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;
- Expanded child death review function
- 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:

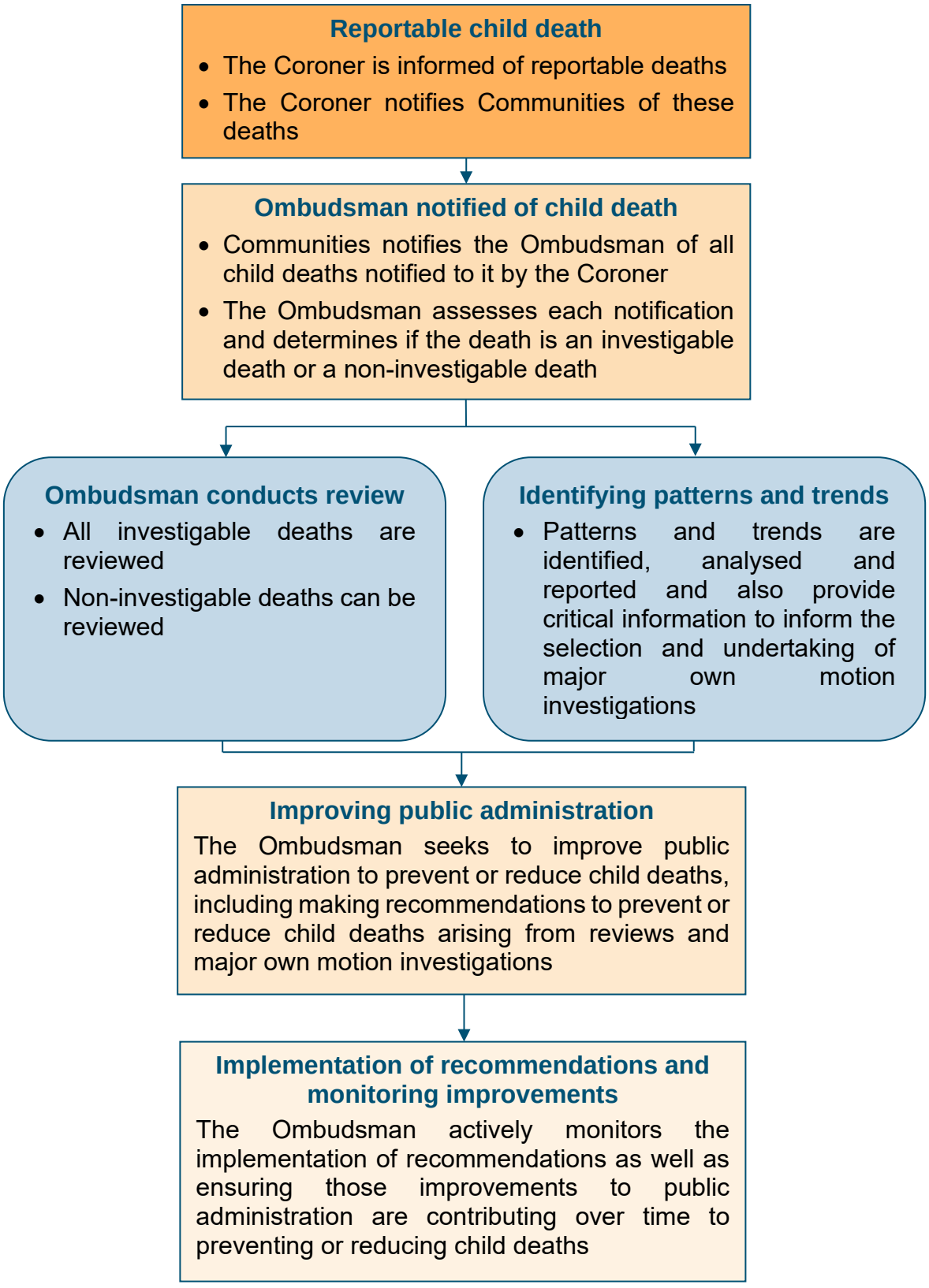
- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children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

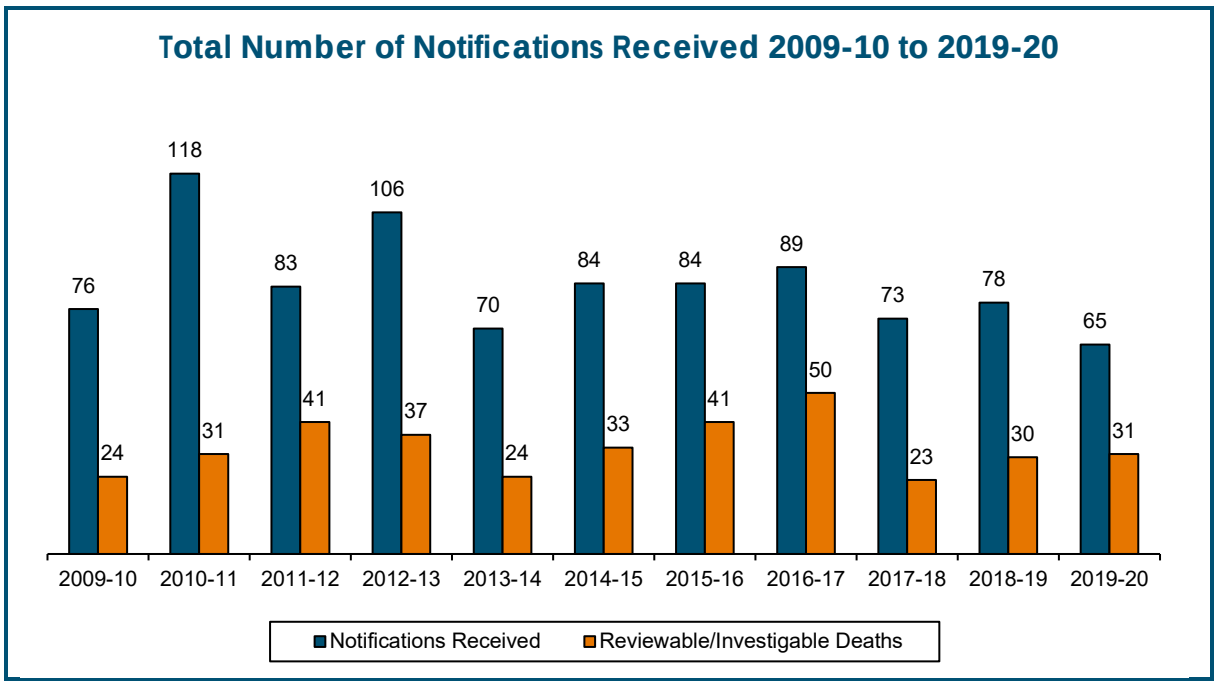
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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 2019-20, there were 31 child deaths that were investigable and subject to review from a total of 65 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 17 years from 2003-04 to 2019-20. It is important to note that an investigable death is one which meets the legislative criteria and does not necessarily mean that the death was preventable, or that there has been any failure of the responsibilities of Communities.

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

Year	A	B	C	D
	Total WA child deaths (excluding stillbirths) (See Note 1)	Child deaths reported to the Coroner (See Note 2)	Child deaths where the child or a relative of the child was known to Communities (See Note 3)	Reviewable/ investigable child deaths (See Note 4 and Note 5)
2003-04	177	92	42	19
2004-05	212	105	52	19
2005-06	210	96	55	14
2006-07	165	84	37	17
2007-08	187	102	58	30
2008-09	167	84	48	25
2009-10	201	93	52	24
2010-11	203	118	60	31
2011-12	150	76	49	41
2012-13	193	121	62	37
2013-14	156	75	40	24
2014-15	170	93	48	33
2015-16	178	92	61	41
2016-17	181	91	60	50
2017-18	138	81	37	23
2018-19	175	81	37	30
2019-20	135	67	38	31

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

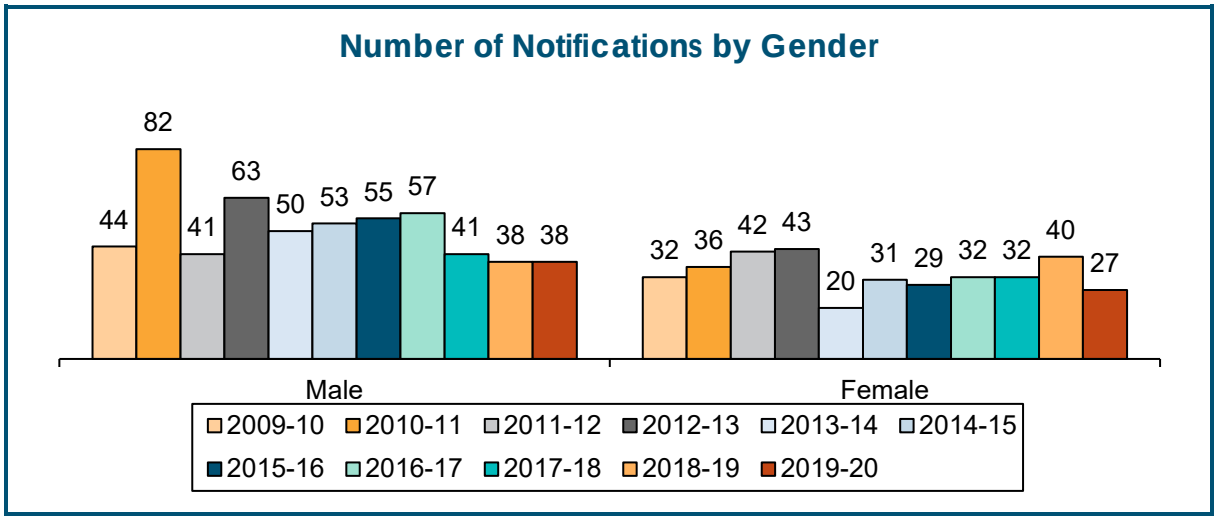
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

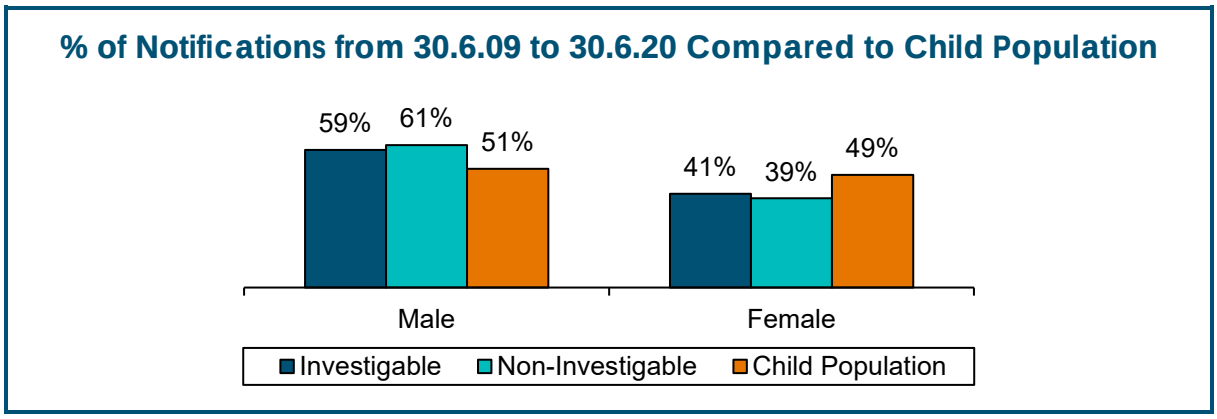
The following charts show:

- The number of children in each group for each year from 2009-10 to 2019-20; and
- For the period from 30 June 2009 to 30 June 2020, 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 11 years, male children are over-represented compared to the population for both investigable and non-investigable deaths.

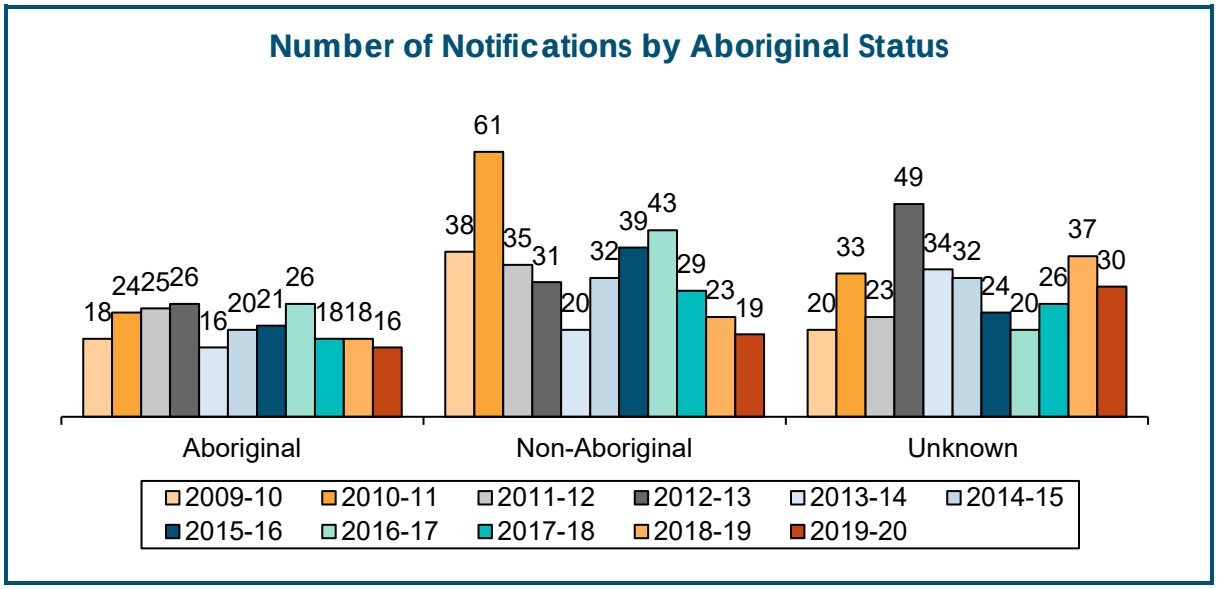


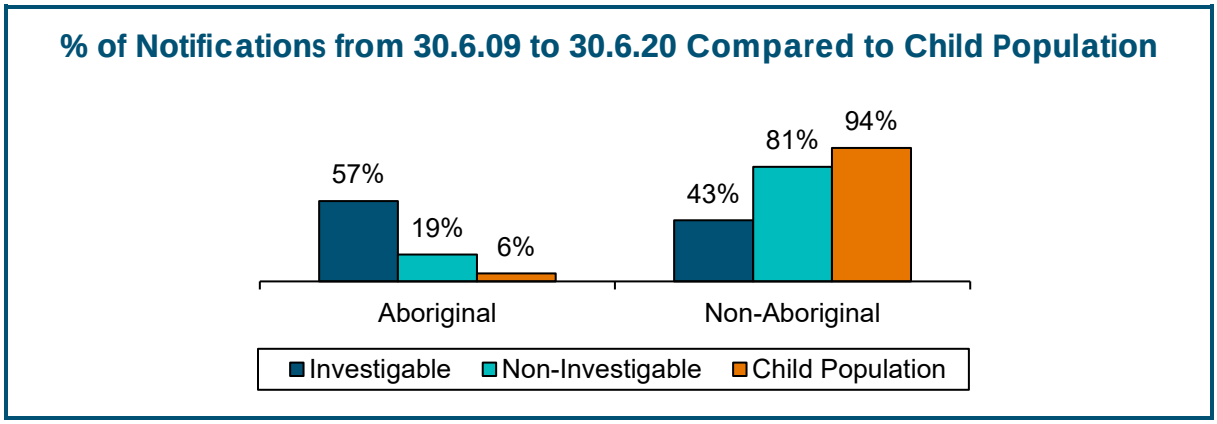


Further analysis of the data shows that, considering all 11 years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

Aboriginal status

As shown in the following charts, Aboriginal children are over-represented compared to the population in all deaths and more so for investigable deaths.





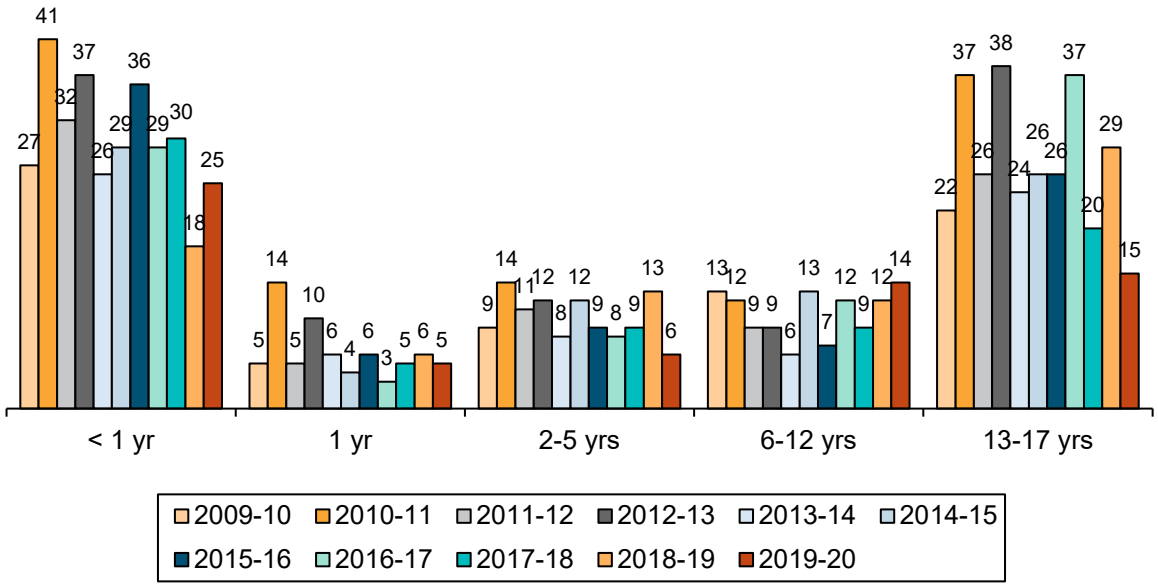
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

Further analysis of the data shows that Aboriginal children are more likely than non-Aboriginal children to be under the age of one and living in regional and remote locations.

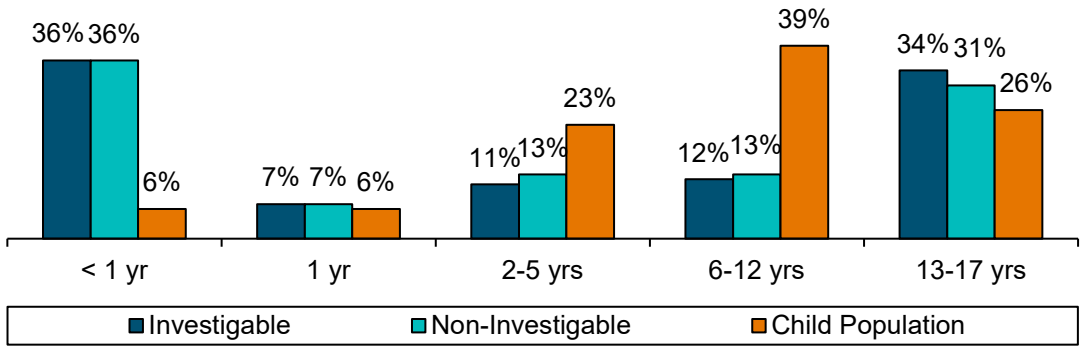
Age groups

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

Number of Notifications by Age of Child



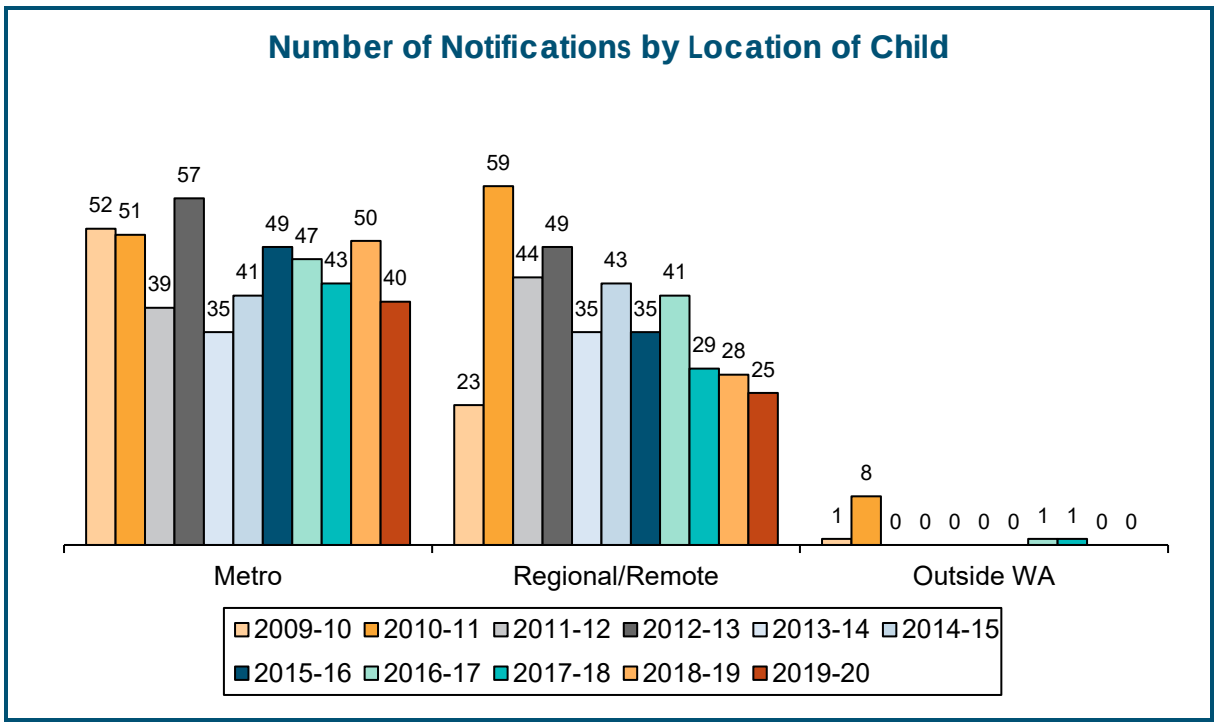
% of Notifications from 30.6.09 to 30.6.20 Compared to Child Population



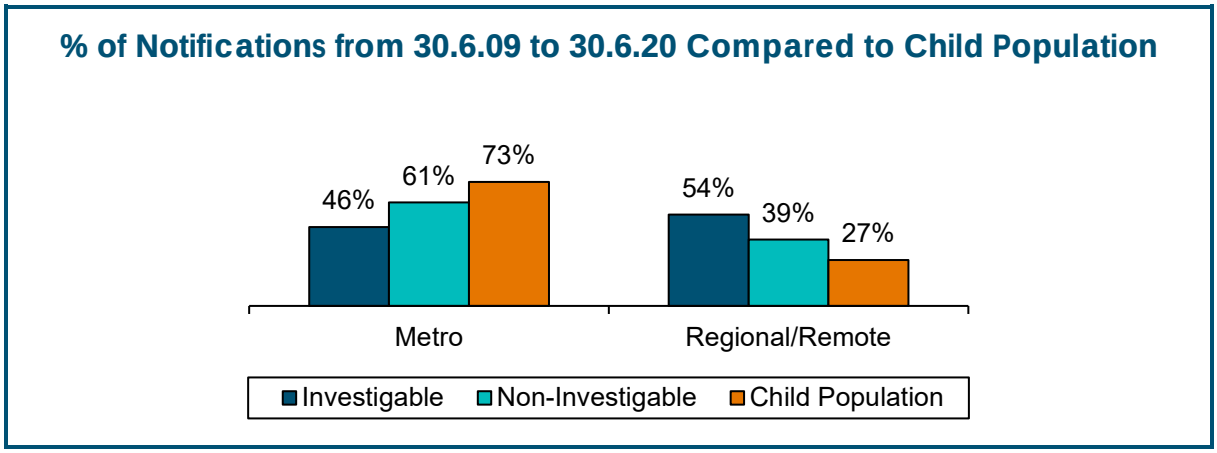
A more detailed analysis by age group is provided later in this section.

Location of residence

As shown in the following charts, children in regional locations are over-represented compared to the child population as a whole, and more so for investigable deaths.



Note: Outside WA includes children whose residence is not in Western Australia, but the child died in Western Australia. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the place of residence of the child.



Further analysis of the data shows that 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

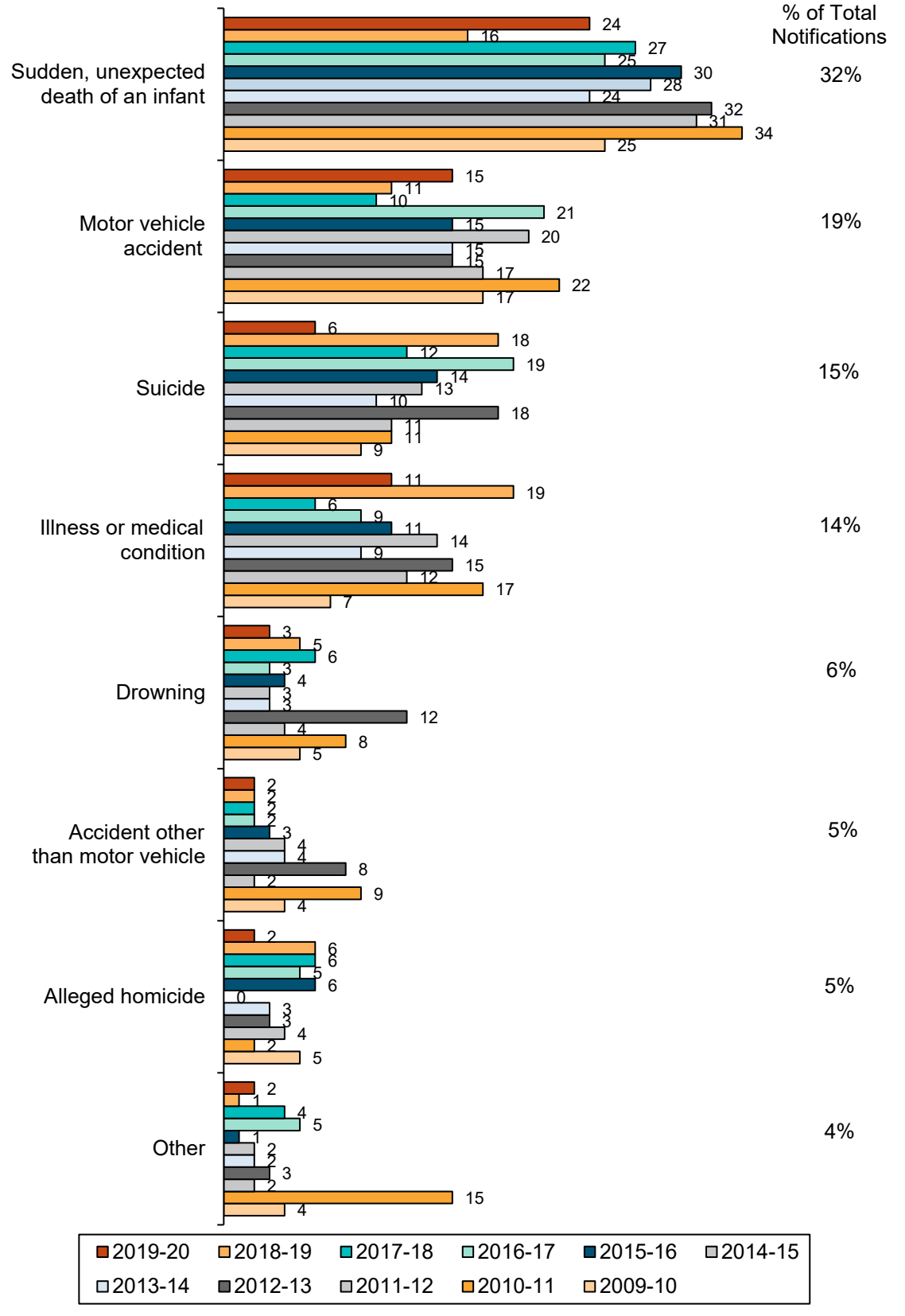
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally 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 2020.

Circumstances of Child Deaths



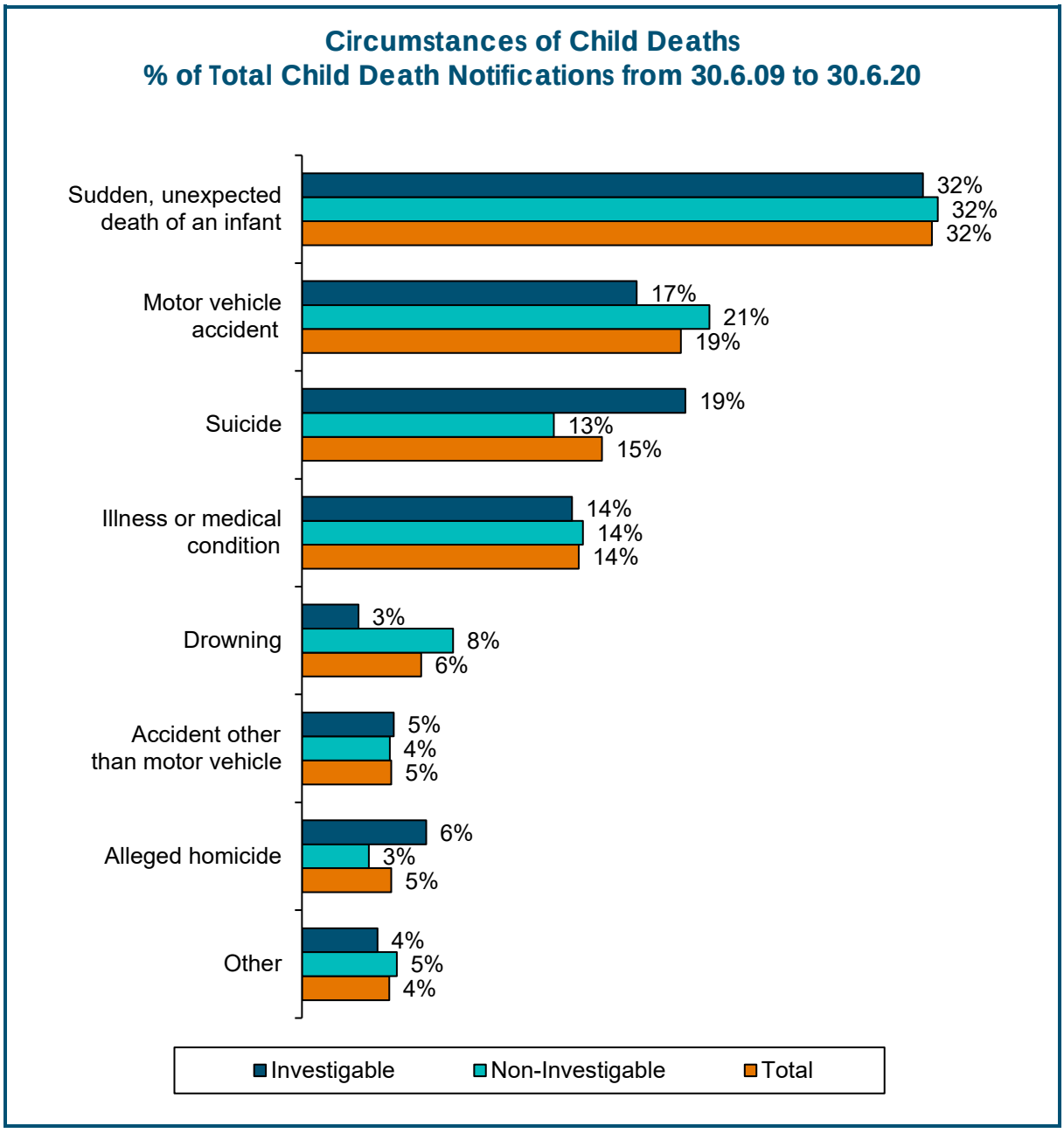
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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

The two main circumstances of death for the 926 child death notifications received in the 11 years from 30 June 2009 to 30 June 2020 are:

- Sudden, unexpected deaths of infants, representing 32% of the total child death notifications from 30 June 2009 to 30 June 2020 (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, 21% in 2018-19 and 37% in 2019-20); and
- Motor vehicle accidents, representing 19% of the total child death notifications from 30 June 2009 to 30 June 2020 (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, 14% in 2018-19 and 23% in 2019-20).

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
2019-20	2	15	11		2	3	24	6	2

* 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 2020.

Social or Environmental Factor	% of Finalised Reviews from 30.6.09 to 30.6.20
Family and domestic violence	74%
Parenting	61%
Drug or substance use	48%
Alcohol use	47%
Parental mental health issues	28%
Homelessness	23%

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 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 nearly a third of the cases.

Reasons for contact with Communities

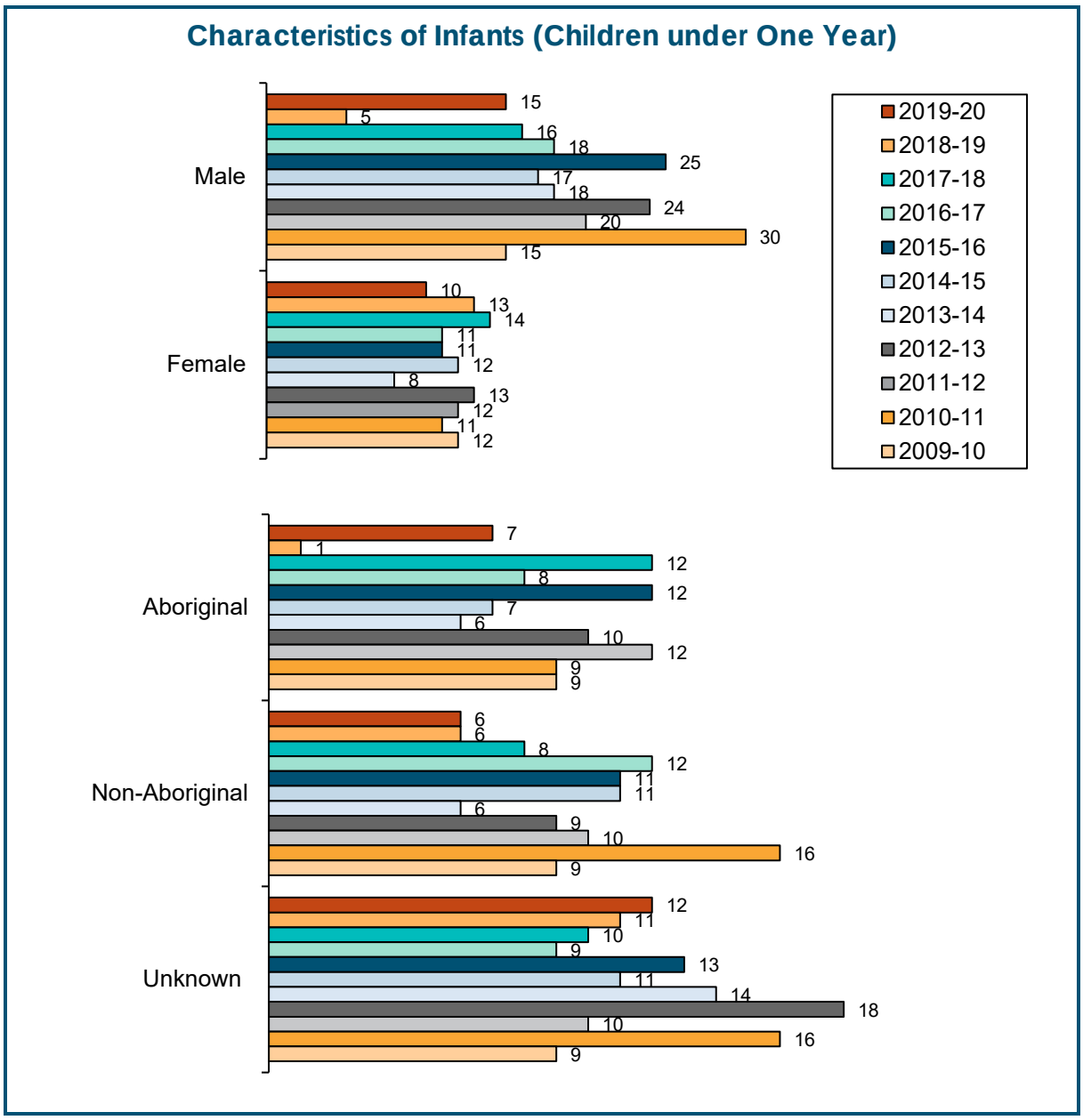
In child deaths notified to the Ombudsman in 2019-20, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

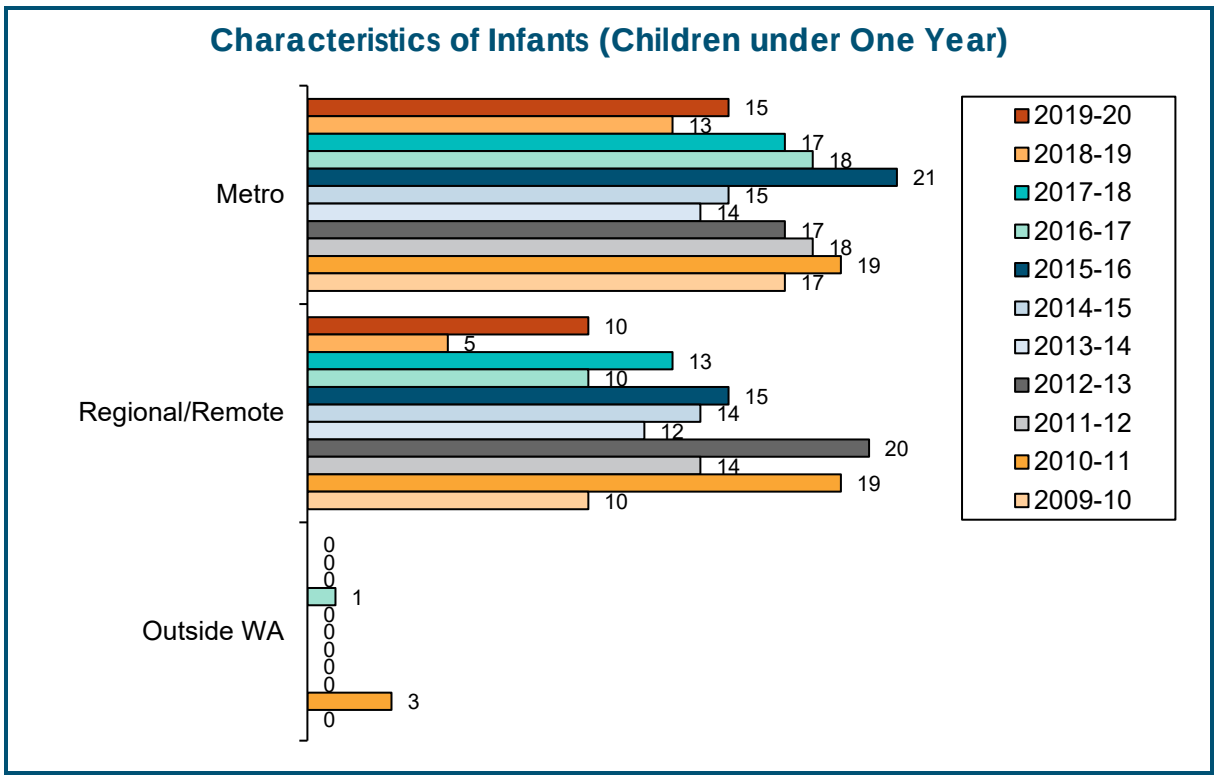
Analysis of children in particular age groups

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 926 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2020, there were 330 (36%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.



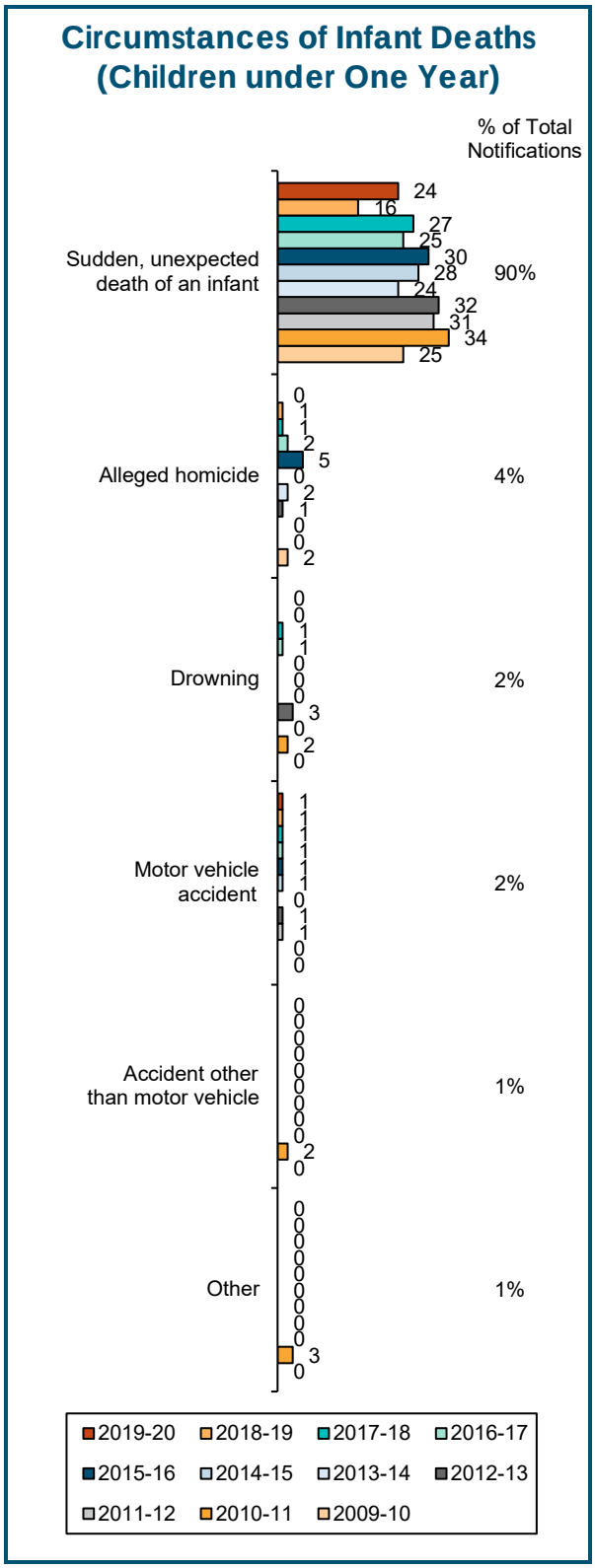


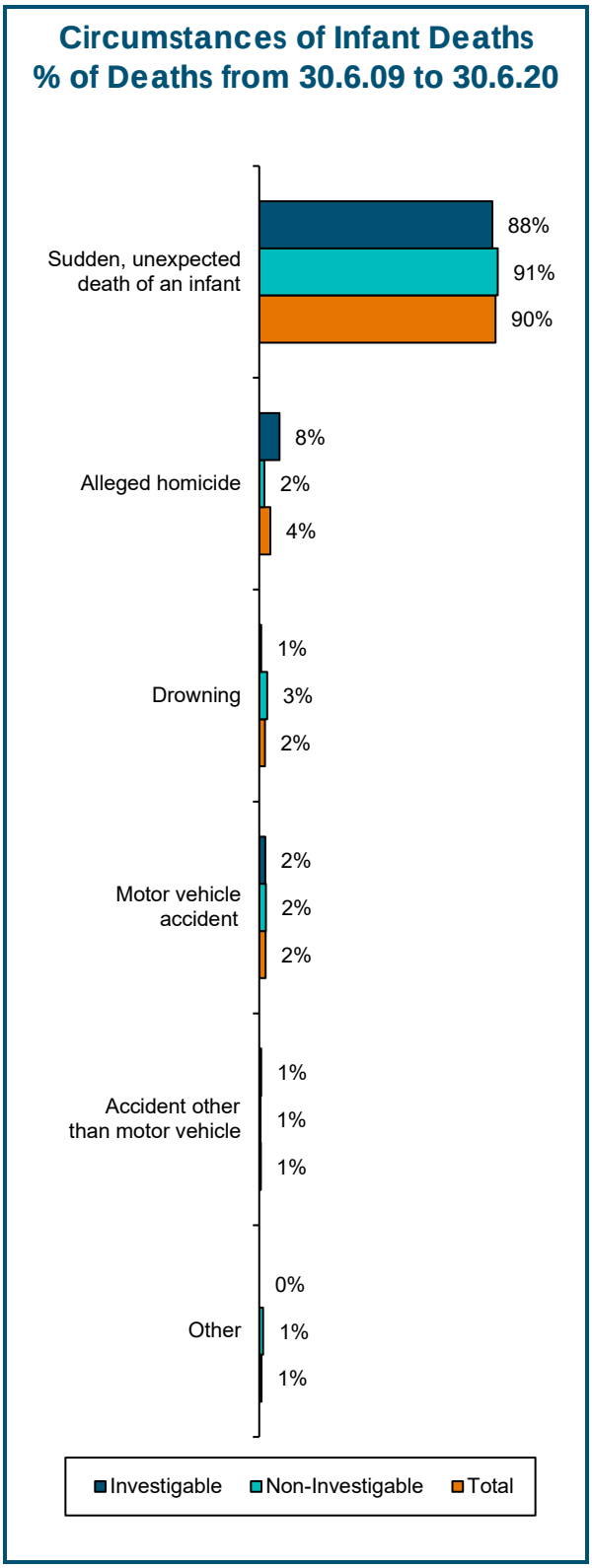
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 64% of investigable infant deaths and 60% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 65% of investigable deaths and 30% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 53% of investigable infant deaths and 37% 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 330 infant deaths, 296 (90%) were categorised as sudden, unexpected deaths of an infant and the majority of these (191) 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.





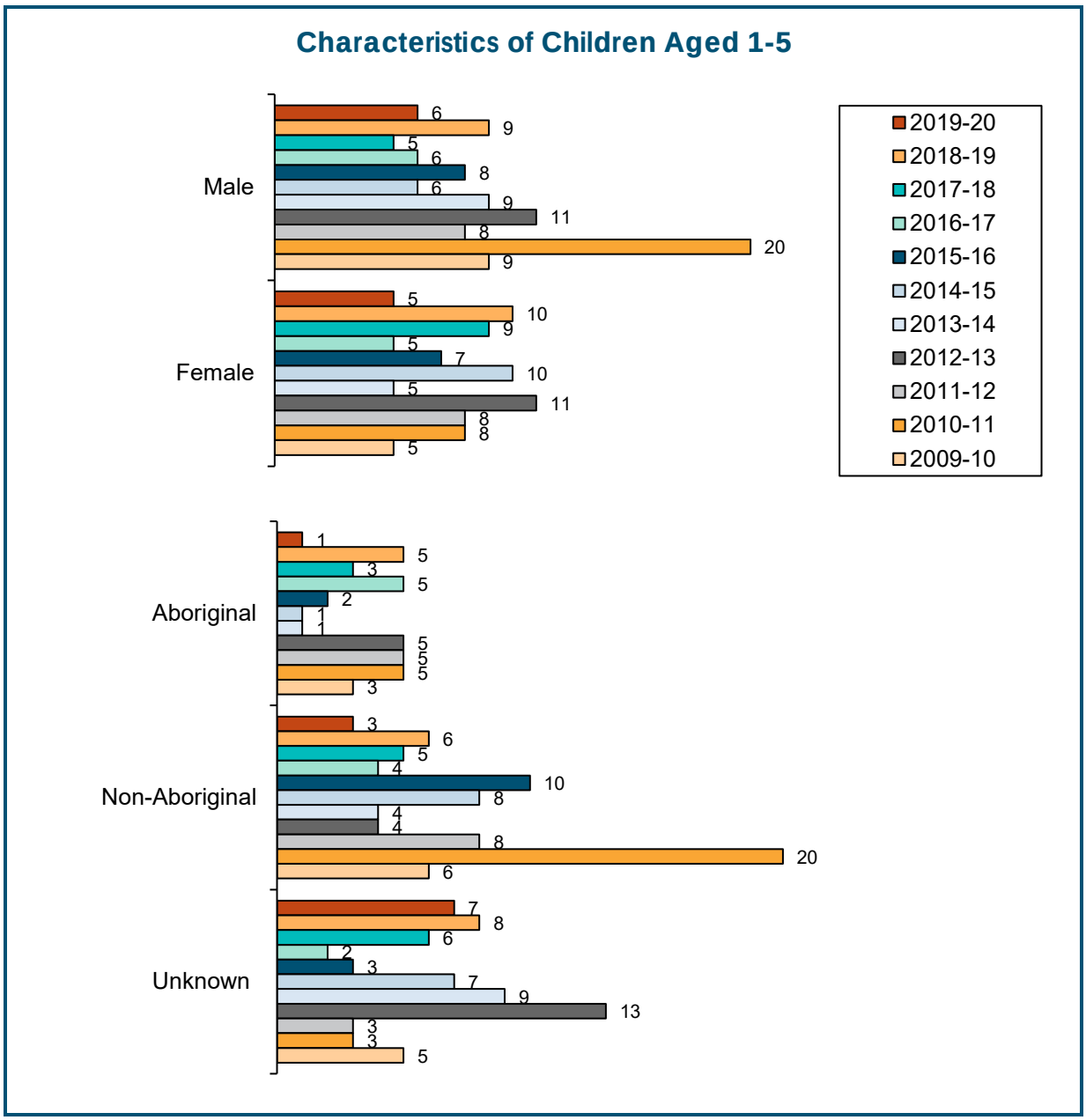
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

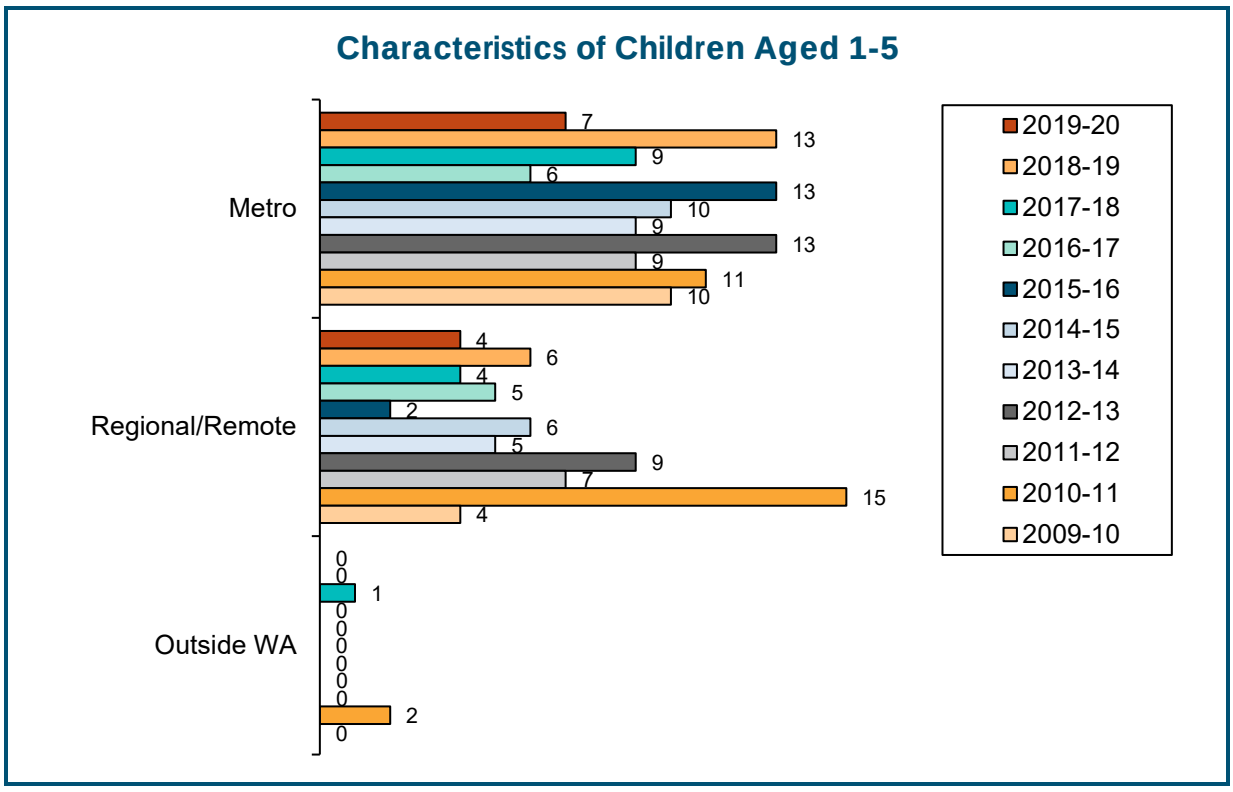
One hundred and thirty deaths of infants were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 926 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2020, there were 180 (19%) related to children aged from 1 to 5 years.

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



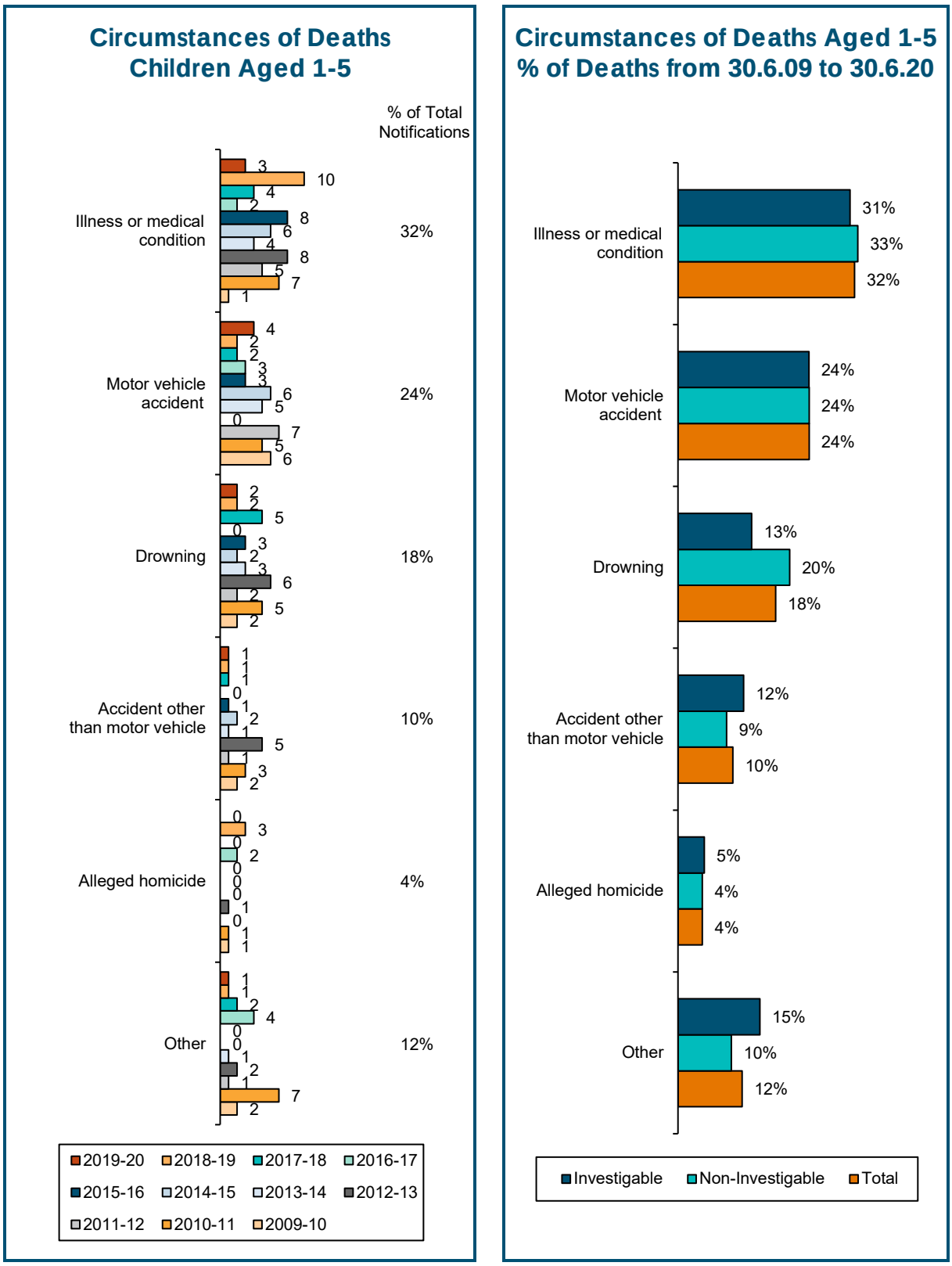


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 57% of investigable deaths and 52% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Aboriginal children – 52% of investigable deaths and 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 – 42% 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 (24%) and drowning (18%).



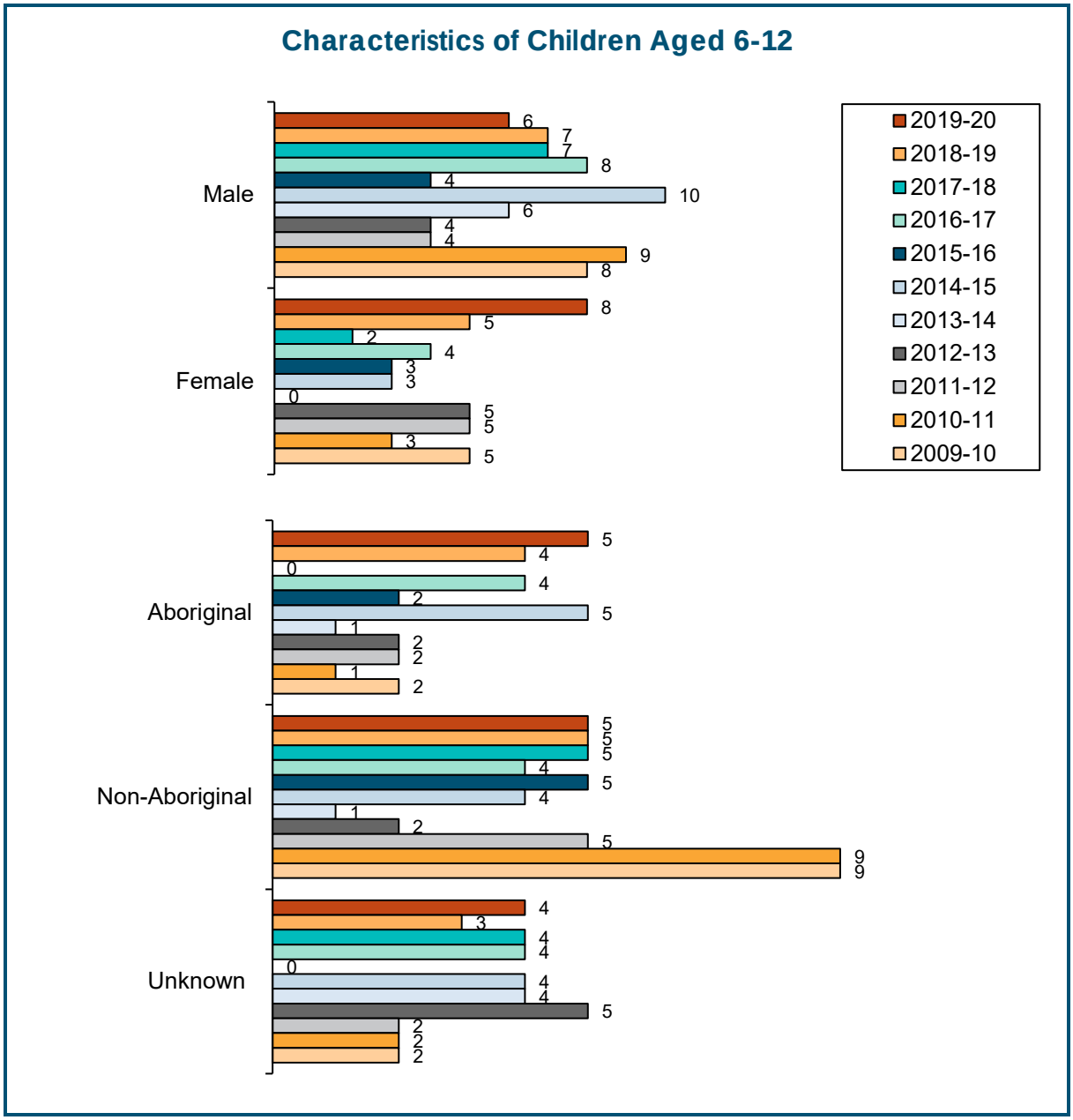
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

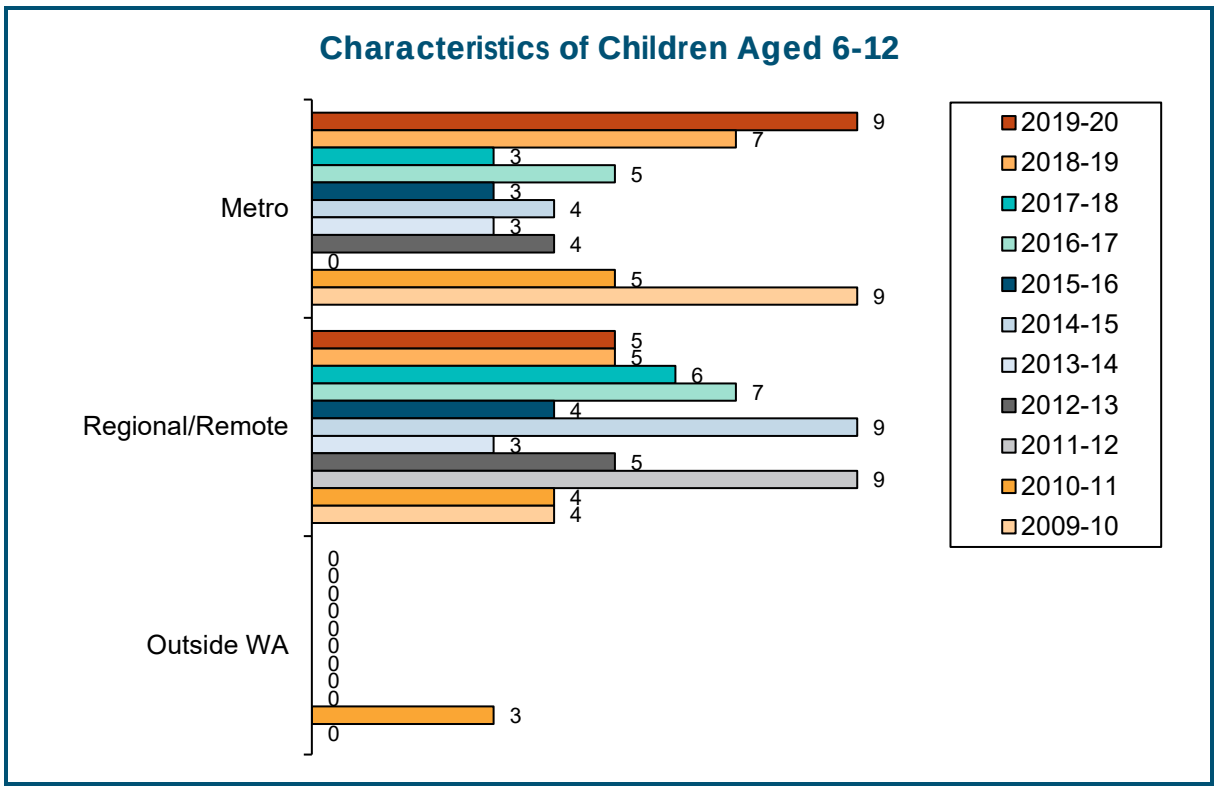
Sixty seven deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of children aged 6 to 12 years

Of the 926 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2020, there were 116 (13%) related to children aged from 6 to 12 years.

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



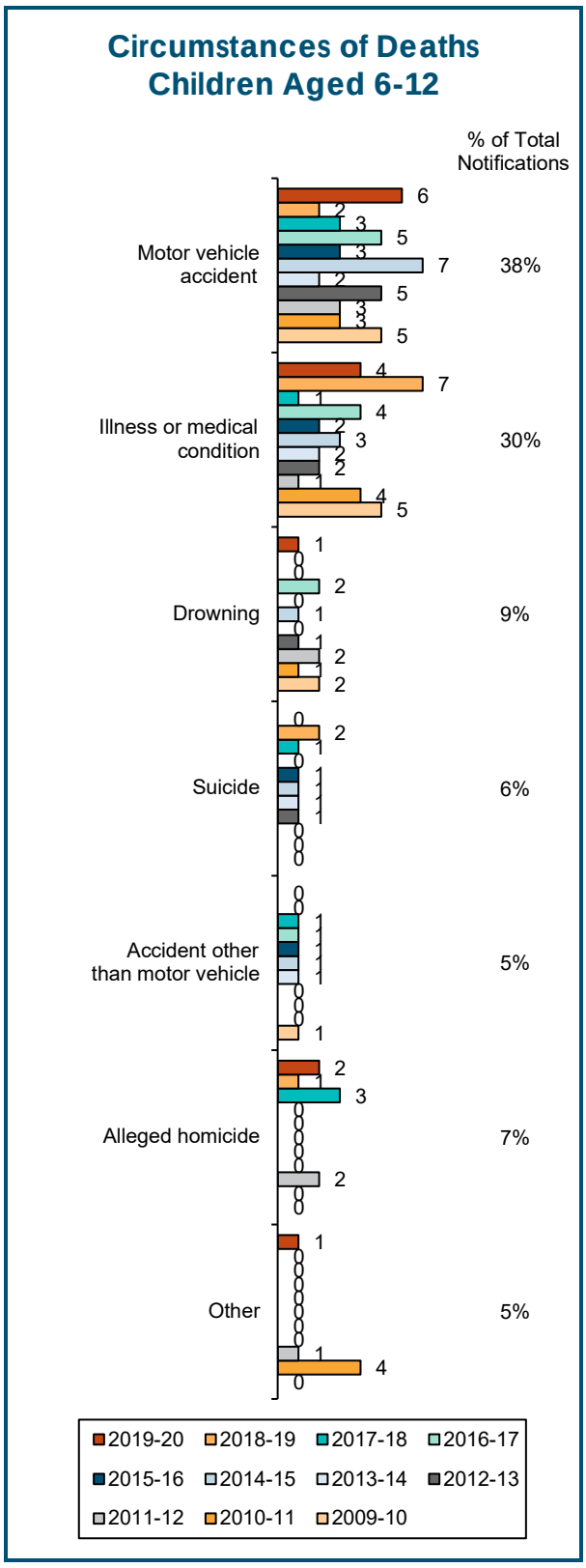


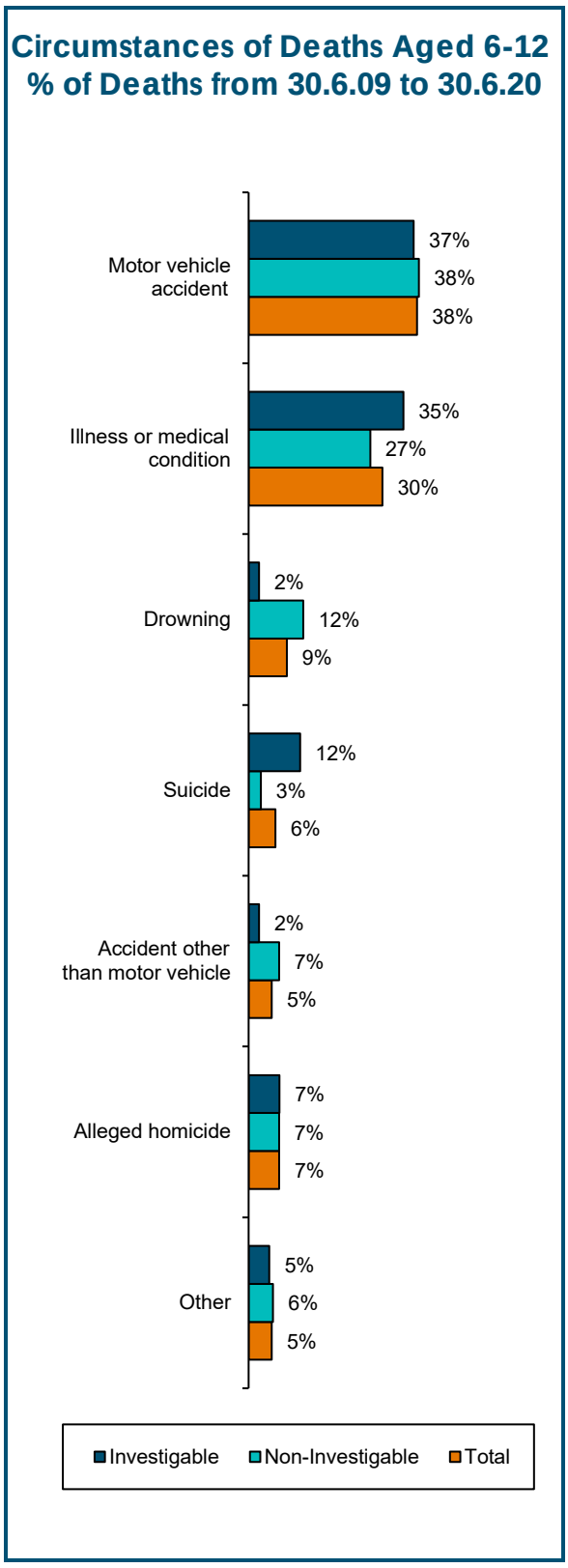
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 49% of investigable deaths and 71% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population;
- Aboriginal children – 54% of investigable deaths and 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 – 65% of investigable deaths and 45% 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 (38%), followed by illness or medical condition (30%) and drowning (9%).





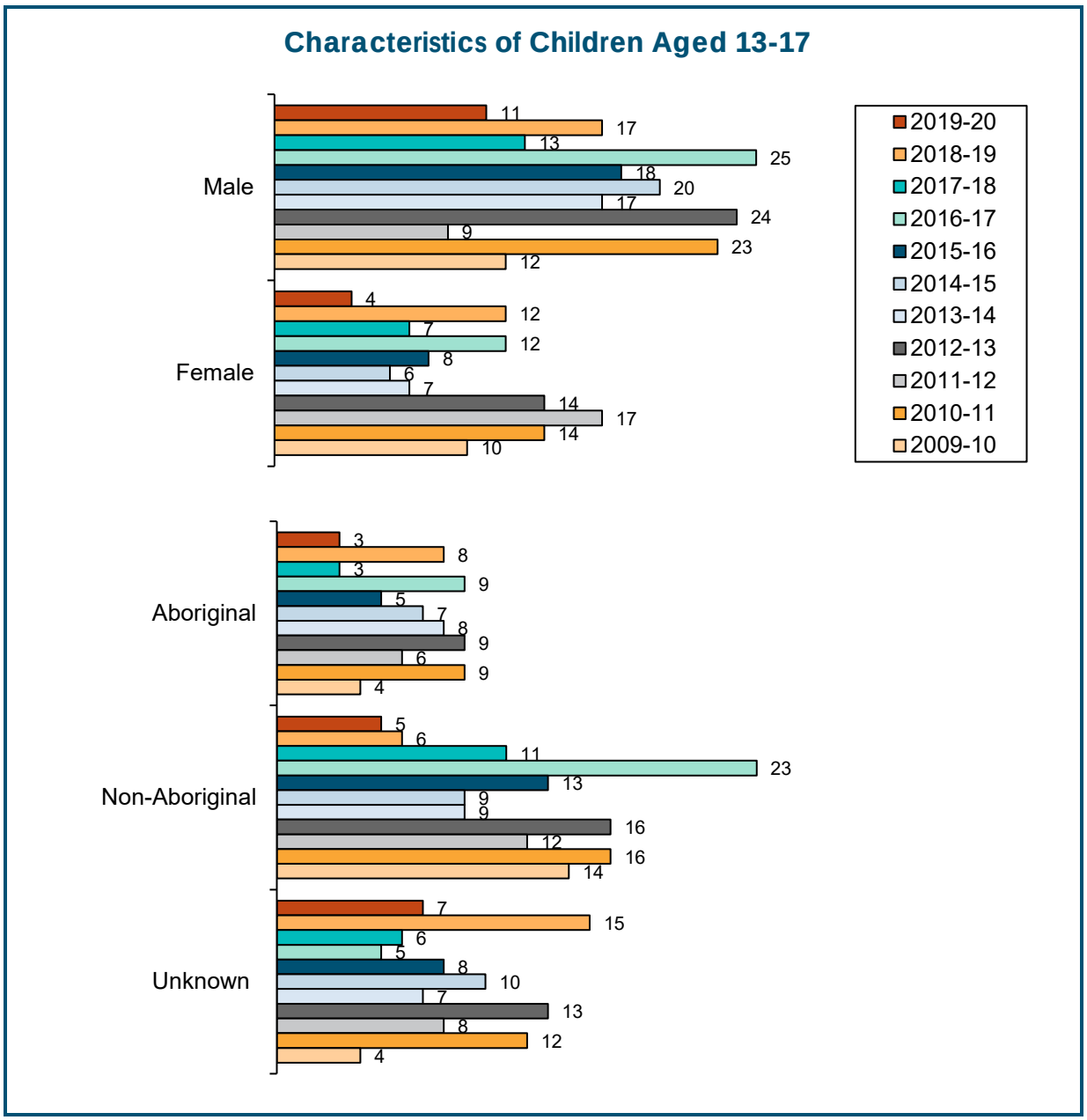
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

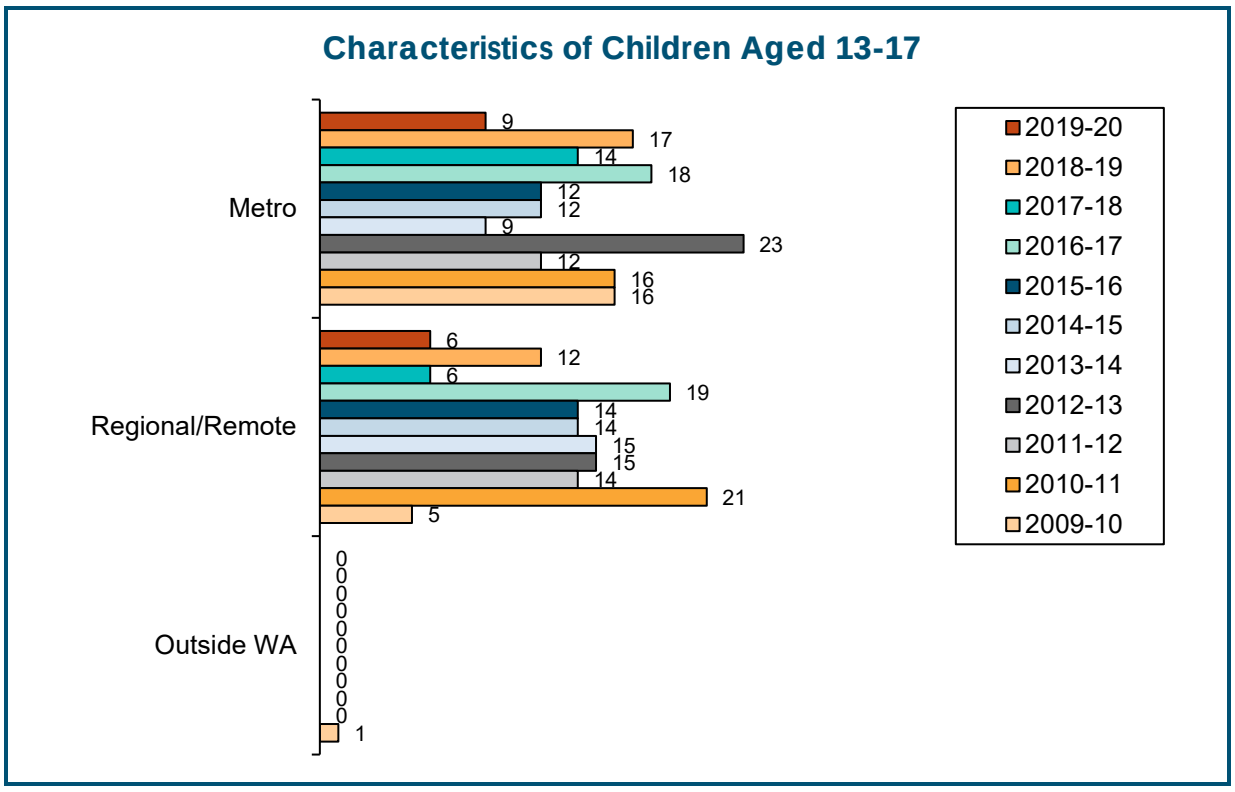
Forty three deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of children aged 13 – 17 years

Of the 926 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2020, there were 300 (32%) related to children aged from 13 to 17 years.

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



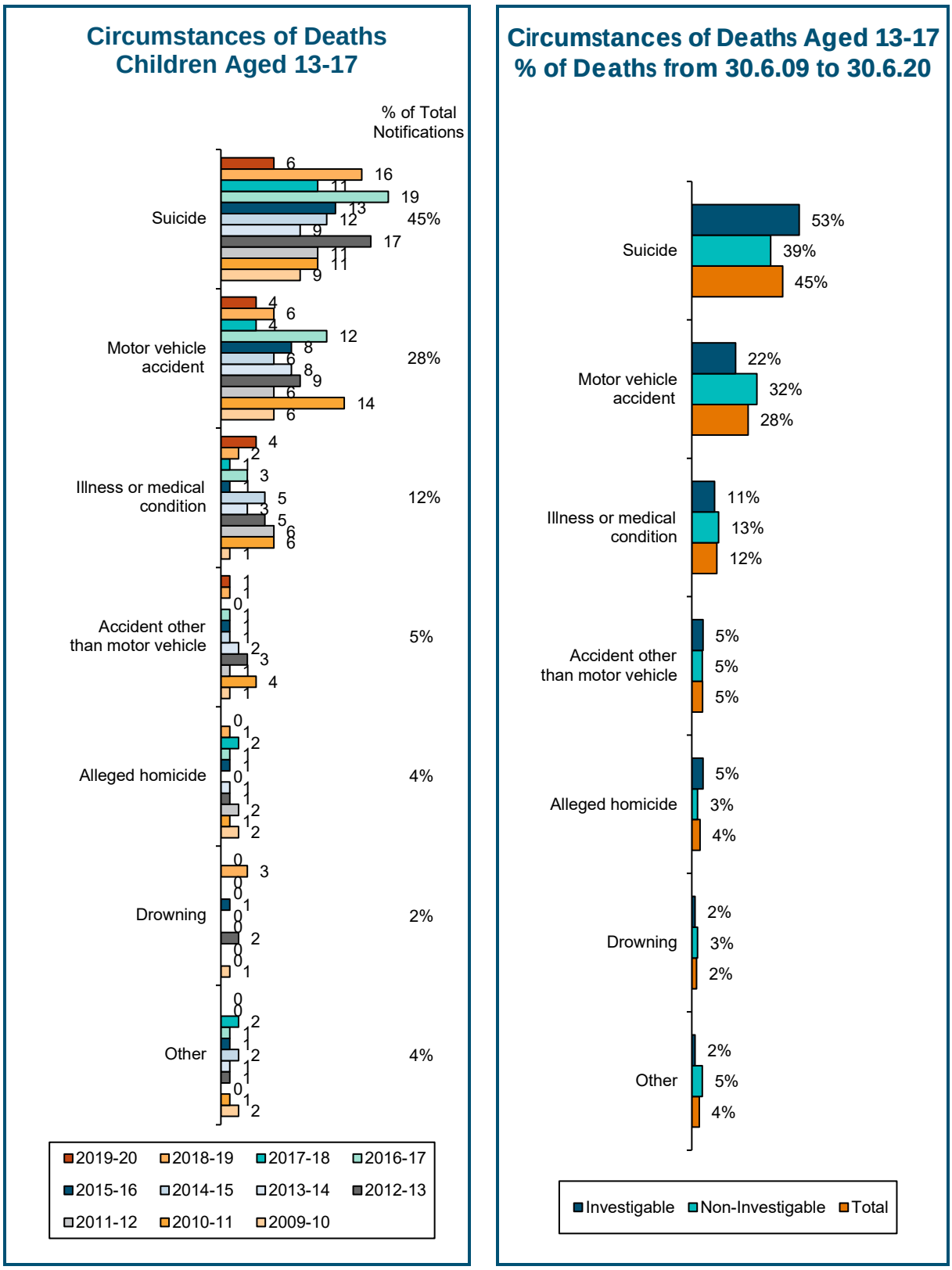


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 60% of investigable deaths and 65% of non-investigable deaths of children aged 13 to 17 were male compared to 51% in the child population;
- Aboriginal children – 53% of investigable deaths and 14% of non-investigable deaths of children aged 13 to 17 were Aboriginal compared to 6% in the child population; and
- Children living in regional or remote locations – 57% 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.

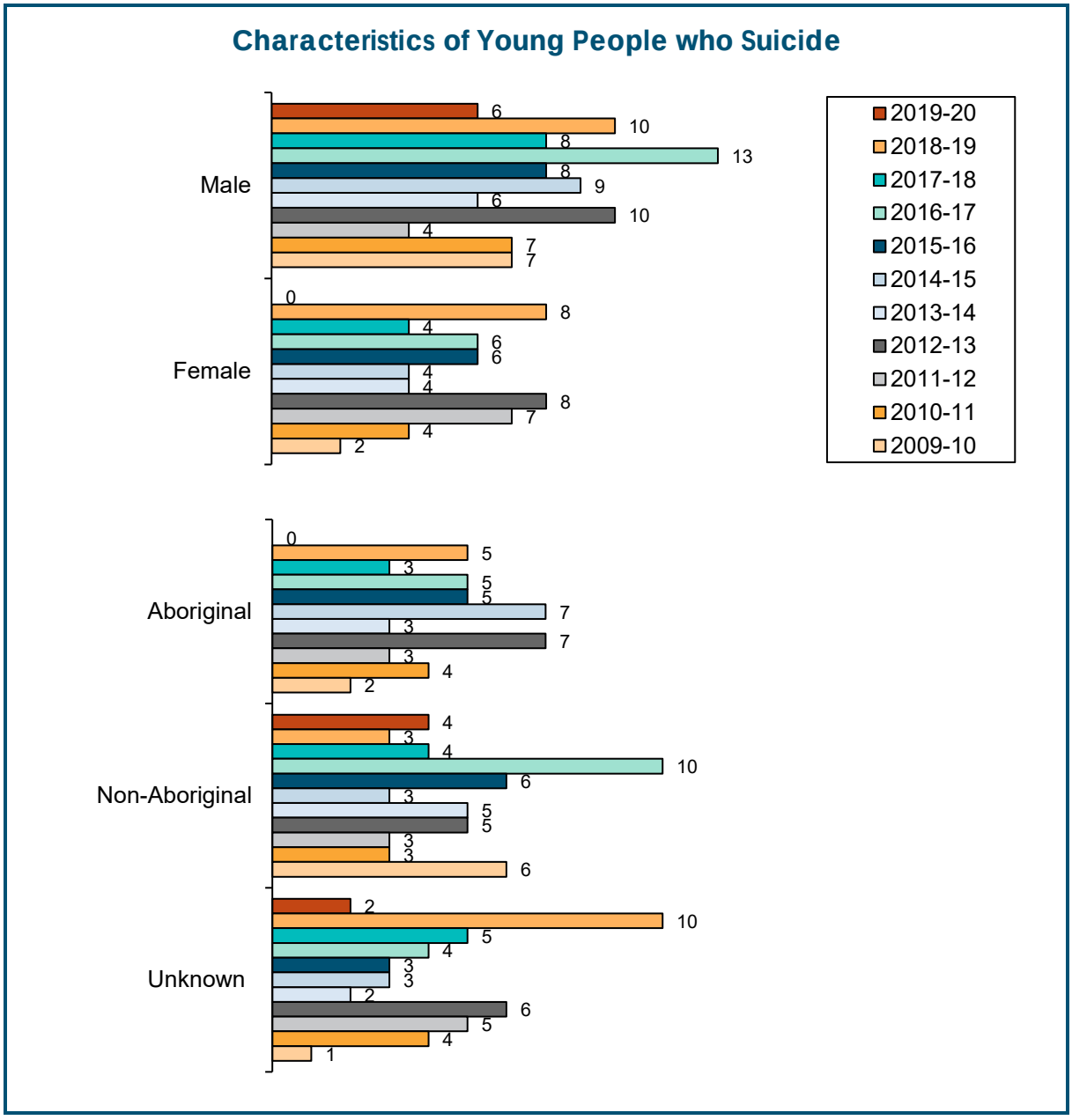
One hundred and twenty five deaths of children aged 13 to 17 years were determined to be investigable deaths.

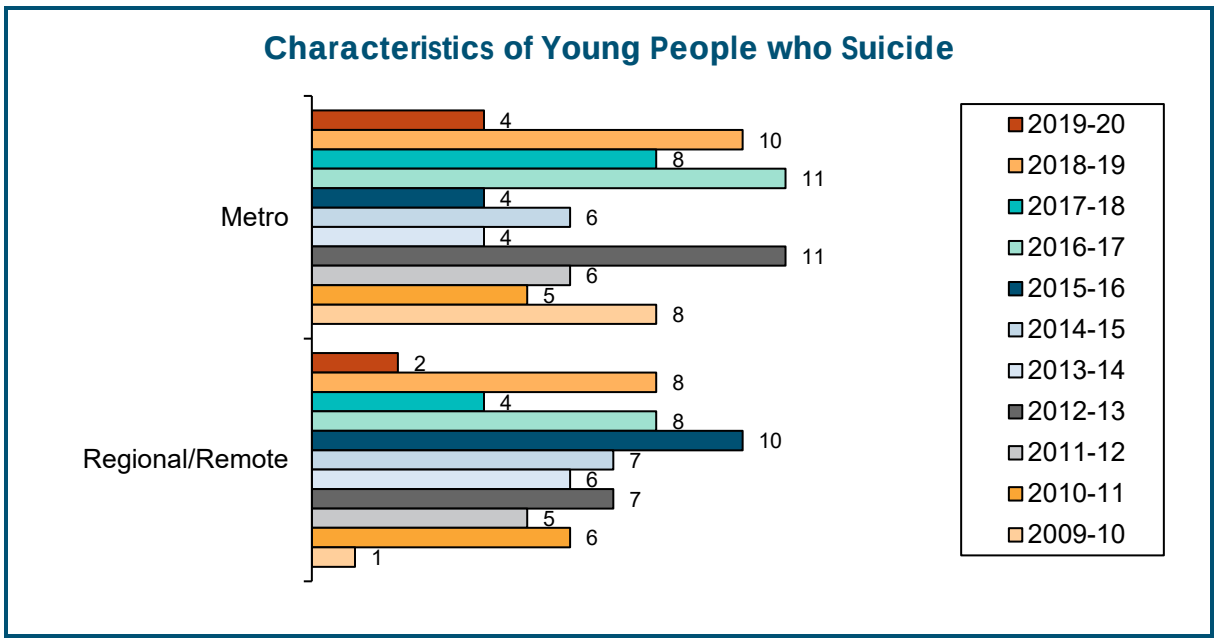
Suicide by young people

Of the 141 young people who apparently took their own lives from 30 June 2009 to 30 June 2020:

- Seven were under 13 years old;
- Six were 13 years old;
- Thirteen were 14 years old;
- Twenty nine were 15 years old;
- Thirty nine were 16 years old; and
- Forty seven 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:

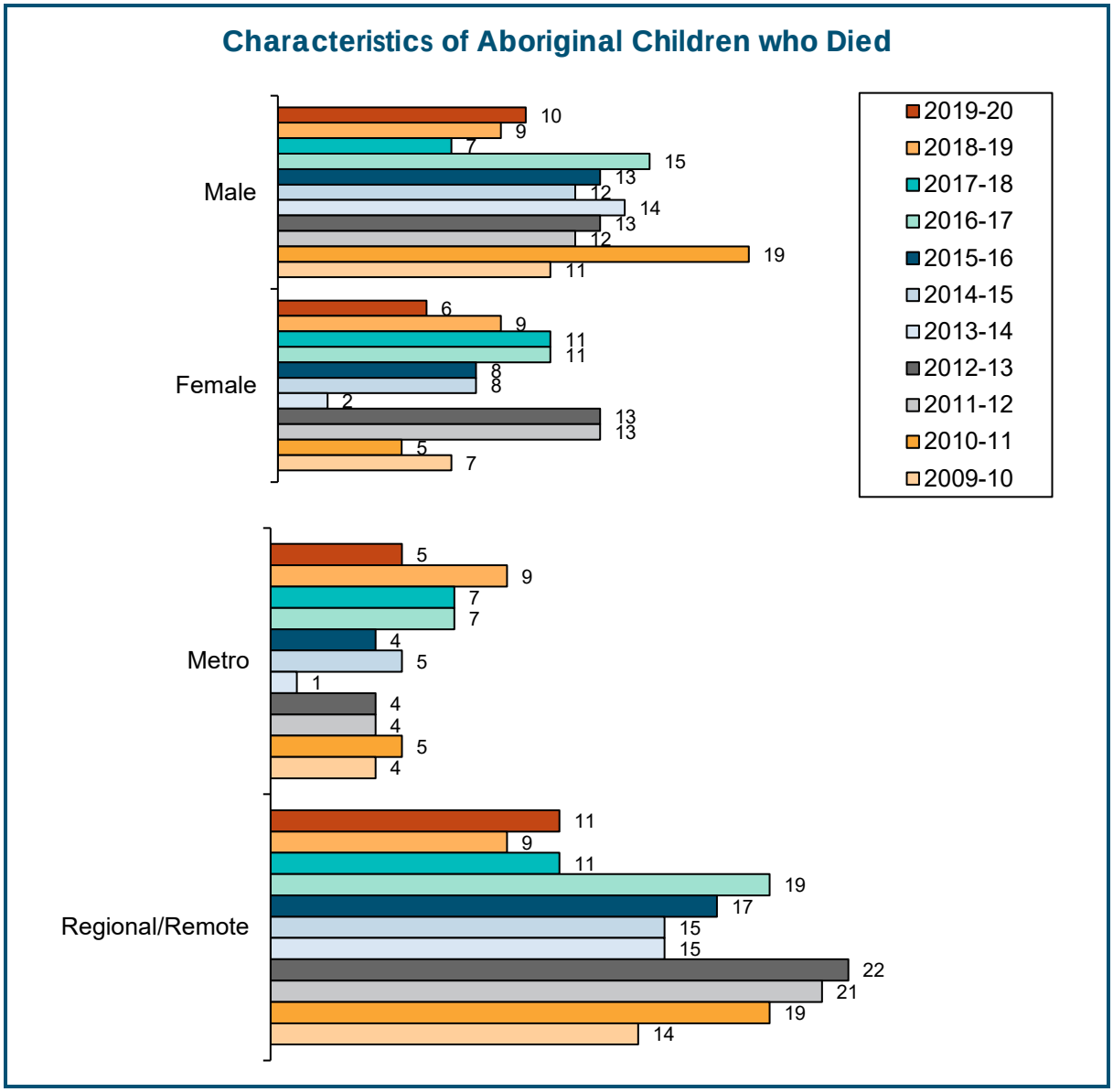
- Males – 56% of investigable deaths and 69% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 96 apparent suicides by young people where information on the Aboriginal status of the young person was available, 63% of the investigable deaths 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 59% of investigable suicides by young people and 31% 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

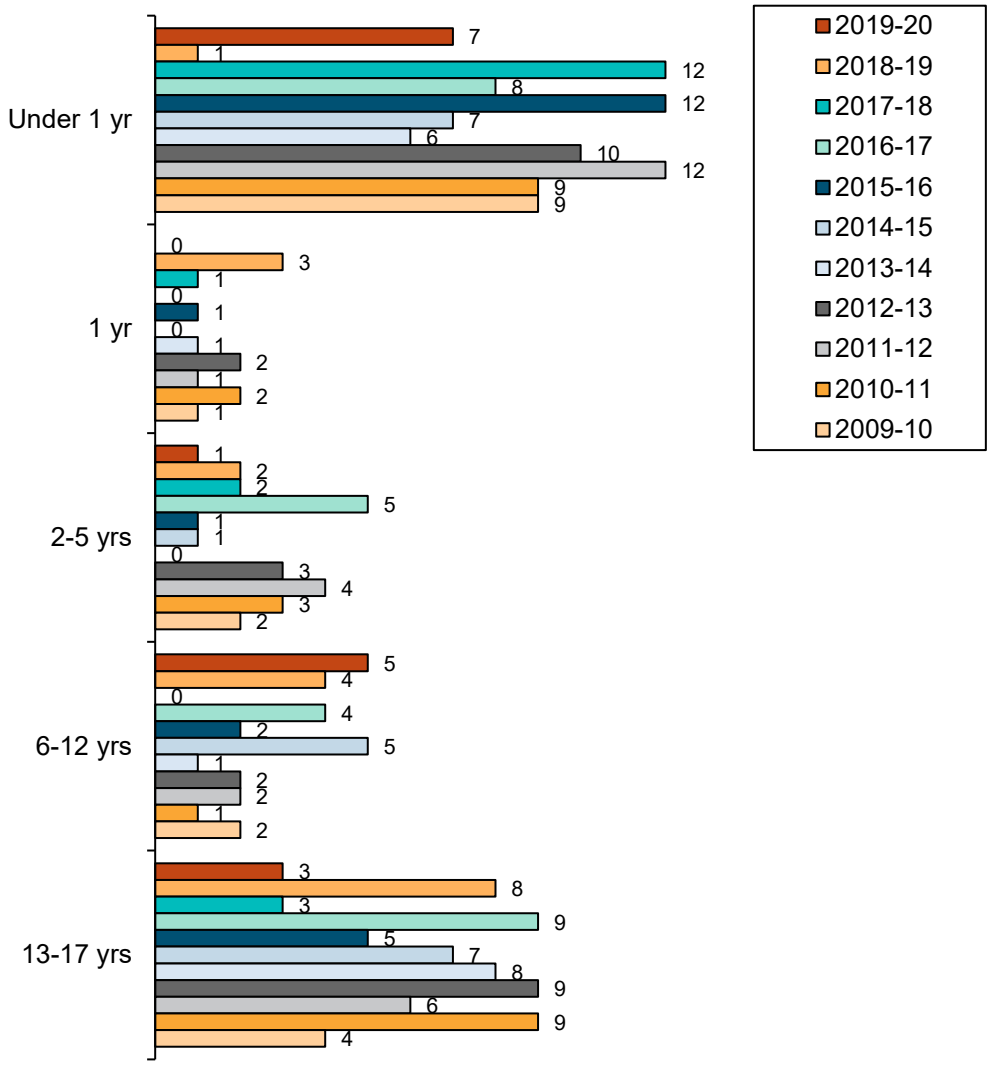
Of the 598 child death notifications received from 30 June 2009 to 30 June 2020, where the Aboriginal status of the child was known, 228 (38%) of the children were identified as Aboriginal.

For the notifications received, the following chart demonstrates:

- Over the 11 year period from 30 June 2009 to 30 June 2020, the majority of Aboriginal children who died were male (59%). For 2019-20, 63% 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 11 year period, 76% of Aboriginal children who died lived in regional or remote communities.

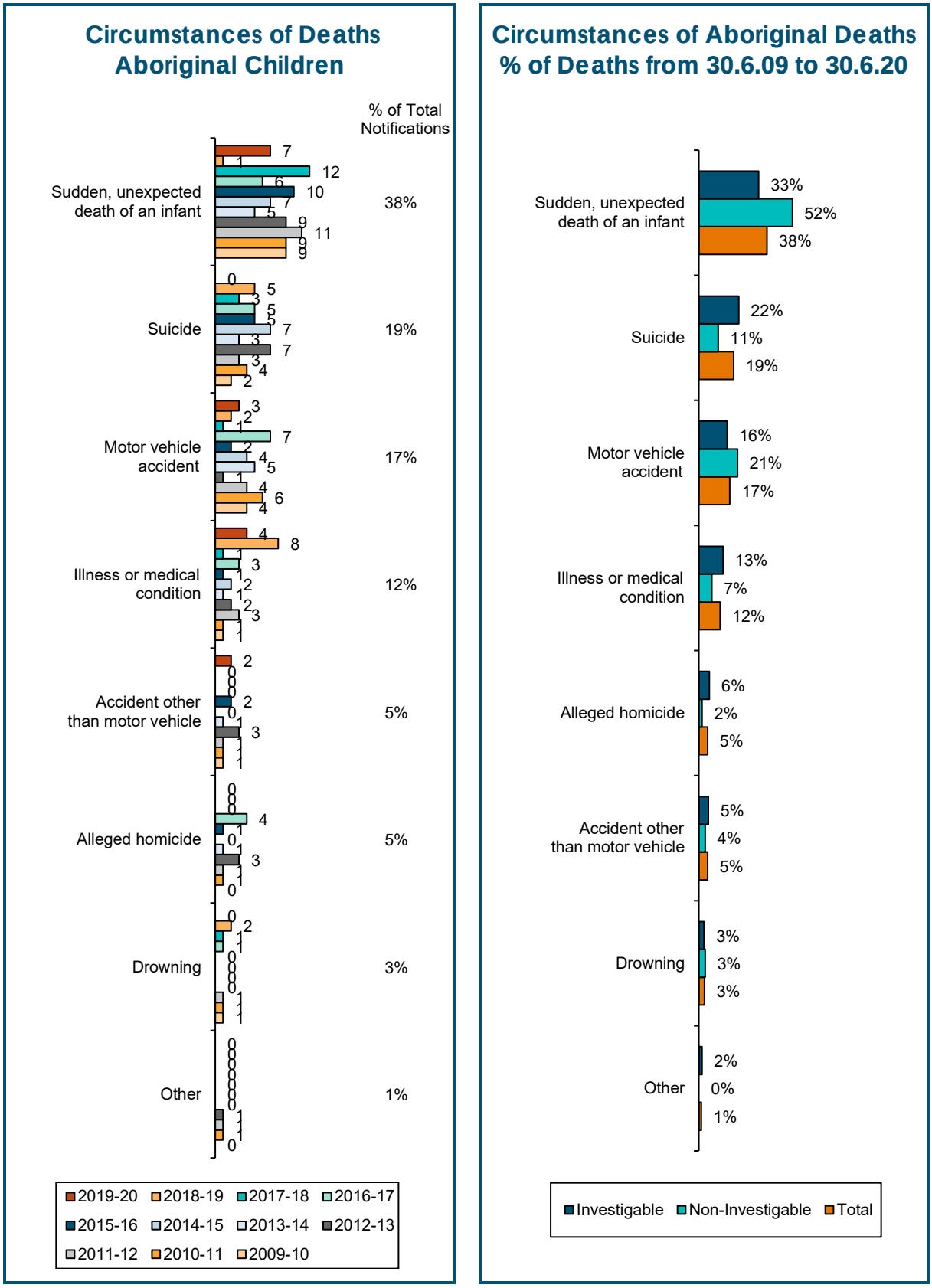


Characteristics of Aboriginal Children who Died



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 (38%), suicide (19%), and motor vehicle accidents (17%) are the largest circumstance of death categories for the 228 Aboriginal child death notifications received in the 11 years from 30 June 2009 to 30 June 2020.



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

Patterns, Trends and Case Studies Relating to Child Death Reviews

Deaths of infants

Sleep-related infant deaths

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

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

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

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

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

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

Case Study

Baby A

Baby A, an Aboriginal infant, 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 assessment and safety planning to promote Baby A's safety and wellbeing. Communities had engaged Baby A's parent with Best Beginnings Plus, a Communities' run programme which provides education and support to promote parenting.

Following a review of Baby A's death, which noted that Communities had commissioned the Berry Street Childhood Institute to undertake a review of the earlier version of Best Beginnings Plus, the Ombudsman made the following recommendations:

1. That, by 1 July 2020, Communities provides the Ombudsman with:
    - A copy of the adjusted Intensive Family Support (IFS) Monitoring Framework and clarification on how this has been developed to 'better reflect the impact and effectiveness of Best Beginnings Plus (BB Plus)' and how ongoing monitoring will ensure IFS integration into BB Plus, to provide a child protection response, is effective; and
    - A copy of the formal Review of BB Plus against *The Berry Street Childhood Institute: A review of Best Beginnings as part of a Child Protection strategy focussed on engaging earlier with vulnerable families, July 2016*, with clarification on how 'greater integration with Child Protection work' has been strengthened to ensure compliance with the responsibilities under the *Children and Community Services Act 2004*.
2. That, in providing the formal Review of BB Plus against the Berry St Report in accordance with Recommendation 1, Communities also provide clarification on how Communities conducted a 'comprehensive examination and development of the model from an Aboriginal perspective' involving 'co-design' with 'Aboriginal consultants' to ensure BB Plus is culturally safe for use with Aboriginal families.

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.

The Ombudsman's *Investigation into ways to prevent or reduce deaths of children by drowning* noted that for 47 per cent of the child drownings examined, the fatal drowning incident occurred in a private swimming pool. Further, that for 66 per cent of the hospital admissions for drowning examined, the non-fatal drowning incident occurred in a swimming pool. It was also noted that for fatal drownings examined, children aged one to four years who died by drowning, the incident more frequently occurred in a private swimming pool. Of the 25 recommendations made by the Ombudsman in the *Investigation into ways to prevent or reduce deaths of children by drowning*, 22 related to the construction and inspection of residential pool fencing.

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.

Care planning for children in the CEO's care

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

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

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

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

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

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

Case Study

Child B

At the time of Child B's death, Child B and Child B's school aged siblings, were in the care of the Chief Executive Officer of Communities.

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

1. Communities considers the findings of this review (including, when appropriate in Communities' view to provide a holistic approach and plan, the outcome of any other relevant reviews of the deaths of children in the care of the CEO by the Ombudsman or other oversight agencies) and provides the Ombudsman, within six months of the finalisation of this review, with Communities' plan to enhance compliance with Communities' legislative responsibilities to children in the CEO's care, as administered through Communities' practice requirements, associated with:
   - assessment and management of family and/or significant other carers;
   - care planning (including cultural care planning);
   - reunification planning; and
   - responding to concerns for the safety and wellbeing of children in the CEO's care.

2. Communities considers the findings of this review and whether offering first aid training on a periodic basis, in regional areas (as it is in metropolitan areas) is indicated for family carers, significant other carers and foster carers.

Deaths of primary school aged children from motor vehicle accidents

In 2019-20, the Ombudsman received six notifications of the deaths of children aged six to 12 years in the circumstances of motor vehicle accidents. Three of these 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 2019-20, 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 2020.

Further details of 'A report on giving effect to the recommendations arising from the Ombudsman's *Investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people* 2014*'* are provided in the Own Motion Investigations and Administrative Improvement section.

Case Study

Adolescent C

Adolescent C died in the circumstances of apparent suicide. In the months prior to Adolescent C's death, concerns were raised regarding alleged neglect in Adolescent C's homelife. Adolescent C was receiving mental health care and support. Adolescent C was enrolled in a school in regional WA but had very poor school attendance. Following a review of Adolescent C's death, it was identified that change was required to improve inter-agency communication and collaboration for young people who are identified as 'Group 1' (experience factors of suicidal ideation or self-harm, substance abuse, mental health problems, adverse family experience and child maltreatment) in the Ombudsman's *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (2014) and the Ombudsman made the following recommendations:

1. Communities provides the Ombudsman with a report by 31 July 2020 evaluating the effectiveness of the new Regional '*Children and Young People At Risk Meetings*' framework, including commentary relating to each of the six points detailed in the 'Purpose' section of the *Terms of Reference - Regional District Children and Young People At Risk Meetings (September 2019)*.
2. That WA Country Health Service (**WACHS**) Child and Adolescent Mental Health Service (**CAMHS**) considers, as part of the intake assessment process for a new client, that identification of the young person's circumstances and categorisation as being in Group 1-4, based on 'factors associated with suicide' outlined in the Ombudsman's *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (2014), to determine whether a timely referral to Regional District 'Children and Young People At Risk Meetings', is indicated.
3. WACHS, as a Service Delivery Partner to the Regional District YARN meetings, provides the Ombudsman with a report by 31 July 2020, summarising, from WACHS's perspective, whether the Regional District 'Children and Young People At Risk Meetings' model assists WACHS to ensure a multi-agency response to address 'social factors such as living conditions and environmental factors' for young people at risk of suicide.
4. DOE considers where, following the suicide of a student or community member postvention support follow-up is being implemented, actions to ensure students at 'attendance risk', are being afforded this support.
5. DOE, as a Service Delivery Partner to the Regional District YARN meetings, provides the Ombudsman with a report by 31 July 2020, summarising, from DOE's perspective, whether the Regional District 'Children and Young People At Risk Meetings' model assists Regional District High School to support and engage with students at 'attendance risk'.

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 taking action consistent with legislative responsibilities of the *Children and Community Services Act 2004*, to escalate the response to child safety and wellbeing concerns, in the context of parental non-engagement.
- Not taking action consistent with legislative responsibilities of the *Children and Community Services Act 2004*, to hold the best interests of the child as paramount when determining to close a case with the rationale of 'unable to assess' in circumstances when a family could be located.
- Not adequately meeting policies and procedures relating to Safety and Wellbeing Assessments and safety planning.
- Not adequately meeting policies and procedures relating to pre-birth planning.
- Not documenting the application of evidence-based theoretical knowledge to inform critical decision making to safeguard an infant.
- 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 undertaking care planning to promote the bests interests of a young person in the context of youth drug use, youth mental health and youth justice issues, and associated placement instability.
- Not adequately meeting policy and procedures to promote the best interests of a child in the CEO's care, or to assess, review and support carers.
- Missed opportunity to identify a young person at risk as meeting the circumstances for identification as Group 1 young person as defined by the Ombudsman's *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (2014) and take action to reduce the risk of suicide.
- 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.
- 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 2019-20 arising from child death reviews (certain recommendations may be de-identified to ensure confidentiality).

1. Communities considers the findings of this review (including, when appropriate in Communities' view to provide a holistic approach and plan, the outcome of any other relevant reviews of the deaths of children in the care of the CEO by the Ombudsman or other oversight agencies) and provides the Ombudsman, within six months of the finalisation of this review, with Communities' plan to enhance compliance with Communities' legislative responsibilities to children in the CEO's care, as administered through Communities' practice requirements, associated with:
   - assessment and management of family and/or significant other carers;
   - care planning (including cultural care planning);
   - reunification planning; and
   - responding to concerns for the safety and wellbeing of children in the CEO's care.
2. Communities considers the findings of this review and whether offering first aid training on a periodic basis, in regional areas (as it is in metropolitan areas) is indicated for family carers, significant other carers and foster carers.
3. DOE confirms to the Ombudsman at the completion of Semester 1, 2020 that, for all students identified as at 'severe attendance risk' at the completion of the 2019 school year who are enrolled at Regional District High School for the 2020 school year, they have either:
   - A 'documented plan' in accordance with DOE's *Student Attendance in Public Schools Policy and Procedures (2015)* and aligned with Recommendations 15 and 16 of the Ombudsman's major own motion investigation report *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (2014); or
   - An interagency plan developed through, and case managed by, the Regional District Youth at Risk Network; or
   - Have an improved school attendance rate and no longer meet the criteria for requiring a 'documented plan' as outlined in the DOE's *Student Attendance in Public Schools Policy and Procedures (2015)*.

4. DOE provides the Ombudsman with a report at the completion of Semester 1, 2020, that outlines:
    - the revised approaches aimed at improving attendance at Regional District High School in 2020 and indicates how they have engaged with and embedded the 'five cultural standards' outlined in DOE's *Aboriginal Cultural Standards Framework (2015)*;
    - in the context of Regional District High School's engagement with the 'five cultural standards' outlined in DOE's *Aboriginal Cultural Standards Framework (2015)*, where the school places itself on the 'continuum'; and
    - how DOE reviews (including but not limited to the Public School Review process) the effectiveness of these revised approaches aimed at improving attendance, to ensure that Regional District High School is on the pathway to becoming 'culturally responsive' ('proficient') on the 'continuum' of the 'five cultural standards' outlined in DOE's *Aboriginal Cultural Standards Framework (2015).*
5. Communities provides the Ombudsman with a report by 31 July 2020 evaluating the effectiveness of the new Regional '*Children and Young People At Risk Meetings*' framework, including commentary relating to each of the six points detailed in the 'Purpose' section of the *Terms of Reference - Regional District Children and Young People At Risk Meetings (September 2019)*.
6. That WACHS CAMHS considers, as part of the intake assessment process for a new client, that identification of the young person's circumstances and categorisation as being in Group 1-4, based on 'factors associated with suicide' outlined in the Ombudsman's *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (2014), to determine whether a timely referral to Regional District 'Children and Young People At Risk Meetings', is indicated.
7. WACHS, as a Service Delivery Partner to the Regional District YARN meetings, provides the Ombudsman with a report by 31 July 2020, summarising, from WACHS's perspective, whether the Regional District 'Children and Young People At Risk Meetings' model assists WACHS to ensure a multi-agency response to address 'social factors such as living conditions and environmental factors' for young people at risk of suicide.
8. DOE considers where, following the suicide of a student or community member postvention support follow-up is being implemented, actions to ensure students at 'attendance risk', are being afforded this support.
9. DOE, as a Service Delivery Partner to the Regional District YARN meetings, provides the Ombudsman with a report by 31 July 2020, summarising, from DOE's perspective, whether the Regional District 'Children and Young People At Risk Meetings' model assists Regional District High School to support and engage with students at 'attendance risk'.
10. That, by 1 July 2020, Communities provides the Ombudsman with:
    - A copy of the adjusted *Intensive Family Support (IFS) Monitoring Framework* and clarification on how this has been developed to 'better reflect the impact and effectiveness of Best Beginnings Plus (BB Plus)' and how ongoing monitoring will ensure IFS integration into BB Plus, to provide a child protection response, is effective; and
    - A copy of the formal Review of BB Plus against *The Berry Street Childhood Institute: A review of Best Beginnings as part of a Child Protection strategy focussed on engaging earlier with vulnerable families, July 2016*, with

clarification on how 'greater integration with Child Protection work' has been strengthened to ensure compliance with the responsibilities under the *Children and Community Services Act 2004*.

11. That, in providing the formal Review of BB Plus against the Berry St Report in accordance with Recommendation 10, Communities also provide clarification on how Communities conducted a 'comprehensive examination and development of the model from an Aboriginal perspective' involving 'co-design' with 'Aboriginal consultants' to ensure BB Plus is culturally safe for use with Aboriginal families.
12. That Communities, including but not necessarily limited to in the circumstances of developing the Communities' *Action Plan for At Risk Youth*, considers the findings of this review with a view to enhancing collaborative case management arrangements with Department of Justice to promote the safety and wellbeing of young people in the care of the CEO subject to detention at Banksia Hill Detention Centre and/or community based dispositions and provides a report to the Ombudsman within six months of the finalisation of this review with the results of this consideration.
13. Communities provides the Ombudsman with a report within 12 months of the finalisation of this review outlining Communities' strategies to monitor the provision of supervision (quantity and quality) to child protection staff in accordance with Communities' practice requirements.
14. In implementing the 'voluntary actions' outlined in Communities' 2019 internal 'child death case review' following the deaths of [Child A] and [Child B], that the Regional District identifies what action is required to ensure:
    - Assessment and safety planning for vulnerable infants that is consistently compliant with legislative responsibilities under the *Children and Community Services Act 2004*;
    - The use of available legislative powers 'to escalate its response to concerns for the safety and wellbeing of children, in the context of parental non-engagement'; and
    - That Child Safety Investigations are not closed with the documented rationale of 'unable to assess' when a family's location is known to Communities.

Steps taken to give effect to the recommendations arising from child death reviews in 2017-18

The Ombudsman made 30 recommendations about ways to prevent or reduce child deaths in 2017-18. 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: As Communities implements the 'consistent intake' process, as set out in the Organisational Reform Briefing, Communities considers, in view of the findings of this child death review and Recommendation 1 [*Annual Report 2016-17* as set out below] arising from this office's review of the death of [Infant A], whether any further steps are required to ensure this 'consistent intake' process appropriately responds to hospital social worker referrals regarding infant safety and wellbeing concerns and supports interagency communication and collaboration.

> **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 FDV), harm and/or neglect within the meaning of section 28 of the Children and Community Services Act 2004.**
>
> **Note –** as documented in the *Ombudsman Western Australia Annual Report 2018-19*, this recommendation has been implemented, and the guidelines are available in the *Casework Practice Manual Chapter 2.2.18 High Risk Infants.*

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned**
>
> The Department of Communities (Communities) implemented the Central Intake Model consisting of a decision-making tool, centralised intake team, and new workflow processes. The Central Intake Team became operational on 3 July 2017 to improve the consistency of the assessment of notifications of concerns for children and decision-making in relation to intake for further investigation.
>
> **Statewide Referral and Response Service**
> Communities Statewide Referral and Response Service is a newly formed district made up of the Crisis Care Unit, Mandatory Reporting Service, Domestic Violence Helplines, Central Intake Team (inclusive of a Housing Officer), ChildFIRST and the Family Support Network Child Protection Leads. All referrals of concerns for children in the metropolitan area are now processed by the Central Intake Team. Regional

and remote referrals are processed by locally based duty officers. Referrals include those received from hospital social workers, in 2019, Communities received 2821 recorded referrals.

Interaction Tool
The Interaction Tool was introduced in July 2017 and is used to assess all child protection contacts, at the point of initial referral, to determine whether further action by Communities is required.

Compliance
From 1 January 2019 to 31 December 2019, the Central Intake Team completed 13008 Interactions, 6249 of which held a concern for child. The Interaction Tool was applied to 5393 of these Interactions, totalling 86 per cent compliance with the use of the Interaction Tool.

The safety questionnaire is accompanied by a practice guidance document.

Training
The Central Intake Team completed Interaction Tool: Consistent Decision-Making Guide training during their orientation week 26 – 30 June 2017. In 2018, Communities rolled out the training to all Districts, 274 child protection staff attended. The Interaction Tool training (now called Interaction Assessment training) has now been incorporated into Communities Orientation Training Program 2 for all new child protection workers.

Independent Evaluation
On 1 February 2019, Communities approved an independent evaluation of the Interaction Tool to be undertaken by the Australian Centre for Child Protection (ACCP) in South Australia. The project commenced on 28 October 2019 and will run for a period of eight months. The focus of the review will include the application and appropriateness of the Interaction Tool. The independent evaluation will also consider whether the monitoring framework that is in place remains relevant and appropriate. The evaluation approach includes:

- site visits to meet with staff, observe the application of the Interaction Tool and to interview staff who have applied the tool;
- selection and analysis of a variety of cases assessed used the Interaction Tool, and
- review of the Interaction Tool against appropriate and relevant legislative frameworks, legal definitions and the monitoring framework.

ACCP will present findings and recommendations from the evaluation of the Interaction Tool and provide a final report in the third quarter of 2020.

Casework Practice Manual (CPM)
Processing referrals and interactions forms Chapter 2.2.2 of Communities CPM which provides guidance to child protection workers when information is received that raises concerns about a child's wellbeing. The entry provides child protection workers must apply the Interaction Tool to determine whether an intake is recommended.

Department of Communities Voluntary Action
Communities Statewide Referral and Response Service establishes a plan outlining how use of the Interaction Tool within the Central Intake Team and Crisis Care Unit will be increased and monitored.

It is anticipated by this Office that the independent evaluation of the Interaction Tool will likely identify if there are any current issues in responding to hospital social worker referrals regarding infant safety and wellbeing concerns.

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

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

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

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned**
>
> **Professional Development**
> Workshop: Orientation Program 2 – *Integration of Child protection Practice and Signs of Safety Days* 3-5: Assessing Child Abuse and Neglect Using Signs of Safety (now called Child Safety Investigations). Aim: To extend participants' knowledge and skills to assess and respond to child abuse and neglect using the Signs of Safety Child Protection Practice Framework. Communities Learning and Development data reveals that 671 child protection staff have completed Orientation Program 2, this includes 26 staff from the Metropolitan District.
>
> **Metropolitan District Learning Calendar 2019-20**
> The Metropolitan District's Learning Calendar for 2019-20 included the delivery of the following training:
> - *Signs of Safety International Gathering 2019 – "A Grandmother's Questions…Learnings from a Child Death Review"*. Metropolitan District presented our learnings from a Child Death Review to an international audience. The presentation is on Communities Knowledge Hive and available to all child protection staff.
> - *Child Safety Investigation* training was delivered locally in May 2019.
> - *Advanced Practice and Leadership in Signs of Safety* (3-day training) and *Advanced Safety Planning* (1 day training) was delivered locally in September 2019.
> - Lunch box learning events also occurred, including *Advanced Safety Planning with Care Teams*.
> - The District Conference was held in November 2019, and featured *Stopping Family Violence* as the keynote speaker.

- *Trajectory Training* was delivered locally in February 2020.
- Aboriginal Practice Leaders and Specialist Community Child Protection Worker attended *Blurred Borders* in February and March 2020.
- *Stability and Connection Training* is planned for May 2020.

Compliance
Communities produce Standards Monitoring Reports for each District on a 2-yearly cycle. 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 Metropolitan District in the October 2018 Final Report received commendation for 'safety planning during the Safety and Wellbeing Assessment process involved children, their parent/s, extended family, persons of significance to the child and utilised the Signs of Safety mapping process to inform the safety planning' (QS11.8).

Department of Communities Voluntary Action
Communities Metropolitan District will develop a local Learning Calendar for 2020 to build upon the seven areas of learning identified in the 2018 Action Plan.

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

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

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

This recommendation has been actioned

Standards Monitoring Unit
To give effect to this recommendation, the Standards Monitoring Unit (SMU) updated the report format, Required Action report, and requisite templates as per the revised standards and to meet the needs of Communities Leadership Team. The method of information gathering was also modified to include evidence from staff and stakeholders, including face to face interviews, electronic surveys, and document reviews. The sample for children in care and Safety and Wellbeing Assessment's was also increased to reflect the number of cases being managed by the districts.

In preparation for cycle six, SMU undertook 29 information sessions across 17 districts and other work practice units. In cycle six, SMU are collecting information from the districts to ascertain the barriers in achieving consistent practice for Communities critical priorities and to determine what strategies have been used that have

successfully resulted in embedded change for the district. SMU will analyse the information to identify systemic barriers within the agency and collate a bank of successful strategies to be shared with district offices.

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

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

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 3 December 2018, in which Communities relevantly informed this Office of the progress taken to implement recommendations 2 and 3. Further information, as outlined above, was provided by Communities in a letter to this Office dated 12 May 2020.

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

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

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 3 December 2018, in which Communities relevantly informed this Office of the progress taken to implement recommendation 5. Further information, as outlined at Recommendation 2 above, was provided by Communities in a letter to this Office dated 12 May 2020.

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

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

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned**
>
> **Casework Practice Manual**
> Safe infant sleeping forms Chapter 1.2.8 of the revised CPM which provides information and practice guidance to staff on safe infant sleeping practices and the risk of co-sleeping where Communities has an ongoing role working with families and carers with infants.
>
> Communities is aware of the risks associated with co-sleeping and provides guidance to families and carers to avoid these risks and safely care for their children. As part of making assessments, child protection workers and Best Beginnings Plus workers need to consider the sleeping arrangements of families with babies, both at the families' primary residences and other sleep locations such as the homes of friends or relatives.
>
> When working with a family with an infant, child protection workers and Best Beginnings Plus workers must advise about co-sleeping and factors that increase or reduce this risk within the first four weeks of the baby's birth (where involved), and, where appropriate, provide information and the following resources:
> - Women and Newborn Health Service of WA: Safe Infant Sleeping Information for Parents, Carers and Families
> - SIDS and Kids WA: *Reducing the Risk of SUDI in Aboriginal Communities*
> - SIDS and Kids webpage: Safe Sleeping in Other Languages, and
> - Quitnow webpage: *Pregnancy and Quitting* for information on SIDS.
>
> Refer to Recommendation 24

It is noted that Casework Practice Manual Chapter 1.2.8 *Safe infant sleeping* was reviewed and modified by Communities subsequent to this recommendation being made. It is also noted that Chapter 2.2.18 *High-risk infants* (developed in November 2018 in response to an Ombudsman 2016-17 recommendation – See Recommendation 1 above) requires the promotion of safe infant sleeping. At Recommendation 22 below, Communities informed this Office that '[i]n 2020, *Responding to High-risk Infants* training will become compulsory for all Child Protection Workers, Best Beginnings Plus Workers and Child Protection Team Leaders'.

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

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

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

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 18 December 2018, in which Communities relevantly informed this Office that:

> In relation to the first dot point of your recommendation, the Department has prepared an overview response to the current initiatives relating to the Aboriginal Services and Practice Framework 2016-2018. The current Framework will cease at the end of December 2018; options are being explored for a new or updated framework which takes a more integrated, whole-of-government approach to service design, in keeping with the former Department of Child Protection and Family Support's amalgamation into the Department of Communities…
>
> In relation to Aboriginal leadership within the structure of the Department of Communities, the Department has recently established and filled the position of Executive Director, Priority Initiatives, Strategy and Transformation. This position, reporting directly to the Assistant Director General, Strategy and Transformation, will have responsibility for the future strategic development of the Aboriginal Services and Practice Framework priorities, and will provide overall leadership for Aboriginal initiatives within the Department.

This Office subsequently requested that Communities updates the Office on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned**
>
> **Aboriginal Cultural Capability Reform Program**
> The Aboriginal Cultural Capability Reform Program (ACCRP) represents a targeted component of Communities' strategy to improve outcomes for Aboriginal people. The ACCRP will lead development of a culturally competent workforce that recognises and appreciates Aboriginal values and traditions, and includes understanding how culture influences behaviours, as well as interpretations and evaluations of behaviours.
>
> The ACCRP will consider recommendations from the following reports in the context of best implementation approaches to lead critical learning programs that empower our whole of Department workforce, carers and community sector agencies to work with and in partnership with Aboriginal people:

- Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities (Gordon Review, 2002)
- Review of the Department for Community Development (Ford Review, 2007)
- Service Priority Review (2017)
- Department of Communities Agency Capability Review (2019)
- Cultural Competency Audit of Child Protection Staff and Foster Care and Adoptions manual (2019)

Minister for Community Services Aboriginal Advisory Panel

The Aboriginal Advisory Panel is to provide strategic advice, regional and metropolitan context, and co-develop new approaches to policy formation and service design and delivery, with respect to the responsible Minister's portfolio (Child Protection; Women's Interests; Prevention of Family and Domestic Violence; Community Services). The Panel consists of 15 members, representing geographical coverage, cultural links, gender, expertise and interests. The priorities for the Panel align to the work of the Ombudsman, with a priority being the development of a dedicated Aboriginal Family Safety Strategy. The Panel met for the first time in December 2019 and again in March 2020. At the meeting in March 2020 Panel members were nominated to form a sub group to be involved with the Aboriginal Family Safety Strategy.

Aboriginal Practice Leaders

Conducting a Child Safety Investigation forms Chapter 2.2.4 in the Casework Practice Manual and provides culturally responsive practice guidance to child protection workers. Child protection workers must consult with an Aboriginal Practice Leader (APL) once a child or family is identified as Aboriginal. The purpose of this consultation is to contribute to the development of an effective plan for the investigation that takes into consideration cultural issues. All consultations with an APL must be documented.

From October 2019, there has been additional functionality added to Assist to enable APL consultation to be recorded in the Case Plan. This improves consistency in how Communities records consultations, including APL consults, and to make it easier for staff to record and locate important consultations on the electronic records systems. At a workshop on 19 November 2019, this new recording practice was communicated to the APL group, including the benefits in relation to data capture.

Communities continues to offer opportunities for joint learning, mentoring and networking when APL group meet every 12 weeks. The purpose of these meetings includes to promote consistency and quality of consultations across the state, including promoting the use of 'Request for Aboriginal Practice Leader Consultation'. In practice, this resource is used as a tool to help frame an APL consultation so that discussions can be targeted to relevant issues for a child and their family and considered in context. APL support staff to access resources and information specific to a family's cultural group and plan for how best to engage the parents and deliver culturally responsive practice.

Communities Professional Practice Unit includes two APLs and a Senior Consultant Aboriginal Practice. These specialist staff provide additional support to APL staff across the state on complex matters involving Aboriginal children and their families.

Communities provided this Office with a letter dated 19 May 2020, in which Communities relevantly informed this Office of the implementation of a 'new leadership structure…organised into seven divisions'. It is noted that one of the new divisions is 'Aboriginal Outcomes', providing '[c]larification of where Aboriginal leadership is placed in Communities' organisational structure' as required by the second dot point to this recommendation. Further, Communities provided this Office with a letter dated 25 May 2020, in which Communities relevantly informed this Office of the commitment to establish a specialist child protection unit to '…drive improved outcomes for children in care and their families, and those at risk of entering the system', which will be 'led by a Senior Practitioner and a Senior Aboriginal Practitioner'.

Aboriginal Cultural Council

Communities has also informed this Office of the establishment of the Aboriginal Cultural Council (**the Council**), which supports Communities to exercise governance, strategy and responsibilities within a culturally secure framework. The Council's role is to provide advice to the Communities Leadership Team.

Communities has informed that the Council is responsible for:

- Providing cultural advice and information that supports Aboriginal inclusion and reconciliation to create better outcomes for Aboriginal people.
- Offering advice from an Aboriginal perspective, ensuring policy and practice development is informed with a cultural viewpoint.
- Advising on Aboriginal inclusion initiatives to produce a range of services and programs that build on and factor in cultural capability and cultural competency.
- Guiding the Department to build cultural capabilities in attitudes, behaviours, skills and acknowledge, by offering cultural advice.
- Identifying emerging trends for the Aboriginal community, to enable the co-development of responsive, innovative and practical programs that deliver optimal outcomes for Aboriginal people.
- Providing information and cultural intelligence to the Department's Reconciliation Action Plan working group with a focus on race relations, equality and equity, institutional integrity, unity and historical acceptance.
- Supporting the Department to gain a deeper understanding of Aboriginal culture and society and deliver reforms through Aboriginal Services and Sector Improvement Initiatives.
- Identifying opportunities to ensure that the Department creates a culturally cohesive working environment, enabling the practice of contemporary and traditional customs pertinent to:
  - Aboriginal family, kinships and skin groups.
  - Aboriginal culture and traditional practices.
  - Country for aboriginal people, that is local, and place-based.

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

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

Steps taken to give effect to the recommendation

DOE provided this Office with a letter dated 8 February 2019, which included a report outlining actions taken by the Regional School to give effect to this recommendation, and a copy of the *Attendance Plan 2018-2021*.

This Office subsequently requested that DOE updates the Office on the steps taken to give effect to the recommendation. In response, DOE provided a letter to this Office dated 23 April 2020, which relevantly informed this Office that:

> …the Department of Education initiated a full review of its approach to attendance, including its policy and procedures, support for schools and partnerships with other agencies and providers. The review covers three key actions:
>
> 1. A cross-agency approach to addressing the complex matter of low student attendance in remote and/or very disadvantaged communities.
> 2. Development of operational approaches to provide stronger and more targeted support for schools.
> 3. Updates to policy, procedures and guidance that improve schools' local decision making to meet their legislated obligations.

The DOE letter included a report that relevantly informed this Office that:

> The Regional School Attendance Plan 2018-2021 focusses on early years education, family support, building positive relationships and increasing the number of days of attendance for those students with a regular pattern of attendance.
>
> The Attendance Plan covers nine areas. Implementation and progress of these areas are outlined below:
>
> 1. Ensuring children are enrolled in school:
> - Increased communication and assistance has been provided to parents to complete enrolment packages.
> - An increase in the number of home visits undertaken by Aboriginal and Islander Education Officers (AIEOs).
> - The school formalises Section 24 arrangements for students who are in the Regional area for a short time with their home school.
>
> 2. Giving direct support to schools and communities with the greatest need:
> - The Attendance Team comprising of a School Based Attendance Officer (SBAO), Youth Education Officer (YEO), deputy principals and Academy staff (Clontarf, Girls Academy and Shooting Stars) develop strategies to address attendance concerns with Western Australia Police Force and the Youth Hub.
> - Vocational Education and Training (VET) is offered to secondary school students to engage them in work readiness activities and placements with Aboriginal training agencies and employers. A new Vocational Trainer and Assessor position has been advertised.

- Additional school psychology services (hours) have enabled greater assessment of student needs.
- The inclusion of the Regional Program has enabled the educational screening of students in a more structured and regular way resulting in teaching and learning programs that better cater to the individual student.

3. Ensuring support and action in the early years and at transition points:
- Kindilink and Kindy Ready in the Regional Town have both had positive outcomes on student attendance.
- Regional School continues its work with the local Catholic school the Regional playgroup and a Non-Government Organisation to develop positive parent-school relationships, and share the attendance message on a regular basis.

4. Recognising initiatives that encourage student attendance and parent participation:
- Work has been ongoing to rebuild the Girls Academy to support attendance for female students in Term 1, 2020.
- Assemblies and community events have been coordinated by a school based committee to develop events that encourage school and parent participation.
- The school has invested significant resourcing into student services in order to promote a positive school culture including appointing:
    - a secondary and primary level 3 administrator; and
    - three full time student services support officers who are directly responsible for the implementation of student support services.
- The investment in student services allows for greater capacity for administration staff to focus on building the learning environments making connections and meeting and planning with partners such as families and the community.
- The school has a full-time Macquarie Literacy Program (MAQLIT) instructor who runs individual and small group literacy development skills with secondary school students demonstrating challenges in literacy mastery.

5. Notifying parents early where non-attendance is a serious issue:
- Developing individual stories (profiles) for students with non-attendance has been integral to the development of tailored and group programs.
- Many of the school's long-term non-attenders have high street presence and criminal convictions. An engagement plan is in place, in partnership with the police to work with male students.

6. Supporting parents to take responsibility for their child's attendance at school:
- Non-Government Organisation (in conjunction with Kindilink) conducts the Positive Parenting Program delivered by the Department's School Psychology Service.
- The school partnership with the regional office attendance coordinator has resulted in fortnightly home visits and a number of agency briefings during Term 1, 2020 in order to improve understandings about attendance.
- Community health, family welfare services and the Community's women's resource agency have provided parenting workshops.
- AIEOs are allocated time to conduct home visits with teaching staff to improve relationships with the parents and community.

7. Establishing partnerships with local businesses and agencies to improve attendance:
- Meetings with staff from the Youth Centre has resulted in positive after school initiatives and enables attendance conversations to occur in student areas of influence.
- Partnerships with police and the Youth Centre to increase access to programs, such as breakfast programs, and initiatives linked to good standing policy, and

end of term rewards for students who are attending, role modelling positive engagement and representing the school and community in external events have been implemented.

- A school based, externally funded Indigenous Rangers class was established and conducted during 2019 to engage and provide training for students failing to meet minimum attendance and participation levels. Funding for this program has ceased, however, to continue preparation for work for these young people the resources purchased by the school will be utilised to enable community maintenance courses conducted for targeted non-attending students and their community work program officers.
- The Academies and YEO run regular On Country trips to celebrate fortnightly 100% or positive increases in attendance for each year group.

8. Providing professional learning for school staff and community members on how to address poor attendance:

- In 2019, school staff explored Tracks to Two-Way Learning as a means to develop the strength of inter-cultural teaching and learning through a co-design process in a more culturally powerful manner and demonstrate to students that their cultural background is relevant and respected.
- In 2020, planning has continued around the foundations of the Tracks to Two Way Learning including the review and possible implementation of English as an Additional Language or Dialect progress maps for those students who are on modified learning programs.
- The Aboriginal Cultural Standards Framework to enact best practice in Aboriginal education is utilised by the school. In 2020, an audit of staff understanding in relation to using the Aboriginal Cultural Standards Framework was conducted. This identified staff are aware, and have personal buy-in, to ongoing understanding of the cultural context of the community the school supports.
- The school has conducted regular workshops during staff induction programs to complement this work in the use of Integris, ACADEMY (student attendance management systems) and information about the attendance process related to how and when to engage the SBAO and AIEOs.
- Student services staff meet fortnightly to discuss the status of students on individual education plans.
- AIEO staff have, as a team, developed a cultural induction program which is delivered to all staff during professional development opportunities.
- Training hours and resourcing have been allocated to AIEOs to facilitate the completion of the Macquarie Literacy Program training.
- In 2020, additional school psychologists to deliver assessment support for primary and secondary teachers has resulted in a greater number of students having the differentiated teaching and learning program individual students required to engage in a positive school environment.

9. Making regular attendance a priority:

- The Regional Attendance Coordinator:
    - provides support to the school and families in relation to the development of attendance plans;
    - supports SBAOs with home visits;
    - works with SBAOs and families to find solutions to non-attendance and assist with referrals to agencies that may be able to support families in relation to concerns they have regarding their child or themselves (mental health, drug and alcohol etc.); and
    - supports Remote Schools Attendance Strategy and the governance committee, which includes Child and Adolescent Mental Health, Youth Centre, Community's Sport and Recreation Centre Girls Academy and Clontarf, to promote school attendance and support before and after school activities.

- Regular school cluster meetings are held to look critically at attendance patterns with the aim of identifying areas where improvements can be made.
- Student services staff meet fortnightly with external partners such as WA Police, Department of Communities and the Community's Aboriginal Medical Services to generate and review student wellbeing plans and education plans. These are disseminated to all staff through online student profiles.

In an email dated 18 May 2020, DOE relevantly informed this Office that:

> …in 2017 Regional School conducted a review of their school attendance plan and drafted the 2018-2021 plan. The Ombudsman's findings were incorporated into the development of the 2018-2021 plan which has continued to address the Ombudsman's findings and recommendation.

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

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

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned**
>
> **Department of Communities Voluntary Action**
> Communities has undertaken to amend the Casework Practice Manual to expressly require that child protection workers must, in assessing and determining the response by Communities, consider the entire family, including any siblings related to the child about which a report is made. The following entries will be amended by 10 April 2020:
> - 2.2.2 Processing referrals and interaction
> - 2.2.3 Initial Inquiry
> - 2.2.4 Conducting a Child Safety Investigation

It is noted that amendments to these chapters have now been completed and include directions such as:

> You **must** consider the referral in the context of the family and household members, including whether there are any siblings or other children affected, and whether the Department may have a role in regards to these children.

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

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

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned**
>
> Refer to Recommendation 9

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

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

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned**
>
> **Regional District Leadership Group Strategic Plan 2018 – 2022**
> The Regional District Leadership Group's vison for 2018-2022 is to work collaboratively to deliver responsive, integrated and effective human services to improve the wellbeing of Regional District children, families and communities.
>
> **Regional District Annual Plan July 2019 - June 2020**
> Communities Strategic Plan identifies three strategic priorities, each with specified objectives. The Regional District strategic priorities are as follows:
>
> 1. *We will support individuals and families to lead their best life:*
> - New service delivery models that create flexible ways for individuals and families to identify and access the support they need, when and where they need it
> - People are better supported to navigate the human services system
> - The human services system better supports the people we serve
>
> 2. *We will mobilise local solutions:*
> - District Leadership Groups across the State that are empowered and equipped to deliver on local priorities

- Our regions make decisions and deliver supports that make sense for that region
- Local people and entities have the capacity to determine, design and deliver the supports they need
- Community development and collective impact approaches are commonplace

3. We will CREATE and transform:

- Passionate, high-performing leaders transform our agency and the human services system
- Our values guide our decisions and actions, every time, and create cultural security and inclusion
- A skilled, committed and diverse workforce that makes a big difference
- An effective, efficient and responsive agency that is supported by an integrated set of business systems and an appropriate governance and performance framework

Regional District Children and Young People At Risk Meetings

The Regional District Children and Young People At Risk Meetings framework supersedes the Regional District High Risk Youth and Family Strategy. In October 2019, Communities reported the following improvements to the framework:

- A new structure for Children and Young People At Risk meetings was developed and includes a Referral and Shared Case Plan that is dedicated to each individual. These resources will enable actions to be clearly articulated and agreed upon including clear reasons for exit to be tracked.
- A lead agency is identified for each individual who will act as a conduit between services and the family, ensure family are consulted and included in actions, and drive the follow up of actions including liaison with nominated agencies as identified in the Shared Case Plan.
- Exit from the Children At Risk meeting occurs when agencies are collaborating and services for the child, young person and their family are in place. The lead agency will continue to coordinate services until the concerns are resolved.
- Communities will commit to assessing the child or young person's risk by applying the Interaction Tool. This will assist in determining what action Communities will take in responding to the concerns raised for the child in the meeting. Communities will communicate the outcome of their assessment to the lead agency within one week of the meeting. If Communities determines a child safety investigation is required, Communities will become the lead agency until the assessment is completed.
- The Adverse Childhood Experience scale is included in the Referral and Shared Case Plan to guide the vulnerability level, and to highlight potential services required.
- The new structure and resources will be reviewed in six months and adjustments made as required.

Compliance

The Ombudsman, in their Preliminary View following their investigation into the death of Child D, noted that the purpose of the framework is consistent with the findings of the Ombudsman's *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (2014) highlighting the importance of inter-agency collaboration in preventing and reducing suicide by young people who experience multiple risk factors and are known to multiple State government agencies. Communities will undertake an Independent Process Review of the Regional District Children and Young People At Risk Meetings during 2020.

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

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

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 18 December 2018, in which Communities relevantly informed this Office of the steps taken to give effect to recommendations 9, 10 and 11. Further information, as outlined at Recommendation 9,10 and 11 above, was provided by Communities in a letter to this Office dated 12 May 2020.

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

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

Steps taken to give effect to the recommendation

DOE provided this Office with a letter dated 8 February 2019, which included a report outlining actions taken by the Regional School to give effect to this recommendation, and a copy of the *Attendance Plan 2018-2021*.

This Office subsequently requested that DOE updates the Office on the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 23 April 2020. See Recommendation 8.

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

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

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned**
>
> **Revised Bilateral Schedule**
> Communities Policy and Service Design are in consultation with the Department of Health to review the Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby Is Identified as at Risk of Abuse and/or Neglect. A Meeting has been scheduled with the Department of Health for late March 2020 to progress discussions.

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

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

Steps taken to give effect to the recommendation

Communities provided this Office with a copy of the *Interagency Pre-birth Protocol Position Paper* (December 2017) at meetings on 19 July 2018 and 3 August 2018. In a letter dated 9 January 2019, Communities informed this Office that:

> Since the Pre-birth Planning Position Paper was provided to the Ombudsman in July 2018, 12 months of funding has been secured to pilot a centrally coordinated Pre-birth facilitation model. The funding is for two experienced Senior Practice Development Officers who will facilitate the majority of Pre-birth Planning meetings taking place at King Edward Memorial Hospital and Fiona Stanley Hospital. Recruitment for the positions is currently in progress with an anticipated commencement date of February 2019.
>
> Another key component of the Pre-birth Project is the development of a State-wide training package for facilitators, child protection workers and other key professionals involved in the Pre-birth Planning meetings. This training is closely linked with the Casework Practice Manual entry "Identifying, assessing and responding to high-risk

infants" and will align with other child protection training programs such as "Responding to High Risk Infants". Training on Pre-birth planning was recently delivered to staff at Peel District. There will also be additional targeted training for facilitators of Pre-birth Planning meetings on facilitation/mediation.

It is anticipated the two new positions and training for staff will improve both the consistency and quality of the facilitation of the meetings, improve engagement of families in the process (with particular consideration to Aboriginal families), and enable more robust safety planning for infants. The centralised model will also enable improved recording regarding Pre-birth activities which occur at these two lead hospitals in the metropolitan area and across the State. A monitoring and evaluation framework for the project will be developed in early 2019.

This Office requested that Communities provide an update of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

This recommendation has been actioned

Pre-birth Planning Project Overview and Evaluation
The *Pre-birth Planning Project Overview and Evaluation Framework* provides an overview of the Pre-birth Developmental Project and outlines the parameters of quantitative and qualitative data being collected to inform an evaluation of pre-birth planning activity. The evaluation will focus on the inter-agency meetings in accordance with the Bilateral Schedule and the Signs of Safety Child Protection Practice Framework. The evaluation will consider data from across WA, with the Pilot enabling comparative data with a focus on improvements to the process and outcomes for families.

It is understood that the *Pre-birth Planning Project Overview and Evaluation Framework* was developed from the Pre-Birth Project referred to in the letter from Communities dated 9 January 2019.

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

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

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 9 January 2019, in which Communities relevantly informed this Office that:

Communities wrote to the Ombudsman's office on 11 June 2018 and on 3 September 2018 outlining Departmental responses to the two recommendations made by the Australian Centre for Child Protection (ACCP) in relation to the Signs of Safety Reloaded Project. The Ombudsman's office noted that the correspondence of 11 June 2018 addressed Recommendation two by ACCP, and requested further information in relation to Recommendation one. Communities provided this on 3 September 2018.

Additional information on Signs of Safety was provided in the presentation…on 21 November 2018.

This Office requested that Communities provide an update of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

This recommendation has been actioned

Signs of Safety Reloaded Phase 2
Communities *Signs of Safety Reloaded Phase 2* was finalised with a proposed scope for *Signs of Safety Reloaded Phase* 3. Phase 3 will encompass activities from Phase 2 including the development of tools, training, practice support forums and other resources.

Professional Development
In 2019. Communities delivered professional development sessions regarding danger statements and safety goals to Service Delivery**.**

Workshop: Orientation Program 2 – *Integration of Child protection Practice and Signs of Safety*. Days 3-5: Assessing Child Abuse and Neglect Using Signs of Safety. Aim: To extend participants' knowledge and skills to assess and respond to child abuse and neglect using the Signs of Safety Child Protection Practice Framework. Communities Learning and Development data reveals that 671 child protection staff have completed Orientation Program 2 – Integration of Child protection Practice and Signs of Safety, this includes 27 staff from the South West District.

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

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

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

This recommendation has been actioned

Casework Practice Manual
Case allocations, management, transfer, requests for co-working or services, shared case management and case closure forms Chapter 2.2.7 of the Casework Practice Manual and provides guidance on the Monitored List.

Children aged 5 years and younger who are not in the CEO's care may only be placed on the Monitored List after the Child Safety Investigation has been commenced and in exceptional circumstances. This must be approved by the District Director and the decision reviewed every two weeks. If any additional information or concerns are received an urgent review should occur to consider immediate allocation.

Cases that involve children in the CEO's care who are 2 years of age or under must not be placed on the Monitored List.

Children in the CEO's care who are aged between 3 and 5 years may be placed on the Monitored List in extraordinary circumstances, but the decision must be approved by the Executive Director and/or District Director every month and be approved by the Executive Director every three months.

High-risk infants' forms Chapter 2.2.17 of the Casework Practice Manual. A high-risk infant refers to an unborn infant or a child between 0-2 years of age considered to be at increased likelihood of significant harm or death due to the presence of risk factors. All high-risk infants must be actively case managed until the risk factors have been addressed and there is sufficient safety to close the case. These cases must not be placed on the monitored list.

Compliance
Communities Professional Practice Unit provides District Directors with the *Team Leader Monitored Cases* report monthly, identifying children 5 years and under on the Monitored List. The report highlights new additions to the list and children aged 2 years and under. The Professional Practice Unit requires each District to send monthly approvals for children to be placed on or remain on the monitored list.

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

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

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 9 January 2019, in which Communities relevantly informed this Office of the steps taken to give effect to recommendations 14, 15, 16 and 17. Further information, as outlined at Recommendation 14, 15, 16 and 17 above, was provided by Communities in a letter to this Office dated 12 May 2020.

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

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

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

Steps taken to give effect to the recommendation

WACHS provided this Office with a letter dated 16 December 2018, in which WACHS relevantly informed this Office that:

> The Regional District Hospital A (RDHA) Non-Accidental Injury (NAI) Risk Assessment Form, and Flowchart Procedure for Children Aged 16 and Under (Attachment 1) was developed by a multidisciplinary team at RDHA to ensure that at risk children are assessed and provided intervention as required. The program was implemented at RDHA in 2017 and has subsequently been rolled out to Regional District Hospital B (RDHB) in 2018.
>
> For all children under the age of 16 who present to the Emergency Department (ED) at RDHA or RDHB with an injury, burn or toxicology related presentation a MR P14A Emergency Paediatric Injury Risk Assessment Form (Attachment 1) is completed by the attending medical practitioner or nurse.
>
> A safety assessment is completed by the medical practitioner or nurse and is scored. Safety decisions and a management plan are formulated based upon this safety assessment score. An immediate plan of care is put into place. If identified as being required a referral to CPFS is completed.
>
> All children that are deemed at risk are followed up independently and discussed at the individual hospital's Emergency Department NAI Paediatric Review meeting. Each child is reviewed to ensure that correct follow up has occurred. Once a child has been considered at risk and the referral for follow up has been made there are regular interagency meetings between WACHS Region and CPFS to monitor ongoing requirements.

This Office requested that WACHS provide an update on the steps taken to give effect to the recommendation. In response, WACHS provided a letter to this Office dated 25 March 2020, containing a report prepared by the WACHS Regional District.

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

> Since the last updates provided on the 11 June 2018 and 16 December 2018 WACHS Regional District has implemented and imbedded the referral process to the Department of Child Protection and Family Services (CPFS) and the "Child at Risk Alert"
>
> WACHS Regional District has implemented a comprehensive referral process that has embedded the use of the DCPS Concern referral form. In the instance where Sexual

Abuse is an area of concern this form is completed in conjunction with the Mandatory Report

With the introduction of WebPAS across WACHS a "Child at Risk" alert has been created and is utilised as defined in *Child at Risk Alert Procedure* February 2018 (see attachment)

This alert can be viewed state-wide and integrates into the Community Health Information System (CHIS) that was implemented in 2018 and the BOSSnet system that commenced implementation in 2020.

WACHS Regional District Regional Resource Centre has implemented the Non-Accidental Injury pathways as outlined in the Department of Health Guidelines for Protecting Children. WACHS Regional District Regional Resource Centre undertakes multidisciplinary case management for children at risk identified as residential or residing within the region. The multidisciplinary case management ensures interagency communication and referrals are captured and implemented, and includes antenatal and perinatal interagency meetings.

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

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

Steps taken to give effect to the recommendation

WACHS provided this Office with a letter dated 11 June 2018, in which WACHS relevantly informed this Office that:

WACHS have established a Paediatric Non-Accidental Injury Reference Group with representation from appropriate clinical staff. The Group will consider policies and procedures currently existing within WACHS, as well as the recommendations made as part of this and other ombudsman reviews regarding the issue of non-accidental injury in children.

WACHS provided this Office with a letter dated 16 December 2018, in which WACHS relevantly informed this Office that:

WACHS has considered the finding of this review and implemented the following:

- *WACHS Paediatric NA/ Reference Group.* (Attachment 2) Formed in 2018 with representation from WACHS regional medical, nursing, allied health and community staff, and Statewide Protection of Children Coordination Unit. The group provides clinical oversight and governance regarding the WACHS ciinical response to at risk children within its facilities. This has included commencing a review and standardisation of policies and procedures across WACHS whilst integrating local requirements.
- *WACHS Family and Domestic Violence* (FDV) Project. (Attachment 3) Commenced in 2018 the Project has focused on development of WACHS policy and pathways for delivery of clinical services, region specific referral guides to local services, education and training resources and support guidelines for staff affected by FDV.

- *WACHS Director Paediatrics*. Created in 2018 this position provides specialist medical advice and clinical governance throughout WACHS to ensure evidence based clinical service delivery.
- *WACHS WebPAS Child at Risk Alert*. (Attachment 4 and 5) Implemented in 2017, Alert raised in WebPAS and integrated into the Community Health Information System (CHIS) as a flag for health professionals who may have concerns for a child regarding health outcomes and may be considered at risk. It is also a useful communication tool for at risk children presenting at multiple health sites, within and across regions. Community Mental Health Services utilise PSOLIS as a tool for identifying at risk children and notifications regarding plan of care.

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

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

Steps taken to give effect to the recommendation

WACHS provided this Office with a letter dated 16 December 2018, in which WACHS relevantly informed this Office of the steps taken to give effect to recommendations 19 and 20, as outlined above.

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

Recommendation 22: Communities considers the findings of this review in the circumstances of the current development and implementation of 'evidence based practice guidelines associated with identifying and responding to infants at high risk of emotional abuse (including exposure to family and domestic violence), harm and/or neglect within the meaning of section 28 of the *Children and Community Services Act (2004)*' and incorporates in the 'evidence based practice guidance' appropriate practice guidance associated with the investigation of infant injury, including in consultation with health services where medical review is indicated or has occurred.

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

This recommendation has been actioned

High-Risk Infants

High-risk infants' policy was introduced into Communities Casework Practice Manual on 2 November 2018 and provides information and practice guidance on responding to abuse and neglect of unborn infants and high-risk infants.

Professional Development
Communities Learning and Development data reveals that 497 child protection staff have completed Responding to High-Risk Infants, this includes training for 140 staff across six regional districts.

Pathways of Care through South West Emergency Services
The Pathways of Care through South West Emergency Services outlines Communities and the Western Australian Country Health Service's response to child protection concerns that require medical advice or assessment.

Department of Communities Voluntary Action
Communities is reviewing the Casework Practice Manual entries pertaining to family and domestic violence to align with this recommendation. In doing so, Communities will consider the following amendments:

- 2.3.4 *Responding to perpetrators of emotional abuse – family and domestic violence* to include reference to the practice guidance outlined in 2.2.17 High-risk infants.
- 2.2.17 *High risk infants*, in assessing infants and unborn infants, will include where Communities (including Family and Domestic Violence Response Teams (FDVRT)) receives information that:
  - *a victim or perpetrator of family and domestic violence is expecting a child*
  - *a parent involved in an Initial Inquiry or Child Safety Investigation is expecting a child*
- FDVRT Operating Procedures, 2.2.3 *Initial Inquiry* and 2.2.4 *Conducting a Child Safety Investigation* to align with the above practice requirements.
- FDVRT Operating Procedures to include mechanisms for FDVRT to assess unborn infants.
- FDVRT to include the use of the Interaction Tool for all Family Violence Incident Reports where child protection concerns are evident, and/or the parents are involved with Communities.

In 2020, *Responding to High-risk Infants* training will become compulsory for all Child Protection Workers, Best Beginnings Plus Workers and Child Protection Team Leaders. Learning and Development will review the *Responding to High-risk Infants* training to ensure that the key practice requirements contained in the CPM entry are strengthened in the training. In particular, the importance of ensuring that any infant with a bruise is required to be assessed by a Paediatrician (preferable with child protection experience) on the same day or in regional and remote areas, by a medical service which consults with a Paediatrician on the same day.

Child Protection Workers must attend the medical service with the infant or phone the medical service prior to the infant being assessed in order to provide the relevant medical professional with information about the child protection concerns.

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

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

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned**
>
> Refer to Recommendation 17

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

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

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned**
>
> **Professional Development**
> Communities offers the following Workshops and eLearning Online training courses to child protection staff.
>
> eLearning Online: *Safe Sleeping*
> The eLearning Online Learning *Safe Sleeping* training is for Communities staff, sector staff, and carers. Aim: To reduce the risk of sudden unexpected deaths in infants, including the risk that can occur when babies co-sleep. The course provides professionals working with families and infants current evidenced based information on safe sleeping practices. Communities Learning and Development data reveals that 382 child protection staff have completed *Safe Sleeping* since April 2014.

Workshop - Orientation Program 3: *Intensive Family Support*

The Orientation Program 3: *Intensive Family Support* training is for Communities Child Protection staff. Aim: To provide better targeted earlier intervention responses to support families. Communities Learning and Development data reveals that 233 child protection staff have completed Orientation Program 3, including 15 staff from the South West District. In February 2020 this program was run in the Pilbara with more than 30 staff attending.

South West District Learning Calendar 2018-19

The South West District's Learning Calendar for 2018-19 included the delivery of the following training:

- Infant Ages and Stages Questionnaire and Safe Sleeping – 13 February 2018
- Safe Sleeping – 13 November 2018
- Responding to High-Risk Infants – 12-13 February 2019, 31 July 2019
- Assessing High-Risk Infants (incl Safe Sleeping) – 26 November 2019

Refer to Recommendation 6

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

Recommendation 25: Communities provides the Ombudsman with a report on actions taken to give effect to recommendations 22, 23 and 24, including a status report on the development and implementation of 'evidence based practice guidelines associated with identifying and responding to infants at high risk of emotional abuse (including exposure to family and domestic violence), harm and/or neglect within the meaning of section 28 of the *Children and Community Services Act (2004)*' within six months of the finalisation of this child death review.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 10 December 2018, in which Communities relevantly informed this Office of the steps taken to give effect to recommendations 22, 23 and 24. Further information, as outlined at Recommendations 22, 23 and 24 above, was provided by Communities in a letter to this Office dated 12 May 2020.

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

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

Steps taken to give effect to the recommendation

WACHS provided this Office with a letter dated 16 December 2018, in which WACHS relevantly informed this Office that:

> As outlined within the WA Country Health Service (WACHS) Regional District response to the Ombudsman's preliminary view regarding this case, the following was implemented locally:
>
> - Review of processes and communication processes related to the identification of at risk babies within maternity services across WACHS Regional District sites.
> - Development of a Social Work referral checklist for midwives to complete with antenatal patients across WACHS Regional District sites.
> - Education and promotion of the use of the special child health referrals to midwives at all WACHS Regional District sites.
> - Attendance at Regional Hospital C and Regional Hospital D maternity wards multidisciplinary handovers by community nurse managers or clinical nurse specialists to enable identification of special child health referrals.
> - Implementation of the WebPAS Child at risk alert system.
>
> Since the provision of the final view, WACHS South West has undertaken the following:
>
> - Implementation of the WACHS Regional District Social Work referral pathway across all sites.
> - Ongoing promotion and education to maternity staff regarding the WACHS Regional District Special Child Health referrals.
> - Provision of weekly reports to the STORK (Statewide perinatal database) administrators identifying at risk patients requiring a special child heath referral.
> - Development of an audit plan to manually audit STORK WACHS Regional District records to ensure compliance within the pathway. This audit will be completed in the final quarter of 2019.
> - Implementation of twice weekly visits by the Clinical Nurse Specialist to Maternity wards to ensure completion of Specialist Child Health Referrals.
> - Extension of the Regional District – Child at Risk Program. The Regional District Unborn and Newborn Babies at Risk (BAR) Program (Attachment 1) and Children at Risk (CAR) Program (Attachment 2) commenced in 2016. The programs routinely identify at risk children for discussion between CPFS and WACHS Regional District staff, allowing early engagement with families regarding support services and planning for infant protection.
>
>   In 2018 WACHS Regional District Social Work commenced identification and assessment of all children under two presenting to WACHS Regional District Emergency Departments with injury, including burns and ingestion (Attachment 3). If concerns are raised a review is completed by the Paediatric

> Injury Assessment Team and follow up competed. A WebPAS alert is raised as required for future monitoring.

This Office requested that the relevant WACHS Regional District 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 25 March 2020, containing a report prepared by WACHS Regional District.

In the relevant WACHS Regional District report, the relevant WACHS Regional District relevantly informed this Office that:

> Since the last report, an audit commenced in July 2019 - February 2020 identifying any Special Child Health Referral (SCHR) that were considered to be missed once the child health nurse has seen the family.
>
> …
>
> Increased communication with midwifery unit and wards has resulted in increased collaboration between maternity staff and community health.
>
> The addition of the Child Health Nurse attending twice a week to Maternity site handovers has been an excellent initiative and benefit for improved communication.
>
> This is an addition to increased awareness and training of the midwifery staff in completing timely SCHR. Reminders are now placed at each computer.
>
> Ongoing audits of non-receivable of Special Child Health referrals will continue.
>
> There has been great improvement across the region in the detailed ISOBAR handover from social work for clients of vulnerability and who are monitored through the Babies at Risk (BAR) and Children at Risk (CAR) meetings.
>
> Currently, a WACHS working group is in the process of developing a WACHS wide procedure for information sharing and handover of children between child health services across the metropolitan area and WACHS and vice versa.

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

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

Steps taken to give effect to the recommendation

WACHS provided this Office with a letter dated 16 December 2018, in which WACHS relevantly informed this Office that:

> WACHS has considered the finding of this review and to ensure implementation of the Child Injury Surveillance Program in all WACHS EDs the WACHS Paediatric Non-Accidental Injury (NAI) Reference Group (Attachment 4) was formed in 2018. The group has included regional representation consisting of WACHS medical, nursing, allied health, child health and population health staff and Statewide Protection of Children Coordination Unit (SPOCC).
>
> The group provides clinical oversight and governance regarding the WACHS clinical response to at risk children within its facilities and has commenced reviewing all programs currently undertaken within WACHS sites.
>
> Whilst standardisation of policies and procedures across WACHS is not possible secondary to the differing level of service delivery, processes are being reviewed to ensure that the requirements outlined within the Guidelines for Protecting Children are met whilst integrating local requirements.
>
> In addition WACHS has created a Director Paediatrics position that provides clinical advice and governance related to clinical service delivery across all WACHS sites. WACHS has also implemented the WebPAS Child at Risk Alert policy as a flag for health professionals who may have concerns for a child regarding health outcomes and may be considered at risk (Attachment 5 and 6). This alert is also a useful communication tool for at risk children presenting at multiple health sites, within and across regions. Community Mental Health Services utilise PSOLIS as a tool for identifying at risk children and notifications regarding plan of care.

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

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

Steps taken to give effect to the recommendation

WACHS provided this Office with a letter dated 16 December 2018, in which WACHS relevantly informed this Office that:

> As outlined above, WACHS has considered the findings and has implemented the WACHS Paediatric NAI Reference Group to support the implementation of the Guidelines for Protecting Children. The group includes representation from child health and population health staff as well as SPOCC representation.

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

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

Steps taken to give effect to the recommendation

WACHS provided this Office with a letter dated 16 December 2018, in which WACHS relevantly informed this Office of the steps taken to give effect to recommendations 26, 27 and 28, as outlined above.

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

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

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 12 May 2020, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

This recommendation has been actioned

Casework Practice Manual
'*Alcohol and other drug issues'* forms Chapter 1.4.1 of the Casework Practice Manual which guides child protection workers in assessing and responding to alcohol and other drug (AOD) issues.

Assessment
Where a young person has an AOD issue, child protection or Parent Support workers must consider the young person's circumstances, including co-occurring issues such as isolation, disengagement from education, family and domestic violence, and other at-risk behaviours. Safety planning and referral to appropriate services, treatment and support options should occur.

Safety planning
If a young person in the CEO's care has an AOD issue, child protection workers must develop a safety plan with the young person and/or their family and carers and record the details on Assist.

If a young person who is not in the CEO's care presents to a district office with an AOD issue, child protection workers must consider making a referral to Parent Support, Intensive Family Support Team and developing a safety plan with the young person and/or their family and carers.

When undertaking an external Signs of Safety mapping to assess an allegation of abuse and/or neglect, child protection workers must consider whether an AOD specialist working with a parent or young person should be invited to participate.

Treatment referrals
Where a young person in the CEO's care has an AOD issue, child protection workers must make sure that referral to appropriate services, treatment and support occurs. Collaboration needs to occur with the referred agency. Child protection workers must liaise with the service to exchange information and consider the effect of any treatment plans.

Where a young person not in the CEO's care but is known to the Department and is a current client of an AOD service, the child protection worker or Parent Support worker must liaise with the service to exchange information and consider the effect of any treatment plans.

Action Plan for At Risk Youth
Communities has drafted an Action Plan for At Risk Youth (the Action Plan) for Minister McGurk's consideration. It is yet to be endorsed. The Action Plan will define how Communities will work alongside young people, families and the community to improve outcomes for at risk young people. The Action Plan replaces the now acquitted 'At Risk Youth Strategy 2015-2018'.

Western Australian Alcohol and Drug Interagency Strategy 2018-2022
The Western Australian Alcohol and Drug Interagency Strategy 2018-2022 (WAADIS) is Western Australia's key policy document that outlines strategies to prevent and reduce the adverse impacts of AOD in Western Australia. WAADIS operates under the national framework of supply, demand and harm reduction and is underpinned by two core elements: first and foremost a focus on prevention and early intervention; and secondly, on providing support for those who need it.

Communities supports the implementation of WAADIS through representation on the Drug and Alcohol Strategic Senior Officers Group (DASSOG) and development of Annual Agency Plans.

Department of Communities Voluntary Actions
Communities will provide a copy of the Action Plan for At Risk Youth to the Ombudsman Western Australia once endorsed by Minister McGurk.

Policy and Service Design will consider the need for the development of more detailed guidelines under the WAADIS Annual Agency Plan in consultation with relevant agencies if required.

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 2019-20, timely review processes have resulted in 63% of all reviews being completed within six months.

Expanded child death review function

During 2019-20, the Office undertook significant work on expanding the child death review function to include consideration of all child deaths that occur in Western Australia, including child deaths that may not have been reviewed under an existing child death review mechanism.

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.

Details of own motion investigations are provided in the Own Motion Investigations and Administrative Improvement section.

Monitoring recommendations from 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;
- *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; and
- *Investigation into ways to prevent or reduce deaths of children by drowning*, which was tabled in Parliament in November 2017.

Details of the Office's monitoring of the steps taken to give effect to recommendations arising from 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;
- Engaging with other child death review bodies in Australia and New Zealand through interaction with the Australian and New Zealand Child Death Review and Prevention Group;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of child deaths; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

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 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 two times in 2019-20 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);
- Professor Donna Chung (Health Science, Curtin University);
- Ms Angela Hartwig (Women's Council for Domestic and Family Violence Services WA);
- Associate Professor Michael Wright (Health Sciences, Curtin University); 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 (**WA Police Force**) also attended the meetings in 2019-20.

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 2019-20 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;
    - WA Police Force; and
    - Other accountability and similar agencies including the Commissioner for Children and Young People and the Office of the Chief Psychiatrist;
- 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 established a Principal Aboriginal Liaison Officer position 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 position was established 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 2019-20 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.