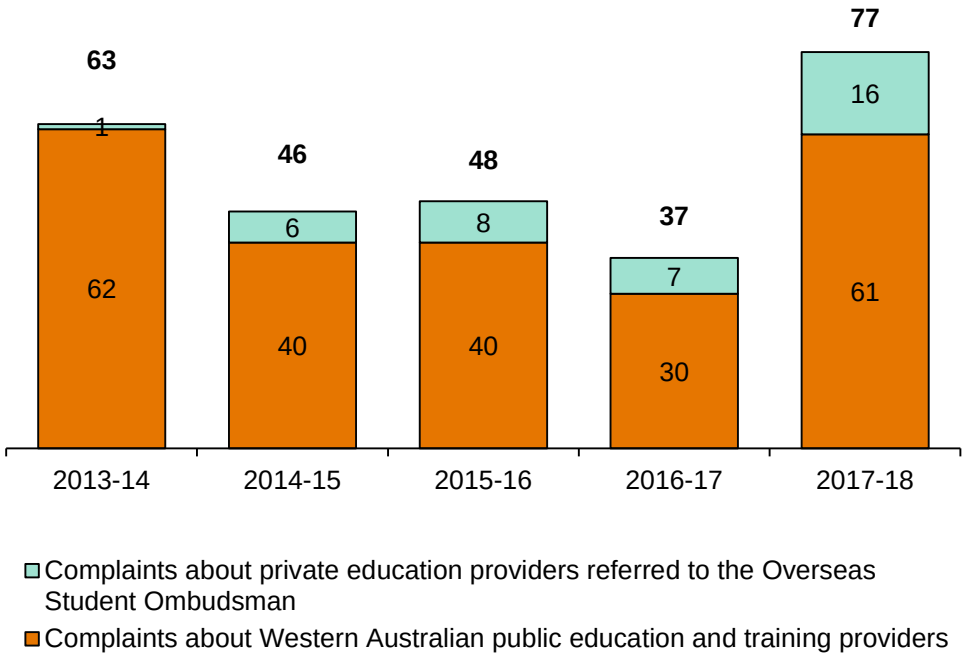
- Provides a free complaint resolution service;
- Is independent and impartial and does not represent either the overseas students or education and training providers; and
- Can make recommendations arising out of investigations.

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

Complaints lodged with the Office under the National Code

Education and training providers are required to comply with 11 standards under the National Code. In dealing with these complaints, the Ombudsman considers whether the decisions or actions of the agency complained about comply with the requirements of the National Code and if they are fair and reasonable in the circumstances.

Complaints Received from Overseas Students under the National Code between 2013-14 and 2017-18



During 2017-18, the Office received 77 complaints from overseas students, including 61 complaints about public education and training providers. Fifty complaints about public education and training providers were about universities, six were about TAFE colleges and five were about other education providers. The Office also received 16 complaints that, after initial assessment, were found to be about a private education provider. The Office referred these complainants to the Overseas Students Ombudsman.

The 61 complaints by overseas students about public education and training providers involved 82 separate allegations. There are more allegations than complaints because one complaint may cover more than one issue. The most common issues raised by overseas students were decisions about:

- Termination of enrolment (20);
- Fees and charges (12);
- Enrolment (11);
- Management of academic misconduct (8);
- Examinations and assessments (6); and
- Transfers between education and training providers (5).

During the year, the Office finalised 55 complaints about 75 issues.

Public Interest Disclosures

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

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

During the year, three disclosures were received.

Indian Ocean Territories

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

Terrorism

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

Requests for Review

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

In 2017-18, 11 reviews were undertaken, representing half of one per cent of the total number of complaints finalised by the Office. In all cases where a review was undertaken, the original decision was upheld.

Child Death Review

Overview

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

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

Background

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

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

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

- The CDRC together with its current resources be relocated to the Ombudsman (Recommendation 31); and

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

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

The Role of the Ombudsman in relation to Child Death Reviews

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

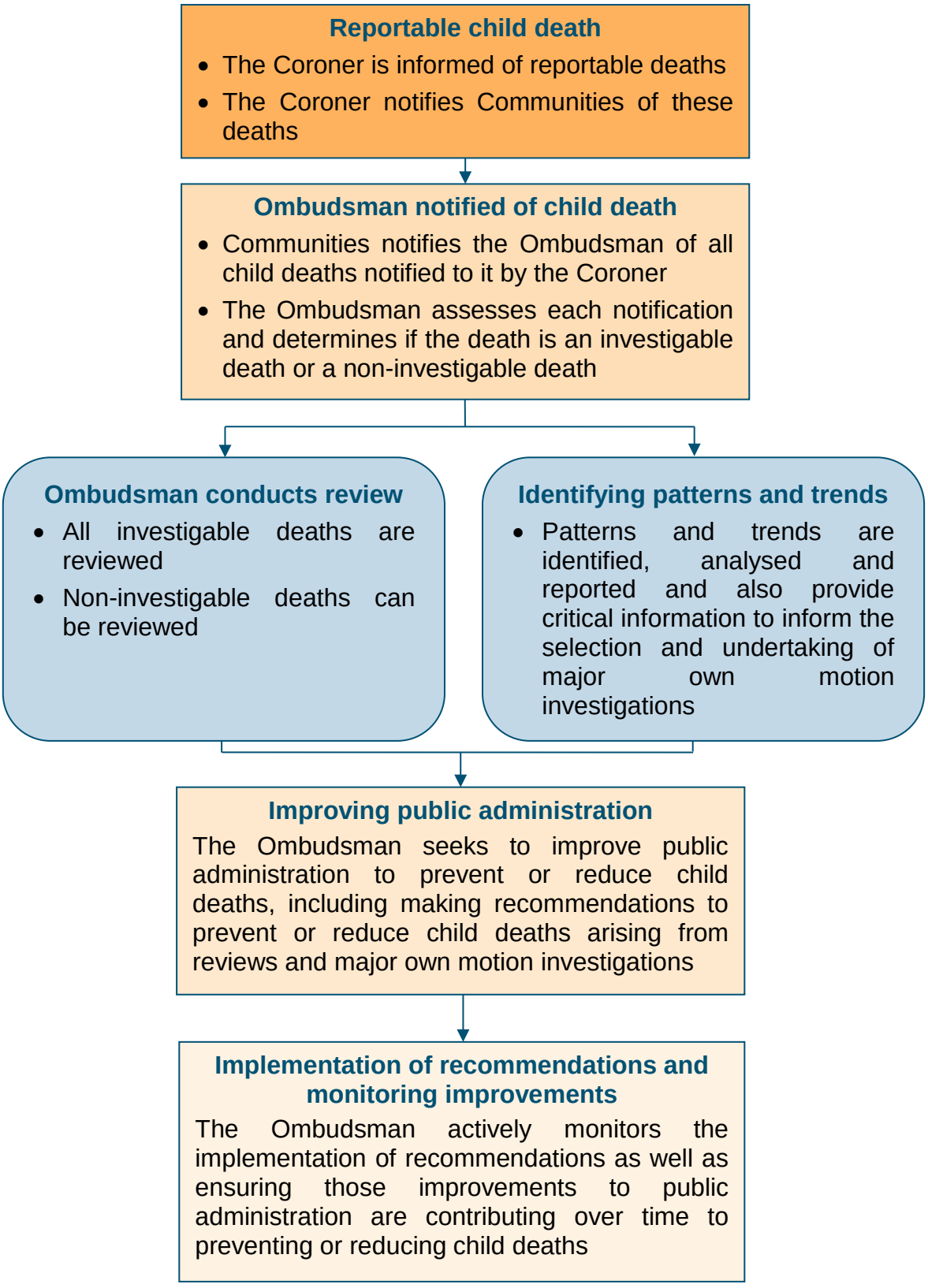
- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children 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.

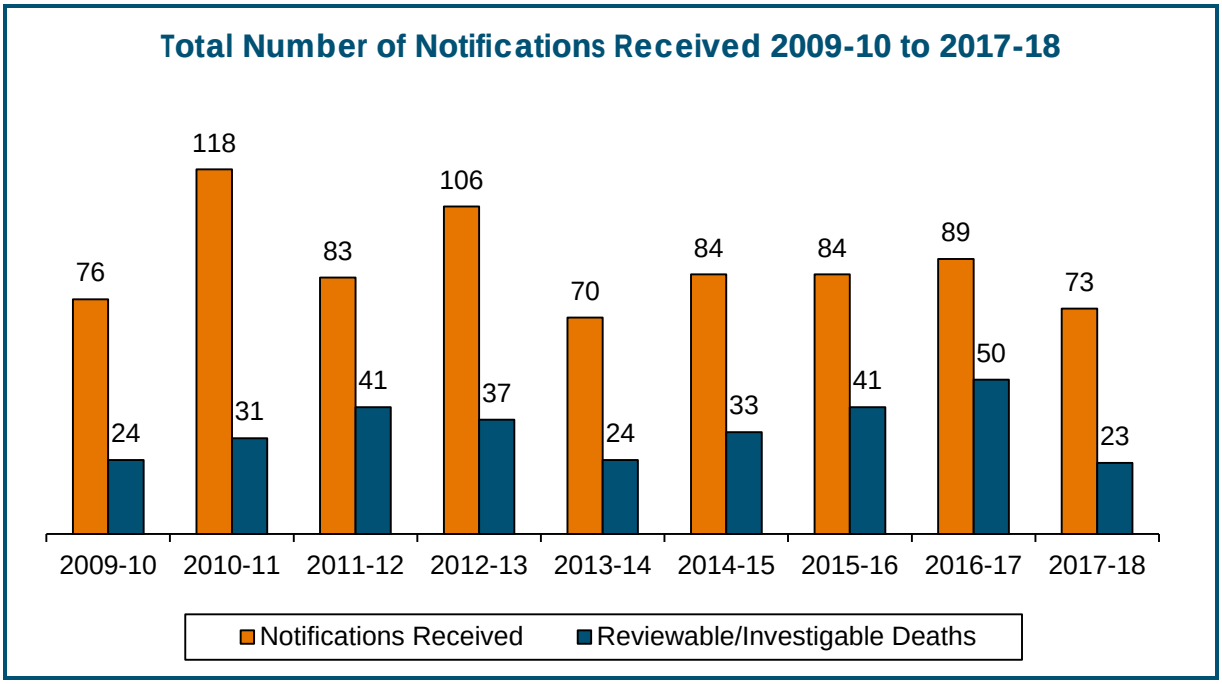
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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

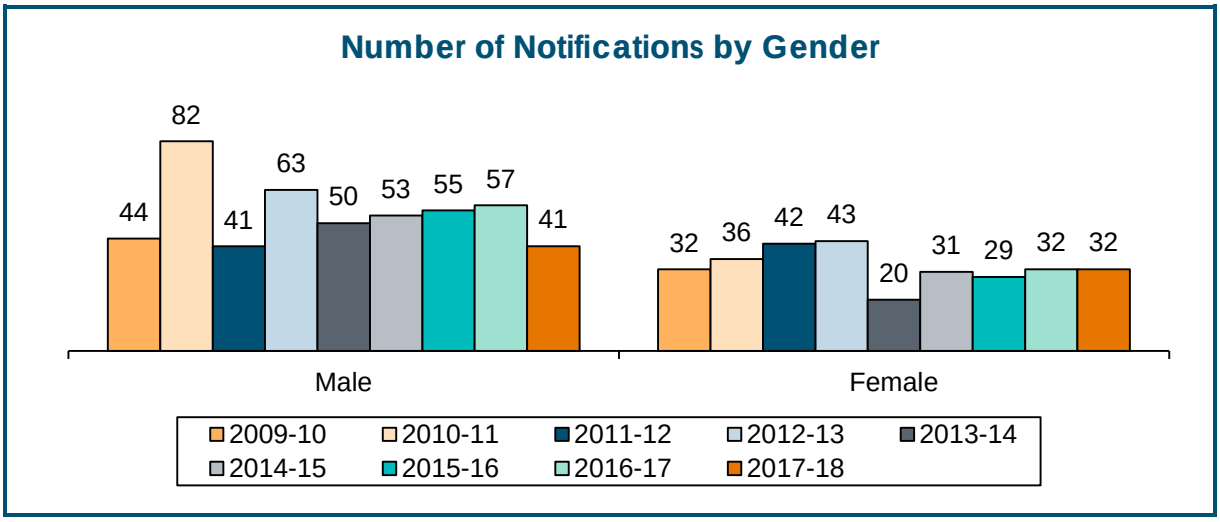
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

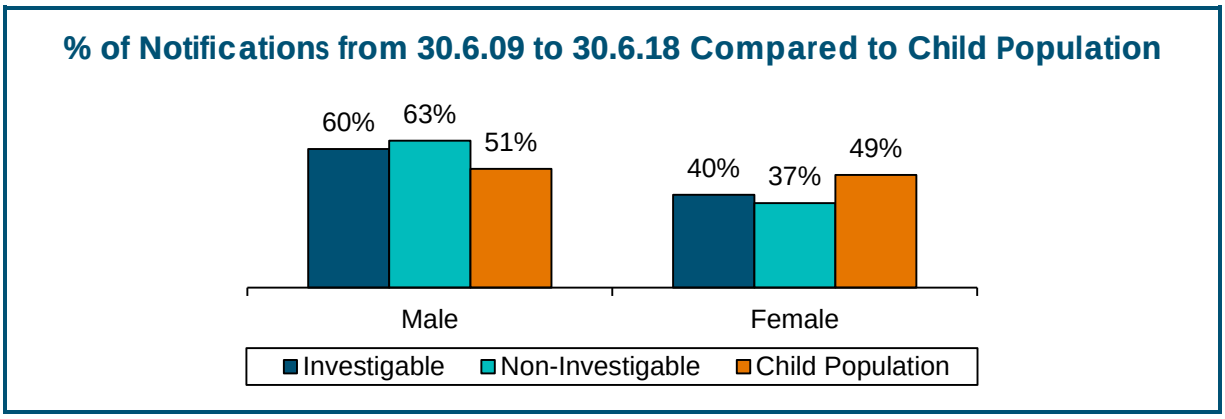
The following charts show:

- 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.

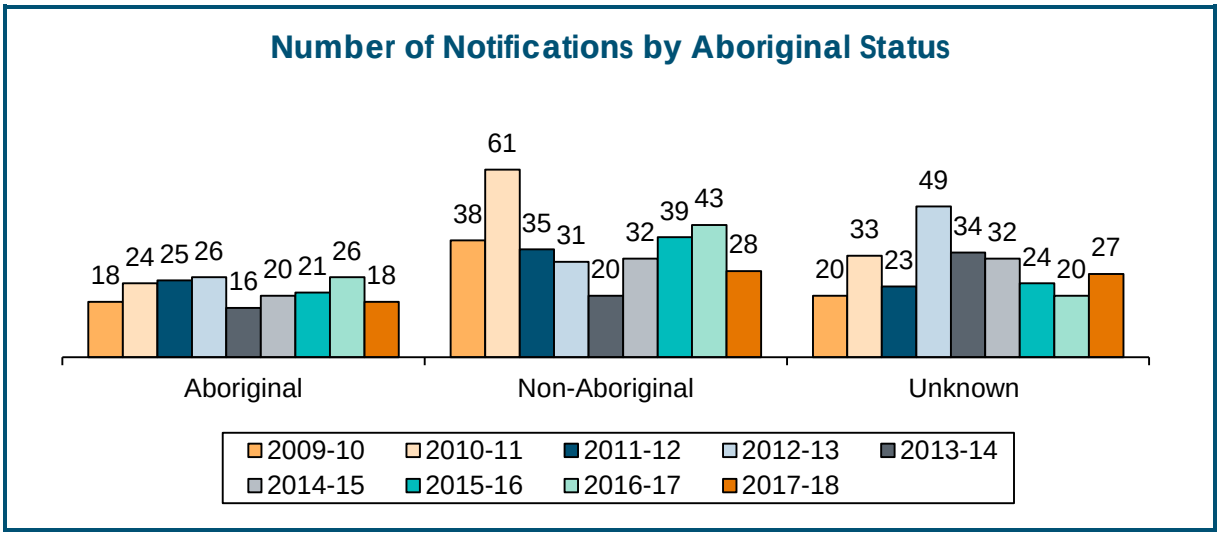


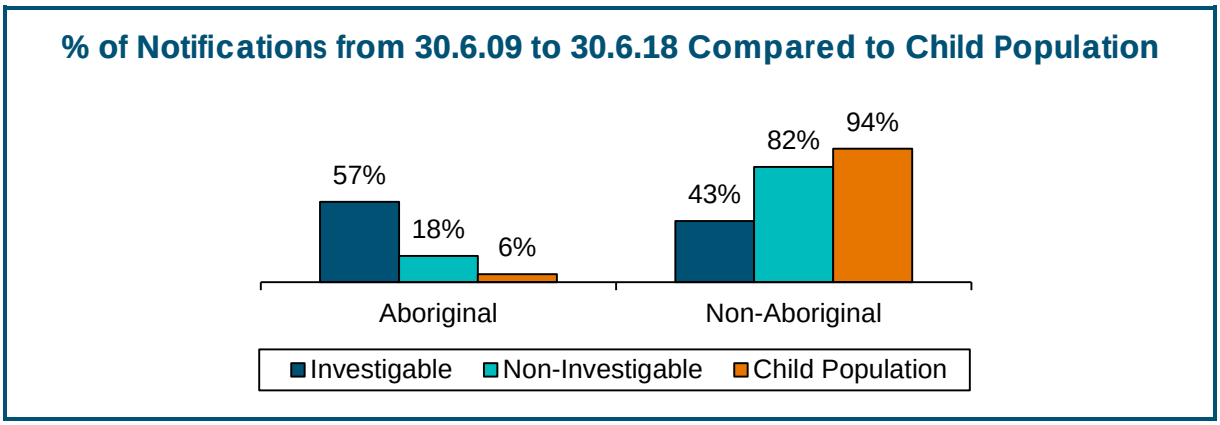


Further analysis of the data shows that, considering all nine years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

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.





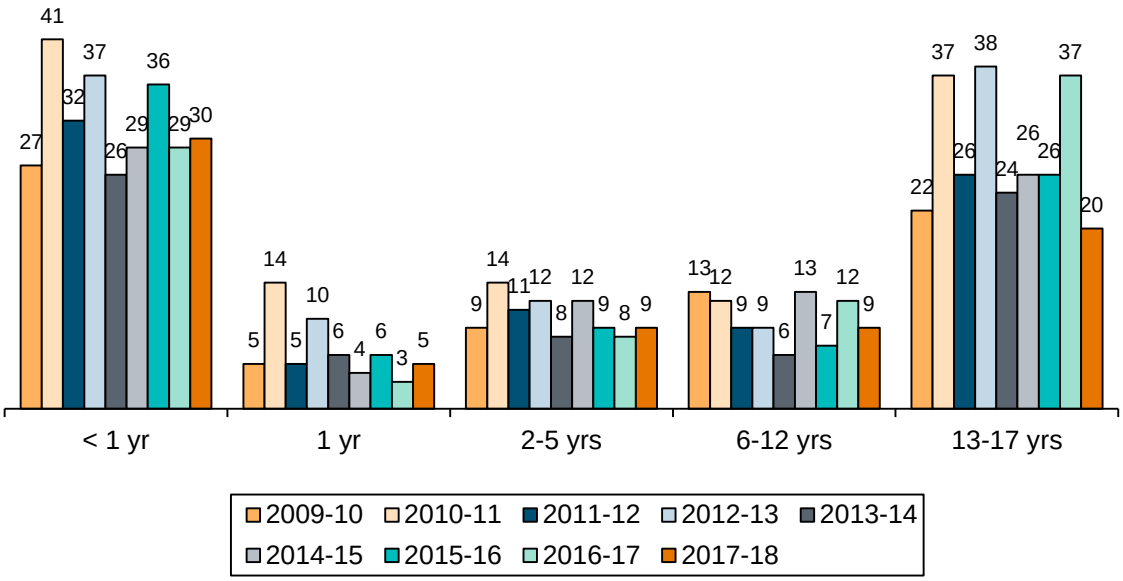
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

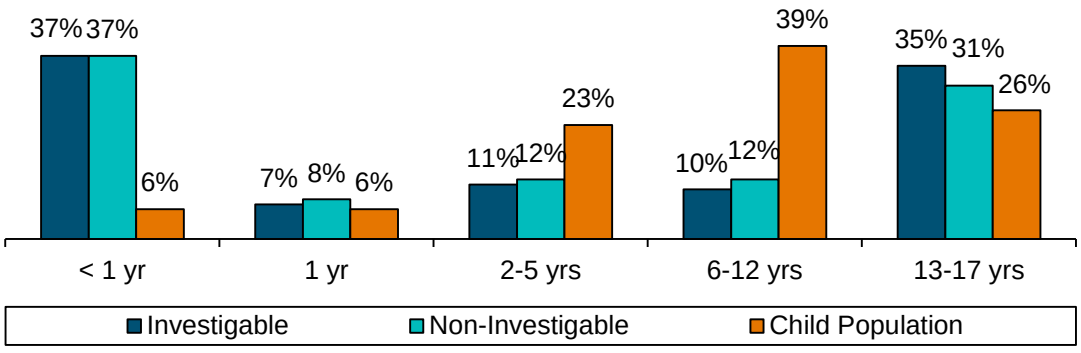
Age groups

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



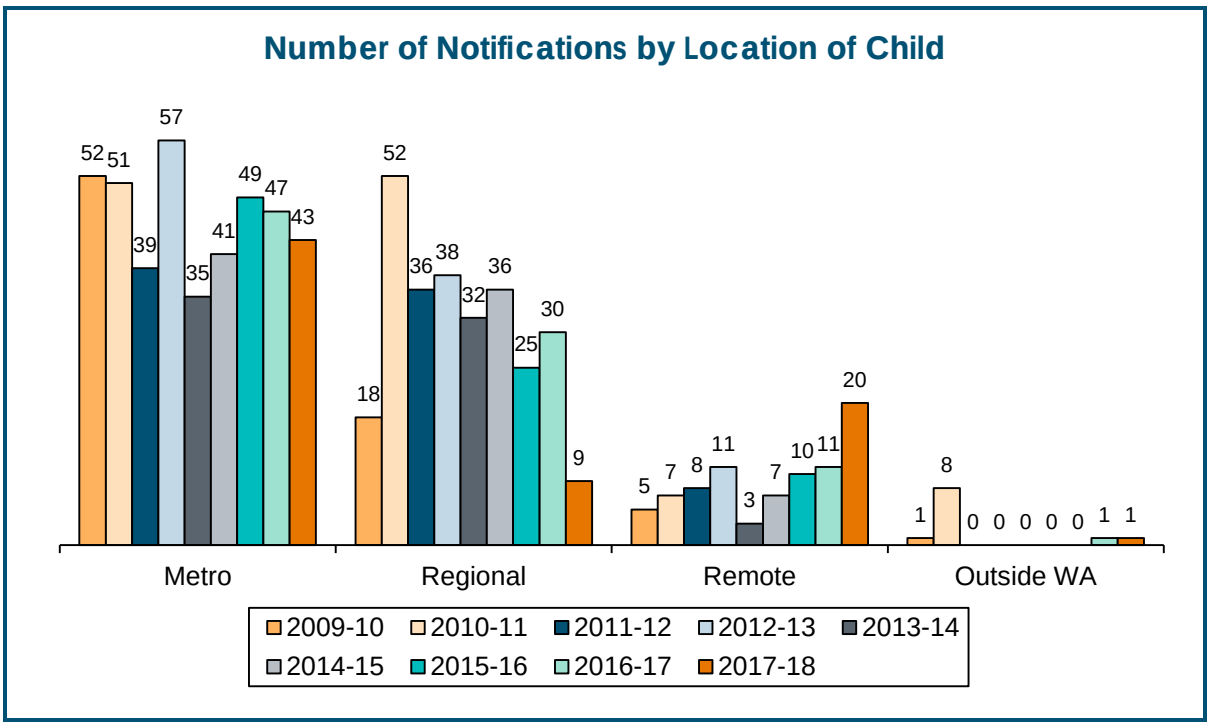
% of Notifications from 30.6.09 to 30.6.18 Compared to Child Population



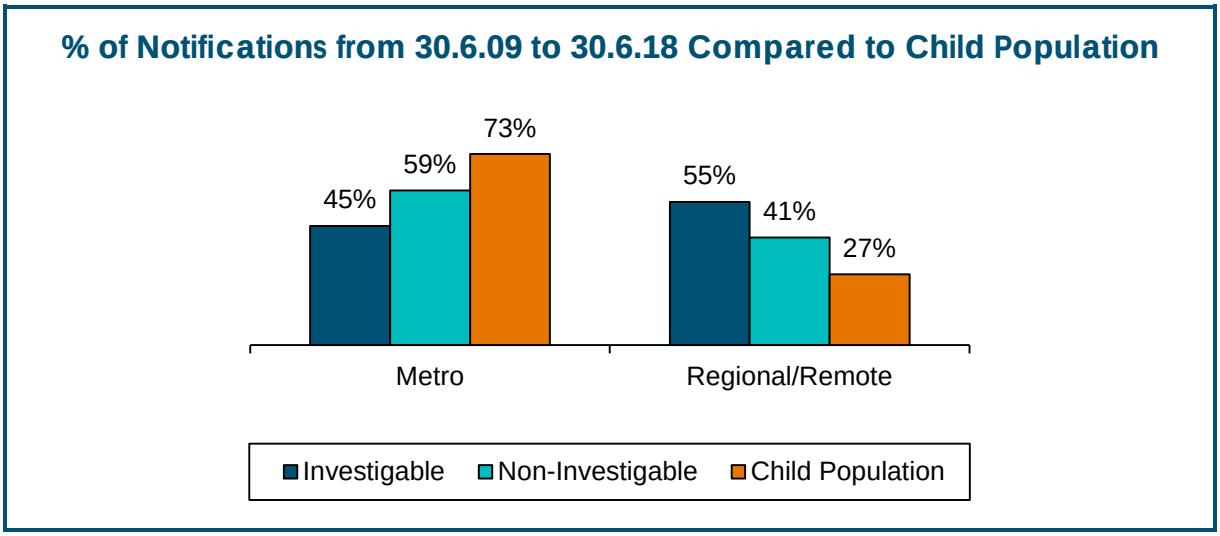
A more detailed analysis by age group is provided later in this section.

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

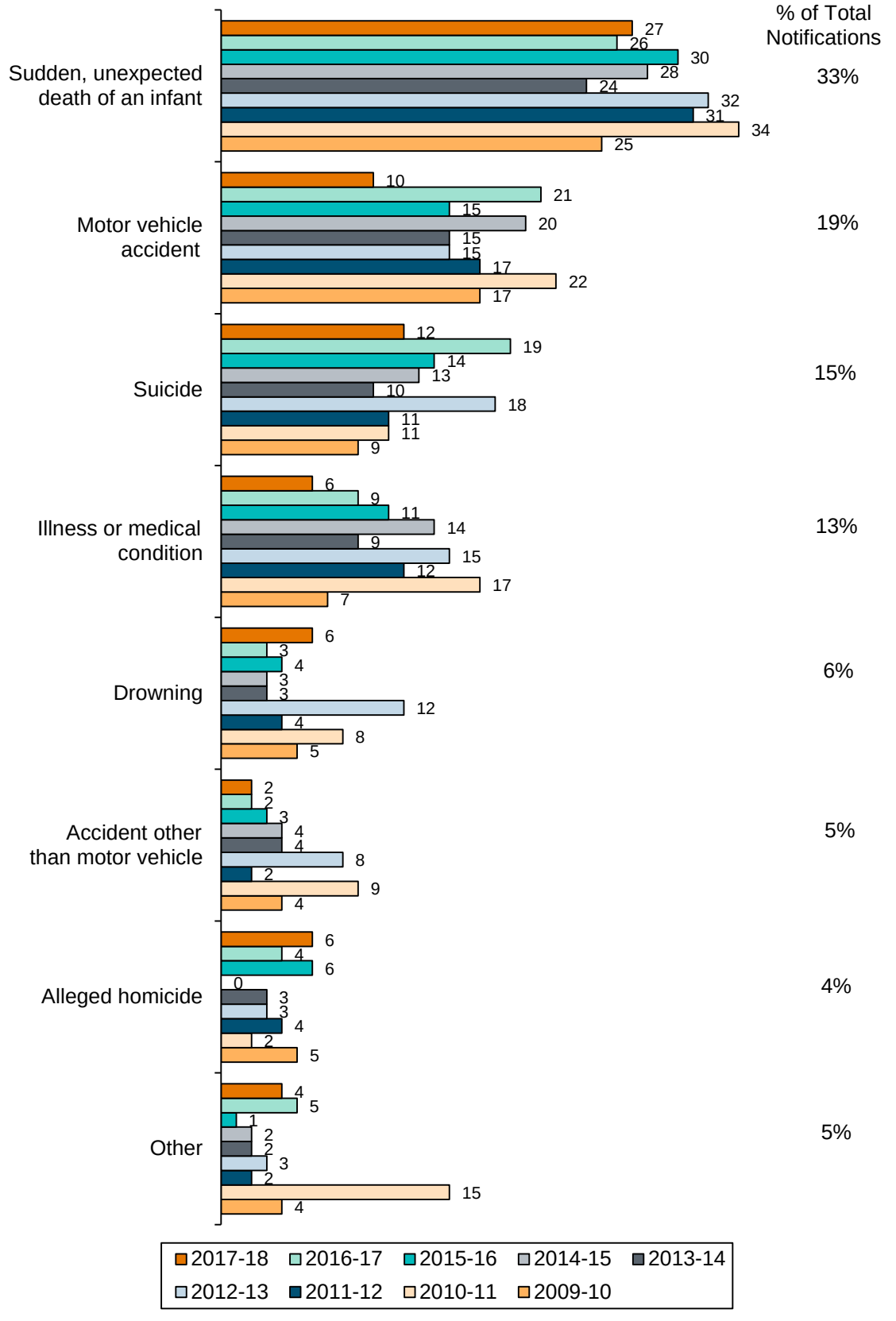
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally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



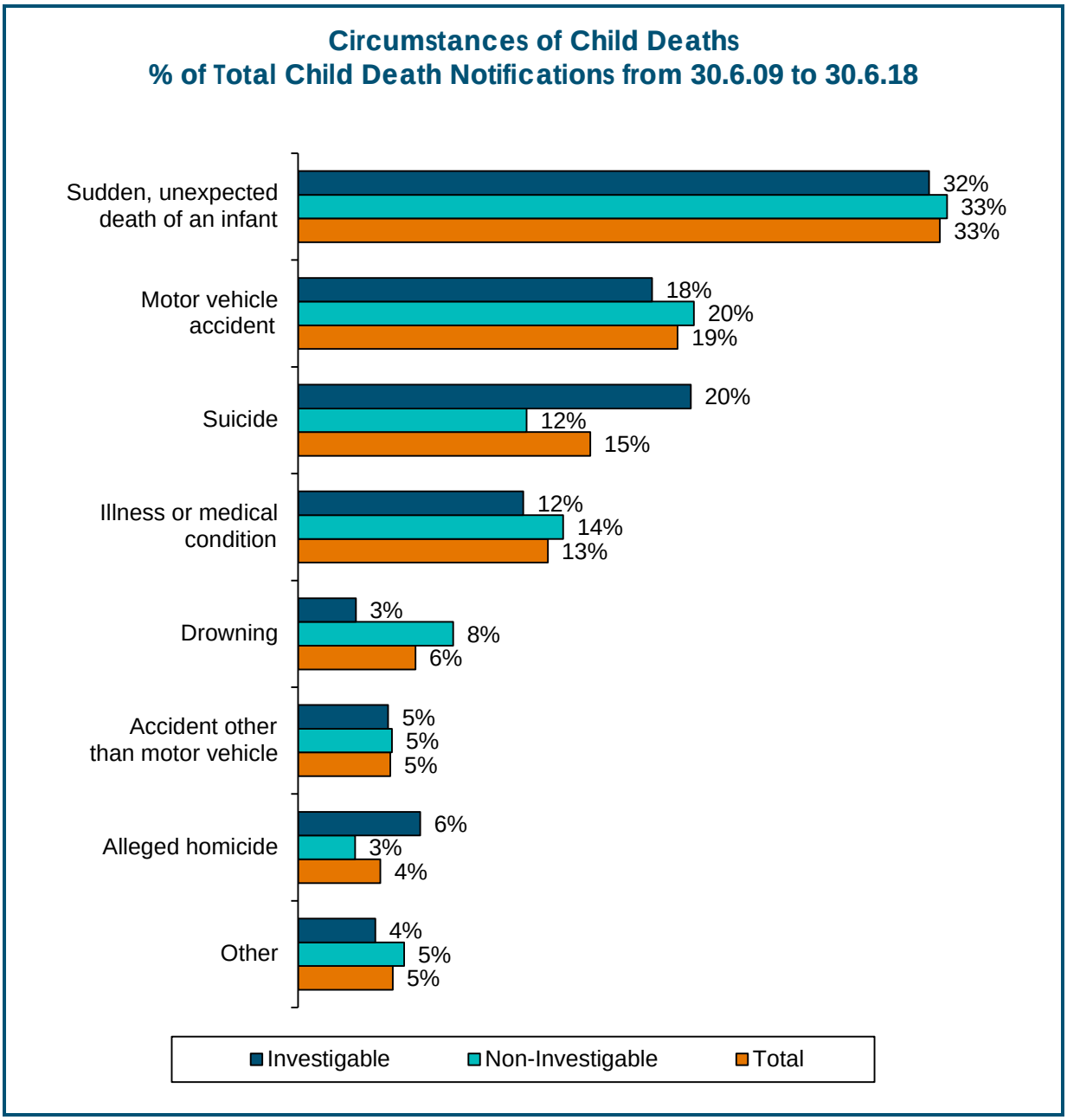
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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

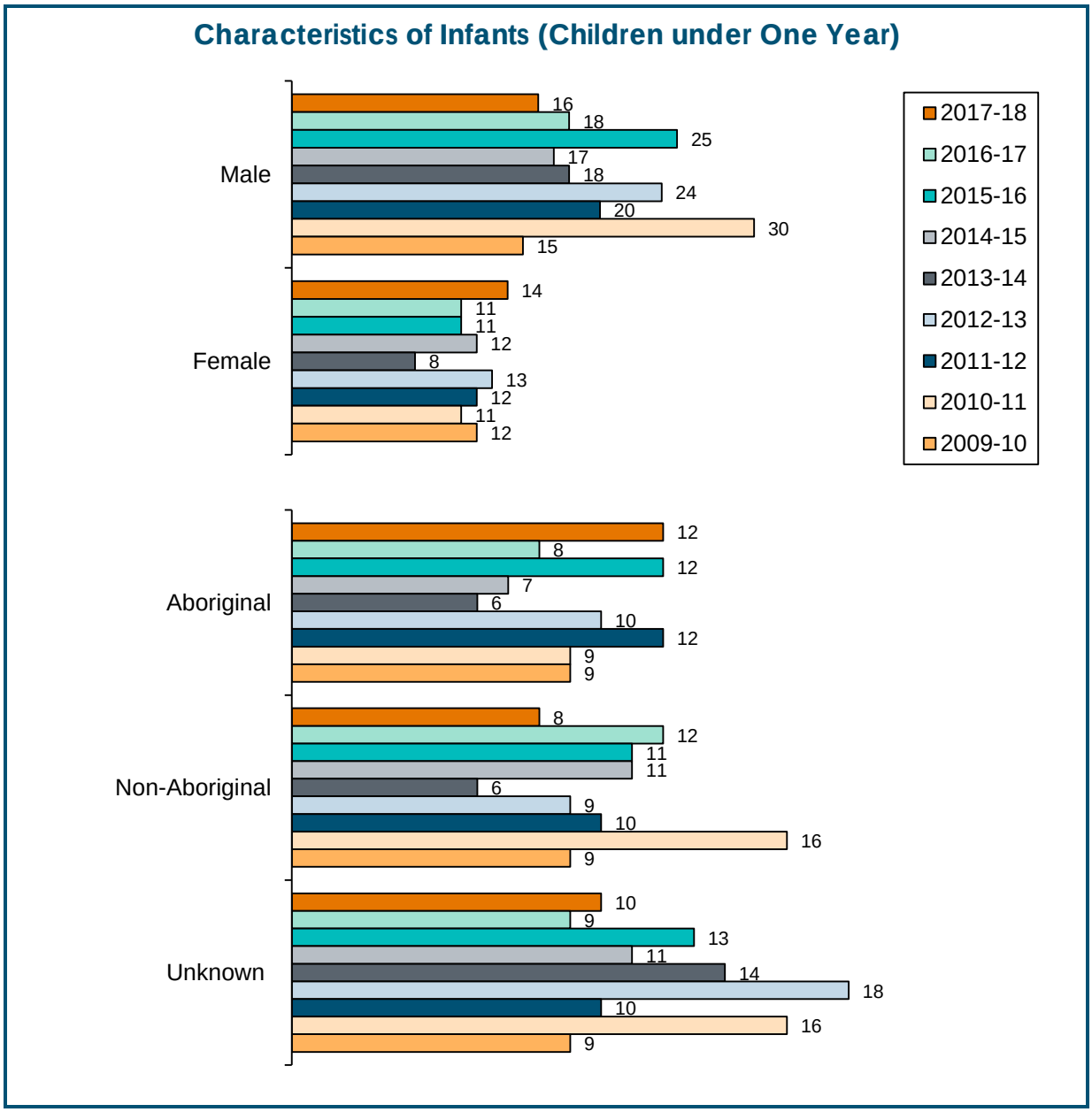
In child deaths notified to the Ombudsman in 2017-18, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

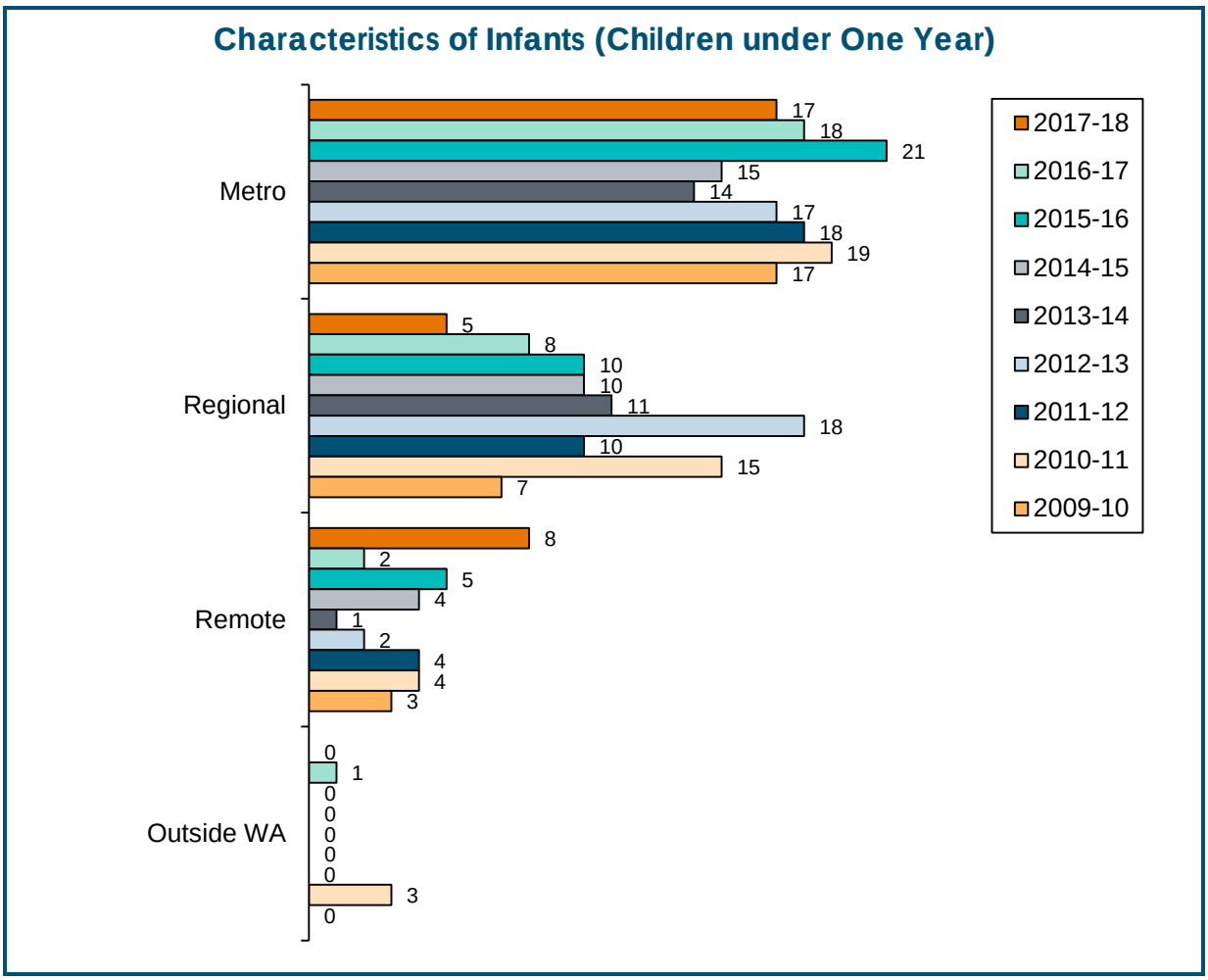
Analysis of children in particular age groups

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.



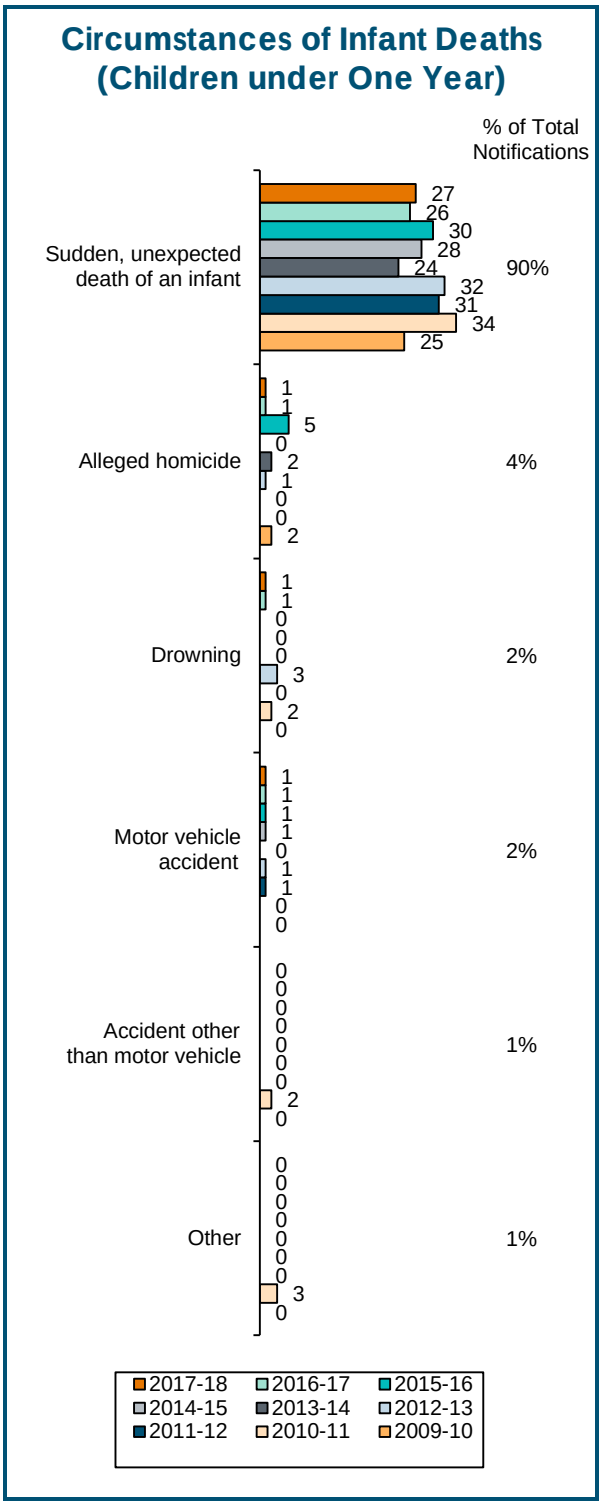


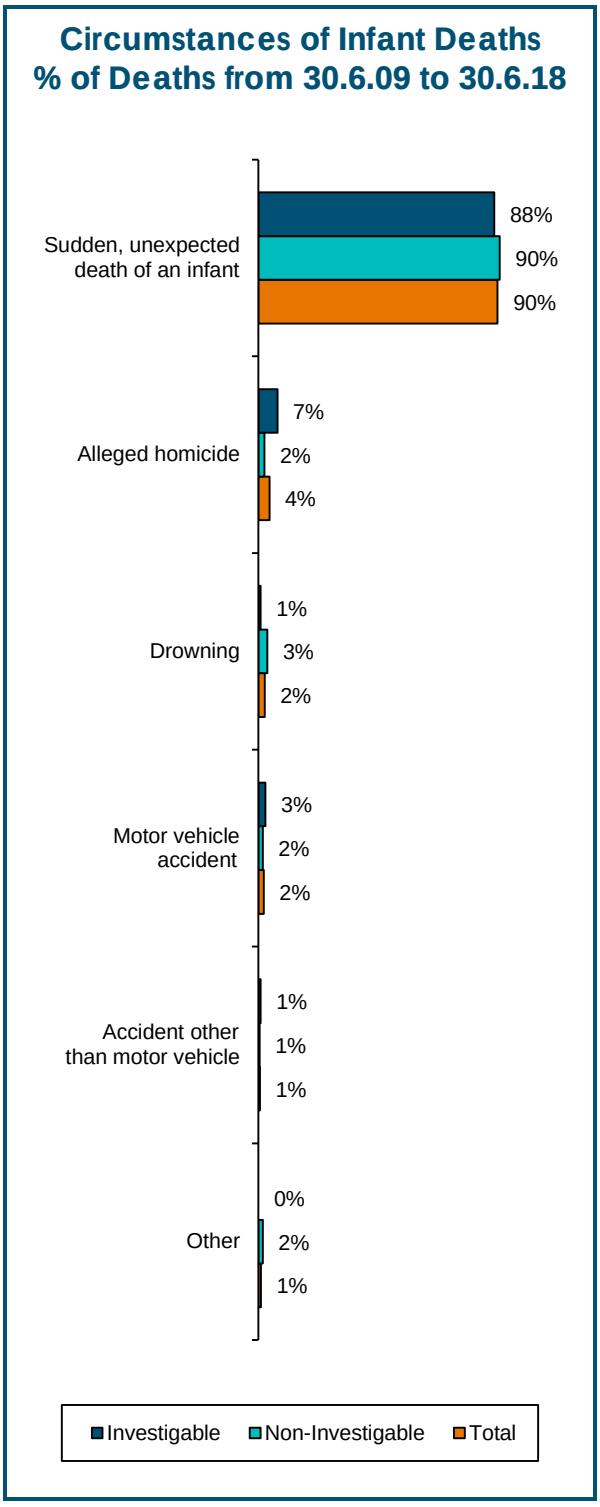
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.





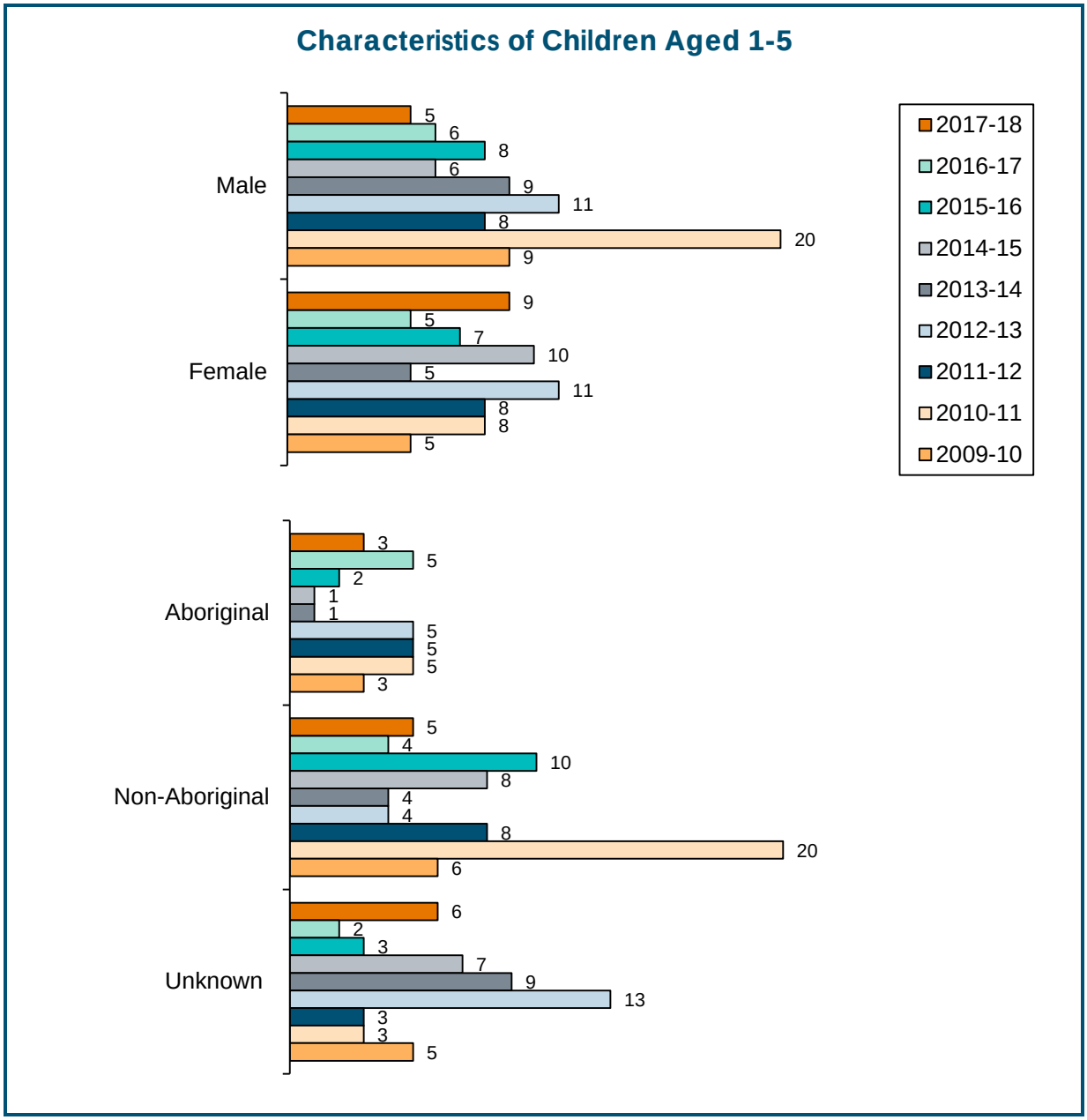
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

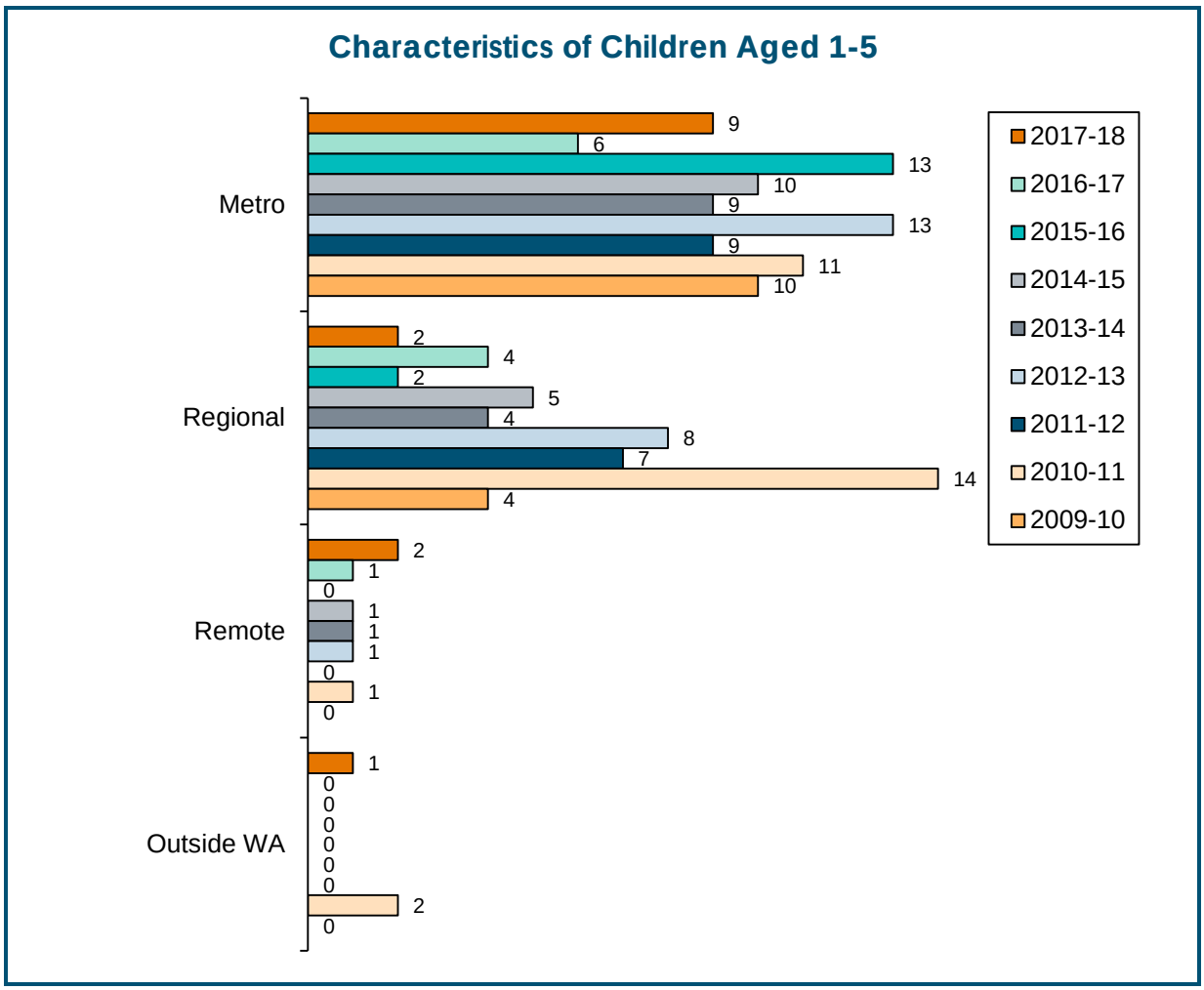
One hundred and eleven deaths of infants were determined to be investigable deaths.

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.



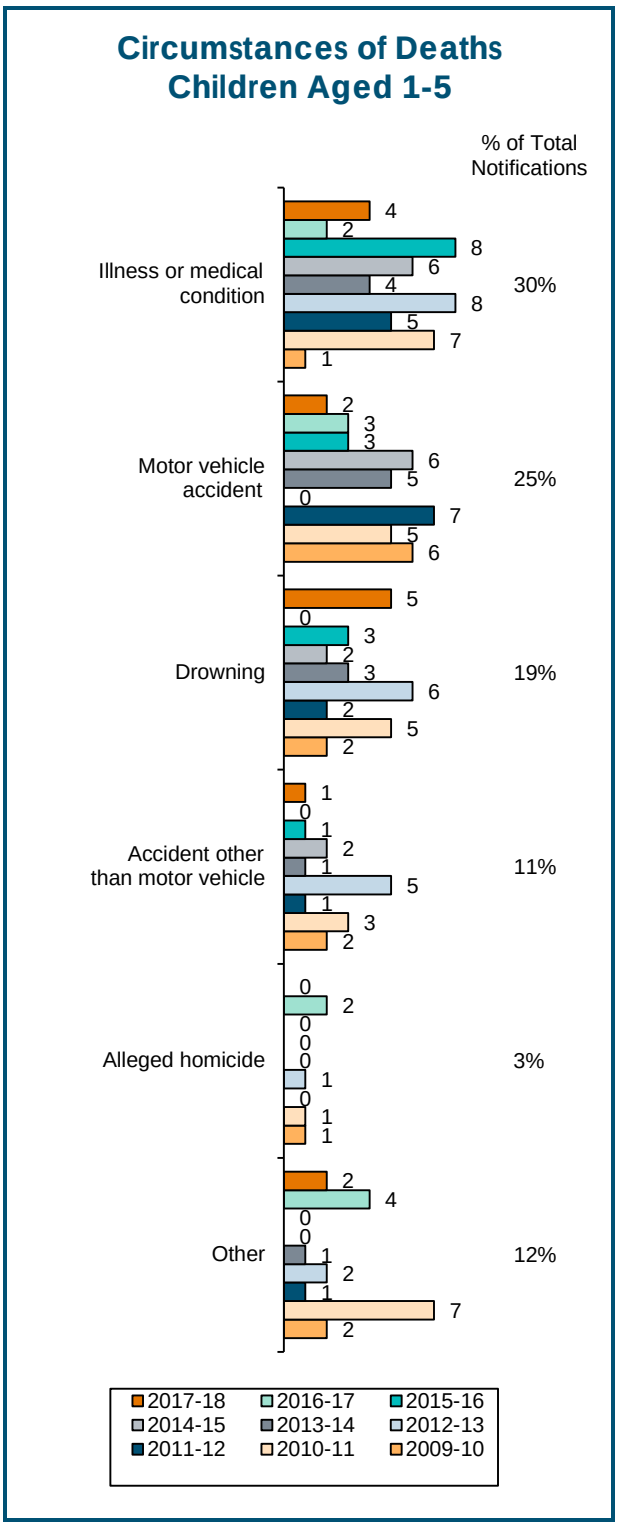


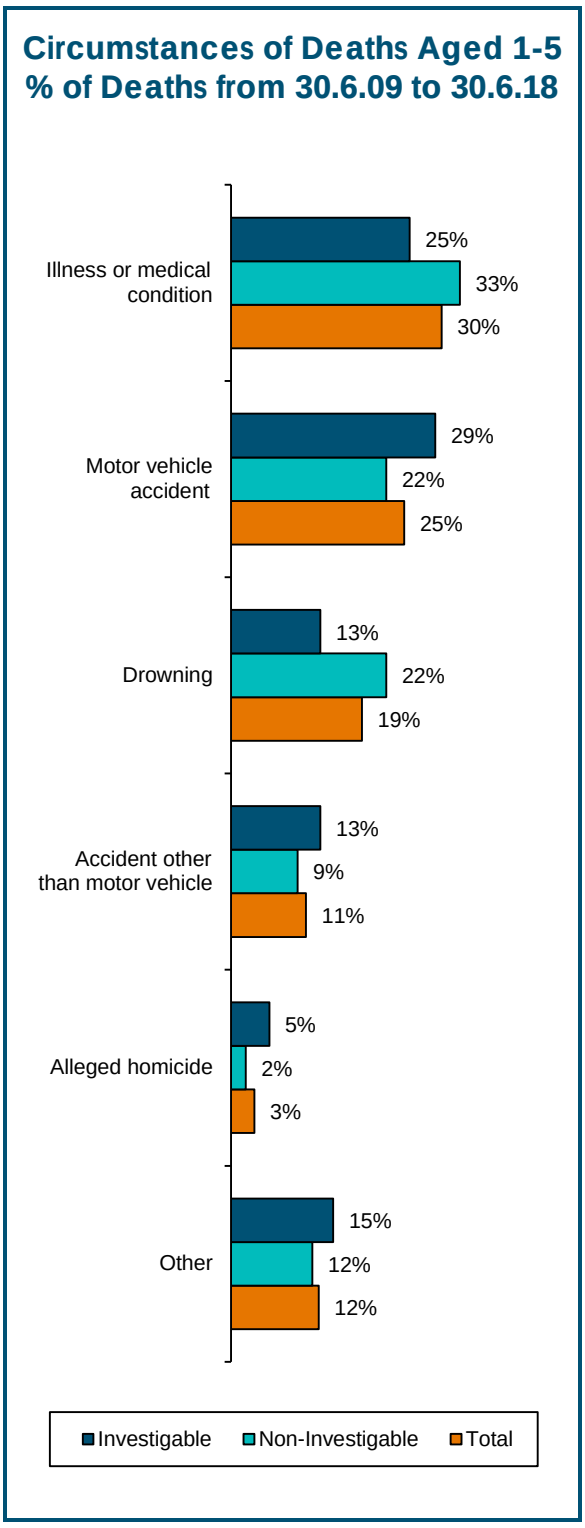
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).





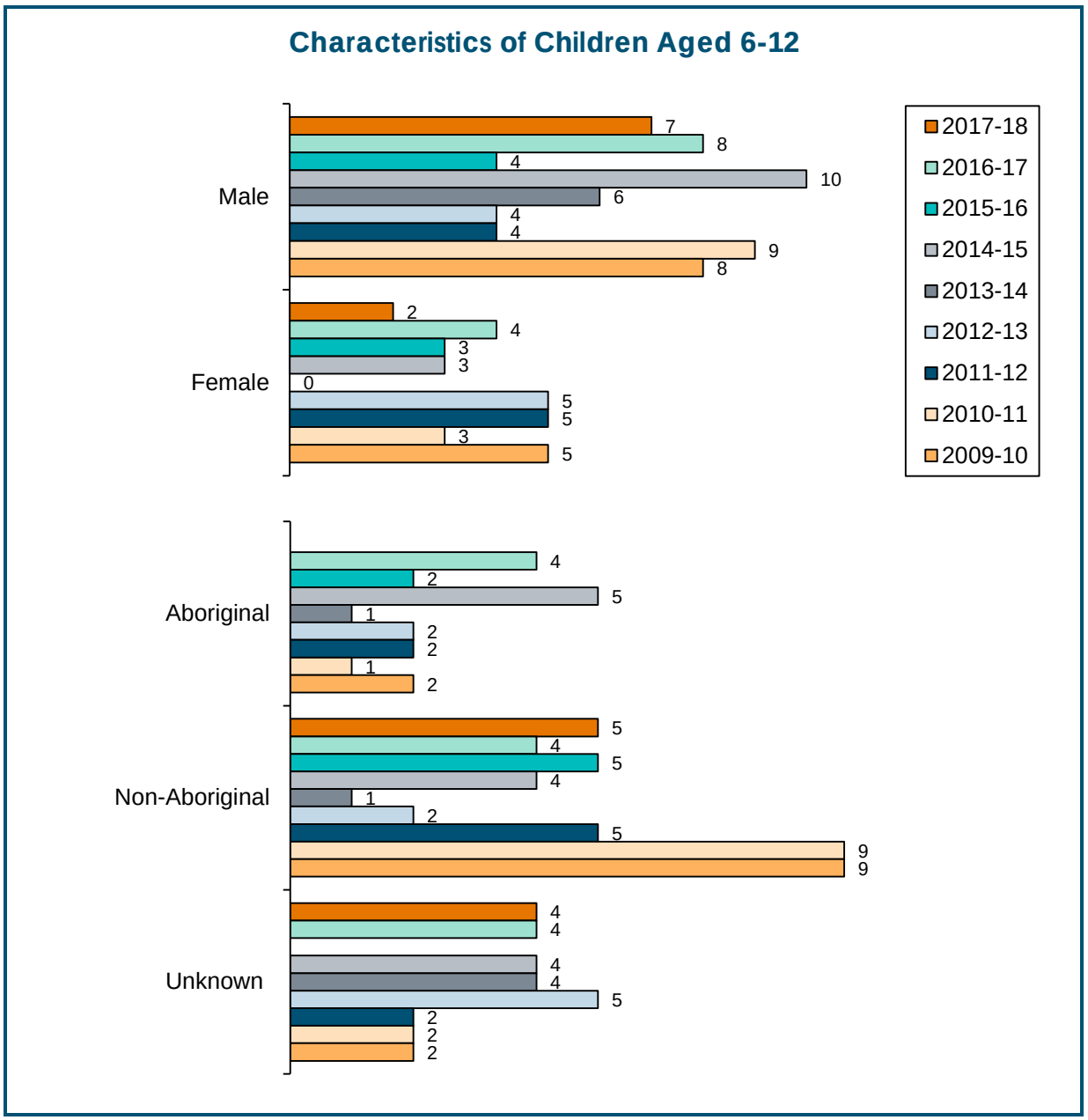
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

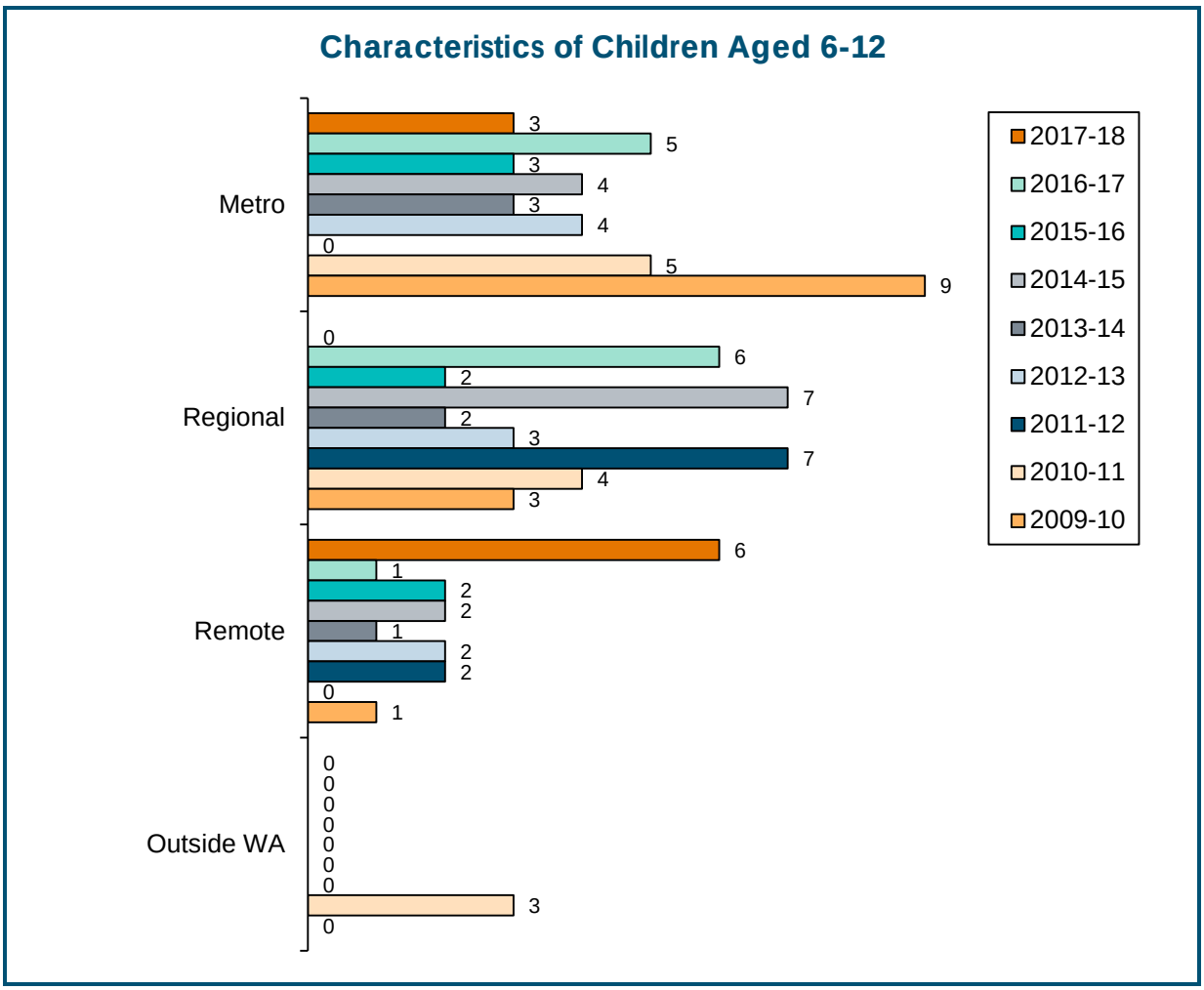
Fifty five deaths of children aged 1 to 5 years were determined to be investigable deaths.

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.



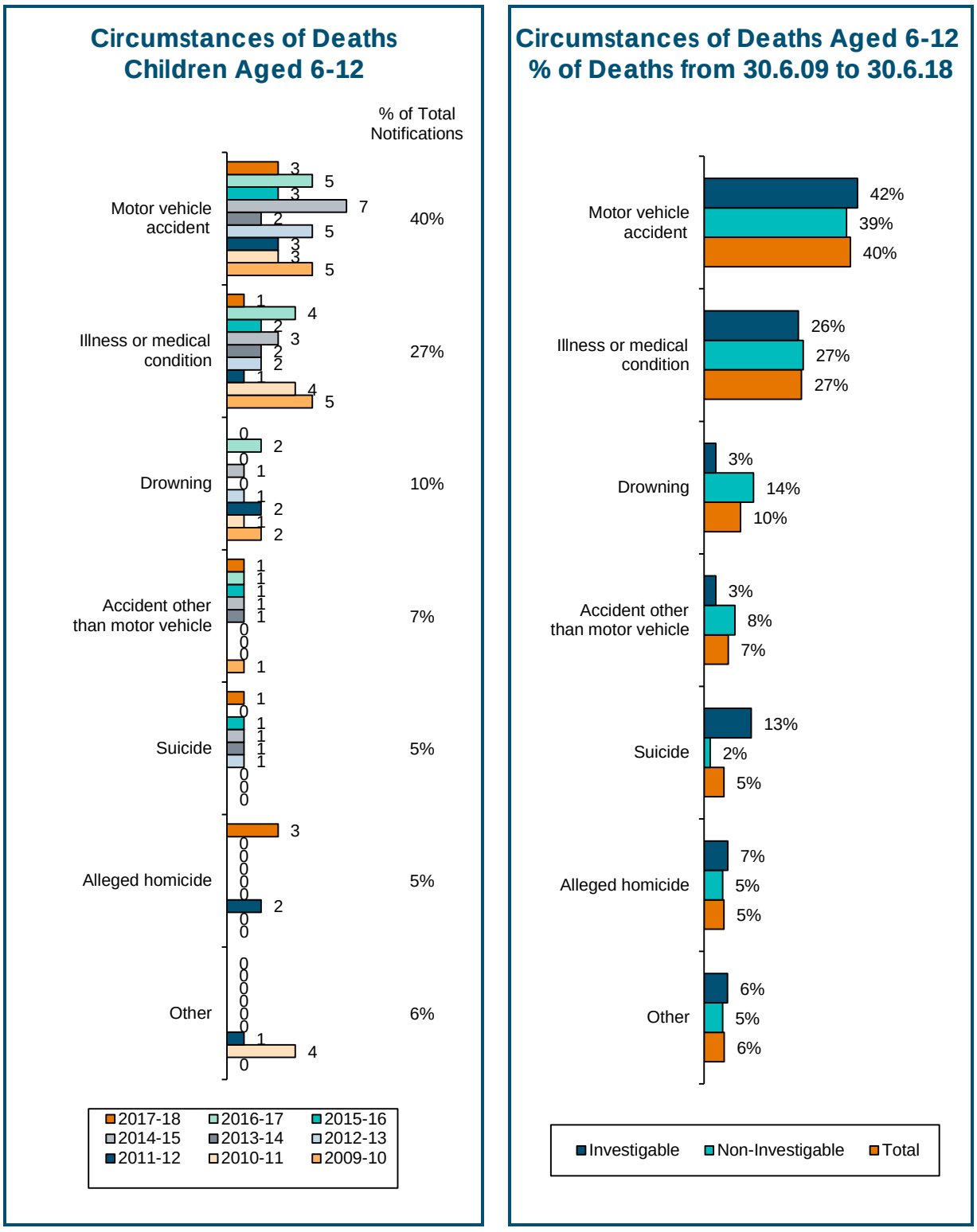


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).



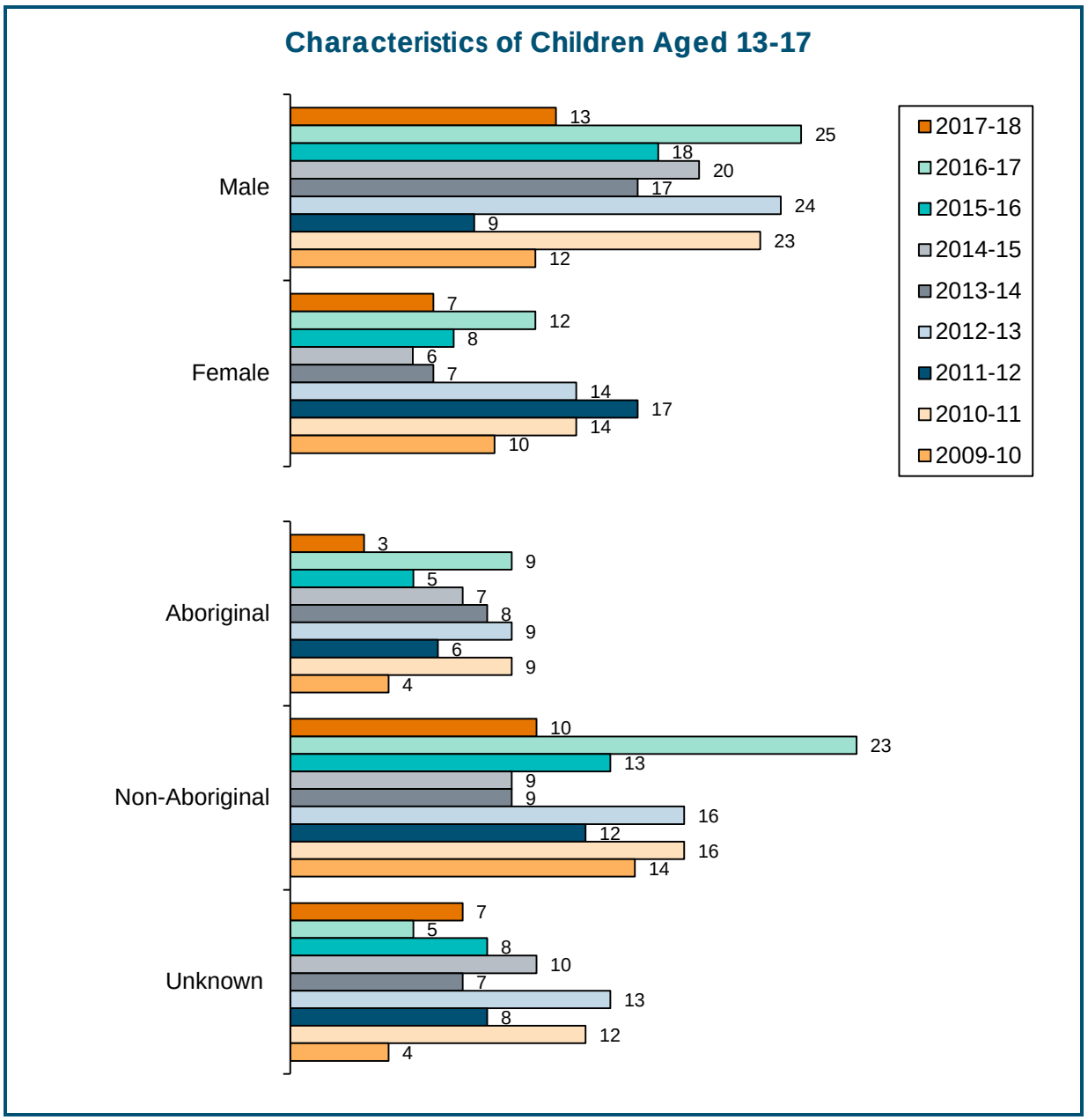
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

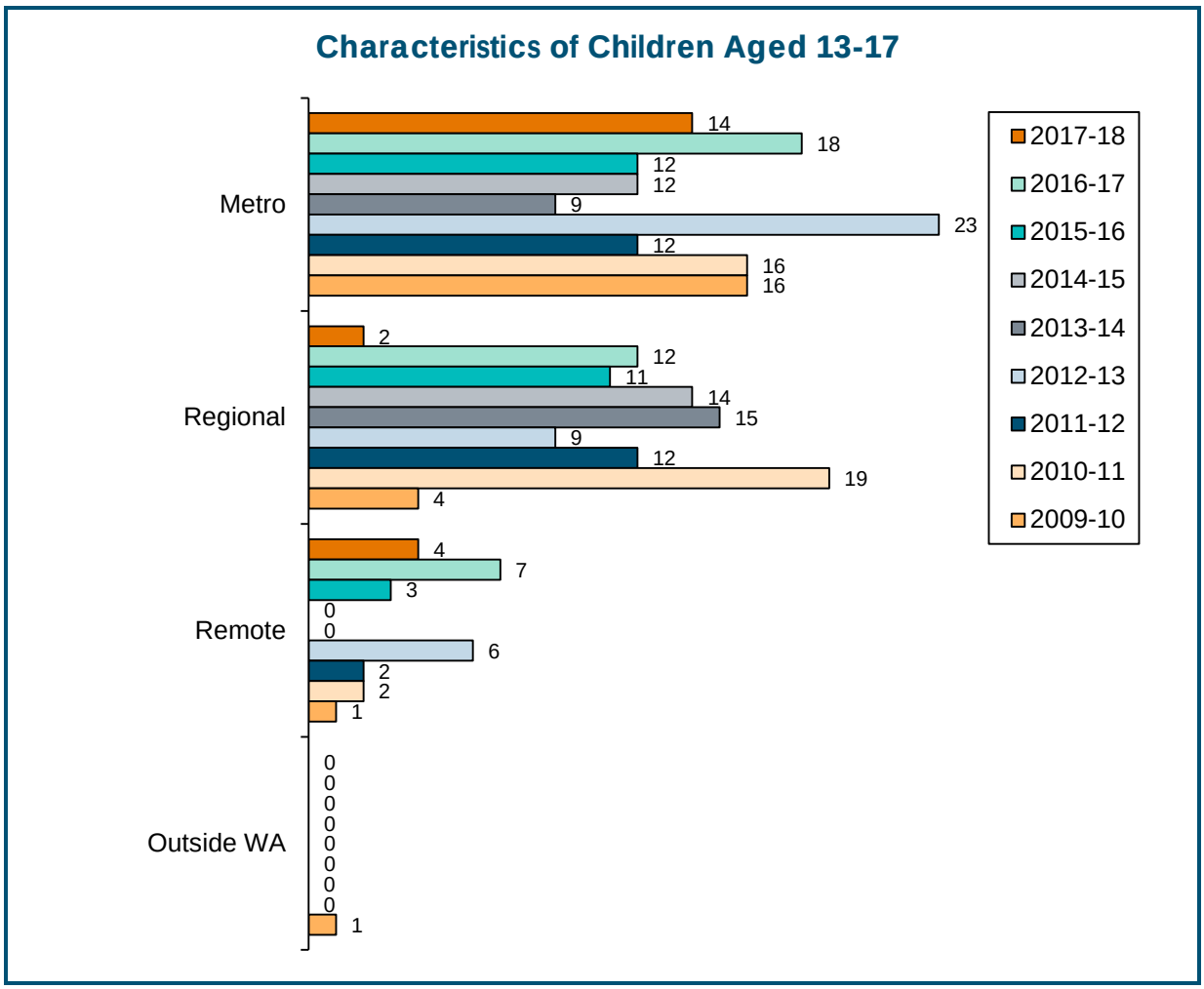
Thirty one deaths of children aged 6 to 12 years were determined to be investigable deaths.

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.



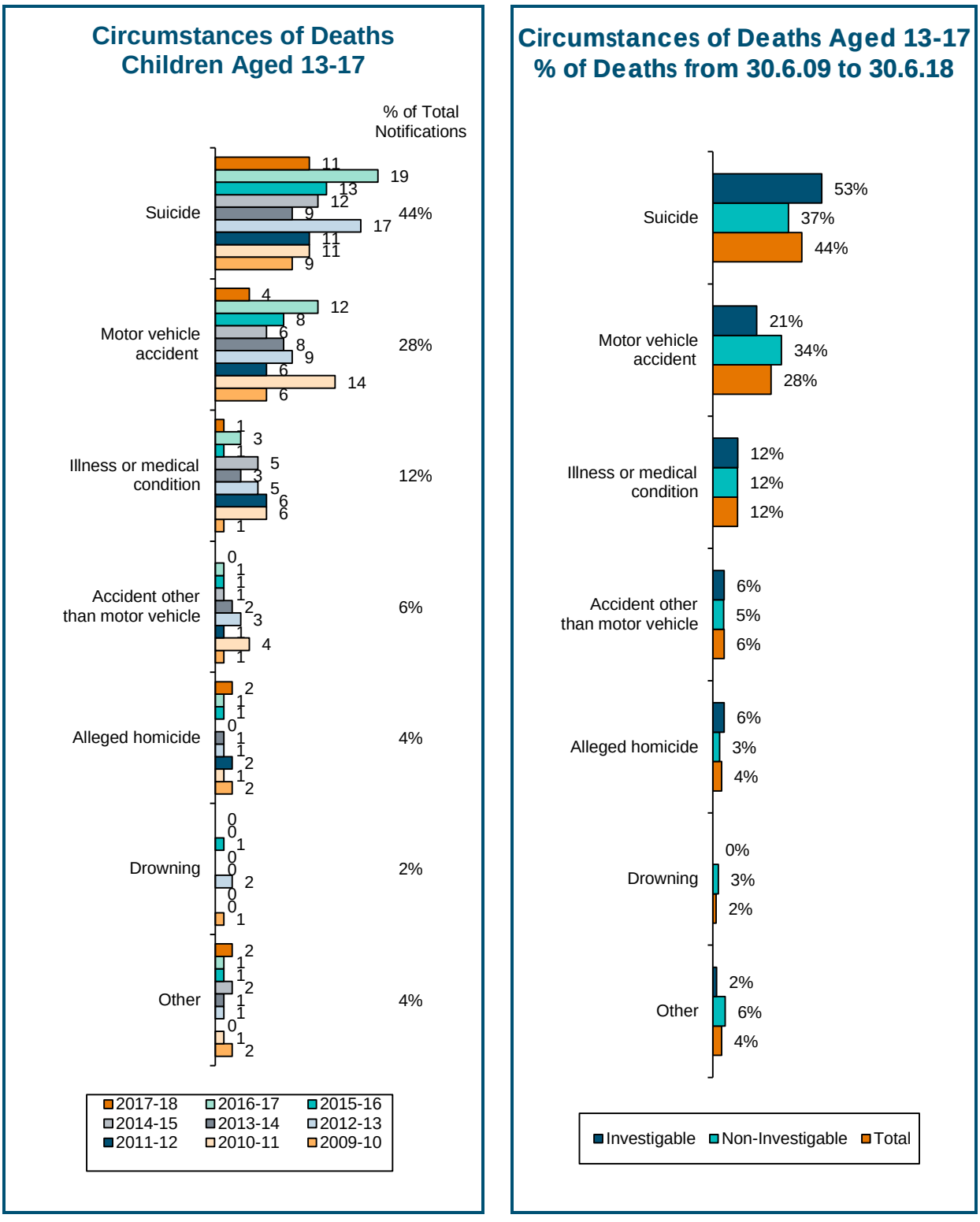


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.

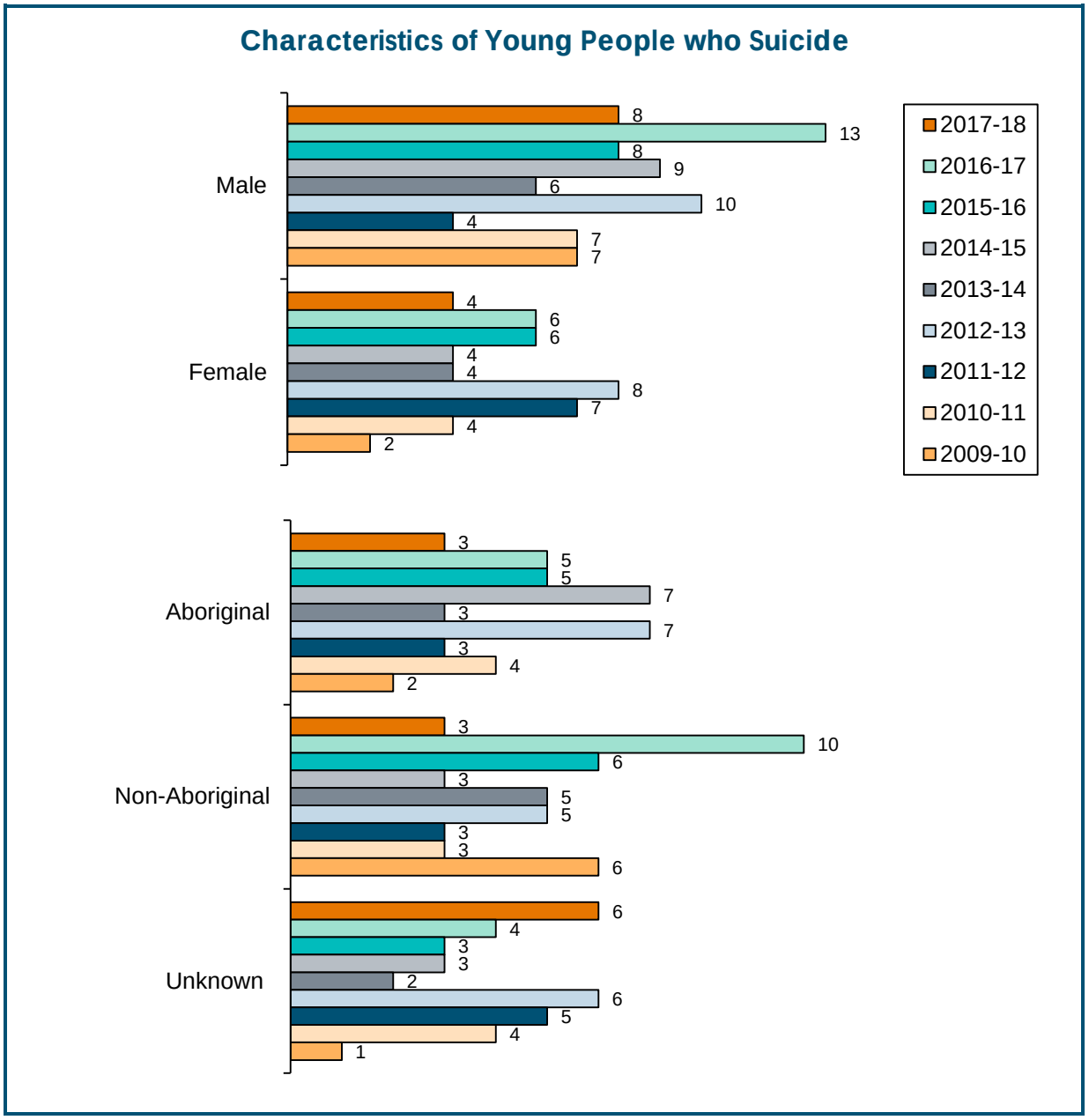
One hundred and seven deaths of children aged 13 to 17 years were determined to be investigable deaths.

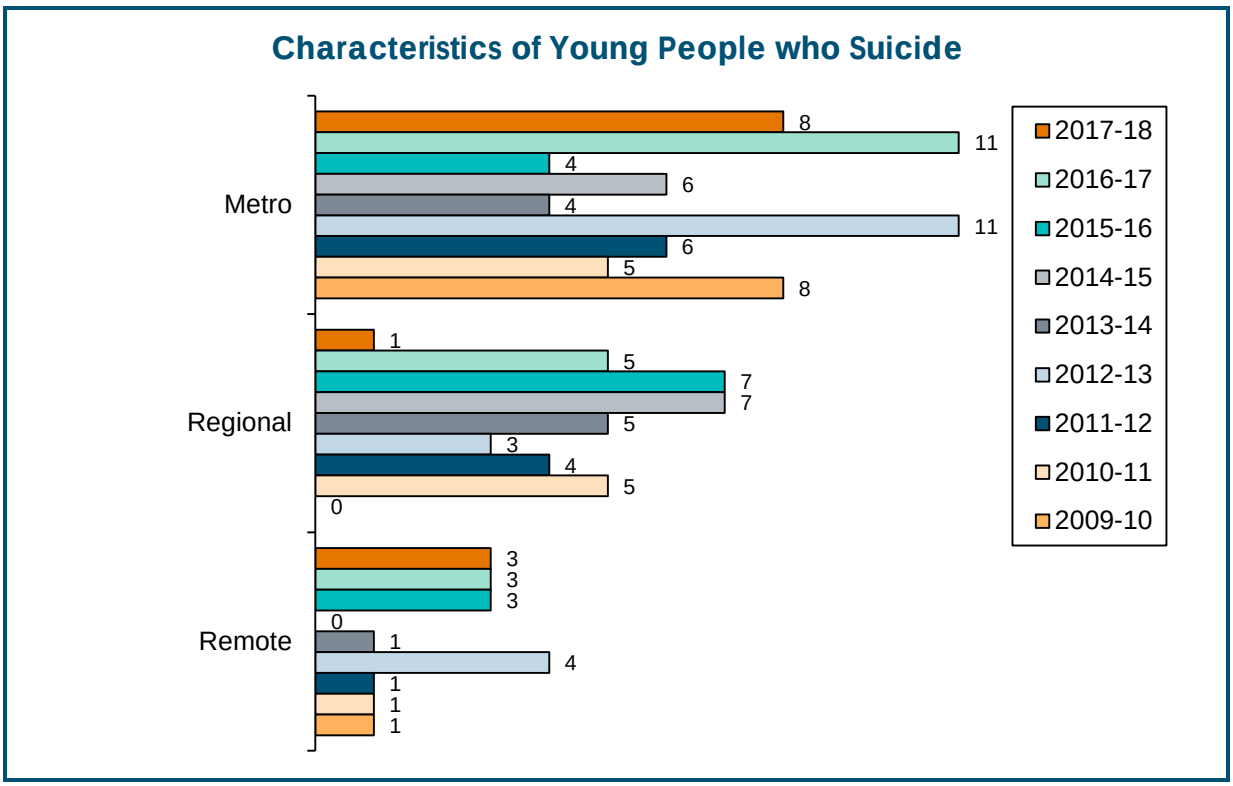
Suicide by young people

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:

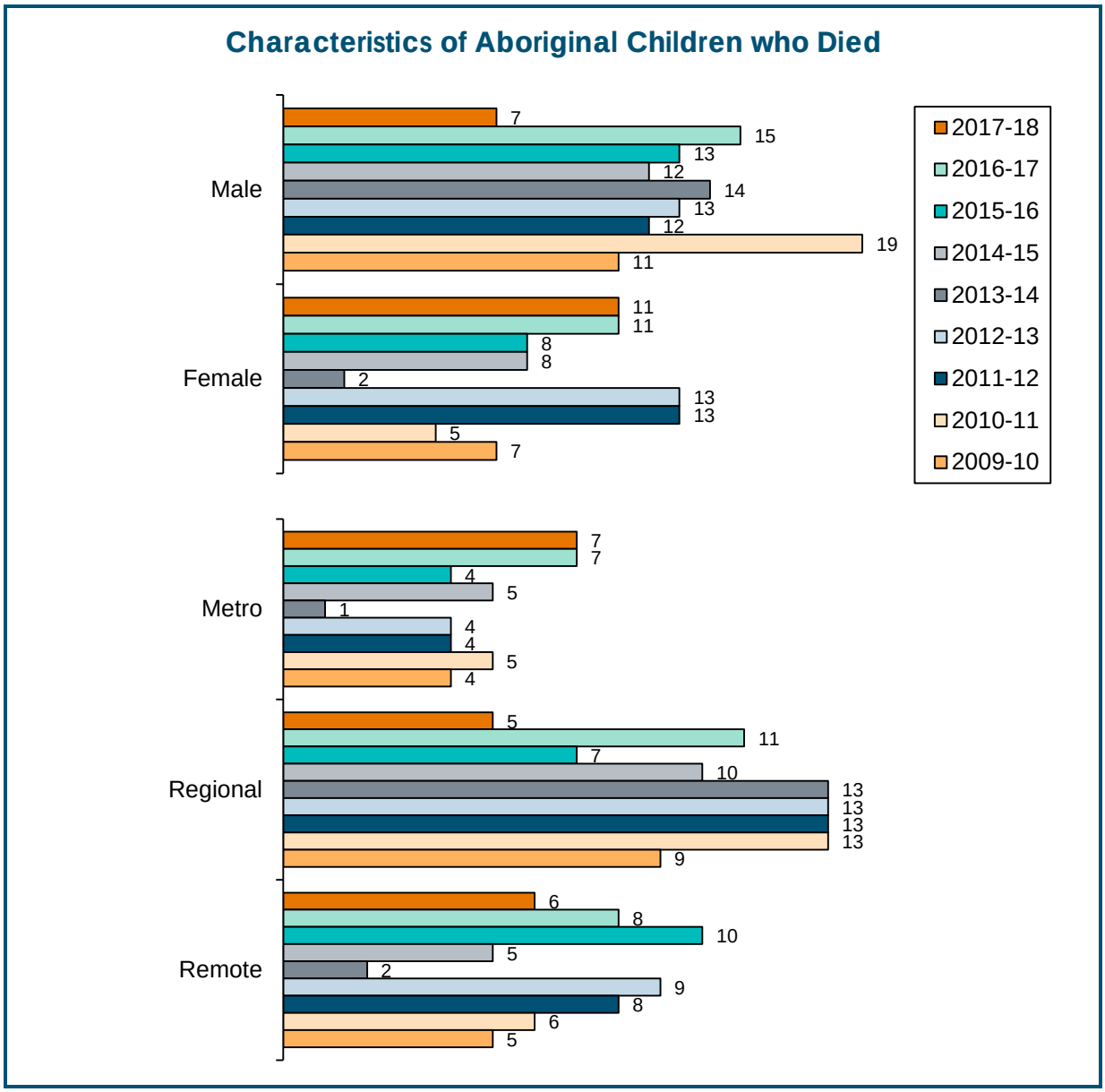
- Males – 52% of investigable deaths and 71% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 83 apparent suicides by young people where information on the Aboriginal status of the young person was available, 66% of the investigable deaths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

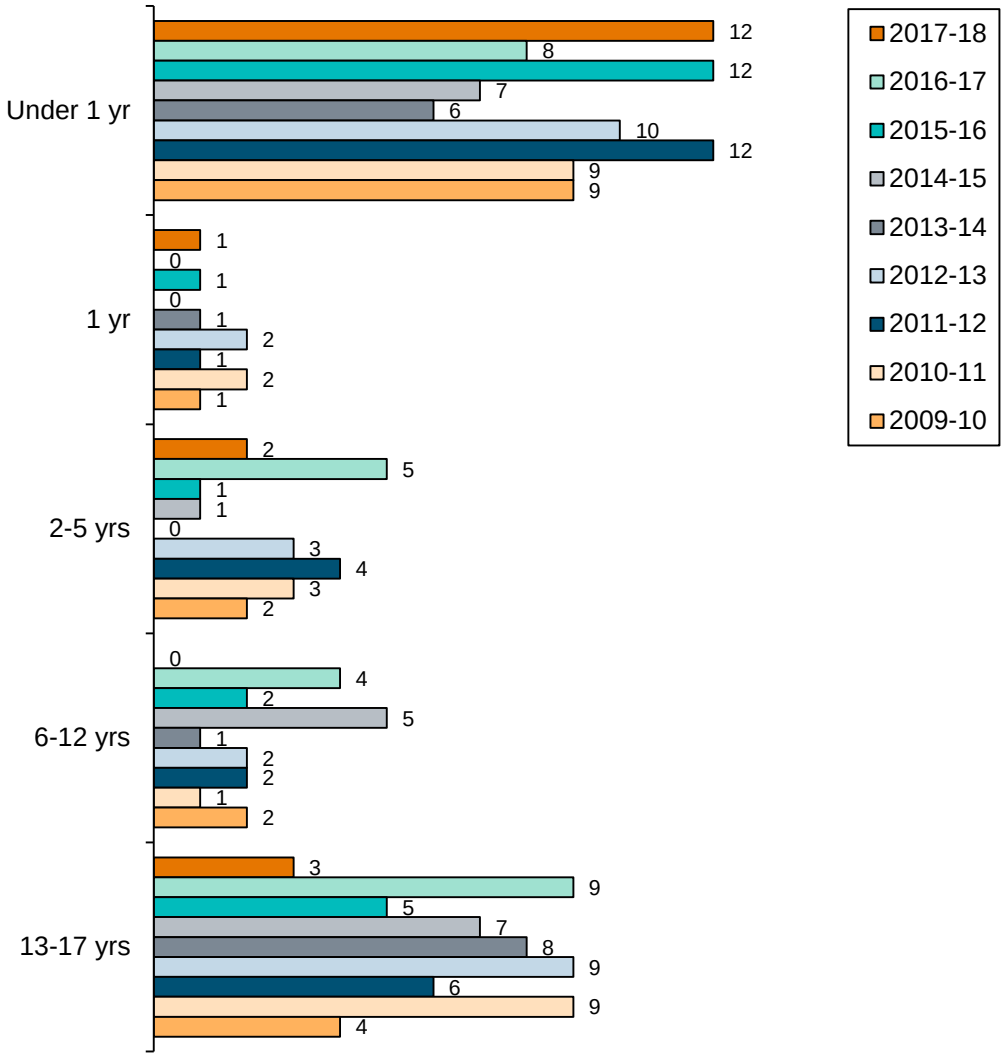
Of the 521 child death notifications received from 30 June 2009 to 30 June 2018, where the Aboriginal status of the child was known, 194 (37%) of the children were identified as Aboriginal.

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.

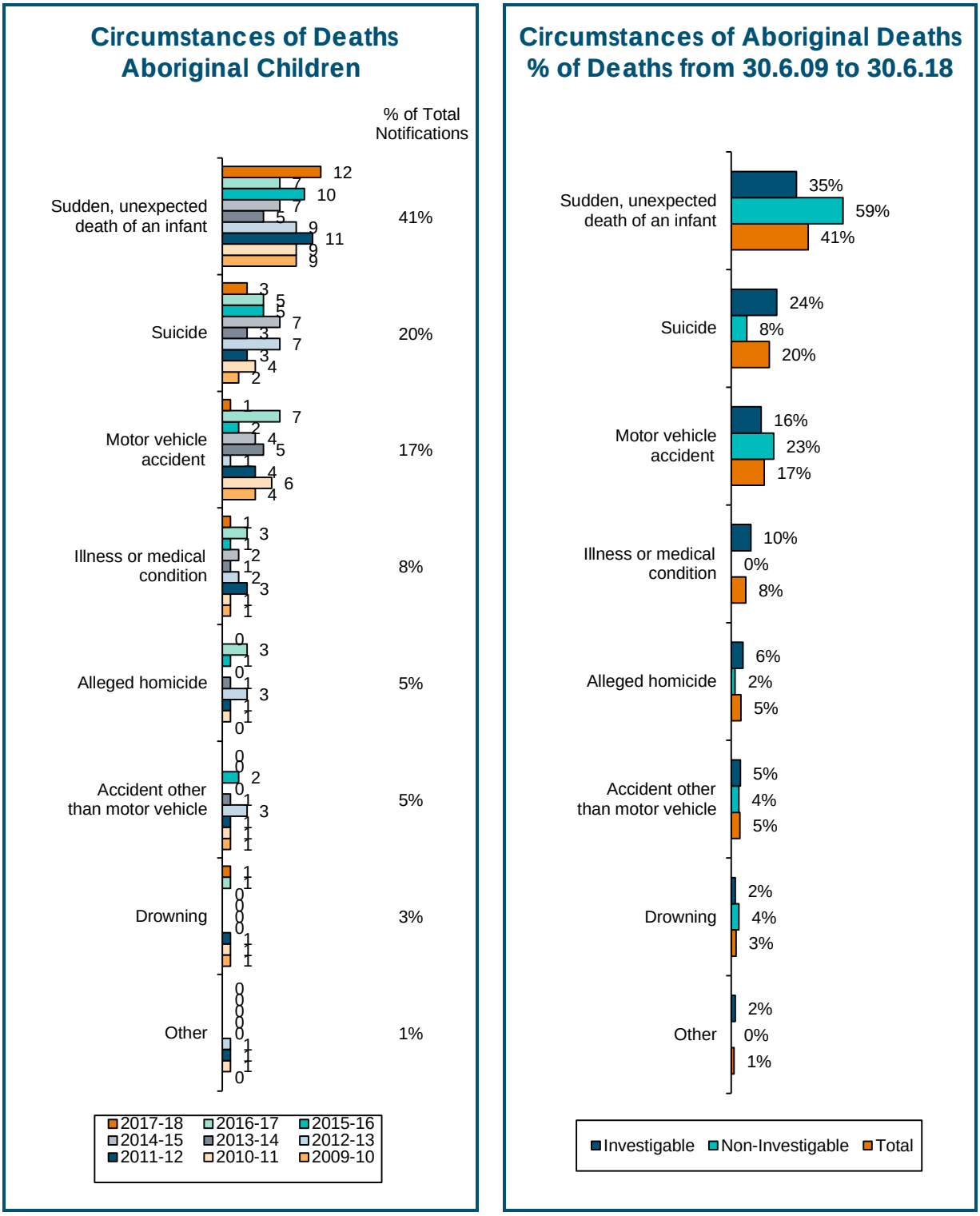


Characteristics of Aboriginal Children who Died



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.

Family and Domestic Violence Fatality Review

Overview

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

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

Background

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

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

The National Plan is endorsed by the Council of Australian Governments and supported by the *First Action Plan 2010-2013: Building a Strong Foundation* (available at www.dss.gov.au), which established the 'groundwork for the National Plan', and the *Second Action Plan 2013-2016: Moving Ahead* (available at www.dss.gov.au) and the *Third Action Plan 2016-2019* (available at www.dss.gov.au), which build upon this work. The *Fourth Action Plan 2019-2022* is currently being developed, and is due for release in 2019.

The *WA Strategic Plan for Family and Domestic Violence 2009-13*, included the following principles:

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

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

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

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

In 2017, the State Government released the *Stopping Family and Domestic Violence Policy*, which sets out 21 new initiatives for responding to family and domestic violence. This document supersedes *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities* (**State Strategy**) and the *Freedom from Fear Action Plan 2015*. Also in 2017, the first Minister for the Prevention of Family and Domestic Violence was appointed. In 2018, the Department of Communities has convened a family and domestic violence policy consortium, comprising representatives from government, community sector services, Aboriginal Community Controlled Organisations and academia, to develop a comprehensive project plan for the development of a 10-year across-government

strategy to reduce family and domestic violence. The Office, as an observer, has contributed to this policy consortium. The findings and recommendations from the Ombudsman's family and domestic violence fatality reviews and major own motion investigations will contribute to the development of this new State strategy.

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

Working arrangements have been established to support implementation of the role with Western Australia Police (**WAPOL**) and the Department of Communities (**Communities**) and with other agencies, such as the Department of Justice (**DOJ**) and relevant courts.

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

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

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

Information regarding the use of terms

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

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

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

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

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

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

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

(d) One of whom is a child who —

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

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

  or

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

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

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

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

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

(b) Is related to the person's —

  (i) Spouse or former spouse; or

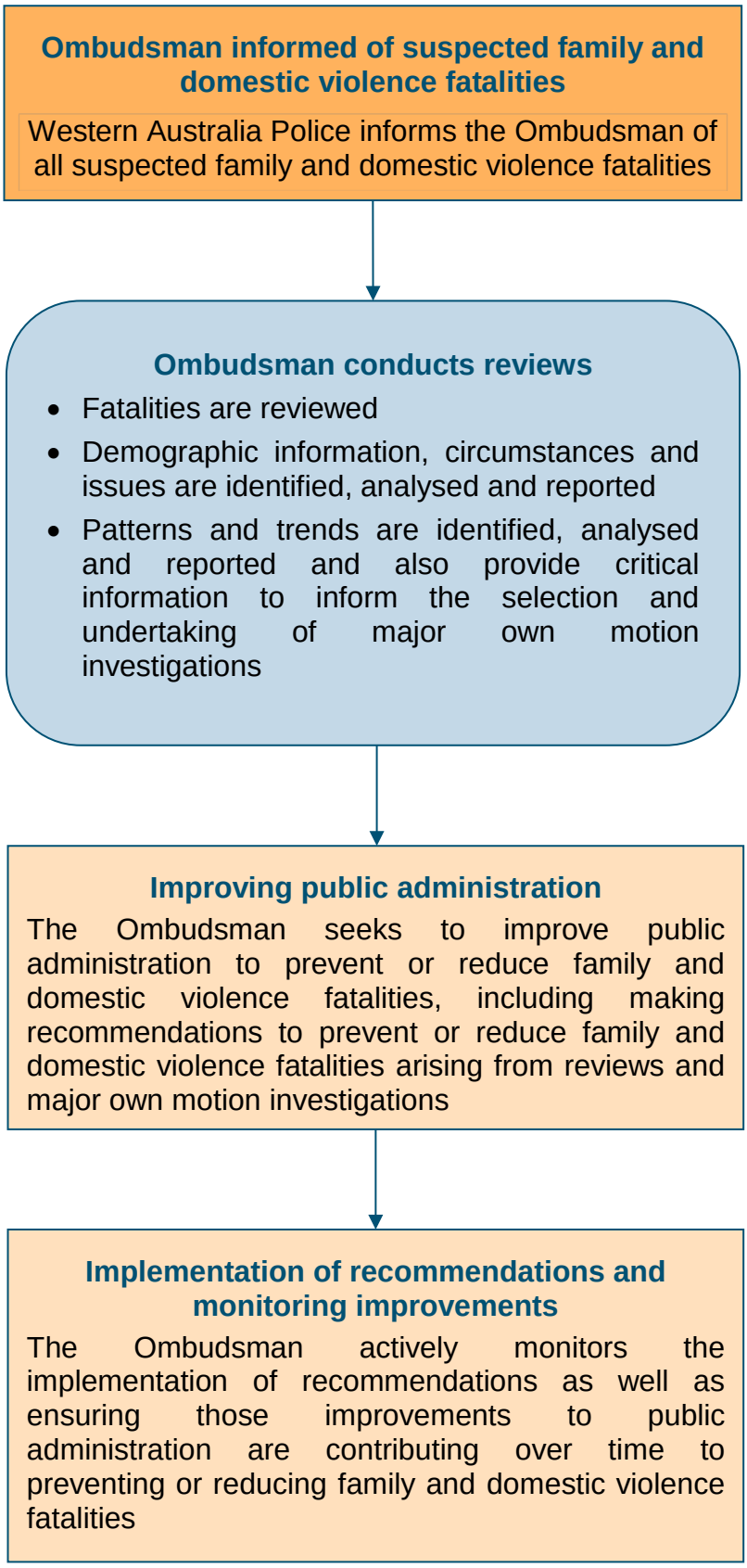
  (ii) De facto partner or former de facto partner.

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

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

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

The Family and Domestic Violence Fatality Review Process



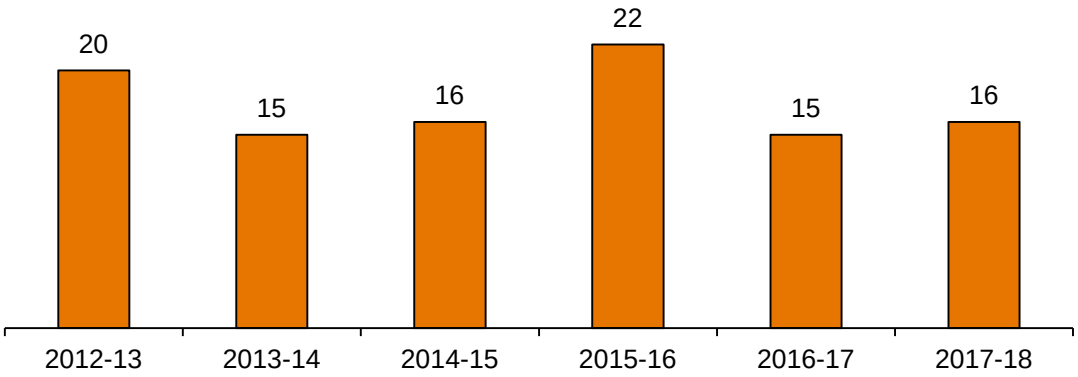
Analysis of Family and Domestic Violence Fatality Reviews

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

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

Number of family and domestic violence fatality reviews

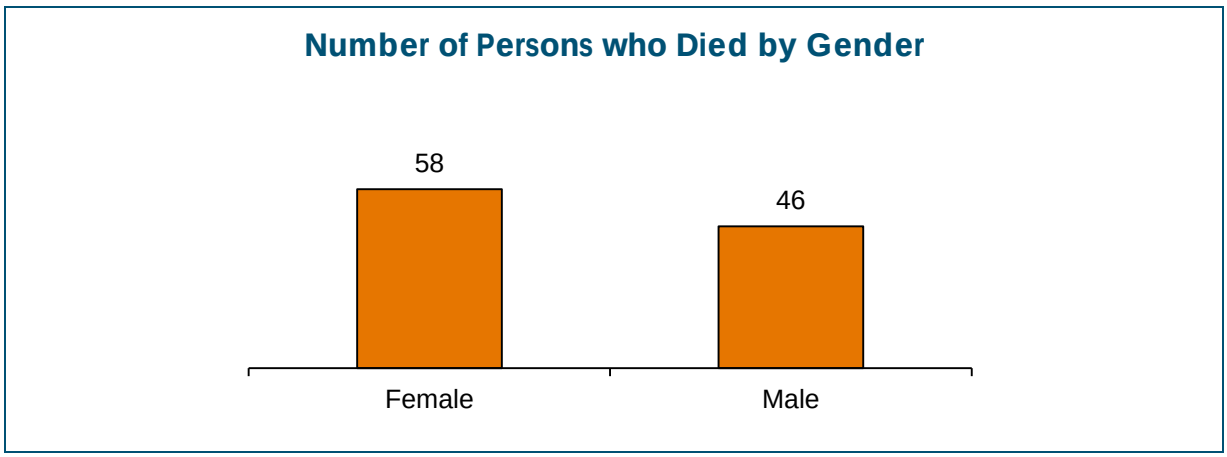
In 2017-18, the number of reviewable family and domestic violence fatalities received was 16, compared to 15 in 2016-17, 22 in 2015-16, 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

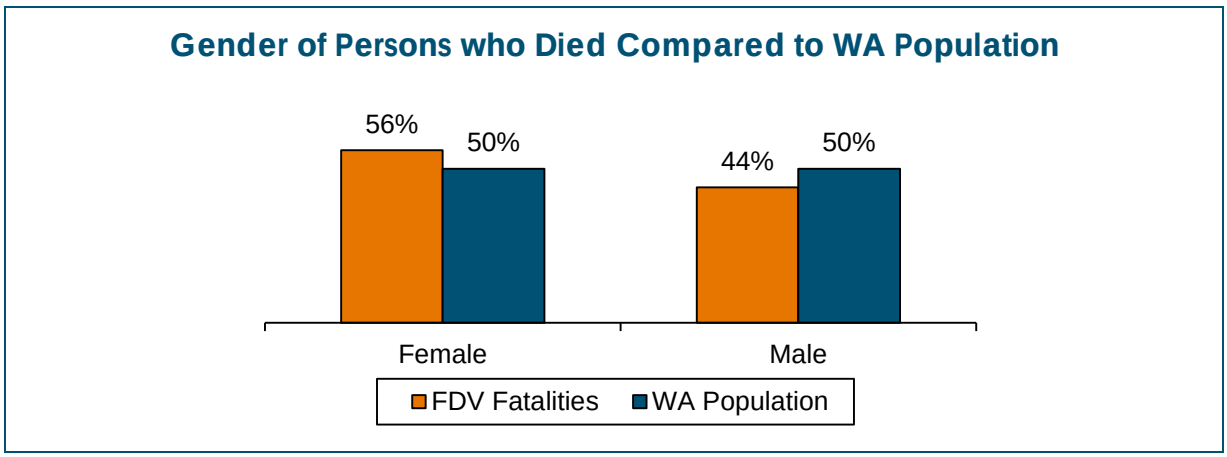


Demographic information identified from family and domestic violence fatality reviews

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

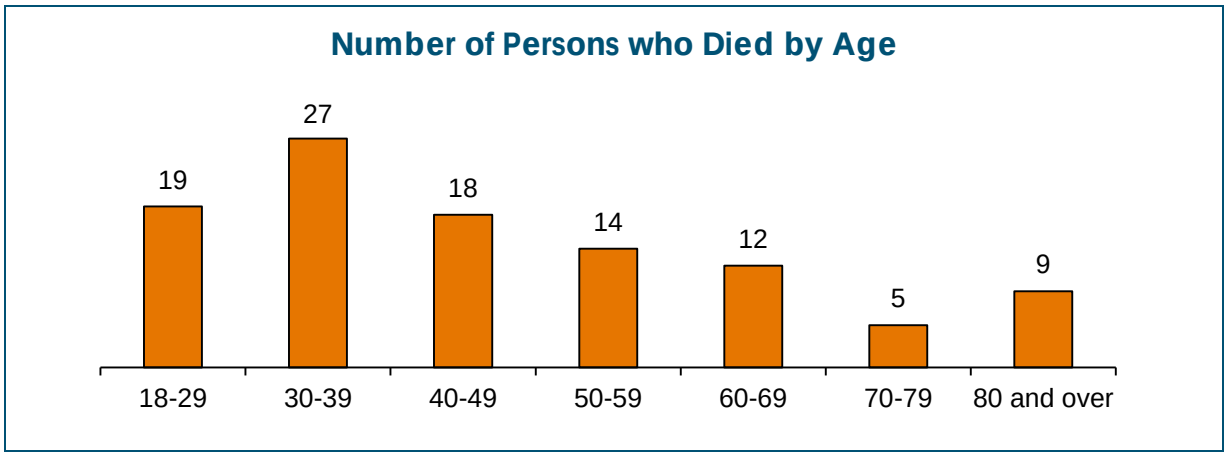
The following charts show characteristics of the persons who died for the 104 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2018. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

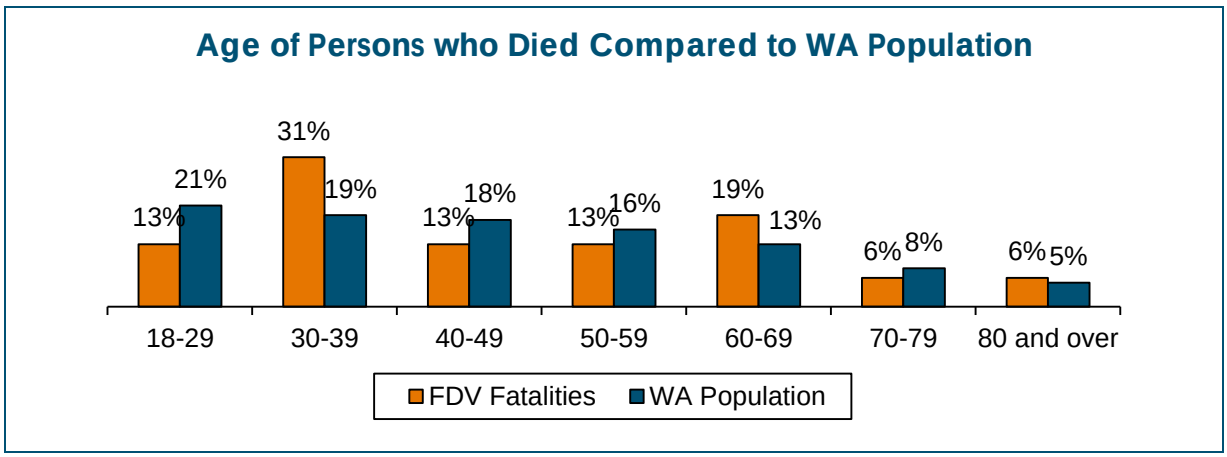




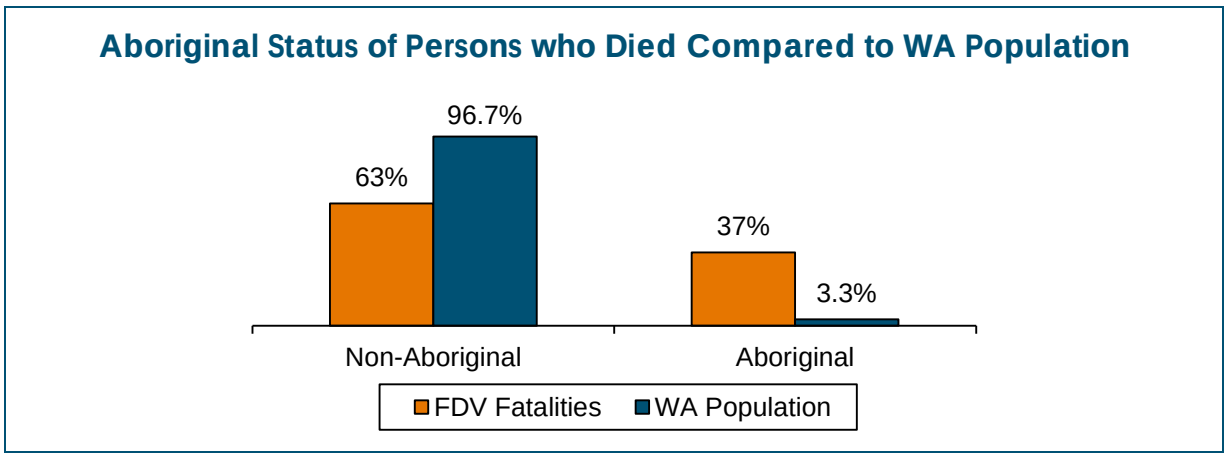
Compared to the Western Australian population, females who died in the six years from 1 July 2012 to 30 June 2018, were over-represented, with 56% of persons who died being female compared to 50% in the population.

In relation to the 58 females who died, 54 involved a male suspected perpetrator, three involved a female suspected perpetrator, and one involved multiple suspected perpetrators of both genders. Of the 46 men who died, eight were apparent suicides, 19 involved a female suspected perpetrator, 17 involved a male suspected perpetrator and two involved multiple suspected perpetrators of both genders.

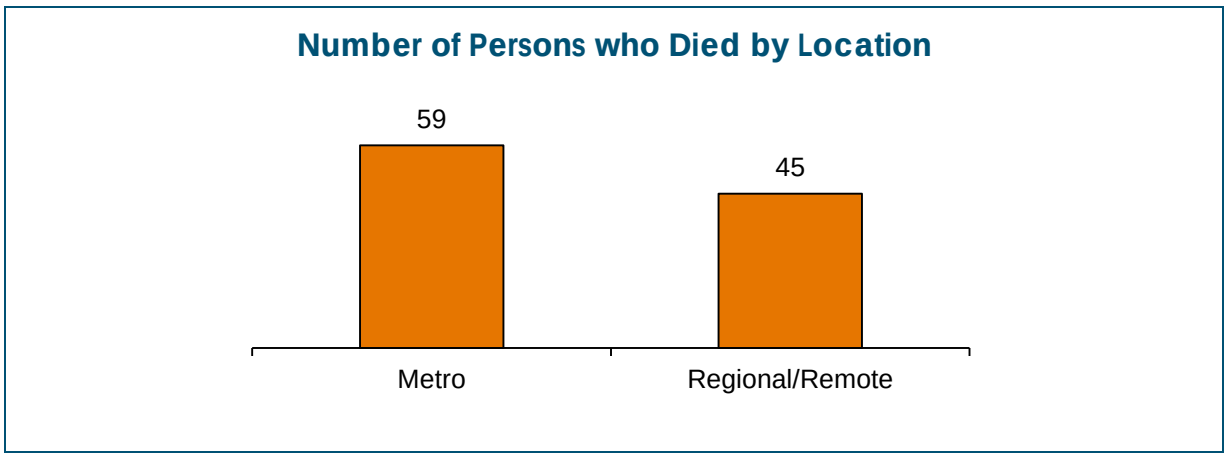


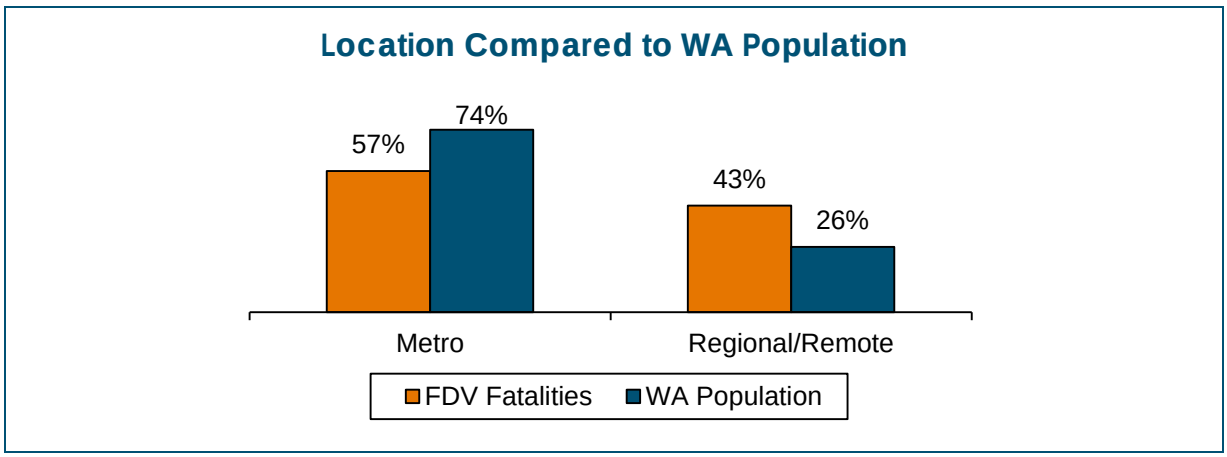


Compared to the Western Australian population, the age groups 30-39 and 60-69 are over-represented, with 31% of persons who died being in the 30-39 age group compared to 19% of the population, and 19% of persons who died being in the 60-69 age group compared to 13% of the population.



Compared to the Western Australian population, Aboriginal people who died were over-represented, with 37% of people who died in the six years from 1 July 2012 to 30 June 2018 being Aboriginal compared to 3.3% in the population. Of the 39 Aboriginal people who died, 23 were female and 16 were male.





Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 43% of the people who died in the six years from 1 July 2012 to 30 June 2018 living in regional or remote locations, compared to 26% of the population living in those locations.

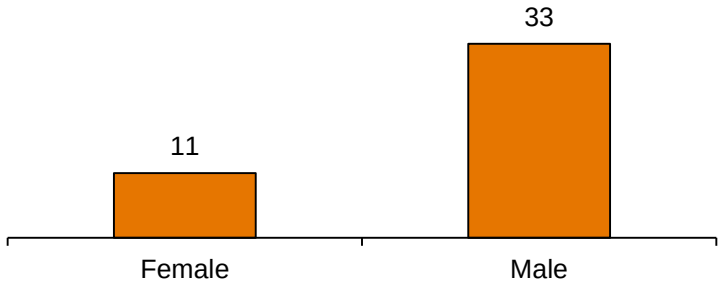
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2018 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2018.

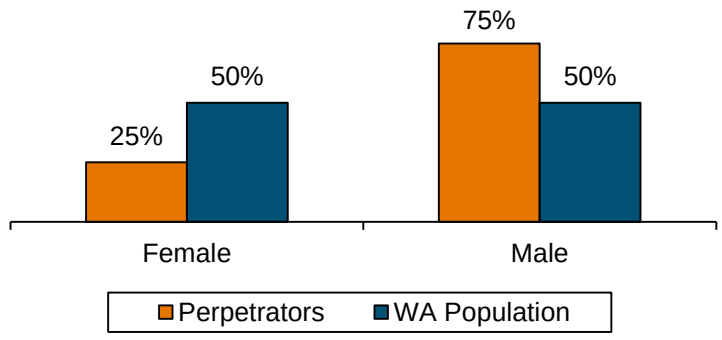
Of the 104 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2018, coronial and criminal proceedings were finalised in 44 cases.

Information is obtained on a range of characteristics of the perpetrator including gender, age group and Aboriginal status. The following charts show characteristics for the 44 perpetrators where both the coronial process and the criminal proceedings have been finalised.

Perpetrator by Gender



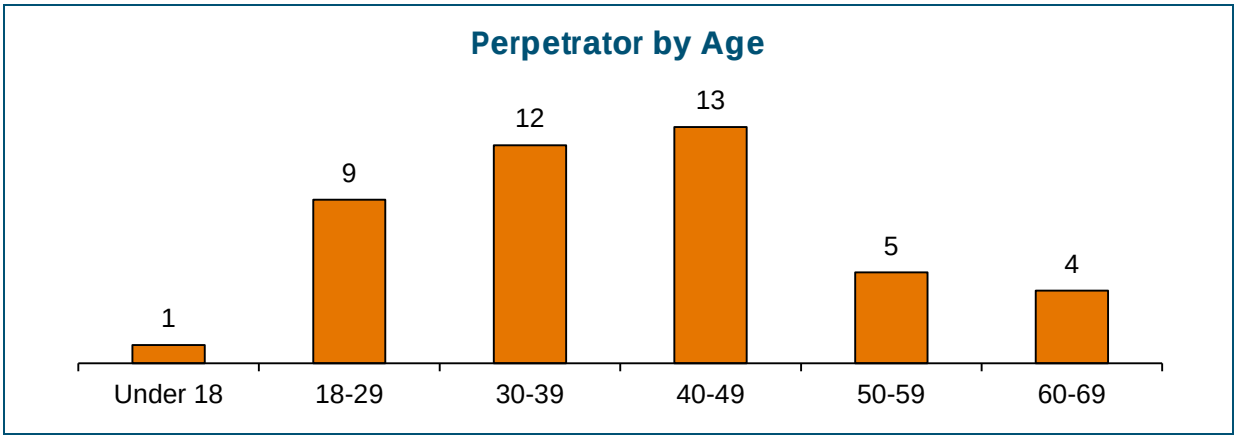
Gender of Perpetrators Compared to WA Population

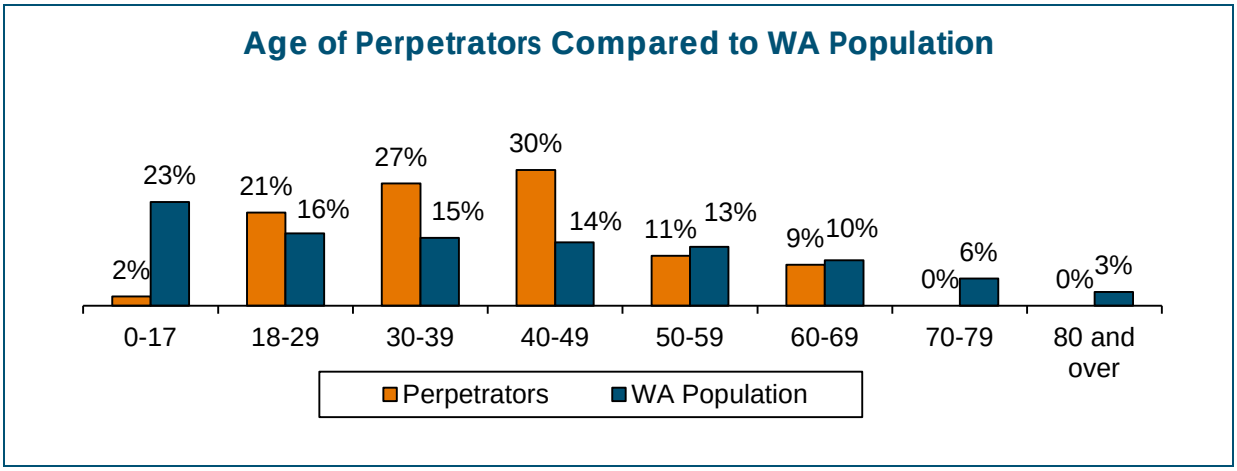


Compared to the Western Australian population, male perpetrators of fatalities in the six years from 1 July 2012 to 30 June 2018 were over-represented, with 75% of perpetrators being male compared to 50% in the population.

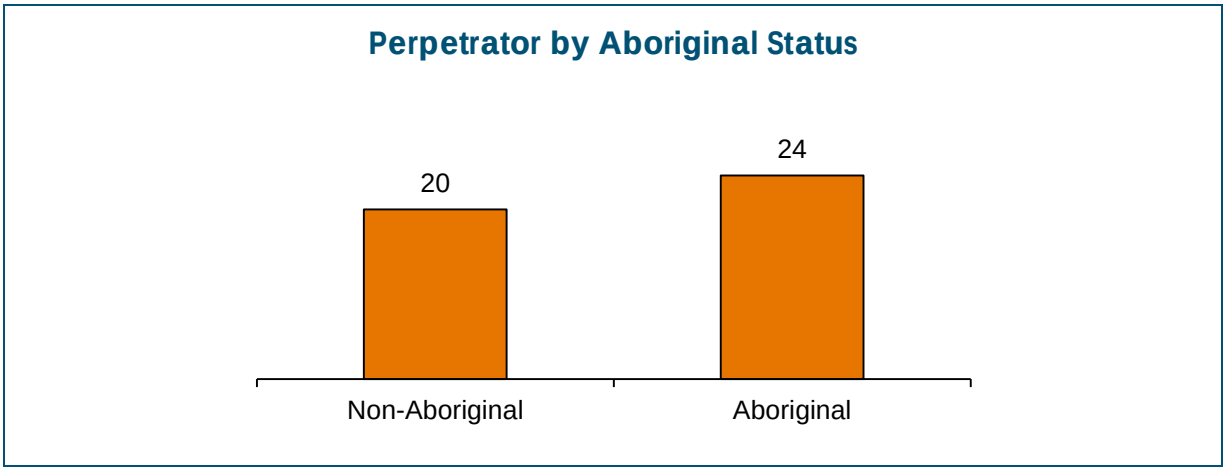
Ten males were convicted of manslaughter and 23 males were convicted of murder. Eight females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death and two females were convicted of murder.

In the 11 fatalities where the perpetrator was female, the person who died was male. Of the 33 fatalities where the perpetrator was male, in 27 fatalities the person who died was female, and in six fatalities the person who died was male.

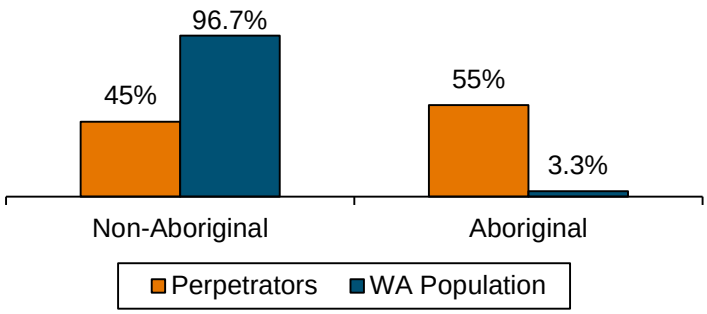




Compared to the Western Australian population, perpetrators of fatalities in the six years from 1 July 2012 to 30 June 2018 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 21% of perpetrators being in the 18-29 age group compared to 16% in the population, 27% of perpetrators being in the 30-39 age group compared to 15% in the population, and 30% of perpetrators being in the 40-49 age group compared to 14% in the population.



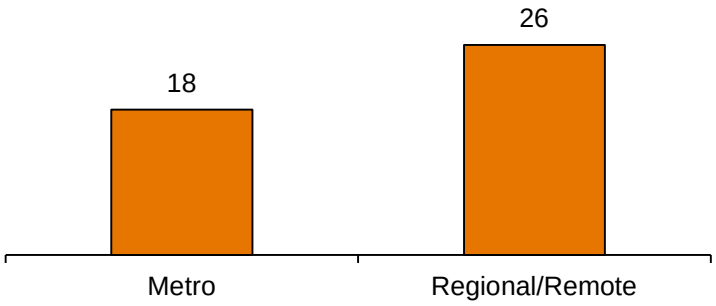
Aboriginal Status of Perpetrators Compared to WA Population



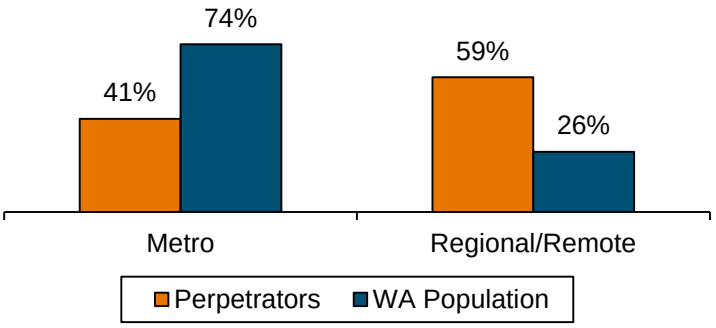
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the six years from 1 July 2012 to 30 June 2018 were over-represented with 55% of perpetrators being Aboriginal compared to 3.3% in the population.

In 22 of the 24 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location



Perpetrators by Location Compared to WA Population



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

Compared to the Western Australian population, the people who died in the six years from 1 July 2012 to 30 June 2018, who were living in regional or remote locations, were over-represented, with 59% of the people who died living in regional or remote locations compared to 26% of the population living in those locations.

Circumstances in which family and domestic violence fatalities have occurred

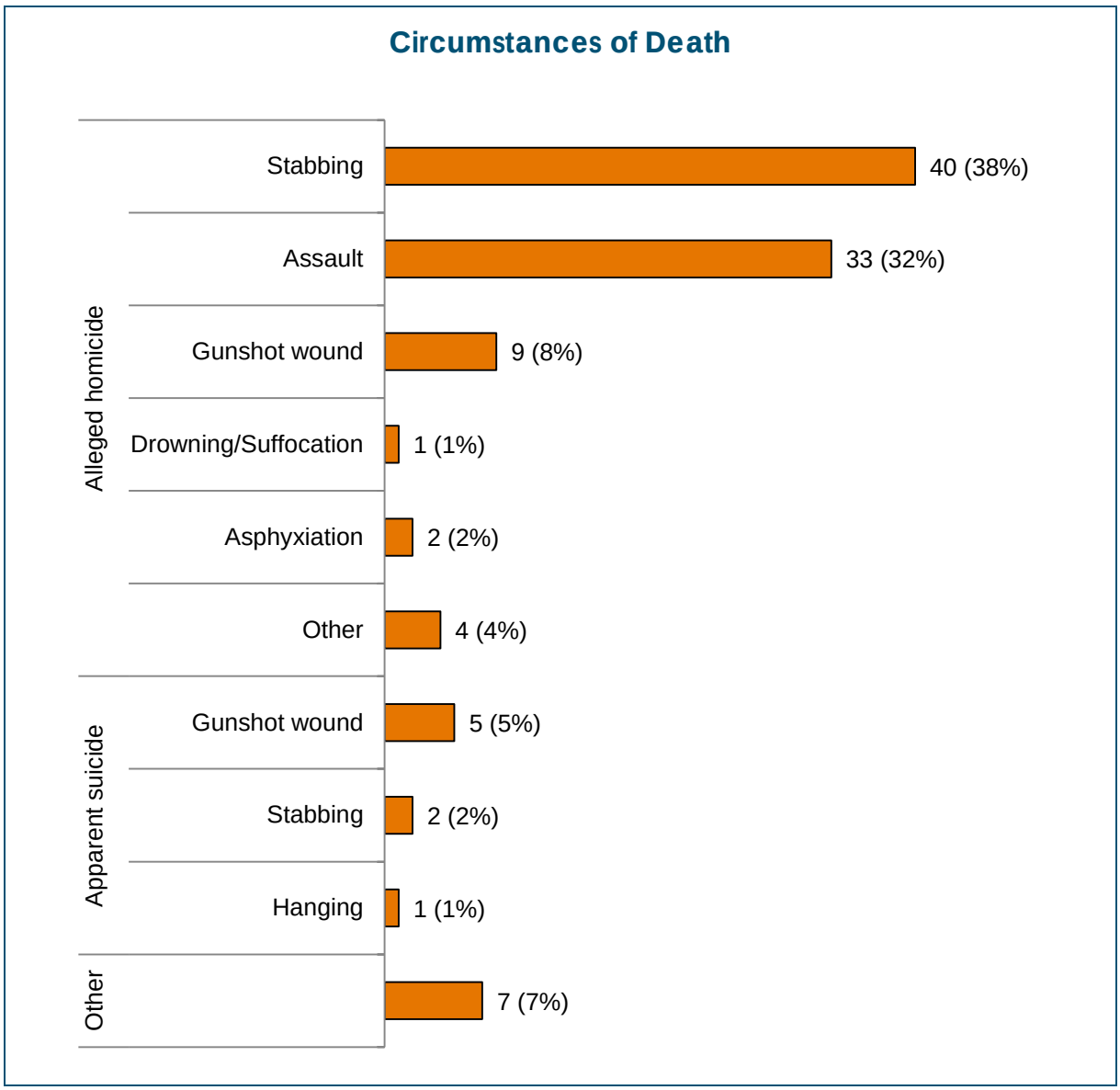
Information provided to the Office by WAPOL about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

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

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

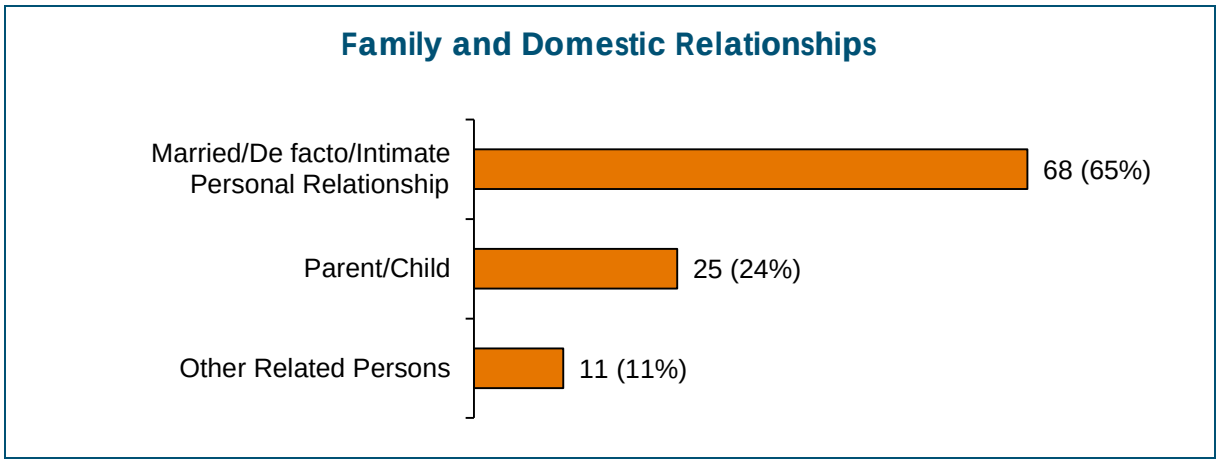
The principal circumstances of death in 2017-18 were alleged homicide by gunshot wound and stabbing.

The following chart shows the circumstance of death as categorised by the Ombudsman for the 104 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2018.



Family and domestic relationships

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



Of the 104 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2018:

- 68 fatalities (65%) involved a married, de facto or intimate personal relationship, of which there were 59 alleged homicides, seven apparent suicides and two in other circumstances. The 68 fatalities included 12 deaths that occurred in six cases of alleged homicide/suicide and, in all six cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. The seventh apparent suicide involved a male. Of the remaining 53 alleged homicides, 38 (72%) of the people who died were female and 15 (28%) were male;
- 25 fatalities (24%) involved a relationship between a parent and adult child, of which there were 20 alleged homicides, one apparent suicide and four in other circumstances. Of the 20 alleged homicides, six (30%) of the people who died were female and 14 (70%) were male. Of these 20 fatalities, in 13 cases (65%) the person who died was the parent or step-parent and in seven cases (35%) the person who died was the adult child or step-child; and
- There were 11 people who died (11%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, four (36%) were female and seven (64%) were male.

Patterns, Trends and Case Studies Relating to Family and Domestic Violence Fatality Reviews[2]

State policy and planning to reduce family and domestic violence fatalities

At the time of writing this report, the Communities website *Family and Domestic Violence Strategic Planning* page (available at www.dcp.wa.gov.au) states Communities is the lead agency responsible for family and domestic violence strategic planning in Western Australia. Communities is currently leading the development of a 10-year across-government strategy to reduce family and domestic violence.

The Ombudsman's family and domestic violence fatality reviews and the Ombudsman's major own motion investigation *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, have identified that there is scope for State Government departments and authorities to improve the ways in which they respond to family and domestic violence. In the report, the Ombudsman recommended that, consistent with the National Plan:

> Recommendation 1: DCPFS, as the lead agency responsible for family and domestic violence strategy planning in Western Australia, in the development of Action Plans under *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, identifies actions for achieving its agreed Primary State Outcomes, priorities among these actions, and allocation of responsibilities for these actions to specific state government departments and authorities.

[2] In this section, DCPFS refers to the (then) Department of Child Protection and Family Support (now Communities), and DOTAG refers to the (then) Department of the Attorney General (now DOJ).

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

Type of relationships

The Ombudsman finalised 90 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2018.

For 60 (67%) of the finalised reviews of family and domestic violence fatalities, the fatality occurred between persons who, either at the time of death or at some earlier time, had been involved in a married, de facto or other intimate personal relationship. For the remaining 30 (33%) of the finalised family and domestic violence fatality reviews, the fatality occurred between persons where the relationship was between a parent and their adult child or persons otherwise related (such as siblings and extended family relationships).

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

For the 90 finalised reviews, the circumstances of the fatality were as follows:

- For the 60 intimate partner fatalities, 51 were alleged homicides, seven were apparent suicides, and two were other circumstances; and
- For the 30 non-intimate partner fatalities, 24 were alleged homicides, one was an apparent suicide, and five were other circumstances.

Intimate partner relationships

Of the 51 intimate partner relationship fatalities involving alleged homicide:

- There were 36 fatalities where the person who died was female and the suspected perpetrator was male, one where the person who died was female and there were multiple suspected perpetrators of both genders, 11 where the person who died was male and the suspected perpetrator was female, one where the person who died was male and the suspected perpetrator was male, and two where the person who died was male and there were multiple suspected perpetrators of both genders;
- There were 21 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In 13 of these fatalities the person who died was female and in eight the person who died was male;
- There were 24 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, nine at the residence of the person who died or the residence of the suspected perpetrator, five at the residence of family or friends, and 13 at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 26 fatalities where the person who died lived in regional and remote areas, and in 19 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 30 non-intimate partner fatalities, there were 21 fatalities involving a parent and adult child and nine fatalities where the parties were otherwise related.

Of the 24 non-intimate partner fatalities involving alleged homicide:

- There were six fatalities where the person who died was female and the suspected perpetrator was male, three where the person who died was female and the suspected perpetrator was female, 11 where the person who died was male and the suspected perpetrator was male, and four where the person who died was male and the suspected perpetrator was female;
- There were five non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 12 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, nine at the residence of the person who died or the residence of the suspected perpetrator, and three at the residence of family or friends or in a public place; and
- There were seven fatalities where the person who died lived in regional and remote areas.

Prior reports of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reports of alleged family and domestic violence between the parties. In 31 (61%) of the 51 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2018, alleged family and domestic violence between the parties had been reported to WAPOL and/or to other public authorities. In seven (29%) of the 24 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2018, alleged family and domestic violence between the parties had been reported to WAPOL and/or other public authorities.

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

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, found that the research literature identifies that there are higher rates of family and domestic violence among certain communities in Western Australia. However, there are limitations to the supporting data, resulting in varying estimates of the numbers of people in these communities who experience family and domestic violence and a limited understanding of their experiences.

Of the 38 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, from the records available:

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

- 22 of the people who died lived in regional/remote Western Australia.

Examination of the family and domestic violence fatality review data provides some insight into the issues relevant to these communities. However, these numbers are limited and greater insight is only possible through consideration of all reported family and domestic violence, not just where this results in a fatality. The report found that neither the then State Strategy nor the *Achievement Report to 2013* identified any actions to improve the collection of data relating to different communities experiencing higher rates of family and domestic violence, for example through the collection of cultural, demographic and socioeconomic data. In the report, the Ombudsman recommended that:

> Recommendation 2: In developing and implementing future phases of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, DCPFS collaborates with WAPOL, DOTAG and other relevant agencies to identify and incorporate actions to be taken by state government departments and authorities to collect data about communities who are overrepresented in family and domestic violence, to inform evidence-based strategies tailored to addressing family and domestic violence in these communities.

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

In relation to data collation about communities over-represented in family and domestic violence, and how this is used to inform evidence-based strategies tailored to addressing family and domestic violence in these communities, the Ombudsman will continue to monitor the development, implementation and effectiveness of the proposed 10-year family and domestic violence strategy for Western Australia, and plan for responding to Aboriginal family violence.

Identification of family and domestic violence incidents

Of the 38 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, WAPOL was the agency to receive the majority of these reports. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, noted that DCPFS may become aware of family and domestic violence through a referral to DCPFS and subsequent assessment through the duty interaction process. Identification of family and domestic violence is integral to the agency being in a position to implement its family and domestic violence policy and processes to address perpetrator accountability and promote victim safety and support. However, the Ombudsman's reviews and own motion investigations have identified missed opportunities to identify family and domestic violence in interactions.

In the report, the Ombudsman made two recommendations (Recommendations 7 and 39) that WAPOL and DCPFS ensure all reported family and domestic violence is correctly identified and recorded. *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that WAPOL and DCPFS had proposed steps to be taken to give effect to

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

Provision of agency support to obtain a violence restraining order

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

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

Support to victims in reported incidences of family and domestic violence

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

> Recommendation 9: WAPOL amends the *Commissioner's Operations and Procedures Manual* to require that victims of family and domestic violence are provided with verbal information and advice about violence restraining orders in all reported instances of family and domestic violence.
>
> Recommendation 10: WAPOL collaborates with DCPFS and DOTAG to develop an 'aide memoire' that sets out the key information and advice about violence restraining orders that WAPOL should provide to victims of all reported instances of family and domestic violence.
>
> Recommendation 11: WAPOL collaborates with DCPFS and DOTAG to ensure that the 'aide memoire', discussed at Recommendation 10, is developed in consultation with Aboriginal people to ensure its appropriateness for family violence incidents involving Aboriginal people.

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

Support to obtain a violence restraining order on behalf of children

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, also examined the response by DCPFS to prior reports of family and domestic violence

involving 30 children who experienced family and domestic violence associated with the 30 fatalities. The report found that DCPFS did not provide any active referrals for legal advice or help from an appropriate service to obtain a violence restraining order for any of the children involved in the 30 fatalities. In the report, the Ombudsman recommended that:

> Recommendation 44: DCPFS complies with the requirements of the *Family and Domestic Violence Practice Guidance*, in particular, that '[w]here a VRO is considered desirable or necessary but a decision is made for the Department not to apply for the order, the non-abusive adult victim should be given an active referral for legal advice and help from an appropriate service'.

Further, the report noted DCPFS's *Family and Domestic Violence Practice Guidance* also identifies that taking out a violence restraining order on behalf of a child 'can assist in the protection of that child without the need for removal (intervention action) from his or her family home', and can serve to assist adult victims of violence when it would decrease risk to the adult victim if the Department was the applicant. In the report, the Ombudsman made three recommendations relating to DCPFS's improved compliance with the provisions of its *Family and Domestic Violence Practice Guidance* in seeking violence restraining orders on behalf of children (Recommendations 45, 46 and 47), including:

> Recommendation 45: In its implementation of section 18(2) of the *Restraining Orders Act 1997*, DCPFS complies with its *Family and Domestic Violence Practice Guidance* which identifies that DCPFS officers should consider seeking a violence restraining order on behalf of a child if the violence is likely to escalate and the children are at risk of further abuse, and/or it would decrease risk to the adult victim if the Department was the applicant for the violence restraining order.

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

Support during the process of obtaining a violence restraining order

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identified the importance of opportunities for victims to seek help and for perpetrators to be held to account throughout the process for obtaining a violence restraining order, and that these opportunities are acted upon, not just by WAPOL but by all State Government departments and authorities. In the report the Ombudsman recommended that:

> Recommendation 14: In developing and implementing future phases of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, DCPFS specifically identifies and incorporates opportunities for state government departments and authorities to deliver information and advice about violence restraining orders, beyond the initial response by WAPOL.

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

and domestic violence fatalities, November 2016, identified that DCPFS had taken steps to give effect to this recommendation.

The findings and recommendations from the Ombudsman's family and domestic violence fatality reviews and major own motion investigations will contribute to the development of the 10-year across-government strategy to reduce family and domestic violence. The Office will also monitor the implementation of Recommendation 14 from the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015 in the development of the new state strategy.

Support when a violence restraining order has not been granted

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, examined a sample of 41,229 hearings regarding violence restraining orders and identified that an application for a violence restraining order was dismissed or not granted as an outcome of 6,988 hearings (17%) in the investigation period. In cases where an application for a violence restraining order has been dismissed it may still be appropriate to provide safety planning assistance. In the report, the Ombudsman recommended that:

> Recommendation 25: DOTAG, in collaboration with DCPFS, identifies and incorporates into *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, ways of ensuring that, in cases where an application for a violence restraining order has been dismissed, if appropriate, victims are provided with referrals to appropriate safety planning assistance.

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

The findings from the Ombudsman's family and domestic violence fatality reviews and the own motion investigations will contribute to the development of the 10-year across-government strategy to reduce family and domestic violence.

Provision of support to victims experiencing family and domestic violence

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

> The purpose of risk assessment is to determine the risk and safety for the adult victim and children, taking into consideration the range of victim and perpetrator risk factors that affect the likelihood and severity of future violence.
>
> Risk assessment must be undertaken when family and domestic violence has been identified…
>
> Risk assessment is conducted for a number of reasons including:
>
> - evaluating the risk of re-assault for a victim;
> - evaluating the risk of homicide;
> - informing service system and justice responses;

- supporting women to understand their own level of risk and the risk to children and/or to validate a woman's own assessment of her level of safety; and
- establishing a basis from which a case can be monitored.

(pages 36-37)

The Ombudsman's family and domestic violence fatality reviews and the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, have noted that, where agencies become aware of family and domestic violence, they do not always undertake a comprehensive assessment of the associated risk of harm and provide support and safety planning.

In the report, the Ombudsman made eight recommendations (Recommendations 40 – 44 and 48 – 50) to public authorities that they ensure compliance with their family and domestic violence policy requirements, including assessing risk of future harm and providing support to address the impact of experiencing family and domestic violence.

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

In 2017-18, through the reviews of family and domestic violence fatalities, the Office has continued to examine compliance with family and domestic violence policy, in relation to promoting victim safety, and has made recommendations to agencies to improve family and domestic violence policy compliance.

Case Study

Case Study A

Mr A had been in prison for offences that had occurred in the context of family and domestic violence. Following his release from prison, Mr A fatally assaulted his intimate partner, Ms Z. Mr A has been convicted of murder. The Ombudsman made the following recommendation in 2017-18:

> DOJ considers what additional action can be taken to promote the safety of family and domestic violence victims and the community, prior to the release of all prisoners convicted of offences committed in the context of family and domestic violence and assessed as a high risk of committing further offences, irrespective of whether they are released on parole or to freedom, and provides a report to the Ombudsman by 31 December 2017 outlining actions to address this issue.

Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 31 (61%) of the 51 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2018, prior family and domestic violence between the parties had been reported to WAPOL and/or other public authorities. The Ombudsman's reviews identify where perpetrators have a history of reported violence, with one or more

partners, and examines steps taken to hold perpetrators to account for their actions and support them to cease their violent behaviors, in accordance with the intent of the State Strategy.

Fatalities with no prior reported family and domestic violence

Based on the information available to the Office, in 20 (39%) of the 51 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2018, the fatal incident was the only family and domestic violence between the parties that had been reported to WAPOL and/or other public authorities. It is important to note, however, research indicating under-reporting of family and domestic violence. The Australian Bureau of Statistics' *Personal Safety Survey 2016* (www.abs.gov.au) collected information about help seeking behaviours, noting that:

- In the most recent incident of physical assault by a male, women were most likely to be physically assaulted by a male that they knew (92% or 977,600).

and

- Two-thirds of men and women who experienced physical assault by a male did not report the most recent incident to police (69% or 908,100 for men and 69% or 734,500 for women).

The Ombudsman's reviews provide information on family and domestic violence fatalities where there is no previous reported history of family and domestic violence, including cases where information becomes available after the death to confirm a history of unreported family and domestic violence, drug or alcohol use, or mental health issues that may be relevant to the circumstances of the fatality.

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

Family violence involving Aboriginal people

Of the 90 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2018, Aboriginal Western Australians were over-represented, with 29 (32%) persons who died being Aboriginal. In all but one case, the suspected perpetrator was also Aboriginal. There were 23 of these 28 fatalities where the person who died lived in a regional or remote area of Western Australia, of which 19 were intimate partner fatalities.

The Ombudsman's family and domestic violence fatality reviews and the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identify the over-representation of Aboriginal people in family and domestic violence fatalities. This is consistent with the research literature that Aboriginal people are 'more likely to be victims of violence than any other section of Australian society' (Cripps, K and Davis, M, *Communities working to reduce Indigenous family violence*, Brief 12, June 2012, Indigenous Justice Clearinghouse, New South Wales, p. 1) and that Aboriginal people experience family and domestic violence at 'significantly higher rates than other Australians' (Aboriginal and Torres Strait Islander Social Justice Commissioner, *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities – Key Issues, An overview paper of research and findings by*

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

Contextual Factors for family violence involving Aboriginal people

As discussed in the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, the research literature suggests that there are a number of contextual factors contributing to the prevalence and seriousness of family violence in Aboriginal communities and that:

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

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

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

More recently, the ANROWS (Australian National Research Organisation for Women's Safety) Horizons Research Report entitled *Innovative Models in addressing violence against Indigenous women: Final report* (January 2018, available at www.anrows.org.au):

> This research report undertakes a critical inquiry into responses to family violence in a number of remote communities from the perspective of Aboriginal people who either work within the family violence space or have had experience of family violence. It explicitly foregrounds Indigenous knowledge of family violence, arguing that Indigenous knowledge departs from what we call in this report "mainstream knowledge"1 in a number of critical respects. The report is based on qualitative research in three sites in Australia: Fitzroy Crossing (Western Australia), Darwin (Northern Territory), and Cherbourg (Queensland). It supports the creation of a network of regionally based Indigenous family violence strategies owned and managed by Indigenous people and linked to initiatives around alcohol reduction, intergenerational trauma, social and emotional wellbeing, and alternatives to custody. The key theme running through our consultations was that innovative practice must be embedded in Aboriginal law and culture. This recommendation runs counter to accepted wisdom regarding intervention in family and domestic violence, which tends to assume that gender trumps other differences, and that violence against women results from similar forms of oppression, linked to gender inequalities and patriarchal forms of power. While not disputing the role of gender and coercion in underpinning much violence against Indigenous women, we, nonetheless, claim that a distinctively Indigenous approach to family violence necessitates exploring causal factors that reflect specifically Indigenous experiences of colonisation and its aftermath.
> (page 9)

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

A separate strategy to prevent and reduce Aboriginal family violence

In examining the family and domestic violence fatalities involving Aboriginal people, the research literature and stakeholder perspectives, the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities,* November 2015, identified a gap in that there is no strategy solely aimed at addressing family violence experienced by Aboriginal people and in Aboriginal communities.

The findings of the report strongly support the development of a separate strategy that is specifically tailored to preventing and reducing Aboriginal family violence. This can be summarised as three key points.

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

Secondly, the research literature, discussed in Chapter 6 of the report suggests a distinctive '…nature, history and context of family violence in Aboriginal and Torres Strait Islander communities' (National Aboriginal and Torres Strait Islander Women's Alliance, *Submission to the Finance and Public Administration Committee Inquiry into Domestic Violence in Australia*, National Aboriginal and Torres Strait Islander Women's Alliance, New South Wales, 31 July 2014, p. 5). The research literature

further suggests that combating violence is likely to require approaches that are informed by and respond to this experience of family violence.

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

The report also identified that development of the strategy must include and encourage the involvement of Aboriginal people in a full and active way, at each stage and level of the development of the strategy, and be comprehensively informed by Aboriginal culture. Doing so would mean that an Aboriginal family violence strategy would be developed with, and by, Aboriginal people. In the report, the Ombudsman recommended that:

> Recommendation 4: DCPFS, as the lead agency responsible for family and domestic violence strategic planning in Western Australia, develops a strategy that is specifically tailored to preventing and reducing Aboriginal family violence, and is linked to, consistent with, and supported by *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*.
>
> Recommendation 6: In developing a strategy tailored to preventing and reducing Aboriginal family violence, referred to at Recommendation 4, DCPFS actively invites and encourages the involvement of Aboriginal people in a full and active way at each stage and level of the process, and be comprehensively informed by Aboriginal culture.

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

In 2017, the State Government released the *Stopping Family and Domestic Violence Policy*, which sets out 21 new initiatives for responding to family and domestic violence. This document supersedes *Western Australia's Family and Domestic Violence Strategy to 2022* and the *Freedom from Fear Action Plan 2015*. Also in 2017, the first Minister for the Prevention of Family and Domestic Violence was appointed. In 2018, Communities has convened a family and domestic violence policy consortium, comprising representatives from government, community sector services, Aboriginal Community Controlled Organisations and academia, to develop a comprehensive project plan for the development of a 10-year across-government strategy to reduce family and domestic violence. The Office, as an observer, has contributed to this policy consortium. The findings and recommendations from the Ombudsman's family and domestic violence fatality reviews and major motion investigations will contribute to the development of this new state strategy.

Case Study

Case Study B

As part of a review of a family and domestic violence fatality, to further understand how agencies are working together, and with Aboriginal people and communities, the Office convened a roundtable in November 2017. The roundtable was attended by Aboriginal cultural consultants as well as relevant public sector agencies.

Further, the Ombudsman's major own motion investigation, tabled in Parliament on 19 November 2015, titled *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* specifically considered issues of agency engagement with Aboriginal Family Violence. In particular, Recommendations 4, 5 and 6 which state:

> **Recommendation 4**
>
> DCPFS, as the lead agency responsible for family and domestic violence strategic planning in Western Australia, develops a strategy that is specifically tailored to preventing and reducing Aboriginal family violence, and is linked to, consistent with, and supported by *Western Australia's Family and Domestic Violence Prevention strategy to 2022: Creating Safer Communities*.
>
> **Recommendation 5**
>
> DCPFS, in developing the Aboriginal family violence strategy referred to at recommendation 4, incorporates strategies that recognise and address the co-occurrence of alcohol use and Aboriginal family violence.
>
> **Recommendation 6**
>
> In developing a strategy tailored to preventing and reducing Aboriginal family violence, referred to at Recommendation 4, DCPFS actively invites and encourages the involvement of Aboriginal people in a full and active way at each stage and level of the process, and be comprehensively informed by Aboriginal culture.

Further again, these recommendations have been examined in *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* which was tabled in Parliament on 10 November 2016.

To further examine the implementation of these recommendations, this Office requested clarification from Communities as the lead agency responsible for family and domestic violence strategic planning in Western Australia. This Office was informed that Communities will develop a 10-year family and domestic violence strategy for Western Australia, which will include a specific plan for responding to the issue of Aboriginal Family Violence. The Office made the following recommendation:

> Communities provides the Ombudsman with a report on the steps taken to give effect to Recommendations 4, 5 and 6 of the Ombudsman's major own motion investigation report *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* by 31 December 2018.

Limited use of violence restraining orders

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identified that while Aboriginal people are significantly over-represented as victims of family and domestic violence, they are less likely than non-Aboriginal people to seek a violence restraining order. The report examined the research literature and views of stakeholders on the possible reasons for this lower use of violence restraining orders by Aboriginal people, identifying that the process for obtaining a violence restraining order is not necessarily always culturally appropriate for Aboriginal victims and that Aboriginal people in regional and remote locations face additional logistical and structural barriers in the process of obtaining a violence restraining order.

In the report, the Ombudsman recommended that:

> Recommendation 23: DOTAG, in collaboration with key stakeholders, considers opportunities to address the cultural, logistical and structural barriers to Aboriginal victims seeking a violence restraining order, and ensures that Aboriginal people are involved in a full and active way at each stage and level of this process, and that this process is comprehensively informed by Aboriginal culture.

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

The November 2015 report noted that data examined by the Office concerning the use of police orders and violence restraining orders by Aboriginal people in Western Australia indicates that Aboriginal victims are more likely to be protected by a police order than a violence restraining order. This data is consistent with information examined in the Ombudsman's reviews of family and domestic violence fatalities involving Aboriginal people. In the report, the Ombudsman recommended that:

> Recommendation 16: DCPFS considers the findings of the Ombudsman's investigation regarding the link between the use of police orders and violence restraining orders by Aboriginal people in developing and implementing the Aboriginal family violence strategy referred to in Recommendation 4.

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

The findings from the Ombudsman's family and domestic violence fatality reviews and the own motion investigations will contribute to the development of the 10-year across-government strategy to reduce family and domestic violence, and monitor the implementation of Recommendation 16 from the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015.

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

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

In the report, the Ombudsman recommended that:

> Recommendation 5: DCPFS, in developing the Aboriginal family violence strategy referred to at Recommendation 4, incorporates strategies that recognise and address the co-occurrence of alcohol use and Aboriginal family violence.

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

The findings and recommendations from the Ombudsman's family and domestic violence fatality reviews and major own motion investigations will contribute to the development of the 10-year across-government strategy to reduce family and domestic violence.

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

Of the 29 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2018 involving Aboriginal people, 23 (79%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Twelve (41%) of the Aboriginal people who died lived in the Kimberley region, which is home to 1.4 per cent of all people and 19 per cent of Aboriginal people in the Western Australian population.

As outlined above, *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that Communities had taken steps and proposed steps to be taken to give effect to Recommendations 4 and 6 of the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015. These recommendations related to DCPFS developing 'a strategy

that is specifically tailored to preventing and reducing Aboriginal family violence' that would encompass all regions of Western Australia and Communities actively inviting and encouraging 'the involvement of Aboriginal people in a full and active way at each stage and level of the process' and being 'comprehensively informed by Aboriginal culture'.

Case Study

Case Study C

The Ombudsman's review of a family and domestic violence fatality identified limitations in data being captured, including Aboriginal status of the victim and perpetrator, to inform family violence service development and evaluation. The Office made the following recommendation:

- Communities takes steps to ensure data being captured by the Family and Domestic Violence Region Team (**FDVRT**) process includes Aboriginal status of the victim and perpetrator, to inform FDVRT and family violence service development and evaluation.

Factors co-occurring with family and domestic violence

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

Co-occurrence with alcohol and other drug use

Consistent with the research literature discussed relating to the co-occurrence between alcohol consumption and/or drug use and incidents of family and domestic violence (as outlined in the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015), the National Plan (available at www.dss.gov.au) observes that:

> Alcohol is usually seen as a trigger, or a feature, of violence against women and their children rather than a cause. Research shows that addressing alcohol in isolation will not automatically reduce violence against women and their children. This is because alcohol does not, of itself, create the underlying attitudes that lead to controlling or violent behaviour.
> (National Council to Reduce Violence against Women and their Children, 2009, *Background Paper to Time for Action, The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009–2021*, Australian Government, p. 29).

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

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

On the information available, relating to the 75 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2018, the Office's reviews identify where alcohol use and/or drug use are factors associated with the fatality, and where there may be a history of alcohol use and/or drug use.

	ALCOHOL USE		DRUG USE	
	Associated with fatal event	Prior history	Associated with fatal event	Prior history
Person who died only	3	3	3	7
Suspected perpetrator only	3	12	7	10
Both person who died and suspected perpetrator	22	24	6	11
Total	**28**	**39**	**16**	**28**

The Ombudsman's reviews and *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, have identified that in Western Australia, the State Strategy does not mention or address alcohol and its relationship with family and domestic violence. However, the goal of the Mental Health Commission's *Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015* (**the Framework**) is to 'prevent and reduce the adverse impacts of alcohol and other drugs in the Western Australian community' (page 5). This Framework is currently being revised by the Mental Health Commission, in consultation with the Drug and Alcohol Strategic Senior Officers Group, as stated at www.mhc.wa.gov.au (and correct at the time of writing this report).

As one of these adverse impacts, the Framework highlights 'violence and family and relationship breakdown' as a result of 'problematic drug and alcohol use' (page 3). Stakeholders have suggested to the Ombudsman that programs and services for victims and perpetrators of violence in Western Australia, including family and domestic violence, do not address its co-occurrence with alcohol and other drug abuse. Specifically, this means that programs and services addressing family and domestic violence:

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

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

- Address perpetrators' violent behaviour; or

- Respond to the needs of victims resulting from their experience of family and domestic violence.

The concerns of stakeholders are consistent with the research literature as outlined in the report. Given the level of recorded alcohol use associated with the Ombudsman's reviews, in the report the Ombudsman recommended that:

> Recommendation 3: DCPFS, in collaboration with the Mental Health Commission and other key stakeholders, includes initiatives in Action Plans developed under the *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, which recognise and address the co-occurrence of alcohol use and family and domestic violence.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that in relation to Recommendation 3, the Mental Health Commission and DCPFS had taken steps and proposed steps to be taken to give effect to this recommendation. The Office will continue to monitor, and report on, the steps being taken to implement this recommendation. The Office will monitor the development, implementation and effectiveness of the proposed *Western Australian Alcohol and Drug Interagency Strategy 2018-2022*, and the 10-year across-government strategy to reduce family and domestic violence, in responding to family and domestic violence and co-occurrence with alcohol and drugs.

Co-occurrence of mental health issues

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

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

and

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

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

Issues identified in Family and Domestic Violence Fatality Reviews

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

It is important to note that:

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

- Not providing culturally informed practice guidance for responding to Aboriginal family violence.
- Not adequately implementing family and domestic violence policies and procedures.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities to address family and domestic violence victim safety.
- Missed opportunity to collate data relevant to informing the development, and evaluation, of strategies and services to reduce or prevent family and domestic violence.
- Not undertaking sufficient inter-agency communication to enable effective case management and collaborative responses.
- Inaccurate recordkeeping.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following nine recommendations were made by the Ombudsman in 2017-18 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. DOJ develops a family and domestic violence policy to direct and co-ordinate its commitment to achieving the Primary State Outcomes of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022*. Further, the family and domestic violence policy identifies the needs of Aboriginal people and includes specifically tailored strategies for preventing and reducing Aboriginal family violence which are linked to, and consistent with, *Western Australia's Family and Domestic Violence Prevention Strategy to 2022*.

2. DOJ develops a process to identify all offenders convicted of offences that occurred in the context of family and domestic violence entering the prison system and reports on this group in offender statistics and other relevant reports.

3. DOJ considers, as part of its current review into prisoner management, the

management of prisoners serving an effective sentence of six months or less for an offence that occurred in the context of family and domestic violence who have been identified as a high risk of re-offending and develops strategies to promote perpetrator accountability and support these prisoners to cease their violent behaviour.

4. DOJ is to provide a report to the Ombudsman within six months of the finalisation of this family and domestic violence fatality review outlining actions taken by DOJ to review its information release and sharing policies to support greater collaboration processes to promote the safety of victims of offences that occurred in the context of family and domestic violence.

5. That DOJ considers, in the context of current agency program review and resourcing provisions, what steps will be taken to improve the rate of prisoners assessed as requiring family and domestic violence treatment programs assessing these programs during their imprisonment to promote perpetrator accountability and support these prisoners to cease their violent behaviour, in accordance with DOJ's responsibilities for offender management and rehabilitation and commitment to promoting perpetrator accountability and victim safety as outlined in the *Western Australia's Family and Domestic Violence Prevention Strategy to 2022*, and provides a report to the Ombudsman by [nominated date] outlining the steps taken to address this issue.

6. DOJ provides a report to the Ombudsman, within three months of the finalisation of this review, outlining work undertaken by the Adult Justice Services Division to address 'the gap' identified by DOJ, in its letter [relevant to this family and domestic violence fatality review], regarding the assessment of 'domestic violence offenders ... in the custodial environment'.

7. DOJ considers what additional action can be taken to promote the safety of family and domestic violence victims and the community, prior to the release of all prisoners convicted of offences committed in the context of family and domestic violence and assessed as a high risk of committing further offences, irrespective of whether they are released on parole or to freedom, and provides a report to the Ombudsman by [nominated date] outlining actions to address this issue.

8. Communities takes steps to ensure data being captured by the Family and Domestic Violence Response Team process includes Aboriginal status of the victim and perpetrator, to inform Family and Domestic Violence Response Team and family violence service development and evaluation.

9. Communities provides the Ombudsman with a report on the steps taken to give effect to Recommendations 4, 5 and 6 of the Ombudsman's major own motion investigation report *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* by [nominated date].

The Ombudsman's *Annual Report 2018-19* will report on the steps taken to give effect to the nine recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2016-17. The Ombudsman's *Annual Report 2019-20* will report on the steps taken to give effect to the nine recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2017-18.

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

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

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

Recommendation 1: That WAPOL considers whether action is required to strengthen processes associated with the receipt, assessment and verification of intelligence related to threats to kill made in family and domestic relationships, to ensure the prioritisation of victim safety and perpetrator accountability.

Steps taken to give effect to the recommendation

The Office requested that WAPOL inform the Office of the steps taken to give effect to the recommendation. In response, WAPOL provided a range of information in a letter to this Office dated 9 August 2017 (**the WAPOL Letter**).

In the WAPOL Letter, WAPOL relevantly informed the Office that:

> WA Police has implemented actions to strengthen processes associated with the receipt, assessment and verification of intelligence related to threats to kill and to ensure prioritisation of victim safety and perpetrator accountability.
>
> Regular, formal meetings are held between WA Police and the Department of Corrective Services (**DCS**) Intelligence Services to review and facilitate improved operational response to intelligence gathered by DCS personnel.
>
> Where DCS identify allegations of serious imminent, threats to life, WA Police are notified and resources tasked immediately. In circumstances where a threat is serious but not imminent, a report is recorded on the Intelligence Data Management (IDM) system and assessed by an intelligence co-ordinator for further consideration.
>
> An Incident Report is generated on the WA Police Incident Management System (IMS) and allocated to a relevant business area for investigation.
>
> Where family violence is identified as a factor, the Incident Report is 'flagged' with a marker, ensuring District Family Protection Units are notified and Family and

Domestic Violence Response Team (FDVRT) protocols are applied.

Additional advantages of recording the information on IMS include the provision of a formal trigger to place investigative accountability on business units and individual officers and a compliance mechanism to ensure timely investigation within the WA Police Investigation Framework.

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

Recommendation 2: That WAPOL considers whether action is required to strengthen processes and procedures to promote that the interrogation of data systems identifies contemporaneous and relevant information upon which to inform the allocation of matters to the appropriate WAPOL division for action.

Steps taken to give effect to the recommendation

The Office requested that WAPOL inform the Office of the steps taken to give effect to the recommendation. In response, WAPOL provided a range of information in a letter to this Office dated 9 August 2017.

In the WAPOL Letter, WAPOL relevantly informed the Office that:

WA Police has implemented actions to strengthen processes associated with the receipt, assessment and verification of intelligence related to threats to kill and to ensure prioritisation of victim safety and perpetrator accountability.

Regular, formal meetings are held between WA Police and the Department of Corrective Services (**DCS**) Intelligence Services to review and facilitate improved operational response to intelligence gathered by DCS personnel.

Where DCS identify allegations of serious imminent, threats to life, WA Police are notified and resources tasked immediately. In circumstances where a threat is serious but not imminent, a report is recorded on the Intelligence Data Management (IDM) system and assessed by an intelligence co-ordinator for further consideration.

An Incident Report is generated on the WA Police Incident Management System (IMS) and allocated to a relevant business area for investigation.

Where family violence is identified as a factor, the Incident Report is 'flagged' with a marker, ensuring District Family Protection Units are notified and Family and Domestic Violence Response Team (FDVRT) protocols are applied.

Additional advantages of recording the information on IMS include the provision of a formal trigger to place investigative accountability on business units and individual officers and a compliance mechanism to ensure timely investigation within the WA Police Investigation Framework.

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

Recommendation 3: That WAPOL considers current procedures to determine whether action is required to strengthen the timely provision of intelligence to WAPOL prosecutors to inform bail applications and associated bail conditions.

Steps taken to give effect to the recommendation

The Office requested that WAPOL inform the Office of the steps taken to give effect to the recommendation. In response, WAPOL provided a range of information in a letter to this Office dated 9 August 2017.

In the WAPOL Letter, WAPOL relevantly informed the Office that:

> WA Police policy and training directs investigating officers to provide timely intelligence to prosecutors in order to inform bail conditions. This is predominately confined to intelligence held within WA Police databases due to Information Technology (IT) limitations existing across agencies, as platforms do not readily interact and have limited interoperability.
>
> WA Police Prosecuting personnel are sometimes restricted in opportunity to engage in comprehensive intelligence gathering, particularly when applications for bail are made at the discretion of the accused person and the timing of such actions are often unknown and at short notice.
>
> Dialogue is ongoing to explore the possibility of strengthening systems, however a number of issues exist including lack of access to intelligence held by other agencies and limitation of access to external agencies outside of office hours which may preclude this.

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

Recommendation 4: That WAPOL takes all reasonable steps to ensure that actions allocated to WAPOL arising from the Family and Domestic Violence Response Team (FDVRT) triage meetings are undertaken in a timely manner and consistent with the FDVRT Operating Procedures and WAPOL's Family and Domestic Violence Policy.

Steps taken to give effect to the recommendation

The Office requested that WAPOL inform the Office of the steps taken to give effect to the recommendation. In response, WAPOL provided a range of information in a letter to this Office dated 9 August 2017.

In the WAPOL Letter, WAPOL relevantly informed the Office that:

> The current WA Police policies and procedures have recently been reviewed and provide advice and accountabilities to WA Police personnel involved in the FDVRT process. All police FDVRT actions are allocated to relevant Victim Safety Unit or Family Protection Unit who are accountable for actioning tasks and record the actions on an IMS running sheet.
>
> The implementation of a threshold for reports to the FDVRT is scheduled for tiered implementation across the state in July and August 2017. The threshold intends to focus the resources of the FDVRT on the families most in need of support, to

maximise effort.

The reduced volume of reports forwarded for FDVRT attention will provide the capacity to complete triage in a timely manner and actively engage in support actions and interventions allocated.

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

Recommendation 5: That WAPOL takes all reasonable steps to ensure its cumulative knowledge associated with the circumstances of recidivist family and domestic violence offending, in addition to perpetrator offending histories, is utilised at FDVRT triage meetings to inform the identification of high risk cases for referral and management via multi-agency case management.

Steps taken to give effect to the recommendation

The Office requested that WAPOL inform the Office of the steps taken to give effect to the recommendation. In response, WAPOL provided a range of information in a letter to this Office dated 9 August 2017.

In the WAPOL Letter, WAPOL relevantly informed the Office that:

> The implementation of a threshold for reports to the FDVRT is scheduled to be implemented across the State in July and August 2017. The threshold intends to focus the resources of the FDVRT on families most in need of support, to maximise effort.
>
> The reduced volume of reports for FDVRT attention will afford the Family Protection and Victim Support Units capacity to interrogate WA Police databases and 'value add' to reports prior to publishing for FDVRT triage.

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

Recommendation 6: That the Department of Health (DOH) considers amending and/or supplementing DOH's *Guideline for Responding to Family and Domestic Violence 2014*, to provide its staff with guidance on implementing the outlined procedures associated with identifying and responding to family and domestic violence in circumstances where a patient presents as intoxicated.

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, DOH provided a range of information in a letter to this Office dated 6 September 2017 (**the DOH Letter**).

In the DOH Letter, DOH relevantly informed the Office that:

> …on 1 July 2016, the Health Services Act 2016 commenced operation introducing a contemporary, devolved governance model for the WA Health system. The *Health Services Act 2016* clarifies roles and responsibilities at each level of the system, establishing the Director General of the Department of Health as the System Manager responsible for the overall management of the WA health system and the

Health Service Providers (Child and Adolescent Health Service, North Metropolitan Health Service, East Metropolitan Health Service, South Metropolitan Health Service and WA Country Health Service and Health Service Support) as separate statutory authorities…

Policy Governance Arrangements

The *Health Services Act 2016* introduced the concept of Policy Frameworks to the WA health system. On 1 July 2016 Operational Directives, Information Circulars and other policy documents relevant to the governance of the WA health system were allocated to one of the 19 policy frameworks and issued to the WA health system by the System Manager. Policy frameworks are binding on Health Service Providers.

On 5 April 2017 the *WA Health System Policy Governance Policy* was issued to govern policy frameworks and the policy documents that sit within them. The WA health system is still in a transitional phase.

Operational Directives issued prior to 1 July 2016 do not reflect the new governance model therefore the roles and responsibilities of Health Service Providers and the Director General, as System Manager in some cases are not clear. However, the Department of Health is about to embark on a process of reviewing and refining each policy framework so all policy documents within each framework are reflective of the new governance model, mandatory requirements are clear, and compliance and monitoring processes well-articulated and undertaken on a regular basis.

One policy issue that has yet to be resolved is the issue of statewide policy. Statewide policy is policy that is developed by subject matter experts within Health Service Providers and is intended to apply to the entire WA health system. This is a complex issue as Health Service Providers do not have the power under the *Health Services Act 2016* to:

- Issue policy frameworks;
- Monitor another Health Service Provider's performance; or
- Monitor another Health Service Provider's compliance with a policy.

One example of a statewide policy is Operational Directive 0523/14 *Responding to Family and Domestic Violence (Guidelines and Reference Manual)* (**OD 0523/14**). This policy is developed by the Women's Health, Genetics and Mental Health Directorate located at the Women and Newborn Health Service within the North Metropolitan Health Service. Due to the statewide policy issue not being resolved, OD 0523/14 was not allocated to a policy framework at 1 July 2016. The OD remains in force, however, as it is not part of a policy framework it is therefore not mandated on Health Service Providers under the Health Services Act 2016. Work is currently progressing in resolving the statewide policy issue…

…Once the issues regarding statewide policy are resolved, it will become clearer as to how this policy can be mandated on the WA health system and how compliance and evaluation of the policy will occur

In the meantime, the Women's Health, Genetics and Mental Health Directorate are currently in the process of updating OD 0523/14 and this policy will be reviewed and amended to reflect the new governance model, along with other required process updates.

[DOH] note that family violence was discussed at the August 2017 COAG Health Council and that it is a critical issue for the WA health system to address. Therefore, [DOH] will prioritise resolving the policy governance arrangements and clarifying the roles and responsibilities of the System Manger and the Health Service Providers in

this area…

It is also noted by this Office that during the review of this family and domestic violence fatality, DOH informed the Office in a letter dated 4 June 2015 that:

> Recommendation [6] is currently being considered by the Women Newborn Health Service's (WNHS) Women's Clinical Care Unit, as a component of the current FDV education and training sessions. Alcohol and drug use is a major risk factor for FDV, as outlined in the current assessment form. The WNHS Women's Health Clinical Support Program FDV trainer organised a videoconference forum with the WACHS Kimberley which occurred on 18 May 2015. At least 7 sites amounting to over 50 people attended this event. The issue of people presenting intoxicated was discussed at this forum.

In the context of the introduction of the *Health Services Act 2016*, this Office notes the work being undertaken to clarify how Operational Directive 0523/14 *Responding to Family and Domestic Violence (Guidelines and Reference Manual)* can be mandated on the WA health system and how compliance and evaluation will be undertaken.

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

Recommendation 7: That DOH liaises with the relevant community service and Communities to clarify information relating to the criteria for referral and services available from the relevant community service, and updates the family and domestic violence Local Service Information sheet accordingly.

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 provided a range of information in a letter to this Office dated 15 June 2017 (**the WACHS Letter**), containing a report prepared by WACHS.

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

> Family and Domestic Violence folders in each department outline:
>
> - Information for staff
> - WACHS procedures and guidelines
> - Documentation – screening and assessment tools/Referral forms – FDV950, FDV951, FDV952
> - Local support services
> - Contact phone numbers
> - Patient education – handouts/pamphlets

In its June 2017 report, WACHS further relevantly informed the Office that:

> FDV951 Assessment form – comprehensive 12 page document is completed. Tick box checklist which prompts for referrals and is signed and dated.

Operational Directive 0523/14 *Responding to Family and Domestic Violence (Guidelines and Reference Manual)* includes a template titled *Local Service Information*, which can be provided to patients who attend health services when

family and domestic violence is a presenting issue.

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

Recommendation 8: That DOH ensures the knowledge and views of clinicians, and other health services throughout the Region, are incorporated in current planning to address the issues of family and domestic violence in the Region.

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 provided a range of information in a letter to this Office dated 15 June 2017, containing a report prepared by WACHS.

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

> Broome Hospital nursing staff are encouraged to discuss alerting police to FDV assaults with the patient whilst in ED – if consent is not provided and FDV considered High Risk as per FDV951 the case is referred … for assessment +/- information sharing with the Kimberley FDV response team comprised of WAPOL, CPFS and Anglicare; as per MOU and Section 28B of the *Children and Community Services Act 2004*.
>
> A BHS representative attends Multi Agency Case Management meetings for identified high risk patients and place High risk alerts … in patient files which direct clinician response.

In providing information to this Office for the review, WACHS stated:

> …the emergency department doctors often have to make assumptions about whether a case is FDV. There is regularly a lack of information by women about what has happened. The incidents are often without consequence and it is thought that disclosure has a potential to lead to "punishment" for the victim at home. Other victims are intoxicated (alcohol or drugs) … there is a perception of multi-system failure often due to lack of safe housing; limitations on what police can do; and shelters/refuges not answering the phone after 10.00pm; or declining to provide assistance…

It is noted by this Office that during the review of this family and domestic violence fatality, DOH informed the Office in a letter dated 4 June 2015 that:

> The Kimberley region currently has a DCPFS working group. The DCPFS conducted consultations in all Kimberley towns, through local working groups and in the second half of 2014. WACHS Kimberley was represented at these consultations. The Kimberley Family Violence Regional Plan is not yet a pubic document, however is close to public release which addresses care for victims, and perpetrators, of FDV. The draft Kimberly Family Violence Regional Plan outlines a 2015-2016 work plan, in which WACHS Kimberley will be the lead agency to implement strategies and initiatives identified by the working group.

Safer Families, Safer Communities Kimberley Family Violence Regional Plan 2015 - 2020 was finalised in 2015.

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 family and domestic violence fatalities. 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 one half of reviews being completed within three months and 67% of reviews completed within 12 months.

Major Own Motion Investigations Arising from Family and Domestic Violence Fatality Reviews

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

On 19 November 2015, the Ombudsman tabled in Parliament a report entitled *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*. Recommendation 54 of the report is as follows:

> Taking into account the findings of this investigation, DCPFS:
>
> - conducts a review to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance;
> - develops an associated action plan to overcome identified barriers; and
> - provides the resulting review report and action plan to this Office within 12 months of the tabling in the Western Australian Parliament of the report of this investigation.

Section 25(4) of the *Parliamentary Commissioner Act 1971* relevantly provides as follows:

> (4) If under subsection (2) the Commissioner makes recommendations to the principal officer of an authority he may request that officer to notify him, within a specified time, of the steps that have been or 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.

On 13 October 2016, the Director General of the (then) Department for Child Protection and Family Support (**DCPFS**) provided the Ombudsman with two documents constituting DCPFS's response to Recommendation 54. These were the *Family and Domestic Violence Practice Guidance Review Report* and the *Family and Domestic Violence – Practice Guidance Implementation*.

On 10 November 2016, the Ombudsman tabled in Parliament *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, which, among other things, identified that:

> The review report and action plan have been provided to the Office within 12 months of the tabling of the FDV Investigation Report, and will be reviewed by the Office and the results of this review reported on in the Office's 2016-17 Annual Report.

In the Office's *Annual Report 2016-17*, the Office identified that (the then) DCPFS's response to Recommendation 54 had been reviewed and that the Office's analysis would be tabled separately.

The Office has now concluded its review of the (now) Department of Communities' (**Communities**) review report. The Office has considered the *Family and Domestic Violence Practice Guidance Review Report* and that Communities has conducted a project to review its family and domestic violence practice guidance. The focus of the review conducted by Communities was to identify and recommend amendments to Communities' family and domestic violence practice guidance. The review did not include any actions 'to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance'. Further, while Communities identified several issues which potentially relate to barriers to effective implementation, a range of Communities' 'proposed actions' to overcome these potential barriers were not considered to be appropriate.

Following consideration of all of the above matters, the review conducted by Communities did not constitute a review to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance. As developing an associated action plan to overcome identified barriers was contingent on conducting a review to identify those barriers, the *Family and Domestic Violence – Practice Guidance Implementation* document did not constitute an associated action plan to overcome identified barriers.

In a pleasing response to this finding, Communities indicated the following:

> Communities acknowledges this finding and confirms it is a priority for Communities to address and implement the intent of the recommendation. It was the intent of the *Family and Domestic Violence Practice Guidance Review Report* (the report) and the *Family and Domestic Violence Practice Guidance Implementation* to do so. The report did help to identify a range of issues that limit the implementation of policy and practice guidance, and Communities has undertaken numerous activities and processes to address these. These include:
>
> - new toolkits for assessment and safety planning in cases of emotional abuse - family and domestic violence, which aim to support child protection workers to form an evidence-based professional judgement, and include practice examples of how to gather information to inform assessments, analyse the information, and practice examples of safety planning;
> - mandatory training concerning family and domestic violence for new and current employees to have a focus on effectively engaging perpetrators, including assessments within the training and in the field;
> - workshops and presentations with Team Leader and Senior Practice Development Officer groups to encourage strong leadership within districts of the policy and practice guidance;

- case consultation with child protection workers to provide opportunities for staff to reflect on and plan their practice;
- a centralised intake model in July 2017, including a 'threshold tool' to provide a consistent response to child protection referrals;
- a partnership with Curtin University, the University of Melbourne and the Safe and Together Institute in order to integrate techniques in working with perpetrators into practice; and
- a practice audit is currently being undertaken to assess the implementation to date of the family and domestic violence practice guidance, and to establish a baseline from which further audits or reviews of practice can be measured. The audit examines 50 cases (three from each district) at various stages of Communities' Child Protection and Family Support division involvement, identifies areas for practice improvement and provides opportunities to work with districts to improve understanding of key issues in the intersection between child protection and family and domestic violence.

Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

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

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

Stakeholder Liaison

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

The Ombudsman's Advisory Panel

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

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

The Panel met four times in 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).

In 2017-18, observers from Western Australia Police, the Department of Communities, the Department of Health, the Department of Education, the Department of Justice, and the Mental Health Commission also attended the meetings.

Key stakeholder relationships

There are a number of public authorities and other bodies that interact with or deliver services to those who are at risk of family and domestic violence or who have experienced family and domestic violence. Important stakeholders, with which the Office liaised as part of the family and domestic violence fatality review function in 2017-18, included:

- The Coroner;

- Relevant public authorities including:
  - Western Australia Police;
  - The Department of Health and Health Service Providers;
  - The Department of Education;
  - The Department of Justice;
  - The Department of Communities;
  - The Mental Health Commission; and
  - Other accountability and similar agencies including the Commissioner for Children and Young People;
- The Women's Council for Domestic and Family Violence Services WA and relevant non-government organisations; and
- Research institutions including universities.

Aboriginal and regional communities

In 2016, the Ombudsman appointed a Principal Aboriginal Liaison Officer to:

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

A Senior Aboriginal Advisor was appointed in January 2018 to assist the Principal Aboriginal Liaison Officer in this important work. Through the leadership of the Principal Aboriginal Liaison Officer, and Senior Aboriginal Advisor, the Panel and outreach activities, work was undertaken through the year to continue to build relationships relating to the family and domestic violence fatality review function with Aboriginal and regional communities, including by communicating with:

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

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

Own Motion Investigations and Administrative Improvement

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

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

Improvements from Complaints and Reviews

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

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

Own Motion Investigations

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

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

Own motion investigations that arise out of child death and family and domestic violence fatality reviews focus on the practices of agencies that interact with children and families and aim to improve the administration of these services to prevent or reduce child deaths and family and domestic violence fatalities.

Selecting topics for own motion investigations

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

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

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

Monitoring the implementation of recommendations

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

In addition, significant work was undertaken during the year on two reports in relation to the steps taken to giving effect to the recommendations arising from own motion investigations.

Own Motion Investigations in 2017-18

In 2017-18, significant work was undertaken on:

- *Investigation into ways to prevent or reduce child deaths by drowning*, tabled in Parliament on 23 November 2017;
- *A report on giving effect to the recommendations arising from the Investigation into ways to prevent or reduce child deaths by drowning* to be tabled in Parliament in 2018;
- *A report on giving effect to the recommendations arising from the Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, to be tabled in Parliament in 2018-19;
- An investigation into deaths of children who drowned in a dam or river; and
- A report on giving effect to Recommendation 54 of the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*.

Investigation into ways to prevent or reduce deaths of children by drowning

In November 2017, the Office tabled in Parliament the report of a major own motion investigation, *Investigation into ways to prevent or reduce deaths of children by drowning.*

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

To undertake the investigation, the Office conducted an extensive literature review, comprehensively considered 34 deaths of children by drowning notified to the Office over a six year investigation period, surveyed all local governments in Western Australia (to which the Office received a 99 per cent response rate), selected five local governments for further investigation, collected and analysed comprehensive information regarding the number of private swimming pools in local government districts and the quality of the swimming pool barrier inspection process, engaged with the Department of Commerce, the Building Commissioner, the Department of Health, the Department of Local Government and Communities and relevant non-government and not-for-profit organisations.

The Office also collected and analysed de-identified information regarding the number of children admitted to a hospital or who attended an emergency department at a hospital following a non-fatal drowning incident. The Office found that 258

children were admitted to a hospital and 2,310 children attended an emergency department at a hospital following a non-fatal drowning incident.

The Ombudsman found that a range of work has been undertaken by the Department of Commerce and the Building Commissioner to administer their respective responsibilities in relation to swimming pool safety.

The Ombudsman also found that there is important further work that should be done. This work is detailed in the findings of this report. It will be critical that this work is undertaken with strong cooperation between the Department of Mines, Industry Regulation and Safety, the Building Commissioner, local governments and other key stakeholders, including intra-agency, inter-agency and cross sectoral arrangements – this is the most efficient and effective way to achieve positive change.

Arising from the findings, the Ombudsman made 25 recommendations about ways to prevent or reduce deaths of children by drowning. The Ombudsman is very pleased that the Department of Commerce and the Building Commissioner have agreed to these recommendations.

In keeping with the Ombudsman's commitment to Parliament to ensure Parliament is informed about the implementation of investigations, the Office will actively examine the steps taken to give effect to the recommendations and report the results of this examination to Parliament in 2018.

The full report, *Investigation into ways to prevent or reduce deaths of children by drowning* is available at www.ombudsman.wa.gov.au/drowningsreport.

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

Through the review of the circumstances in which and why child deaths occurred, the Ombudsman identified a pattern of cases in which young people appeared to have died by suicide. Of the child death notifications received by the Office since the child death review function commenced, nearly a third related to children aged 13 to 17 years old. Of these children, suicide was the most common circumstance of death, accounting for nearly forty per cent of deaths. Furthermore, and of serious concern, Aboriginal children were very significantly over-represented in the number of young people who died by suicide. For these reasons, the Ombudsman decided to undertake a major own motion investigation into ways that State government departments and authorities can prevent or reduce suicide by young people.

The report of the findings and recommendations arising from that investigation, titled *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, was tabled in Parliament on 9 April 2014. The report made 22 recommendations to four government agencies about ways to prevent or reduce suicide by young people. Each agency agreed to these recommendations.

During 2017-18, significant work was undertaken on a report by the Office on the steps taken to give effect to the 22 recommendations arising from the findings of this report. The report will be tabled in Parliament in 2018-19.

Continuous Administrative Improvement

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

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

Guidance for Public Authorities

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

Publications

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

Workshops for public authorities

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

Workshops are targeted at people responsible for making decisions or handling complaints as well as customer service staff. The workshops are also relevant for supervisors, managers, senior decision and policy makers as well as integrity and governance officers who are responsible for implementing and maintaining complaint handling systems or making key decisions within a public authority.

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

Working collaboratively

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

Inspection and Monitoring Functions

Telecommunications interception records

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

In 2017-18, significant work was undertaken on *A report on the monitoring of the infringement notices provisions of The Criminal Code*, tabled in Parliament on 30 November 2017 by the Minister for Police as required by section 723 (6) of the *Criminal Code Amendment (Infringement Notices) Act 2011*.

A report on the monitoring of the infringement notices provisions of The Criminal Code

In 2017-18, the Office provided *A report on the monitoring of the infringement notices provisions of The Criminal Code* to the Minister for Police and the Commissioner of Police and the report was tabled in Parliament by the Minister for Police on 30 November 2017.

In accordance with the relevant provisions of *The Criminal Code*, Parliament gave the Ombudsman an important function to keep under scrutiny the operation of the infringement notices provisions of *The Criminal Code*, relevant regulations made under *The Criminal Code* and the relevant provisions of the *Criminal Investigation (Identifying People) Act 2002* in relation to infringement notices (**Criminal Code infringement notices**). Importantly, this scrutiny included review of the impact of the operation of the provisions on Aboriginal and Torres Strait Islander communities.

The infringement notices provisions of *The Criminal Code* and the relevant regulations allow authorised officers to issue Criminal Code infringement notices for two prescribed offences, with a modified penalty of $500.

The report found that considerable positive work has been undertaken by WAPOL to implement Criminal Code infringement notices effectively and identified opportunities for further work to be undertaken by WAPOL.

The report also found that the key economic objectives arising from the introduction of Criminal Code infringement notices have been achieved, including anticipated outcomes relating to reducing administrative demands on police officers and avoided court appearances for alleged offenders.

The report identified a range of impacts of the introduction of Criminal Code infringement notices on Aboriginal and Torres Strait Islander communities (and in doing so also identified impacts for other people and communities experiencing vulnerability). The report identifies a range of measures to address these impacts (and concomitantly makes recommendations about these measures).

While certain of these recommended measures are specific to Criminal Code infringement notices, mostly these recommended measures are applicable to the impact of the broader criminal justice system on Aboriginal and Torres Strait Islander people (particularly the overrepresentation of Aboriginal and Torres Strait Islander people in the criminal justice system, including as recipients of Criminal Code infringement notices).

The report makes 34 recommendations relating to proposed amendments to the relevant regulations made under *The Criminal Code* as well as the proposed introduction of, or amendments to, other legislation, schemes, policies, procedures and other measures. The Ombudsman is very pleased that WAPOL has accepted each of the recommendations directed to them.

The full report, *A report on the monitoring of the infringement notices provisions of The Criminal Code*, is available at www.ombudsman.wa.gov.au/infringementnoticesreport.

Criminal organisations control

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

In accordance with the *Criminal Organisations Control Act 2012*, a report was prepared by the Ombudsman for the monitoring period ending 1 November 2017. A copy of this report was provided to the Minister for Police and the Commissioner of Police in accordance with the *Criminal Organisations Control Act 2012.*

Collaboration and Access to Services

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

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

Working Collaboratively

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

Integrity Coordinating Group

Members: Western Australian Ombudsman; Public Sector Commissioner; Corruption and Crime Commissioner; Auditor General; and Information Commissioner.

Background:

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

The Office's involvement:

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

2017-18 initiatives:

The Office was involved in the ICG's graduate program, which involves a graduate working in each of the member agencies over a two year period in total.

International Ombudsman Institute

Background:

The International Ombudsman Institute (**IOI**), established in 1978, is the only global organisation for the cooperation of more than 190 independent Ombudsman institutions from more than 100 countries worldwide. The IOI is organised in six regional chapters (Africa, Asia, Australasia & Pacific, Europe, the Caribbean & Latin America and North America). The IOI is governed by a World Board of which the Western Australian Ombudsman is the 2nd Vice-President.

The Office's involvement:

The Office is a member of the IOI. The IOI is governed by a World Board, of which the Ombudsman was elected 2nd Vice-President of the IOI in November 2016. The Ombudsman previously served as the Treasurer of the IOI from March 2014 to November 2016 and President of the Australasian and Pacific Ombudsman Region (**APOR**) of the IOI from November 2012 to March 2014.

2017-18 initiatives:

In November 2017, the Office hosted the 29th APOR Conference, *Connections in our Australasian-Pacific Region*. Further details about the Conference are provided later in this section.

In January 2018, the Ombudsman undertook an official visit to the Office of the Chief Ombudsman of Thailand in Bangkok and also undertook investigation field visits in the Phuket province including participating in, and addressing meetings in relation to, two major Ombudsman investigations regarding the delivery of significantly cheaper electricity for the residents of Panyee Island and the provision of more effective and efficient transport for the people of Phuket and its many visitors.

In April 2018, the Ombudsman attended a meeting of the World Board of the IOI in Toronto, Canada.

Immediately prior to the meeting of the World Board of the IOI in Toronto, the Ombudsman attended the United Nations (**UN**) in New York to participate in a formal event between the IOI and the UN hosted by Ambassador Jan Kickert, Permanent Representative of Austria to the UN and Ambassador Geraldine Byrne Nason, Permanent Representative of Ireland to the UN.

The event also included recognition of the 40th anniversary of the IOI and was followed by IOI delegates being received at the Austrian Ambassador's residence, attended by a number of Permanent Representatives to the UN, including Her Excellency Gillian Bird, Permanent Representative of Australia to the UN. The Ombudsman also attended the offices of the Australian Mission to the UN and met with Her Excellency to discuss IOI work with the UN.

Information sharing with Ombudsmen from other jurisdictions

Background:

Where appropriate, the Office shares information and insights about its work with Ombudsmen from other jurisdictions, as well as with other accountability and integrity bodies.

2017-18 initiatives:

The Office exchanged information with a number of Parliamentary Ombudsmen and industry-based Ombudsmen during the year.

Australia and New Zealand Ombudsman Association

Members: Parliamentary and industry-based Ombudsmen from Australia and New Zealand.

Background:

The Australia and New Zealand Ombudsman Association (**ANZOA**) is the peak body for Parliamentary and industry-based Ombudsmen from Australia and New Zealand.

The Office's involvement:

The Office is a member of ANZOA. The Office periodically provides general updates on its activities and also has nominated representatives who participate in interest groups in the areas of Aboriginal complaints handling, first contact, business improvement, policy and research, and public relations and communications.

In 2017-18, ANZOA held their biennial conference in Wellington, New Zealand. In addition to staff attendance as delegates, the Acting Assistant Ombudsman Monitoring participated in the 'Innovation Showcase' panel session of the Conference, presenting on the Office's commitment to the Western Australian Parliament to examine and report to Parliament on the steps taken by government to give effect to recommendations arising from major own motion investigations not more than 12 months after the tabling of the investigation.

29th Australasian and Pacific Ombudsman Region Conference

In November 2017, the Office hosted the 29th APOR Conference *Connections in our Australasian-Pacific Region*. Participants included the Ombudsman and senior staff of Ombudsman offices from Australia, New Zealand, Hong Kong, Taiwan and the Pacific Island nations of the Cook Islands, Papua New Guinea, Samoa, the Solomon Islands, the Kingdom of Tonga and Vanuatu.

The theme of the APOR Conference explored the present and future challenges and opportunities for the institution of the Ombudsman in the Australasian and Pacific Region in enhancing citizens' redress, undertaking major investigations intended to improve the administration of the laws of Parliament, supporting the rule of law as well as working collaboratively with developing nations in our region.

The APOR Conference was opened by Her Excellency the Honourable Kerry Sanderson AC, Governor of Western Australia. APOR President and Ombudsman, Hong Kong, Ms Connie Lau JP provided an Opening Address, followed by an Opening Address by 2nd Vice-President of the IOI and Western Australian Ombudsman, Chris Field.

Importantly, the APOR Conference included a session on *Engagement with First Peoples*. This session considered the criticality of service delivery and engagement by Ombudsman offices that acknowledges, respects and supports the history, culture, and practice of First Peoples.

The Conference was part of a three day program, commencing with delegates being welcomed to Western Australia at a Reception at Parliament House hosted by the Speaker of the Legislative Assembly, the Honourable Peter Watson MLA on Monday 27 November 2017, followed by the Conference on Tuesday 28 November and a business meeting, an optional investigations training program and a tour of Kings Park for interstate and international delegates on Wednesday 29 November.

Copies of speeches and presentations, and photos of the event are available on the Ombudsman's website.

Ombudsmen from the Australasian and Pacific Ombudsman Region

Chris Field, Western Australian Ombudsman and 2nd Vice-President of the IOI (left), and Connie Lau JP, Ombudsman, Hong Kong and President of APOR (right), addressing the APOR Conference

APOR Conference delegates

Providing Access to the Community

Communicating with complainants

The Office provides a range of information and services to assist specific groups, and the public more generally, to understand the role of the Ombudsman and the complaint process. Many people find the Office's enquiry service and complaint clinics held during regional visits assist them to make their complaint. Other initiatives in 2017-18 include:

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

Access to the Ombudsman's services

The Office continues to implement a number of strategies to ensure its complaint services are accessible to all Western Australians. These include access through online facilities as well as more traditional approaches by letter and through visits to the Office. The Office also holds complaint clinics and delivers presentations to

community groups, particularly through the Regional Awareness and Accessibility Program. Initiatives to make services accessible include:

- Access to the Office through a Freecall number, which is free from landline phones;
- Access to the Office through email and online services. The importance of email and online access is demonstrated by its use this year in 66% of all complaints received;
- Information on how to make a complaint to the Ombudsman is available in 15 languages and features on the homepage of the Ombudsman's website. People may also contact the Office with the assistance of an interpreter by using the Translating and Interpreting Service;
- The Office's accommodation, building and facilities provide access for people with disability, including lifts that accommodate wheelchairs and feature braille on the access buttons and people with hearing and speech impairments can contact the Office using the National Relay Service;
- The Office's Regional Awareness and Accessibility Program and Youth Awareness and Accessibility Program target awareness and accessibility for regional and Aboriginal Western Australians as well as children and young people;
- The Office attends events to raise community awareness of, and access to, its service, such as the Financial Counsellors' Association of WA conference in October 2017, and Homeless Connect in November 2017; and
- The Office's visits to adult prisons and the juvenile detention centre provide an opportunity for adult prisoners and juvenile detainees to meet with representatives of the Office and lodge complaints in person.

Ombudsman website

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

- Members of the public on the complaint handling services provided by the Office as well as links to other complaint bodies for issues outside the Ombudsman's jurisdiction;
- Public authorities on decision making, complaint handling and conducting investigations;
- Children and young people as well as information for non-government organisations and government agencies that assist children and young people, including downloadable print material tailored for children and young people. The

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

- Access to the Ombudsman's reports such as the *Investigation into ways to prevent or reduce deaths of children by drowning*;
- The latest news on events and collaborative initiatives such as the Regional Awareness and Accessibility Program; and
- Links to other key functions undertaken by the Office such as the Energy and Water Ombudsman website and other related bodies including other Ombudsmen and other Western Australian accountability agencies.

The website continues to be a valuable resource for the community and public sector as shown by the increased use of the website this year. In 2017-18:

- The total number of visits to the website has increased by 27% to 233,340 page visits compared to 184,221 page visits in 2016-17, and more than doubled since 2015-16;

The total number of visits to the website has increased by 27% to 233,340 page visits compared to 184,221 page visits in 2016-17, and more than doubled since 2015-16.

- The top two most visited pages (besides the homepage and the Contact Us page) on the site were *The role of the Ombudsman* and *What you can complain about*; and
- The Office's *Effective Handling of Complaints Made to Your Organisation Guidelines* and *Procedural Fairness Guidelines* were the two most viewed documents. The Office's most recent reports also regularly featured in the top 10 most downloaded documents each month.

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

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

'Ask the Ombudsman' on 6PR's *Perth Tonight*

The Office continues to provide access to its services through the Ombudsman's regular appearances on Radio 6PR's *Perth Tonight* program. Listeners who have complaints about public authorities or want to make enquiries have the opportunity to call in and speak with the Ombudsman live on air.

The segment allows the public to communicate a range of concerns with the Ombudsman. The segment also allows the Office to communicate key messages about the Ombudsman and Energy and Water Ombudsman jurisdictions, the outcomes that can be achieved for members of the public and how public administration can be improved. The Ombudsman appeared on the 'Ask the Ombudsman' segment in August and October 2017 and February, May and June 2018.

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2017-18. Two regional visits were conducted, to Bunbury, Busselton, Collie and Harvey in the South West Region in February and March 2018 and to Geraldton in the Mid West Region in June 2018. The visits included activities such as:

- Complaint clinics, which provided an opportunity for members of the local community to raise their concerns face-to-face with the staff of the Office;
- Meetings with the Aboriginal community to discuss government service delivery and where the agencies may be able to assist;
- Liaison with community, advocacy and consumer groups; and
- Liaison with public authorities, including meetings with senior officers and workshops for public officers on *Good Decision Making* and *Effective Complaint Handling*.

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

The Program enables the Office to:

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

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

Aboriginal engagement

In 2016-17, the Office developed the *Aboriginal Action Plan*, a comprehensive whole-of-office plan to address the significant disadvantage faced by Aboriginal people in Western Australia. The plan contributes to an overall goal of developing an organisation that is welcoming and culturally safe for Aboriginal people and meets the unique needs of the Aboriginal community it serves.

In 2018, the Office appointed two additional Aboriginal staff: a Senior Aboriginal Advisor that reports to the Office's Principal Aboriginal Liaison Officer and an Aboriginal Enquiry and Investigating Officer (both of which are identified s. 50(d) positions under the *Equal Opportunity Act 1984*). The Office also engaged an Aboriginal artist to produce an artwork for the Office. The artwork is featured on the cover of this report and will be used as a theme for the Office's publications (see inside back cover for further details).

The Principal Aboriginal Liaison Officer and Senior Aboriginal Advisor attended events and meetings with government and non-government service providers to discuss particular issues affecting the Aboriginal community and raise awareness of the Office's role.

The Office also continued its engagement with the Aboriginal community through:

- Aboriginal community information sessions as part of its Regional Awareness and Accessibility Program;
- Visits to prisons and detention centres accompanied by Aboriginal staff and Aboriginal consultants, as part of its Prison Program; and
- Consultation with the Aboriginal community for major investigations and reports, including in relation to its function to monitor the Infringement Notices provisions of *The Criminal Code*. See further details in the Own Motion Investigations and Administrative Improvement section.

The Principal Aboriginal Liaison Officer also coordinated cultural awareness information and events throughout the year, including a smoking ceremony attended by staff of the Office and offices of co-located agencies, and information to staff about culturally important dates and events being held in the community.

Smoking Ceremony

Staff attending the Smoking Ceremony at Albert Facey House

From left: Alison Gibson, Principal Aboriginal Liaison Officer; Dr Richard Walley OAM; Nicole Casley, Senior Aboriginal Advisor; and Merinda Willis, Aboriginal Enquiry and Investigating Officer.

Youth Awareness and Accessibility Program

The Office has a dedicated youth space on the Ombudsman Western Australia website with information about the Office specifically tailored for children and young people, as well as information for non-government organisations and government agencies that assist children and young people, and a suite of promotional materials targeted at, and tailored for, children and young people.

The Office continued its proactive visiting program to vulnerable groups of children in the child protection system. During 2017-18, the Office visited:

- The Kath French Secure Care Centre in June 2018;
- One residential group home in the Perth metropolitan area in June 2018; and
- Two family group homes and one residential group home in the South West Region in February and March 2018 and one residential group home in the Mid West Region in June 2018.

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

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

Prison Program

The Office continued the Prison Program during 2017-18. Eight visits were made to prisons and the juvenile detention centre to raise awareness of the role of the Ombudsman and enhance accessibility to the Office for adult prisoners and juvenile detainees in Western Australia.

Speeches and Presentations

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

Ombudsman's speeches and presentations

- *Ethics, Professionalism and Confidentiality*, presented to University of Western Australia Legal Internship Students in August 2017;
- *The Ombudsman*, presented to University of Western Australia Foundation of Public Law Students in October 2017;
- *29th Australasian and Pacific Ombudsman Region Conference*, Opening Address, in November 2017;

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

Speeches and presentations by other staff

- *Ombudsman Western Australia*, to East Metropolitan Health Service Aboriginal Health Forum in July 2017;
- *The Western Australian Ombudsman* to members of the community in sessions held in collaboration with the Public Sector Commission and the Office of the Information Commissioner titled 'Building public trust: Integrity, accountability and transparency in the WA public sector', held in July, October, and November 2017;
- *The Role and Functions of the Ombudsman*, to the Independent Visitors Service Conference in October 2017;
- *The Role of the Ombudsman*, to the Aboriginal Legal Service Justice Conference in November 2017;
- *The Role and Functions of the Ombudsman*, to Melaleuca Remand and Reintegration Facility staff in July 2017, Casuarina Prison staff in December 2017 and Acacia Prison staff in June 2018;
- *The Role of the Ombudsman*, to University of Western Australia administrative law students in February 2018;
- *The Role and Functions of the Ombudsman*, to staff at the City of Joondalup and the City of Stirling in April 2018; and
- *The Role and Functions of the Ombudsman* to Edith Cowan University administrative law students in April 2018.

Liaison with Public Authorities

Liaison relating to complaint resolution

The Office liaised with a range of bodies in relation to complaint resolution in 2017-18, including:

- The Department of Justice;
- The Department of Transport;
- The Department of Education;
- The Department of Communities;
- Western Australia Police;
- The Office of the Inspector of Custodial Services;
- The Commissioner for Children and Young People;
- The Corruption and Crime Commission; and
- Various local governments.

Liaison relating to reviews and own motion investigations

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

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

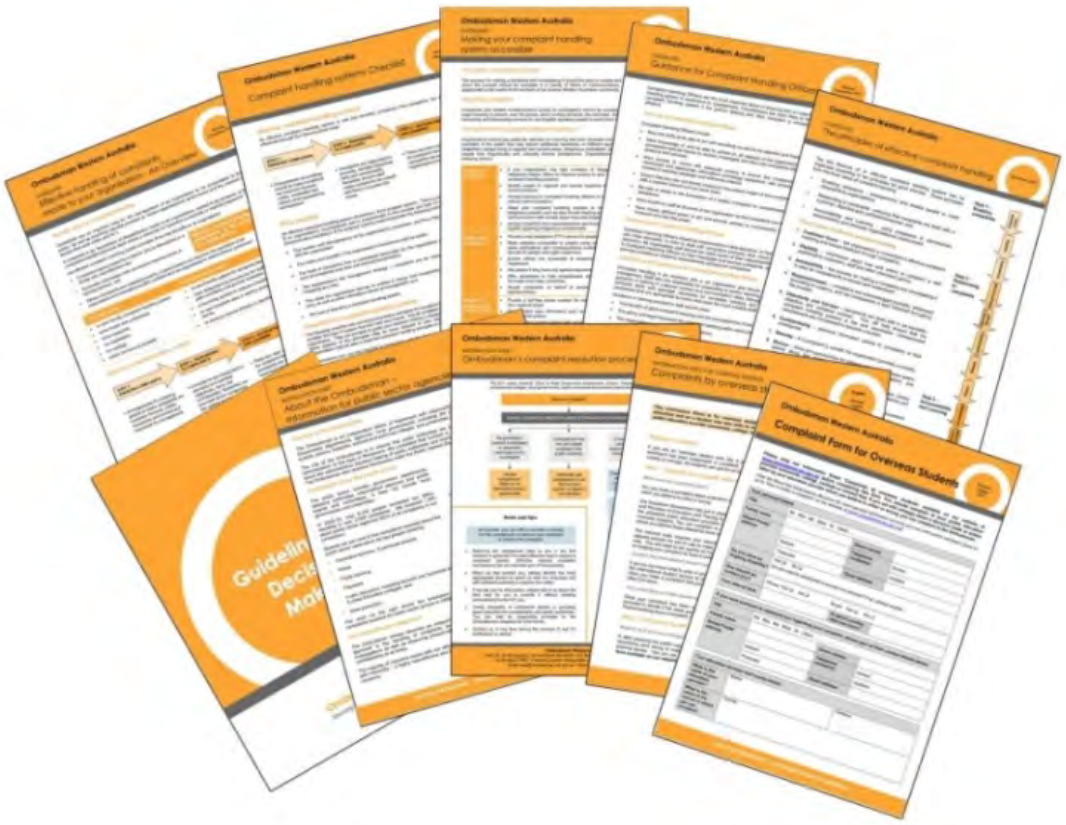
Liaison relating to inspection and monitoring functions

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

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

Publications

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



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