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;
- Patterns, trends and case studies relating to 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) State 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:

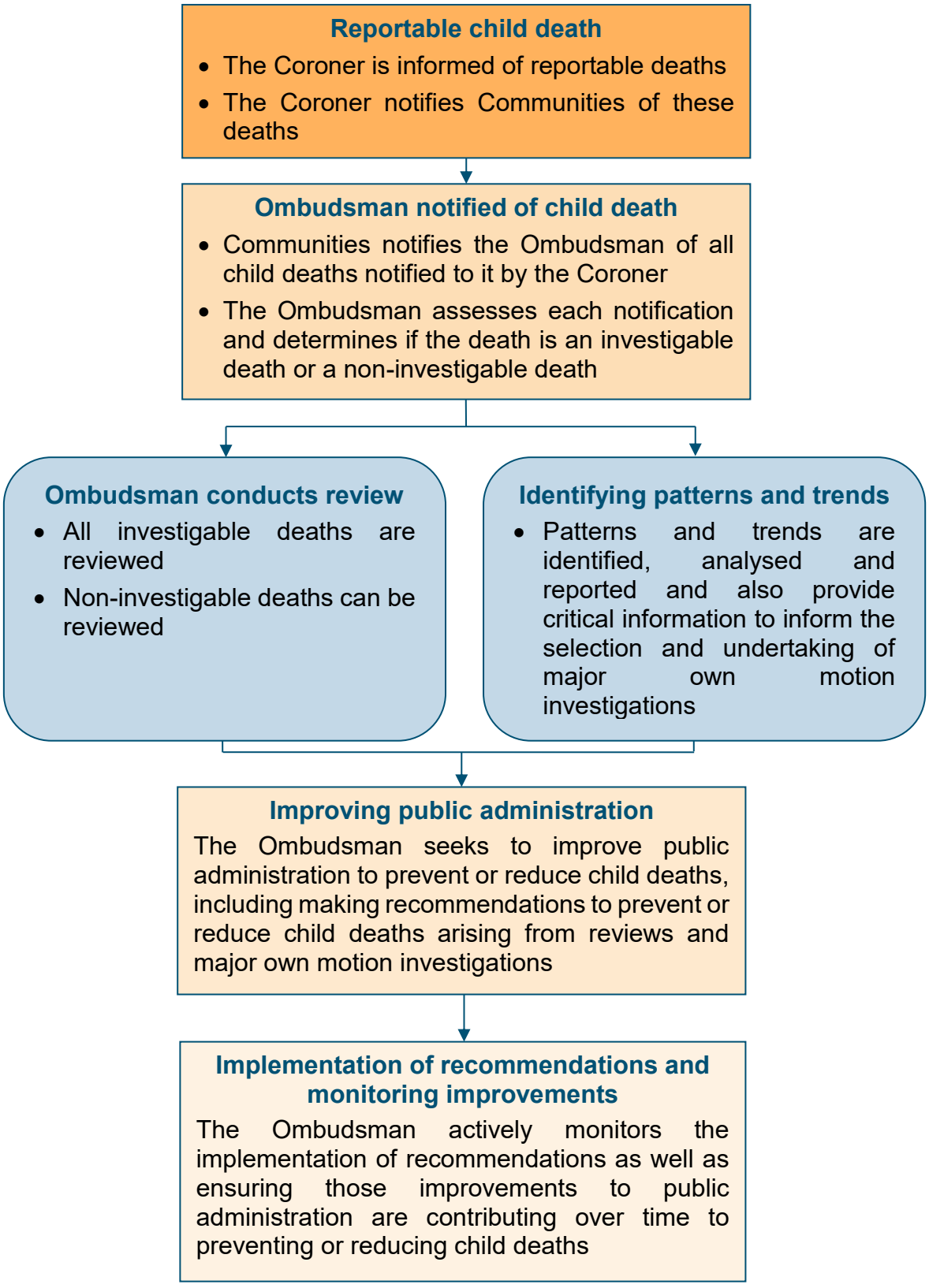
- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children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

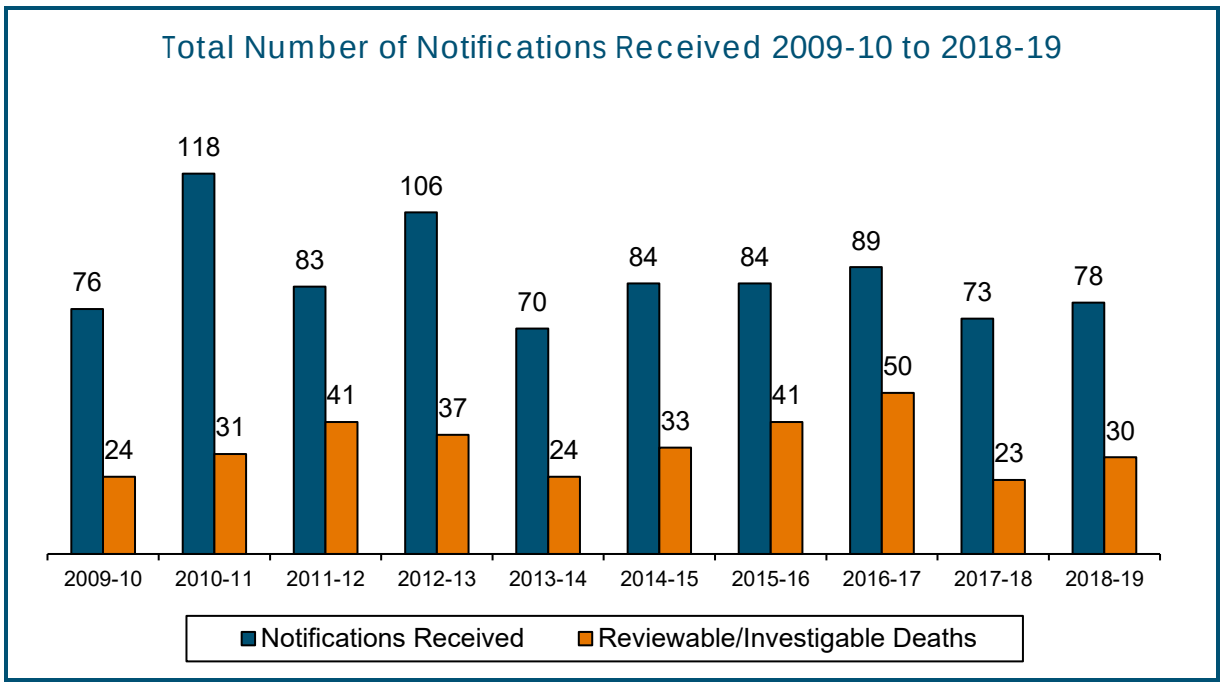
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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 2018-19, there were 30 child deaths that were investigable and subject to review from a total of 78 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 16 years from 2003-04 to 2018-19. 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 Total WA child deaths (excluding stillbirths) (See Note 1)	B Child deaths reported to the Coroner (See Note 2)	C Child deaths where the child or a relative of the child was known to Communities (See Note 3)	D 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	138	81	37	23
2018-19	165	81	37	30

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

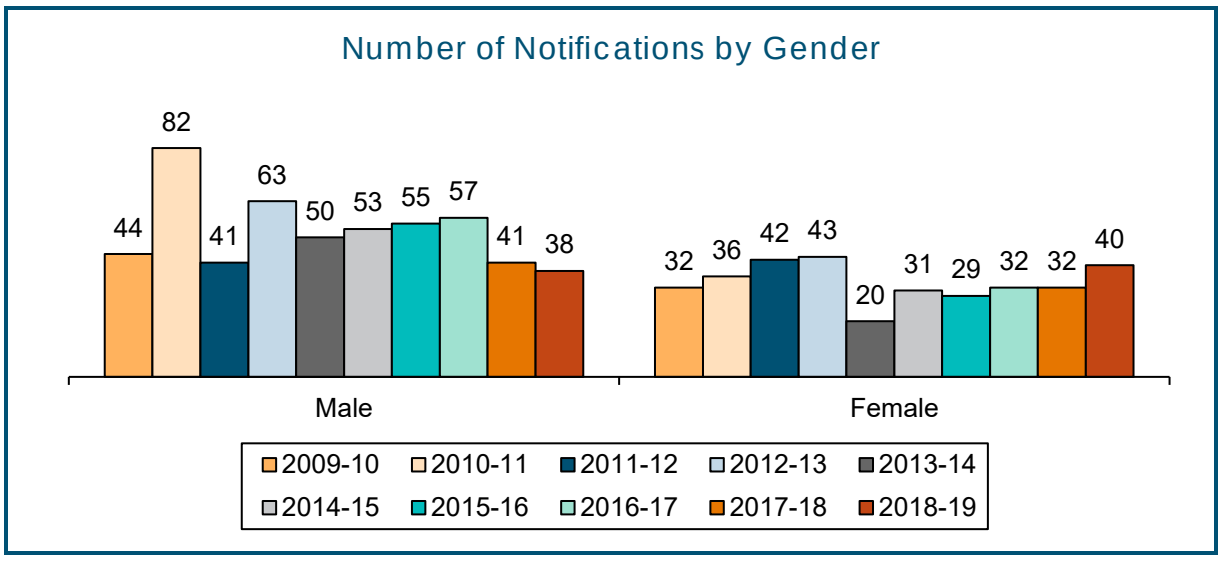
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

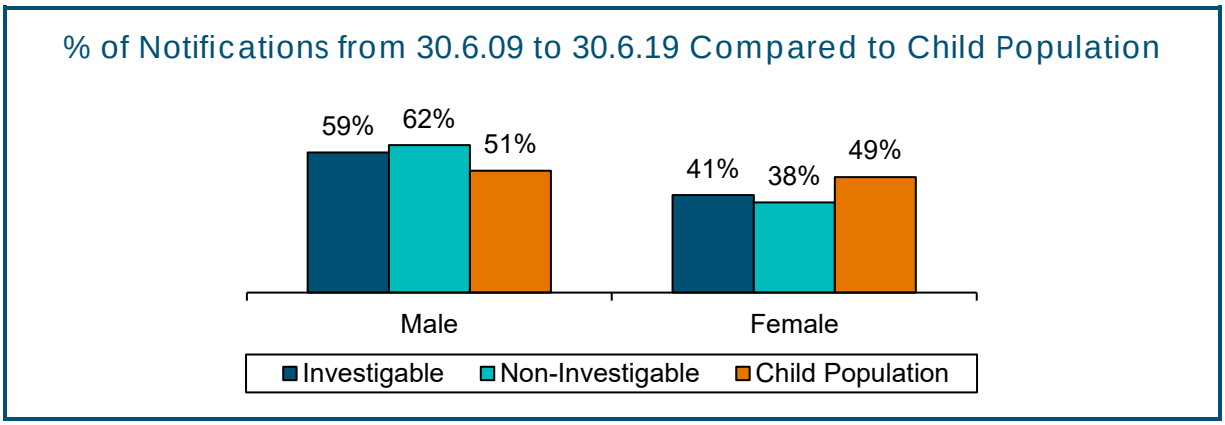
The following charts show:

- The number of children in each group for each year from 2009-10 to 2018-19; and
- For the period from 30 June 2009 to 30 June 2019, 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 10 years, male children are over-represented compared to the population for both investigable and non-investigable deaths.

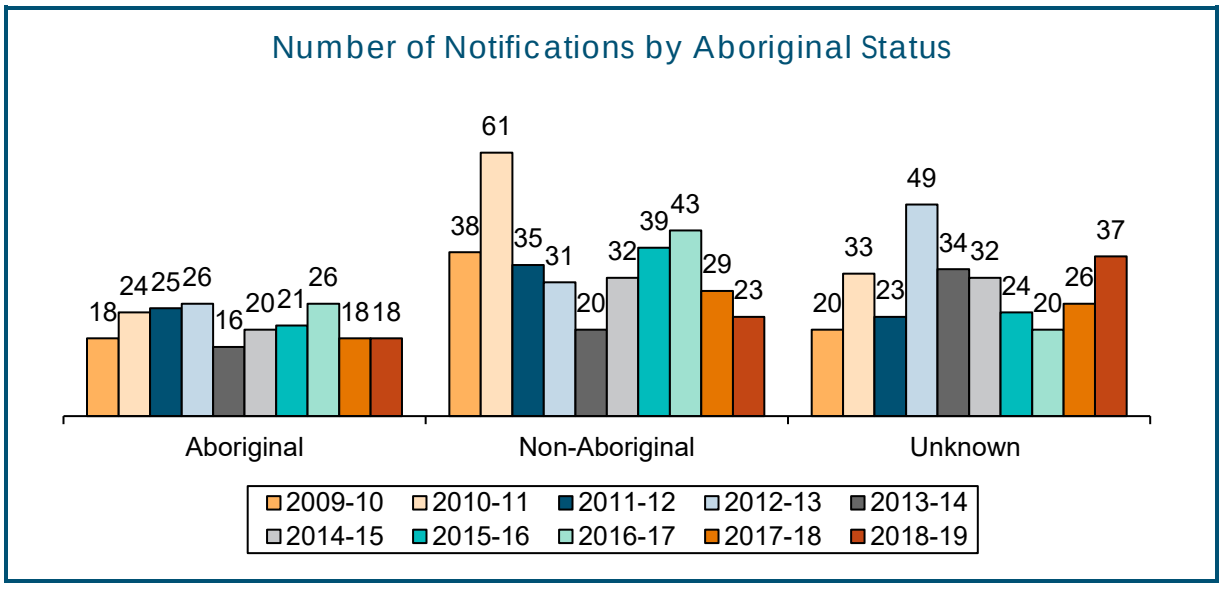


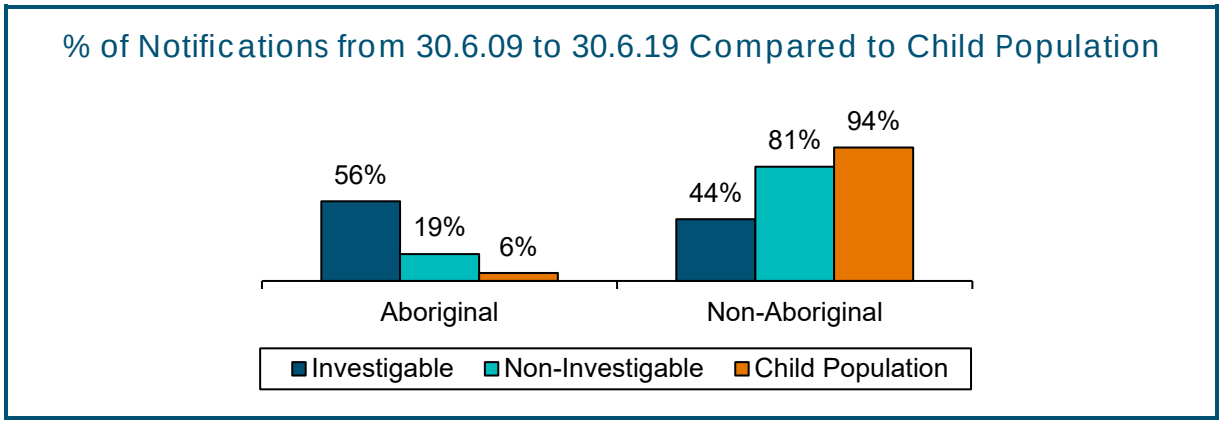


Further analysis of the data shows that, considering all 10 years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

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.



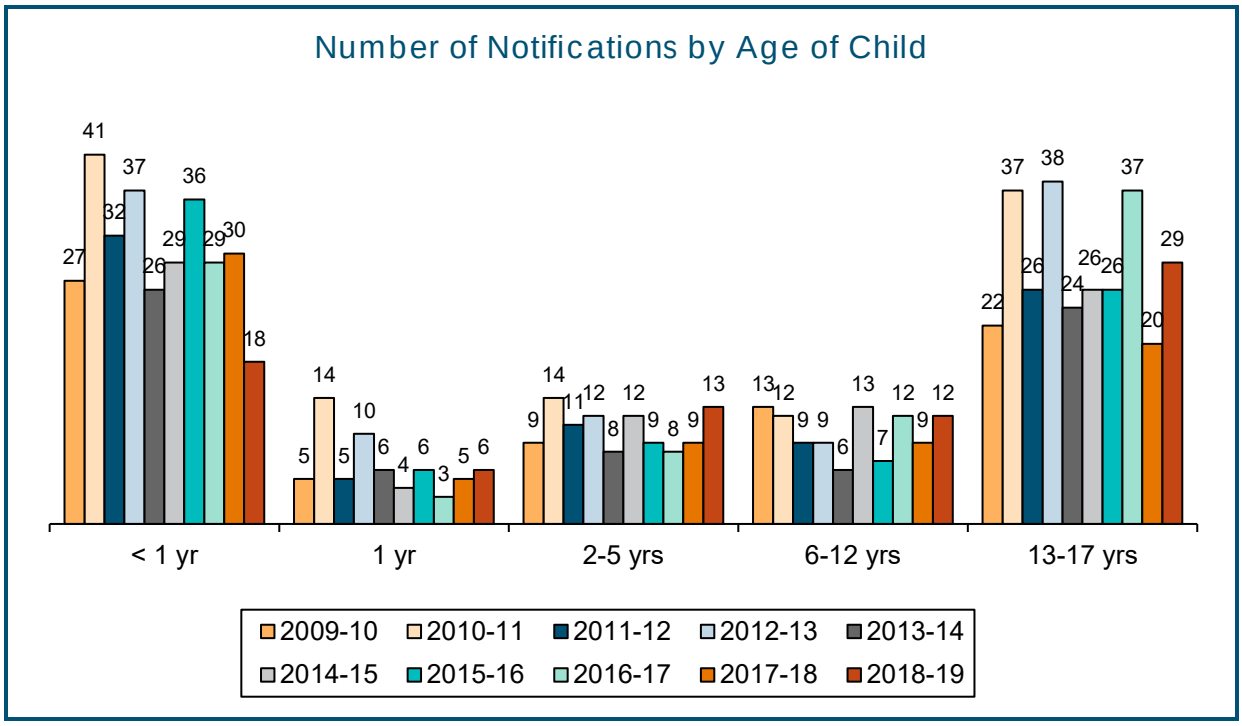


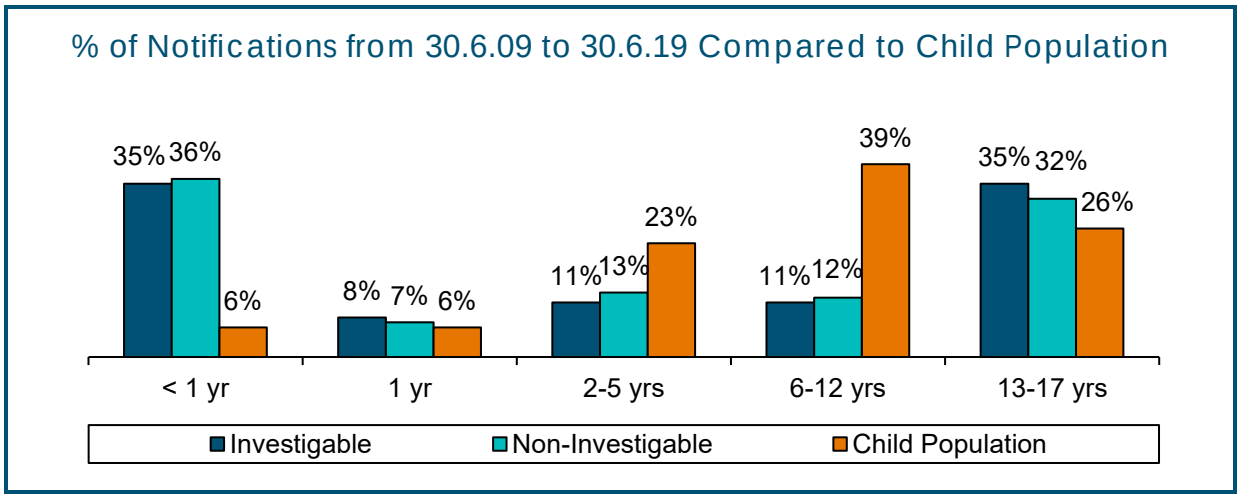
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

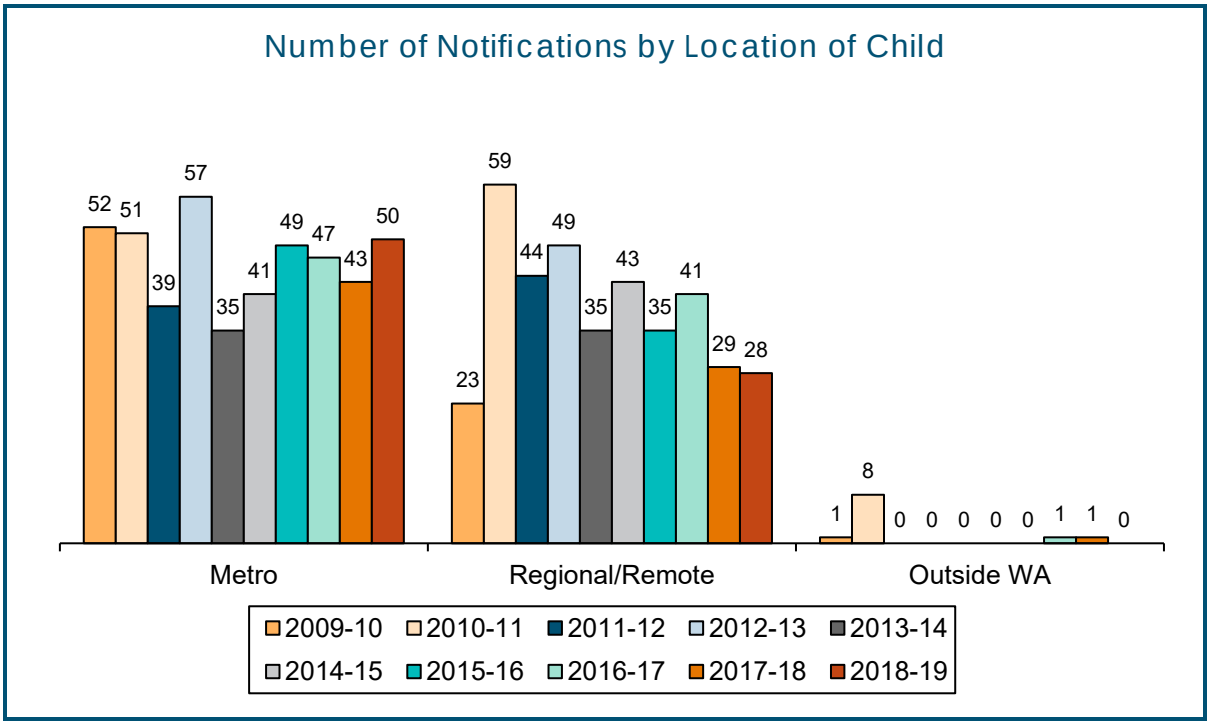




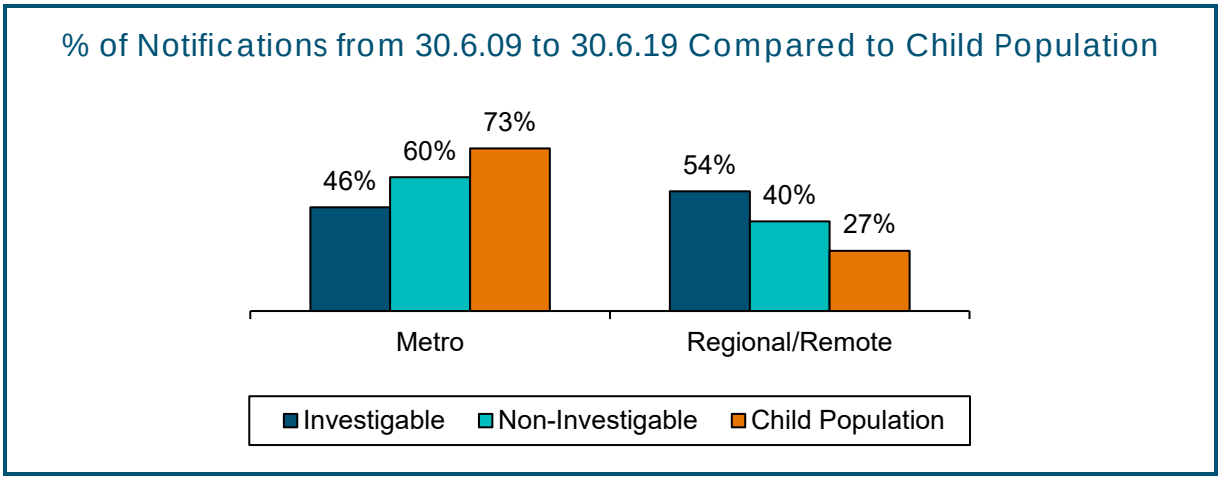
A more detailed analysis by age group is provided later in this section.

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 76% 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.

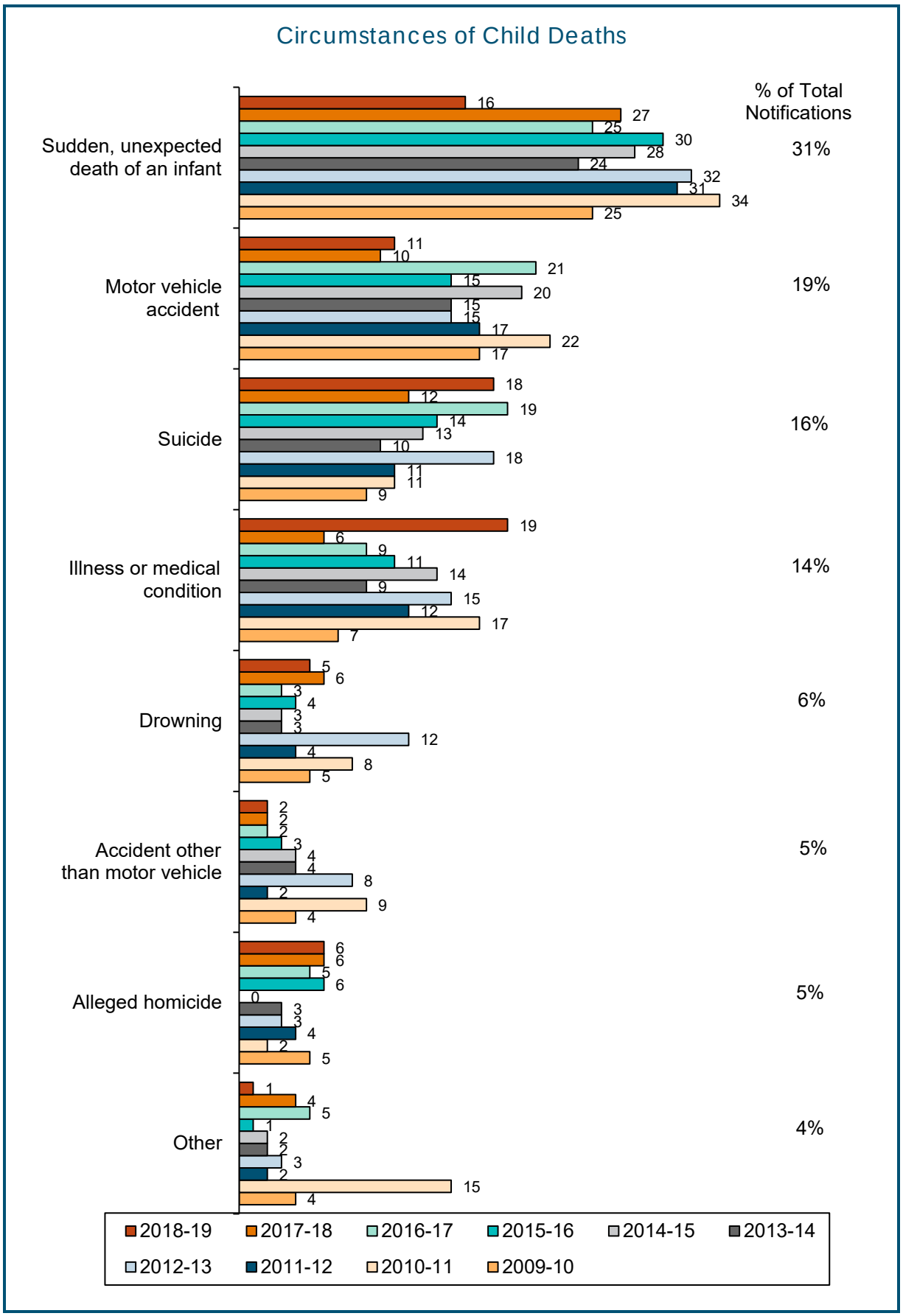
Circumstances in which child deaths have occurred

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 2019.



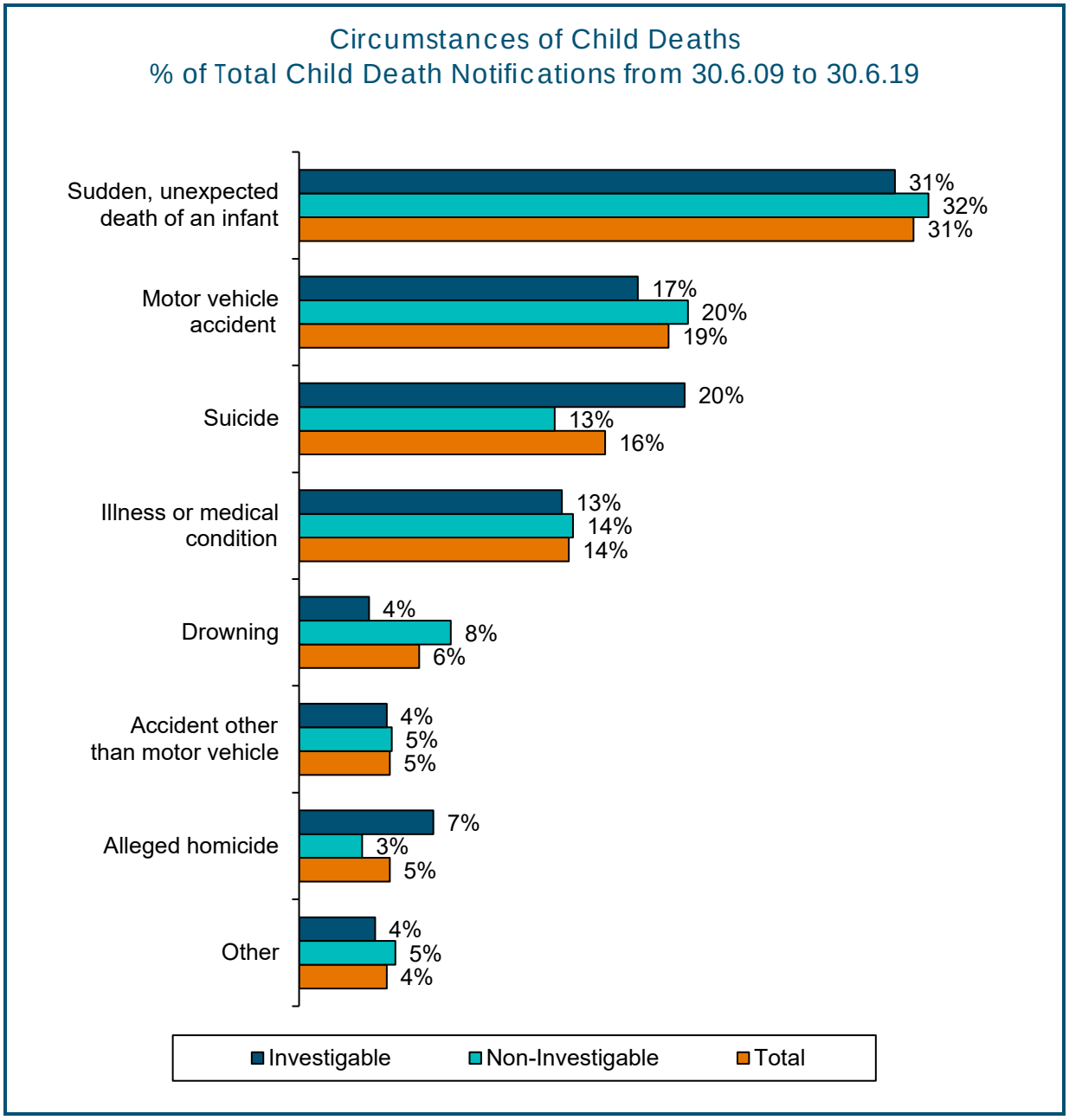
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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 861 child death notifications received in the 10 years from 30 June 2009 to 30 June 2019 are:

- Sudden, unexpected deaths of infants, representing 31% of the total child death notifications from 30 June 2009 to 30 June 2019 (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, 28% in 2016-17, 37% in 2017-18 and 21% in 2018-19); and
- Motor vehicle accidents, representing 19% of the total child death notifications from 30 June 2009 to 30 June 2019 (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, 14% in 2017-18 and 14% in 2018-19).

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		5	3	25	19	5
2017-18	2	10	6		6	6	27	12	4
2018-19	2	11	19		6	5	16	18	1

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

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

Note 2: The data for the Ombudsman is based on the notifications received by the Ombudsman during the year. The types of circumstances are as used in the Ombudsman's Annual Reports. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Social and environmental factors associated with investigable child deaths

A number of social and environmental factors affecting the child or their family may impact on the wellbeing of the child, such as:

- Family and domestic violence;
- Drug or substance use;
- Alcohol use;
- Parenting;
- Homelessness; and
- Parental mental health issues.

Reviews of investigable deaths often highlight the impact of these factors on the circumstances leading up to the child's death and, where this occurs, these factors are recorded to enable an analysis of patterns and trends to assist in considering ways to prevent or reduce future deaths.

It is important to note that the existence of these factors is associative. They do not necessarily mean that the removal of this factor would have prevented the death of a child or that the existence of the factor necessarily represents a failure by Communities or another public authority.

The following table shows the percentage of investigable child death reviews associated with particular social and environmental factors for the period 30 June 2009 to 30 June 2019.

Social or Environmental Factor	% of Finalised Reviews from 30.6.09 to 30.6.19
Family and domestic violence	72%
Parenting	60%
Drug or substance use	47%
Alcohol use	45%
Parental mental health issues	27%
Homelessness	25%

One of the features of the investigable deaths reviewed is the co-existence of a number of these social and environmental factors. The following observations can be made:

- Where family and domestic violence was present:
  - Parenting was a co-existing factor in nearly two-thirds of the cases;
  - Alcohol use was a co-existing factor in over half of the cases;
  - Drug or substance use was a co-existing factor in over half of the cases;
  - Homelessness was a co-existing factor in over a quarter of the cases; and
  - Parental mental health issues were a co-existing factor in nearly a third of the cases.
- Where alcohol use was present:
  - Parenting was a co-existing factor in over three quarters of the cases;
  - Family and domestic violence was a co-existing factor in over three quarters of the cases;
  - Drug or substance use was a co-existing factor in nearly two thirds of the cases; and
  - Homelessness was a co-existing factor in over a third of the cases.

Reasons for contact with Communities

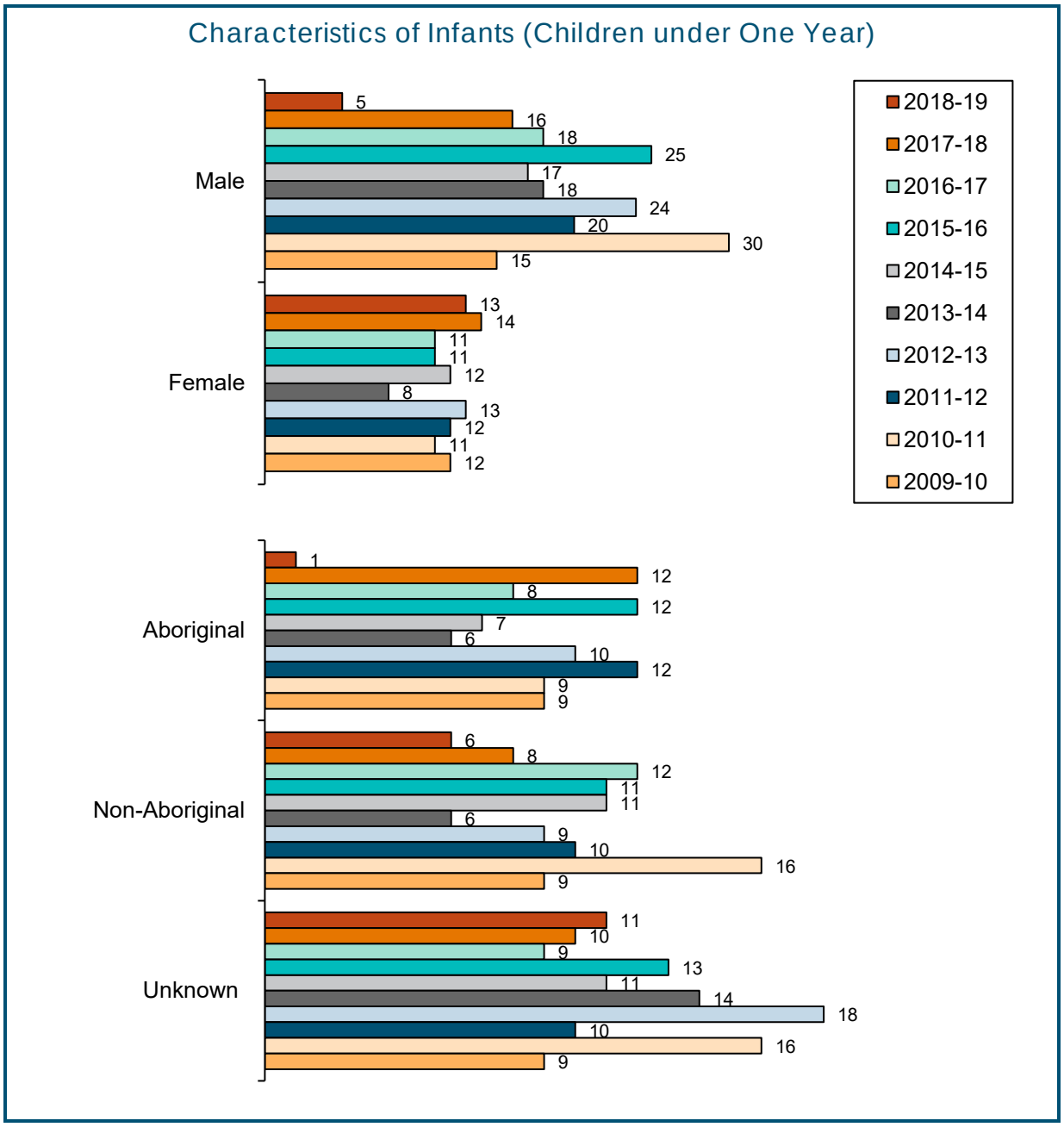
In child deaths notified to the Ombudsman in 2018-19, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

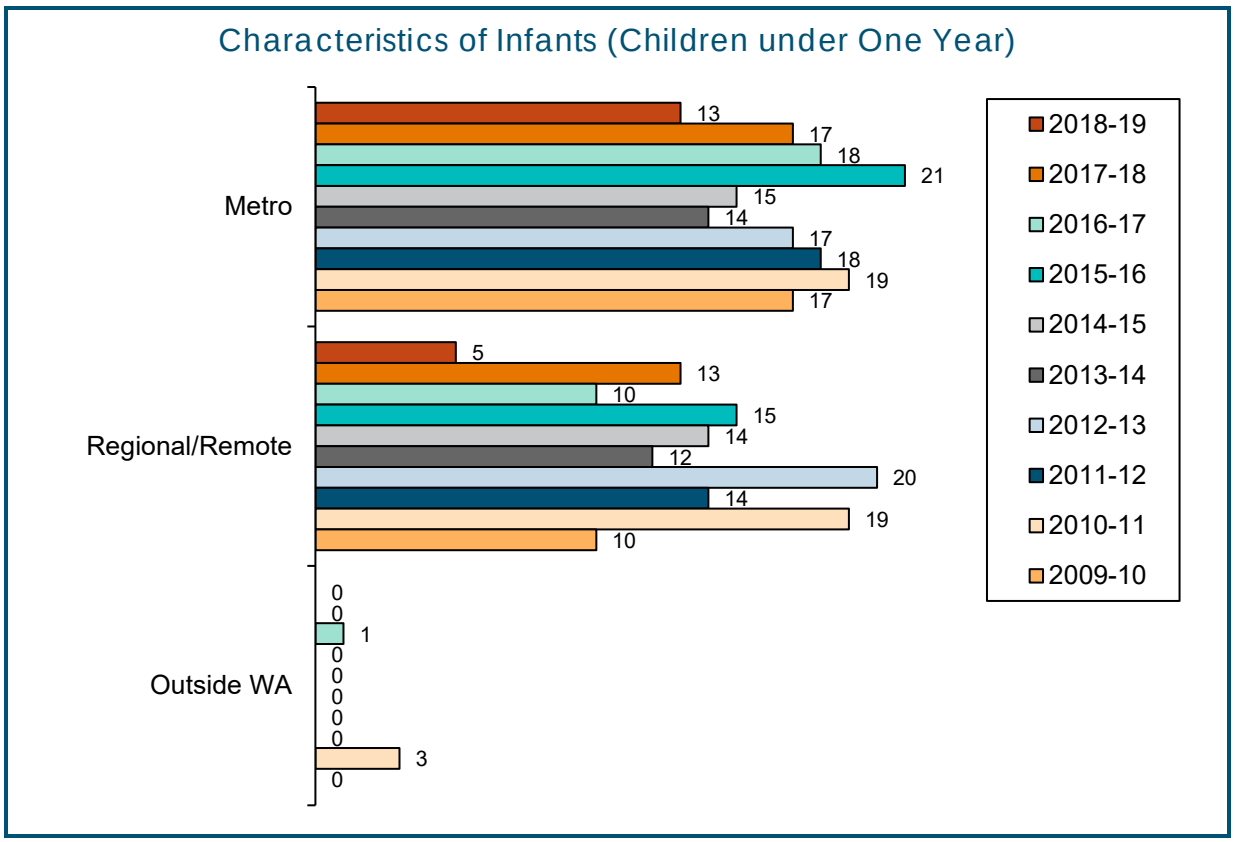
Analysis of children in particular age groups

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 861 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2019, there were 305 (35%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.



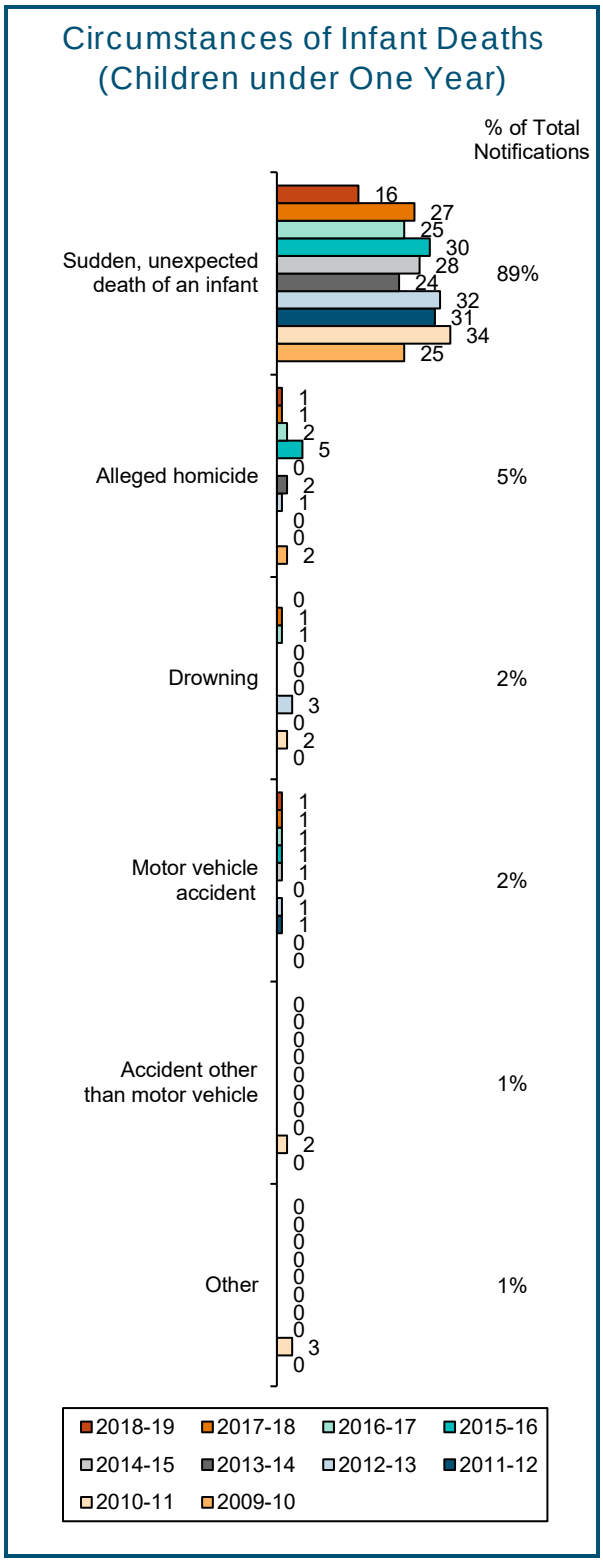


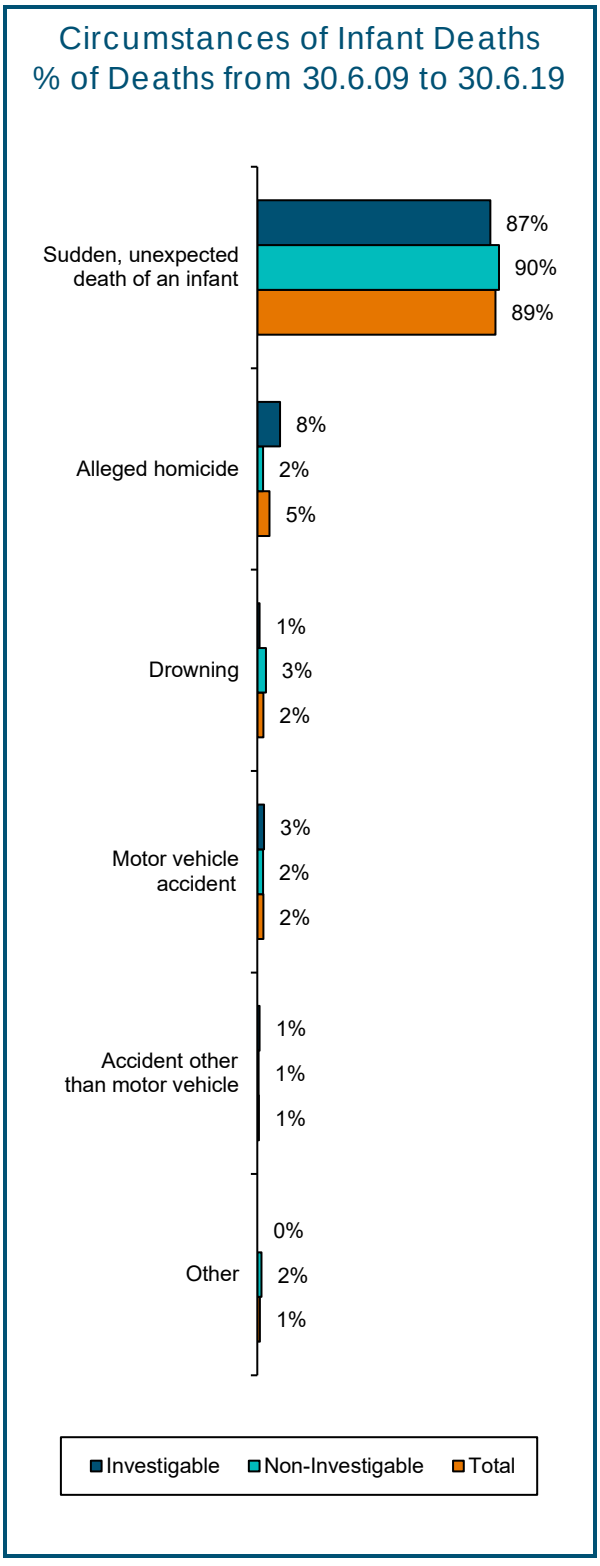
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 64% of investigable infant deaths and 60% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 64% of investigable deaths and 31% 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 38% 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 305 infant deaths, 272 (89%) were categorised as sudden, unexpected deaths of an infant and the majority of these (174) 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.





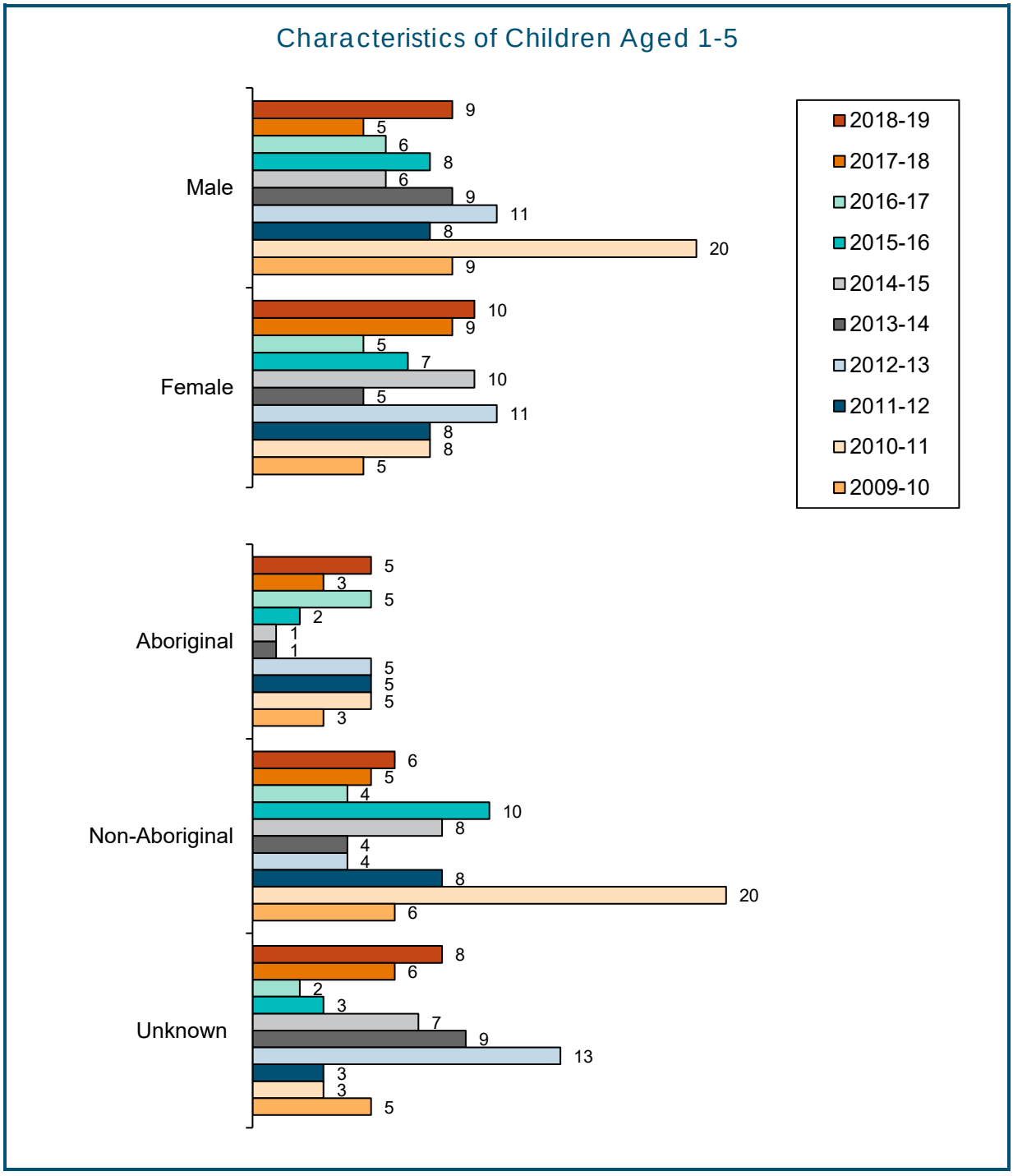
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

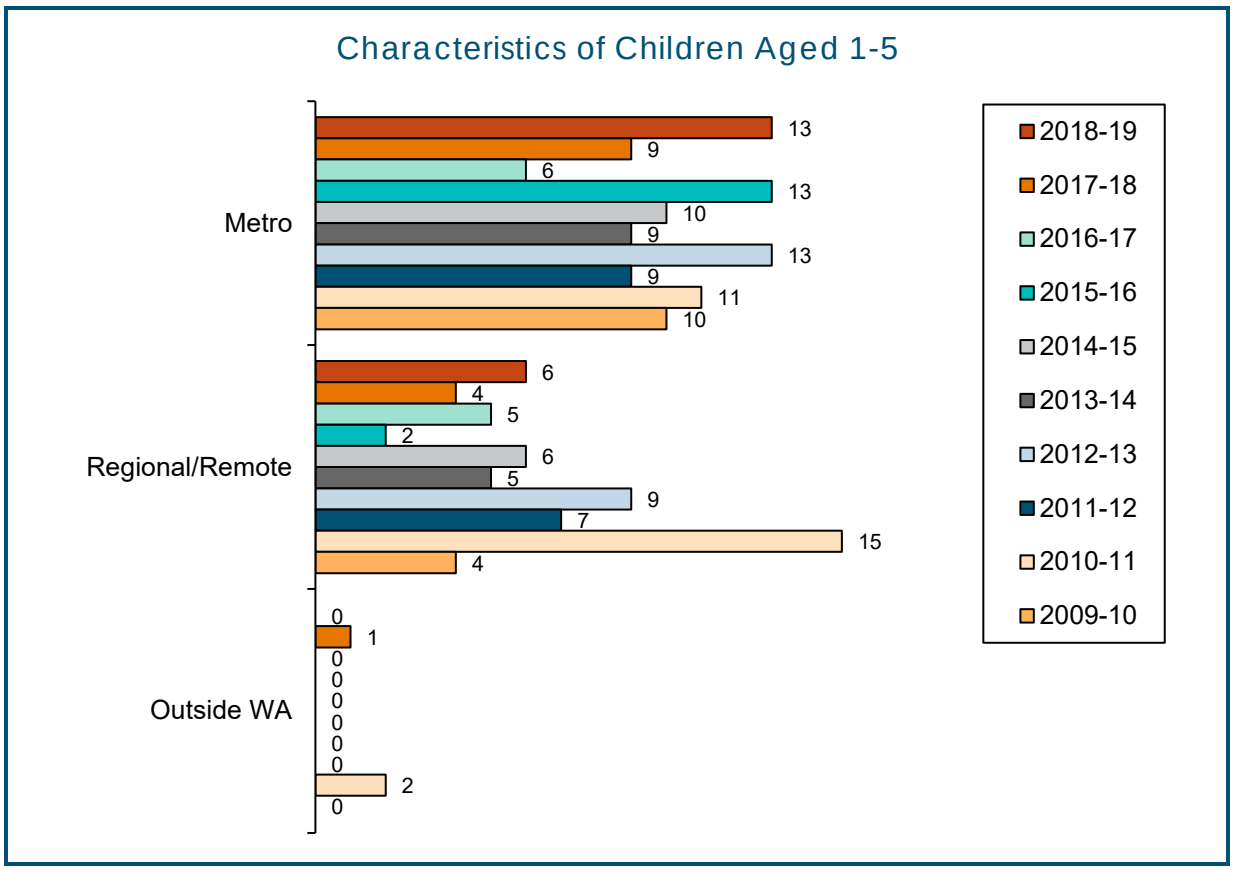
One hundred and seventeen deaths of infants were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 861 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2019, there were 169 (20%) related to children aged from 1 to 5 years.

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





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

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

- Males – 56% of investigable deaths and 53% 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 12% 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 – 41% of investigable deaths and 35% 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 (32%), followed by motor vehicle accidents (23%) and drowning (18%).

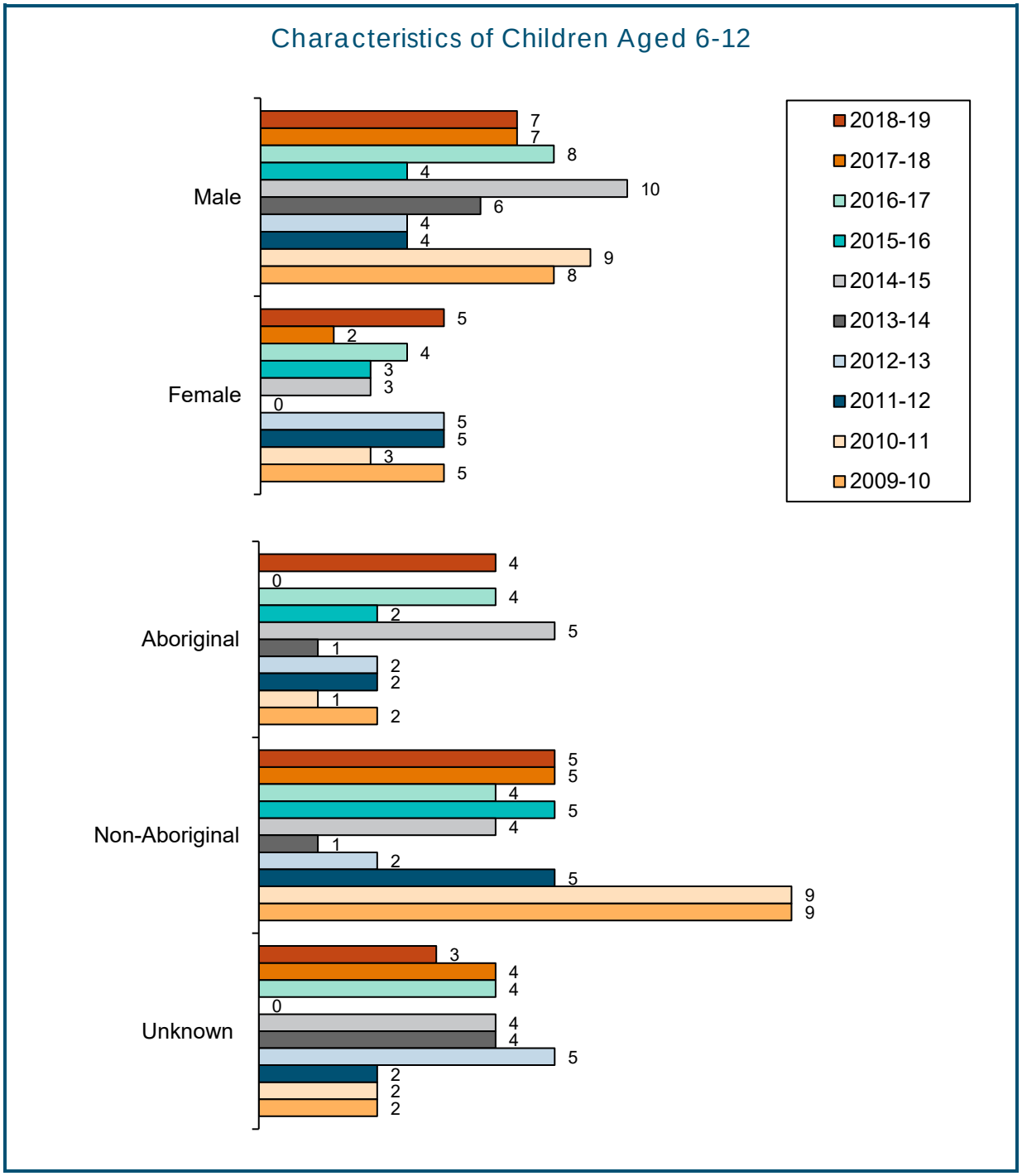
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

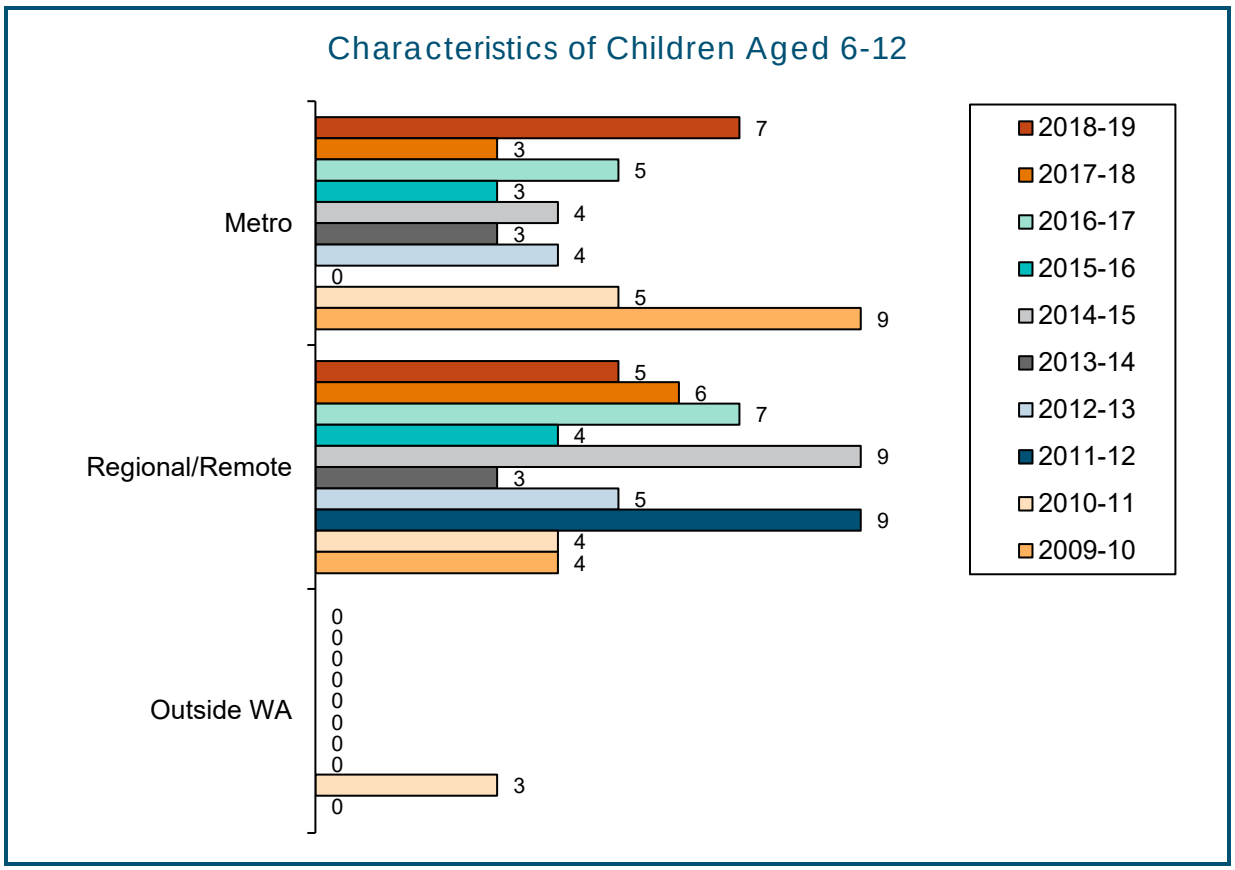
Sixty one deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of children aged 6 to 12 years

Of the 861 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2019, there were 102 (12%) related to children aged from 6 to 12 years.

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



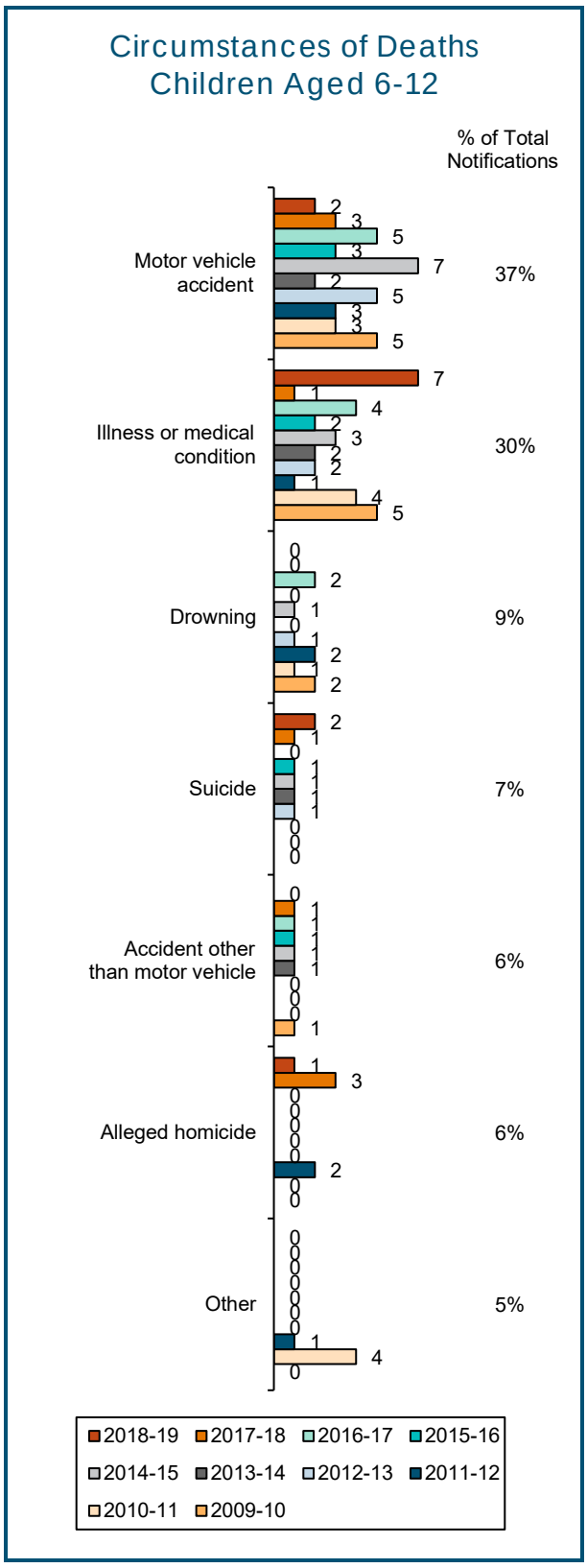


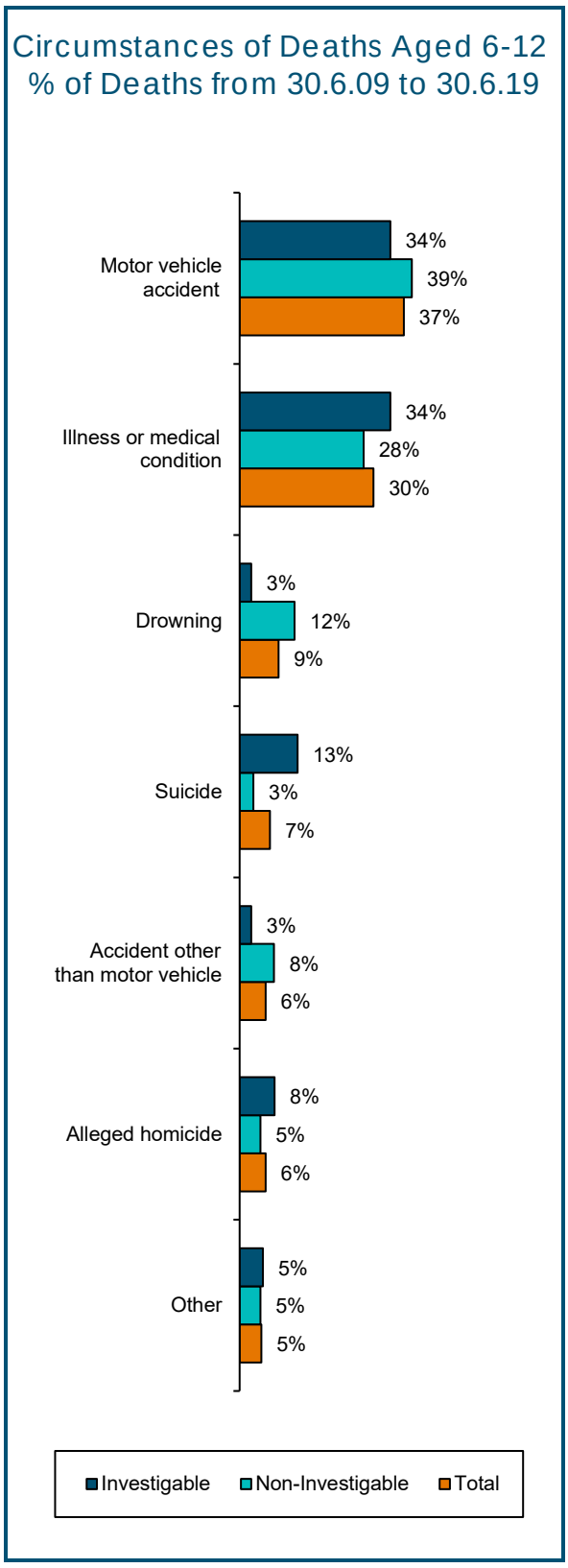
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 53% of investigable deaths and 73% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population;
- Aboriginal children – 50% of investigable deaths and 16% 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 – 66% of investigable deaths and 48% 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 (37%), followed by illness or medical condition (30%) and drowning (9%).





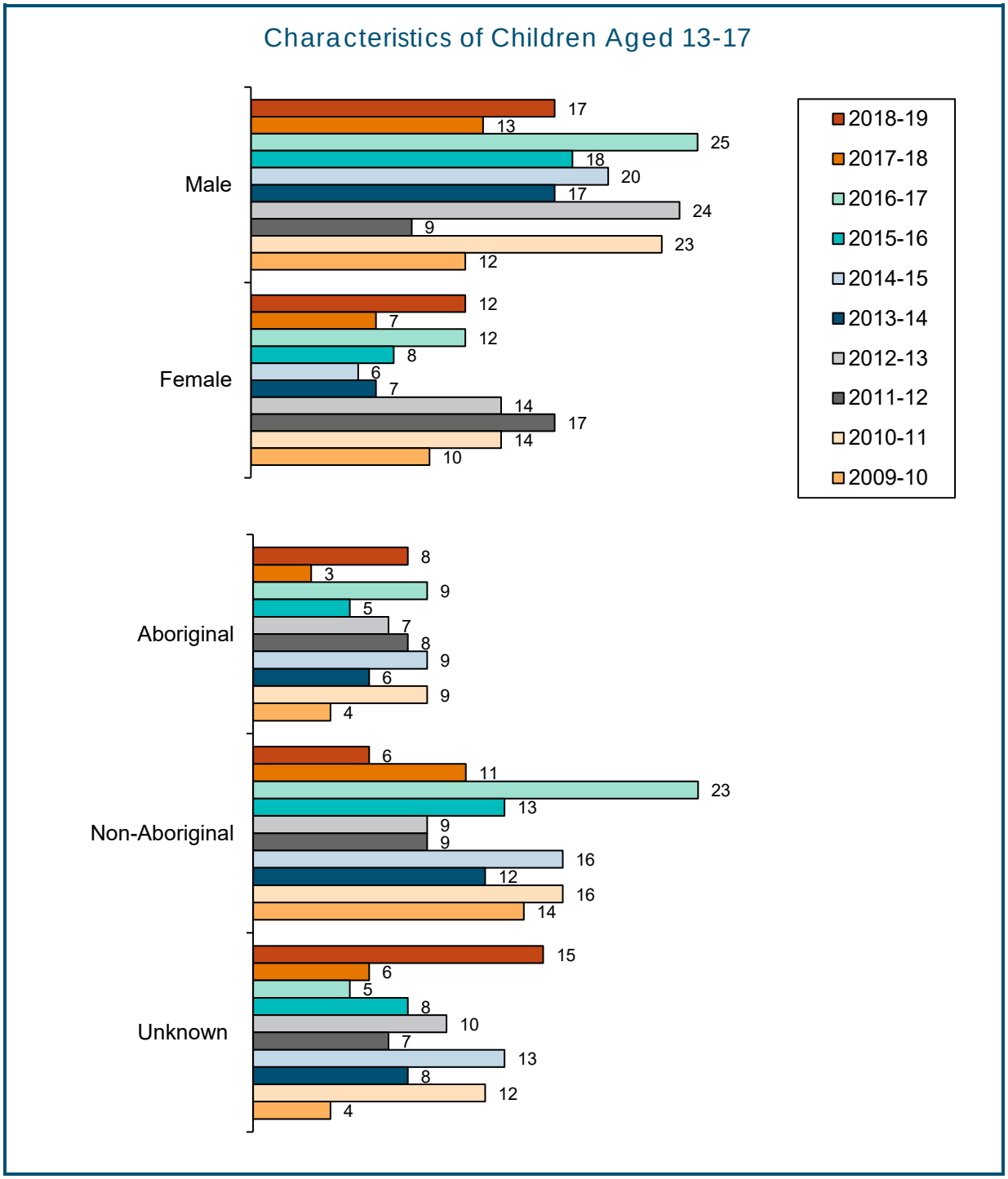
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

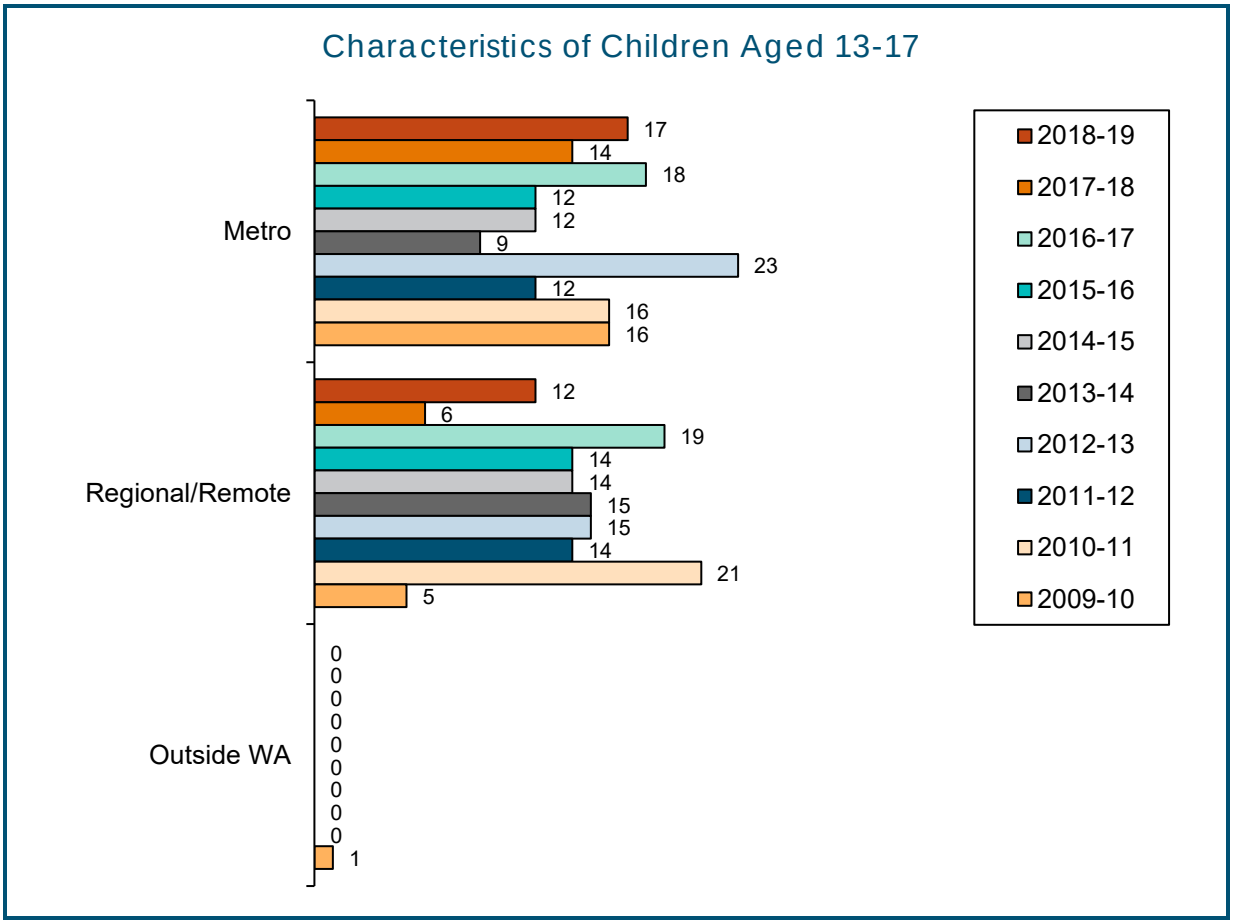
Thirty eight deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of children aged 13 – 17 years

Of the 861 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2019, there were 285 (33%) related to children aged from 13 to 17 years.

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



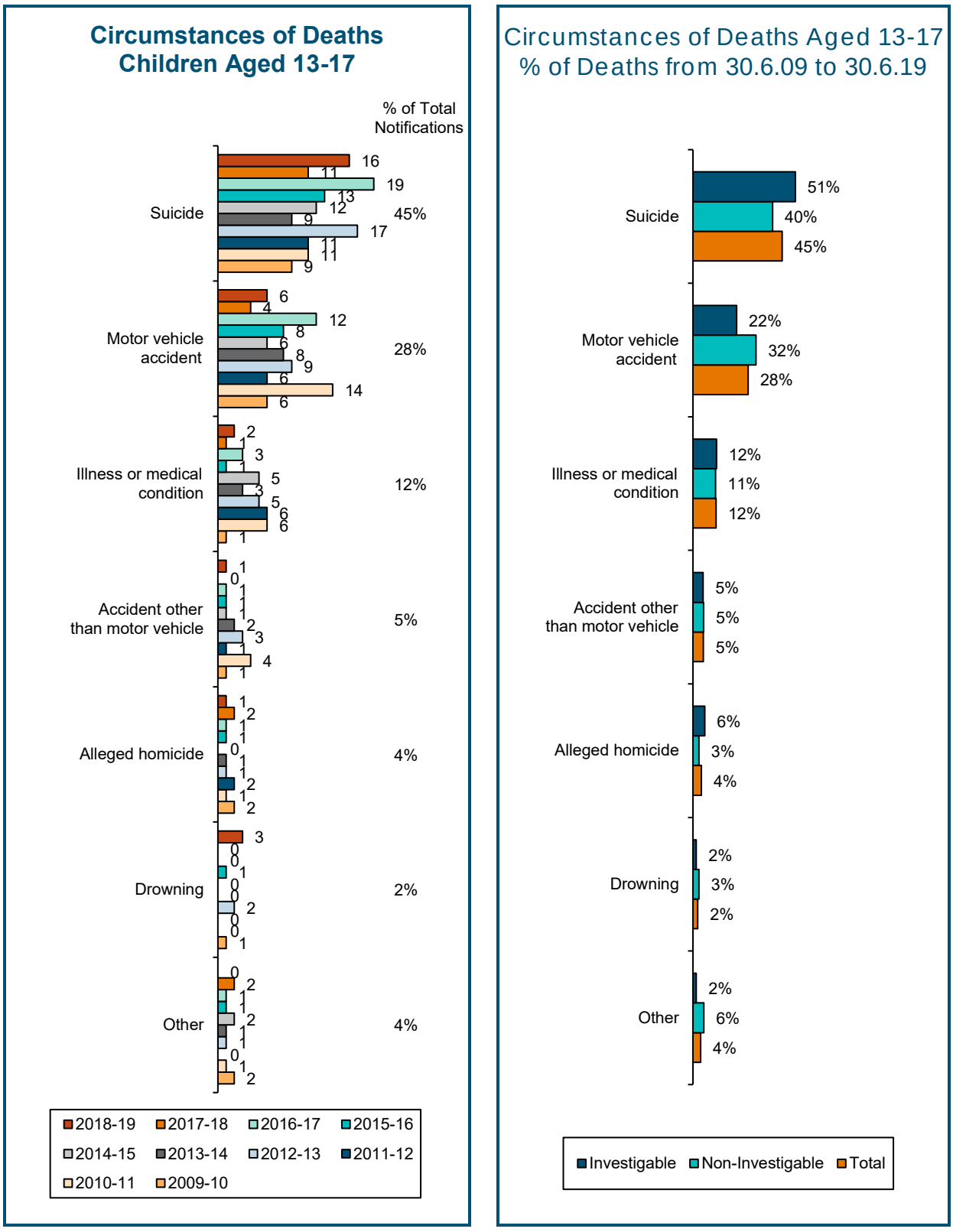


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 58% of investigable deaths and 66% of non-investigable deaths of children aged 13 to 17 were male compared to 51% in the child population;
- Aboriginal children – 54% 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 – 58% of investigable deaths and 40% 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 (45%), 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.

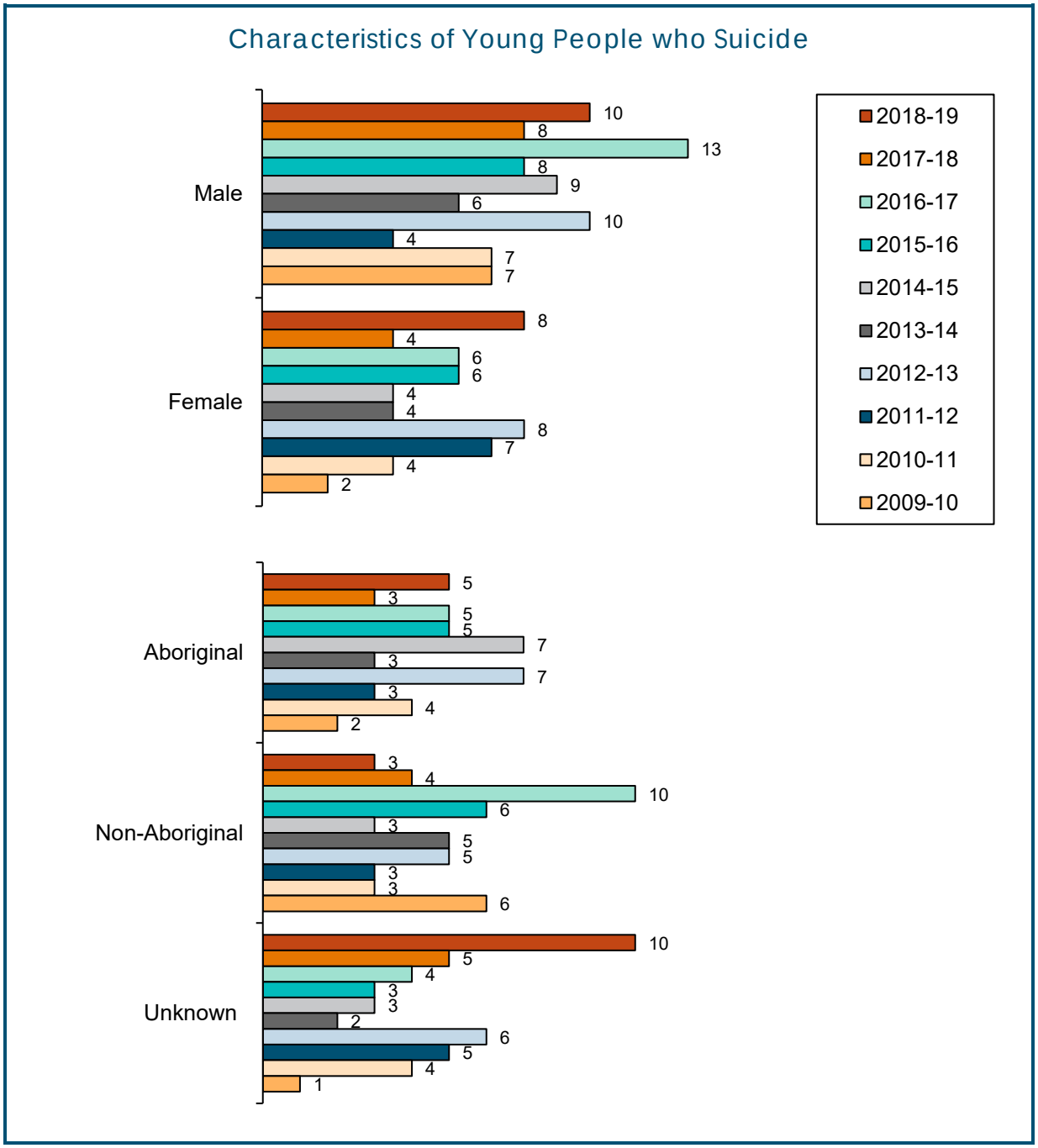
One hundred and eighteen deaths of children aged 13 to 17 years were determined to be investigable deaths.

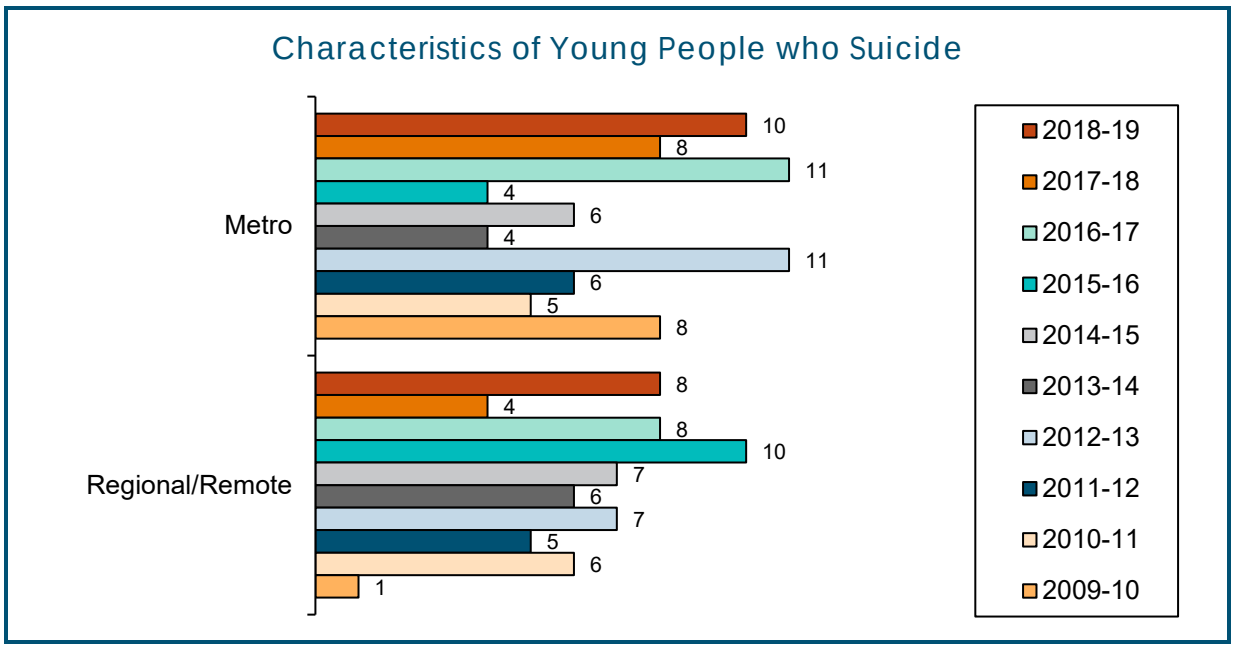
Suicide by young people

Of the 135 young people who apparently took their own lives from 30 June 2009 to 30 June 2019:

- Seven were under 13 years old;
- Six were 13 years old;
- Thirteen were 14 years old;
- Twenty nine were 15 years old;
- Thirty five were 16 years old; and
- Forty five were 17 years old.

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





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

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

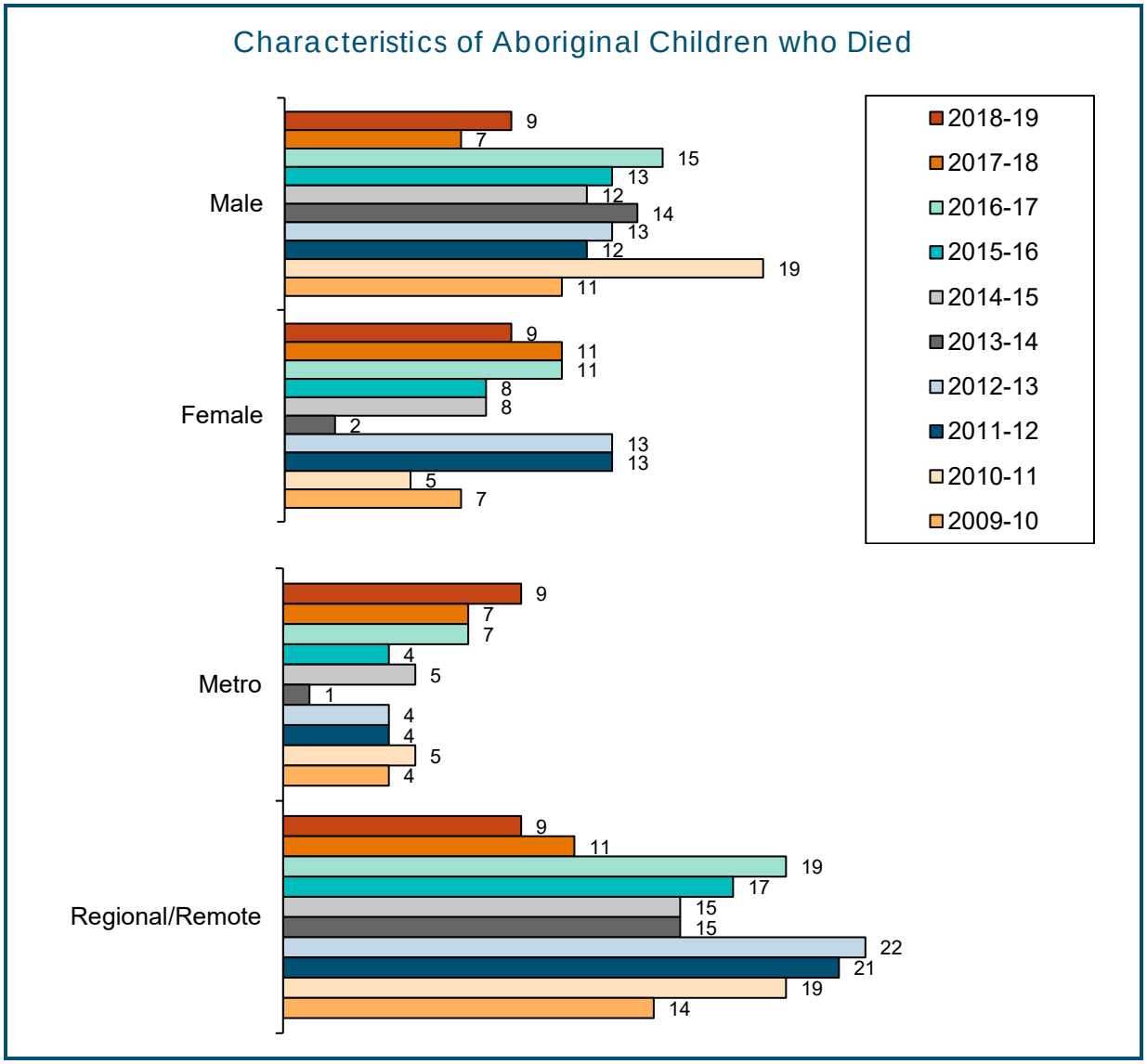
- Males – 53% of investigable deaths and 68% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 92 apparent suicides by young people where information on the Aboriginal status of the young person was available, 67% of the investigable deaths and 17% 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 32% 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

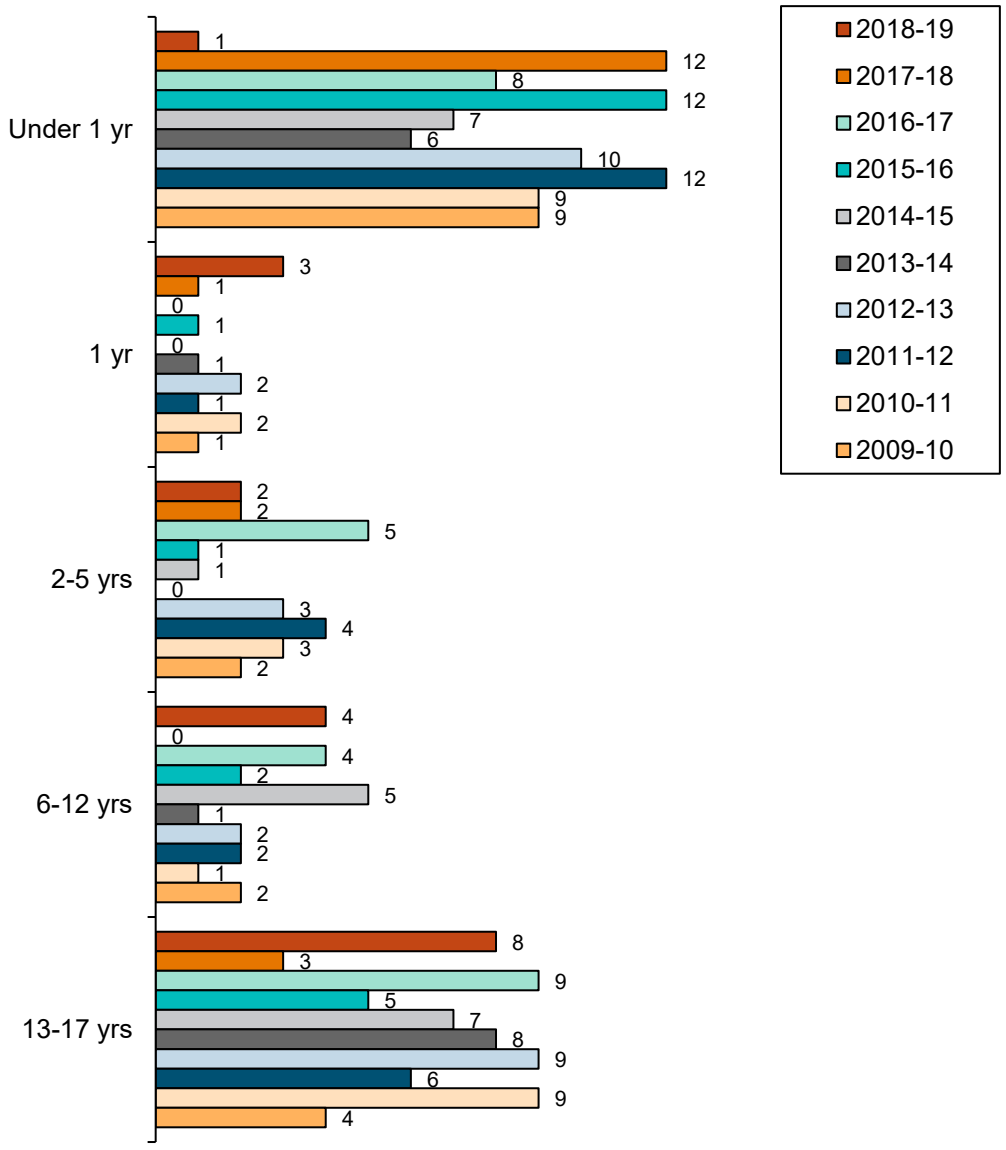
Of the 563 child death notifications received from 30 June 2009 to 30 June 2019, where the Aboriginal status of the child was known, 212 (38%) of the children were identified as Aboriginal.

For the notifications received, the following chart demonstrates:

- Over the 10 year period from 30 June 2009 to 30 June 2019, the majority of Aboriginal children who died were male (59%). For 2018-19, 50% 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 10 year period, 76% of Aboriginal children who died lived in regional or remote communities.

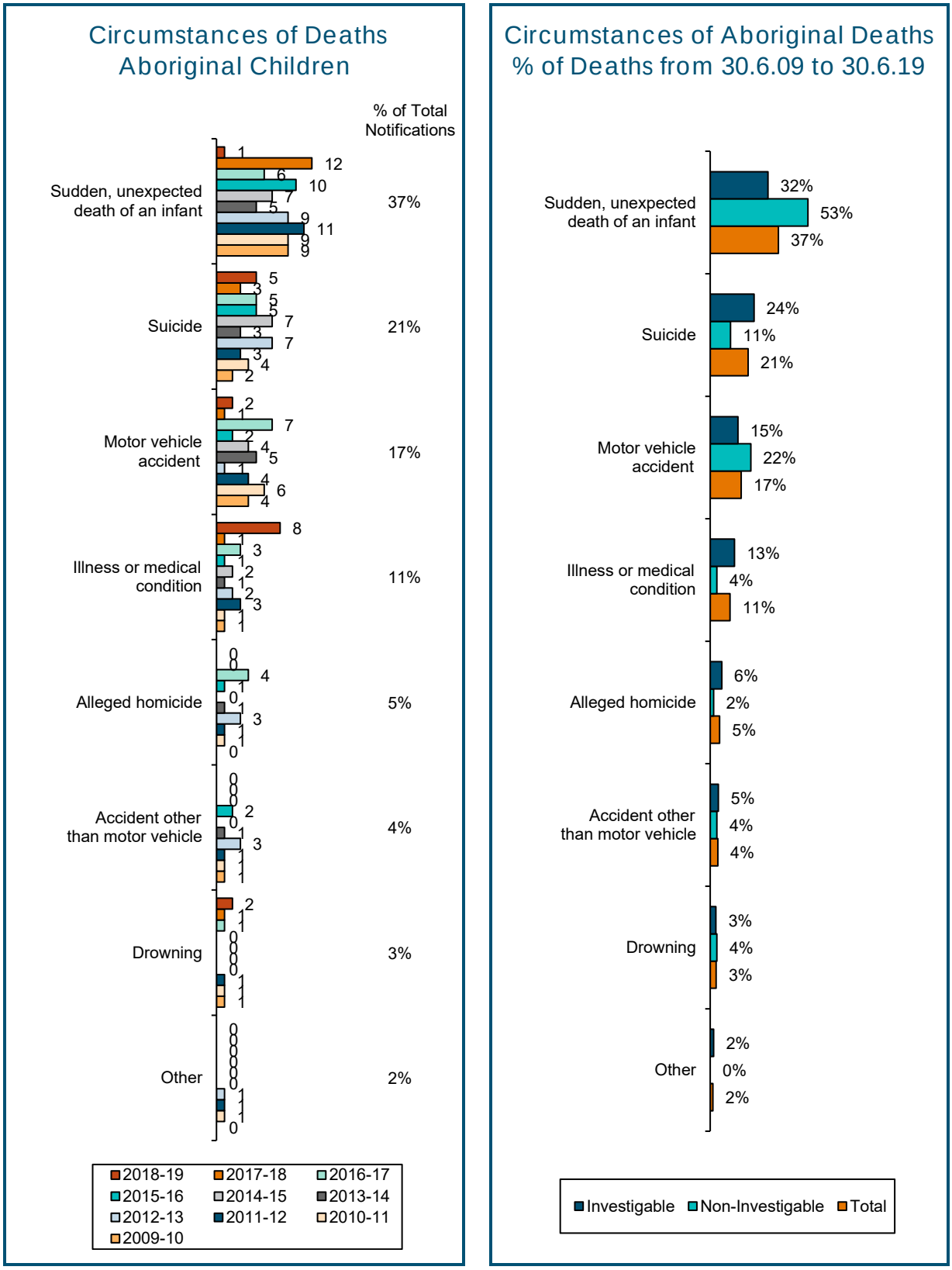


Characteristics of Aboriginal Children who Died



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 (37%), suicide (21%), and motor vehicle accidents (17%) are the largest circumstance of death categories for the 212 Aboriginal child death notifications received in the 10 years from 30 June 2009 to 30 June 2019.



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.

Deaths of infants

Sleep-related infant deaths

Through the undertaking of child death reviews, the Office identified a need to undertake an own motion investigation into the number of deaths that had occurred after infants had been placed to sleep, referred to as 'sleep-related infant deaths'.

The investigation principally involved the Department of Health (**DOH**) but also involved the (then) Department for Child Protection and the (then) Department for Communities. The objectives of the investigation were to analyse all sleep-related infant deaths notified to the Office, consider the results of our analysis in conjunction with the relevant research and practice literature, undertake consultation with key stakeholders and, from this analysis, research and consultation, recommend ways the departments could prevent or reduce sleep-related infant deaths.

The investigation found that DOH had undertaken a range of work to contribute to safe sleeping practices in Western Australia, however, there was still important work to be done. This work particularly included establishing a comprehensive statement on safe sleeping that would form the basis for safe sleeping advice to parents, including advice on modifiable risk factors, that is sensitive and appropriate to both Aboriginal and culturally and linguistically diverse communities and is consistently applied state-wide by health care professionals and non-government organisations at the antenatal, hospital-care and post-hospital stages. This statement and concomitant policies and practices should also be adopted, as relevant, by the (then) Department for Child Protection and the (then) Department for Communities.

The investigation also found that a range of risk factors were prominent in sleep-related infant deaths reported to the Office. Most of these risk factors are potentially modifiable and therefore present opportunities for the departments to assist parents, grandparents and carers to modify these risk factors and reduce or prevent sleep-related infant deaths.

The report of the investigation, titled *Investigation into ways that State Government departments and authorities can prevent or reduce sleep-related infant deaths,* was tabled in Parliament in November 2012. The report made 23 recommendations about ways to prevent or reduce sleep-related infant deaths, all of which were accepted by the agencies involved.

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

Case Study

Baby A

Baby A died during sleep in the context of environmental circumstances that are risk factors for sleep-related infant deaths (see *Investigation into ways that State Government departments and authorities can prevent or reduce sleep-related infant deaths* for information on infant and environmental risk factors for sleep-related infant deaths). In the months prior to Baby A's death, there had been interagency communication and collaboration to assess alleged parental alcohol and drug use, and associated action to promote Baby A's safety and wellbeing.

Following a review of Baby A's death, the Ombudsman made the following recommendations:

1. Given the issues identified with undertaking assessment and safety planning to administer the responsibilities under the *Children and Community Services Act 2004* in relation to the protection and wellbeing of a child, in this review, Communities provides the Ombudsman with a report by 30 September 2019 that outlines what steps will be undertaken by Communities to ensure critical decision making in assessment and safety planning is:
    - Consistent and compliant with the provisions and intent of *the Children and Community Services Act 2004*;
    - Informed by evidenced-based knowledge and skills related to child protection work; and
    - Operationalised by an effective and efficient policy and procedural framework.
2. Given the issues identified with the use of Signs of Safety (and for the application of/compliance with the Signs of Safety Child Protection Practice Framework), in this review and other reviews undertaken by the Ombudsman, and given that the Signs of Safety Child Protection Practice Framework has now been in place for ten years, and also given the University of South Australia Australian Centre for Child Protection Report and Framework Assessment of the Signs of Safety policies and administrative frameworks to operationalise reloaded projects, Communities provides the Ombudsman with a report by 30 September 2019 that outlines what steps will be undertaken by Communities to ensure that the 'Signs of Safety Reloaded' project provides an optimal policy and administrative framework to operationalise Communities' responsibilities under the *Children and Community Services Act 2004*.

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 deaths of children 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 deaths of children by drowning* are provided in the Own Motion Investigations and Administrative Improvement section.

A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce deaths of children by drowning, tabled in Parliament in November 2018, identified that steps have been taken to give effect to the Ombudsman's recommendations.

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 a motor vehicle accident. In the months prior to Child B's death, concerns were raised regarding alleged parental drug use and the associated impact on the care of the children in Child B's family. Child B's sibling had not attended school for many months and could not be located. The sibling had been placed on the *Student Whose Whereabouts is Unknown* List.

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

1. Communities, in collaboration with DOE, reviews the *Memorandum of Understanding Between the Department for Child Protection and Family Support and Department of Education (2013)* associated with the administration of the *Students Whose Whereabouts is Unknown* List to consider processes for the interagency identification and management of children on the *Students Whose Whereabouts is Unknown* List, including those who are in the care of the Communities' Chief Executive Officer and/or those who have come to the attention of Communities in the circumstances of reported child safety and wellbeing concerns, in order to locate these children on the *Students Whose Whereabouts is Unknown* List and collectively promote their best interests and re-engagement with education where indicated.

2. DOE, in collaboration with Communities, reviews the *Memorandum of Understanding Between the Department for Child Protection and Family Support and Department of Education (2013)* associated with the administration of the *Students Whose Whereabouts is Unknown* List to consider processes for the interagency identification and management of children on the *Students Whose Whereabouts is Unknown* List, including those who are in the care of the Communities' Chief Executive Officer and/or those who have come to the attention of Communities in the circumstances of reported child safety and wellbeing concerns, in order to locate these children on the *Students Whose Whereabouts is Unknown* List and collectively promote their best interests and re-engagement with education where indicated.

3. DOE provides the Ombudsman with a report within 12 months of the finalisation of this child death review outlining actions taken to give effect to recommendation 7 and processes, proposed and/or implemented, associated with monitoring the effectiveness of revised interagency practices to locate children on the *Students Whose Whereabouts is Unknown* List.

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 2018-19, the Ombudsman received two notifications of the deaths of children aged six to 12 years in the circumstances of motor vehicle accidents. Both 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 45% 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 2018-19, 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 2019.

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.

Case Study

Adolescent C

Adolescent C died in the circumstances of apparent suicide. Adolescent C was enrolled in a school in regional WA but had very poor school attendance. Following a review of Adolescent C's death, the Ombudsman made the following recommendations:

1. That DOE's Statewide Services, with input from the Aboriginal Education Teaching and Learning Directorate, reviews the findings of this child death review, through the lens of the *Aboriginal Cultural Standards Framework (2015)*, and works with the Regional School staff and school community to develop a plan to provide 'strengthened support and intervention for students' in accordance with DOE's *New Initiatives in Aboriginal Education (2017)* and *Aboriginal Cultural Standards Framework (2015)* to improve school attendance and students' social wellbeing, and to optimise academic outcomes.

2. DOE reviews and revises the current plan to implement the Expert Review Group 10 'prescribed improvement strategies', in association with the Regional School staff and school community, the Regional Executive Director and DOE's Statewide Services, including the Aboriginal Education Teaching and Learning Directorate, as appropriate, to ensure timely and effective improvement in relation to the 12 'major findings' identified by the Expert Review Group in 2013.

3. DOE provides the Ombudsman with a report by 1 March 2019 on the outcomes of recommendations 2 and 3.

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.
- Not taking action consistent with legislative responsibilities of the *Children and Community Services Act 2004*, and associated policy, to determine whether children were in need of protection or whether action was required to safeguard child wellbeing.
- Not adequately meeting policies and procedures relating to Safety and Wellbeing Assessments and safety planning.
- 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.
- Not adequately meeting policies and procedures relating to Safety and Wellbeing Assessments for an infant, in a timely manner.
- 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 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 opportunity to support the development and implementation of 'prescribed improvement strategies' following school reviews.
- 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.
- Missed opportunity to provide training on 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 2018-19 arising from child death reviews (certain recommendations may be de-identified to ensure confidentiality).

1. Communities takes all necessary steps to ensure that administrative processes associated with assessment of child wellbeing reports do not prevent Communities from seeking information from other relevant government and non-government agencies.
2. Communities Regional District reiterates to staff what their responsibilities are in applying a trauma informed and culturally appropriate approach when working with Aboriginal children and young people, to promote the safety and wellbeing of, and improve outcomes for, Aboriginal children, families and communities when they come into contact with Communities, in accordance with the purpose of the *Aboriginal Services and Practice Framework 2016-2018*.
3. That DOE's Statewide Services, with input from the Aboriginal Education Teaching and Learning Directorate, reviews the findings of this child death review, through the lens of the *Aboriginal Cultural Standards Framework (2015)*, and works with the Regional School staff and school community to develop a plan to provide 'strengthened support and intervention for students' in accordance with DOE's *New Initiatives in Aboriginal Education (2017)* and *Aboriginal Cultural Standards Framework (2015)* to improve school attendance and students' social wellbeing, and to optimise academic outcomes.
4. DOE reviews and revises the current plan to implement the Expert Review Group 10 'prescribed improvement strategies', in association with the Regional School staff and school community, the Regional Executive Director and DOE's Statewide Services, including the Aboriginal Education Teaching and Learning Directorate, as appropriate, to ensure timely and effective improvement in relation to the 12 'major findings' identified by the Expert Review Group in 2013.
5. DOE provides the Ombudsman with a report by 1 March 2019 on the outcomes of recommendations 3 and 4.
6. Communities, in collaboration with DOE, reviews the *Memorandum of Understanding Between the Department for Child Protection and Family Support and Department of Education (2013)* associated with the administration of the *Students Whose Whereabouts is Unknown* List to consider processes for the interagency identification and management of children on the *Students Whose Whereabouts is Unknown* List, including those who are in the care of the Communities' Chief Executive Officer and/or those who have come to the attention of Communities in the circumstances of reported child safety and wellbeing concerns, in order to locate these children on the *Students Whose Whereabouts is Unknown* List and collectively promote their best interests and re-engagement with education where indicated.
7. DOE, in collaboration with Communities, reviews the *Memorandum of Understanding Between the Department for Child Protection and Family Support and Department of Education (2013)* associated with the administration of the *Students Whose Whereabouts is Unknown* List to consider processes for the interagency identification and management of children on the *Students Whose Whereabouts is Unknown* List, including those who are in the care of the Communities' Chief Executive Officer and/or those who have come to the

attention of Communities in the circumstances of reported child safety and wellbeing concerns, in order to locate these children on the *Students Whose Whereabouts is Unknown* List and collectively promote their best interests and re-engagement with education where indicated.

8. DOE provides the Ombudsman with a report within 12 months of the finalisation of this child death review outlining actions taken to give effect to recommendation 7 and processes, proposed and/or implemented, associated with monitoring the effectiveness of revised interagency practices to locate children on the *Students Whose Whereabouts is Unknown* List.
9. Given the issues identified with undertaking assessment and safety planning to administer the responsibilities under the *Children and Community Services Act 2004* in relation to the protection and wellbeing of a child, in this review, Communities provides the Ombudsman with a report by 30 September 2019 that outlines what steps will be undertaken by Communities to ensure critical decision making in assessment and safety planning is:
    - Consistent and compliant with the provisions and intent of the *Children and Community Services Act 2004*;
    - Informed by evidenced-based knowledge and skills related to child protection work; and
    - Operationalised by an effective and efficient policy and procedural framework.
10. Given the issues identified with the use of Signs of Safety (and for the application of/compliance with the *Signs of Safety Child Protection Practice Framework*), in this review and other reviews undertaken by the Ombudsman, and given that the *Signs of Safety Child Protection Practice Framework* has now been in place for ten years, and also given the University of South Australia Australian Centre for Child Protection Report and Framework Assessment of the Signs of Safety policies and administrative frameworks to operationalise reloaded projects, Communities provides the Ombudsman with a report by 30 September 2019 that outlines what steps will be undertaken by Communities to ensure that the 'Signs of Safety Reloaded' project provides an optimal policy and administrative framework to operationalise Communities' responsibilities under the *Children and Community Services Act 2004*.
11. Communities ensures that, during the course of supervision provided (in accordance with Chapter 4.1.7 of Communities' *Casework Practice Manual*) in 2019, all child protection workers are supported in relation to developing their theoretical knowledge and practice skills regarding drug/alcohol assessment and safety planning to guide professional judgement in administering Communities' responsibilities in accordance with the *Children and Community Services Act 2004*, including identifying further learning strategies and professional development when appropriate.
12. When developing a Team Leader Program for Communities' *Child Protection Learning Pathway*, Communities considers the findings of this case and data on team leader formal learning participation (as provided for this review), and determines what mandatory formal learning and regular updates are required to ensure team leaders are supported to be proficient in undertaking the delegated responsibilities in approving critical decisions in child protection assessment and safety planning.
13. Communities provides a report to the Ombudsman on the completion of recommendation 12 by 30 September 2019.

Steps taken to give effect to the recommendations arising from child death reviews in 2016-17

The Ombudsman made 31 recommendations about ways to prevent or reduce child deaths in 2016-17. The Office has requested that the relevant public authorities notify the Ombudsman regarding:

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

Recommendation 1: The Department develops and implements evidence based practice guidelines associated with identifying and responding to infants at high risk of emotional abuse (including exposure to family and domestic violence), harm and/or neglect within the meaning of section 28 of the *Children and Community Services Act 2004.*

Steps taken to give effect to the recommendation

The Department provided this Office with a letter dated 30 October 2018, in which the Department relevantly informed this Office that:

> I am pleased to provide you with a copy of the Department of Communities' (the Department), Casework Practice Manual (CPM) update titled 'Identifying, Assessing and Responding to High Risk Infants' and the related resource titled, 'Determining Whether an Infant is at Risk of Significant Harm'.
>
> The additional resource highlights the unique vulnerabilities of infants and facilitates evidence based assessment of those infants considered to be at high risk of harm, due to the child abuse and neglect. The development of such policy arose from the Ombudsman's recommendations following the tragic death of [infant] in 2015, and the Department's continuous aim to reduce preventable child deaths…

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 15 April 2019, containing a report prepared by the Department (**the Department's report**).

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

> **Casework Practice Manual**
>
> The Casework Practice Manual (CPM) entries *'2.2.14 Identifying, Assessing and Responding to High Risk Infants'*, and the '*Related Resource – Determining Whether an infant is at risk of significant harm*' will be referenced in the existing CPM *Chapter 2.2 'Assessment and Investigation Processes'*.
>
> This CPM will be promoted by management during regular staff supervision for all child protection workers to implement, and new staff will be provided introductory information during compulsory Orientation training. Communities will monitor Critical Priority Areas measured in the *Better Care Better Services* Standards Monitoring and reporting cycles.
>
> **Professional Development**
>
> Communities have introduced Learning and Development workshops and Online Learning resources relevant to High Risk Infants. The Department of Health *Online*

Learning Safe Sleeping training continues to be well attended with an average 85 staff completing this between 2016 and 2018.

Communities have developed a *Pre-birth planning meetings and High-Risk Infants* workshop to prepare practitioners for pre-birth planning meetings including post birth safety planning for high risk infants, these workshops are scheduled for 3rd and 10th May 2019. Communities Professional Practice Unit will review staff attendance following the workshops and deliver training out in the Districts to ensure all staff complete this.

Communities has developed a *High Risk Infant* workshop for child protection workers to learn and observe infants and young children in interaction with their parents to inform assessment and to plan appropriate support interventions. The workshops were delivered by Policy to Senior Practice Development Officers in February 2019 whom will then deliver the training package to their own Districts.

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

Recommendation 2: The Department provides a report to the Ombudsman within six months of the finalisation of this child death review outlining actions taken by DCPFS to give effect to Recommendation 1.

Steps taken to give effect to the recommendation

The Department provided this Office with updates on the actions taken to give effect to Recommendation 1 on 17 October 2017, 29 December 2017 and 7 March 2018. As noted above, a copy of the Department's Casework Practice Manual section 'Identifying, Assessing and Responding to High Risk Infants' was provided to this Office on 30 October 2018.

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

Recommendation 3: The Department considers its compliance with its record keeping obligations in the context of this case and provides a report to the Ombudsman within six months of the finalisation of this child death review outlining the results of this consideration.

Steps taken to give effect to the recommendation

The Department provided this Office with a letter dated 29 December 2017, in which the Department relevantly informed this Office that:

A range of activities are undertaken by Corporate Information to support the practice of sound record keeping, ensuring compliance with the State Records Act and the Department's policy requirements including:

- Corporate Information has a Records Management Policy which is regularly reviewed, elements of which are presented in the Administration Manual as well as the Case practice manual, the relevant elements of the policy statement sets out expectations and requirements for case workers in respect of Records Management.
- "Good practice" is promulgated through Corporate Induction online training for all new Departmental staff.

- Learning Development Centre (LDC) run Objective (The Departments Electronic and Document Records Management System) and Assist training days.
- Corporate Information designated officers (Senior Records Management Consultant, Manager Records Management, Senior Records Officers) undertake site visits outlining Records Management good practice and Objective systems training (site visits are restricted to Metro locations due to budget restrictions.
- The Manager Corporate Information and the Director Corporate Information at every opportunity continue to re-inforce the need for record keeping good practice whenever the opportunity arises.
- Regular consultation occurs with the Information Service Division Client Applications Section who support Assist and Objective looking at Help Desk requests to review all perceived literacy and educational deficiencies.
- Participation at yearly Department Mentors Conferences highlighting Objective database findings on user behaviour and promoting a general awareness of good information management to stress the importance of the management of information as and asset of corporate value.

The following activities have been implemented in the relevant Regional District:

- Recording is now a standing agenda item for discussion at District Staff Meetings.
- A standard feature in Supervision sessions with case managers and support officers.
- Numerous all staff reminder emails.
- Integrated into all local learning sessions.
- A stand-alone session on recording requirements was completed on 11 December 2017.
- Team leaders via supervision, and random audits will identify individuals not meeting recording requirements. Staff identified will be targeted for case audits and improvement action.
- The Senior Practice Development Officer, Assistant District Director and Assist Mentor will undertake random monthly audits of case files for all teams; with improvement actions implemented where issues are identified.
- The importance of updating family groups to include relevant members and unborn babies has been emphasised with staff and is quality assured by the district mentor on a monthly basis (where pre-birth planning occurs).
- The Child Safety Team (who receives new child protection concerns for the district) include these recording elements as a standing agenda item in their team meetings and as a focus of duty officer's supervision.

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

Recommendation 4: Having agreed to implement Recommendation 1, arising from this office's review of the death of [Child A] the Department reviews [Child B's] case to determine if Crisis Care Unit staff require specific guidelines to support timely responses to safety and wellbeing concerns for infants.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

Background

Crisis Care Unit staff, at the time, were not privy to the information contained on the Best Beginnings file. The Child Protection Worker undertook a search of electronic records for the notifier of the family subject to the concerns. At the time of call there was no information on the families Assist or Objective file which corroborated the notifiers concerns, nor was there prior history to suggest the parents posed an immediate risk to their infant. The information was sent to the relevant District and actioned the following morning. Crisis Care staff reported this was an exceptional situation, had the Child Protection Worker been privy to the internal mapping, their response would have been immediate with Police attendance likely.

Casework Practice Manual

The Casework Practice Manual (CPM) has been extensively updated. *Identifying, assessing and responding to high-risk infant's* forms Chapter 2.2.14 of the CPM, which guides child protection works in:

- Understanding the types of abuse and neglect specific to high risk infants and identifying what risk factors may be present for a high risk infant
- Determining when an infant is at risk of significant harm, undertaking an assessment of these risks and taking action to reduce risks
- Procedures for child protection practice with high risk infants and their families including response to abuse and neglect and safety planning.

'*Best Beginnings Plus'* now forms Chapter 1.2.2 of the revised CPM which guides staff in the referral, intake and service delivery of the Best Beginnings Plus (BB) service.

Best Beginnings Plus

To give effect to this recommendation, Communities has enhanced practice by requiring BB file notes and records be kept and placed on the family case file in Assist and Objective. The BB Plus worker does not maintain separate case files, all records of home visits and correspondence are now held in the one case file for the family. If at any time a BB Plus worker has concerns about the safety or wellbeing of a child, they must immediately discuss this with the Intensive Family Support Team Leader to determine the appropriate response.

Professional Development

Pre-Birth Planning Meetings and High Risk Infants training is being rolled out to prepare Child Protection Workers for pre-birth planning meetings including post birth safety planning for high risk infants.

Compliance

The Senior Practice Development Officer, Statewide Referral and Response Service (Crisis Care Unit, Central Intake Team, and Domestic Violence Helplines) completes internal case mapping with Child Protection Workers on a weekly basis as a learning opportunity and forum to reflect on and improve case practice.

The Department's report indicates that consideration has been given to this recommendation, and relevant guidelines to support timely responses to safety and wellbeing concerns for infants have been identified and updated.

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

Recommendation 5: The Department continues to take all reasonable steps to achieve compliance with the Department's policy and practice requirements regarding the provision of safe infant sleeping information as detailed in the Department's Casework Practice Manual Chapter 3.2 *Safe Infant Sleeping*.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

Casework Practice Manual

'*Safe Infant Sleeping*' now forms Chapter 1.2.7 of the revised CPM which provides information and practice guidance to staff on safe infant sleeping practices and the risk of co-sleeping where the Department of Communities has an ongoing role working with families and carers with infants.

Refer to Recommendation 1 re: *Identifying, Assessing and Responding to High Risk Infants*.

Professional Development

Communities has introduced Learning and Development workshops and eLearning Online relevant to High Risk Infants.

Communities Professional Practice Unit created a new workshop *Responding to High Risk Infants,* participants will learn to observe infants and young children in interaction with their parents to inform assessment and to plan appropriate supportive interventions. These workshops were rolled out in March 2019.

Communities Professional Practice Unit created a new workshop *Pre-Birth Planning meetings and High Risk Infants* which will commence in April 2019. This full day workshop aims to prepare practitioners for pre-birth planning meetings including post birth safety planning for high risk infants.

Communities Learning and Development data reveals that 316 staff have completed the eLearning Online *Safe Sleeping* course since April 2014.

The Department of Health *Online Learning Safe Sleeping* training continues to be well attended by with an average 85 per year between 2016 and 2018, increased from 33 in 2015.

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

Recommendation 6: The Department takes all reasonable steps to ensure compliance with the practice requirements outlined in Chapter 9.3 Placement with a Relative Carer or Significant of the *Casework Practice Manual*.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

Casework Practice Manual

'*Family or significant other care*' now forms Chapter 3.1.4 of the revised CPM which informs senior child protection workers (SCPWs) of the practice and procedures associated with assessing, supporting and reviewing a family or significant other carer applicant or approved carer.

Building a Better Future: Out-of-Home Care Reform

To give effect to this recommendation, Communities launched *Building a Better Future: Out-of-Home Care Reform* in 2016, with a plan to roll out changes over a five-year period to ensure all children in care receive the safe, stable and nurturing home they deserve. Communities will develop more inclusive assessment and review processes for family carers, and enhance training to child protection workers to improve support to family carers.

Professional Development

Communities has provided numerous training exercises for child protection workers to ensure compliance with this practice requirement. A one-day *Family Care Assessor Training* workshop was completed in November 2017 attended by 39 staff, and a further two-day *Family Care Assessor Training* workshop completed in May 2018 attended by 62 staff. These workshops had a cultural focus, training staff in how to engage Aboriginal family carers and their families, how to assess in a culturally appropriate way, and how to assess non-Aboriginal carers caring for Aboriginal children in their ability to keep these children connected to their culture, community and country. These workshops also trained staff in how to gather evidence and align that evidence to the carer competencies outlined in s 4(1)(a) *Children and Community Services Regulations 200*6 to make an informed assessment and recommendation. Multiple training sessions were completed from June through to September 2018 for staff who supervise assessors and quality assure family care assessments, including the development of a supervision tool to assist staff in quality assurance.

Compliance

Communities *Critical Priorities and Operational Reports* are provided to District Directors monthly to monitor compliance of significant areas of case practice including 'households approved for placement under section 79(2)(b) and children placed for more than six months', and 'family carer households with children currently placed and overdue reviews at end of month'.

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

Recommendation 7: The Department takes all reasonable steps to ensure compliance with documented plans to monitor the health, safety and wellbeing of children in Provisional Protection and Care of the Department.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

Needs Assessment Tool

Communities implemented a new *Needs Assessment Tool* in December 2016 to assist child protection workers to consistently identify and assess the complex and individual needs of children in care. The tool uses 21 questions to capture information covering nine dimensions of wellbeing, and is used within 90 days of a child entering care and then each year after or when the needs of a child changes.

Better Care, Better Services

To give effect to this recommendation, Communities has reviewed and updated the *Better Care, Better Services: Safety and quality standards for children and young people in care* in 2017. At Standard 4, paragraph 4.2, indicators of health compliance provide that the overall needs of a child or young person are met, in particular under the following dimensions of wellbeing:

a) Children and young people have their physical, developmental, and mental health needs assessed and managed in a timely manner
b) Children and young people are supported to attend health appointments and can expect any actions, concerns, and outcomes from these appointments to be communicated to and followed up by those responsible for planning and meeting their needs
c) Children and young people are provided with health treatments (including medication) and are supported to understand and manage their health needs over time, and
d) The child or young person's health requirements are recorded in a written document that is reviewed on a regular basis and at a minimum, annually.

Compliance

Communities *Critical Priorities and Operational Reports* are provided to District Directors monthly and measure compliance against a key performance indicator that children entering provisional protection and care will have a provisional care plan completed within seven days. For the period October 2017 to September 2018, overall compliance was at 93%.

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

Recommendation 8: The Department takes all reasonable steps to ensure compliance with the practice requirements outlined in Chapter 10.6 Health Care Planning of the *Casework Practice Manual*.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

> **Casework Practice Manual**
>
> '*Health care planning*' now forms Chapter 3.4.8 of the revised CPM which guides child protection workers in the health care planning processes for children in the CEO's care. When a child comes into the CEO's care, a child protection worker must arrange for an initial medical assessment with a general practitioner within 20 days, then have an annual health assessment thereafter.
>
> **Professional Development**
>
> Learning and Development's *Orientation Program 4 – The Care Team Approach to Planning* focuses on the roles, responsibilities and expectations of the 'corporate parent' and stakeholders involved in children in care practice. This training is delivered to all child protection staff.

It is also noted that Department's report indicated that information provided by the Department for Child Death Review Recommendation 7 is also relevant to this response.

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

Recommendation 9: The relevant Department Metropolitan District reiterates to staff with the delegated responsibility to approve critical decisions for the child's best interests, including but not limited to approvals of SWA and case closure, what their responsibilities are in providing such approvals.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

> **District Response**
>
> The relevant Metropolitan District Director affirms that all Safety and Wellbeing Assessments (SWA) will be approved by a Team Leader, Senior Practice Development Officer, Assistant District Director or District Director only. Further, all SWA's will evidence a safety plan, and all safety plans developed in case practice must be approved by a Team Leader prior to being placed on the file and provided

to family and services. Team Leaders will ensure safety plans are focused on actions and behaviour that create and sustain safety.

Safety and Wellbeing Assessment Project

To give effect to this recommendation, Communities undertook a review of Safety and Wellbeing Assessments (SWA) in 2018, via the *SWA Project*, to promote better critical thinking and documented analysis of information concerning allegations of abuse, and to bring about better clarity and consistencies of SWA's across the state.

The *SWA Project* produced its findings and recommendations in January 2019, the key changes include:

- SWA name will change to Child Safety Investigation (CSI)
- There will be one status Actual Harm Continuing Risk (AHCR), this will replace ASH and PR status
- The option of standard of care and critical incidents will be utilised for children in care, it will not be an automatic CSI unless it meets the criteria for a tier 2 investigation

State-wide roll out of the *SWA Project* will include a 2-day compulsory training package commencing May 2019. Each District will develop local strategies via SWA Champions, with ongoing review, evaluation and monitoring to occur over a 12-month period.

Professional Development

The relevant Metropolitan District Director reports Child Protection Workers have completed, and are scheduled to complete the following training:

- Family and Domestic Violence training October and December 2017 with ongoing training by FDV Champions to occur throughout 2019
- Drug and Alcohol policy and practice workshop in 2017
- Safety and Wellbeing Assessment training on 3 January 2019
- The Impact of Methamphetamine Use on Parents 10 April 2019
- Signs of Safety training will occur in the second quarter of 2019
- Collaborative education workshops with Adolescent Mental Health Service – dates to be confirmed

Compliance

Communities *Critical Priorities and Operational Reports* are provided to District Directors monthly and reveal work volumes, including Interactions, Initial Inquiries, and Safety and wellbeing Assessments. Between 2016 to 2018, Safety and Wellbeing Assessments commenced in the relevant Metropolitan District have increased from an average of 51.84 per month in 2016 to an average of 117 per month in 2018.

Communities *WLM Allocated and Monitored Cases per District Planning Cycle No. 20117* revealed at the end of 2017, the relevant Metropolitan District held 41.50 FTE of which 34.40 was available to manage cases, *Cycle No. 20129* ending 2018, revealed the relevant Metropolitan District held 47.50 FTE of which 35.00 FTE was available to manage cases.

Communities produce *Standards Monitoring Reports* for each District on a 2-yearly cycle, the standards were revised and updated in 2018. Quality Standard 11 stipulates '*The Department of Communities undertakes comprehensive assessments of child protection concerns, and if required, takes action to safeguard or promote the child or young person's wellbeing.'* The relevant Metropolitan District in the January 2019 Final Report received commendations for their consistent

recording of approval of decisions as required in legislation, and the Department's policies and practice guidelines (QS11.6).

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

Recommendation 10: The Department is to provide a report to the Ombudsman, within six months of the finalisation of this child death review, outlining the outcomes of the Department's three-month project to analyse pre-birth planning data and activity (in accordance with the *Bilateral Schedule: Interagency Collaborative Processes when an Unborn or Newborn Baby is Identified as at Risk of Abuse and/or Neglect (2013)*) across each of the Department's seventeen Districts.

Steps taken to give effect to the recommendation

The Department provided this Office with a letter dated 10 January 2018, in which the Department relevantly informed this Office that:

> Several options relating to the ongoing implementation of the pre-birth planning process are currently being considered to:
>
> - Better manage the increase in volume of pre-birth meetings
> - Improve consistent facilitation of pre-birth meetings
> - Improve recording and data collection to more accurately reflect the time and effort required of child protection workers to do pre-birth planning.

This Office subsequently requested that the Department updates the Office on 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 15 April 2019, containing a report prepared by the Department.

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

> **Pre-birth Planning**
>
> To give effect to this recommendation, Communities has provided a response on 9 January 2019, to the [infant] Child Death Review, and provided copies of the Signs of Safety Audit Report 2016 and the Pre-Birth Position Paper (December 2017). This response informed that no further analysis report regarding Pre-Birth Planning was being developed.
>
> **Update on pre-birth planning initiatives**
>
> The Bilateral Schedule between Communities and the Department of Health remains subject to review. The existing Schedule remains fully functional, and pending the outcome of the joint review.
>
> In February 2019, two new temporarily funded Senior Practice Development Officers (SPDOs) were recruited to the Professional Practice Unit as part of a pilot with King Edward Memorial Hospital (KEMH) and Fiona Stanley Hospital (FSH). The two SPDOs are tasked with facilitating the majority of pre-birth meetings for women birthing at KEMH and FSH.
>
> The pilot is focussed on improving the consistency and quality of facilitation, early engagement and safety planning with families where there are risks for an unknown child. This will be enabled / supported by:

- having the same (experienced and skilled) facilitator complete all three meetings;
- improved independence with the facilitator being from Professional Practice Unit – independent from the Districts and decisions being made by the District staff; and
- specific consideration by the facilitators around key areas such as engagement with Aboriginal families and engagement of perpetrators of family and domestic violence in the pre-birth planning process.

To support improvement in pre-birth practice and facilitation state-wide, work is progressing on the development of a CPM entry specific for pre-birth planning and training packages on pre-birth engagement and planning with families and facilitation of meetings, including expectations of the facilitator and child protection staff, before, during and after pre-birth meetings. The training and CPM entry will align closely with the 'Responding to High Risk Infants' content with a focus on the development of robust safety plans. This training will roll out during 2019.

Systems have been developed to centrally coordinate and enable the Professional Practice Unit to track pre-birth activity across the state and collect additional data (such as lawyer assisted meetings, evidence of engagement with families prior to the first meeting, attendance by Aboriginal Practice Leaders at meetings, and engagement with fathers in the pre-birth planning meetings).

The KEMH and FSH 12 month pilot will be evaluated.

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

Recommendation 11: The relevant the Department's Regional District reiterates to staff with the delegated responsibility to approve critical decisions for the child's best interests, including but not limited to approvals of SWA and case closure, what their responsibilities are in providing such approvals.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

Delegated Responsibility to approve Critical Decisions

To give effect to this recommendation, the relevant Regional District Director affirmed the Senior Practice Development Officer quality assures all SWA's that include pre-birth planning, with District Director approval required where the decision is made that the child will remain in the care of the parents post birth.

The relevant Regional District created an Action Plan in relation to [infant] which captures effectiveness of the actions taken, with stronger emphasis on monitoring of SWAs, and a review of safety plans completed.

Compliance

Communities produce *Standards Monitoring Reports* for each District on a 2-yearly cycle, the standards were revised and updated in 2018. The relevant

Regional District, in the February 2017 Final Report received commendations in numerous areas, those relevant to this recommendation include:

- The Districts continued efforts in the engagement of families and other significant stakeholders through the use of the Signs of Safety Framework to assess safety for children during Safety and Wellbeing Assessments; and
- The improvement of the District in completing written safety plans that were reviewed appropriately and involved families and children when a concern exists for the safety and wellbeing of a child.

The *Critical Priorities and Operational Reports* demonstrates compliance of Safety and Wellbeing Assessments. In 2018, the relevant Regional District recorded compliance of 77% with Priority One (within 1 day), 84% compliance of Priority Two (within 5 days).

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

Recommendation 12: That the Department reviews this case and determines what actions should have been taken by the District to continue to engage with this family to 'effectively assess risks and respond to the needs of the child/family', between 23 November 2015 and [Child C's] death in February 2016, to provide guidance in working with future cases where there are similar circumstances of '[h]ighly mobile and/or transient children and families'.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

Background

The relevant Regional District, following a review of this case acknowledged the missed opportunities to for co-working with Districts when clients move locations frequently. There was a further missed opportunity to engage with the Aboriginal Practice Leader to support the management of this case.

The relevant Regional District facilitated combined development days with relevant Regional Districts with key discussions relating to transience as a risk factor when assessing vulnerable infants and children.

The relevant Regional District Action Plan developed following the death of [infant] references many key actions relevant to this case, in particular:

- Placing a stronger emphasis on the monitoring of SWA's, particularly relating to pregnant women who have, or may historically have had children in care;
- Closer working relationships and communications across the relevant Regional District offices and neighbour Districts that results in shared case management responsibilities; and
- Ensuring supervision is completed compliant with policy and guidelines.

Professional Development

Communities has introduced Learning and Development workshops and Online Learning resources relevant to High Risk Infants. Learning and Development data

confirms that from 2015 to February 2019 254 staff have completed the eLearning Online: *Safe Infant Sleeping*.

Refer to Recommendation 5: *Professional Development workshops*

Refer to Recommendation 10: *update on pre-birth planning initiatives*.

Casework Practice Manual

'*Case allocations, management, transfer, requests for co-working or services, shared case management and case closure'* now forms Chapter 2.2.3 of the revised CPM. The CMP provides guidance to child protection workers on procedures when allocating cases for case management, transfer, shared case management, requesting co-work or services for child protection matters and children in the CEO's care, and the case closure process.

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

Recommendation 13: The Department is to provide a report to the Ombudsman, by 31 December 2017, outlining:

- **Actions taken by the relevant Regional District to address the identified areas and learning opportunities requiring consideration, and inform of their effectiveness; and**
- **Outcomes of the review of the Safety and Wellbeing Assessment approved on 10 November 2015.**

Steps taken to give effect to the recommendation

The Department provided this Office with a letter dated 11 October 2018, in which the Department relevantly informed this Office that:

> An independent SWA review was undertaken of the Safety and Wellbeing Assessment (SWA) of [infant] completed by the relevant Regional District. The SWA commencement date was recorded as at 27 May 2015, with a decision date of 10 November 2015. The SWA was closed as it was assessed that [infant] did not suffer significant harm [actual harm] as a result of neglect.
>
> The reviewer noted;
>
> - The SWA investigation was not completed in accordance with policy requirements that were relevant from May 2015 to December 2015.
> - The district did not screen or use the screening tool for domestic violence as per 4.1 Assessment and Investigation Process as well as 5.1 Family and Domestic Violence Screening and Assessment.
> - As per 5.1 Family and Domestic Violence Screening and Assessment the district did not seek supplementary information (FDVIR) from the WA Police and there is no documentation that staff considered convening a Multi-Agency Case Management meeting (MACM) or providing a referral to the Women's Domestic Violence Helpline.
> - The district did not record family and domestic violence as a secondary issue as per 4.1 Assessment and Investigation Process as well as 15.2 Alcohol and Other Drug Issues.
> - The district did not provide and discuss with the parents information on safe infant sleeping and record this within the SWA Outcome Report as per 4.1 Assessment and Investigation Process.

- The district did not record in the body of the SWA Outcome Report that they discussed with the mother the risk associated with alcohol misuse, risk of foetal alcohol spectrum disorder (FASD) and other post-natal complications for the baby as per 15.2 Alcohol and Other Drug Issues.
- The assessor was not able to locate the District Directors approval within the body of the SWA Outcome Report for the safety plan and or that the baby was allowed to be discharged into the care of his parents.

The independent review recommended that the relevant Regional District substantiate likelihood of significant harm (neglect) for the unborn baby given her mother's alcohol misuse and the domestic violence between the parents. The specific evidence listed in the SWA that the worker should have relied on to inform an assessment of substantiated likelihood of significant harm (neglect) is that the FDV report stated that [mother] was 12 weeks pregnant and both parents were consuming alcohol when the reported FDV incident occurred.

The Department also provided a copy of the Action Plan, outlining progress toward the identified areas of learning, the effectiveness of implementation strategies including what actions have been undertaken to meet the outcomes from the SWA review. This Office's review of this Action Plan confirms steps are being taken by the Regional District to address the identified areas and learning opportunities requiring consideration. The Action Plan includes information on the effectiveness of these actions.

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

Recommendation 14: The Department develops the necessary strategies to assist the relevant Regional District Office in providing 'formal individual supervision' in accordance with Chapter 4.1 *Accountability, Governance and Conduct, Supervision in case practice/service delivery* of the Department's *Casework Practice Manual*.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

Formal Individual Supervision

To give effect to this recommendation, Communities Executive has placed greater importance on Staff Supervision with respect to its oversight role. Since October 2018, Communities has added Staff Supervision to its Critical Priorities measures that will inform to what extent tasks have been completed, in the required timeframe.

Compliance

The relevant Regional District Director has confirmed that *'Supervision remains a priority in the District'* and compliance has improved since 2015. The data available for relevant Regional District Office, records a percentage increase from 54.5% in January 2016 to 72.7% in December 2018.

In the Department's report for Recommendation 14, the Department also referred this Office to the response for Child Death Review Recommendation 23, in which the Department relevantly informed this Office that:

> **Casework Practice Manual**
>
> '*Supervision in case practice / service delivery*' now forms Chapter 4.1.7 of the revised CPM to support regular and high quality individual supervision in case practice / service delivery that supports children and young people in the CEO's care to have improved life chances. Supervision in case practice protects children and young people from abuse and neglect and supports family and individuals at risk or in crisis to manage their lives and keep themselves and their families safe.
>
> **Professional Development**
>
> Communities Learning and Development provide *Supervision and Performance Management* training to equip Team Leaders with the skills, knowledge, attitude and tools to provide supervision to practitioners who are working with vulnerable children and families. Learning and Development will be holding Supervision training for Team Leaders monthly from July 2019, including training delivered to the District corridors to ensure staff compliance with the Casework Practice Manual. District Directors from regional and remote offices support staff to attend Perth to complete the training.

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

Recommendation 15: In developing the next Learning and Development Centre's 'Learning Pathways Map', the Department documents what core Learning and Development Centre training programs are mandatory, across the specific positions (i.e. Case Worker, Team Leader etc) and the timeframe in which they must be completed following commencement to this position.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

> **Learning and Development Pathways Map**
>
> Communities rolled out the new *Child Protection Learning Pathway* in August 2017. The revised *Learning Pathway Map* is mandatory for new staff appointed to the following positions: Child Protection or Field Worker; Aboriginal Practice Leader; Senior Practice Development Officer: Case Support Officer; Youth and Family Support Worker and Parent Visitor: The Child Protection Foundation Orientation Programs are compulsory for new practitioners and will link to workplace assessment, capability and competency development, and supervision.
>
> *Child Protection Learning Pathway*:
>
> Child Protection Induction: Month 1
>
> Child Protection Foundation: Month 1 – 6
>
> - Orientation Program 1: *Child Protection and Signs of Safety*
> - Orientation Program 2: *Trauma-Informed Assessment*

- Orientation Program 3: *Intensive Family Support*
- Orientation Program 4: *Care Team Approach*

Child Protection Foundation Plus: Months 7 – 12

- Core
  - *Family and Domestic Violence*
  - *Aboriginal Cultural Responsiveness*
  - *Responding to High Risk Infants*
  - *Promote change with families with multiple and complex needs*
- Signs of Safety
  - *Safety Planning with Words and Pictures*
  - *Purposeful Conversation Using 3 Houses*
  - *Facilitating Family Meeting Pre-birth Planning*
- Specialist Courses
  - *Child Assessment Interviewing*
  - *AOD & Motivational Interviewing*
  - *Responding to Aggression or TCI for Families*
  - *Carer Assessor*
  - *Circle of Security*

Continuing Professional Development: 1 – 3 years:

It is noted that the Department's report outlines the Learning and Development Pathway Map for Child Protection or Field Worker; Aboriginal Practice Leader; Senior Practice Development Officer: Case Support Officer; Youth and Family Support Worker and Parent Visitor. This Office has been informed that a Learning and Development Pathway Map for Team Leaders is currently being developed.

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

Recommendation 16: The Department develops the necessary strategies to assist the relevant Regional District Office to ensure that every staff member completes Orientation Programs 1, 2 and 3 (or equivalent).

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

> To give effect to this recommendation, the relevant Regional District Director negotiated to have the Orientation Program delivered in the District to facilitate greater numbers of staff attending.
>
> The relevant Regional District Director confirmed all staff have completed Orientation Program 1: *Child Protection and Signs of Safety*, and most staff have completed Orientation Program 2: *Trauma-Informed Assessment.* The District Director confirmed plans for staff to complete Orientation Program 3: *Intensive Family Support* training is scheduled for June 2019.

Compliance

Child Protection Foundation - Pilbara	
Orientation 1: *Child Protection and Signs of Safety*	30 staff members
Orientation 2: *Trauma-Informed Assessment*	19 staff members
Orientation 3: *Intensive Family Support*	9 staff members
Orientation 4: *Care Team Approach*	6 staff members

* This table represents the total number of staff members in the relevant Regional District that have completed Child Protection Foundation Orientation Programs 1 – 4 since 2016.

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

Recommendation 17: That WA Country Health Service (WACHS) provides the Ombudsman with a report, by 31 December 2017, to outline what steps have been taken by the relevant regional hospital, in the context of the issue identified by this child death review, to ensure compliance with the *Memorandum of Understanding Pilbara District Pre-Birth Planning, Addendum to: Bilateral Schedule between CPFS and WA Health "Interagency collaborative processes when an unborn or newborn is identified as at risk of abuse and/or neglect."* (2016).

Steps taken to give effect to the recommendation

This Office requested that WACHS inform the Office of the steps taken to give effect to the recommendation. In response, WACHS provided a range of information in an email to this Office dated 11 July 2019, in which WACHS relevantly informed this Office that:

> Identifying women and children at risk at Hedland Health Campus is tracked and followed up by a Registered Midwife. Four clinical portfolio holders across ED, Paediatrics and Maternity assist with this process via a centralised communication process. Multiple reviewers ensure information is not missed.
>
> Quarterly reporting from CPFS detailing Children in Care and under Guardianship is received to update the Patient Administration System WebPAS with a marker ensuring all staff caring for the patient can identify the needs of the child. There has been an increased focus on education and training for staff at the campus for Mandatory Reporting and Appropriate Referral, with ongoing monitoring of compliance.
>
> The interagency collaborative processes, planning and review of information are adhered to as mandated in the safety planning with CPFS for women and families. Pre-birth planning meetings are instigated by either CPFS or WACHS Pilbara, depending on who has identified, or been informed of, a risk to a new- or unborn bub. The clinicians ensure their focus is on the physical and psychological health needs of the mother, and provide education to the mother and families as to how these impact on the pregnancy and birth outcome. Members of the WACHS Pilbara Hedland Health Campus (HHC) clinical team (Paediatrician, Child Health Nurse, School Health Nurse, ED Clinical Nurse and Coordinator of Nursing and Midwifery) also participate in the Pilbara Child Safety Team meetings, held by CPFS monthly. WACHS Pilbara District Medical Officer is involved on behalf of WACHS Pilbara

(even while now located in Central Office) with CPFS liaison and service coordination. Regular (3 times per year) meetings are held between the Coordinator of Nursing and Midwifery and senior CPFS representatives to review the processes and identify where improvements need to be addressed.

Hedland Health Campus clinicians have embedded the outcomes from the project investigating the paediatric safeguarding processes within the hospital (the MADE Project). This included the implementation of the HHC Emergency Paediatric Injury Risk Assessment. These assessments provide a formal basis and evidence for referrals and discussion at the Pilbara Child Safety Team meetings, or specific individual referrals.

WACHS provided this Office with a copy of the WACHS *WebPAS Child as Risk Alert Procedure*. This procedure requires that where 'health and safety' concerns are identified for an 'unborn child', a 'Child at Risk Alert' is 'added to the maternal webPAS record', which is then 'visible across all WA Health system sites for future reference'. The procedure refers to the 'obligation' of WA Health employees to comply with the *WA Health system Guidelines for Protecting Children 2015*, and states that the 'Child at Risk Alert enables the sharing of relevant information across departments, increasing the opportunities to ensure the ongoing safety and protection of children'.

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

Recommendation 18: The relevant Department Regional District takes all reasonable steps to ensure Child Centred Family Support is provided in accordance with the requirements of the *Family Support (Responsible Parenting) Framework (2013)* and Chapter 3.1 *Family Support* of the *Casework Practice Manual*.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

Casework Practice Manual

'*Family Support and Earlier Intervention*' now forms Chapter 1.2 of the revised CPM.

Family Support and Earlier Intervention

To give effect to this recommendation, Communities reformed Responsible Parenting and developed *Family Support and Earlier Intervention* through an engagement and consultation process with various groups, including Department staff, the community services sector, Aboriginal communities, and other government agencies to ensure better linkage with community sector agencies as a part of the overall service capacity.

Communities, along with other government and community sector agencies, developed *Building Safe and Strong Families: Earlier Intervention and Family Support Strategy in 2016* to best work with families whose children are most vulnerable to poor life outcomes. Earlier, intensive intervention with high risk families before problems become entrenched, coordinated across government and

the community services sector increases safety for children and young people and can divert them from the child protection system.

The significantly higher concentration of social and economic disadvantage and absence of support services impacts upon service and program delivery. The delivery of child protection and family support services in many locations, particularly remote locations, are resource intensive, time consuming and a key issue for the District.

Professional Development

In September 2018, Communities Professional Practice Unit rolled out *Family Finding* Training in the relevant Regional District.

Learning and Development's *Orientation Program 3 – Intensive Family Support* provides training on better targeted earlier intervention responses to support families and prevent children entering the child protection system. This training is delivered to: Child Protection workers, Team Leaders, Parent Visitors, Best Beginnings Plus Officers, Senior Practice Development Officers, and Aboriginal Practice Leaders.

Compliance

Communities *Critical Priorities and Operational Reports* are provided to District Directors monthly to monitor work volumes including compliance with Family Support.

The relevant Regional District *Critical Priorities and Operational Reports* reveal:

- Parent Support Service active cases held by relevant Regional District have increased by an average of 0.75 cases per month in 2016 to 6.5 cases per month in 2018
- Best Beginnings Service active cases held by relevant Regional District have increased by an average of 51.84 cases per month in 2016 to 117 cases per month in 2018
- Intensive Family Support cases in relevant Regional District have increased by an average of 39.11 cases per month in 2017 to 57 cases per month in 2018

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

Recommendation 19: The relevant Department Regional District takes all reasonable steps to complete Provisional Care Plans and associated health care plans in accordance with the requirements of section 39 of the *Children and Community Services Act (2004)*, the *Care Planning Policy (2016)* and Chapters 10.2 *Provisional Care Plans* and 10.6 *Health Care Planning* the *Casework Practice Manual*.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

Casework Practice Manual

'*Care planning*' now forms Chapter 3.4.1 and '*Health care planning*' now forms Chapter 3.4.8 of the revised CPM.

Refer to Recommendation 6 re: *Building a Better Future*.

Refer to Recommendation 7 re: *Better Care, Better Services.*

Refer to Recommendation 8 re: *Health care planning*.

District Response

To give effect to this recommendation, the relevant Regional District has undertaken several measures to ensure compliance with ss 39, 89, 90 *Children and Community Services Act (2004)*, and *Chapters 3.4.1, 3.4.8* Casework Practice Manual. Consistent with the 11-month planning cycle, the relevant Regional District has developed a spreadsheet to track and plan for provisional care plans, care plans and reviews as they are due. Timely completion is monitored via formal supervision and is reviewed as part of a standing agenda item in the monthly Leadership Team meeting.

All aspects of care planning compliance, including preparation, consultation, distribution and complaints management are a standing agenda item for discussion at the monthly Leadership Team meeting. A review of compliance with care planning (health dimensions) is a standing agenda item on the monthly Leadership Team meeting agenda.

The Senior Practice Development Officer rotates between teams reviewing files for compliance with care planning requirements and provides feedback to Child Protection Workers and Team Leaders. In addition, the District mentor reviews compliance requirements with Team Leaders weekly.

Compliance

Communities *Critical Priorities and Operational Reports* are provided to District Directors monthly and reveal work volumes and compliance.

Provisional Care Planning Compliance for relevant Regional District:

Year	Children Entering Care	PPC Care Plan completed on time	% Compliant
Jan 2016	31	19	61%
Jan 2017	24	21	88%
Jan 2018	29	20	69%
Jan 2019	13	9	69%

* The table shows the provisional care planning compliance in the District for the 12 months up to the 1 of January each year.

Communities *WLM Allocated and Monitored Cases per District Planning Cycle No. 20117* at the end of 2017, the relevant Regional District held 28 FTE of which 26.41 was available to manage cases, *Cycle No.20129* revealed at the end of 2018, the relevant Regional District held 29.00 FTE of which 25.70 FTE was available to manage cases.

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

Recommendation 20: The relevant Department Regional District takes all reasonable steps to ensure that assessments of relative carers are completed in accordance with Chapter 9.3 *Care Arrangements with a Family or Significant Other* of the *Casework Practice Manual*.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

District Response

To give effect to this recommendation, the relevant Regional District received support from Fostering and Adoptions Services to conduct overdue *General* and *Family or significant other care* reviews.

Communities Statewide Relieving Team (SRT) commenced in 2017 to provide support to metropolitan and regional and remote Districts. In 2017, SRT provided 107 days of support to the relevant Regional District, and in 2018, 116 days of support to the District. SRT's support has been generally focused on child safety and care team work due to staff shortages.

Refer to Recommendation 6: *Building a Better Future*.

Compliance

Communities *Critical Priorities and Operational Reports* are provided to District Directors monthly and reveal work volumes, including children in relative and significant other care and compliance with carer reviews.

Approved Family Carer Households with up to date reviews:

Year	Approved family carer with children placed	Up to date reviews	% Compliant
Jan 2016	24	11	46%
Jan 2017	20	14	70%
Jan 2018	30	19	63%
Jan 2019	30	16	53%

* The table shows the family carer households with children placed on the 1 January each year. To be compliant the household must have had a review in the preceding 12 months.

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

Recommendation 21: The relevant Department Regional District takes all reasonable steps to ensure that Care Plans are reviewed in the circumstances of a change in placement and include comprehensive cultural plans for Aboriginal children placed with non-Aboriginal carers.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

District Response

To give effect to this recommendation, Communities relevant Regional District recruited a permanent Aboriginal Practice Leader (APL) in 2016 to support cultural planning and assessment and enhanced recording of consultations. The APL reviews all cultural plans for children in care and is formally apart of all consultation and planning for children in care. Team Leaders are working with the APL to review individual cases, and develop a schedule for addressing the outstanding needs of children in care.

Refer to Recommendation 19 re: c*are planning*.

Professional Development

The APL is leading learning and development for staff across the District in culture and key considerations. A report on progress is a standing agenda item on the monthly Leadership Team meeting.

Compliance

Provisional Care Plans endorsed by Aboriginal Practice Leader:

Year	ATSI CIC	Provisional Care Plans Approved	APL endorsed	% Compliant
Jan 2016	147	103	0	0%
Jan 2017	147	97	12	12%
Jan 2018	163	117	15	13%
Jan 2019	157	101	68	67%

* The table represents the children in care in the relevant Regional District on the 1 of January each year. Of these children the table represents those who has a completed provisional care plan in the preceding 12 months. Of these plans the number and proportion of those endorsed by the Aboriginal Practice Leader are shown.

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

Recommendation 22: The Department, in collaboration with a non-government organisation, reviews the support and education provided to the non-government organisation's carers in this case to identify any opportunities for improvement in the future interagency management of children with complex health and care needs placed in out of home care.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

> **The non-government organisation**
>
> The non-government organisation provide a range of placement services to meet the needs of children and young people in the care of the CEO. In accepting the responsibility for the care of a child or young person, the non-government organisation accepts and commits to a high level of accountability and positive outcomes. The non-government organisation has a comprehensive assessment and induction process that all carers complete prior to commencement, ensuring that children and young people are supported only by skilled and confident carers.
>
> The non-government organisation recognises that carers need strong support networks around them and the expertise and skills of qualified Human Services professionals when they are providing support and care to children and young people.
>
> The non-government organisation provides ongoing support to foster carers through the following mechanisms:
>
> - Care team support - Under the General Foster Care Model, each carer has the support of an allocated Care Coordinator who provides avenues to debrief, discuss strategies and provide advice as required. Other members of the Care Team include Supporters of Carers who provide systemic support and development and access to clinical input and Learning and Development staff.
> - Support with behaviour management - There are currently four clinicians attached to the Perth Metropolitan teams. One of their roles is to ensure that carers and Care Co-ordinators have access to positive behaviour support planning that assist in the care and support of the child or young person's needs.
> - Learning and development opportunities - Cares are invited to attend regular training days focusing on a range of topics including behaviour management, working to a case plan, supporting Aboriginal and Torres Strait Islander children in care.
> - 24 hour support - On call telephone support used for duty of care issues or critical incident situations. Designated staff undertake rotational on call duties to ensure carers have access to 24 hour support.
> - Regular networking - Providing carers the opportunity to regularly network with other carers.
> - Carer consultation groups - An opportunity for carers to participate in decision-making processes and contribute to consultative forums regarding foster care issues.
>
> Each carer will have assigned a Care Coordinator who will be available for support and advice. This person will establish with the carer a regular schedule of visits and

will also attend case planning meetings with the carer. Staff are provided supervision, support and training so that they are aware of:

- The legislative and regulatory environment in which they provide care and support
- Policies, procedures and practices relevant to their role
- Strategies and support practices that are encouraged or alternatively restricted or prohibited
- The best ways to support families, children and young people accessing our services.

The non-government organisation uses a range of communication strategies that cater to the needs of internal and external stakeholders. These strategies include a purpose-built Client Information, Recording and Tracking Information System that holds client data. All members of the Care Team are responsible for keeping contemporary and objective case notes that can be used to inform case planning and monitor the development of the child or young person and the case.

Compliance

Communities, through enhancements to procurement of placement services for children in care, will collaborate with the non-government organisation to strengthen communication and reporting mechanisms.

This Office subsequently requested that the Department updates the Office on the steps taken to give effect to the recommendation. In response, the Department provided a range of information in an email to this Office dated 13 June 2019, in which the Department relevantly informed this Office that:

The Department of Communities (Communities) met with the non-government organisation to discuss the level of support provided to carers with children who have complex needs, pursuant to the Ombudsman's Recommendation 22.

As a result, the non-government organisation has strengthened the provision of support provided to carers; including:

The non-government organisation meet with carers on a fortnightly basis to provide clinical and practical support to sustain placements and enhance the child's care experience. The non-government organisation develop safety plans to address acute needs and behavioural concerns of children to help detect and prevent incidents occurring. The non-government organisation on-call support is also provided in conjunction with the routine implementation of client management.

The non-government organisation offers internal and external training to staff and carers, including: First Aid and Medication Administration, Positive Behaviour Support, Trauma and Attachment Workshop, Therapeutic Crisis Intervention, Infection Control and CARE, and Foster Care Training via Communities Leaning and Development.

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

Recommendation 23: The relevant Department Regional District takes all reasonable steps to provide staff supervision in accordance with Chapter 2.4 *Supervision in Case Practice/Service Delivery* of the *Casework Practice Manual* to promote staff compliance with Departmental policies and practice requirements.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

> **District Response**
>
> The relevant Regional District confirmed a supervision schedule for monthly supervision is in place. Despite the best efforts of Team Leaders, staff vacancies (requiring Team Leaders to engage in direct casework due to demand), geographical distance between offices, and competing priorities for staff do impact on the provision of supervision.
>
> **Casework Practice Manual**
>
> '*Supervision in case practice / service delivery*' now forms Chapter 4.1.7 of the revised CPM to support regular and high quality individual supervision in case practice / service delivery that supports children and young people in the CEO's care to have improved life chances. Supervision in case practice protects children and young people from abuse and neglect and supports family and individuals at risk or in crisis to manage their lives and keep themselves and their families safe.
>
> **Professional Development**
>
> Communities Learning and Development provide *Supervision and Performance Management* training to equip Team Leaders with the skills, knowledge, attitude and tools to provide supervision to practitioners who are working with vulnerable children and families. Learning and Development will be holding Supervision training for Team Leaders monthly from July 2019, including training delivered to the District corridors to ensure staff compliance with the Casework Practice Manual. District Directors from regional and remote offices support staff to attend Perth to complete the training.
>
> **Compliance**
>
> Communities HR database revealed relevant Regional District's compliance with supervision has increased by 16% from 2016 to 2018, the District's total average compliance in 2018 was 41.8%.

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

Recommendation 24: The Department takes all reasonable steps to promote compliance with Chapter 14.3 *Alcohol and Other Drug Issues*.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

> **Casework Practice Manual**
>
> '*Alcohol and other drug issues*' now forms Chapter 1.4.1 of the revised CPM which guides child protection workers in assessing and responding to alcohol and other drug issues.
>
> To give effect to this recommendation, Communities requires a Safety and Wellbeing Assessment to be undertaken where alcohol and other drugs are adversely affecting parental functioning. If a young person presents with an alcohol and other drug issue, a referral to Parent Support must be considered and a safety plan developed with the young person and/or their family and carers.
>
> **Professional Development**
>
> Communities deliver an online training module *Alcohol and Other Drugs* to provide child protection workers with a fundamental understanding of the issues associated with problematic alcohol and other drug use.
>
> Communities Learning and Development data confirms that 180 staff have completed the eLearning Online: *Alcohol and Other Drugs – Introduction*, and 101 staff have completed *Assessing Alcohol and Other Drug Problems and Motivational Interviewing*.
>
> Communities staff are also able to access *Alcohol and Other Drug Training* with the Mental Health Commission.

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

Recommendation 25: That the Department ensures that when approving Safety and Wellbeing Assessments the Department confirms that:

- The Signs of Safety Child Framework and associated practice requirements have been implemented;
- Family and domestic violence (FDV) assessment, where appropriate, has been undertaken in accordance with the Department's FDV policy; and
- Drug and alcohol use assessment, where appropriate, has been undertaken in accordance with the Department's *Casework Practice Manual Chapter 14.3 Alcohol and Other Drug Issues*.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

> **Casework Practice Manual**
>
> Safety and Wellbeing Assessment comes under *2.2.2 'Assessment and investigation processes'* of the revised CPM which details the procedures to be followed by child protection workers in relation to safety and wellbeing concerns for a child including where family and domestic violence and alcohol and drug issues are present. Team Leader approval is required for completed outcome reports with casework recommendations addressing harm and care arrangement concerns.
>
> **Safety and Wellbeing Assessments**
>
> Refer to Recommendation 9 re: *SWA Project.*
>
> **Signs of Safety**
>
> To give effect to this recommendation, Communities undertook a review of Signs of Safety through the Reloaded Project to reduce the practice theory gap for staff via professional development and activities in the Monitoring Framework. The *Signs of Safety Reloaded Project* is aligned with the *SWA Project* to streamline implementation. Communities presented The Signs of Safety Reloaded Project to the Ombudsman of Western Australia on 11 November 2018.
>
> The Signs of Safety Capability Matrix focuses on Team Leader / Team Manager's attitudes, behaviours, skill and knowledge in regard to Signs of Safety child protection practice. The matrix supports 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, and parents including their networks and stakeholders. The Team Leader/ Team Manager will self-assess, and then discuss with their line manager during supervision.
>
> **Family and Domestic Violence**
>
> To recognise the significant harm that can be caused by exposing a child to family and domestic violence, the *Children and Community Services Act 2004* was amended in 2016 to provide a definition of emotional abuse which includes exposing a child to an act of family and domestic violence.
>
> 'Family and domestic violence' now forms Chapter 2.3 of the revised CPM which provides guidance and support tools for staff when responding to family and domestic

violence including assessment, safety planning, engaging perpetrators and the benefit of Violence Restraining Orders. The purpose and role of the Family and Domestic Violence Response Teams is also discussed in this chapter.

On 1 July 2016, Communities launched new practice guidance for child protection workers about assessing and responding to family and domestic violence:

- The *Family and Domestic Violence Assessment Toolkit* supports child protection workers to form an evidence based professional judgement whether a child has been significantly harmed, or is likely to be significantly harmed, as a result of exposure to family and domestic violence.
- The *Family and Domestic Violence Safety Planning Toolkit* supports child protection workers to use the knowledge and principles of evidence based family and domestic violence intervention to inform child protection safety planning.
- On 8th June 2018, changes were made to the recording of duty Interactions in Assist, emotional abuse was separated into two different categories, 'emotional abuse – family and domestic violence' and 'emotional abuse – other'.

Communities has shifted focus in relation to cases where FDV is a primary concern. Now, more emphasis is placed on engaging fathers who use violence to hold them responsible for the violence and abuse as opposed to solely working with the victims. The Safe and Together Institute developed the *Safe and Together* model with the understanding that children are best served when agencies can work toward keeping them safe and together with the non-offending parent (the adult domestic violence survivor). The model provides a framework for partnering with domestic violence survivors and intervening with domestic violence perpetrators to enhance the safety and wellbeing of children. Stopping Family Violence, established as a peak organisation for men's behaviour change programs in Western Australia, deliver training in the *Safe and Together* model as accredited trainers. Many trainings have already been delivered to Districts throughout the state…

Professional Development

Communities Learning and Development provide *Supervision and Performance Management* training to equip Team Leaders with the skills, knowledge, attitude and tools to provide supervision to practitioners who are working with vulnerable children and families. Learning and Development will be holding Supervision training for Team Leaders monthly from July 2019, including training delivered to the District corridors to ensure staff compliance with the Casework Practice Manual. District Directors from regional and remote offices support staff to attend Perth to complete the training.

Communities continues to provide a range of key learning opportunities and forums for staff including advanced training and skill development workshops for Team Leaders, Practice Leader days, Learning and Development Networks, and local learning activities. These training opportunities promote compliance and adherence to practice requirements in the application of Safety and Wellbeing Assessments (SWA's), the Signs of Safety Framework, Family and Domestic Violence Policies, and case practice in respect to Alcohol and other Drug Issues.

Refer to Child Protection Learning Pathway – Information Guide.

Compliance

Communities acknowledges the importance of a thorough assessment in guiding staff in the provision and co-ordination of an appropriate response to promote and safeguard the best interests of children and their families where family violence and parental drug and alcohol misuse are present.

Communities *Critical Priorities and Operational Reports* are provided to District Directors monthly. These reports reveal work volumes and compliance with numerous practice areas including Safety and Wellbeing Assessments. District Directors will continue to monitor compliance.

In the Department's report for Recommendation 25, the Department also referred this Office to the response for Child Death Review Recommendation 24, in which the Department relevantly informed this Office that:

> **Alcohol and Other Drug Issues**
>
> **Casework Practice Manual**
>
> '*Alcohol and other drug issues*' now forms Chapter 1.4.1 of the revised CPM which guides child protection workers in assessing and responding to alcohol and other drug issues.
>
> To give effect to this recommendation, Communities requires a Safety and Wellbeing Assessment to be undertaken where alcohol and other drugs are adversely affecting parental functioning. If a young person presents with an alcohol and other drug issue, a referral to Parent Support must be considered and a safety plan developed with the young person and/or their family and carers.
>
> **Professional Development**
>
> Communities deliver an online training module *Alcohol and Other Drugs* to provide child protection workers with a fundamental understanding of the issues associated with problematic alcohol and other drug use.
>
> Communities Learning and Development data confirms that 180 staff have completed the eLearning Online: *Alcohol and Other Drugs – Introduction*, and 101 staff have completed *Assessing Alcohol and Other Drug Problems and Motivational Interviewing*.
>
> Communities staff are also able to access *Alcohol and Other Drug Training* with the Mental Health Commission.

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

Recommendation 26: The Department takes all reasonable steps to achieve compliance with the administration of the Signs of Safety Child Protection Practice Framework and the practice requirements outlined in Chapter 4.1 *Assessment and Investigation Processes* of the *Casework Practice Manual* in response to referrals associated with young people at risk of suicide.

Steps taken to give effect to the recommendation

This 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 15 April 2019, containing a report prepared by the Department.

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

> **Casework Practice Manual**
>
> '*Signs of Safety – child protection practice framework'* now forms Chapter 2.2.11 of the revised CPM and guides child protection staff to work to the *Signs of Safety Child Protection Practice Framework*, including the assessment and investigation of

concerns of abuse and/or neglect, provision of child centred family support and responding to children in the CEO's care.

Refer to Recommendation 25: *Signs of Safety Reloaded Project.*

'*Suicide and self harm'* now forms Chapter 1.4.5 of the revised CPM and guides child protection workers in responding to children, young people and adults with suicidal thoughts and behaviours, and those who self-harm. Communities *Responding to suicidal thoughts or behaviours* resource provides general guidance to child protection workers on how to engage with, and respond to a person experiencing suicidal thoughts or exhibiting concerning behaviours.

Professional Development

Learning and Development's *Orientation Program 1 – Child Protection and Signs of Safety* introduces child protection workers with the knowledge and skills required to respond to child abuse and neglect and to work effectively with children, young people and families in a child protection context. This training is delivered to child protection staff.

Learning and Development in partnership with WA Country Health's Kimberley Suicide Prevention Training Calendar 2019 provides *Aboriginal Mental Health First Aid, Youth Mental Health First Aid,* and *Gatekeeper Suicide Prevention Training* throughout the Kimberley region.

Indigenous Psychological Services (IPS) is providing training in suicide prevention for Aboriginal children and young people through Suicide Prevention in Aboriginal Communities. It is now a requirement that all permanent clinical psychologists complete training in IPS within the first year of their appointment. In 2016-17, 15 clinical psychologists were trained in IPS and in 2017-18 a further 12 completed the training. There are another nine clinical psychologies scheduled to undertake the training in 2018-19.

On 27 July 2018, Therapeutic Care Services facilitated a child protection workshop with a specific focus on suicide awareness, response and prevention. The workshop was attended by 44 Communities clinical psychologists from all regions across the State and included representatives from Youth Justice. The workshop program included two key presentations:

- Demographic data and research around suicide
- Two-hour presentation on dealing with a face to face suicidal client that included a powerful role play

Learning and Development's *Carer Development: The Impact of Attachment Disruption and Developmental Trauma* provides training to staff and carers on attachment and the experiencing of trauma and abuse.

Compliance

To give effect to this recommendation, Communities has strengthened compliance with revised case practice guidance and policies relating to cumulative harm, suicide awareness and prevention through targeted training programs and forums. Communities is working with the Mental Health Commission to develop a screening tool to estimate the numbers of children and young people, with a combination of risk factors / indicators, and considered to be at the highest end of the 'at risk' category.

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

Recommendation 27: DOH develops and implements an appropriate policy associated with the discharge of adolescents from WA Country Health Service (WACHS) Child and Adolescent Mental Health Service.

Steps taken to give effect to the recommendation

This Office requested that WACHS 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 26 April 2019, containing a report prepared by WACHS.

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

- Child and Adolescent Health Service (CAHS) CAMHS now uses the "Transition in Care" Policy. It is currently under consideration for endorsement by WACHS CAMHS.

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

Recommendation 28: DOH takes all reasonable steps to ensure compliance with the WACHS *Missing or Suspected Missing Inpatient Procedure*.

Steps taken to give effect to the recommendation

This Office requested that WACHS 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 26 April 2019, containing a report prepared by WACHS.

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

- All the clinical staff at WACHS Kimberley (WACHS-K) Mental Health Inpatient Unit – Mabu Liyan, are aware of the *WACHS K Absent Without Leave and Missing Persons Procedure*.
- All staff upon induction to the unit are made aware of the policy and how to access it via Healthpoint…

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

Recommendation 29: DOH takes all reasonable and appropriate steps to involve an adolescent's family/community in promoting engagement with mental health services, risk assessment, safety planning and discharge planning.

Steps taken to give effect to the recommendation

This 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 3 April 2019, containing a report prepared by DOH (**the DOH report**).

In the DOH report, DOH relevantly informed this Office that:

DOH

State-wide Standardised Clinical Documentation (SSCD):

In 2014, the Operational Directive 0526/14, State-wide Standardised Clinical Documentation for Mental Health Services came into effect, mandating the use of the prescribed SSCD documents for all WA public mental health services.

The following documents are required under the mandatory policy:

- Triage
- Risk Assessment and Management Plan (Currently on PSOLIS as Brief Risk Assessment)
- Mental Health Assessment
- Physical Examination
- Physical Appearance
- Treatment, Support and Discharge Plan (Currently on PSOLIS as Management Plan)
- Care Transfer Summary.

The Department has a project underway to implement the SSCD onto the Psychiatric Services Online Information System. As an Interim measure, writable SSCD PDFs are available on the Mental Health Unit's Intranet site to allow for the electronic capture of information for those SSCD documents not yet available on PSOLIS…

…The Department has made a submission to the State's Budget process for 2019/20 to gain funding to implement the SSCD onto PSOLIS with the expectation that implementation will be complete by 2021…

Clinical Care of People Who May Be Suicidal Policy:

The Policy references the Policy Supporting Information Document Principles and Best Practice for the Care of People Who May Be Suicidal. Relevant extracts from this document are:

1. Culturally competent care

   Cultural competence enables clinicians to provide care in cross-cultural situations including with Aboriginal people, those from culturally and linguistically diverse backgrounds and people from the lesbian, gay, bisexual, transgender and intersex communities. An awareness of the cultural values and beliefs about health and illness that are held by an Individual and their families are an important consideration in the way that care is provided. (p4)

2. Recognising and responding to people who may be suicidal

   The assessment and decision-making processes relating to the clinical care of a person who may be suicidal is to be conducted In a manner that is collaborative and culturally and development appropriate. Although there are circumstances where a clinician is working alone, most assessments and decisions regarding treatment and safety should be made by a multidisciplinary team in collaboration with the consumer and their family and personal support person. (p5)

3. In balancing risk with safety this document emphasizes:

   - proactive engagement with consumers and their families and personal support person as partners in the risk assessment and safety management process which is based on a trusting relationship. (p5)

4. Assessment must be conducted in collaboration with the individual and where possible and appropriate their family and personal support person and is to encompass:

   a) a detailed evaluation of all aspects of suicidal behaviour and ideation;

b) a psychiatric diagnostic assessment and formulation; and

c) a thorough determination of the psychosocial circumstances contributing to the clinical presentation. In the case of children and adolescents, this involves assessment of parents' / guardians' ability to safeguard their child and contain risk. (p6)

5. The consumer, their family and personal support person should be invited to participate in formal multidisciplinary meetings to develop and review the Safety Plan. Opportunities should be provided for the consumer and their family and personal support person to meet either separately or together, with key clinicians prior to and after the meetings. (p7)
6. The Safety Plan must:
   - formulate strategies to reduce risk and enhance safety which also empower parents/guardians to safeguard the child / adolescent by being active participants in the Safety Plan.
   - identify how the consumer, their family and personal support person and the clinician will regularly monitor the person's safety. (P7)
7. Risk can never be completely eliminated. Positive risk management, which recognises all decisions carry some element of risk, should be integral to the process of safety planning. This approach, which builds on the consumer's strengths and enhances their recovery, is based on a trusting therapeutic relationship and uses the least restrictive practice, it involves:
   - working alongside the consumer and their family and personal support person, weighing up the potential benefits and harms of possible actions (p7)
8. The content of the Safety Plan is to be shared with the consumer, their family and personal support person and if any aspect is not to be communicated, the reason for this decision is to be documented in the clinical file notes. (p8)
9. Discharge plan

   Before discharge, a discharge plan needs to be developed involving the individual and, where at all possible, their family and personal support person. The plan needs to be in a written form and provide details about follow-up arrangements and dates of review appointments, information about community resources, details of services that can be contacted in the event of a worsening of his/her condition and advice about when to return to the ED. The individual and where possible, their family and personal support person should be provided with a copy of the plan, advised to remove lethal means (e.g. firearms) and monitor sudden changes. Patients should not be discharged alone and staff should ensure that family / personal support person are available to supervise in the immediate post discharge period. (p11)

10. Follow-up
    - All people leaving hospital after a suicide attempt or self-harm should be assertively followed up and receive appropriate care from a mental health professional or their General Practitioner (GP). There should be active follow up (e.g. telephone contact, letter, home visit, contacting family member / personal support person) if a person fails to attend his / her post-discharge follow-up appointment to encourage the individual to participate in post-discharge care.
    - People who leave prior to assessment / completion of assessment are at higher risk of repetition and suicide, If a person leaves under these circumstances active attempts at follow-up should be made through phone contact (self and next of kin), or though their GP, mental health services or the police. (p11)

11. Support following self-harm or suicide

> Serious incidents of self-harm or loss of life by suicide are distressing for the person's family, personal support person and friends and for those involved in their care, treatment and support. Mental health services should adopt clear protocols for post-incident management in order to minimise the ongoing impact of such events on staff, family, personal support person and other consumers who may have been involved in, or have developed relationships with, the person. Families and personal support persons should be contacted by the mental health service and offered support as soon as possible after a suspected death by suicide. This should include the offer of referral to bereavement counselling / support services. (p14)…

…HSPs are required to develop / amend local policy within six months of the system-wide mandatory policy publication date that aligns to the Supporting Information Document Principles and Best Practice for the Care of People Who May Be Suicidal. Content of these local policies is monitored by the System-wide Mental Health Clinical Policy Group.

CAHS

The main influence on Child and Adolescent Health Service (CAHS) mental health policy development since 2014 has been the introduction of the Mental Health Act 2014 (MHA).

The MHA has influenced policy review since 2014; also taking into consideration the Office of the Chief Psychiatrist (OCP) Charter of Mental Health Care Principles (Appendix 5). Principle 14 provides guidance on 'Planning which Includes families and carers'.

Family and community engagement with mental health services (for Aboriginal families) is promoted through the Specialised Aboriginal Mental Health Service (SSAMHS). Aboriginal Mental Health Workers (AMHW) establish initial contact upon referral and explain the service to families. They accompany families, where needed, to appointments at CAMHS locations or other suitable locations, including home visits, If appropriate. AMHW's establish close professional relations with the local Aboriginal community and elders to ensure early identification of mental health issues in the children of the community and strive to facilitate early assessment and treatment with an appropriate service. The workers aim to provide a cultural context to the presentation of the child and family at CAMHS and address barriers.

NMHS

North Metropolitan Health Service (NMHS) Youth Mental Health Services (MHS) is a community service that predominantly caters for adolescents between the ages of 16 and 24 years old. NMHS Youth MHS does not provide an inpatient service.

The NMHS Youth Mental Health Service has implemented a checklist utilised at every clinical review (90 day period) of consumers accessing its services. Prompts to engage the consumer's family / significant other through the Youth Mental Health Clinical Review Checklist include:

- A Family, Friend or Carer to support the young person's care, has been identified by the young person and recorded in the medical record
- Welcome Pack provided and discussed with Client and Carer (where indicated)
- The Management Plan has been signed and provided to the Client (and Carer where indicated)
- Discharge Planning commenced with Client and Carer and documented in medical record. If clinically inappropriate this is documented in medical record.

The steps taken by the NMHS Mental Health Adult Program's Sir Charles Gairdner Hospital (SCGH) Mental Health Service include the involvement of a multidisciplinary engagement of the consumer/adolescent, family / carer and any other community involvement in the assessment, care, treatment and discharge planning for the consumer / adolescent This is primarily achieved through individual meetings with the consumer/adolescent as part of ongoing assessment, treatment and discharge planning. Meetings are held with the Clinical Team and consumer/adolescent and family/carer (and significant others) to identify key issues for those involved and to identify strategies and supports to develop a plan for discharge.

Graylands Hospital is an Adult Inpatient Psychiatric Unit for persons aged 18 years and above. On rare occasions, if there is no psychiatric bed available for an adolescent (less than 18 years old), then the following actions are in place:

Adolescents are at least on a 1 on 1 nursing special / chaperone. Family, carers and significant others are involved as part of safety planning, discharge planning and the assessment and management of risk. Patients are repatriated to an adolescent / youth bed as soon as one becomes available. While in the adult setting, age appropriate care is provided. Appropriate liaison and consultation is maintained with the youth services until transfer there.

Community Mental Health Services (CMHS) provide services to adults (18 years and above). Joondalup CMHS only has contact with this client group (adolescent) in an out of hours context, and when this happens they respond as per the Mental Health Act and Child Protection legislation using least restrictive practice but maintaining client safety at all times. Staff would then make sure that Carers and the referring Agency are aware of the outcome of the referral and that it is followed up in normal business hours…

…The Youth Mental Health Clinical Review Checklist was implemented in June 2018.

Stirling CMHS ensures family, carers and significant others are involved as part of safety planning, treatment planning and in the assessment and management of risk. Appropriate liaison and consultation is maintained with the youth services.

The Lower West CMHS approach engages the adolescent, family and any other relevant party in the assessment, care, treatment and discharge planning. This is primarily achieved through individual meetings with the adolescent as part of ongoing assessment, treatment and discharge planning, and meetings with the Clinical Team, adolescent family, and significant others to identify key issues and identify strategies and supports as part of the plan for discharge.

King Edward Memorial Hospital provides a dedicated clinic for adolescent pregnancies which includes access to mental health assessment, monitoring and support. This service extends from the first booking visit in pregnancy through to the delivery, extended inpatient stay (5 days) and up to 6 months mental health follow up post-delivery where required for at risk adolescents. This includes collaboration with parents, families and carers where relevant and support and advocacy around child protection processes.

A targeted adolescent relevant assessment proforma has been developed and is being used to most accurately assess mental health and risk for adolescent patients. It includes information on any child protection issues and family/carer and community agency supports and includes safety and discharge planning. The proforma has been accepted as a standardised form for the Women and Newborn Health Service (WNHS) site and is used to record and communicate regarding adolescent mental health at both intra and interagency levels.

EMHS

- RPBG has a dedicated member of staff (senior Occupational Therapist (OT)) who contact the patient's family soon after the admission (often the same day or next day) to provide information to the family/support person(s) and invite them to a family meeting with the clinical team. Depending on the duration of stay there may be several family meetings where the clinical team discusses with the young person and their family/support person(s) about the goals of admission, diagnosis, treatment, leave, safety and discharge planning. There is also regular liaison in between meetings with families to provide updates on progress and treatment.
- There is a family information session run every alternate Saturday by OT and nursing staff to provide psychoeducation and support to families. Families are provided leaflets on these and there are flyers on the ward with information on these sessions.
- Families are offered resource packs regarding the young person's mental health condition, information on how the family can support the young person and sources of support for the family members themselves.
- All young Aboriginal people are referred to Aboriginal Health Liaison Officers (AHLOs) who liaise with the young person and their families during their admission. AHLOs also attend family meetings where possible.
- The Senior Clinical Psychologist is working on developing brief family interventions for families when our 0.5 FTE Clinical Psychologist resumes. At present, single sessions are offered to families by the Clinical Psychologist for psychoeducation/support that is more specific to the young person's needs as and when requested…

SMHS

The SMHS Rights of Carers and Other Personal Support Persons Policy (which is specific to mental health and applicable to both FSH and RkPG) Includes provision that the carer or close family member of a patient is entitled to be involved in the preparation and review of any treatment, support and discharge plan for the patient This is a reproduction of the statutory provision under s 285(1) of the Mental Health Act 2014. Neither the statutory provision nor the SMHS policy is specific to adolescents.

Other policy/guidelines are either in place or in development and will address this recommendation.

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

Recommendation 30: DOH takes all reasonable steps to recognise and respond to factors impacting upon an adolescent's mental health and safety and wellbeing in a child protection context including consultation with and/or referral to the Department where indicated.

Steps taken to give effect to the recommendation

This 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 3 April 2019, containing a report prepared by DOH.

In the DOH report, DOH relevantly informed this Office that:

> State-wide Standardised Clinical Documentation (SSCD) - see response to recommendation 29…
>
> CAHS
>
> Community CAMHS uses the Choice and Partnership Approach (CAPA), a model of engagement clinical assessment and demand management. CAPA focusses on the experience of the young person, in a collaborative model where clinicians providing the assessment (Choice appointment) act as facilitators for the young person and their family. CAPA provides all families referred to a Community CAMHS service the opportunity to schedule a Choice appointment and determine whether CAMHS is appropriate to their situation.
>
> CAHS is a member of an interagency committee called Young People with Exceptionally Complex Needs (YPECN). This committee is chaired by Child Protection and Family Services (CPFS).
>
> A Bilateral schedule between CPFS and CAMHS outlines the processes for interagency consultation-liaison meetings, referring allegations of child abuse and neglect to CPFS and referring children, adolescents and their families experiencing severe, emotional, psychological, behavioural, social and/or mental health problems to CAMHS.
>
> CAMHS employs Child Protection Consultation Liaison (CPCL) officers to plan and facilitate meetings and promote collaborative working relationships between CAMHS and CPFS. The CPCL officers provide consultation, liaison and training to CAMHS clinicians who are working with children and young people who have experiences of trauma related to maltreatment. CPCL officers also provide consultation and training about Mandatory Reporting and child sexual abuse.
>
> The Community CAMHS Model of Care identifies guiding principles that children and their families have a right to comprehensive and integrated mental health care that meets their individual needs, including timely access to services that ensure assessment, early intervention and treatment Children and families are recognised by CAMHS practitioners as being part of a wider community, and mental health services are viewed as one part of a wider service network. CAMHS staff work in partnership with interagency stakeholders such as Department of Education (DoE), CPFS, Departments of Justice and Disability to influence service delivery via complex case conferences, consultation, liaison and training…
>
> Within the CAMHS inpatient Unit, social work staff provide an advanced social work service and emergency and continuing care to children and adolescents (and their families) with severe mental health disorders within a multi-disciplinary and professional team context. This includes social work assessment, planning and intervention for adolescents and their families and using advanced skills in a range

of therapies including family therapy, individual psychotherapy, parental and couple counselling, group work and other specialist social work interventions as required.

NMHS

The NMHS Youth Mental Health Service ensures that all staff identified as Mandatory reporters complete online training. This training can also be completed by non-mandatory reporters. These staff provide mandatory reports as required.

Youth Mental Health staff refer to and work with DCPFS where child protection issues are identified. Youth Mental Health include DCPFS staff in care planning where the consumer is receiving care from both organisations.

Where DCPFS is involved or other community services, the Social Worker in the NMHS Mental Health Adult Program's Sir Charles Gairdner Hospital (SCGH) Mental Health Service's Consultant Psychiatrist- led multidisciplinary team will coordinate information, liaise with relevant services to support treatment and discharge planning. If there are concerns about the safety and wellbeing of the consumer / adolescent, the Team will take all reasonable steps to recognise and respond to factors impacting on the mental health, safety and wellbeing of the consumer / adolescent.

Community Mental Health Services liaise and refer to DCPFS as required.

King Edward Memorial Hospital provides a dedicated clinic for adolescent pregnancies which includes access to mental health assessment, monitoring and support. This service extends from the first booking visit in pregnancy through to the delivery, extended inpatient stay (5 days) and up to 6 months mental health follow up post-delivery where required for at risk adolescents. This includes collaboration with parents, families and carers where relevant and support and advocacy around child protection processes.

A targeted adolescent relevant assessment proforma has been developed and is being used to most accurately assess mental health and risk for adolescent patients. It includes information on any child protection issues and family/carer and community agency supports and includes safety and discharge planning. The proforma has been accepted as a standardised form (MR086 Youth Mental Health Assessment) for the WNHS site and is used to record and communicate regarding adolescent mental health at both intra and interagency levels.

EMHS

- The unit has a senior social worker 7 days a week and all young people are offered an assessment by the social work team.
- Where there are concerns about the child's safety and wellbeing in the home environment the social worker will liaise and follow-up with DCPFS.
- If the home environment is likely to adversely affect the young person's recovery, social worker requests multiagency meetings where appropriate to discuss discharge planning and recommendations.

SMHS

Fiona Stanley Hospital

- The FSH Family and Domestic Violence Policy provides that where presentation is acute and risk to safety is assessed as high, the hospital should (in partnership with the patient identified as potentially being subject to family and domestic violence) consider referral to the Department of Child Protection and Family Support and other agencies as relevant.
- The Child Protection at Fiona Stanley Hospital Policy is currently under review and could further address this recommendation.

Rockingham Peel Hospital Group (RkPG)

- A Social Worker is involved in all mental health adolescent admissions and assesses if DCPFS involvement is required.
- Mental health, like all other health areas, must comply with mandatory reporting requirements.
- Staff at RkPG mental health have had recent refresher training with the Statewide Protection of Children Coordination Unit (SPOCC).

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

Recommendation 31: The Department is to provide a report to the Ombudsman within six months of the finalisation of this child death review outlining action taken by a Regional District to address the identified areas and learning opportunities requiring further consideration.

Steps taken to give effect to the recommendation

The Department provided this Office with a letter dated 28 November 2017, in which the Department relevantly informed this Office that:

The importance of recording and filing information on the Department's electronic filing system:

- Recording is a standing agenda item for discussion at District Staff Meetings.
- Recording is a standard feature in Supervision sessions with case managers and support officers
- Recording is subject to numerous all staff reminder emails and woven into all local learning sessions.
- Individuals identified with an issue in this area have been targeted for case audits and improvement action.
- Random audits of case files for all teams occur monthly with improvement action implemented where issues are identified.
- A stand-alone session on recording requirements is scheduled for 11 December 2017.

Where concerns for a young person at risk are identified, a consultation must take place with the relevant staff specialist:

- The importance of specialist staff consultation has been reinforced with staff on numerous occasions via emails and district staff meetings.
- Structures have been developed for regular access to specialist staff via Multi-Disciplinary Case Consultation meetings.
- Specialist staff consults form part of supervision discussions.
- Case file audits are undertaken.

Ensure district staff are familiar with the Department's policy on Suicide and Self Harm. Training regarding responses to Suicide and Self Harm will be considered:

- Relevant policy has been circulated and reinforced with staff on numerous occasions via all staff emails and at District staff meetings.
- Suicide Prevention and Intervention Training for relevant staff has been run on 11 and 21 September 2017 with a third session scheduled on 6 December 2017. The intent is, to hold refresher training for staff and ensure incoming staff are trained.

Ensure Safety Plan must meet the required standards as set out in the Signs of Safety Child Protection Practice Framework:

- Staff have received training on safety planning on 16th May 2017 by way of a specific training event.
- Safety planning is woven through all Signs of Safety training delivered in the district. This occurred in February, June and July 2017.
- The District Director must approve all safety plans which are developed as a safe alternative bringing a child into care.
- The District Director signs off on contentious and High Risk Safety Plans.
- Good examples have been shared district wide.
- Safety planning is a topic for conversation at supervision sessions and team meetings as well as Leadership meetings.
- Case audits are undertaken to ensure appropriate Safety plans are in place.

Staff undertake training in assessing child abuse and neglect in respect to cumulative harm:

- Staff development in this area has been woven through local learning opportunities on numerous occasions.
- A stand-alone training session in this area was delivered on 14 November 2017.

This Office subsequently requested that the Department updates the Office on 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 15 April 2019, containing a report prepared by the Department.

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

Compliance

Communities produce *Standards Monitoring Reports* for each District on a 2-yearly cycle, the standards were revised and updated in 2018. The relevant Regional District in the February 2019 Final Report received commendations in Standard 8 *Children and young people are provided high quality and safe care by well trained and supported staff and carers -*

- Staff receive orientation and induction that equips them to perform their duties
- Staff receive ongoing professional development opportunities
- Staff are supported to remain current with contemporary and evidenced based practice in line with the organisation and the Department's frameworks and models of therapeutic care

Summary of District Strengths, relevant to this recommendation, include:

- Learning and Development has been a continued focus for relevant Regional District. At the commenced of each year calendar invites are sent to staff for monthly Signs of Safety meetings. Participation at these training sessions have motivated staff. Other training sessions held locally include Child Assessment Interviewing, Impact of Trauma, Advanced Signs of Safety, Permanency Planning, and Assist which have targeted specific areas of learning as identified by the Leadership Team.

- The APL is proactive in consultations, family findings, and other strategies, such as developing a child-focussed tool for helping Aboriginal children develop their cultural identity. Consultations and recording of consultations have been an area of improvement.

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 family and domestic violence fatalities, 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 2018-19, timely review processes have resulted in 82% 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.

A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce deaths of children by drowning

About the report

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 Office identified that 34 deaths of children by drowning were notified to the Office over a six year investigation period. For this reason, 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.

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 report of the findings and recommendations arising from that investigation, titled *Investigation into ways to prevent or reduce deaths of children by drowning*, was tabled in Parliament on 23 November 2017. The report made 25 recommendations to two government agencies about ways to prevent or deaths of children by drowning. Each

agency agreed to these recommendations. The report is available at: www.ombudsman.wa.gov.au/DrowningsReport.

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

Objectives

- The objectives of the November 2018 report *A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce deaths of children by drowning* were to consider (in accordance with the *Parliamentary Commissioner Act 1971*):
  - The steps that have been taken to give effect to the recommendations;
  - The steps that are proposed to be taken to give effect to the recommendations; or
  - If no such steps have been, or are proposed to be taken, the reasons therefor.
- This report also considered whether the steps taken, proposed to be taken or reasons for taking no steps:
  - seem to be appropriate; and
  - have been taken within a reasonable time of the making of the recommendations.

Methodology

- The Office sought from the Department of Mines, Industry Regulation and Safety and the Building Commissioner a report on the steps taken to give effect to the recommendations arising from the investigation;
- Where further information, clarification or validation was required, the Office liaised with staff from the Department of Mines, Industry Regulation and Safety and the Building Commissioner;
- The Office reviewed and considered the information provided by the Department of Mines, Industry Regulation and Safety and the Building Commissioner and the information, clarification or validation provided to the Office;
- The Office developed a draft report;
- The Office provided the draft report to the Department of Mines, Industry Regulation and Safety and the Building Commissioner; and
- The Office developed a final report.

Summary of Findings

- The Office is very pleased that in relation to all of the recommendations, the Department of Mines, Industry Regulation and Safety and the Building Commissioner have either taken steps, or propose to take steps (or both) to give effect to the recommendations.
- In no instances did the Office find that no steps had been taken to give effect to the recommendations.

Giving effect to the recommendations

- In the report, five recommendations were directed to the Department of Mines, Industry Regulation and Safety:

- Steps have been taken (and in one case are also proposed to be taken) to give effect to four recommendations; and
- Steps are proposed to be taken to give effect to one recommendation.

- In the report, 20 recommendations were directed to the Building Commissioner:
  - Steps have been taken (and, in some cases, are also proposed to be taken) to give effect to 13 recommendations; and
  - Steps are proposed to be taken to give effect to seven recommendations.

It is particularly pleasing that, in giving effect to the recommendations, important improvements have been achieved when compared to the findings identified in the report.

Following the report, the Department of Mines, Industry Regulation and Safety, the Building Commissioner and local governments have made particularly positive progress in the areas of improving consistency and quality of swimming pool inspections and the training and professional development of swimming pool inspectors. The very evident level of national collaboration in relation to portable swimming pools, and Western Australian leadership in relation to this, is also very pleasing.

The death of a child by drowning is a tragedy – for the child's life lost and for the parents, families and communities who have been personally affected by the tragic death. It is the Ombudsman's sincerest hope that the recommendations of the report, and the positive steps that have been taken to give effect to the recommendations, will contribute to preventing and reducing these tragic deaths in the future.

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

Monitoring recommendations from other major own motion investigations

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 three 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 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 Education, the Department of Justice, and Western Australia Police Force also attended the meetings in 2018-19.

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 2018-19 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;
    - The Mental Health Commission;
    - Western Australia Police Force; 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 2018-19 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 Force, Communities and community advocates