# Our Performance in 2018-19

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

# Summary of Performance

## Key Performance Indicators

### Key Effectiveness Indicators

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

| Key Effectiveness Indicators | 2017-18 Actual | 2018-19 Target | 2018-19 Actual | Variance from Target |
|---|---|---|---|---|
| Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies | 100% | 100% | **100%** | Nil |
| Number of improvements to practices or procedures as a result of Ombudsman action | 173 | 100 | **83** | -17 |

Another important role of the Ombudsman is to enable remedies to be provided to people who make complaints to the Office where service delivery by a public authority may have been inadequate. The remedies may include reconsideration of decisions, more timely decisions or action, financial remedies, better explanations and apologies. In 2018-19, there were 182 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman.

### Comparison of Actual Results and Budget Targets

Public authorities have accepted every recommendation made by the Ombudsman, matching the actual results of the past four years and meeting the 2018-19 target.

In 2007-08, the Office commenced a program to ensure that its work increasingly contributed to improvements to public administration.

The 2018-19 actual number of improvements to practices and procedures of public authorities as a result of Ombudsman action (83) is lower than the 2018-19 target (100) as there are fluctuations in improvements from year to year, related to the number, nature and outcomes of investigations finalised by the Office in any given year.

## Key Efficiency Indicators

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

| Key Efficiency Indicators | 2017-18 Actual | 2018-19 Target | 2018-19 Actual | Variance from Target |
|---|---|---|---|---|
| Percentage of allegations finalised within three months | 94% | 95% | **95%** | Nil |
| Percentage of allegations finalised within 12 months | 100% | 100% | **100%** | Nil |
| Percentage of allegations on hand at 30 June less than three months old | 92% | 90% | **91%** | +1% |
| Percentage of allegations on hand at 30 June less than 12 months old | 100% | 100% | **98%** | -2% |
| Average cost per finalised allegation | $1,879 | $1,890 | **$1,895** | +$5 |
| Average cost per finalised notification of death | $17,438 | $17,500 | **$17,816** | +$316 |
| Cost of monitoring and inspection functions | $414,311 | $415,000 | **$415,648** | +$648 |

## Comparison of Actual Results and Budget Targets

The 2018-19 actual results for the Key Efficiency Indicators met, or were comparable to, the 2018-19 target. Overall, 2018-19 actual results represent sustained efficiency of complaint resolution over the last five years.

The average cost per finalised allegation in 2018-19 ($1,895) is comparable with the 2018-19 target ($1,890) and the 2017-18 actual ($1,879). Since 2007-08, the efficiency of complaint resolution has improved significantly with the average cost per finalised allegation reduced by a total of 36% from $2,941 in 2007-08 to $1,895 in 2018-19.

The average cost per finalised notification of death ($17,816) is comparable with the 2018-19 target ($17,500) and the 2017-18 actual ($17,438).

The cost of monitoring and inspection functions ($415,648) is comparable with the 2018-19 target ($415,000) and the 2017-18 actual ($414,311).

For further details, see the Key Performance Indicator section.

## Summary of Financial Performance

The majority of expenses for the Office (75%) relate to staffing costs. The remainder is primarily for accommodation, communications and office equipment.

| Financial Performance | 2017-18 Actual ('000s) | 2018-19 Target ('000s) | 2018-19 Actual ('000s) | Variance from Target ('000s) |
|---|---|---|---|---|
| Total cost of services (sourced from Statement of Comprehensive Income) | $11,931 | $9,985 | **$10,412** | +$427 |
| Income other than income from State Government (sourced from Statement of Comprehensive Income) | $2,214 | $2,135 | **$2,438** | +$303 |
| Net cost of services (sourced from Statement of Comprehensive Income) | $9,717 | $7,850 | **$7,973** | +$123 |
| Total equity (sourced from Statement of Financial Position) | $1,031 | $1,422 | **$916** | -$506 |
| Net increase/decrease in cash held (sourced from Statement of Cash Flows) | -$1,351 | $20 | **$199** | +$179 |
| **Staff Numbers** | **Number** | **Number** | **Number** | **Number** |
| Full time equivalent (FTE) staff level at 30 June | 61 | 66 | **61** | -5 |

### Comparison of Actual Results and Budget Targets

The variation between the 2018-19 actual results and the targets for the Office's total cost of services is primarily due to staffing required to enable the Office to meet the workload associated with the role of the Energy and Water Ombudsman. These costs were fully offset by an increase in revenue.

The variation between the 2018-19 actual results and the target for the Office's revenue is primarily due to additional funding approved by the Board of the Energy and Water Ombudsman (Western Australian) to enable the Office to meet the workload associated with the role of the Energy and Water Ombudsman.

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

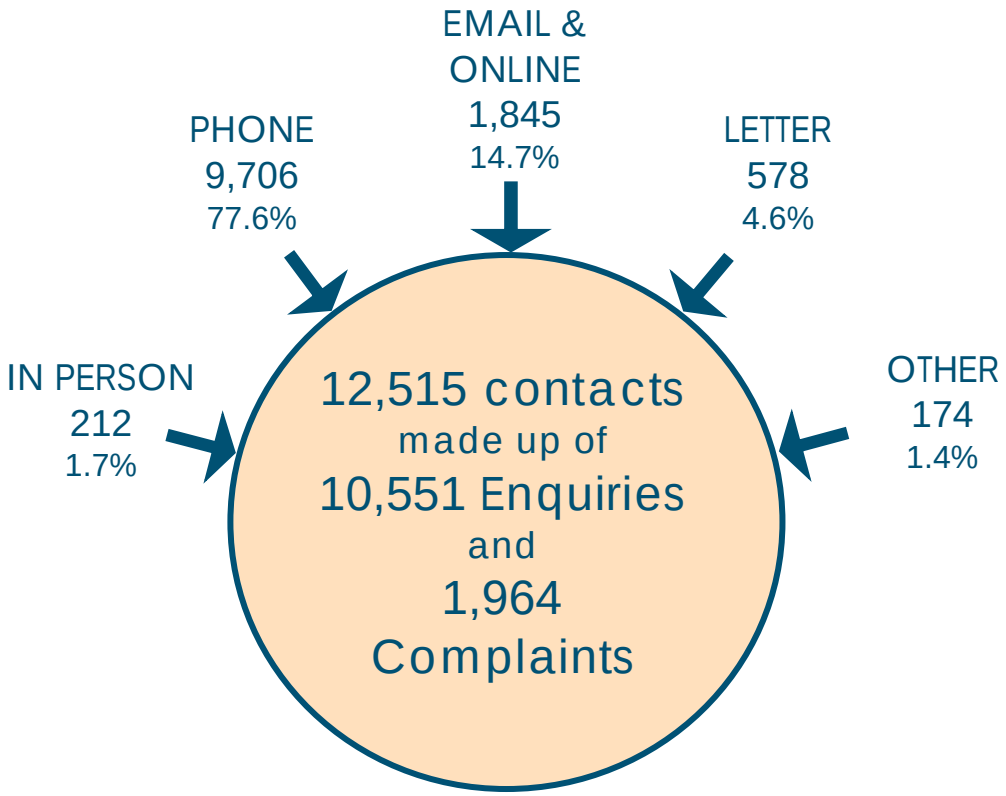
# Complaint Resolution

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

## Contacts

In 2018-19, the Office received 12,515 contacts from members of the public consisting of:

- 10,551 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 1,964 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

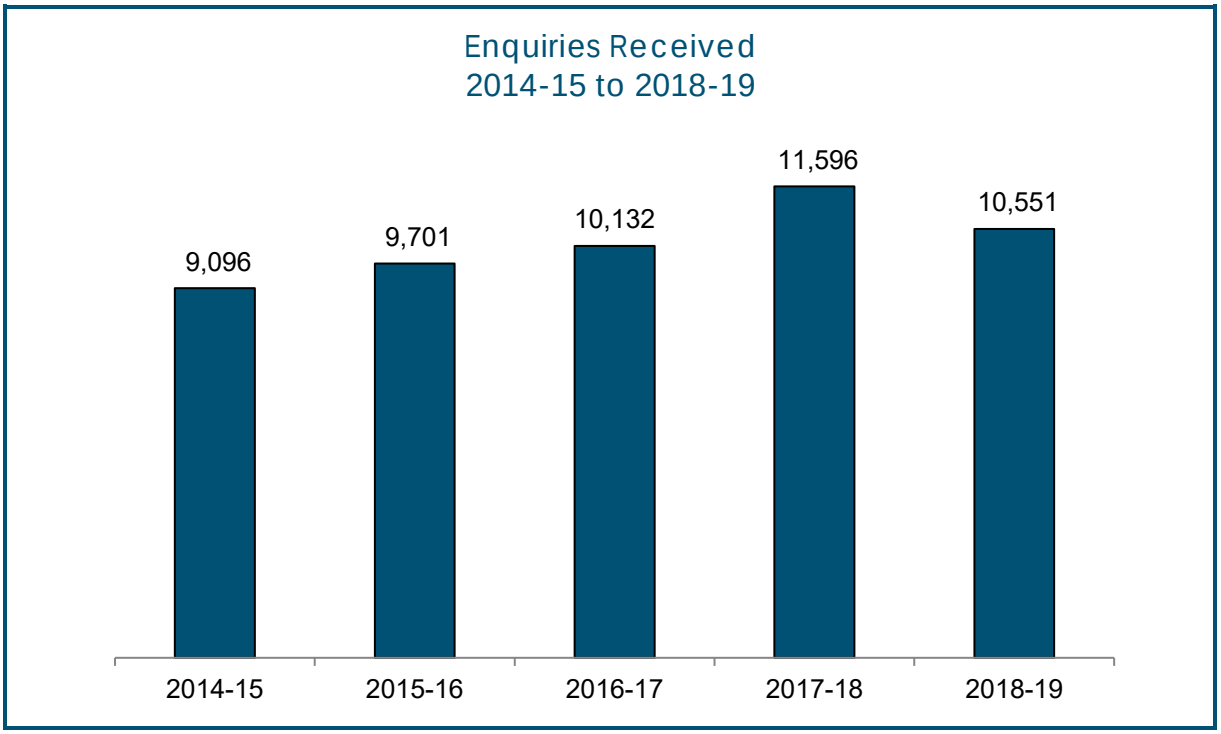


## Enquiries Received

There were 10,551 enquiries received during the year.

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

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

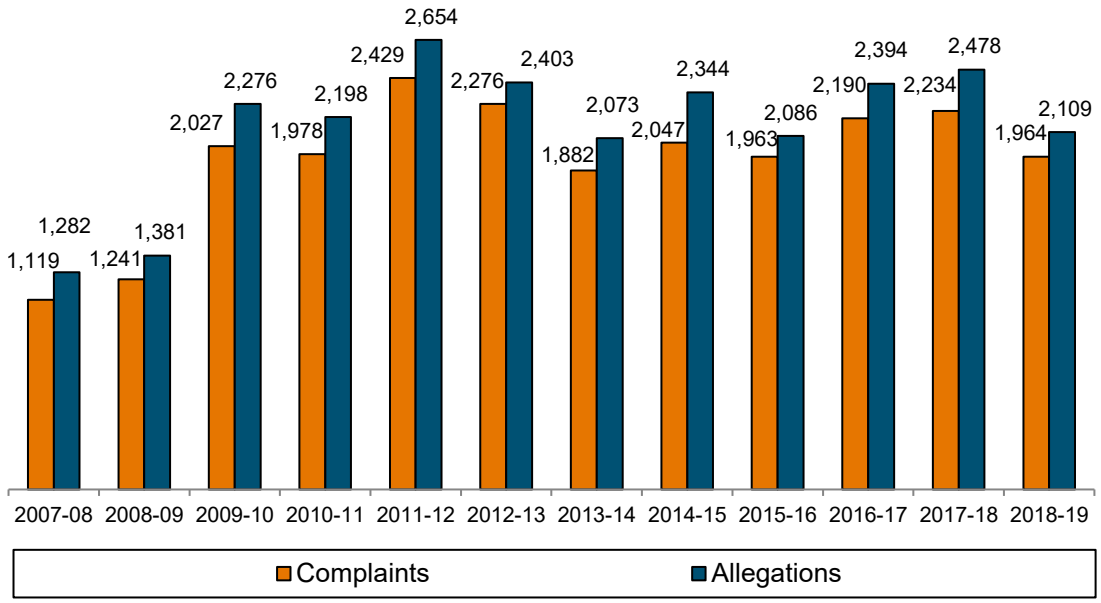



Enquirers are encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

## Complaints Received

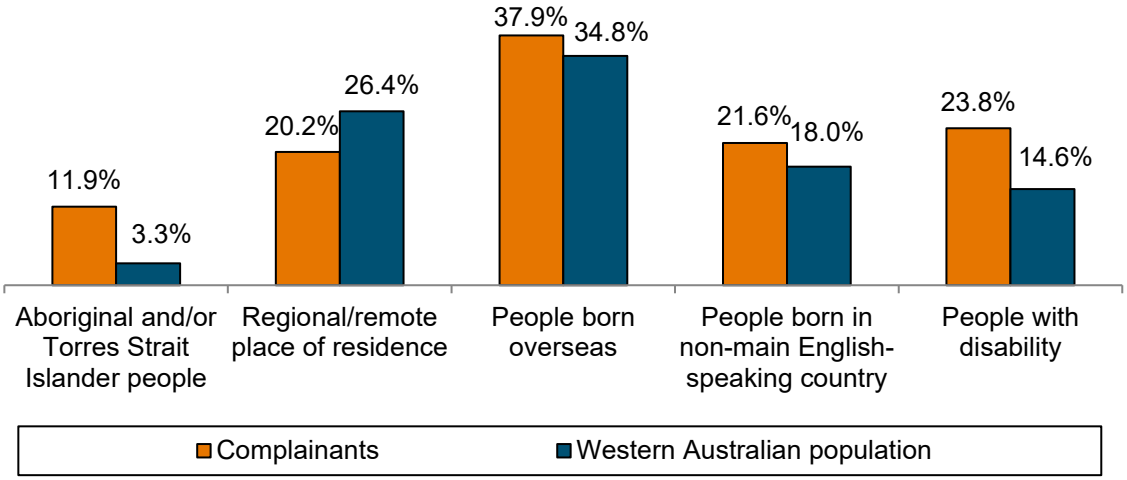
In 2018-19, the Office received 1,964 complaints, with 2,109 separate allegations, and finalised 1,986 complaints. There are more allegations than complaints because one complaint may cover more than one issue.

### Total Number of Complaints and Allegations Received 2007-08 to 2018-19




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

### Characteristics of Complainants in 2018-19

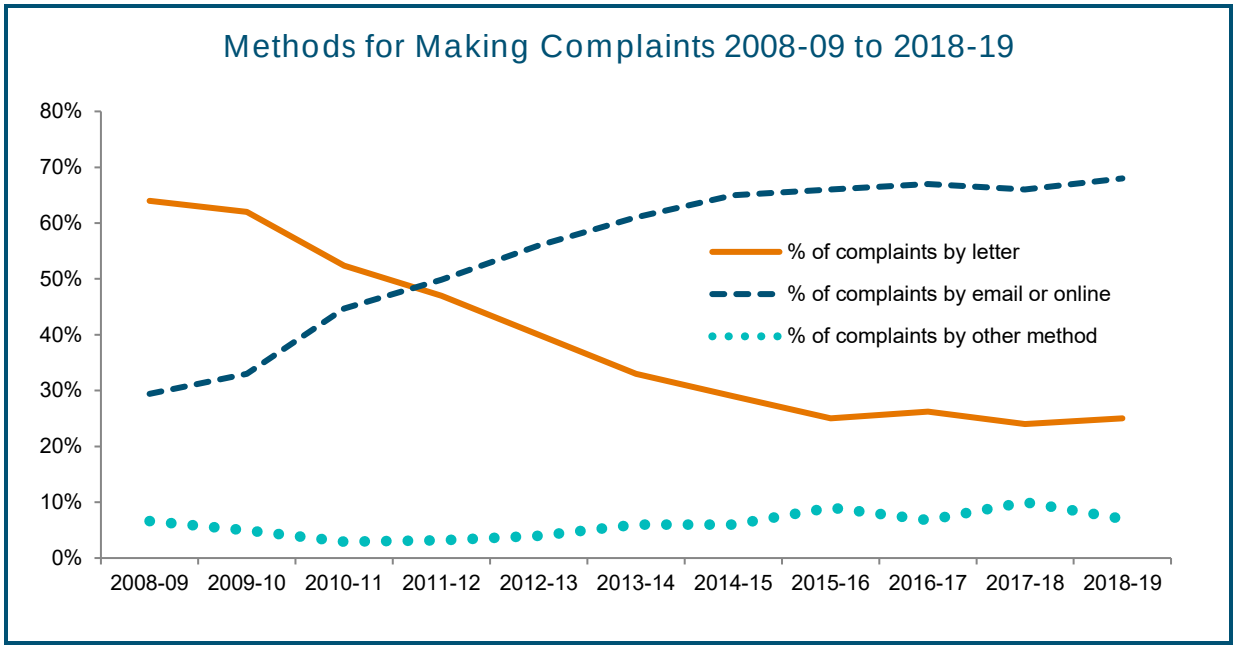



**NOTE:** Non-main English-speaking countries as defined by the Australian Bureau of Statistics are countries other than Australia, the United Kingdom, the Republic of Ireland, New Zealand, Canada, South Africa and the United States of America. Being from a non-main English-speaking country does not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

## How Complaints Were Made

Over the last 11 years, the use of email and online facilities to lodge complaints has increased and the proportion of people who lodge complaints by letter has declined.

In 2018-19, 68% of complaints were lodged by email or online, compared to 25% by letter and seven per cent by other methods including during regional visits and in person.




## Resolving Complaints

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

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

## Time Taken to Resolve Complaints

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

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

Building on the program, the Office developed and commenced a new organisational structure and processes in 2011-12 to promote and support early resolution of complaints. There have been further enhancements to complaint handling processes in 2018-19, in particular in relation to the early resolution of complaints.

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

In 2018-19:

- The percentage of allegations finalised within 3 months was 95%; and
- The percentage of allegations on hand at 30 June less than 3 months old was 91%.

95% of allegations were finalised within 3 months.

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

- The average age of complaints has decreased from 173 days to 48 days; and
- Complaints older than 6 months have decreased from 40 to 6.

## Complaints Finalised in 2018-19

There were 1,986 complaints finalised during the year and, of these, 1,517 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 874 were finalised at initial assessment, 594 were finalised after an Ombudsman investigation and 49 were withdrawn.

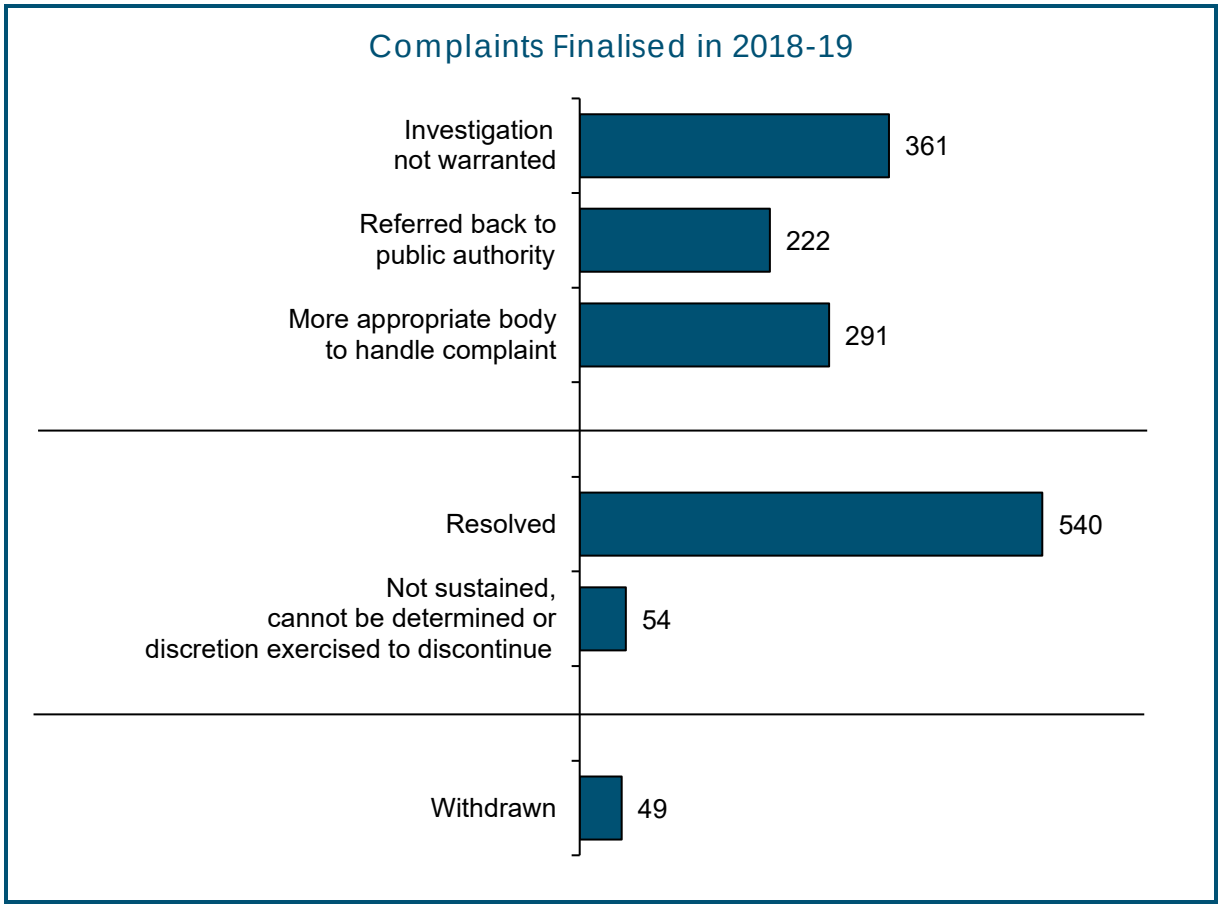
### Complaints finalised at initial assessment

A quarter (25%) of the 874 complaints finalised at initial assessment were referred back to the public authority to provide it with an opportunity to resolve the matter before investigation by the Ombudsman. This is a common and timely approach and often results in resolution of the matter. The person making the complaint is asked to contact the Office again if their complaint remains unresolved. In a further 291 (33%) complaints finalised at the initial assessment, it was determined that there was a more appropriate body to handle the complaint. In these cases, complainants are provided with contact details of the relevant body to assist them.

## Complaints finalised after investigation

Of the 594 complaints finalised after investigation, 88% were resolved through the Office's early resolution approach. This involves Ombudsman staff contacting the public authority to progress a timely resolution of complaints that appear to be able to be resolved quickly and easily. Public authorities have shown a strong willingness to resolve complaints using this approach and frequently offer practical and timely remedies to resolve matters in dispute, together with information about administrative improvements to be put in place to avoid similar complaints in the future.

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

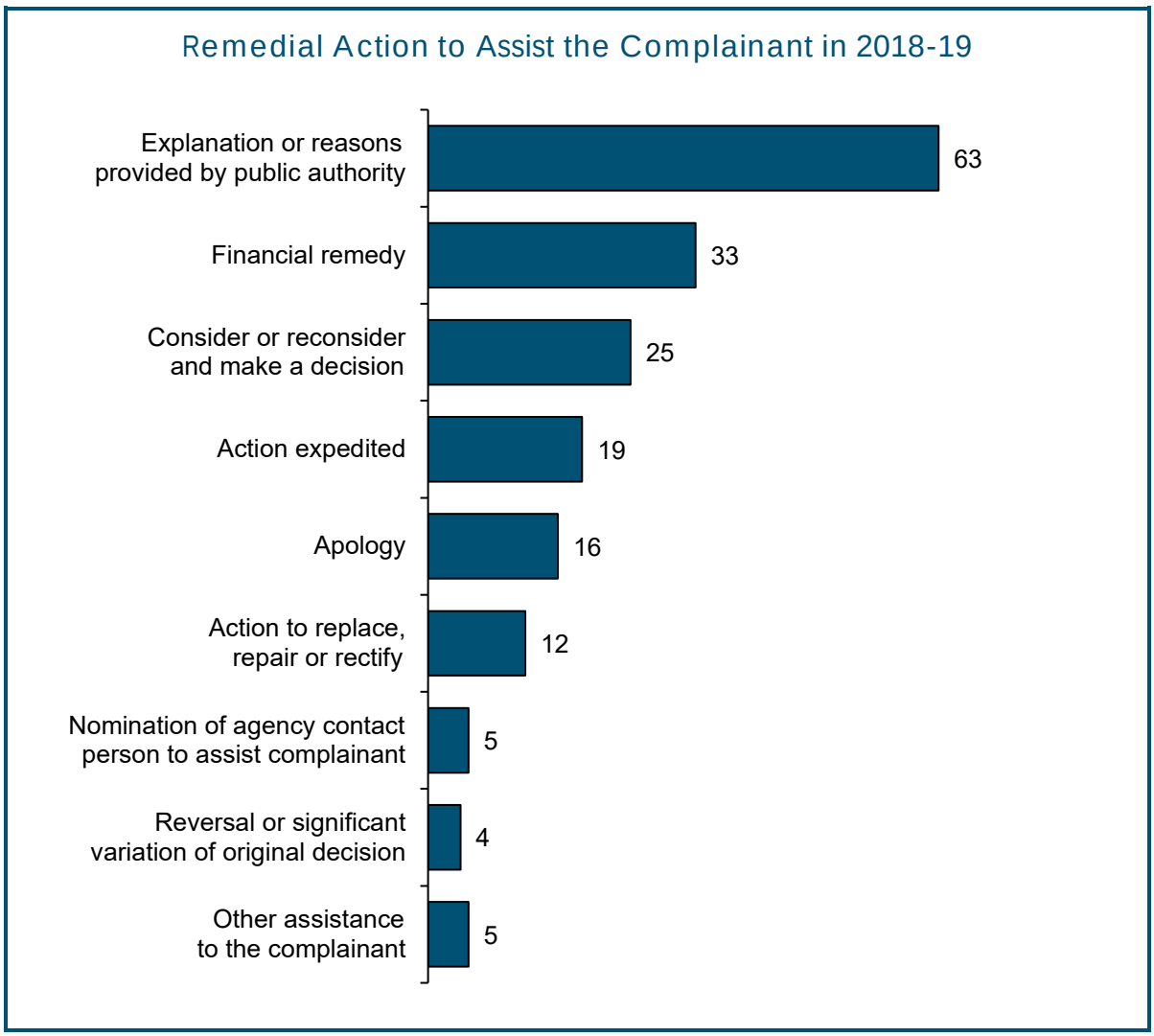



**Note**: Investigation not warranted includes complaints where the matter is not in the Ombudsman's jurisdiction.

## Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2018-19, there were 182 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman. In some cases, there is more than one action to resolve a complaint. For example, the public authority may apologise and reverse their original decision. In a further 56 instances, the Office referred the complaint to the public authority following its agreement to expedite examination of the issues and to deal directly with the person to resolve their complaint. In these cases, the Office follows up with the public authority to confirm the outcome and any further action the public authority has taken to assist the individual or to improve their administrative practices.

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






## Case Study

### Young people get access to the internet

A group of young people living in accommodation provided by a public authority contacted the Ombudsman to complain that they did not have adequate access to the internet. They said this meant they were missing out on education, as they needed the internet for their homework, and could not communicate with their friends.

Following an investigation by the Ombudsman, the public authority acknowledged the provision of internet was an access issue across all accommodation provided by the public authority. The public authority confirmed that it would progress the installation of internet access to all relevant accommodation across Western Australia.

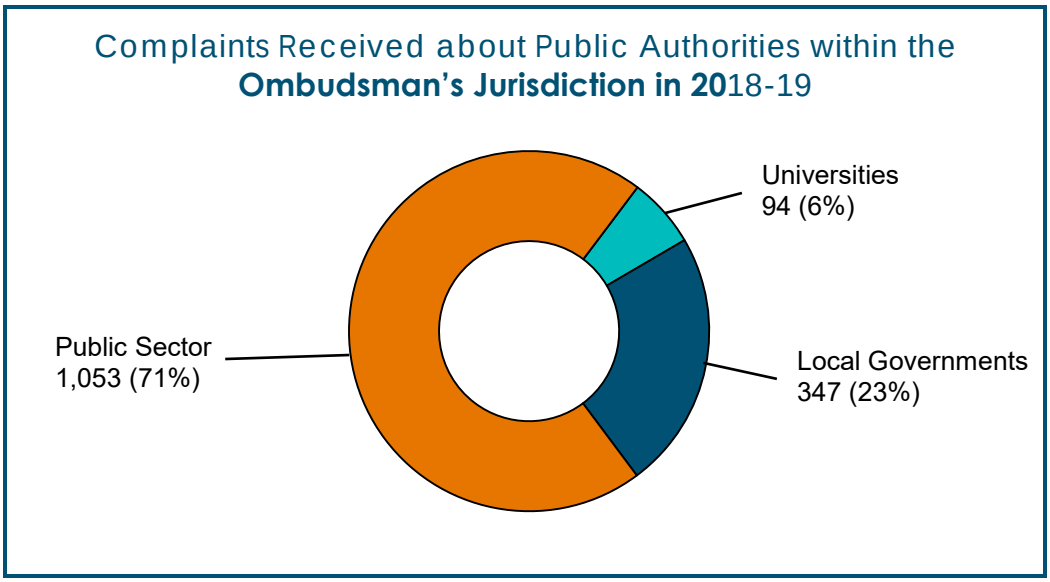
## Outcomes to improve public administration

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

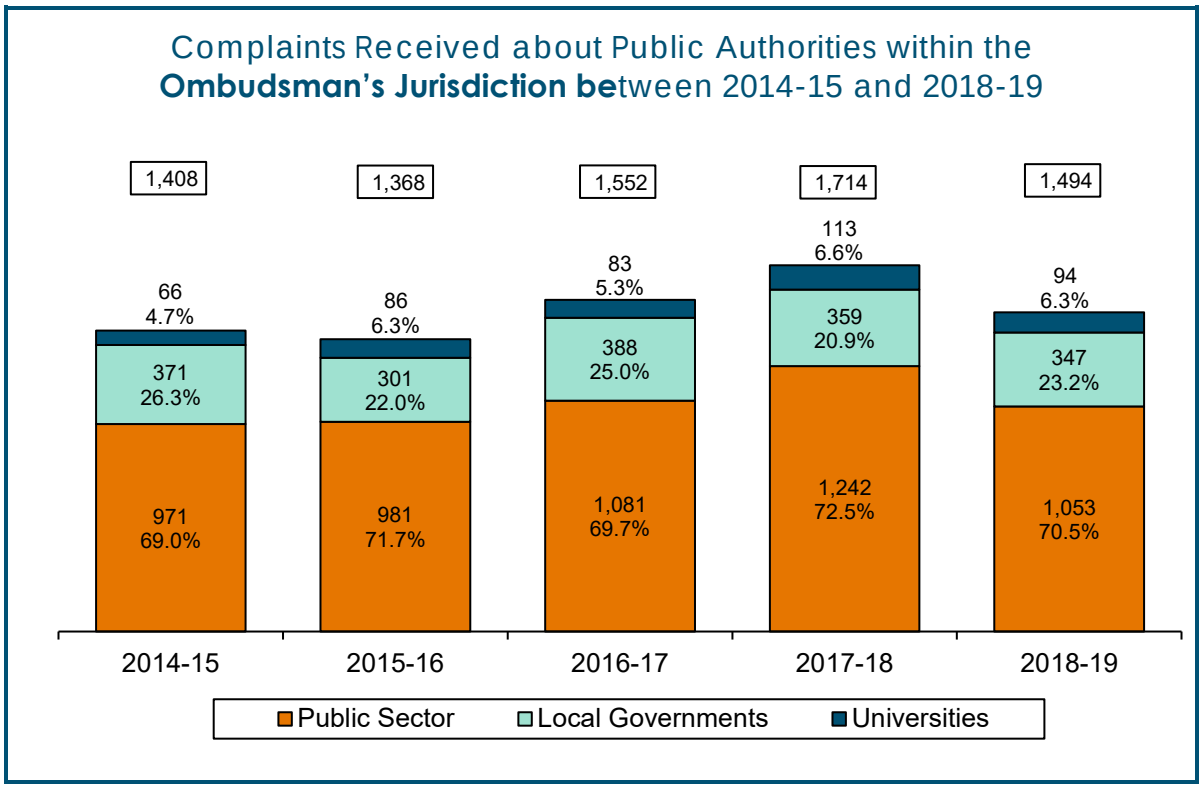
# About the Complaints

Of the 1,964 complaints received, 1,494 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 470 complaints were about bodies outside the Ombudsman's jurisdiction. In these cases, Ombudsman staff provided assistance to enable the people making the complaint to take the complaint to a more appropriate body.

Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (1,053 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (347 complaints); and the university sector (94 complaints).

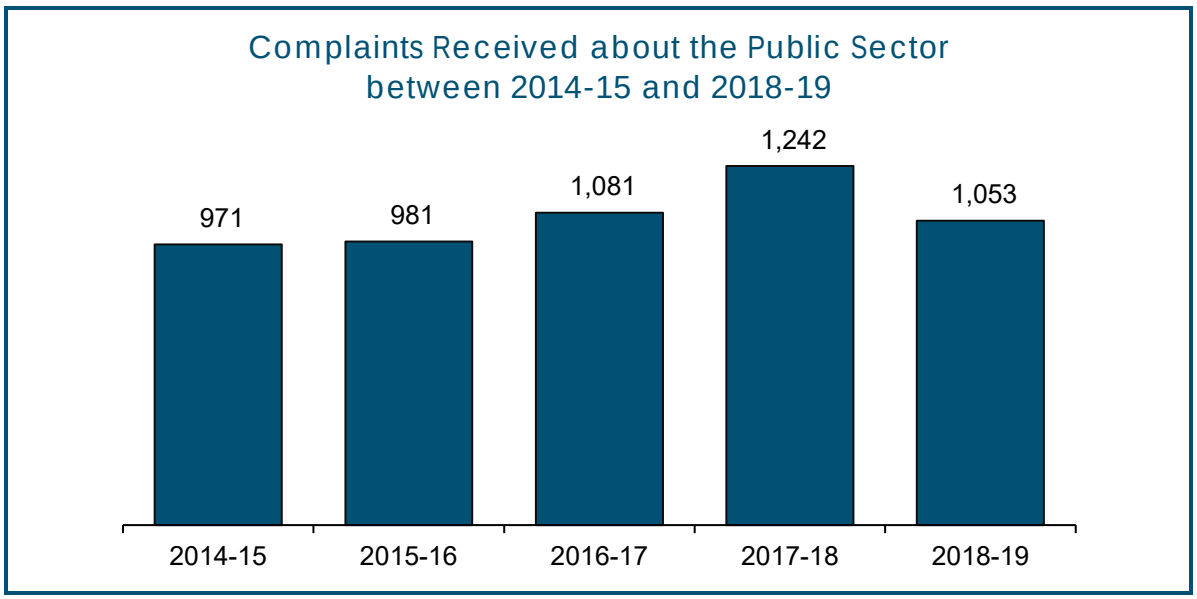


The proportion of complaints about each sector in the last five years is shown in the following chart.

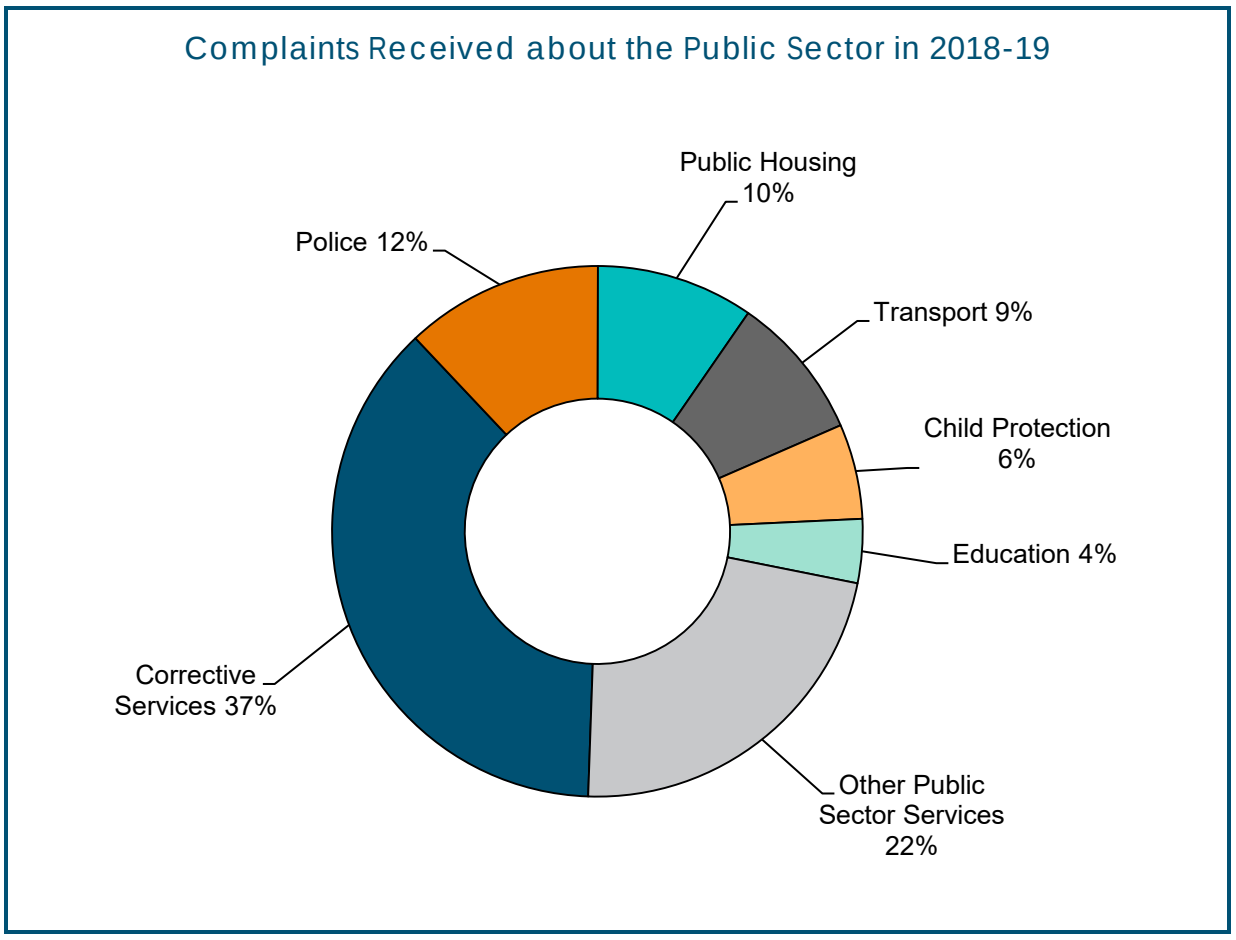



## The Public Sector

In 2018-19, there were 1,053 complaints received about the public sector and 1,070 complaints were finalised. The number of complaints about the public sector as a whole since 2014-15 is shown in the chart below.



Public sector agencies deliver a very diverse range of services to the Western Australian community. In 2018-19, complaints were received about key services as shown in the following chart.




Of the 1,053 complaints received about the public sector in 2018-19, 78% were about six key service areas covering:

- Corrective services, in particular prisons (394 or 37%);
- Police (127 or 12%);
- Public housing (101 or 10%);
- Transport (93 or 9%);
- Child protection (61 or 6%); and
- Education, including public schools and TAFE colleges (41 or 4%). Information about universities is shown separately under the university sector.

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

## Outcomes of complaints about the public sector

In 2018-19, there were 161 actions taken by public sector bodies as a result of Ombudsman action following a complaint. These resulted in 129 remedies being provided to complainants and 32 improvements to public sector practices.

The following case studies illustrate the outcomes arising from complaints about the public sector. Further information about the issues raised in complaints and the outcomes of complaints is shown in the following tables for each of the six key areas and for the other public sector services as a group.


### Charges to tenant waived and staff training provided

A tenant was charged by a public authority for repairs and maintenance after the tenant had vacated the property and a third party entered the property and caused damage. The tenant complained to the Ombudsman that their individual circumstances meant they were not liable for the charges.

Following enquiries by the Ombudsman, the public authority reviewed the charges and acknowledged that the correct procedures had not been followed. As a result, the public authority agreed to waive the charges and conduct training to avoid a similar occurrence in the future.

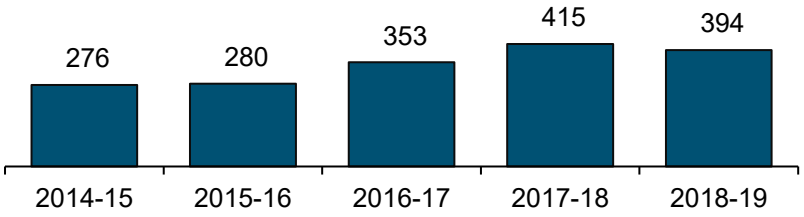

### Prison phone charges reviewed

A prisoner complained they were being charged incorrectly for outgoing telephone calls to a local number in the metropolitan area.

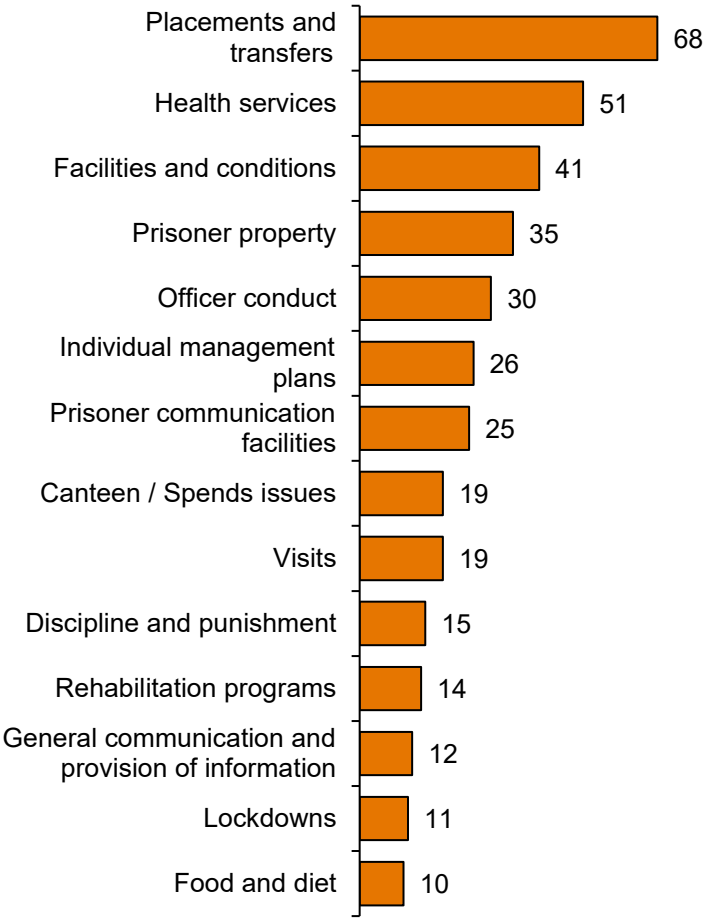
Following enquiries by the Ombudsman, the public authority reviewed the charges and determined the call rate was incorrect. The public authority apologised to the prisoner and reimbursed the overcharged amount. The public authority also agreed to review the charges from the site to ensure no one else was similarly overcharged and change the telephone software programming to reflect the correct call rate.

## Corrective Services

### Complaints received




### Most common allegations

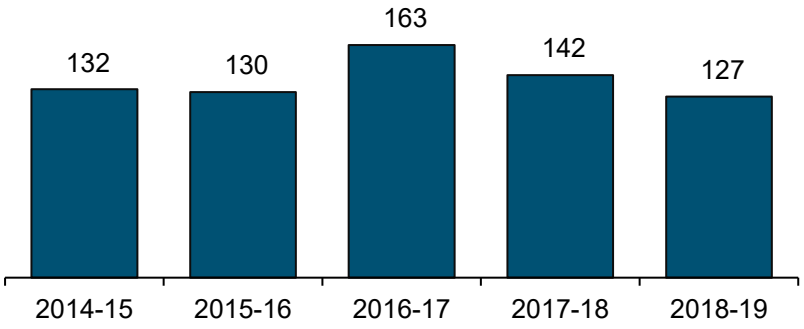



### Outcomes achieved

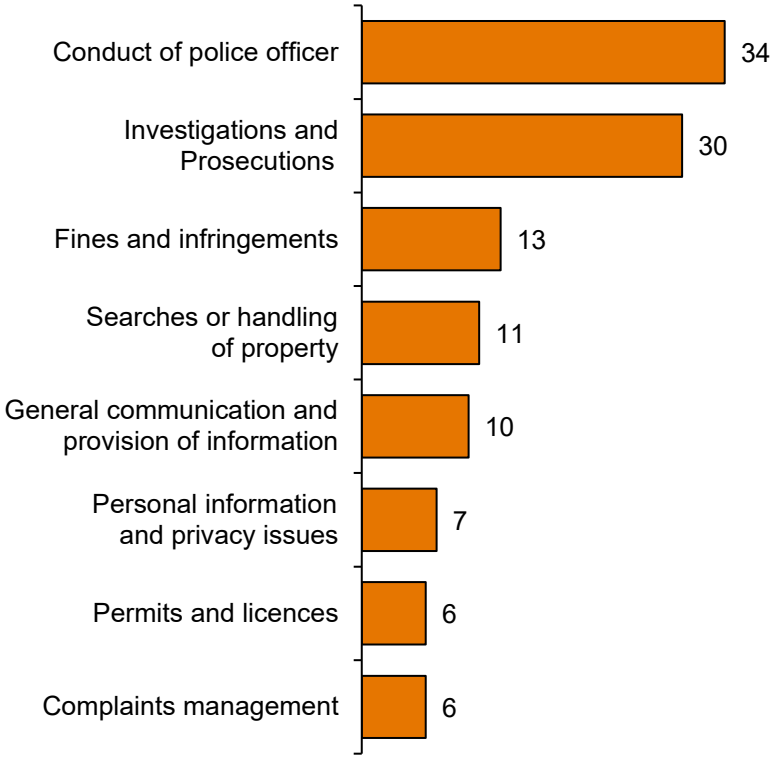
- Financial payment, or monetary charge reduced/refunded;
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to policy, procedure, business systems or practices;
- Conduct audit or review;
- Improved recordkeeping; and
- Staff training.

## Police

### Complaints received




### Most common allegations

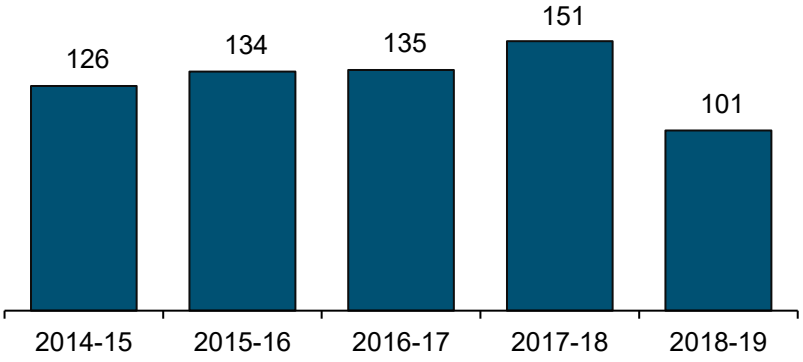



### Outcomes achieved

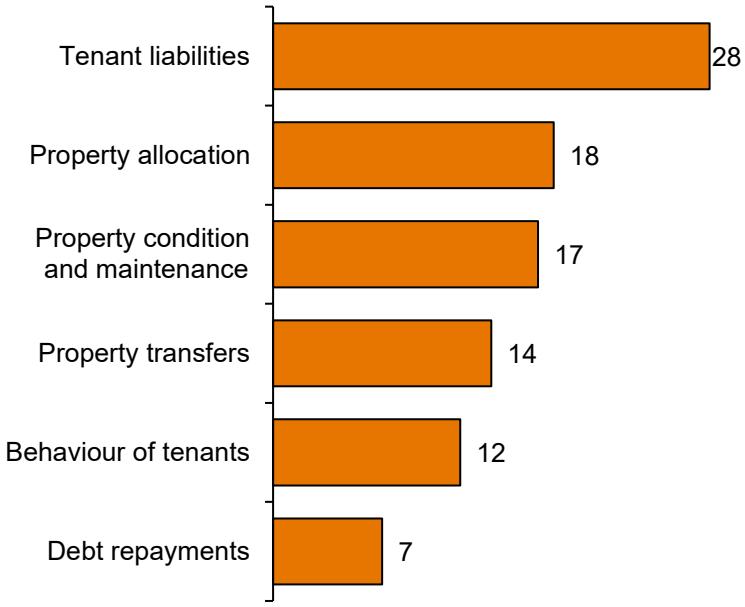
- Apology given;
- Explanation given or reasons provided; and
- Change to business systems or practices.

## Public Housing

### Complaints received




### Most common allegations

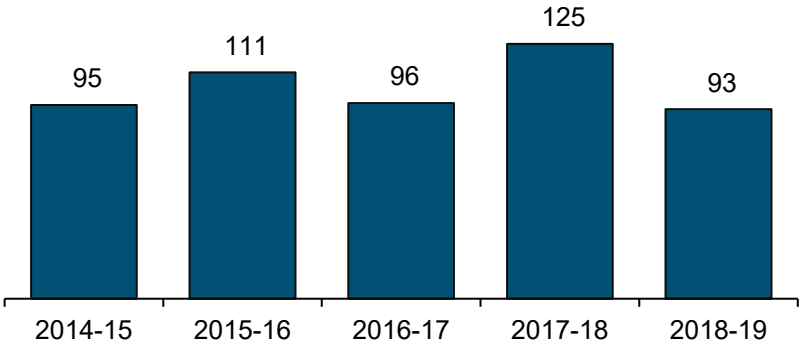



### Outcomes achieved

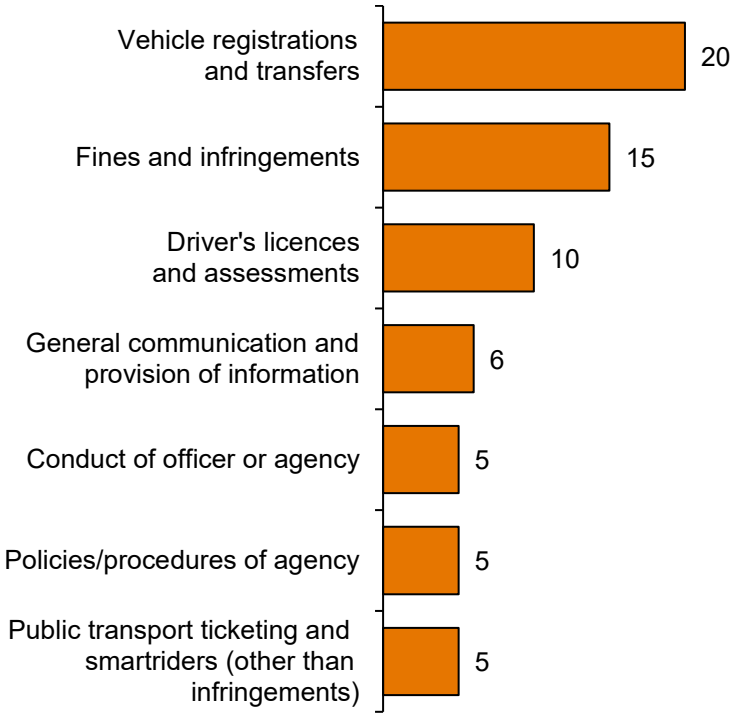
- Monetary charge reduced or withdrawn;
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to business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

## Transport

### Complaints received




### Most common allegations

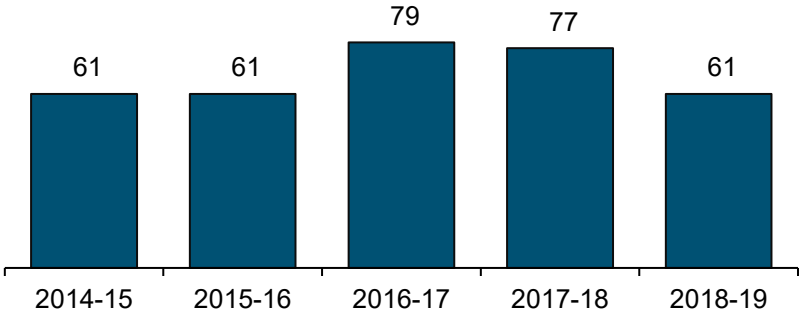



### Outcomes achieved

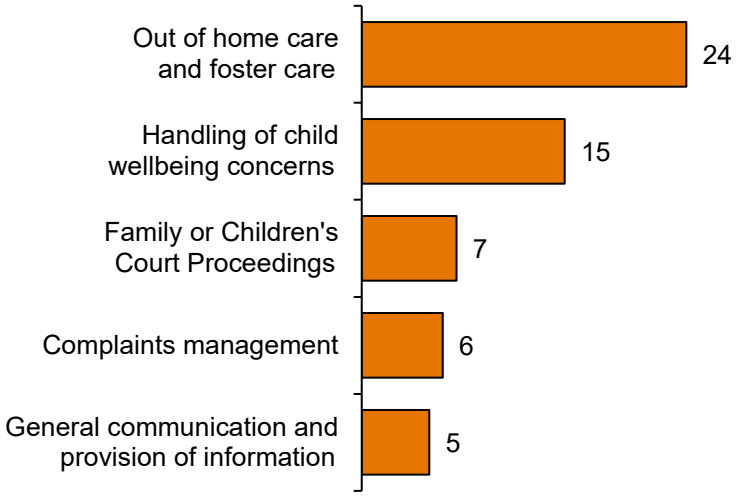
- Monetary charge withdrawn, refunded or rebate given;
- Action to replace, repair or rectify a matter;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy or procedure; and
- Staff training.

## Child Protection

### Complaints received




### Most common allegations

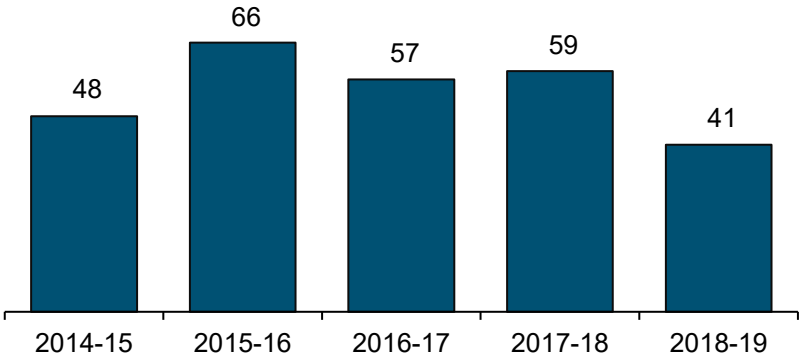



### Outcomes achieved

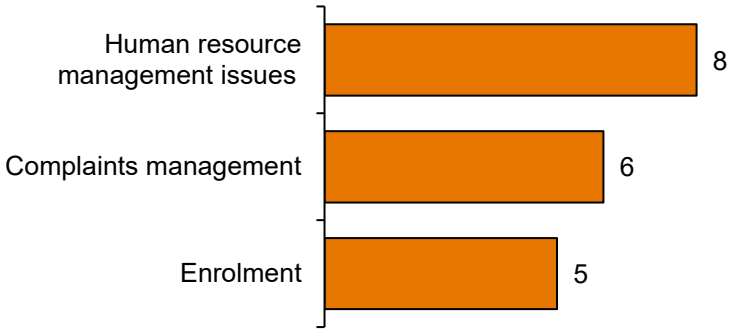
- Action expedited; and
- Explanation given or reasons provided.

## Education

### Complaints received




### Most common allegations



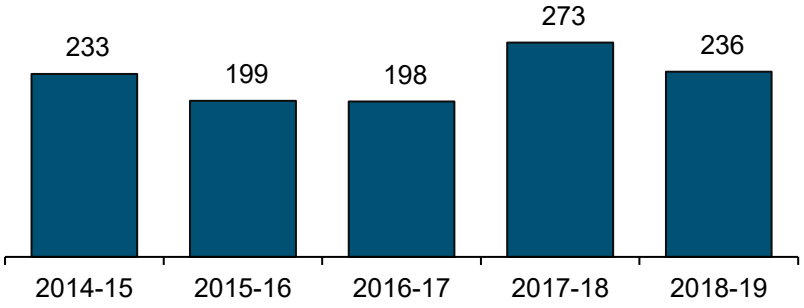

These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2018* relating to TAFE colleges and other public education agencies. Further details on these appeals are included later in this section.

### Outcomes achieved

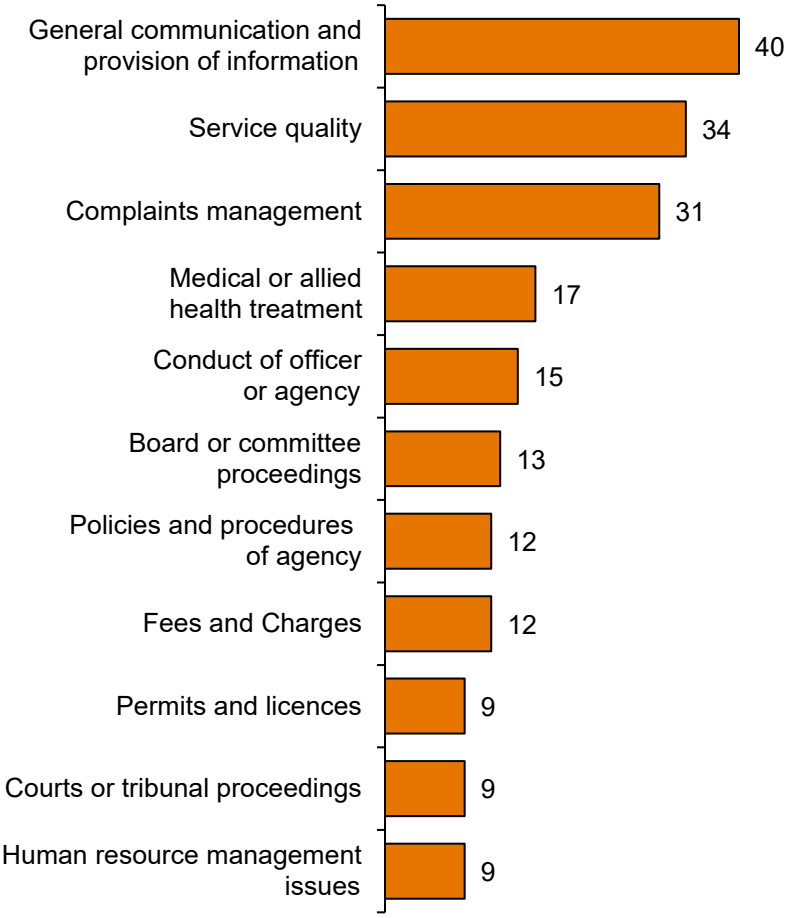
- Action to replace, repair or rectify a matter;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to business systems or practices;
- Conduct audit or review; and
- Update to publications or website.

## Other Public Sector Services

### Complaints received




### Most common allegations




### Outcomes achieved

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

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

## Case Study

### Application for transfer approved

A tenant applied to a public authority for a priority transfer from their rental property on medical grounds, which was declined. The tenant complained to the Ombudsman.

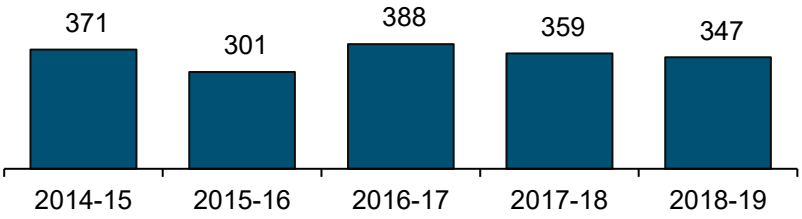
Following enquiries by the Ombudsman, the public authority gave further consideration to the tenant's particular circumstances and the medical evidence provided. Having reviewed the matter, the public authority made a discretionary decision to approve the transfer.

## The local government sector

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

### Local Government

**Complaints received**




**Most common allegations**


**Outcomes achieved**

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

## Case Study

### Local government assists resident

A person complained to the Ombudsman that a local government was not taking reasonable action to address vegetation on the verge adjacent to their property which was causing damage to their fence.

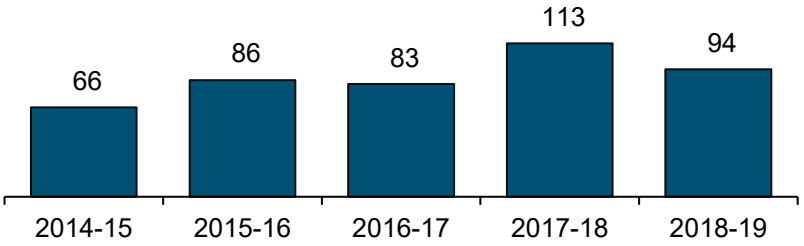
Following enquiries by the Ombudsman, the local government conducted a site inspection and noted that the offending vegetation did not originate from its verge. However, to assist the resident, the local government agreed to remove the vegetation, spray the area as a deterrent and conduct regular inspections to monitor possible regrowth.

## The university sector

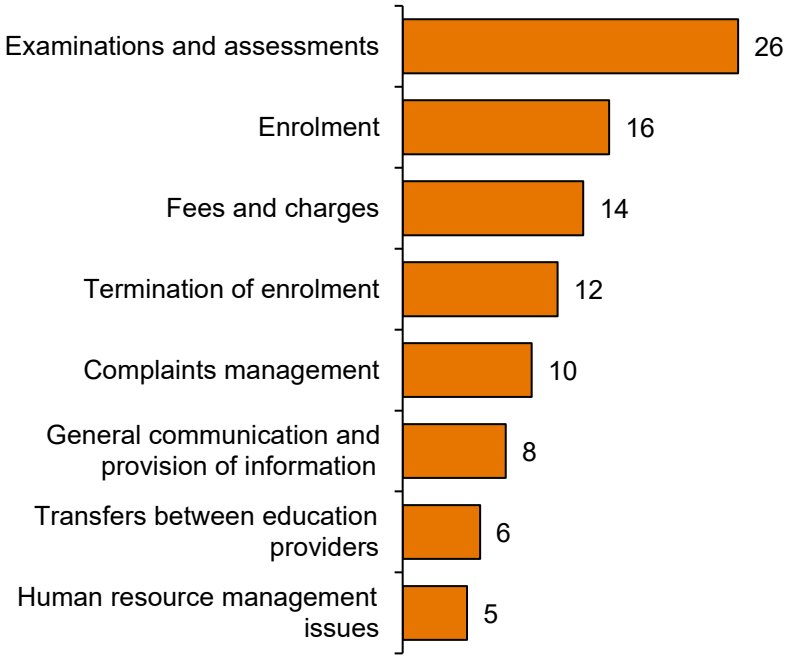
The following section provides further details about the issues and outcomes of complaints for the university sector.

### Universities

**Complaints received**




**Most common allegations**




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

**Outcomes Achieved**

- Monetary charge reduced, withdrawn or refunded;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Explanation given or reasons provided;
- Change to policy, procedure, business systems or practices;
- Update to publications or website;
- Improved recordkeeping; and
- Staff training.

## Case Study

### Student given opportunity to apply for readmission

A student applied for readmission to their university after being excluded. The university declined the request for readmission and decided that the student's re-enrolment would be denied for two further academic years. The student complained to the Ombudsman.

As a result of the Ombudsman's investigation, the university reviewed its decision and agreed to reverse its decision preventing the student from applying for readmission in future academic years. The university also agreed to amend its procedures to ensure that where the university proposes to deny re-enrolment, the student is provided with sufficient notice to allow them a reasonable opportunity to consider and respond to all material being considered by the decision maker.



## Other Complaint Related Functions

### Reviewing appeals by overseas students

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

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

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

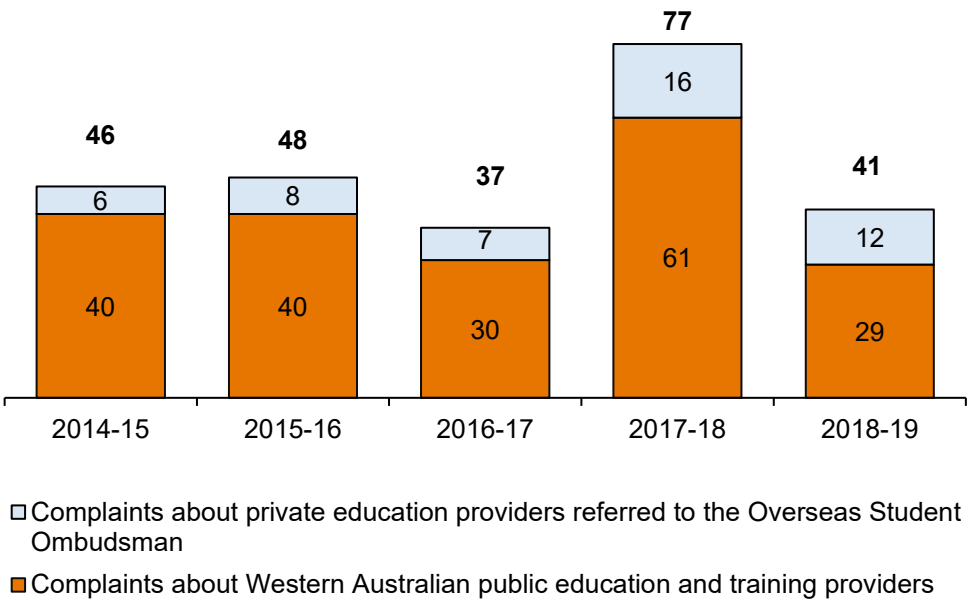
In Western Australia, the Ombudsman is the external appeals body for overseas students studying in Western Australian public education and training organisations. The Overseas Students Ombudsman is the external appeals body for overseas students studying in private education and training organisations.

#### Complaints lodged with the Office under the National Code

Education and training providers are required to comply with 11 standards under the National Code. In dealing with these complaints, the Ombudsman considers whether

the decisions or actions of the agency complained about comply with the requirements of the National Code and if they are fair and reasonable in the circumstances.

Complaints Received from Overseas Students under the National Code between 2014-15 and 2018-19




During 2018-19, the Office received 41 complaints from overseas students, including 29 complaints about public education and training providers. All 29 complaints about public education and training providers were about universities, and none were about TAFE colleges or other education providers. The Office also received 12 complaints that, after initial assessment, were found to be about a private education provider. The Office referred these complainants to the Overseas Students Ombudsman.

The 29 complaints by overseas students about public education and training providers involved 34 separate allegations. There are more allegations than complaints because one complaint may cover more than one issue. The most common issues raised by overseas students were decisions about:

- Examinations and assessments (10);
- Termination of enrolment (7);
- Enrolment (6);
- Fees and charges (5);
- Transfers between education and training providers (4); and
- Management of academic misconduct (1).

During the year, the Office finalised 46 complaints about 54 issues.

## Case Study

### University reconsiders its decision not to release student

An international student requested to be released from their university course to enable study with a different provider located in another state, on compassionate grounds due to family circumstances. The university decided that the student did not meet the criteria for release, based on the evidence provided. The student appealed the university's decision but was unsuccessful, and they complained to the Ombudsman.

As a result of the Ombudsman's investigation, the university reviewed the new information and documentation provided by the student and reversed its decision to deny the request for release. The university also agreed to adopt a new format to record its decisions about applications for release and to provide students with information about the evidence required to support applications for release.

## Case Study

### University refunds tuition fees

A university student was expelled from a university for engaging in academic misconduct. By the time the internal review process for the expulsion decision was finalised, the student had provisionally enrolled in a further semester of study and paid the relevant tuition fees. After the university's expulsion decision, the student applied for a refund of the tuition fees for units in which they were provisionally enrolled, but the university refused. The student complained to the Ombudsman.

As a result of the Ombudsman's investigation, the university reconsidered the application of its tuition refund policy and agreed to refund the tuition fees.

## Public Interest Disclosures

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

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

During the year, two disclosures were received.

## Indian Ocean Territories

Under a service delivery arrangement between the Ombudsman and the Australian Government, the Ombudsman handles complaints about State Government departments and authorities delivering services in the Indian Ocean Territories and about local governments in the Indian Ocean Territories. There were no complaints received during the year.

## Terrorism

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

# Requests for Review

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

In 2018-19, six reviews were undertaken, representing less than one third of one per cent of the total number of complaints finalised by the Office. In all cases where a review was undertaken, the original decision was upheld.

# Child Death Review

## Overview

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

- Background;
- The role of the Ombudsman in relation to child death reviews;
- The child death review process;
- Analysis of child death reviews;
- 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:

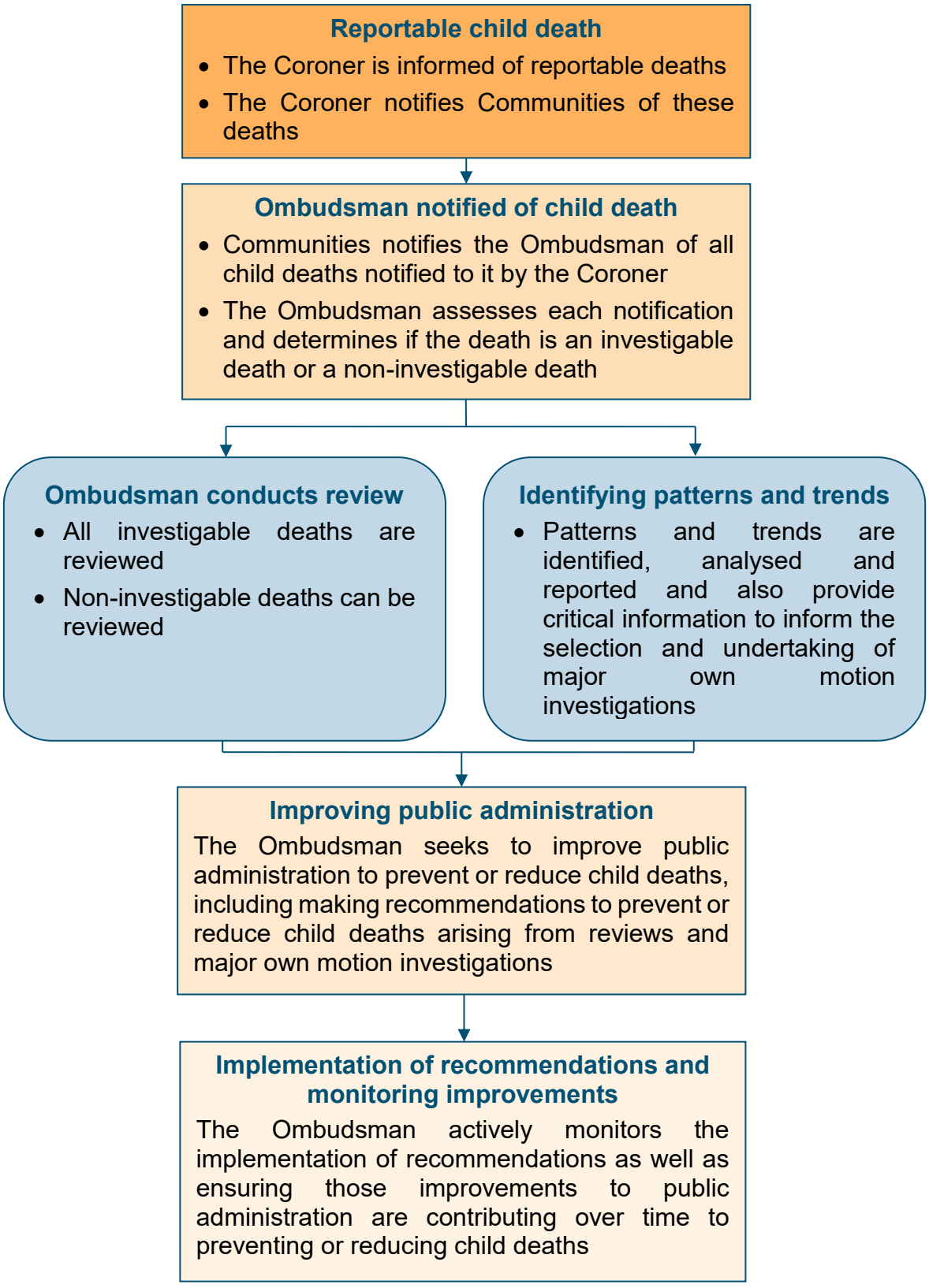
- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children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

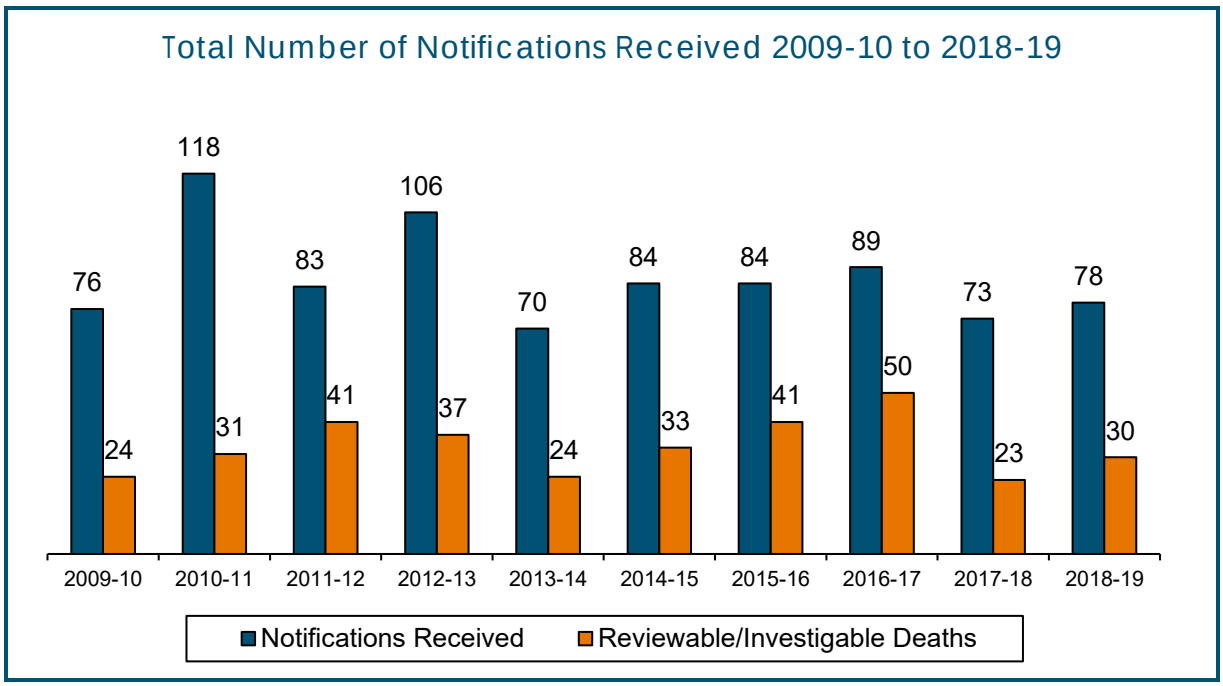
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

### 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<br>Total WA child deaths (excluding stillbirths)<br>(See Note 1) | B<br>Child deaths reported to the Coroner<br>(See Note 2) | C<br>Child deaths where the child or a relative of the child was known to Communities<br>(See Note 3) | D<br>Reviewable/ investigable child deaths<br>(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

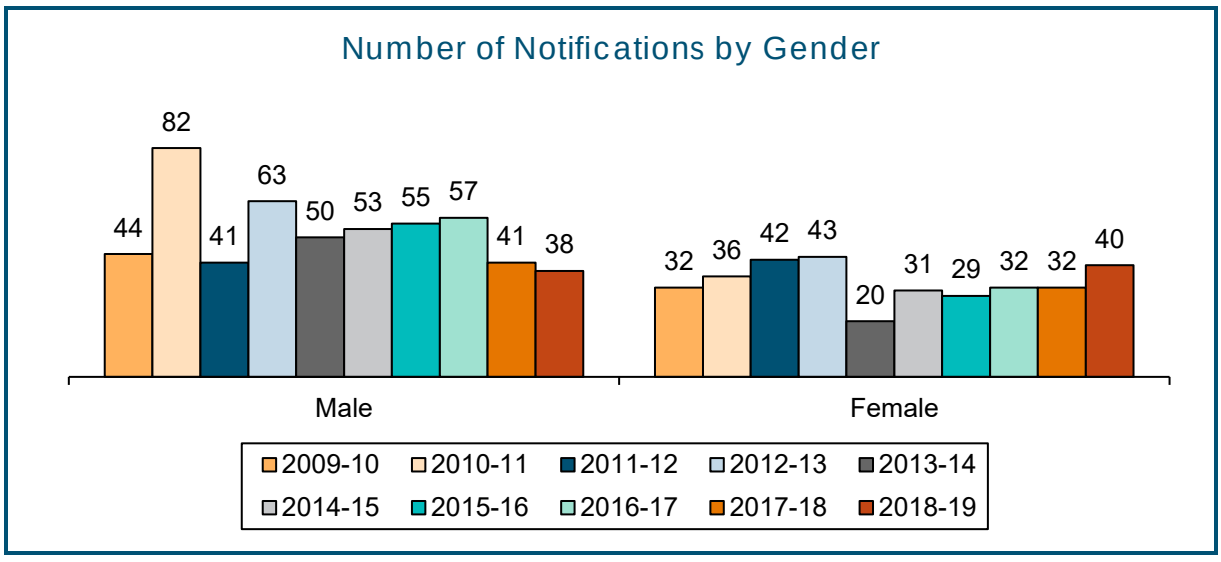
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

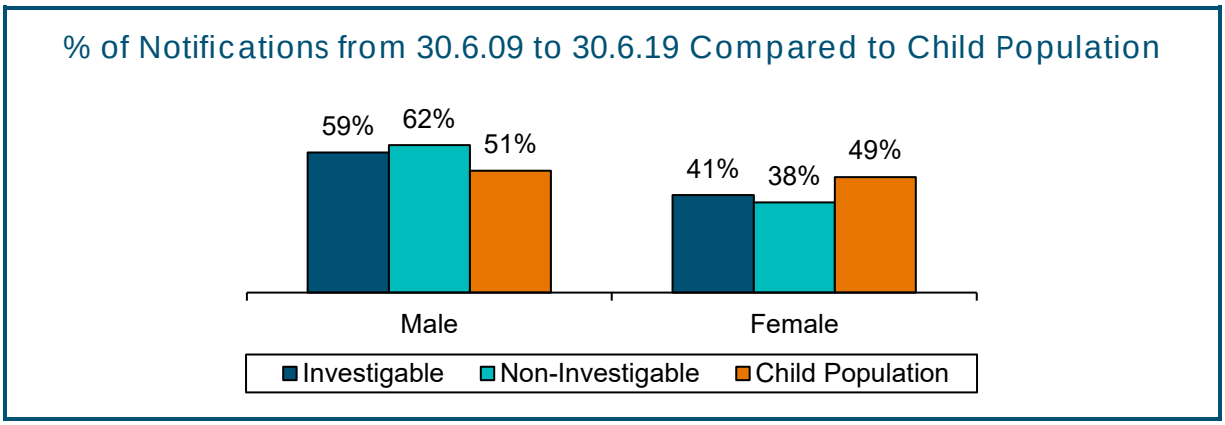
The following charts show:

- 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.



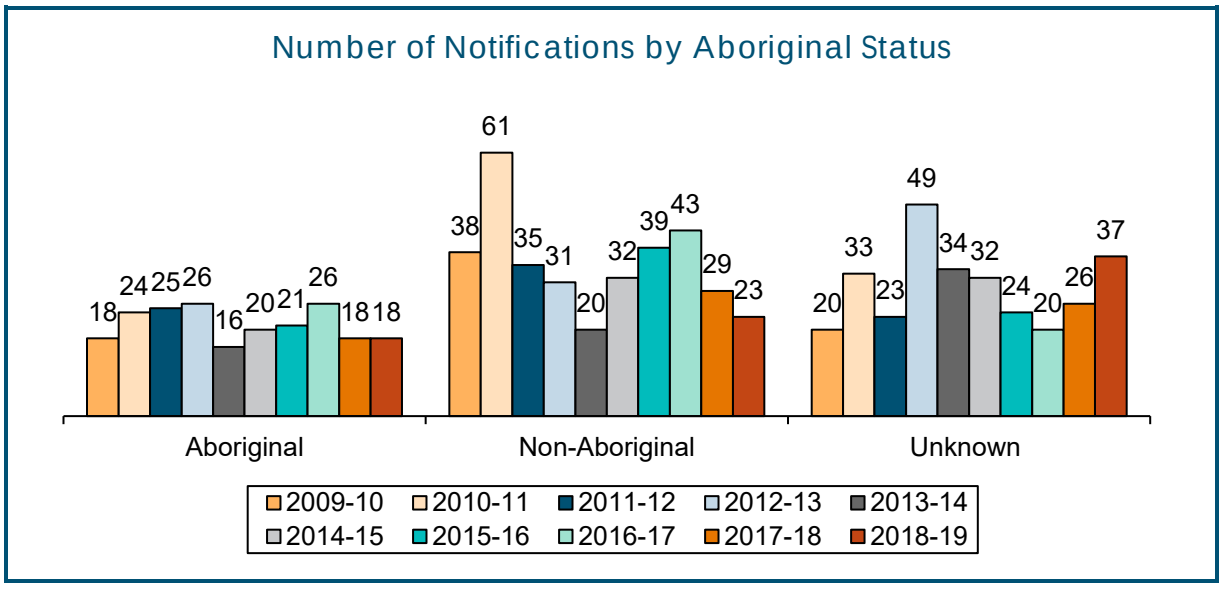


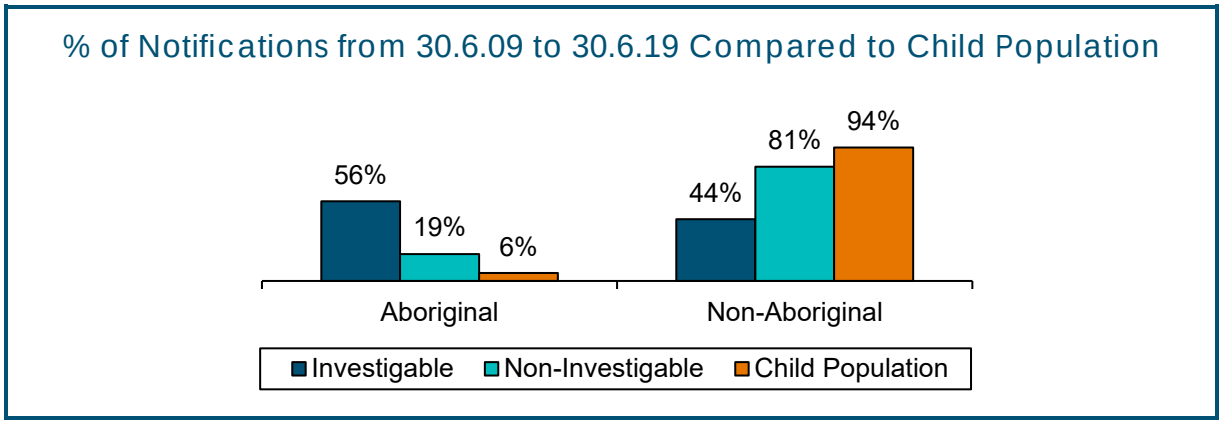

Further analysis of the data shows that, considering all 10 years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

## 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.





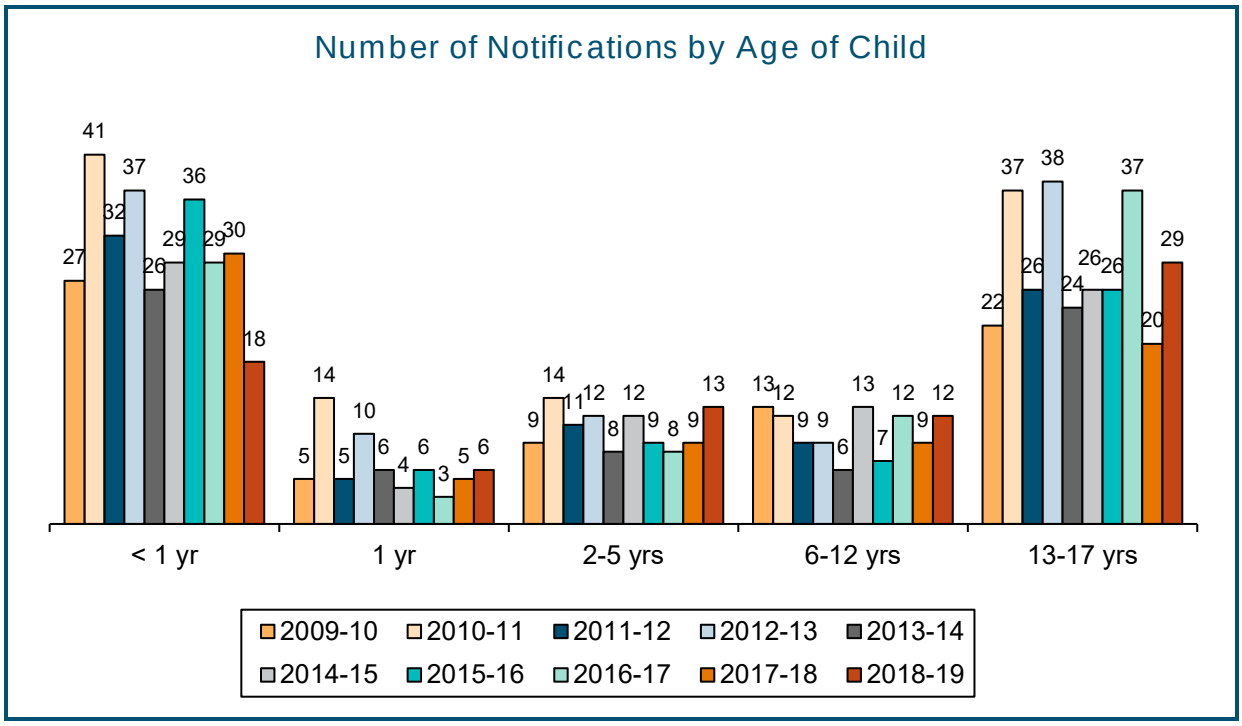



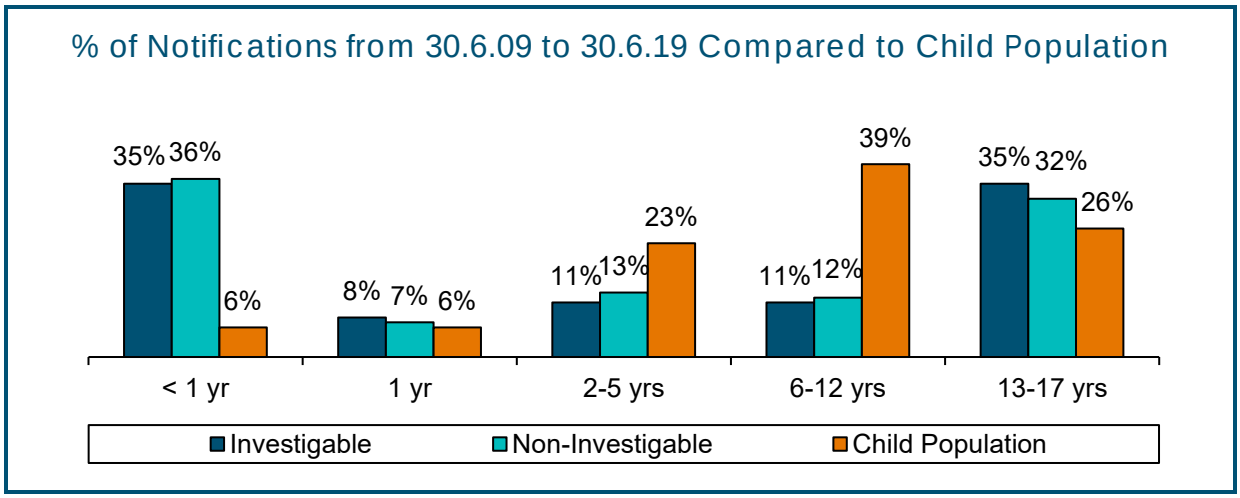

**Note**: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

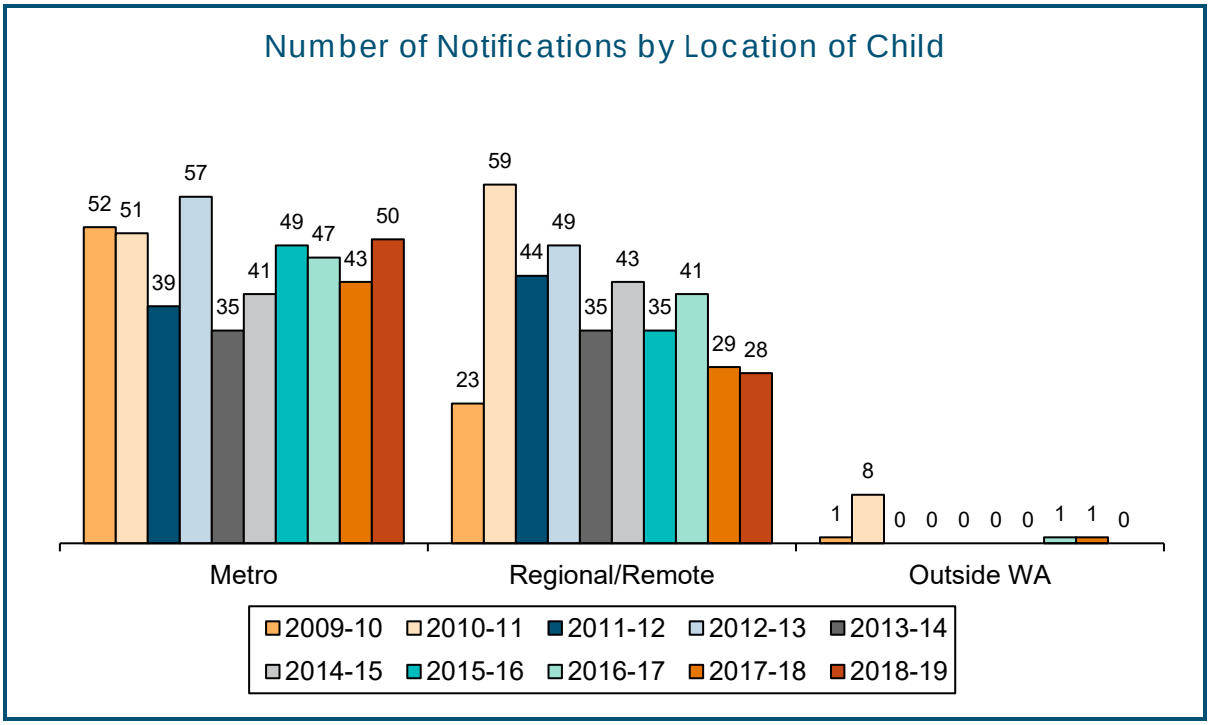


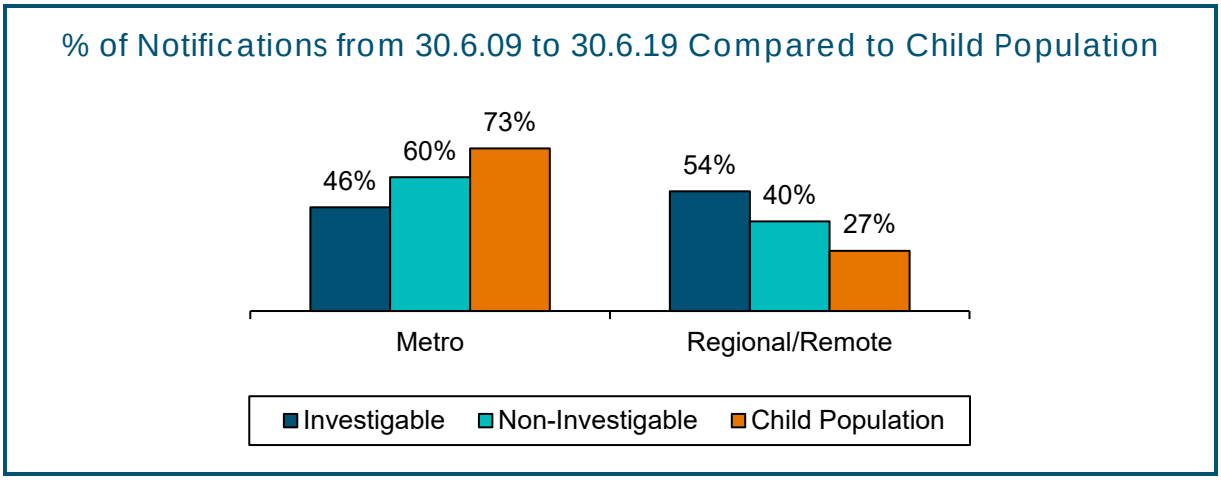

A more detailed analysis by age group is provided later in this section.

## 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.

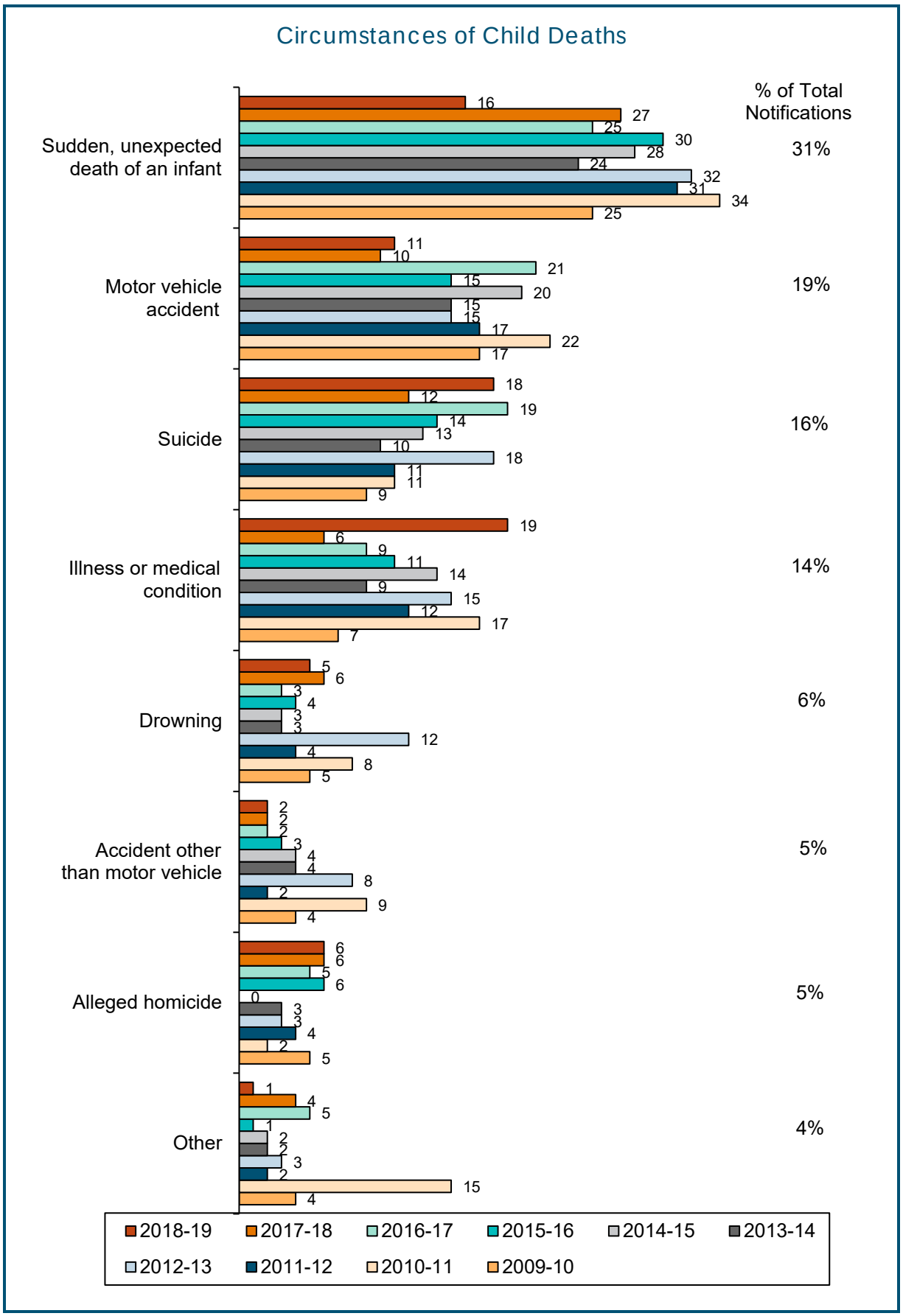
## Circumstances in which child deaths have occurred

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.



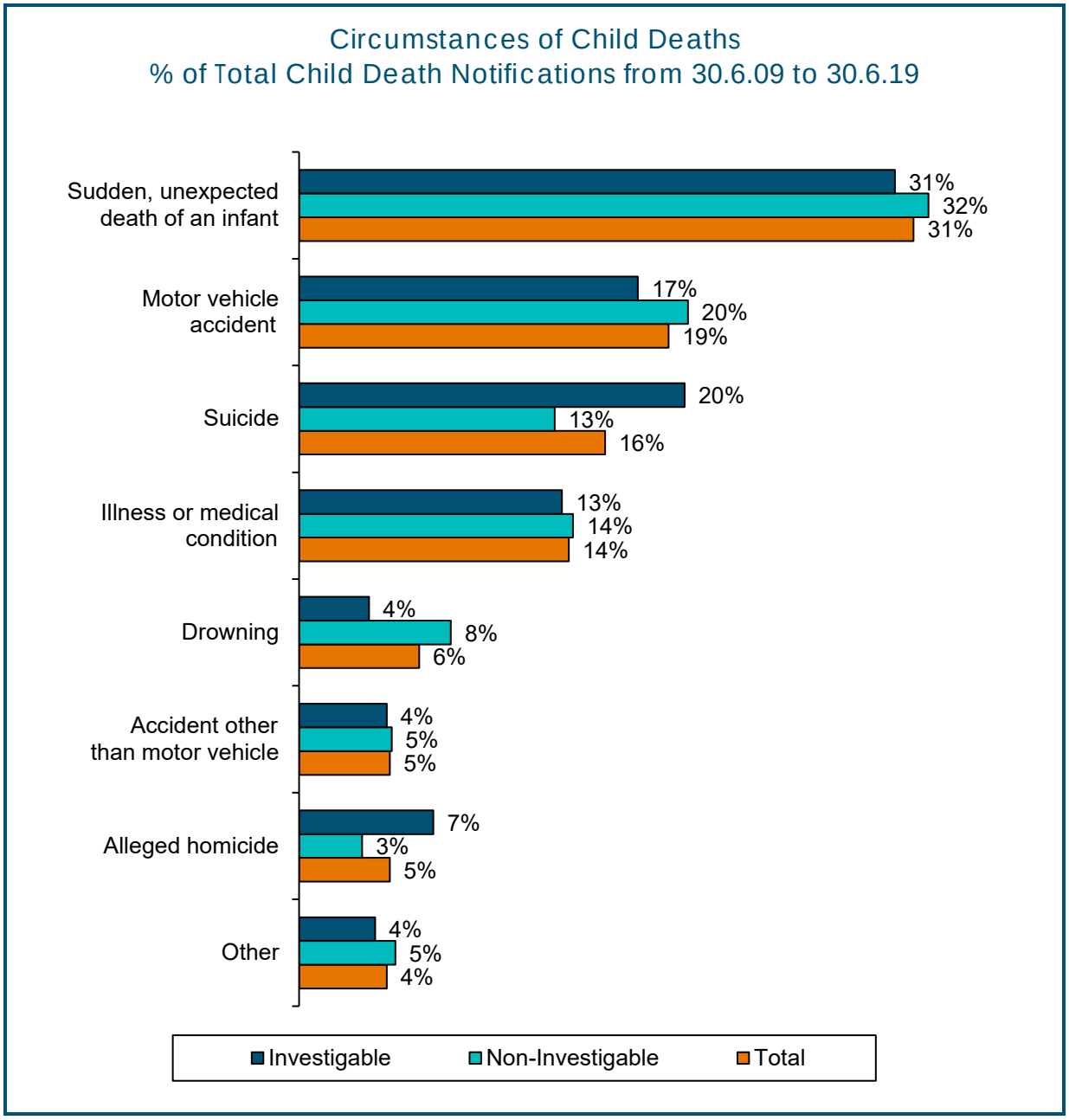

**Note 1**: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

**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

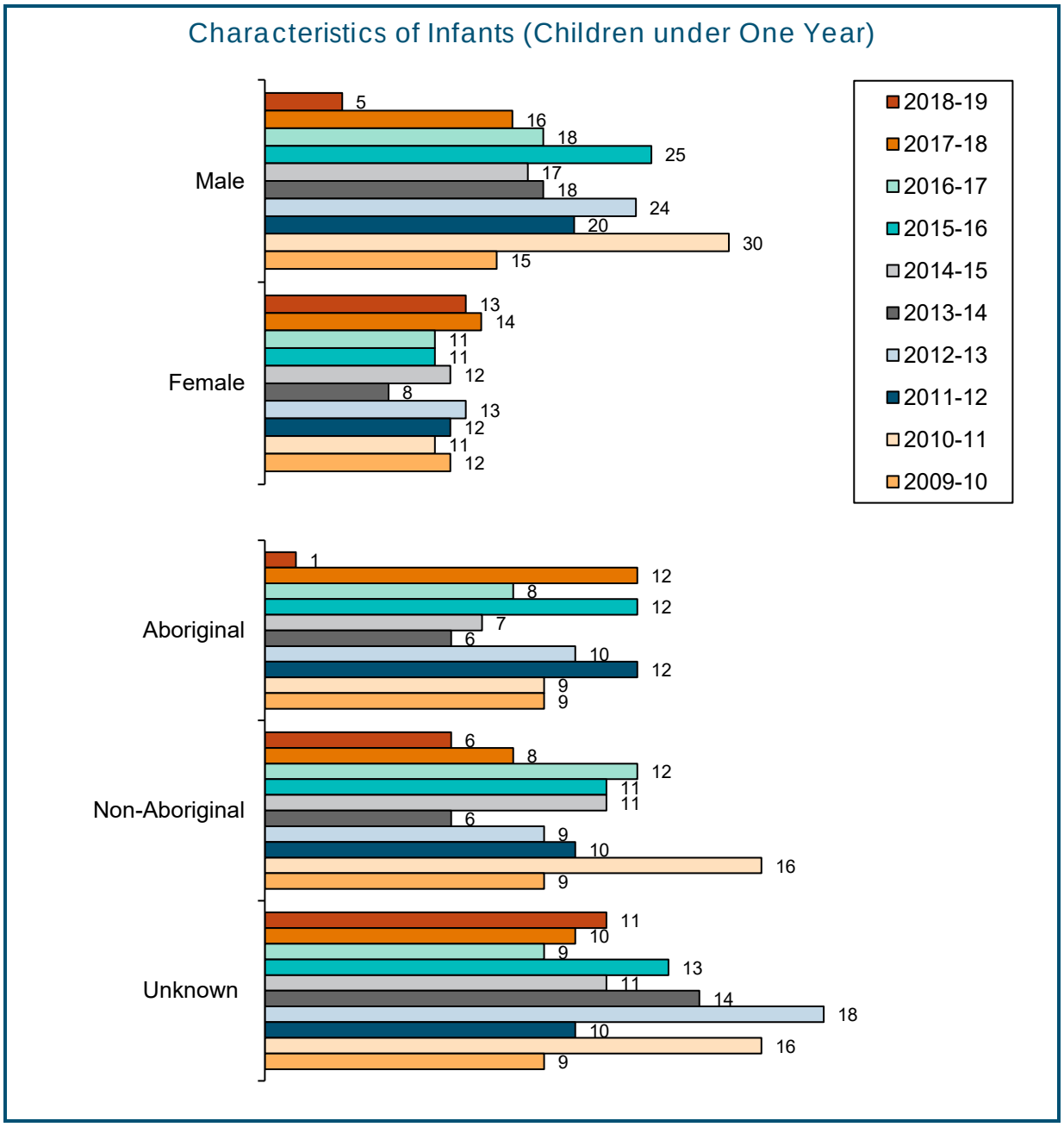
In child deaths notified to the Ombudsman in 2018-19, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

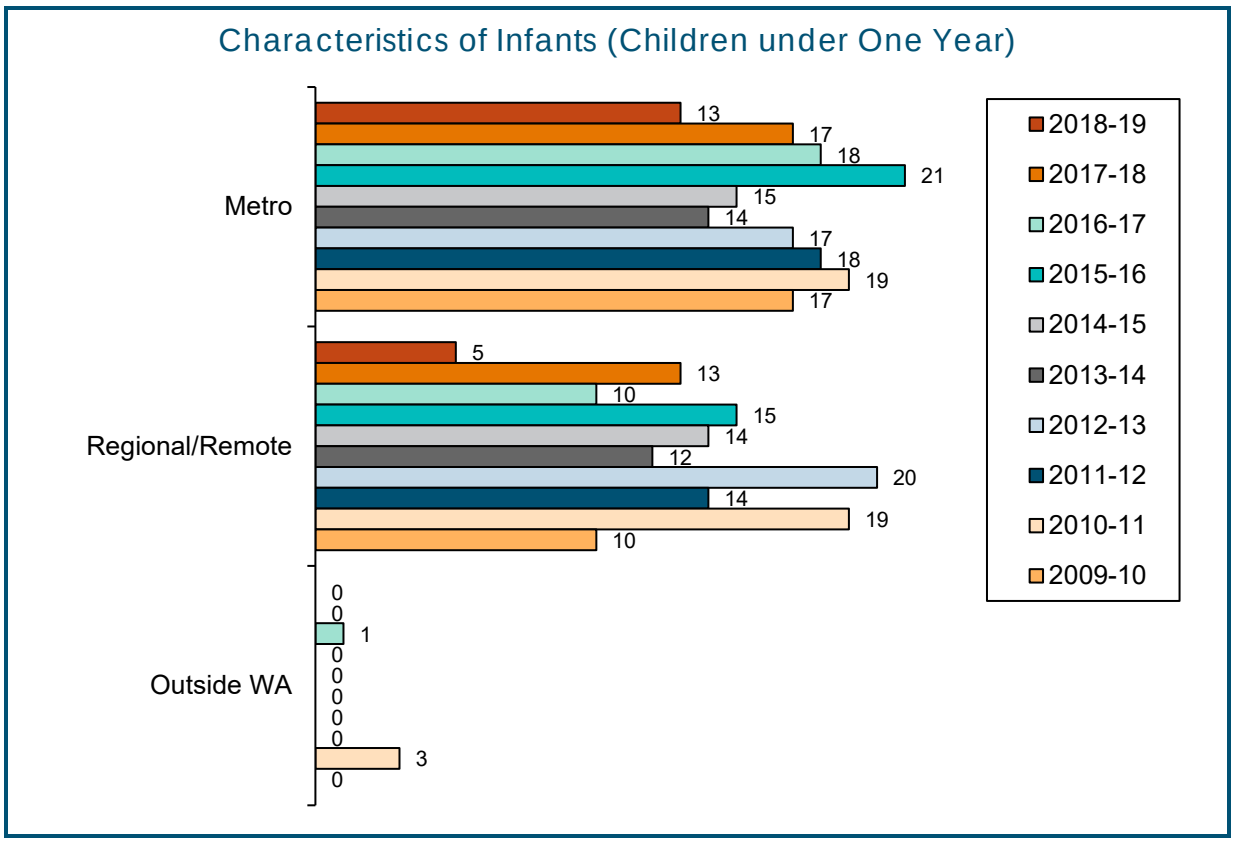
## Analysis of children in particular age groups

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.



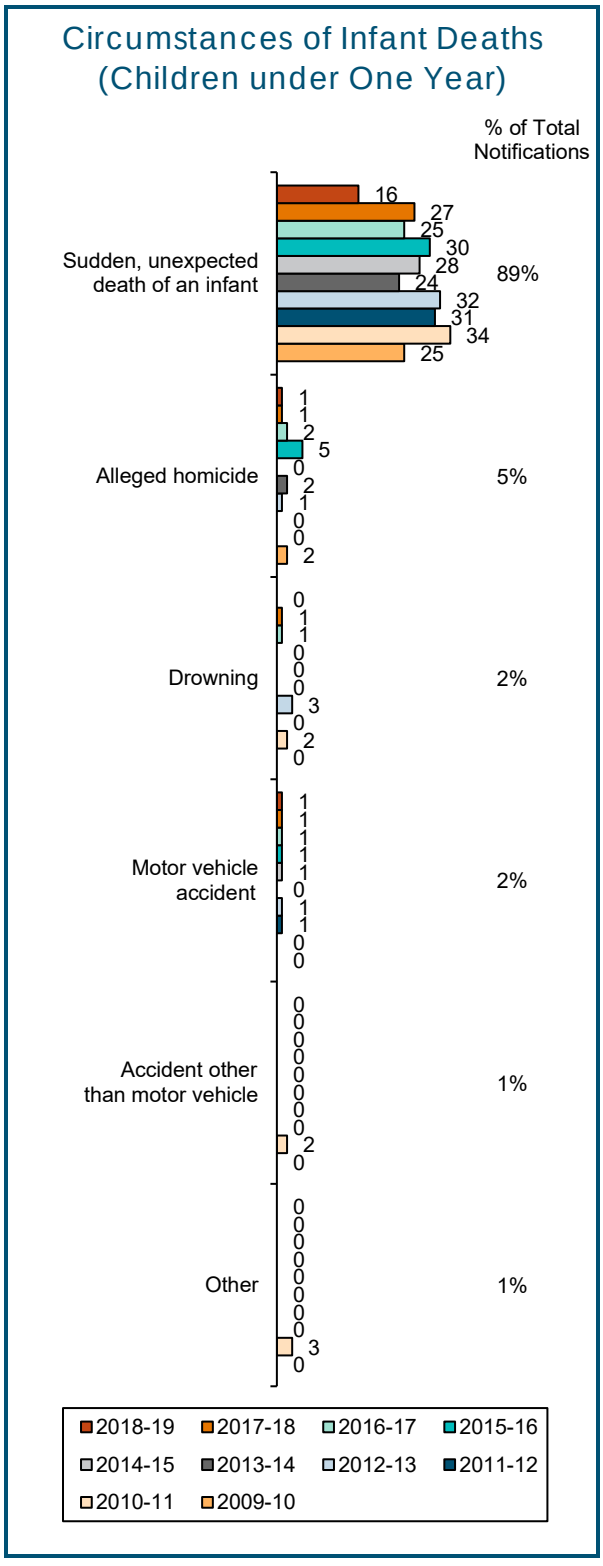


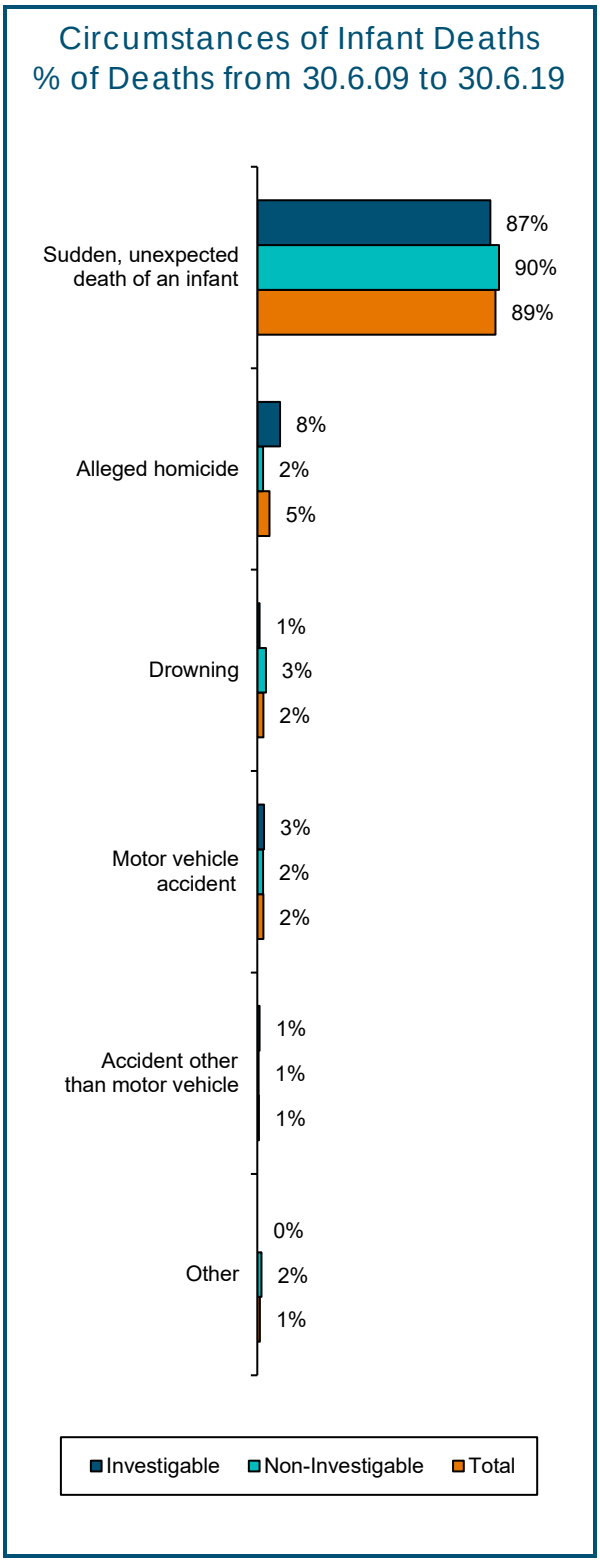

**Note**: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.



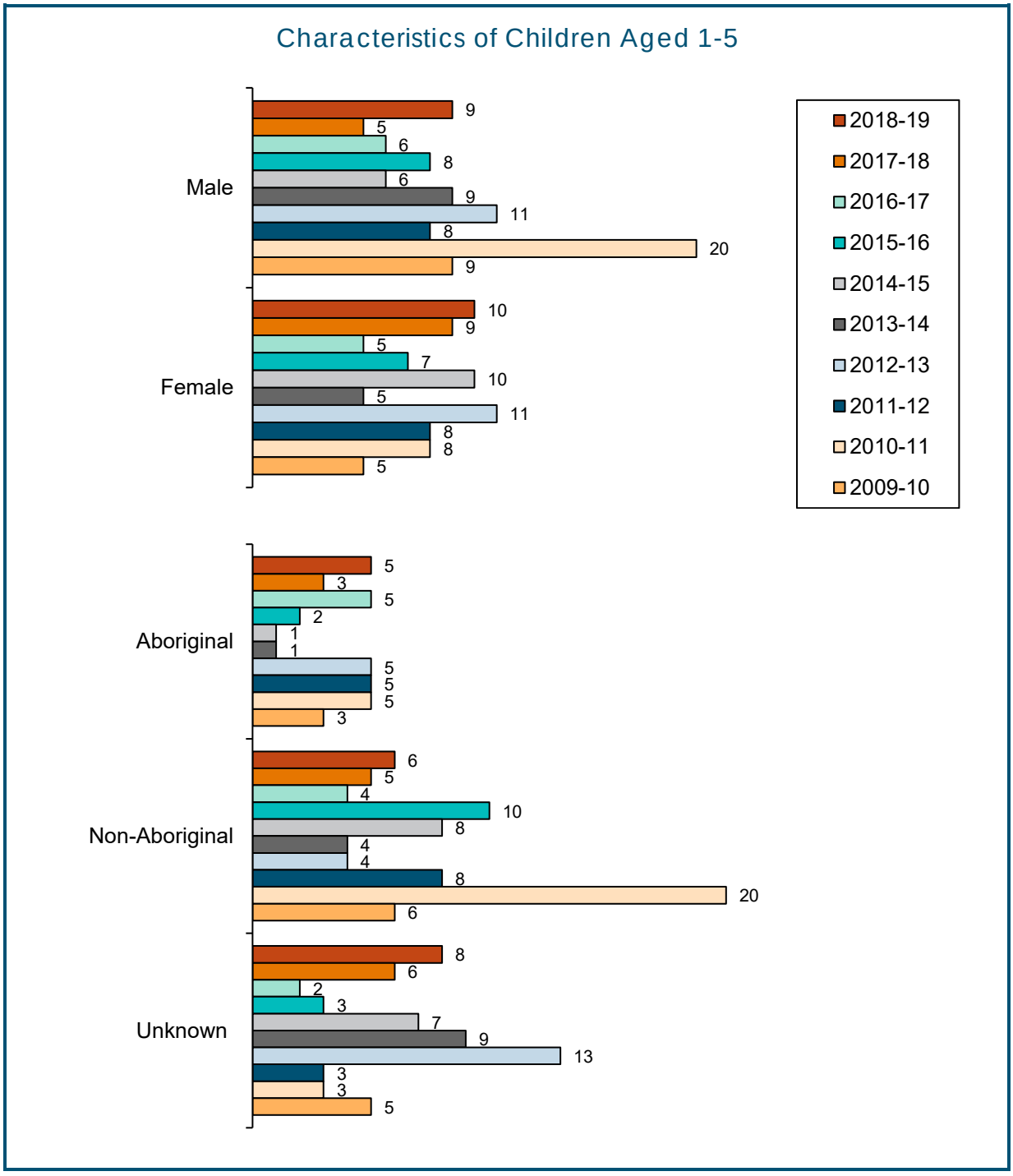

**Note**: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

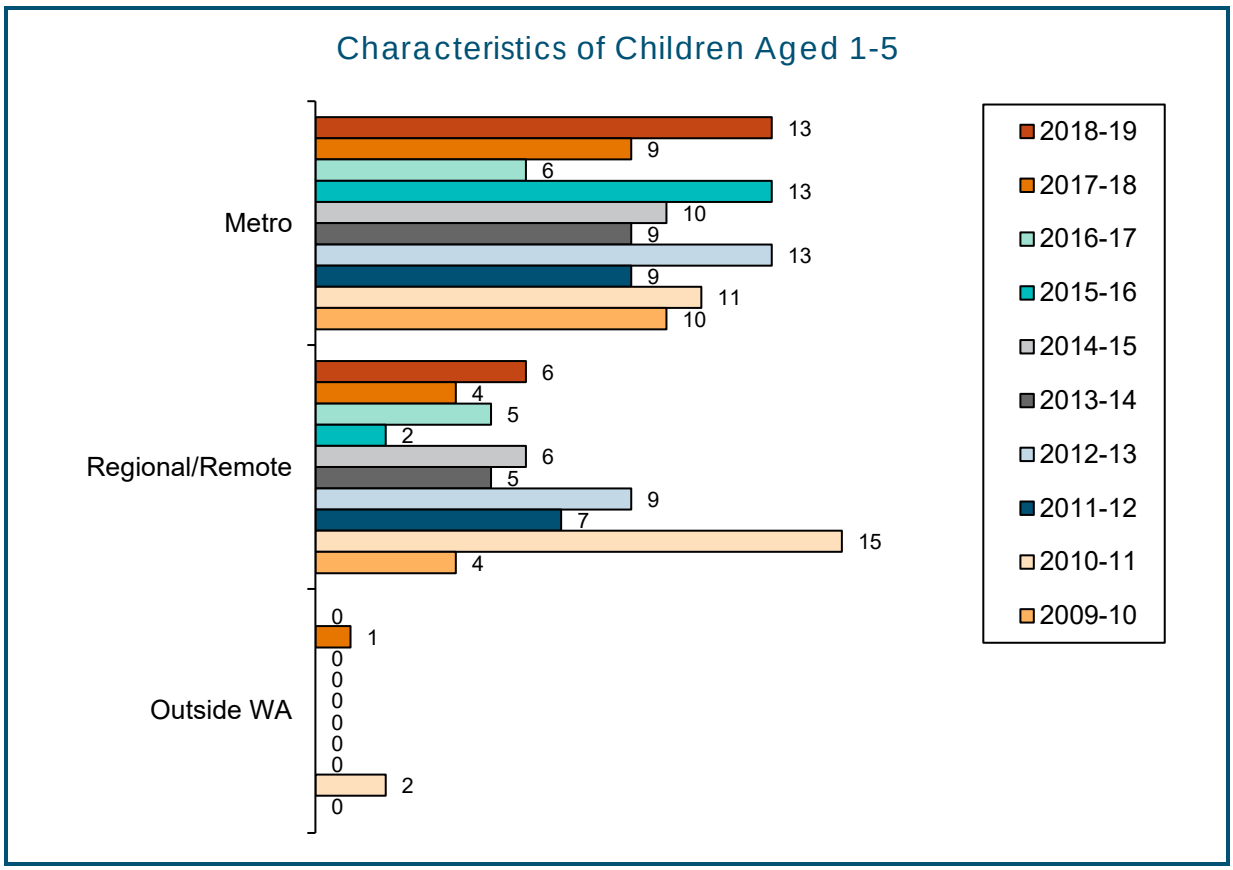
One hundred and seventeen deaths of infants were determined to be investigable deaths.

## 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%).

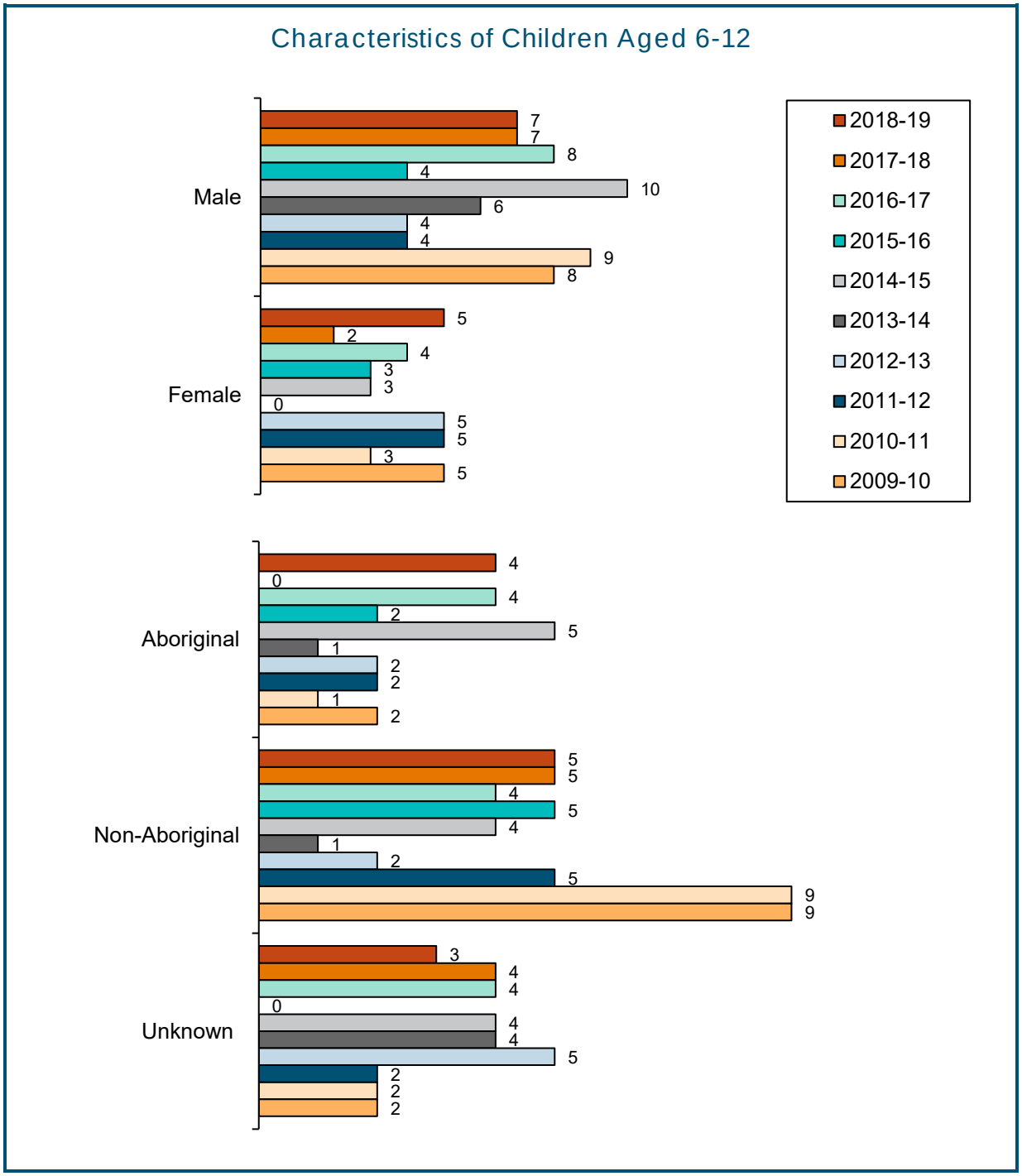

**Note**: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

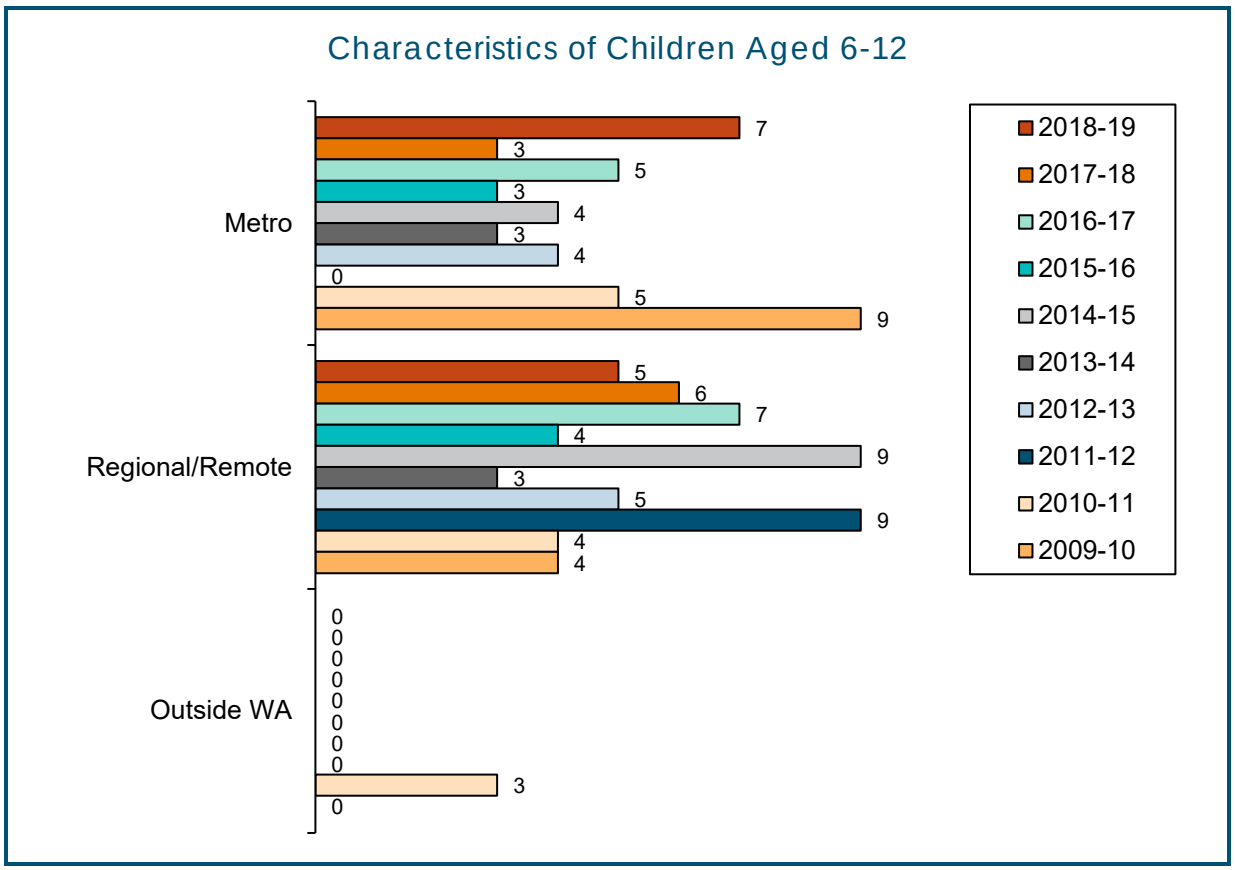
Sixty one deaths of children aged 1 to 5 years were determined to be investigable deaths.

## 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.



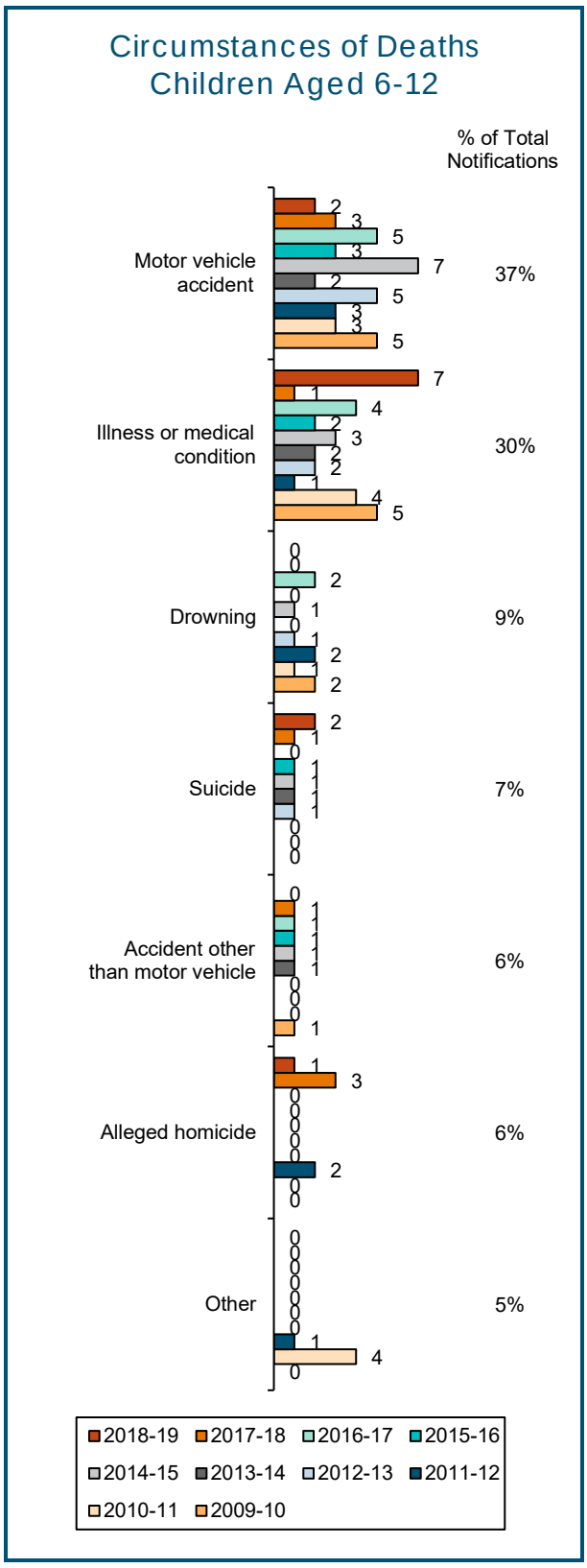


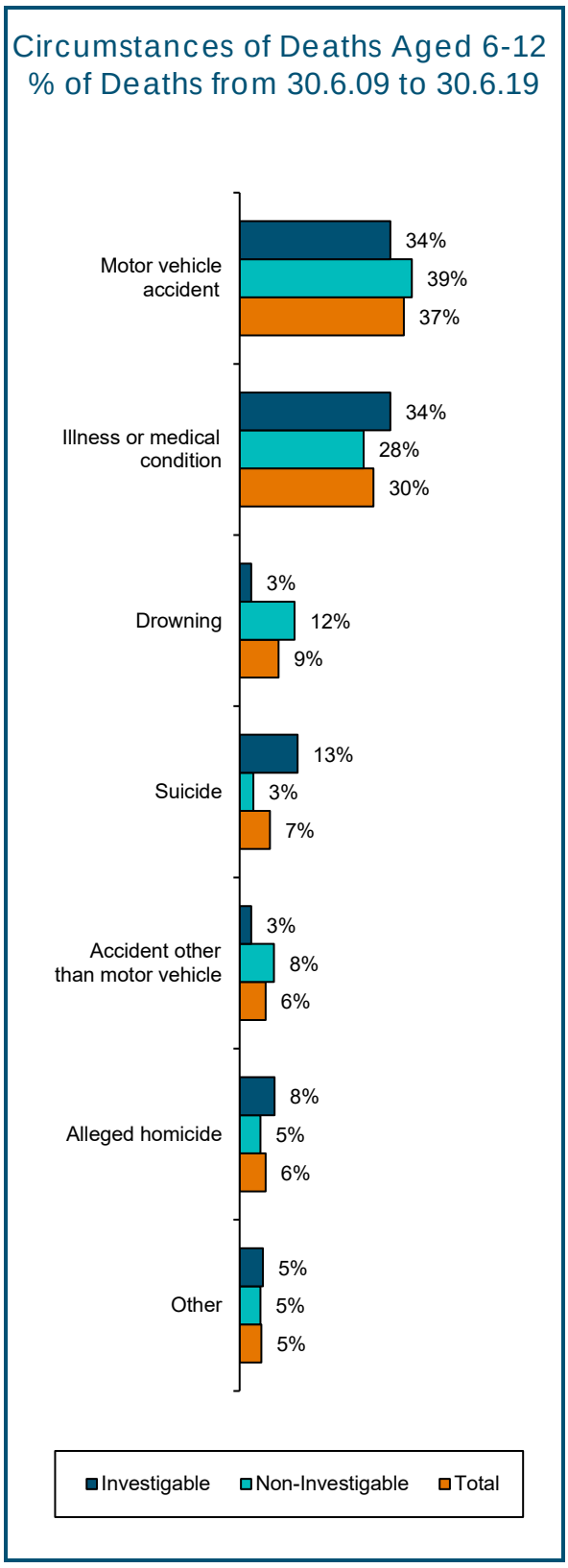

**Note**: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).



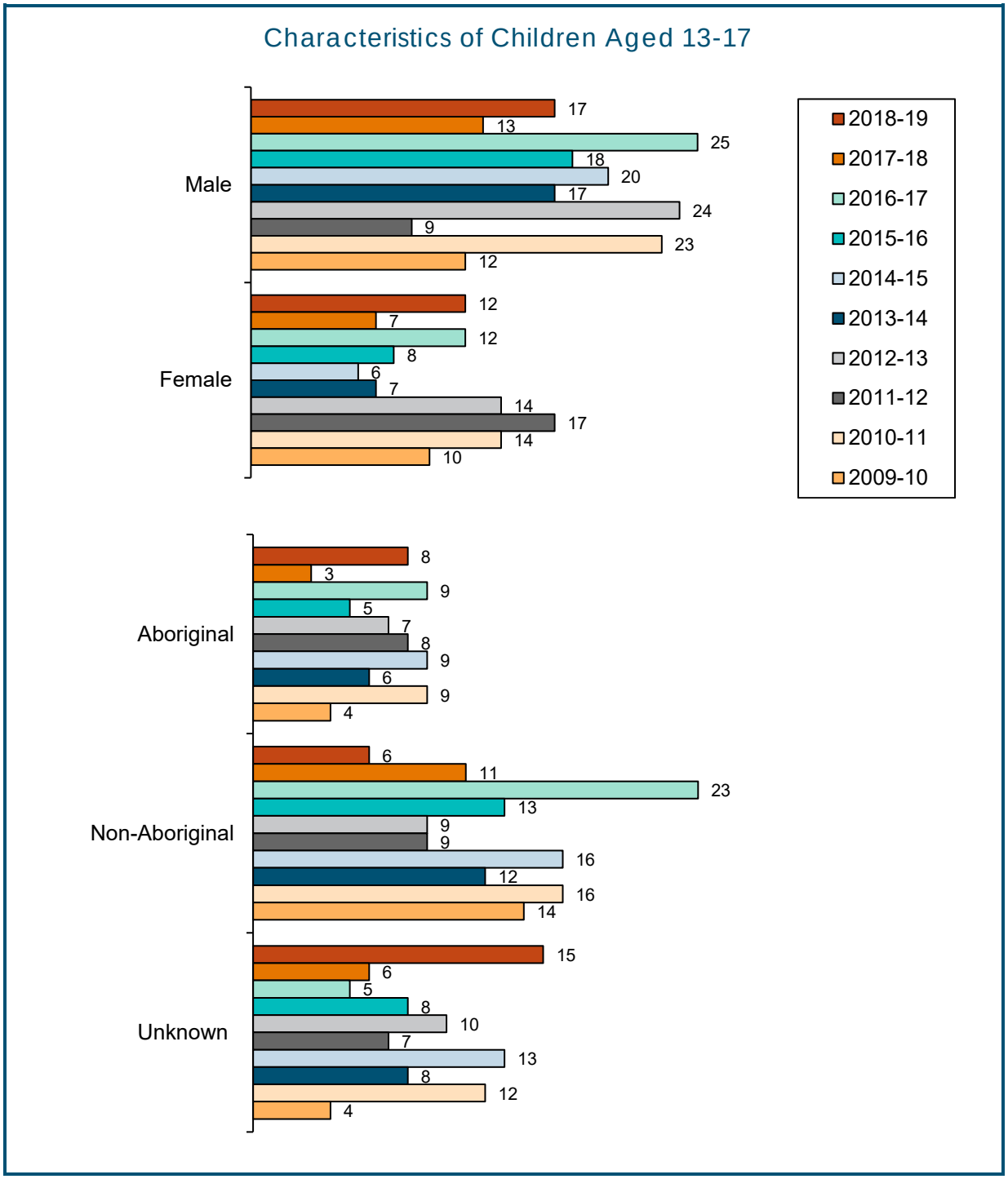

**Note**: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

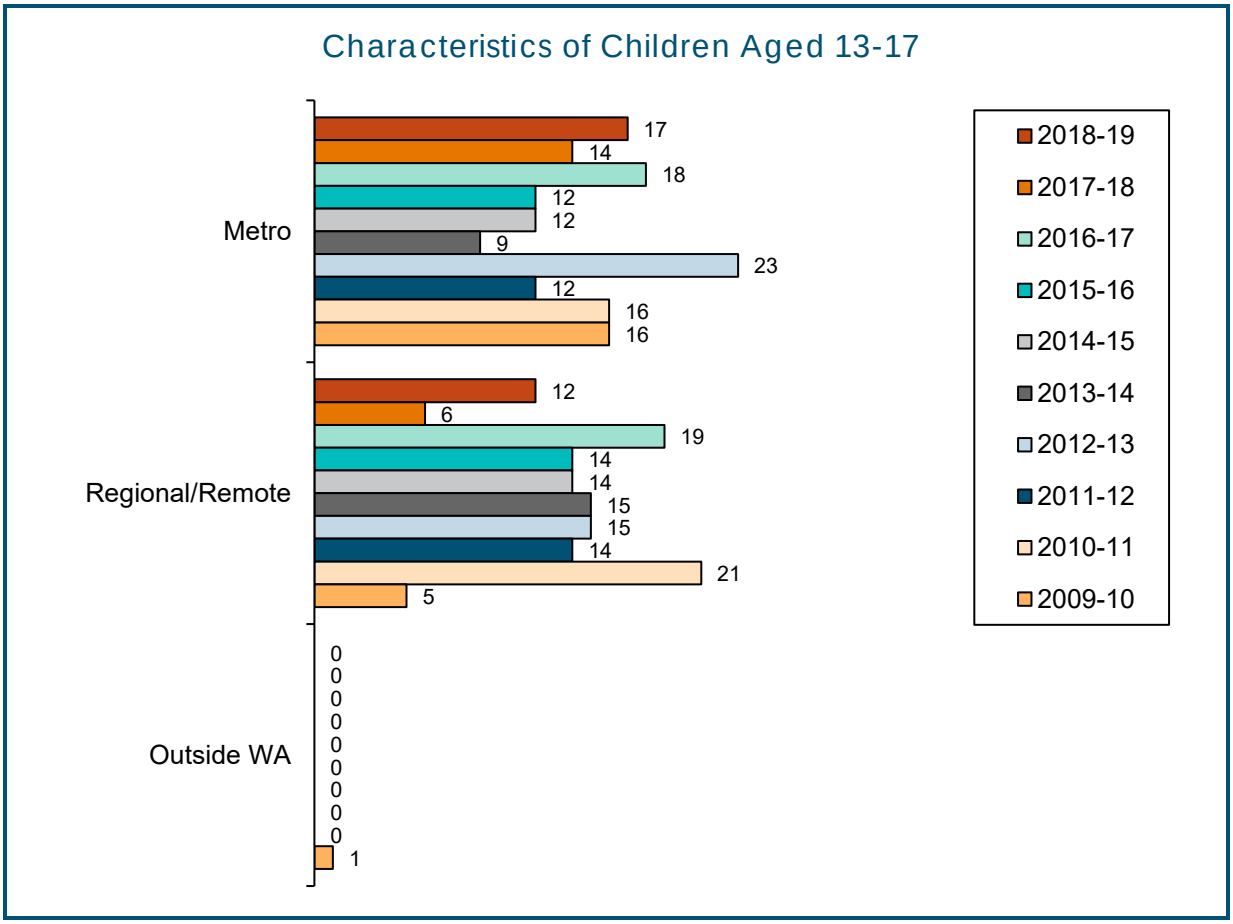
Thirty eight deaths of children aged 6 to 12 years were determined to be investigable deaths.

## 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.



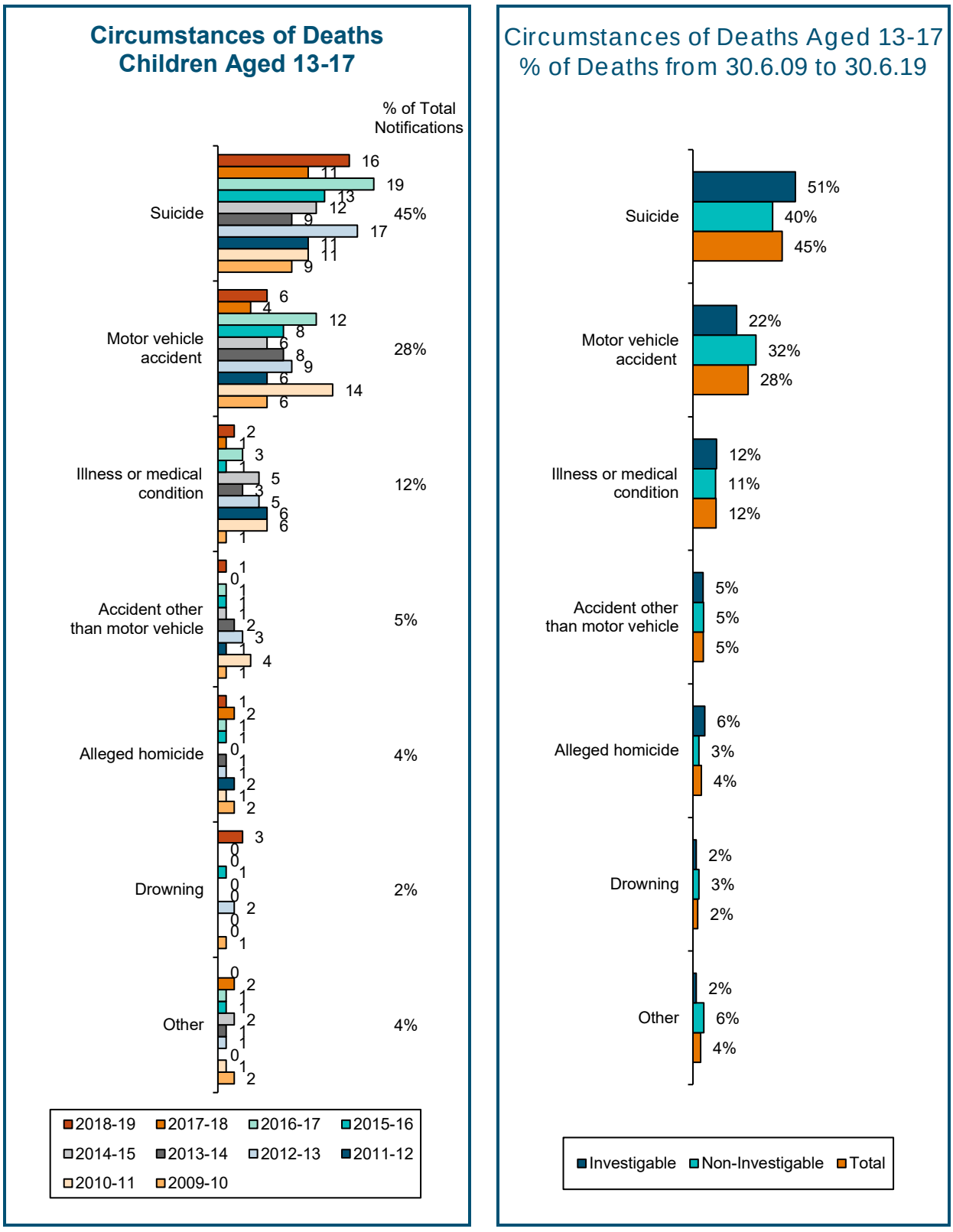



**Note**: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.

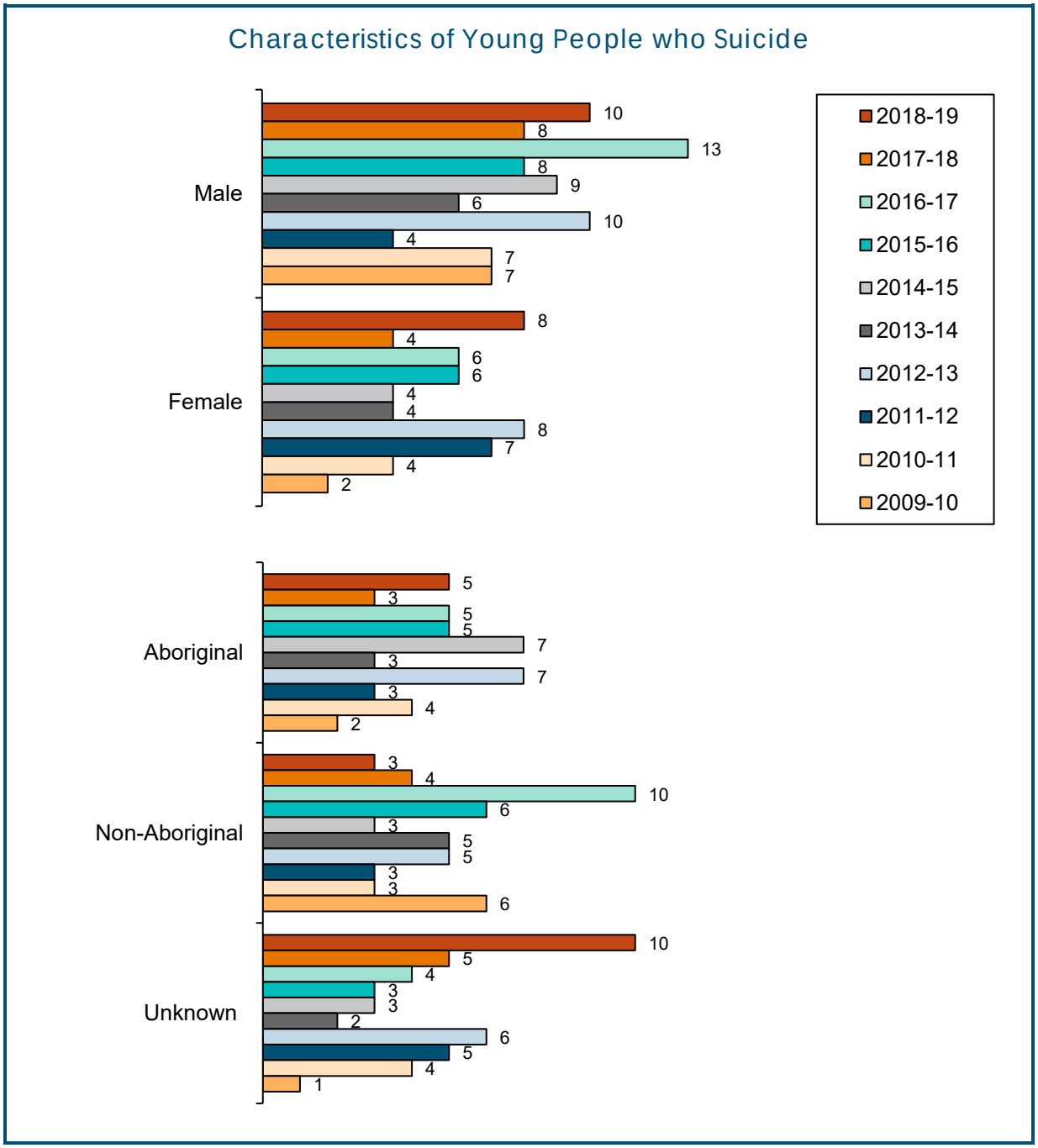
One hundred and eighteen deaths of children aged 13 to 17 years were determined to be investigable deaths.

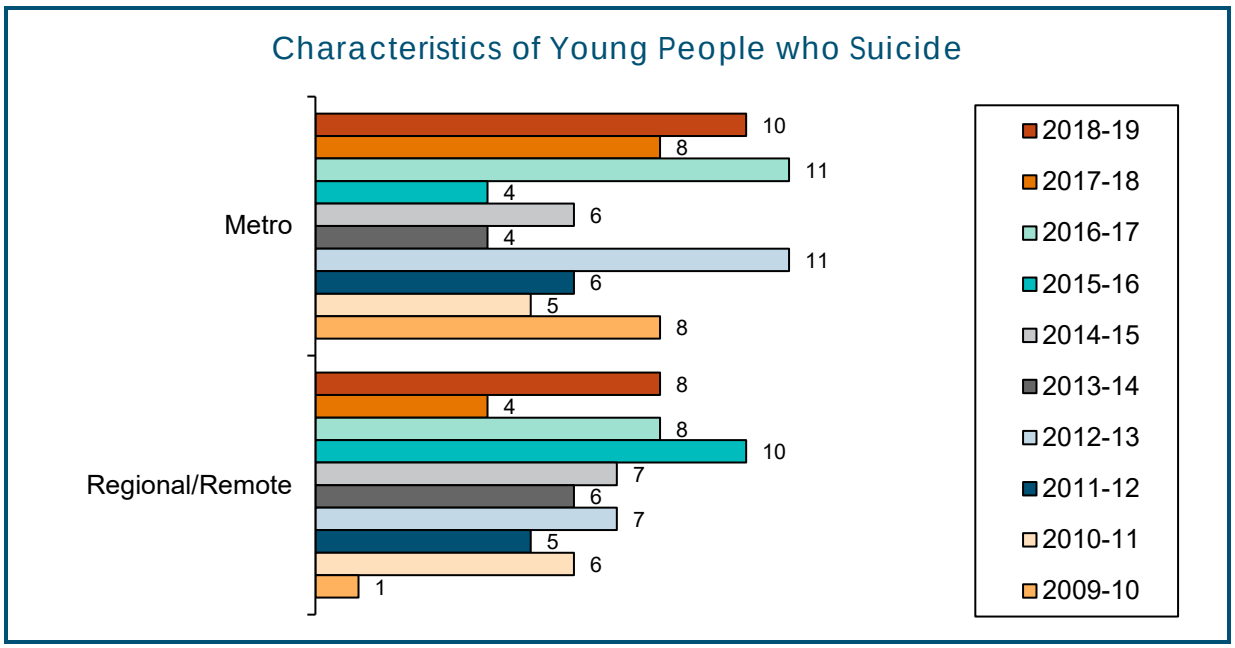
## Suicide by young people

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:

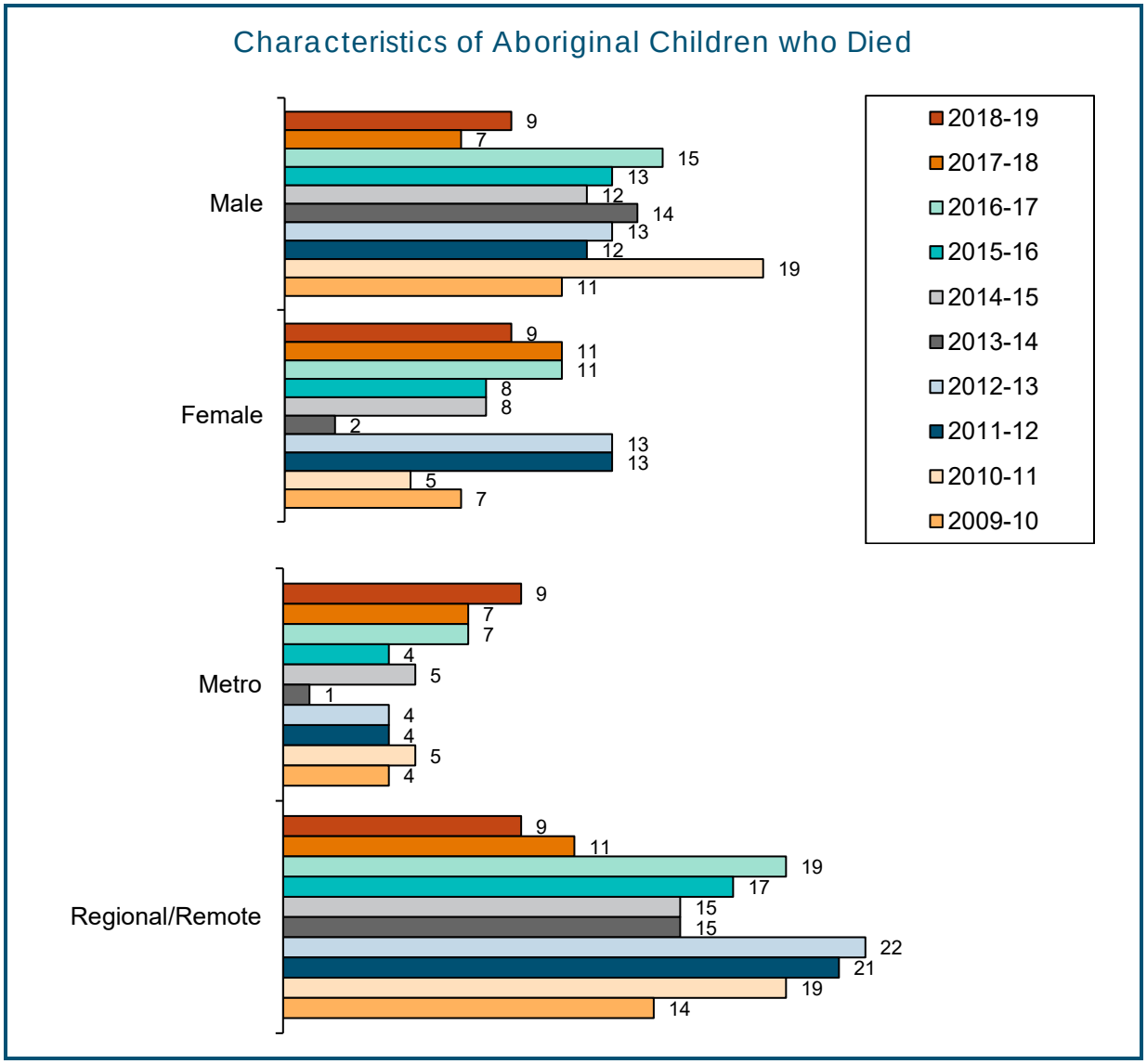
- Males – 53% of investigable deaths and 68% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 92 apparent suicides by young people where information on the Aboriginal status of the young person was available, 67% of the investigable deaths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

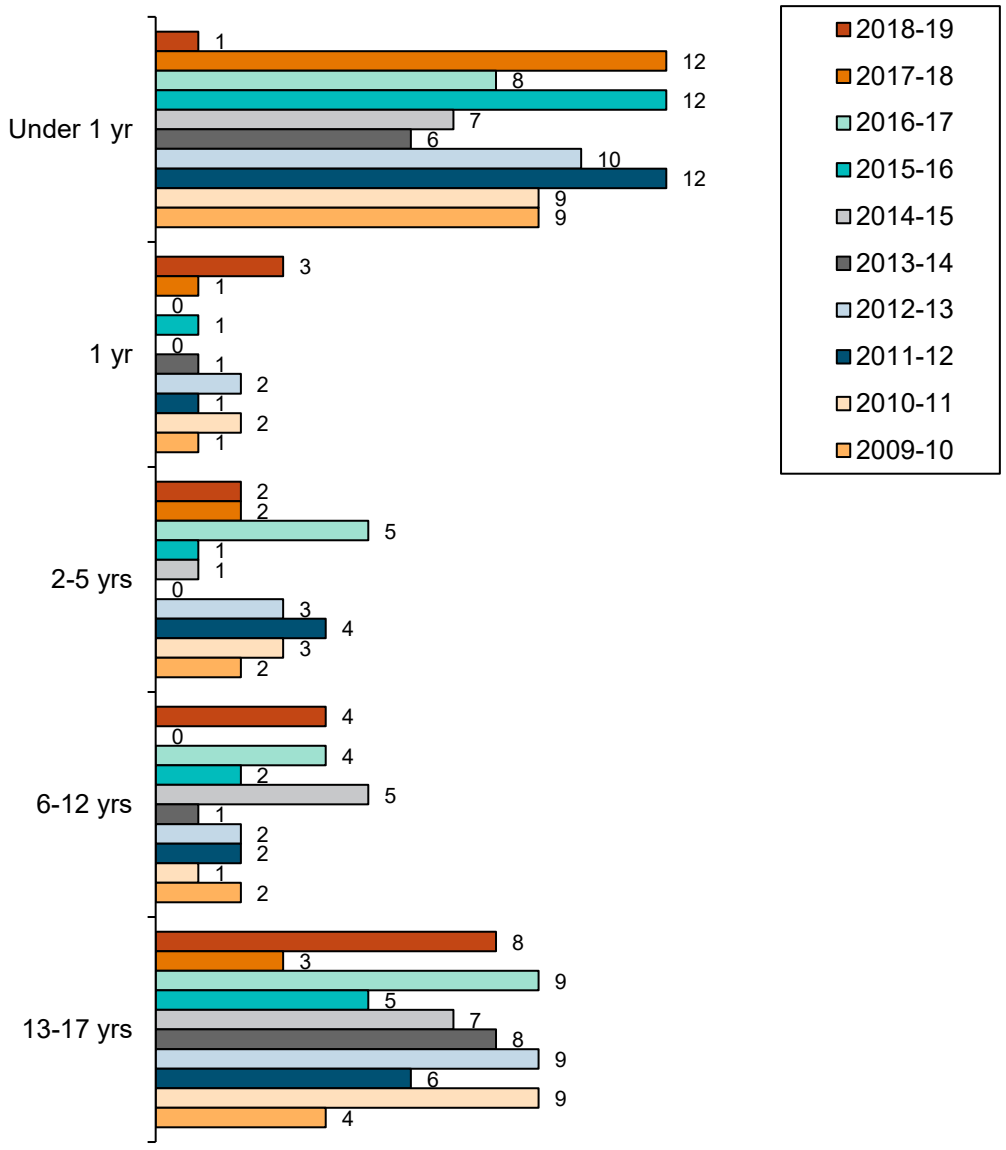
Of the 563 child death notifications received from 30 June 2009 to 30 June 2019, where the Aboriginal status of the child was known, 212 (38%) of the children were identified as Aboriginal.

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.

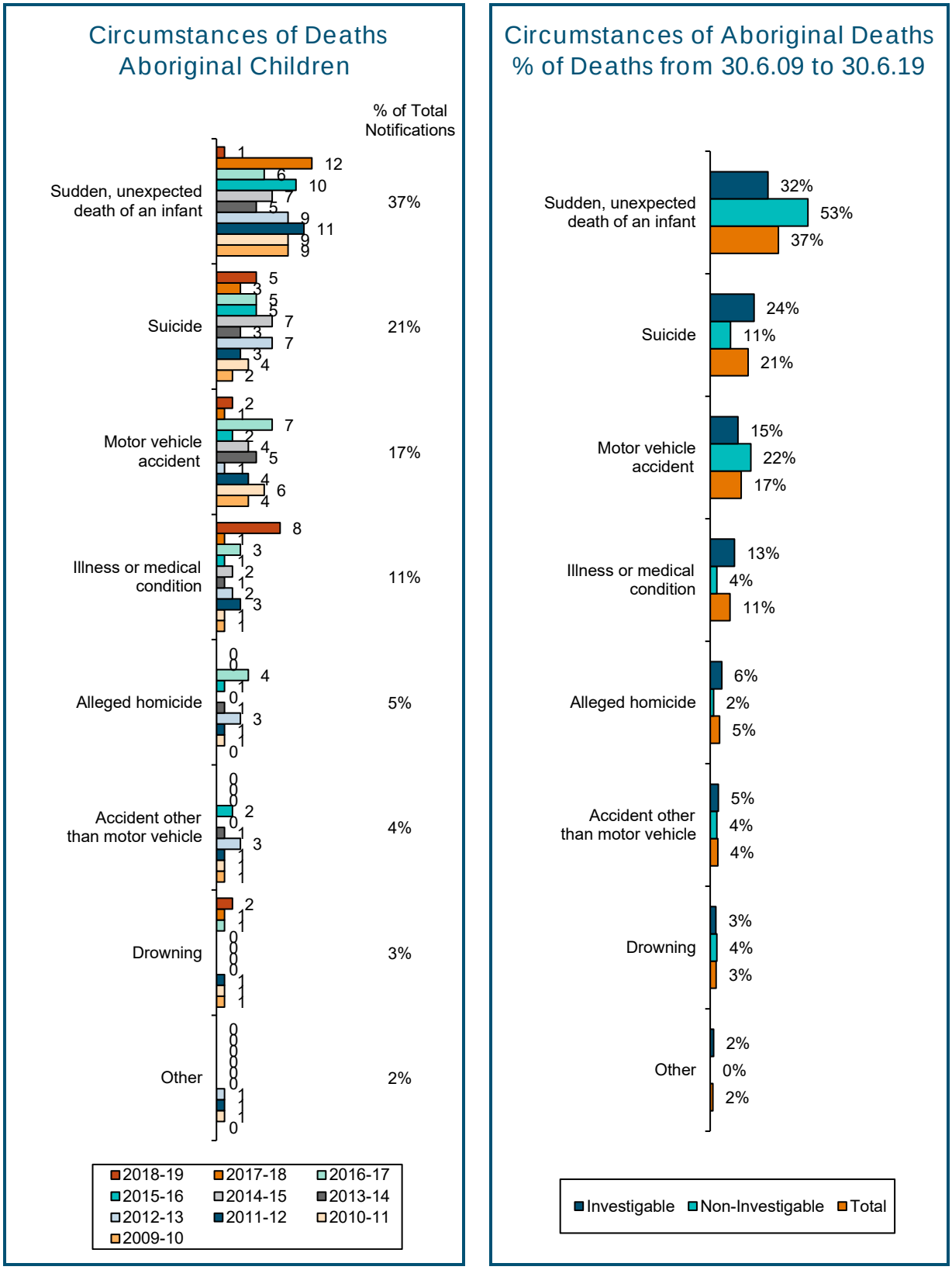


## Characteristics of Aboriginal Children who Died




**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

# Family and Domestic Violence Fatality Review

## Overview

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

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

## Background

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

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

The National Plan is endorsed by the Council of Australian Governments and supported by the *First Action Plan 2010-2013: Building a Strong Foundation*, which

established the 'groundwork for the National Plan', and the *Second Action Plan 2013-2016: Moving Ahead* and the *Third Action Plan 2016-2019*, which build upon this work. The *Fourth Action Plan 2019-2022: Turning the Corner* (available at www.dss.gov.au), as the final action plan of the National Plan, sets out an 'agenda to achieve change by: improving existing initiatives, addressing gaps in previous action plans, providing a platform for future policy to reduce domestic, family and sexual violence'.

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

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

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

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

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

In 2017, the State Government released the *Stopping Family and Domestic Violence Policy*, which sets out 21 new initiatives for responding to family and domestic violence. This document supersedes *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities* (**former State Strategy**)

and the *Freedom from Fear Action Plan 2015*. Also in 2017, the first Minister for the Prevention of Family and Domestic Violence was appointed. In 2018, the Department of Communities (**Communities**) commenced working on the development of a *10 Year Strategy for Reducing Family and Domestic Violence* (**State Strategy**). The findings and recommendations from the Ombudsman's family and domestic violence fatality reviews and major own motion investigations will contribute to the development of this State Strategy.

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

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

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

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

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

### Information regarding the use of terms

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

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

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

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

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

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

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

(d) One of whom is a child who —

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

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

  or

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

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

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

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

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

(b) Is related to the person's —

  (i) Spouse or former spouse; or

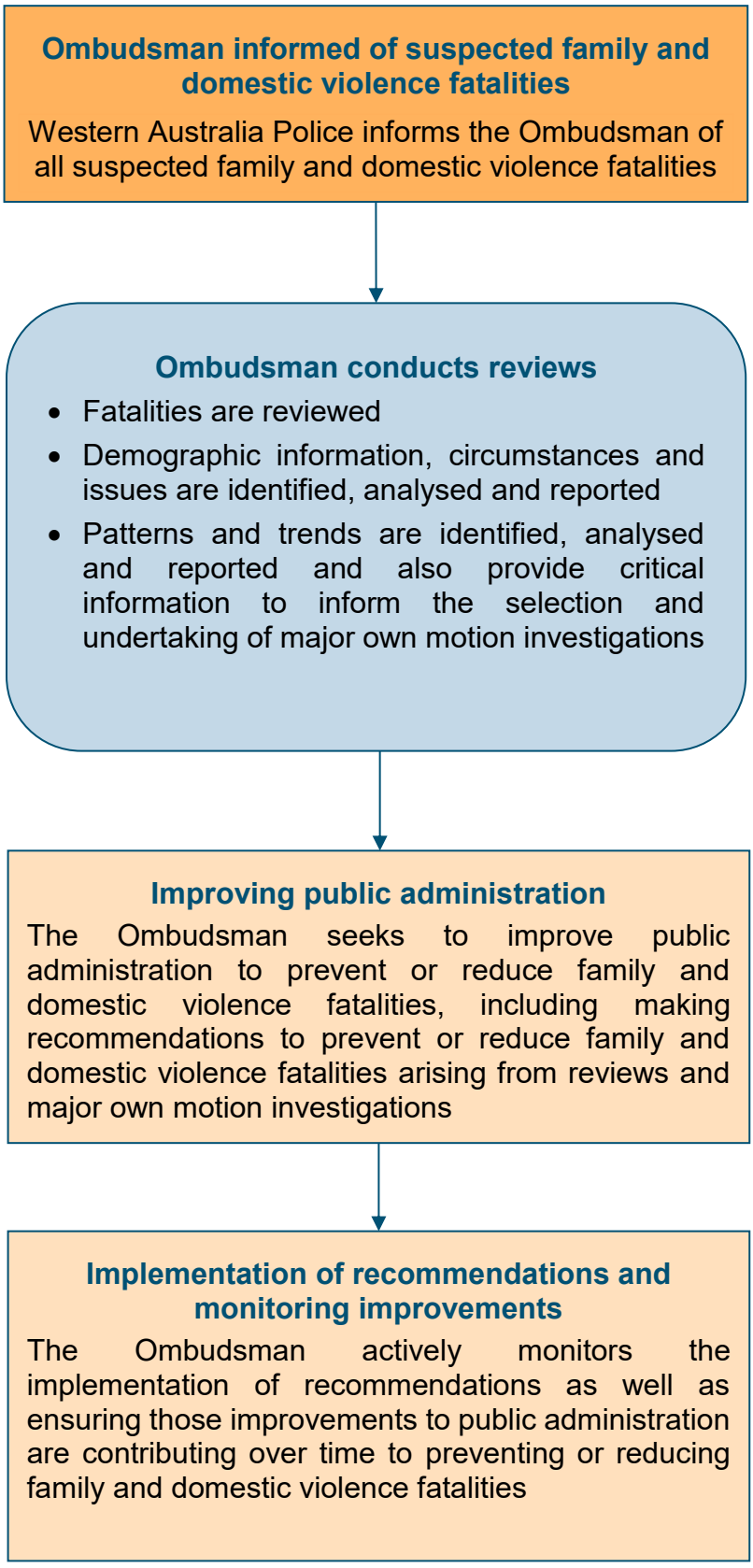
  (ii) De facto partner or former de facto partner.

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

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

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

# The Family and Domestic Violence Fatality Review Process



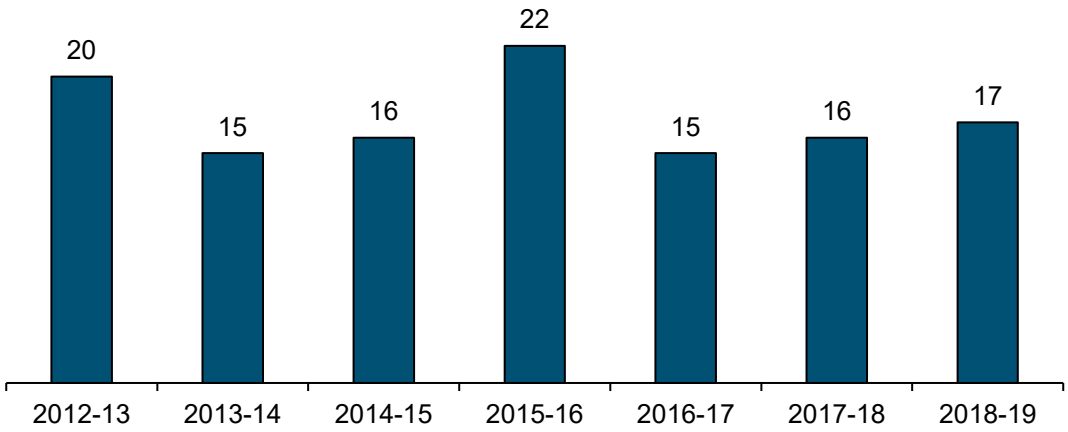
# Analysis of Family and Domestic Violence Fatality Reviews

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

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

## Number of family and domestic violence fatality reviews

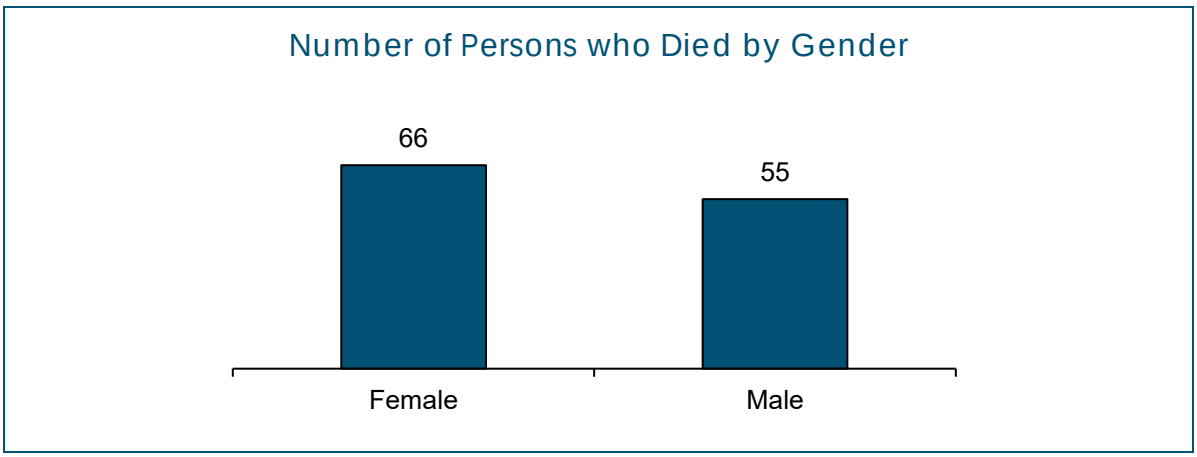
In 2018-19, the number of reviewable family and domestic violence fatalities received was 17, compared to 16 in 2017-18, 15 in 2016-17, 22 in 2015-16, 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

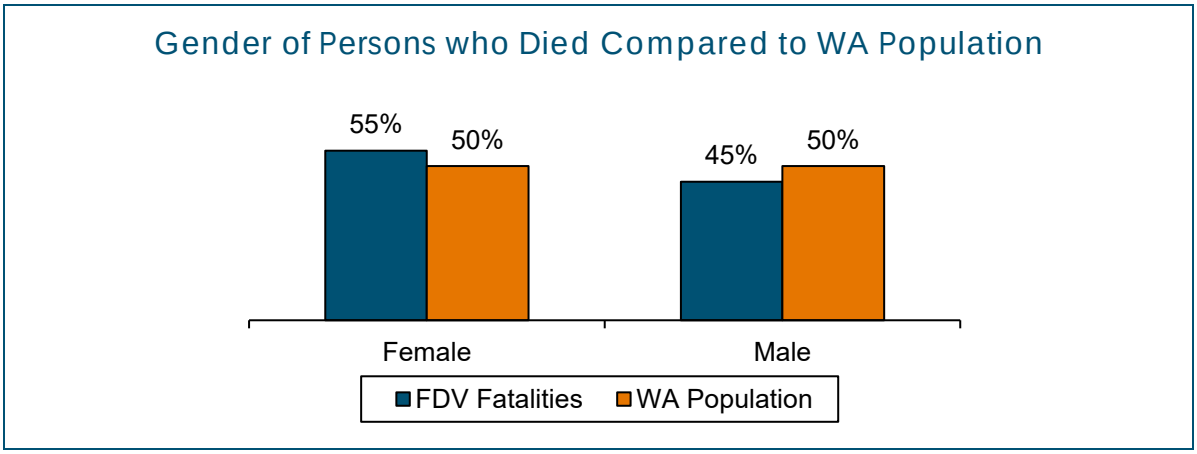



## Demographic information identified from family and domestic violence fatality reviews

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

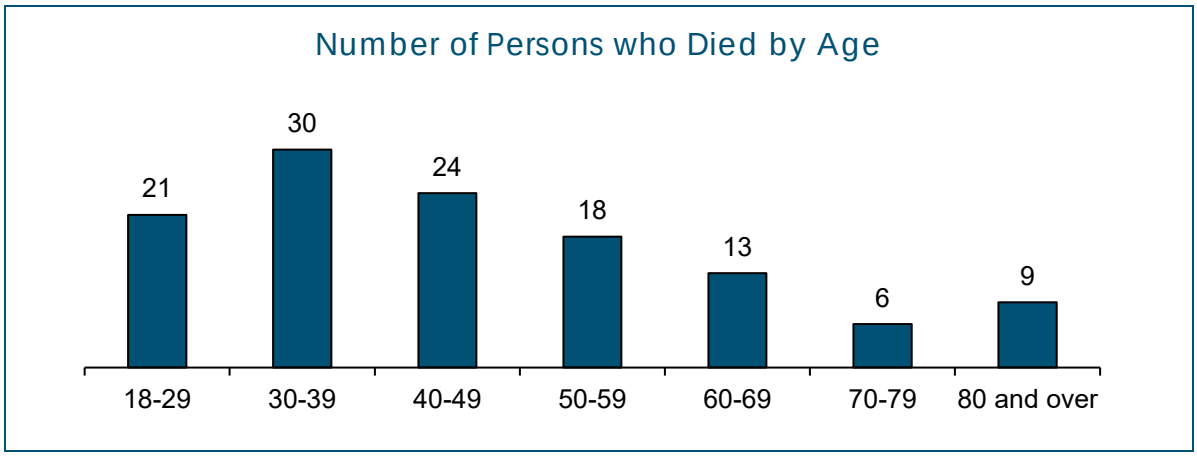
The following charts show characteristics of the persons who died for the 121 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2019. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

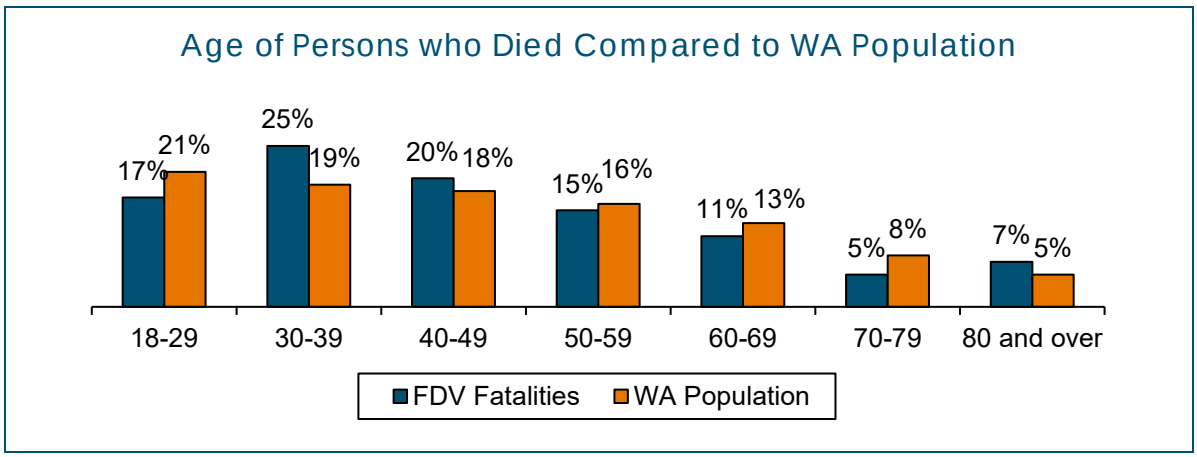


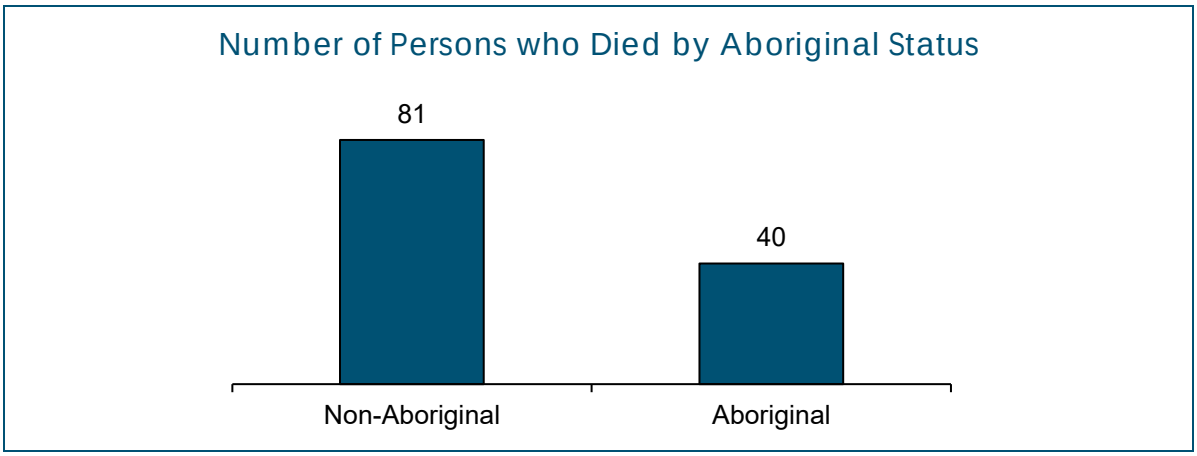

Compared to the Western Australian population, females who died in the seven years from 1 July 2012 to 30 June 2019, were over-represented, with 55% of persons who died being female compared to 50% in the population.

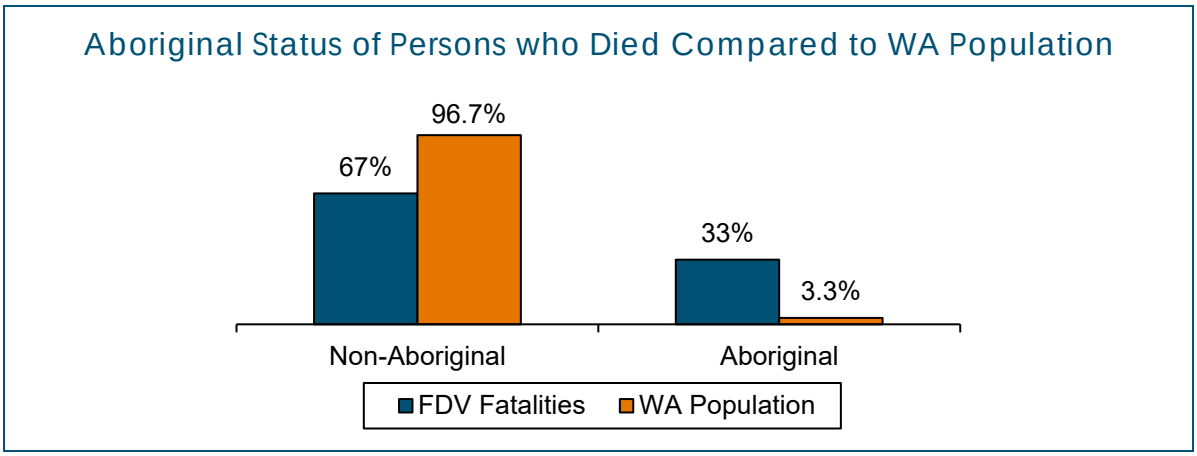
In relation to the 66 females who died, 61 involved a male suspected perpetrator, four involved a female suspected perpetrator, and one involved multiple suspected perpetrators of both genders. Of the 55 men who died, nine were apparent suicides, 24 involved a female suspected perpetrator, 20 involved a male suspected perpetrator and two involved multiple suspected perpetrators of both genders.



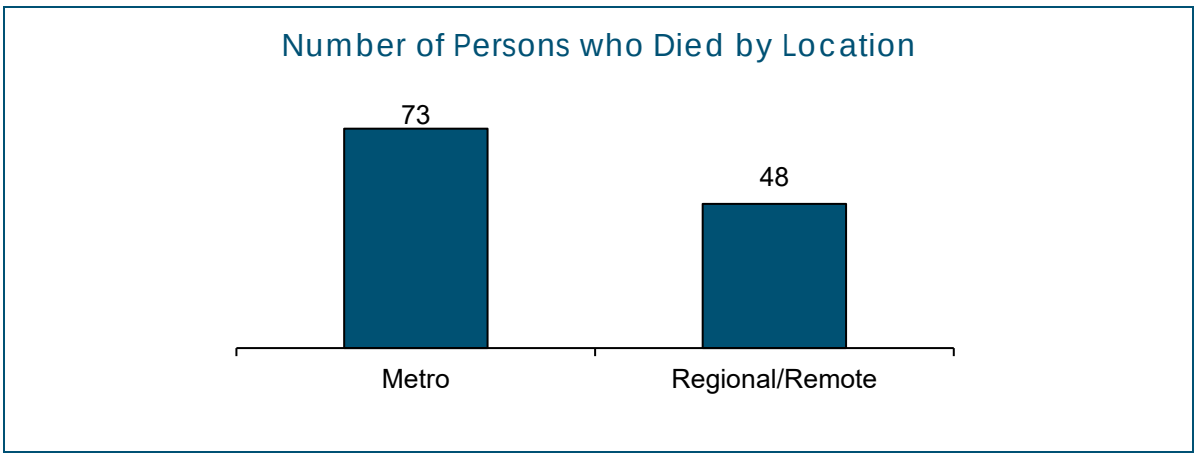


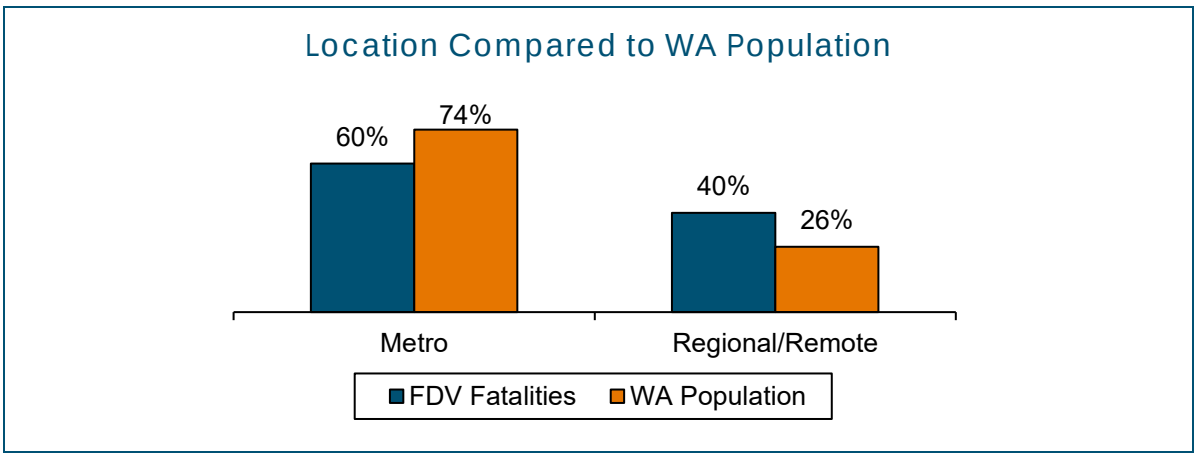

Compared to the Western Australian population, the age groups 30-39, 40-49 and 80 and over are over-represented, with 25% of persons who died being in the 30-39 age group compared to 19% of the population, 20% of persons who died being in the 40-49 age group compared to 18% of the population and seven per cent of persons who died being in the 80 and over age group compared to five per cent of the population.




Compared to the Western Australian population, Aboriginal people who died were over-represented, with 33% of people who died in the seven years from 1 July 2012 to 30 June 2019 being Aboriginal compared to 3.3% in the population. Of the 40 Aboriginal people who died, 23 were female and 17 were male.



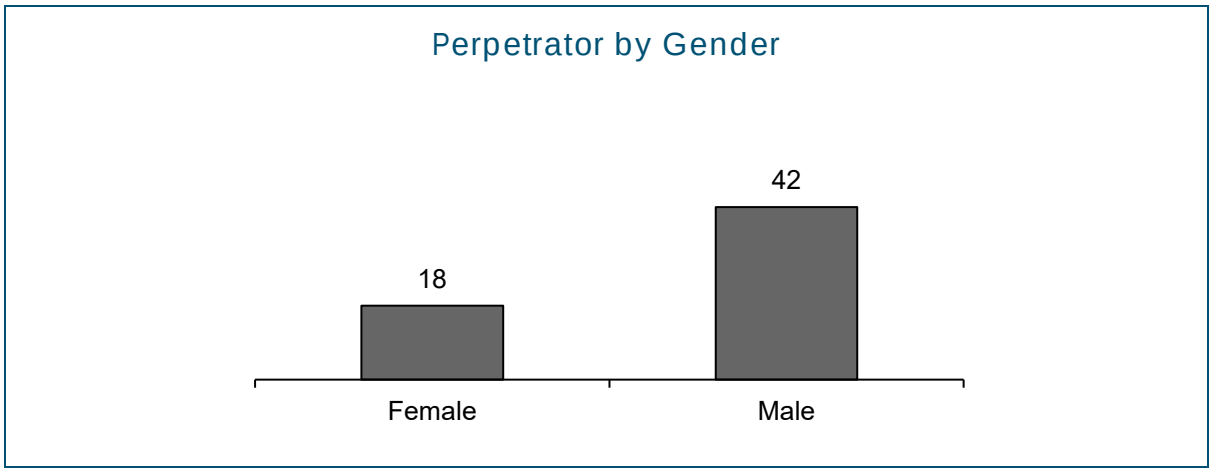

Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 40% of the people who died in the seven years from 1 July 2012 to 30 June 2019 living in regional or remote locations, compared to 26% of the population living in those locations.

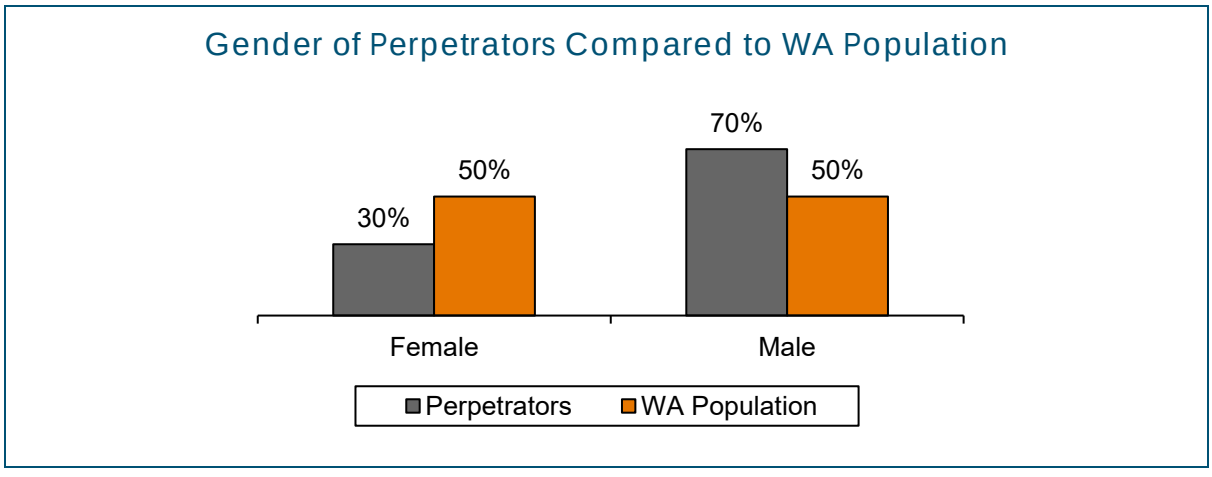
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2019 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2019.

Of the 121 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2019, coronial and criminal proceedings were finalised in relation to 60 perpetrators.

Information is obtained on a range of characteristics of the perpetrator including gender, age group and Aboriginal status. The following charts show characteristics for the 60 perpetrators where both the coronial process and the criminal proceedings have been finalised.



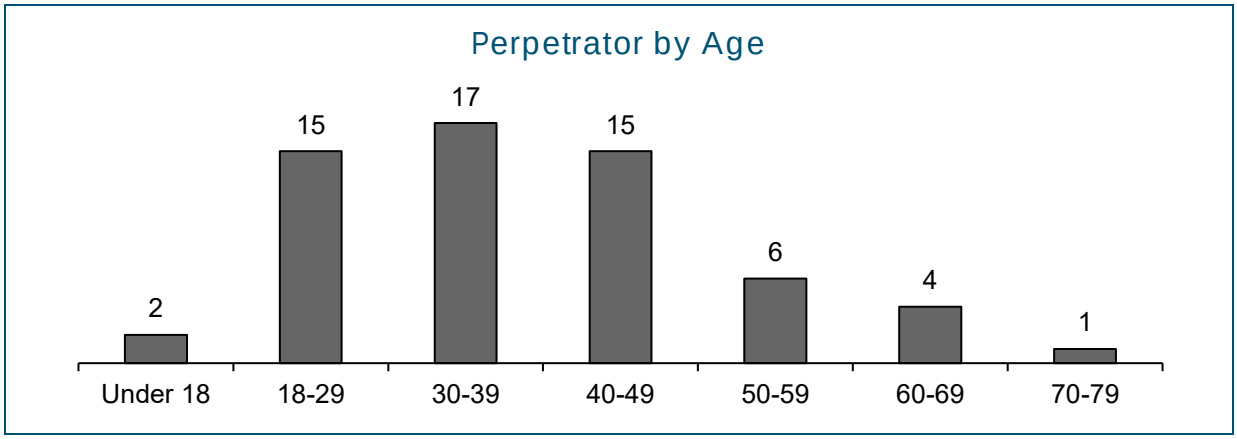



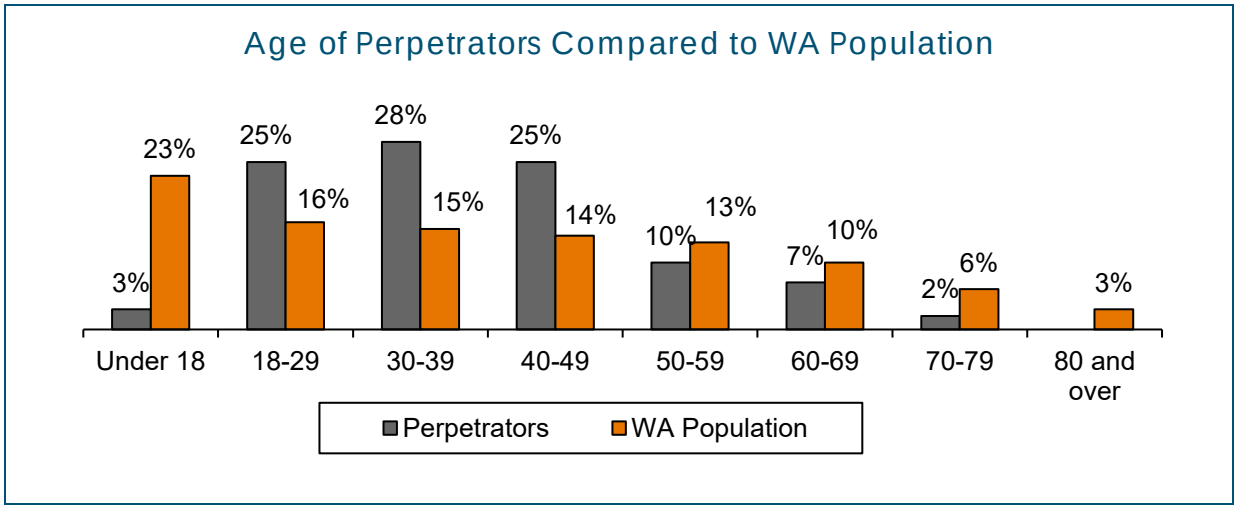

Compared to the Western Australian population, male perpetrators of fatalities in the seven years from 1 July 2012 to 30 June 2019 were over-represented, with 70% of perpetrators being male compared to 50% in the population.

Fourteen males were convicted of manslaughter and 28 males were convicted of murder. Nine females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death, one female was convicted of accessory after the fact to murder and seven females were convicted of murder.

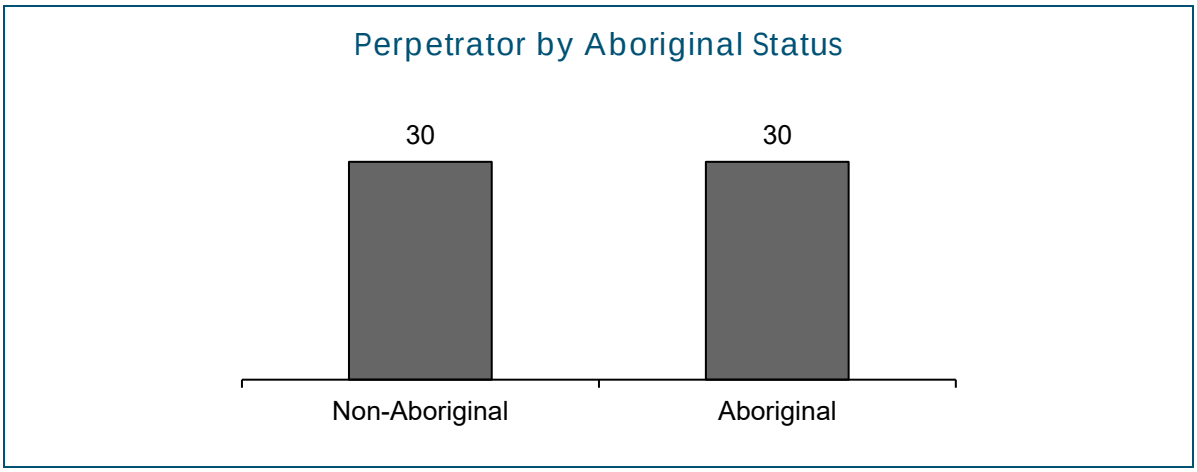
Of the fatalities by the 18 female perpetrators, in 16 the person who died was male, and in two fatalities the person who died was female. Of the 42 fatalities by the 42 male

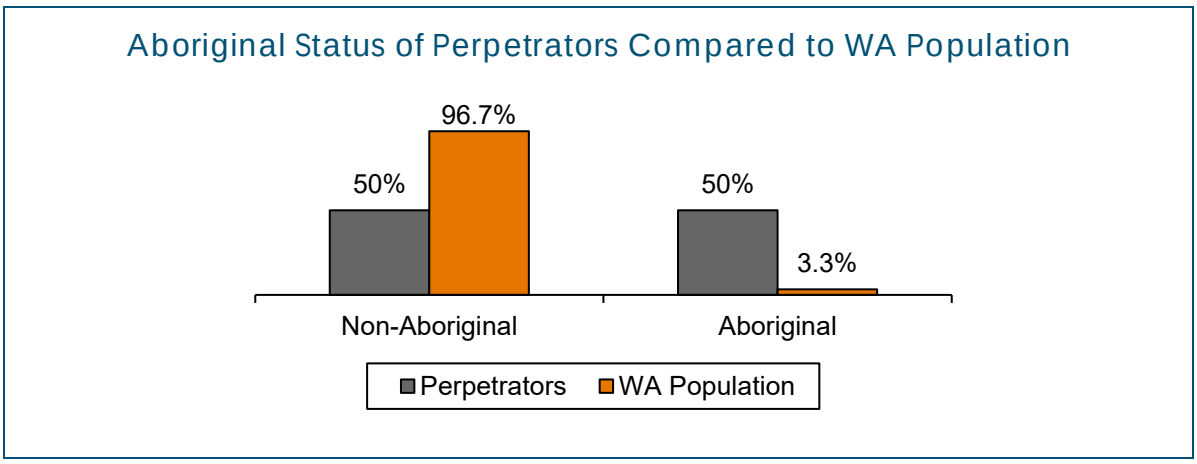
perpetrators, in 34 the person who died was female, and in eight fatalities the person who died was male.



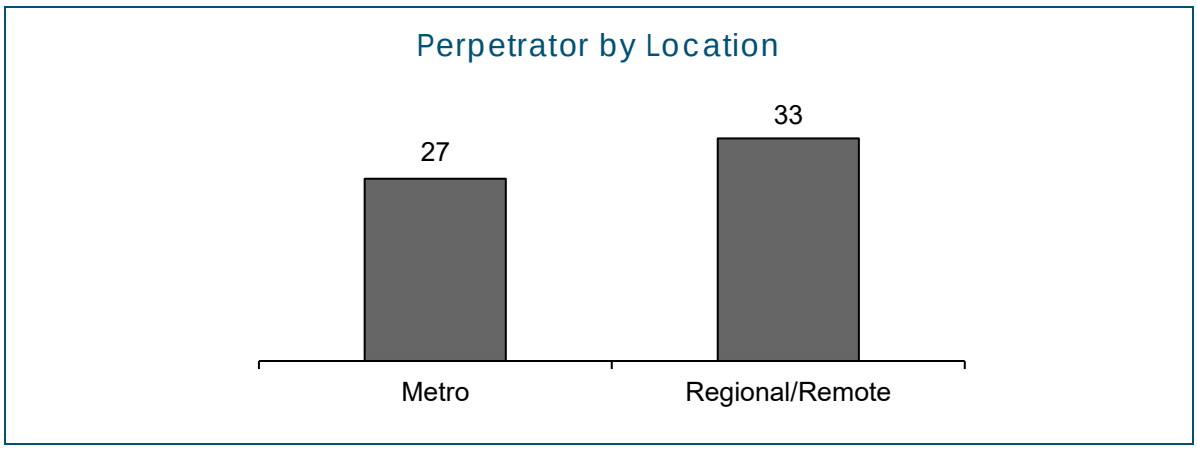

Compared to the Western Australian population, perpetrators of fatalities in the seven years from 1 July 2012 to 30 June 2019 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 25% of perpetrators being in the 18-29 age group compared to 16% in the population, 28% of perpetrators being in the 30-39 age group compared to 15% in the population, and 25% of perpetrators being in the 40-49 age group compared to 14% in the population.

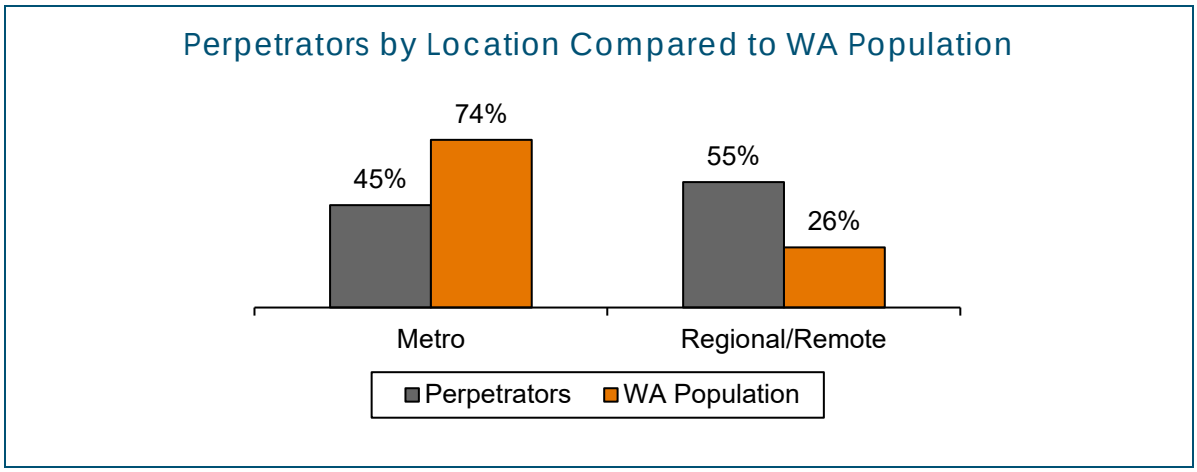





Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the seven years from 1 July 2012 to 30 June 2019 were over-represented with 50% of perpetrators being Aboriginal compared to 3.3% in the population.

In 28 of the 30 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.




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

Compared to the Western Australian population, the people who died in the seven years from 1 July 2012 to 30 June 2019, who were living in regional or remote locations, were over-represented, with 55% of the people who died living in regional or remote locations compared to 26% of the population living in those locations.

## Circumstances in which family and domestic violence fatalities have occurred

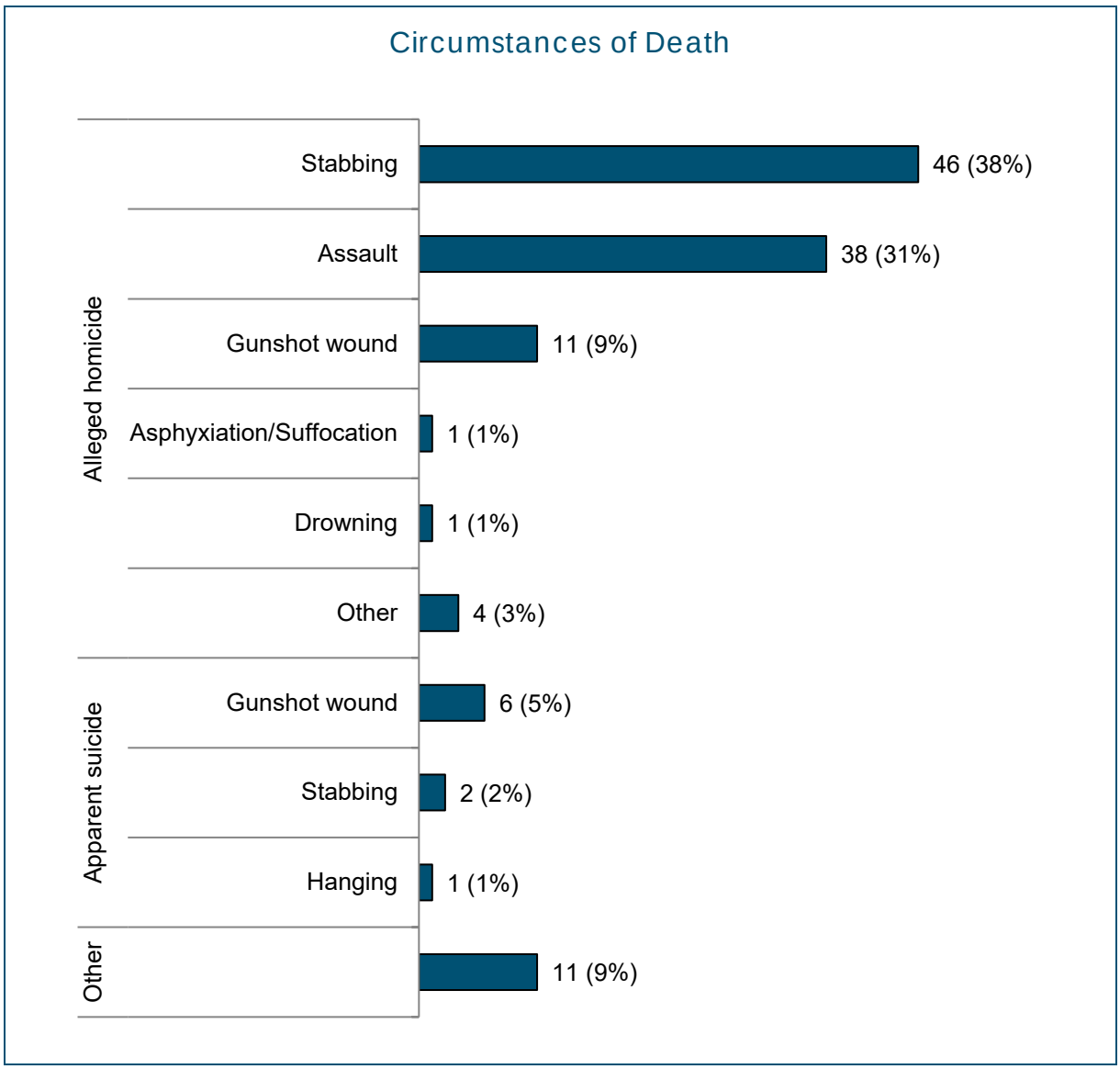
Information provided to the Office by WA Police Force about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

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

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

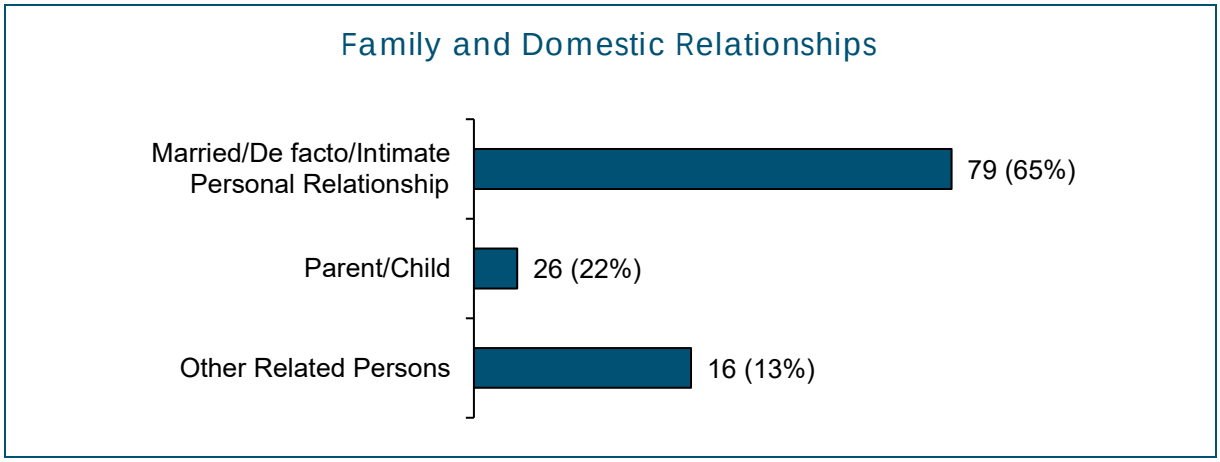
The principal circumstances of death in 2018-19 were alleged homicide by physical assault and stabbing.

The following chart shows the circumstance of death as categorised by the Ombudsman for the 121 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2019.




## Family and domestic relationships

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



Of the 121 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2019:

- 79 fatalities (65%) involved a married, de facto or intimate personal relationship, of which there were 67 alleged homicides, eight apparent suicides and four in other circumstances. The 79 fatalities included 14 deaths that occurred in seven cases of alleged homicide/suicide and, in all seven cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. The eighth apparent suicide involved a male. Of the remaining 60 alleged homicides, 41 (68%) of the people who died were female and 19 (32%) were male;
- 26 fatalities (21%) involved a relationship between a parent and adult child, of which there were 19 alleged homicides, one apparent suicide and six in other circumstances. Of the 19 alleged homicides, six (32%) of the people who died were female and 13 (68%) were male. Of these 19 fatalities, in 12 cases (63%) the person who died was the parent or step-parent and in seven cases (37%) the person who died was the adult child or step-child; and
- There were 16 people who died (13%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, six (37%) were female and 10 (63%) were male.



## Patterns, Trends and Case Studies Relating to Family and Domestic Violence Fatality Reviews[1]

### State policy and planning to reduce family and domestic violence fatalities

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

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

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

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

[1] In this section, DCPFS refers to the (then) Department of Child Protection and Family Support (now Communities), DOTAG refers to the (then) Department of the Attorney General (now DOJ) and WAPOL refers to (then) Western Australia Police (now the Western Australia Police Force).

*domestic violence fatalities*, November 2016, identified that steps have been taken to give effect to the Ombudsman's recommendation. the Ombudsman will continue to monitor the development, implementation and effectiveness of Action Plans in regard to the State Strategy.

## Type of relationships

The Ombudsman finalised 106 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2019.

For 69 (65%) of the finalised reviews of family and domestic violence fatalities, the fatality occurred between persons who, either at the time of death or at some earlier time, had been involved in a married, de facto or other intimate personal relationship. For the remaining 37 (35%) of the finalised family and domestic violence fatality reviews, the fatality occurred between persons where the relationship was between a parent and their adult child or persons otherwise related (such as siblings and extended family relationships).

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

For the 106 finalised reviews, the circumstances of the fatality were as follows:

- For the 69 intimate partner fatalities, 57 were alleged homicides, eight were apparent suicides, and four were other circumstances; and
- For the 37 non-intimate partner fatalities, 29 were alleged homicides, one was an apparent suicide, and seven were other circumstances.

### Intimate partner relationships

Of the 57 intimate partner relationship fatalities involving alleged homicide:

- There were 41 fatalities where the person who died was female and the suspected perpetrator was male, one where the person who died was female and there were multiple suspected perpetrators of both genders, 12 where the person who died was male and the suspected perpetrator was female, one where the person who died was male and the suspected perpetrator was male, and two where the person who died was male and there were multiple suspected perpetrators of both genders;
- There were 23 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In 15 of these fatalities the person who died was female and in eight the person who died was male;
- There were 27 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 10 at the residence of the person who died or the residence of the suspected perpetrator, six at the residence of family or friends, and 14 at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 28 fatalities where the person who died lived in regional and remote areas, and in 20 of these the person who died was Aboriginal.

### Non-intimate partner relationships

Of the 37 non-intimate partner fatalities, there were 23 fatalities involving a parent and adult child and 14 fatalities where the parties were otherwise related.

Of the 29 non-intimate partner fatalities involving alleged homicide:

- There were six fatalities where the person who died was female and the suspected perpetrator was male, four where the person who died was female and the suspected perpetrator was female, 14 where the person who died was male and the suspected perpetrator was male, and five where the person who died was male and the suspected perpetrator was female;
- There were seven non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 11 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 11 at the residence of the person who died or the residence of the suspected perpetrator, and seven at the residence of family or friends or in a public place; and
- There were nine fatalities where the person who died lived in regional and remote areas.

## Prior reports of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reports of alleged family and domestic violence between the parties. In 33 (58%) of the 57 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2019, alleged family and domestic violence between the parties had been reported to WA Police Force and/or to other public authorities. In eight (28%) of the 29 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2019, alleged family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities.

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

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

Of the 41 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, from the records available:

- Three fatalities involved a deceased person with disability;
- None of the fatalities involved a deceased person in a same-sex relationship with the suspected perpetrator;
- 25 fatalities involved a deceased Aboriginal person; and
- 23 of the people who died lived in regional/remote Western Australia.

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

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

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

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

### Identification of family and domestic violence incidents

Of the 41 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, WA Police Force was the agency to receive the majority of these reports. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, noted that DCPFS may become aware of family and domestic violence through a referral to DCPFS and subsequent assessment through the duty interaction process. Identification of family and domestic violence is integral to the agency being in a position to implement its family and domestic violence policy and processes to address perpetrator accountability and promote victim safety and support. However, the Ombudsman's reviews and own motion investigations have identified missed opportunities to identify family and domestic violence in interactions.

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

## Provision of agency support to obtain a violence restraining order

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

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

### *Support to victims in reported incidences of family and domestic violence*

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

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

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

### *Support to obtain a violence restraining order on behalf of children*

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, also examined the response by DCPFS to prior reports of family and domestic violence involving 30 children who experienced family and domestic violence associated with the 30 fatalities. The report found that DCPFS did not provide any active referrals for legal advice or help from an appropriate service to obtain a violence restraining order for any of the children involved in the 30 fatalities. In the report, the Ombudsman recommended that:

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

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

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

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

***Support during the process of obtaining a violence restraining order***

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

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

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

The findings and recommendations from the Ombudsman's family and domestic violence fatality reviews and major own motion investigations will contribute to the development of the State Strategy to reduce family and domestic violence. The Office will also monitor the implementation of Recommendation 14 from the *Investigation into*

*issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, in the development of the State Strategy.

***Support when a violence restraining order has not been granted***

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

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

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

The findings from the Ombudsman's family and domestic violence fatality reviews and the own motion investigations will contribute to the development of the State Strategy to reduce family and domestic violence.

## Provision of support to victims experiencing family and domestic violence

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

> The purpose of risk assessment is to determine the risk and safety for the adult victim and children, taking into consideration the range of victim and perpetrator risk factors that affect the likelihood and severity of future violence.
>
> Risk assessment must be undertaken when family and domestic violence has been identified…
>
> Risk assessment is conducted for a number of reasons including:
>
> - evaluating the risk of re-assault for a victim;
> - evaluating the risk of homicide;
> - informing service system and justice responses;
> - supporting women to understand their own level of risk and the risk to children and/or to validate a woman's own assessment of her level of safety; and
> - establishing a basis from which a case can be monitored.
>
> (pages 36-37)

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

comprehensive assessment of the associated risk of harm and provide support and safety planning.

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

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

In 2018-19, through the reviews of family and domestic violence fatalities, the Office has continued to examine compliance with family and domestic violence policy, in relation to promoting victim safety.

### Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 33 (58%) of the 57 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2019, prior family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities. The Ombudsman's reviews identify where perpetrators have a history of reported violence, with one or more partners, and examines steps taken to hold perpetrators to account for their actions and support them to cease their violent behaviors, in accordance with the intent of the former State Strategy.

The Ombudsman's reviews have examined processes for the rehabilitation of perpetrator behaviours, where perpetrators of family and domestic violence are imprisoned.

## Case Study

### Case Study A

Mr A fatally assaulted his intimate partner, Ms Z. Mr A has been convicted of murder. In the three years prior to this family and domestic violence fatality, Mr A had spent 79% of this time under the direction of DOJ (in prison and on Community Supervision Orders), including for offences that had occurred in the context of family and domestic violence. The Ombudsman's review examined rehabilitation support, as provided by DOJ during this timeframe, and made the following recommendation:

As DOJ develops its agency family and domestic violence strategy, DOJ considers this case in:

- Developing specific strategies to ensure the provision of effective rehabilitation and treatment services for young offenders convicted of offences that occurred within the context of family and domestic violence to assist these young offenders to cease their violent behaviour;
- Developing strategies to promote the safety of young victims of family and domestic violence; and
- Ensuring rehabilitation pathways for Aboriginal youth have been co-designed by Aboriginal people and accord with cultural protocols relating to gender in program delivery.

## Fatalities with no prior reported family and domestic violence

Based on the information available to the Office, in 24 (42%) of the 57 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2019, the fatal incident was the only family and domestic violence between the parties that had been reported to WA Police Force and/or other public authorities. It is important to note, however, research indicating under-reporting of family and domestic violence. The Australian Bureau of Statistics' *Personal Safety Survey 2016* (www.abs.gov.au) collected information about help seeking behaviours, noting that:

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

and

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

The Ombudsman's reviews provide information on family and domestic violence fatalities where there is no previous reported history of family and domestic violence, including cases where information becomes available after the death to confirm a

history of unreported family and domestic violence, drug or alcohol use, or mental health issues that may be relevant to the circumstances of the fatality.

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

## Family violence involving Aboriginal people

Of the 106 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2019, Aboriginal Western Australians were over-represented, with 33 (31%) persons who died being Aboriginal. In all but one case, the suspected perpetrator was also Aboriginal. There were 25 of these 32 fatalities where the person who died lived in a regional or remote area of Western Australia, of which 20 were intimate partner fatalities.

The Ombudsman's family and domestic violence fatality reviews and the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identify the over-representation of Aboriginal people in family and domestic violence fatalities. This is consistent with the research literature that Aboriginal people are 'more likely to be victims of violence than any other section of Australian society' (Cripps, K and Davis, M, *Communities working to reduce Indigenous family violence*, Brief 12, Indigenous Justice Clearinghouse, New South Wales, June 2012, p. 1) and that Aboriginal people experience family and domestic violence at 'significantly higher rates than other Australians' (Aboriginal and Torres Strait Islander Social Justice Commissioner, *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities – Key Issues, An overview paper of research and findings by the Human Rights and Equal Opportunity Commission, 2001 - 2006*, Human Rights and Equal Opportunity Commission, June 2006, p. 6).

### Contextual Factors for family violence involving Aboriginal people

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

> …violence against women within the Indigenous Australian communities need[s] to be understood within the specific historical and cultural context of colonisation and systemic disadvantage. Any discussion of violence in contemporary Indigenous communities must be located within this historical context. Similarly, any discussion of "causes" of violence within the community must recognise and reflect the impact of colonialism and the indelible impact of violence perpetrated by white colonialists against Indigenous peoples
>
> … A meta-evaluation of literature…identified many "causes" of family violence in Indigenous Australian communities, including historical factors such as: collective dispossession; the loss of land and traditional culture; the fragmentation of kinship systems and Aboriginal law; poverty and unemployment; structural racism; drug and alcohol misuse; institutionalisation; and the decline of traditional Aboriginal men's role and status - while "powerless" in relation to mainstream society, Indigenous men may seek compensation by exerting power over women and children...

(Blagg, H, Bluett-Boyd, N, and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 3).

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

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

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

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

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

### A separate strategy to prevent and reduce Aboriginal family violence

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

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

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

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

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

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

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

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

and proposed steps to be taken to give effect to these recommendations. The Ombudsman's reviews have continued to monitor the implementation of these recommendations.

### Limited use of violence restraining orders

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

In the report, the Ombudsman recommended that:

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

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

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

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

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

The findings from the Ombudsman's family and domestic violence fatality reviews and the own motion investigations will contribute to the development of the State Strategy, and the Office will continue to monitor, and report on, the steps being taken to implement Recommendation 16 from the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015.

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

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

In the report, the Ombudsman recommended that:

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

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

The findings and recommendations from the Ombudsman's family and domestic violence fatality reviews and major own motion investigations will contribute to the development of the State Strategy to reduce family and domestic violence.

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

Of the 33 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2019 involving Aboriginal people, 25 (76%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Fourteen (42%) of the Aboriginal people who died lived in the Kimberley region, which is home to 1.4% of all people and 19% of Aboriginal people in the Western Australian population.

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

active way at each stage and level of the process' and being 'comprehensively informed by Aboriginal culture'.

## Factors co-occurring with family and domestic violence

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

### Co-occurrence with alcohol and other drug use

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

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

The National Plan and the *National Drug Strategy 2017-2026* identify initiatives to address alcohol and drug use, and the co-occurrence with family and domestic violence. The Foundation for Alcohol Research and Education's *National framework for action to prevent alcohol-related family violence* (available at www.fare.org.au/national-framework-for-action-to-prevent-alcohol-related-family-violence/) states:

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

On the information available, relating to the 86 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2019, the Office's reviews identify where alcohol use and/or drug use are factors associated with the fatality, and where there may be a history of alcohol use and/or drug use.

| | ALCOHOL USE | | DRUG USE | |
|---|---|---|---|---|
| | Associated with fatal event | Prior history | Associated with fatal event | Prior history |
| Person who died only | 3 | 4 | 3 | 7 |
| Suspected perpetrator only | 6 | 14 | 10 | 13 |
| Both person who died and suspected perpetrator | 26 | 28 | 8 | 15 |
| **Total** | **35** | **46** | **21** | **35** |

The Ombudsman's reviews and *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, have identified that in Western Australia, the former State Strategy did not mention or address alcohol use co-ocurring with family and domestic violence. The Mental Health Commission's *Western Australian Alcohol and Drug Interagency Strategy 2018-2022* acknowledges that 'alcohol and other drug use problems can be linked to a range of negative effects on children and families including…family arguements, injury, neglect, abuse, and violence' (page 29, www.mhc.wa.gov.au). Stakeholders have suggested to the Ombudsman that programs and services for victims and perpetrators of violence in Western Australia, including family and domestic violence, do not address its co-occurrence with alcohol and other drug abuse. Specifically, this means that programs and services addressing family and domestic violence:

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

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

- Address perpetrators' violent behaviour; or
- Respond to the needs of victims resulting from their experience of family and domestic violence.

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

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

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

recommendation. The Office will monitor the implementation and effectiveness of the *Western Australian Alcohol and Drug Interagency Strategy 2018-2022*, and the State Strategy to reduce family and domestic violence, in responding to family and domestic violence and co-occurrence with alcohol and drugs.

### Co-occurrence of mental health issues

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

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

and

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

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

The Ombudsman's reviews have examined steps taken by mental health service providers to assess patient risk of violence and to develop relevant safety planning where appropriate. The Office will continue to monitor action taken by mental health service providers to reduce the risk of family and domestic violence fatalities.

## Case Study

### Case Study B

Mr B fatally assaulted a family member. Prior to this family and domestic violence fatality Mr B had been under the management of a mental health service provider. The Ombudsman's review examined actions taken by the mental health service provider to assess Mr B's risk of violence and the development of an associated safety plan, and made the following recommendation:

In meeting DOH's *Clinical Care of People With Mental Health Problems Who May Be At Risk of Becoming Violent or Aggressive Policy* requirement to develop a local policy for the clinical care of people with mental health problems who may be at risk of becoming violent or aggressive by June 2019, the East Metropolitan Health Service considers the issues identified in this review.

## Issues Identified in Family and Domestic Violence Fatality Reviews

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

It is important to note that:

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

- Not providing culturally informed intervention when responding to Aboriginal family violence.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities to provide perpetrator rehabilitation support.
- Missed opportunities to address family and domestic violence victim safety.
- Missed opportunity to assess risk of harm and develop strategies to reduce or prevent family and domestic violence in the context of mental health issues and/or drug and alcohol use.
- Not undertaking sufficient family and inter-agency communication to enable effective case management and collaborative responses.
- Inaccurate recordkeeping.

## Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following two recommendations were made by the Ombudsman in 2018-19 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. In meeting DOH's *Clinical Care of People With Mental Health Problems Who May Be At Risk of Becoming Violent or Aggressive Policy* requirement to develop a local policy for the clinical care of people with mental health problems who may be at risk of becoming violent or aggressive by June 2019, the East Metropolitan Health Service considers the issues identified in this review.
2. As DOJ develops its agency family and domestic violence strategy, DOJ considers this case in:
   - Developing specific strategies to ensure the provision of effective rehabilitation and treatment services for young offenders convicted of offences that occurred within the context of family and domestic violence to assist these young offenders to cease their violent behaviour;
   - Developing strategies to promote the safety of young victims of family and domestic violence; and
   - Ensuring rehabilitation pathways for Aboriginal youth have been co-designed by Aboriginal people and accord with cultural protocols relating to gender in program delivery.

**The Ombudsman's *Annual Report 2019-20* will report on the steps taken to give effect to the nine recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2017-18. The Ombudsman's *Annual Report 2020-21* will report on the steps taken to give effect to the two recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2018-19.**

### Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2016-17

The Ombudsman made nine recommendations about ways to prevent or reduce family and domestic violence fatalities in 2016-17. The Office has requested that the relevant public authorities[2] 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.

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

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

## 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 (**the Department's report**).

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

> A copy of the Ombudsman's preliminary view was forwarded to the relevant Metropolitan District. The District Director acknowledged this recommendation and undertook to meet with the Assistant District Director and Team Leaders to reiterate key decision-making points and the approval processes for Safety and Wellbeing Assessments (SWAs).

In outlining the implementation of Recommendation 1, the Department's report also referred this Office to the response for Child Death Review Recommendation 9, in which 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.
>
> …
>
> 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 (FDV) 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

It is also noted that the Department's report indicated that information provided by the Department for 2016-17 Child Death Review Recommendations 25 and 26 are also relevant to this response.

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

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

> During 2017, Communities reviewed the findings of the OWA's FDV fatality review as well as the final 2012, 2014 and 2016 Standard and Monitoring Reports. As a result of these reviews, relevant Metropolitan District developed a range of actions to improve practice.

The Department's report further references a letter to this Office, dated 29 November 2017, which reports on actions that have been taken to give effect to Recommendation 2. This letter is detailed in Recommendation 3, below.

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

> In 2018, Communities undertook a review of the Safety and Wellbeing Assessment (SWA), as part of the SWA Project. As a result of the review, a number of recommendations were endorsed by Communities Service Delivery Joint Executive Meeting. This included renaming SWA's to Child Safety Investigations (CSIs) to strengthen the requirement for investigation. Other work from this project includes redeveloping the Assessment and Investigation Casework Practice Manual (CPM) entry to support staff with:
>
> - Achieving compliance with a 30-day timeframe for CSI completion
> - Writing assessments which are grounded in the Signs of Safety framework
> - Aligning CSIs to legislative requirements
>
> Throughout 2019, Communities will be delivering state-wide training for all child protection staff, on the redeveloped CSI processes.

It is also noted that Department's report indicated that information provided by the Department for Child Death Review Recommendations 25 and 26 are also relevant to this response.

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

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

**Steps taken to give effect to the recommendation**

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

> Findings from the 2012, 2014 and 2016 SMU reports have been reviewed by the Department.
>
> - In 2012 the monitors identified ten commendations and nine required actions.
> - In 2014 the monitors identified eight commendations and six required actions, and in 2016 the monitors identified 14 commendations and six required actions.
> - Across all three SMU reports, the required actions were satisfactorily completed within the required timeframe. Only one required action was consistently noted across all three SMU reports, and was in relation to Safety and Wellbeing Assessments (SWA) and Initial Inquiries not being completed within the required timeframes.
> - Whilst SWA compliance is an ongoing issue, it is recognized that the relevant Metropolitan district manage a high workload and staff turnover. To alleviate workload pressure and to improve SWA and Initial Inquiry compliance, the relevant Metropolitan district have utilised the Department's state-wide relieving team (SRT) when required.
>
> The Department's SRT began operation in April 2017. This team can assist where districts may be experiencing unusually high workload demands or where workers are required to target a particular area of practice. The SRT is available for country and metropolitan deployment for up to two weeks at a time.
>
> As a result of the Department reviewing the FDV fatality, the relevant Metropolitan district has identified areas from improvement and has developed a set of actions. The following actions have been taken to give effect to recommendation two:
>
> - All staff will be provided with two-day FDV training. Nineteen staff attended the first FDV training, which was held at the relevant Metropolitan office on 11 and 12 October 2017. The remaining staff will attend the FDV training on 5 and 6 December.
> - Two drug and alcohol workshops, held at the relevant Metropolitan office on 7 and 21 June 2017, were provided to staff in the relevant Metropolitan district. Each of these workshops was attended by approximately forty Child Protection Workers. This was done in conjunction with the South Metropolitan Drug and Alcohol Office. These workshops have increased staff awareness of the impact of drug and alcohol use on parents.
> - An FDV networking workshop has been planned for 29 November 2017, with the local Domestic Violence Support Worker and front-end Child Protection Workers. This workshop seeks to increase staff knowledge of local support services for victims of FDV. It should also increase skills to assess FDV using the Common Risk Assessment and Risk Management Framework (CRARMF) risk assessment tool.

- Relevant Metropolitan district's management team has been closely monitoring the Family Violence Incident Reports (FVIR) triage process and the workload of the Senior Child Protection Worker – Family and Domestic Violence (SCPW-FDV). This is to ensure that SCPW-FDV can be available for Multidisciplinary Case Consultations (MCC).
- MCCs have been implemented in the relevant Metropolitan District, with a minimum of four per week being undertaken. These meetings consider different professional perspectives and provide an opportunity to support staff to apply appropriate policy and practice guidance to child protection cases.

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

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

**Steps taken to give effect to the recommendation**

WACHS provided this Office with a letter dated 14 December 2017, with an attachment setting out the strategies that have been developed. In this letter WACHS relevantly informed this Office that:

> In February and March 2017 the Hedland Health Campus Emergency Department teams began reviewing and compiling relevant guidelines and directives, along with local services to whom referrals could be made.
>
> These discussions were formalised with the Clinical Practice Improvement Coordinator, under the guidance of the Regional Nurse Director and Regional Medical Director, coordinating a project to implement processes for assessment, treatment and referral of adults at risk of Family and Domestic Violence.

This letter also provided a copy of this project plan.

This Office subsequently requested that WACHS updates the Office on 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 (**the WACHS report**).

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

- WACHS has implemented a policy - WACHS Identifying and Responding to Family and Domestic Violence which aims to:
  - Ensure consistent minimum standards for clinicians with regard to identifying and responding to disclosures of family and domestic violence.
  - Support early detection of clients at risk of family and domestic violence.
  - Improve staff awareness of the possible indicators of family and domestic violence.
  - Improve the safety of women and children.
- Ensure compliance with S28b Children and Community Services Act 2004.
- Family and Domestic Violence forms for screening, assessment and referral to other agencies have been developed and published which will support monitoring and audit.

- A Family and Domestic Violence toolkit has been developed and introduced outlining resources available to staff and includes:
  - Referral guidelines.
  - Resources for Clients.
  - Local Family and Domestic Violence resource guide for each WACHS region.
  - Clinical guidance material for Clinicians.
  - Education and training resources.
  - Support for employees who are victims of Family and Domestic violence.
  - Links to Women and Newborn Health Services.

…Note: As a minimum, new WACHS policies are communicated to all staff through a fortnightly CE eNews, and are available online through HealthPoint. This process is also complemented by local communication as well as WACHS induction processes.

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

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

**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:

1. WACHS Central Office has established regular meetings with Child Protection Family Support Services and WAPOL to strengthen the relationships and ensure improved processes are in place across all regions to enable coordinated responses for children at risk and those at risk of domestic violence.
2. WACHS has developed a policy that aims to:
   - Ensure consistent minimum standards for WACHS clinicians with regard to identifying and responding to disclosures of family and domestic violence;
   - Support early detection of clients at risk of family and domestic violence;
   - Improve staff awareness of the possible indicators of family and domestic violence;
   - Improve the safety of women and children; and
   - Ensure compliance with S28b, Children and Community Services Act 2004.

It is noted that in response to Recommendation 4, WACHS had informed this Office that:

- A Family and Domestic Violence toolkit has been developed and introduced outlining resources available to staff and includes:
  - Referral guidelines.
  - Resources for Clients.
  - Local Family and Domestic Violence resource guide for each WACHS region.

- Clinical guidance material for Clinicians.
- Education and training resources.
- Support for employees who are victims of Family and Domestic violence.
- Links to Women and Newborn Health Services.

As indicated above, the WACHS *Family and Domestic Violence toolkit* includes a *Local Family and Domestic Violence resource guide* for each WACHS region. WACHS provided this Office with a copy of *Family and Domestic Violence Local Resource Guide: Pilbara*, and indicated a similar resource is available for each WACHS region. Our review of the *Family and Domestic Violence Local Resource Guide: Pilbara*, which was last updated in March 2019, confirms this resource provides contact details for local and state-wide family and domestic violence support services.

**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 that the Department's Family and Domestic Violence Response Team triage assessments align with the Department's policies and practice requirements associated with responding to family and domestic violence and child safety and wellbeing concerns.**

**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:

> Communities have undertaken the following actions, to give effect to his recommendation:
>
> - During June and July 2018, Communities worked closely with Western Australia Police Force (WA Police Force) to deliver two-day FDV training to new Police Officer recruits to the Family and Domestic Violence Response Teams. Communities, attended all six training sessions and delivered a comprehensive session on child protection.
>
> - In November 2018, updated Practice Guidance for Senior Child Protection Worker - Family and Domestic Violence (SCPW-FDV) was drafted. The updated guidance now includes a requirement that all SCPW-FDV are trained in and use the Central Intake Interaction Tool, to guide their assessments of child safety.
>
> Communities is committed to working closely with the WA Police Force and the Family and Domestic Violence Coordinated Response Services (CRS) to continuously improve the quality of assessment or FDV and child safety wellbeing concerns.

The Office notes that in July 2017 the Department commenced operation of the Central Intake Team which the Department has informed was established to 'create a consistent approach to managing work coming into the Department'. The Department's report states the Department's representative on Family and Domestic Violence Response Teams will now use the same assessment tool used by the Central Intake Team (the Central Intake Interaction Tool) when triaging notifications.

The Department's report indicates that the use of this tool will ensure Family and Domestic Violence Response Team triage assessments will align with policies and practice requirements associated with responding to family and domestic violence and child safety and wellbeing concerns.

It is also noted that information provided by the Department for Child Death Review Recommendation 25 is also relevant to this response.

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

**Recommendation 7: Western Australia Police Force (WA Police Force) takes all reasonable steps to ensure that identified child safety and wellbeing concerns are reported to the Department consistent with procedural requirements included in the Commissioner's Operations and Procedures Manual.**

**Steps taken to give effect to the recommendation**

This Office requested WA Police Force inform the Office of the steps taken to give effect to the recommendation. In response, WA Police Force provided a range of information in a letter to this Office dated 27 March 2019, containing a report prepared by WA Police Force.

In the report, WA Police Force relevantly informed this Office that:

> In August 2016 a review was undertaken in consultation with the Department of Communities and Crisis Care as to the frequency and suitability of referrals made by police to the respective agencies where children at risk were found to be present at Family Violence (FV) incidents.
>
> 1. The feedback provided by the key stakeholders involved in the review suggested that at that point in time they did not hold any concerns about the timeliness of referrals when police had immediate concerns for welfare children at FV incidents.
> 2. General Broadcast numbered 180209 issued on 12 February 2018 titled 'Child Protection Concern Referrals' re-enforced the police requirement to notify the Department of Communities when there are wellbeing concerns for children, in line with the Commissioner's Operations and Procedures Manual.
> 3. This is further re-enforced within the current WA Police Force Code of Practice for the Investigation of Family Violence under the sub-title 'Safety and Wellbeing of Young People and Children' which is available to all police officers when accessing the Family Violence portal on the Intranet site. An intranet monitor count indicates the portal has been accessed over 6500 times since July 2017.

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

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

## Steps taken to give effect to the recommendation

WA Police Force provided this Office with a letter dated 5 January 2018, which confirmed that this review had been undertaken. The letter provided detail on five leanings from this review, which were as follows:

**Learning 1: Initial Police Response and Engagement**

Despite police sharing information with a range of diversionary and support services, there was an identified difficulty between linking with support services on a voluntary basis, and a requirement to engage. WA Police Force will continue to support and encourage victims of family violence to seek assistance with specialised support services, however, the subsequent engagement is at the will of those referred.

Managing families experiencing complex and high levels of dysfunction is challenging, however WA Police Force is committed to providing a co-ordinated response to affected individuals and families to ensure they receive referrals to available appropriate support services.

**The WA Police Force will:**

Continue to enforce law, prevent reoccurrence of crime; and coordinate efforts to connect affected individuals and families to appropriate support services.

**Learning 2: Coordinated Police Response**

The Aboriginal Affairs Division, previously called the Aboriginal and Community Diversity Unit (ACDU) is the current agency resource able to offer assistance and support to police engaging with Aboriginal families who are victims of family violence. Local police did not engage with ACDU in respect to the issues confronted at the deceased's residence.

In 2015, police operated District Victim Support Units. Those units are now replaced with expanded metropolitan Family Violence Teams. In 2015, the South Metropolitan VSU [Victim Support Unit] advised they were unaware of the role of the ACDU in 2015 and had they been, would have readily enlisted their support in engaging with the deceased and her family.

**WA Police Force will:**

Increase police awareness and visibility of the Aboriginal Affairs Division through internal promotion, including a 'From the Line' publication to highlight the availability of the Aboriginal Affairs Division to provide expert advice on cases of complex family violence within the Aboriginal community.

**Learning 3: Information Sharing**

A lack of consolidated information holdings exists in relation to individuals and members of families experiencing complex dysfunction and officers responding to incidents are required to inform themselves prior to attendance. In the case of critical incidents, this opportunity may be limited due to time required to research multiple police systems, whilst providing an expedient response.

**WA Police Force will:**

Continue participation to deliver outcomes for the Community Safety and Family Support Cabinet Sub-Committee including the creation of a framework for information sharing and risk assessment for the relevant government agencies, including a central secure database accessible for WA Police Force, Departments of Health, Communities, Justice and Local Government, and continue to develop improvements in information sharing through the development of the State Operations Control Centre (SOCC) and the WA Police Force Mobility project.

**Learning 4: Police Information Holdings**

WA Police Force documentation of the interaction with the deceased was not recorded in line with WA Police policy CF-01.00 'Using IMS to conduct case and file management'.

The use of the Intelligence Data Management system (IDM) to record interactions with the deceased conflicted with this policy, which recognises the need to manage investigations by creating an accountable record of any actions undertaken upon IMS. Whilst the officer was reminded of this policy and the need to correctly document any future interactions of a similar nature, the potential remains for well-intentioned staff to record interactions in one of multiple disparate and discrete police information recording systems.

WA Police Force continue to work on solutions to improve uniform holdings supporting full mobility.

**WA Police Force will:**

Reinforce awareness of WA Police Force Policy CF-01.00 through an internal broadcast which was disseminated to agency personnel on 14 December 2017 and an endeavour will be made to monitor outcomes.

**Learning 5 – Cultural Security**

The term 'cultural security' in relation to working with Aboriginals suggests an obligation on organisations and individuals to move beyond cultural awareness to actively ensuring cultural needs are met for individuals. Cultural needs are included in practices so all Aboriginals have access to this level of service, not just in those places where there are particularly culturally competent workers. WA Police Force recognises opportunities exist to improve cultural competency, so frontline officers have a greater understanding of the varied issues faced by Aboriginal people. Complexities encountered when working with Aboriginal families following calls for assistance to family violence matters are difficult for police to resolve alone.

Broader understanding of the impact that colonisation has had on Aboriginal people and how our shared history has resulted in intergenerational trauma, ill health, the loss of and culture, language and custom for Aboriginal people and the ongoing disadvantage they experience today will improve policing responses.

**WA Police Force will:**

Develop a strategy to provide greater cultural security; ensuring that adequate practices are put in place so that interactions between members of WA Police Force and Aboriginal people meet cultural needs.

The Commissioner of Police has directed the development of a strategy to improve partnerships and build positive relationships between police and Aboriginal people. The strategy known as 'Aboriginal Strategic Directions Pathways' is under development by the Aboriginal Affairs Division.

The Aboriginal Affairs Division is consulting with internal and external government and non-government partners to provide opportunity for a co-designed strategy.

The aim of the strategy will include minimizing the overrepresentation of Aboriginal people in the criminal justice system, with a focus on culture, family violence, youth diversion and repeat victimisation.

In addition, the University of Notre Dame has recently undertaken an independent review of the concept of 'cultural security' within WA Police Force curriculum, delivery of training and associated policies pertaining to Aboriginal people and engagement. A mapping report identifying areas of strength and weakness is forthcoming.

This Office subsequently requested that WA Police Force updates the Office on the steps taken to give effect to the recommendation. In response, WA Police Force provided a range of information in a letter dated 27 March 2019, containing a report prepared by WA Police Force.

In the report, WA Police Force relevantly informed this Office that:

1. A preliminary Code of Practice for the investigation of all reports of FV has been developed. All WA Police Force officers have access to this document which articulates their roles and responsibilities when attending an FV incident. The WA Police Force is engaging an external consultant to deliver prevention and response strategies for all of the community including vulnerable groups such as the elderly, Aboriginal and Torres Strait Islanders, the disabled and others, to be included in the Code of Practice
2. As part of an operational restructure, 56 staff have been allocated to Metropolitan Family Violence Teams with increased focus on the management of Family and Domestic Violence Response in collaboration with Department of Communities and non-government sectors.
3. Multi-Agency Case Management Meetings have been instigated by the WA Police Force bringing greater volumes of at risk victims and their children into the view of government and support sector services.
4. The WA Police Force recently signed a MOU with the National Indigenous Critical Response Service which is set up to provide culturally appropriate support to Aboriginal families impacted by traumatic events, including FV.
5. In 2018 the WA Police Force established the Aboriginal Affairs Division. Edition 698 'From the line' published on 25 October 2018 detailed the role of this new Division to build, foster and sustain better relationships with the Aboriginal people and communities of Western Australia.
6. The State Government provided a commitment to create a framework for information sharing and risk assessment for relevant government agencies. Data sharing legislation is being drafted by the Department of the Premier and Cabinet and a multi-agency implementation group in response to Service Priority Review recommendations.
7. General Broadcast numbered 171214 issued on 14 December 2017 directed agency personnel to manage FV incidents using the appropriate agency-based computer systems Incident Management System (IMS) or Computer Aided Dispatch (CAD). Internal reviews are conducted within the Family Violence Unit to monitor compliance with this broadcast and other matters associated with response and recording of FV, Feedback is provided to officers as needed to ensure consistency and accountability of service provisions.
8. The Commissioner of Police has established the Aboriginal Police Advisory Forum which met for the first time on 4 September 2018. The forum comprised of the Police Executive and eight Aboriginal leaders from all parts of Western Australia. The forum intends to meet quarterly to raise and discuss issues of importance and to influence and provide feedback on existing policing programs and/or contemporary Aboriginal concerns.

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

**Recommendation 9: That WA Police Force reviews, considers and, if appropriate, amends the current WA Police Force FDV Policy, to include strategies that are specifically tailored to preventing and reducing Aboriginal family violence.**

**Steps taken to give effect to the recommendation**

This Office requested that WA Police Force inform the Office of the steps taken to give effect to the recommendation. In response, WA Police Force provided a range of information in a letter to this Office dated 27 March 2019, containing a report prepared by WA Police Force.

In the WA Police Force report, WA Police Force relevantly informed this Office that:

> The State Government has made a recommendation training include contemporary understandings of the nature and dynamics of Family Violence; and specific issues in relation to Family Violence for Aboriginal communities, multicultural communities, persons with disability, children who are exposed to FDV and children who are perpetrators of FDV.
>
> 1. The WA Police Force have established a new Aboriginal Affairs Division. The Divisions initial program of works will include the development of a strategy to improve partnerships and build positive relationships between police and Aboriginal people. The planning phase has commenced. In addition to the strategic direction documents, the Division will also be creating a Reconciliation Action Plan. Both pieces will require extensive external consultation to ensure Aboriginal people and organisations are self-determining in the frameworks which impact on their communities. The aim of this program of work is to build respect for Aboriginal culture and traditions which leads to better relationships. Good relationships will enable positive and effective partnerships to be developed to address and statistically reduce Aboriginal people as high volume perpetrators and casualties of FV.
> 2. The WA Police Force is engaging an external consultant to communicate with vulnerable groups, including Aboriginal people, to identify opportunities for localised co-designed prevention and response strategies, ensuring the needs of all vulnerable groups are met. Though these recommendations will be utilised to enhance the state-wide Code of Practice, the recommendations themselves should not be to the detriment of specific place based needs of the community. Funding has been allocated to meet this election commitment.. Once finalised, the Code of Practice will be published as an outward facing document on the WA Police Force website.

It is also noted that the Department, the lead agency for family and domestic violence, is currently coordinating work to develop a 10-year across-government strategy to reduce family and domestic violence. This Office was informed that Communities will develop a 10-year family and domestic violence strategy for Western Australia, which will include a specific plan for responding to the issue of Aboriginal Family Violence. WA Police Force is participating in this policy development.

**Following careful consideration of the information provided, steps have been proposed 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 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 family and domestic violence fatalities. 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 50% of reviews being completed within three months and 75% of reviews completed within 12 months.

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

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

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

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

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

> (4) If under subsection (2) the Commissioner makes recommendations to the principal officer of an authority he may request that officer to notify him, within a specified time, of the steps that have been or are proposed to be taken to give effect to the recommendations, or, if no such steps have been, or are proposed to be taken, the reasons therefor.

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

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

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

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

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

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

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

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

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



## Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

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

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

## Stakeholder Liaison

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

## The Ombudsman's Advisory Panel

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

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

The Panel met three times in 2018-19 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).

In 2018-19, observers from Western Australia Police Force, the Department of Communities, the Department of Health, the Department of Education, and the Department of Justice also attended the meetings.

### Key stakeholder relationships

There are a number of public authorities and other bodies that interact with or deliver services to those who are at risk of family and domestic violence or who have experienced family and domestic violence. Important stakeholders, with which the Office liaised as part of the family and domestic violence fatality review function in 2018-19, included:

- The Coroner;
- Relevant public authorities including:
  - Western Australia Police Force;
  - The Department of Health and Health Service Providers;
  - The Department of Education;
  - The Department of Justice;

- The Department of Communities;
- The Mental Health Commission; and
- Other accountability and similar agencies including the Commissioner for Children and Young People;

- The Women's Council for Domestic and Family Violence Services WA and relevant non-government organisations; and
- Research institutions including universities.

## Aboriginal and regional communities

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

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

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

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

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

# Own Motion Investigations and Administrative Improvement

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

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

## Improvements from Complaints and Reviews

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

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

## Own Motion Investigations

One of the ways that the Office endeavours to improve public administration is to undertake investigations of systemic and thematic patterns and trends arising from complaints made to the Ombudsman and from child death and family and domestic

violence fatality reviews. These investigations are referred to as own motion investigations.

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

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

## Selecting topics for own motion investigations

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

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

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

## Monitoring the implementation of recommendations

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

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

## Own Motion Investigations in 2018-19

In 2018-19, significant work was undertaken on:

- *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 on 8 November 2018;
- An investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people, to be tabled in Parliament in 2019; and
- An investigation into family and domestic violence and suicide, to be tabled in Parliament in 2020.

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


Through the review of the circumstances in which, and why, child deaths occurred, the Ombudsman identified a pattern of cases in which children appeared to have died by drowning.

The 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.

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.

Accordingly, on 8 November 2018 the Ombudsman tabled in Parliament *A report on giving effect to the recommendations arising from the Investigation into ways to prevent or reduce deaths of children by drowning'*.

The Office found 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.


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.

The full report, *A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce deaths of children by drowning* is available at www.ombudsman.wa.gov.au/drowningsreport.

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

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

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

During 2018-19, significant work was undertaken on a report by the Office on the steps taken to give effect to the 22 recommendations arising from the findings of this report. The report will be tabled in Parliament in 2019.

## Continuous Administrative Improvement

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

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

## Guidance for Public Authorities

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

### *Good Practice Guidance for the collection of overdue rates for people in situations of vulnerability*

The office has, over a period of time, received complaints regarding the collection of overdue rates for people in situations of vulnerability. Following an investigation by the Office, including considering relevant legislative and regulatory requirements, a review of relevant literature, analysis of good practice and consultation with local governments, the Office has developed Good Practice Guidance for local governments regarding their role in collecting overdue rates owed by people in situations of vulnerability.


The Office has identified four principles reflecting contemporary good practice in the collection of overdue rates for people in situations of vulnerability. These principles are:

1. Good culture;
2. Good decisions;
3. Good support; and
4. Good service.

For each principle, further underpinning guidance is presented. Where helpful, specific initiatives are suggested that reflect potential approaches to implement the guidance.

The Good Practice Guidance is designed to assist local governments to:

- Consider their own policies and practices for the collection of rates and overdue rates in respect to people in situations of vulnerability; and
- Identify any aspects of these policies and practices that may present opportunities for improvement to ensure that the process is efficient and effective for local governments and is fair and equitable for all ratepayers.

All ratepayers have a responsibility to pay overdue rates. The guidance in no way overrides, detracts from, or diminishes, the responsibility of ratepayers to pay overdue rates, consistent with the *Local Government Act 1995*. Nonetheless, a large body of research demonstrates that a fair, reasonable and flexible approach leads to better repayment outcomes and fewer resources expended in the collection of payments.

Implementation of the Good Practice Guidance can, and should, be done in a way that does not impose any unreasonable or inappropriate regulatory costs on local governments (which, of course, are paid for by ratepayers).

It is absolutely appropriate for local governments to consider the relevance, costs and benefits of implementing the four Good Practice Principles and tailor areas of the Good Practice Guidance to their specific circumstances. In particular:

1. Local governments may have already implemented good practice frameworks in relation to assisting people in situations of vulnerability, including in the collection of overdue rates. Where this is the case, the Good Practice Guidance can be used to ensure these existing frameworks adequately address the issues contained in the Good Practice Guidance, rather than the need to write new guidance;
2. Local governments may have either more or less ratepayers in situations of vulnerability and therefore the extent of adoption of guidance underpinning principles may appropriately vary; and
3. It is completely appropriate and reasonable for smaller local governments to consider the practicalities and resources required to tailor the guidance to their specific circumstances.

Read more about the *Local government collection of overdue rates for people in situations of vulnerability: Good Practice Guidance* on the Office's website.

## Publications

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

## Workshops for public authorities

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

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

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

### Working collaboratively

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

## Inspection and Monitoring Functions

### Telecommunications interception records

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

### Criminal organisations control

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

In accordance with the *Criminal Organisations Control Act 2012*, a report was prepared by the Ombudsman for the whole monitoring period ending 1 November 2018. A copy of this report was provided to the Attorney General and the Commissioner of Police in accordance with the *Criminal Organisations Control Act 2012.*

# Collaboration and Access to Services

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

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

## Working Collaboratively

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

**Integrity Coordinating Group**

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

**Background:**

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

**The Office's involvement:**

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

**2018-19 initiatives:**

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

## International Ombudsman Institute

**Background:**

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

**The Office's involvement:**

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

**2018-19 initiatives:**

The Ombudsman visited the Control Yuan in Taiwan. As a central part of this visit, the Ombudsman was extended the privilege of addressing the chamber of the Control Yuan in a plenary session on 14 August. The Ombudsman's address was titled *The role of the Ombudsman in promoting good governance and protecting human rights*.

The Ombudsman was accompanied on the visit by Chief Ombudsman of New Zealand, Judge Peter Boshier. During his visit the Ombudsman and Chief Ombudsman were also received by the Agency Against Corruption, the National Audit Office and the Taipei City Government 1999 Citizen Hotline Call Centre.

The Ombudsman and Assistant Ombudsman Strategic Policy and Projects, National and International Relations, Rebecca Poole, attended the quadrennial conference of the European Region of the IOI in Brussels in October 2018. The conference, *The Ombudsman in an open and participatory society*, was hosted by the Federal Ombudsman of Belgium, on the occasion of the 20th anniversary of the Office of the Federal Ombudsman. The conference also included a ceremony on the occasion of the 40th anniversary of the IOI.

The Conference, held at the Hemicycle, Senate of the Federal Parliament of Belgium, consisted of three plenary sessions. The Ombudsman chaired the second session, *The Ombudsman as a catalyst for citizen participation*. The conference was opened by Ms Christine Defraigne, President of the Senate and the conference dinner was addressed by Mr Didier Reynders, Deputy Prime Minister of Belgium and Minister for Foreign Affairs.

While in Brussels, the Ombudsman participated in an Executive Committee meeting of the World Board of the IOI and met with Mr Justin Brown PSM Australian Ambassador to Belgium, Luxembourg, the European Union and NATO, and on 4 October in Dublin, met with Mr Peter Tyndall, Ombudsman and Information Commissioner for Ireland and President of the IOI (and host of the 2020 World Conference of the IOI) and Mr Richard Andrews, Australian Ambassador to Ireland.

The Ombudsman and Assistant Ombudsman Strategic Policy and Projects, National and International Relations, Rebecca Poole, attended the 30th Australasian and Pacific Ombudsman Region Conference in Auckland, New Zealand. The conference

was themed *Holding governments to account in a changing climate* and was hosted by the Chief Ombudsman of New Zealand.

The Ombudsman addressed the conference on the IOI's perspectives on the major themes of the conference – the role of the Ombudsman in a time of political and social change and the response of nation states and Ombudsmen to climate change. Mr Peter Tyndall, IOI President and Ombudsman and Information Commissioner for Ireland and Mr Günther Kräuter, IOI Secretary General and Ombudsman, Austrian Ombudsman Board attended the Conference, in addition to Australian Ombudsmen, the Hong Kong Ombudsman, the Control Yuan and Ombudsman from the Pacific Island nations of the Cook Islands, Papua New Guinea, Samoa, the Solomon Islands, Tonga and Vanuatu.

The Conference was part of a three day program that included a Business Meeting, training and an official side event. Training was provided on leading effective change and on monitoring places of detention to ensure the human rights of detainees are upheld as part of the Optional Protocol to the Convention Against Torture.

### Information sharing with Ombudsmen from other jurisdictions

**Background:**

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

**2018-19 initiatives:**

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

### Australia and New Zealand Ombudsman Association

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

**Background:**

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

**The Office's involvement:**

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

# Providing Access to the Community

## Communicating with complainants

The Office provides a range of information and services to assist specific groups, and the public more generally, to understand the role of the Ombudsman and the complaint process. Many people find the Office's enquiry service and complaint clinics held during regional visits assist them to make their complaint. Other initiatives in 2018-19 include:

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

## Access to the Ombudsman's services

The Office continues to implement a number of strategies to ensure its complaint services are accessible to all Western Australians. These include access through online facilities as well as more traditional approaches by letter and through visits to the Office. The Office also holds complaint clinics and delivers presentations to community groups, particularly through the Regional Awareness and Accessibility Program. Initiatives to make services accessible include:

- Access to the Office through a Freecall number, which is free from landline phones;
- Access to the Office through email and online services. The importance of email and online access is demonstrated by its use this year in 68% of all complaints received;
- Information on how to make a complaint to the Ombudsman is available in 15 languages and features on the homepage of the Ombudsman's website. People may also contact the Office with the assistance of an interpreter by using the Translating and Interpreting Service;
- The Office's accommodation, building and facilities provide access for people with disability, including lifts that accommodate wheelchairs and feature braille on the access buttons and people with hearing and speech impairments can contact the Office using the National Relay Service;
- The Office's Regional Awareness and Accessibility Program and Youth Awareness and Accessibility Program target awareness and accessibility for regional and Aboriginal Western Australians as well as children and young people;
- The Office attends events to raise community awareness of, and access to, its service, such as the Financial Counsellors' Association of WA conference in October 2018; and
- The Office's visits to adult prisons and the juvenile detention centre provide an opportunity for adult prisoners and juvenile detainees to meet with representatives of the Office and lodge complaints in person.

## Ombudsman website


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

- Members of the public on the complaint handling services provided by the Office as well as links to other complaint bodies for issues outside the Ombudsman's jurisdiction;
- Public authorities on decision making, complaint handling and conducting investigations;
- Children and young people as well as information for non-government organisations and government agencies that assist children and young people, including downloadable print material tailored for children and young people. The youth pages can be accessed at www.ombudsman.wa.gov.au/youth;
- Access to the Ombudsman's reports such as *A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce deaths of children by drowning*;
- The latest news on events and collaborative initiatives such as the Regional Awareness and Accessibility Program; and
- Links to other key functions undertaken by the Office such as the Energy and Water Ombudsman website and other related bodies including other Ombudsmen and other Western Australian accountability agencies.

The website continues to be a valuable resource for the community and public sector as shown by the increased use of the website this year. In 2018-19:

- The total number of visits to the website in 2018-19 was 183,946. This is nearly double the number of visits in 2015-16;
- The top two most visited pages (besides the homepage and the Contact Us page) on the site were *The role of the Ombudsman* and *What you can complain about*; and
- The Office's *Effective Handling of Complaints Made to Your Organisation Guidelines* and *Procedural Fairness Guidelines* were the two most viewed documents.

> The total number of visits to the website in 2018-19 was 183,946, nearly double the number of visits in 2015-16.

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

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


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

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

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

## Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2018-19. Two regional visits were conducted, to Katanning and Albany in the Great Southern Region and Manjimup in the South West Region in November 2018, and to Waroona, Mandurah and Boddington in the Peel Region in May 2019. The visits included activities such as:

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

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

The Program enables the Office to:

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

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

Mary White, Deputy Ombudsman and Marcus Claridge, Assistant Ombudsman Energy and Water, presented workshops on *Good Decision Making* and *Effective Complaint Handling* to state and local government officers in Mandurah on 23 May 2019.

## Aboriginal engagement

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

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

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


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

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

In May 2019, the Office organised and hosted Independent Agency Information Sessions in Perth and Mandurah, which provided representatives from seven independent complaint bodies the opportunity to speak to, and hear from, Aboriginal Elders and service providers. The information sessions included presentations on the roles of:

- The Western Australian Ombudsman;
- Energy and Water Ombudsman Western Australia;
- Commonwealth Ombudsman;
- Telecommunications Industry Ombudsman;
- Australian Financial Complaints Authority;
- Health and Disability Services Complaints Office; and
- Office of the Information Commissioner.

These sessions, part of the Office's engagement strategy and cultural competency with Aboriginal Western Australians, was guided by the Office's Principal Aboriginal Liaison Officer. Very positive feedback was received from attendees and the sessions provided valuable information for our engagement with the Aboriginal community.

Cultural Ceremony conducted by Principal Aboriginal Liaison Officer, Alison Gibson, in Mandurah, May 2019.

Presentation by Principal Aboriginal Liaison Officer, Alison Gibson, at the Independent Agency Information Session in Perth, May 2019.

The Principal Aboriginal Liaison Officer also coordinated cultural awareness information and events throughout the year, including training on *Aboriginal Cultural Awareness* for staff of the Office, and provided information to staff about culturally important dates and events being held in the community.


The Office participated in the State-wide 2019 Street Banner Project for National Reconciliation Week, 27 May to 3 June 2019

Mary White, Deputy Ombudsman (centre) and Alison Gibson, Principal Aboriginal Liaison Officer (right) attended the National Reconciliation Week Breakfast along with the Ombudsman's Advisory Panel Member, Dorinda Cox (left)

## Youth Awareness and Accessibility Program

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

The Office continued its proactive visiting program to vulnerable groups of children in the child protection system. During 2018-19, the Office visited:

- The Kath French Secure Care Centre in June 2019;
- Two family group homes in the Great Southern Region in November 2018; and
- Two residential group homes and one family group home in the Perth metropolitan area in June 2019.

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

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


## Prison Program

The Office continued the Prison Program during 2018-19. Five visits were made to prisons and the juvenile detention centre to raise awareness of the role of the Ombudsman and enhance accessibility to the Office for adult prisoners and juvenile detainees in Western Australia.

# Speeches and Presentations

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

## Ombudsman's speeches and presentations

- *Professionalism, Ethics and Confidentiality*, presented to University of Western Australia Legal Internship Students in August 2018;
- *The role of the Ombudsman in promoting good governance and protecting human rights,* a Keynote address to a Control Yuan Plenary Meeting in August 2018;
- Chaired a Plenary Session entitled *The Ombudsman as a catalyst for citizen participation* at the quadrennial conference of the European Region of the IOI, in October 2018;
- *The Ombudsman*, presented to the visiting delegation of the Western Cape Provincial Parliament in October 2018;
- *The role and functions of the Ombudsman: experiences, developments and issues for government lawyers*, presented to the State Solicitor's Office Government Law Seminar in October 2018;
- *Practice, Procedure and the Law of Parliament*, presented to the Legalwise Seminar in November 2018; and
- *30th Australasian and Pacific Ombudsman Region Conference,* Final Remarks from the International Ombudsman Institute, in November 2018.

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

## Speeches and presentations by other staff

- *Developing and Delivering Culturally Appropriate Ombudsman Services*, presented by the Office's Principal Aboriginal Liaison Officer to staff of the Telecommunications Industry Ombudsman in Melbourne in July 2018;
- *The Ombudsman*, to the University of Western Australia Foundations of Public Law Students in October 2018;
- *The Role and Functions of the Ombudsman,* presented to the Tenancy Network at Tenancy WA in December 2018;
- *The Role and Funcitons of the Ombudsman,* presented to the Civil Law and Human Rights Unit at the Aboriginal Legal Service of Western Australia in February 2019;
- *The Role and Functions of the Ombudsman*, presented to the Community Resilience and Relief Forum at the WA Council of Social Service in May 2019;
- *The Western Australian Ombudsman*, presented by the Deputy Ombudsman in Independent Agency Information Sessions in Perth and Mandurah in May 2019; and
- *Developing and Delivering Culturally Appropriate Ombudsman Services*, presented by the Office's Principal Aboriginal Liaison Officer to staff of the Commonwealth Ombudsman in Perth in May 2019.

# Liaison with Public Authorities

## Liaison relating to complaint resolution

The Office liaised with a range of bodies in relation to complaint resolution in 2018-19, including:

- The Department of Justice;
- The Department of Communities;
- The Department of Transport;
- The Office of the Inspector of Custodial Services;
- The Corruption and Crime Commission;
- Curtin University; and
- University of Western Australia.

## Liaison relating to reviews and own motion investigations

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

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

## Liaison relating to inspection and monitoring functions

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

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

# Publications

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

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