Our Performance in 2019-20

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

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

Summary of Performance

Key Performance Indicators

Key Effectiveness Indicators

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

Key Effectiveness Indicators	2018-19 Actual	2019-20 Target	2019-20 Actual	Variance from Target
Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies	100%	100%	**100%**	Nil
Number of improvements to practices or procedures as a result of Ombudsman action	83	100	**72**	-28

Another important role of the Ombudsman is to enable remedies to be provided to people who make complaints to the Office where service delivery by a public authority may have been inadequate. The remedies may include reconsideration of decisions, more timely decisions or action, financial remedies, better explanations and apologies. In 2019-20, there were 183 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman.

Comparison of Actual Results and Budget Targets

Public authorities have accepted every recommendation made by the Ombudsman, matching the actual results of the past four years and meeting the 2019-20 target.

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

The 2019-20 actual number of improvements to practices and procedures of public authorities as a result of Ombudsman action (72) is lower than the 2019-20 target (100) as there are fluctuations in improvements from year to year, related to the number, nature and outcomes of investigations finalised by the Office in any given year.

Key Efficiency Indicators

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

Key Efficiency Indicators	2018-19 Actual	2019-20 Target	2019-20 Actual	Variance from Target
Percentage of allegations finalised within three months	95%	95%	**95%**	Nil
Percentage of allegations finalised within 12 months	100%	100%	**100%**	Nil
Percentage of allegations on hand at 30 June less than three months old	91%	90%	**92%**	+2%
Percentage of allegations on hand at 30 June less than 12 months old	98%	100%	**99%**	-1%
Average cost per finalised allegation	$1,895	$1,890	**$1,858**	-$32
Average cost per finalised notification of death	$17,816	$17,500	**$17,926**	+$426
Cost of monitoring and inspection functions	$415,648	$415,000	**$408,008**	-$6,992

Comparison of Actual Results and Budget Targets

The 2019-20 actual results for the Key Efficiency Indicators met, or were comparable to, the 2019-20 target. Overall, 2019-20 actual results represent sustained efficiency of complaint resolution over the last five years.

The average cost per finalised allegation in 2019-20 ($1,858) is comparable with the 2019-20 target ($1,890) and the 2018-19 actual ($1,895). Since 2007-08, the efficiency of complaint resolution has improved significantly with the average cost per finalised allegation reduced by a total of 37% from $2,941 in 2007-08 to $1,858 in 2019-20.

The average cost per finalised notification of death ($17,926) is comparable with the 2019-20 target ($17,500) and the 2018-19 actual ($17,816).

The cost of monitoring and inspection functions ($408,008) is comparable with 2019-20 target ($415,000) and the 2018-19 actual ($415,648).

For further details, see the Key Performance Indicator section.

Summary of Financial Performance

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

Financial Performance	2018-19 Actual ('000s)	2019-20 Target ('000s)	2019-20 Actual ('000s)	Variance from Target ('000s)
Total cost of services (sourced from Statement of Comprehensive Income)	$10,412	$11,358	**$11,332**	-$26
Income other than income from State Government (sourced from Statement of Comprehensive Income)	$2,438	$2,201	**$2,493**	+$292
Net cost of services (sourced from Statement of Comprehensive Income)	$7,973	$9,157	**$8,840**	-$317
Total equity (sourced from Statement of Financial Position)	$916	$1,813	**$1,226**	-$587
Net increase/decrease in cash held (sourced from Statement of Cash Flows)	$199	-$14	**$383**	+$397
Staff Numbers	**Number**	**Number**	**Number**	**Number**
Full time equivalent (FTE) staff level at 30 June	61	70	**66**	-4

Comparison of Actual Results and Budget Targets

The variation between the 2019-20 actual results and the targets for the Office's total cost of services is primarily due to staffing required for expansion of child death reviews and to meet the workload associated with the role of the Energy and Water Ombudsman. The additional costs for the Energy and Water Ombudsman were fully offset by an increase in revenue.

The variation between the 2019-20 actual results and the target for the Office's revenue is primarily due to additional funding approved by the Board of the Energy and Water Ombudsman (Western Australian) to enable the Office to meet the workload associated with the role of the Energy and Water Ombudsman.

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

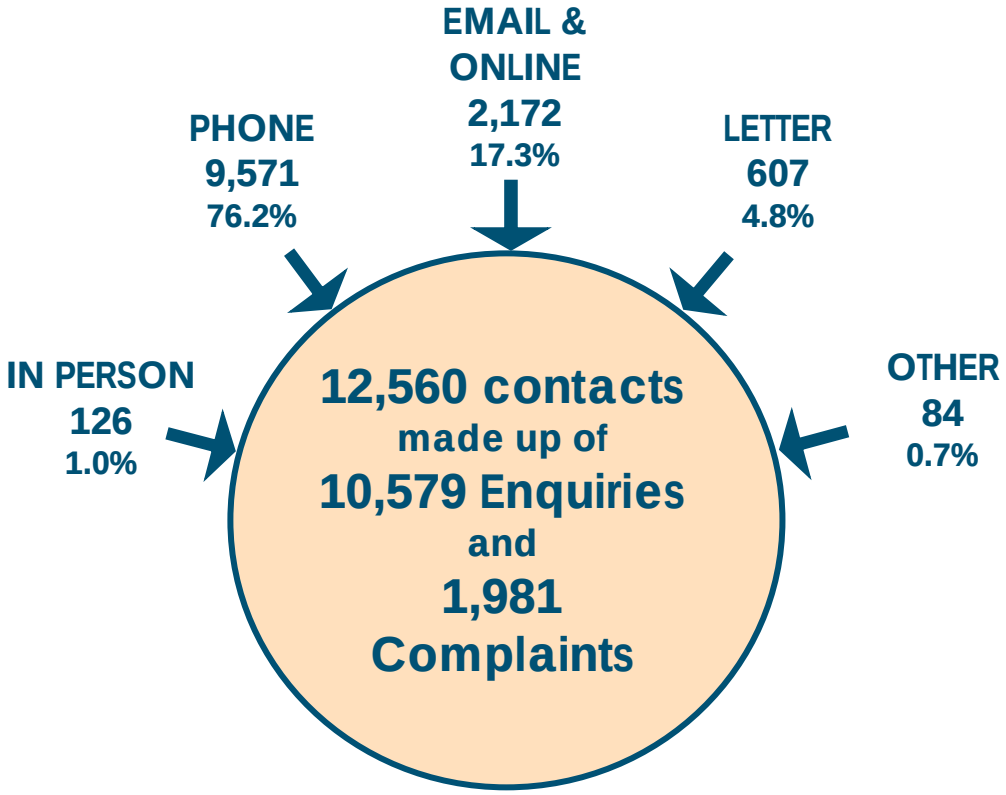
Complaint Resolution

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

Contacts

In 2019-20, the Office received 12,560 contacts from members of the public consisting of:

- 10,579 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 1,981 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

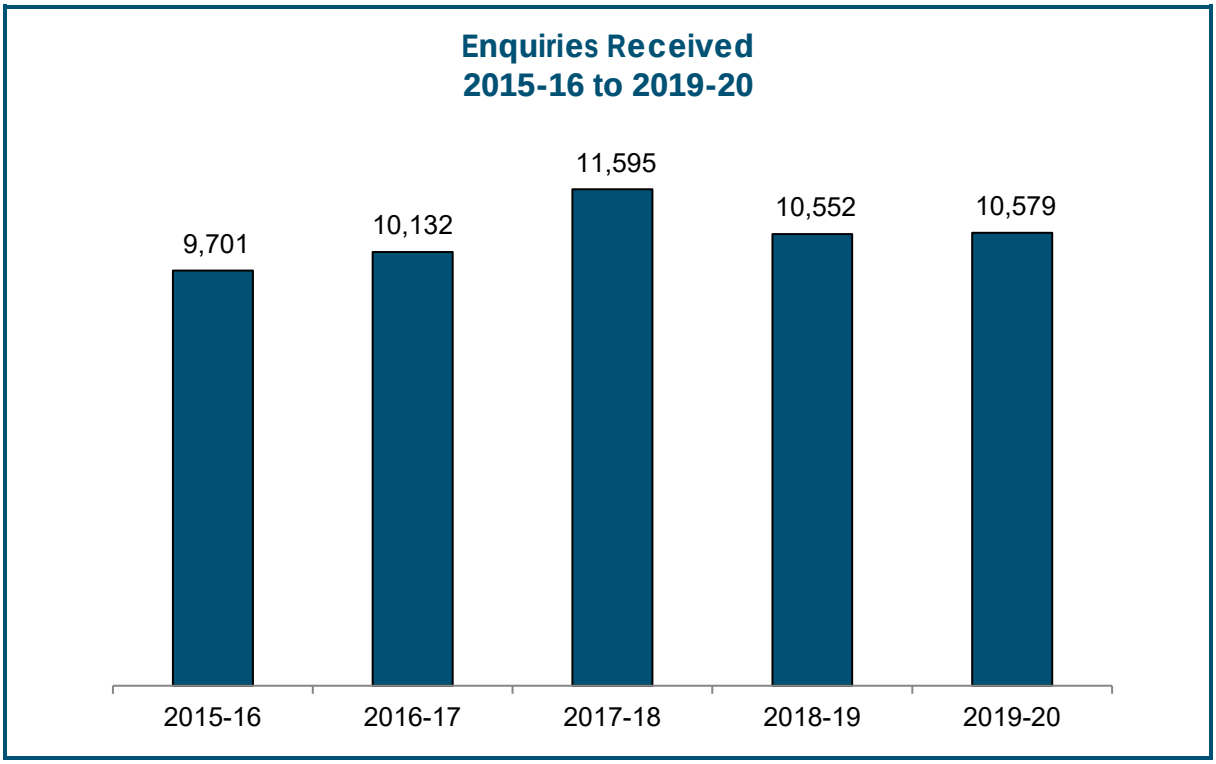


Enquiries Received

There were 10,579 enquiries received during the year.

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

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

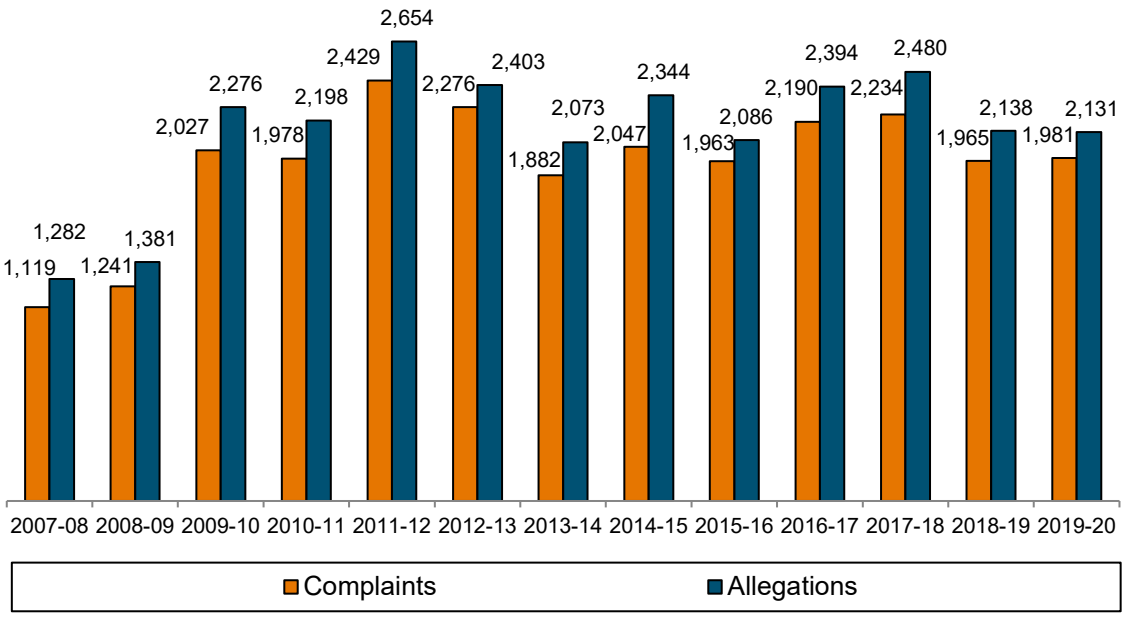


Enquirers are encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

Complaints Received

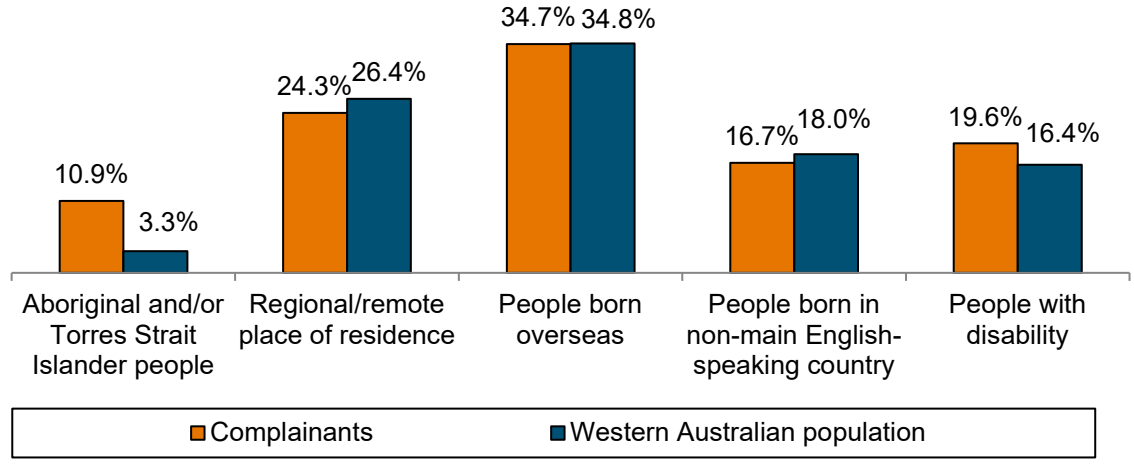
In 2019-20, the Office received 1,981 complaints, with 2,131 separate allegations, and finalised 2,005 complaints. There are more allegations than complaints because one complaint may cover more than one issue.

Total Number of Complaints and Allegations Received 2007-08 to 2019-20



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

Characteristics of Complainants in 2019-20

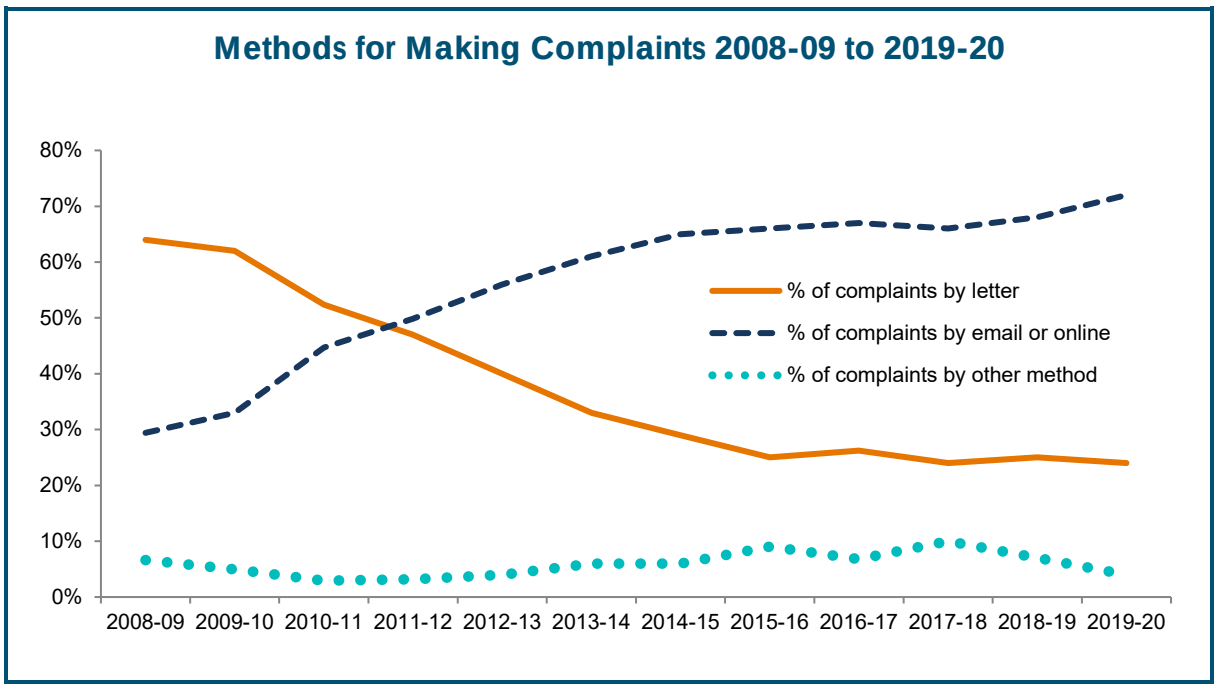


NOTE: Non-main English-speaking countries as defined by the Australian Bureau of Statistics are countries other than Australia, the United Kingdom, the Republic of Ireland, New Zealand, Canada, South Africa and the United States of America. Being from a non-main English-speaking country does not imply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

How Complaints Were Made

Over the last 12 years, the use of email and online facilities to lodge complaints has increased and the proportion of people who lodge complaints by letter has declined.

In 2019-20, 72% of complaints were lodged by email or online, compared to 24% by letter and four per cent by other methods including during regional visits and in person.



Resolving Complaints

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

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

Time Taken to Resolve Complaints

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

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

Building on the program, the Office developed and commenced a new organisational structure and processes in 2011-12 to promote and support early resolution of complaints. There have been further enhancements to complaint handling processes in 2019-20, in particular in relation to the early resolution of complaints.

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

In 2019-20:

- The percentage of allegations finalised within 3 months was 95%; and
- The percentage of allegations on hand at 30 June less than 3 months old was 92%.

95% of allegations were finalised within 3 months.

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

- The average age of complaints has decreased from 173 days to 47 days; and
- Complaints older than 6 months have decreased from 40 to 9.

Complaints Finalised in 2019-20

There were 2,005 complaints finalised during the year and, of these, 1,453 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 880 were finalised at initial assessment, 514 were finalised after an Ombudsman investigation and 59 were withdrawn.

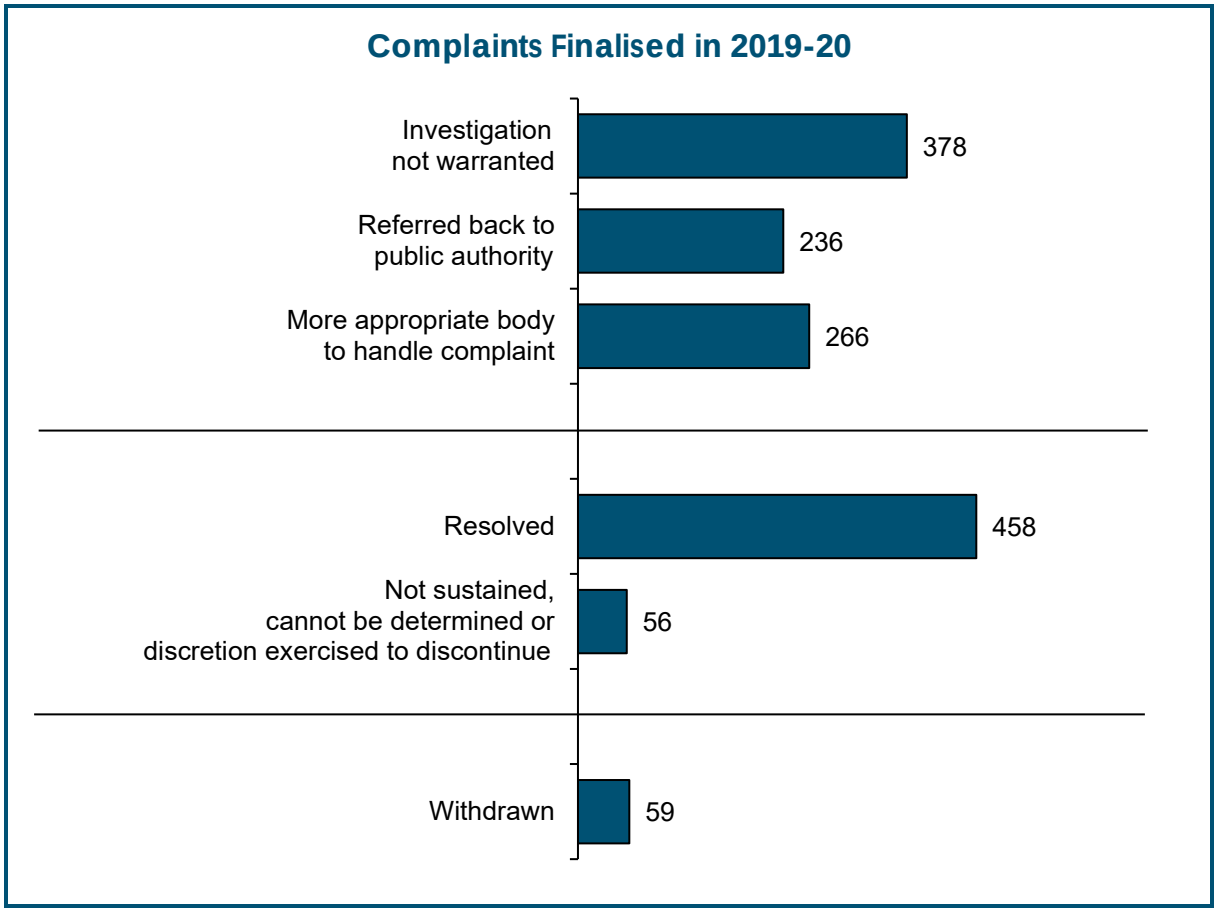
Complaints finalised at initial assessment

Over a quarter (27%) of the 880 complaints finalised at initial assessment were referred back to the public authority to provide it with an opportunity to resolve the matter before investigation by the Ombudsman. This is a common and timely approach and often results in resolution of the matter. The person making the complaint is asked to contact the Office again if their complaint remains unresolved. In a further 266 (30%) of the complaints finalised at initial assessment, it was determined that there was a more appropriate body to handle the complaint. In these cases, complainants are provided with contact details of the relevant body to assist them.

Complaints finalised after investigation

Of the 514 complaints finalised after investigation, 89% were resolved through the Office's early resolution approach. This involves Ombudsman staff contacting the public authority to progress a timely resolution of complaints that appear to be able to be resolved quickly and easily. Public authorities have shown a strong willingness to resolve complaints using this approach and frequently offer practical and timely remedies to resolve matters in dispute, together with information about administrative improvements to be put in place to avoid similar complaints in the future.

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

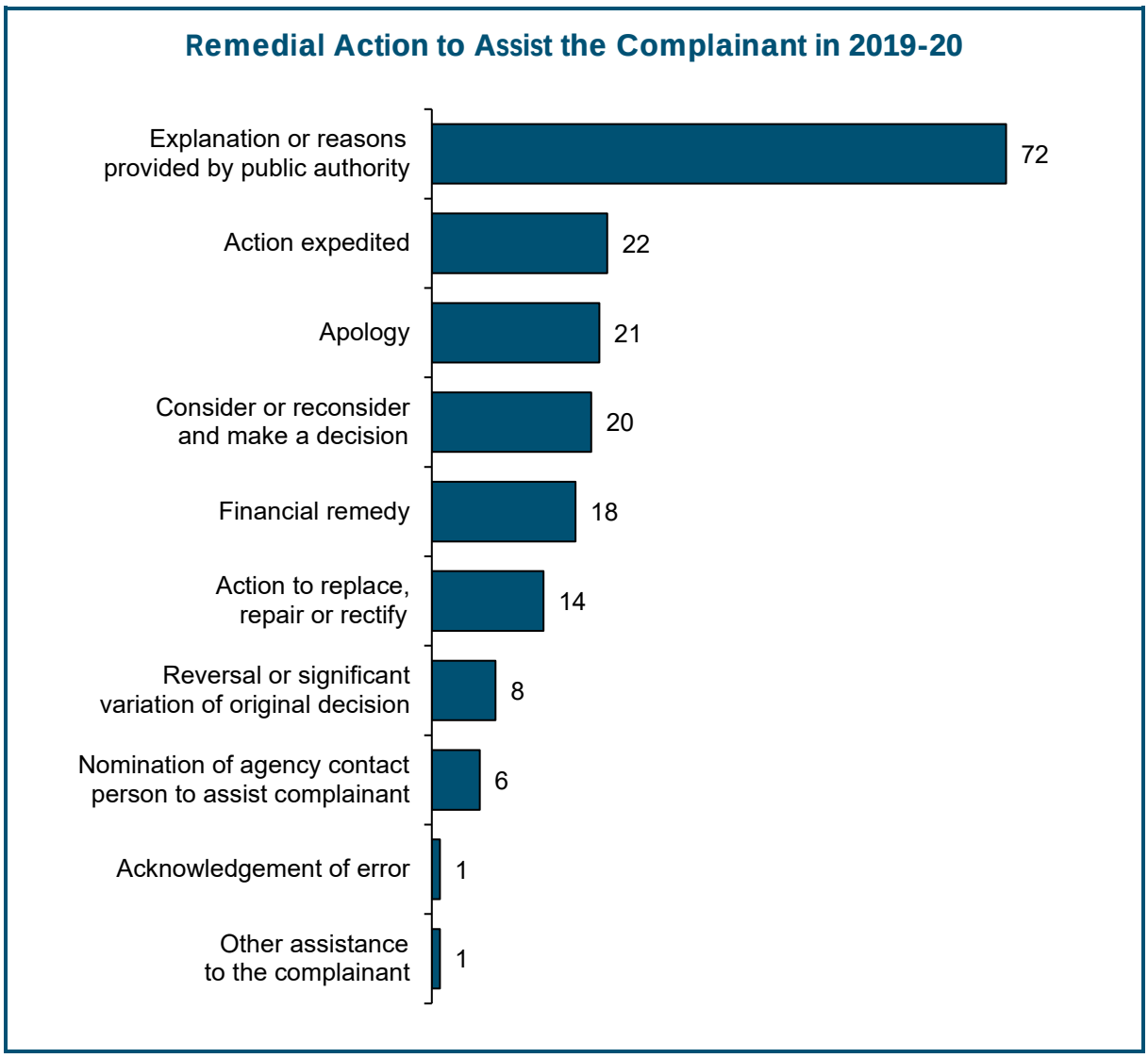


Note: Investigation not warranted includes complaints where the matter is not in the Ombudsman's jurisdiction.

Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2019-20, there were 183 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman. In some cases, there is more than one action to resolve a complaint. For example, the public authority may apologise and reverse their original decision. In a further 42 instances, the Office referred the complaint to the public authority following its agreement to expedite examination of the issues and to deal directly with the person to resolve their complaint. In these cases, the Office follows up with the public authority to confirm the outcome and any further action the public authority has taken to assist the individual or to improve their administrative practices.

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



Case Study

Improved cultural awareness and sensitivity

An Aboriginal Western Australian complained to the Ombudsman that a public authority was not communicating with them and members of their family in a way that was culturally appropriate and safe for Aboriginal people.

Following investigation by the Ombudsman, the public authority agreed to provide a written apology to the person, arrange for an Aboriginal staff member to speak with the person and members of their family, and provide training to staff to improve cultural awareness.

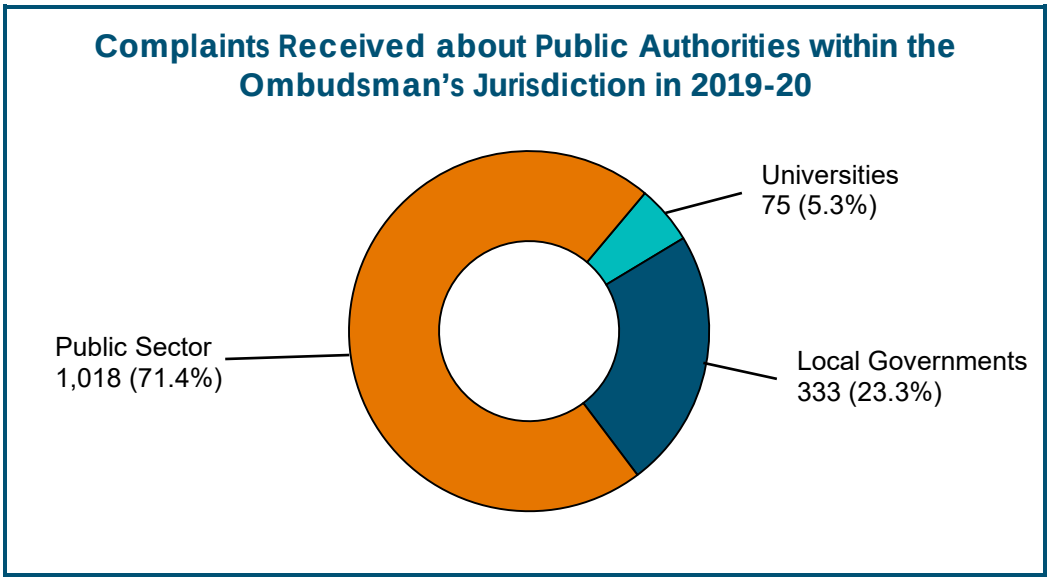
Outcomes to improve public administration

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

About the Complaints

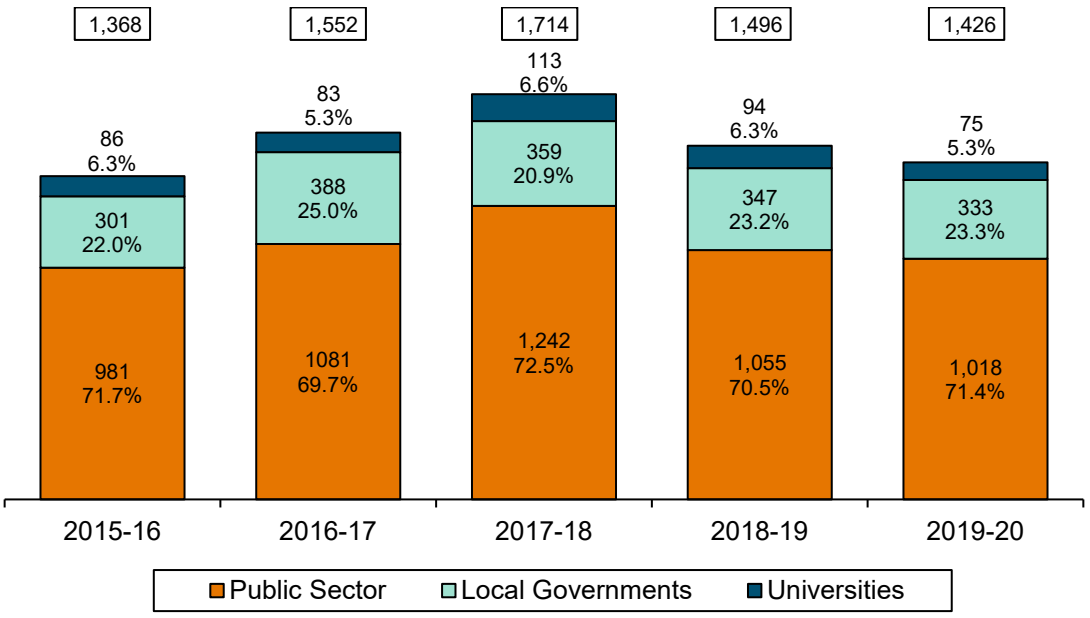
Of the 1,981 complaints received, 1,426 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 555 complaints were about bodies outside the Ombudsman's jurisdiction. In these cases, Ombudsman staff provided assistance to enable the people making the complaint to take the complaint to a more appropriate body.

Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (1,018 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (333 complaints); and the university sector (75 complaints).



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

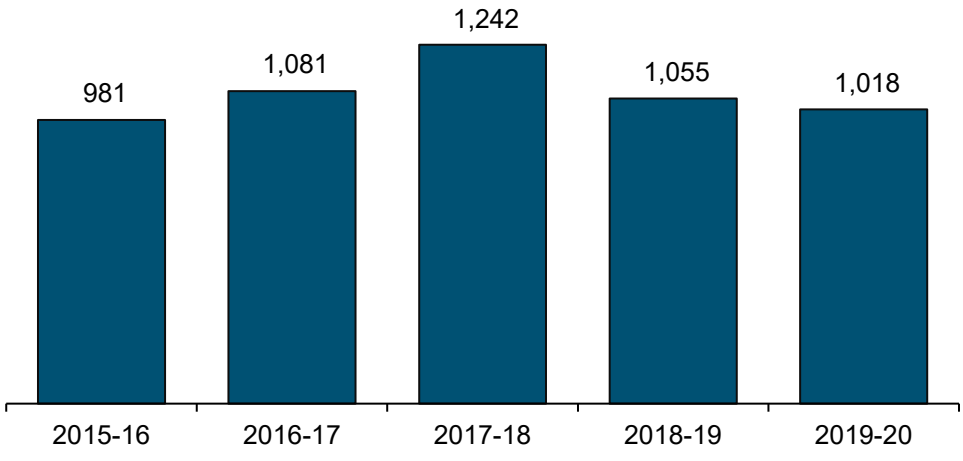
Complaints Received about Public Authorities within the Ombudsman's Jurisdiction between 2015-16 and 2019-20



The Public Sector

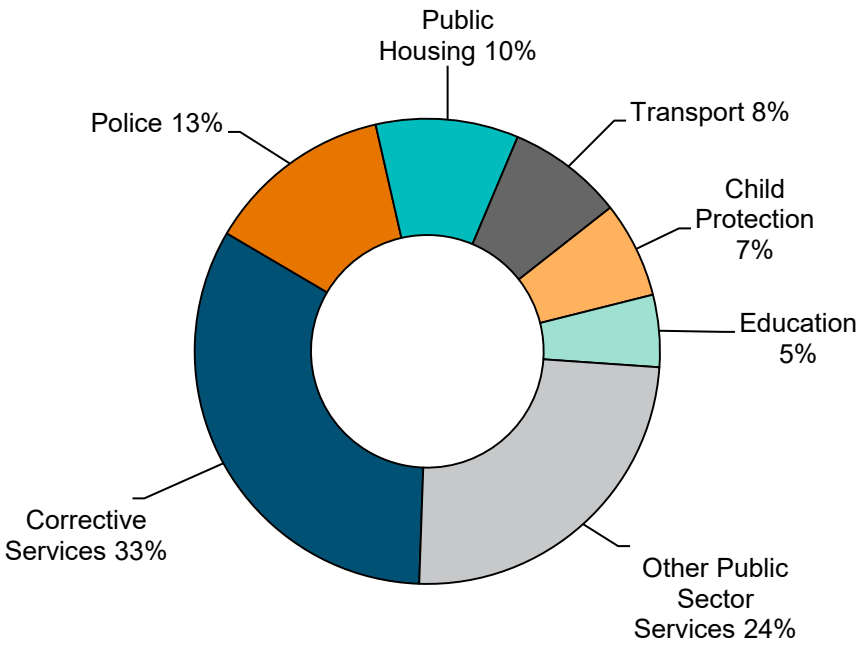
In 2019-20, there were 1,018 complaints received about the public sector and 1,044 complaints were finalised. The number of complaints about the public sector as a whole since 2015-16 is shown in the chart below.

Complaints Received about the Public Sector between 2015-16 and 2019-20



Public sector agencies deliver a very diverse range of services to the Western Australian community. In 2019-20, complaints were received about key services as shown in the following chart.

Complaints Received about the Public Sector in 2019-20



Of the 1,018 complaints received about the public sector in 2019-20, 76% were about six key service areas covering:

- Corrective services, in particular prisons (335 or 33%);
- Police (132 or 13%);
- Public housing (101 or 10%);
- Transport (82 or 8%);
- Child protection (68 or 7%); and
- Education, including public schools and TAFE colleges (51 or 5%). Information about universities is shown separately under the university sector.

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

Outcomes of complaints about the public sector

In 2019-20, there were 161 actions taken by public sector bodies as a result of Ombudsman action following a complaint. These resulted in 128 remedies being provided to complainants and 33 improvements to public sector practices.

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

Refund approved

A person complained to the Ombudsman that a public authority's decision to decline their application for a partial refund of a licence fee was unreasonable because the public authority had given them incorrect information about cancelling the licence which they had relied upon.

Following investigation by the Ombudsman, the public authority acknowledged that reference materials for staff were difficult to interpret and agreed to develop a single source document for staff to utilise to provide a clearer basis for the various policies on refunds and to improve instructions for more complex scenarios. The public authority also approved the refund to the person.

Policy amended

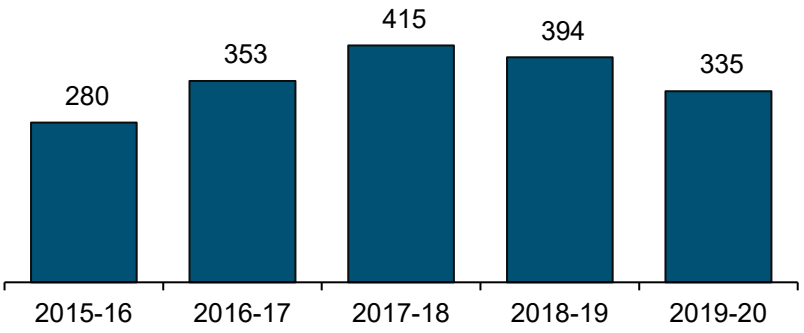
A person complained to the Ombudsman that a public authority failed to enforce a payment that was due to the person.

Following investigation by the Ombudsman, the public authority sought advice about the matter and, as a result of the advice received, reinstated the requirement for the payment to be made to the person, amended its policy and initiated system enhancements to ensure that payments due to an individual were enforced.

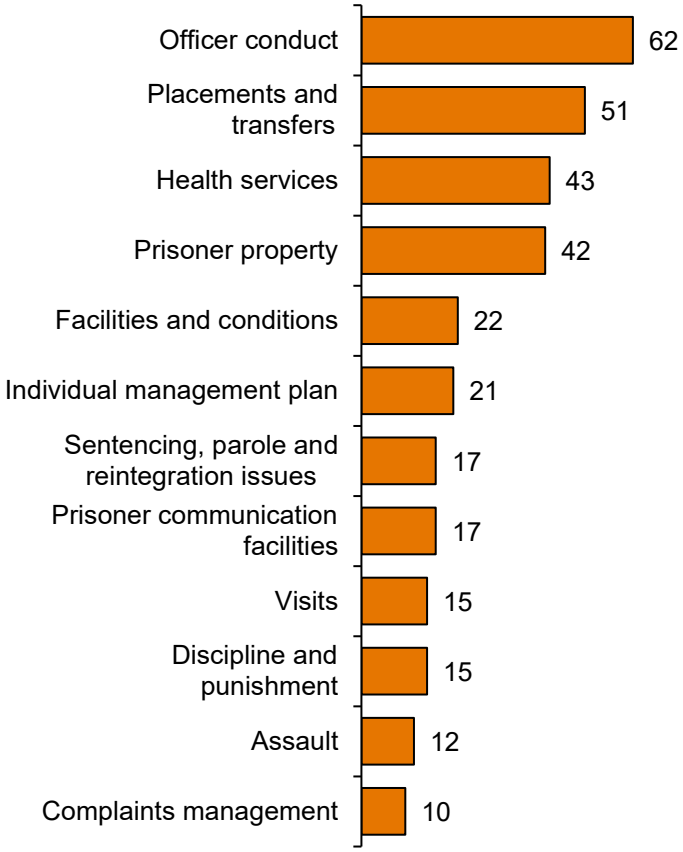
Public sector complaint issues and outcomes

Corrective Services

Complaints received



Most common allegations

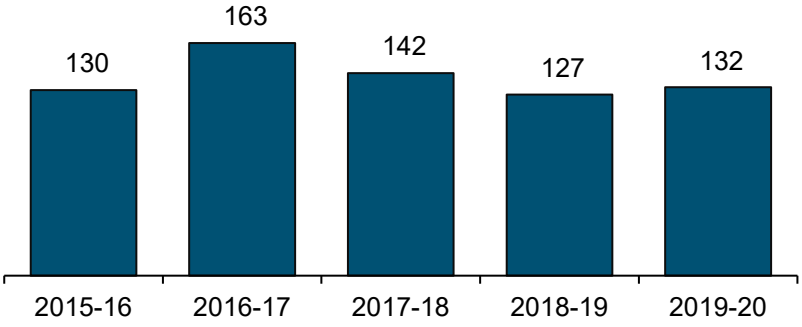


Outcomes achieved

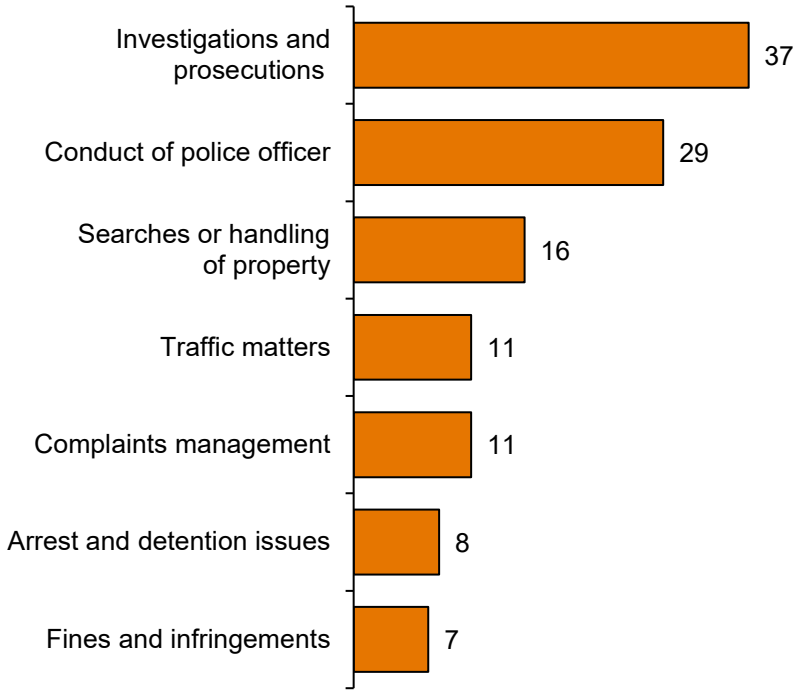
- Financial payment, or monetary charge refunded;
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy, procedure, business systems or practices;
- Conduct audit or review; and
- Staff training.

Police

Complaints received



Most common allegations

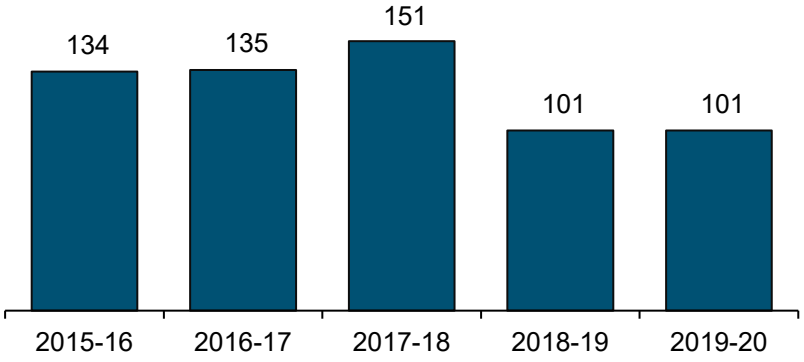


Outcomes achieved

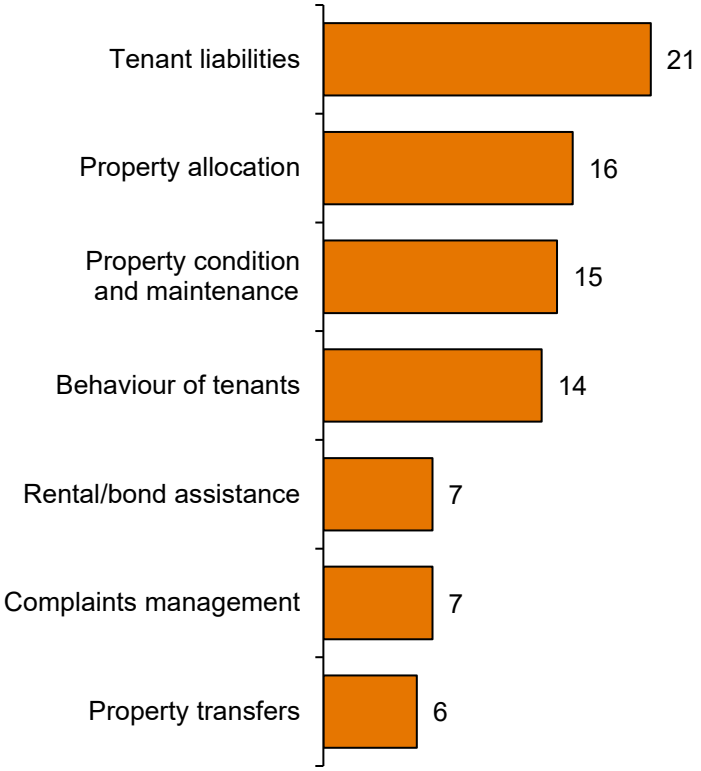
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Explanation given or reasons provided;
- Change to policy, procedure, business systems or practices;
- Conduct audit or review; and
- Staff training.

Public Housing

Complaints received



Most common allegations

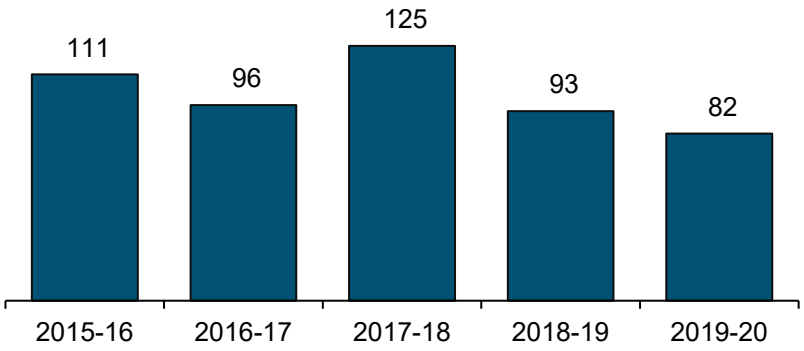


Outcomes achieved

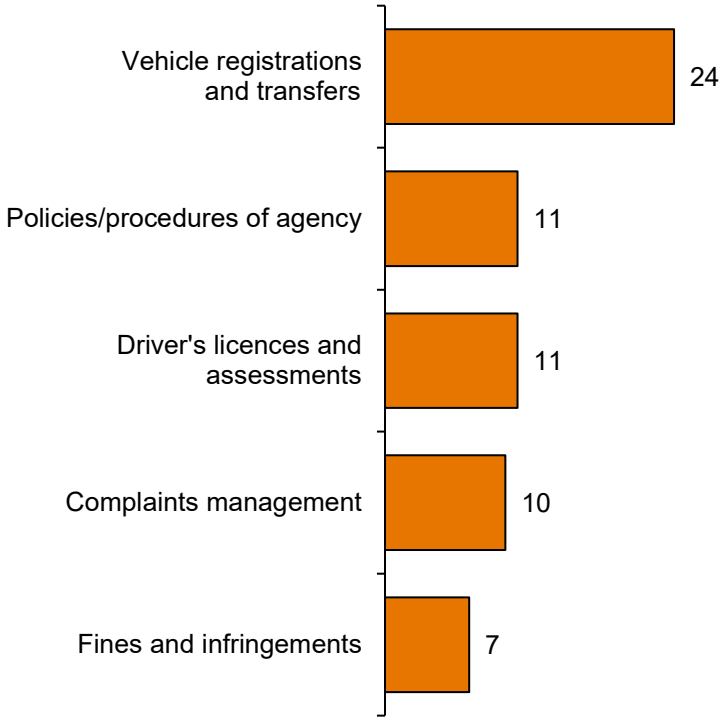
- Monetary charge reduced, refunded or rebate given;
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Acknowledgement of error;
- Action expedited;
- Explanation given or reasons provided;
- Conduct audit or review; and
- Staff training.

Transport

Complaints received



Most common allegations

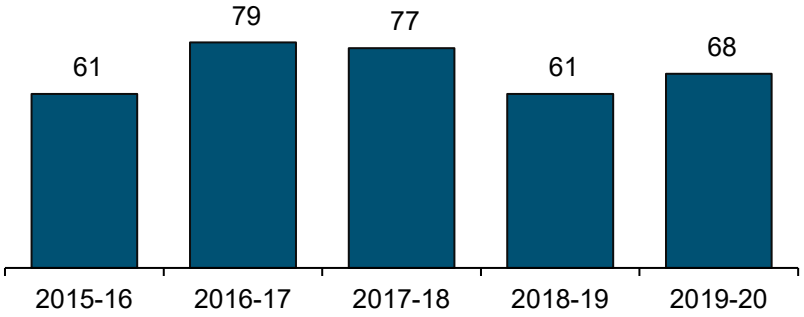


Outcomes achieved

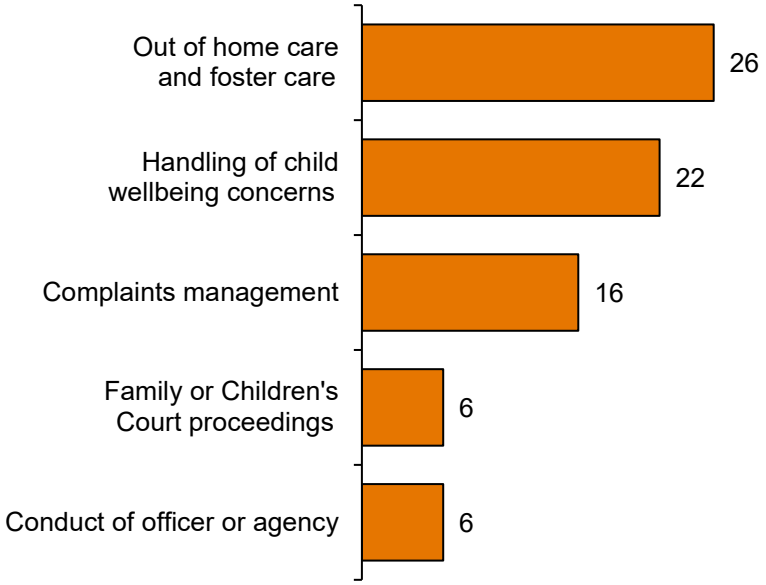
- Financial payment or monetary charge refunded;
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to business systems or practices; and
- Conduct audit or review.

Child Protection

Complaints received



Most common allegations

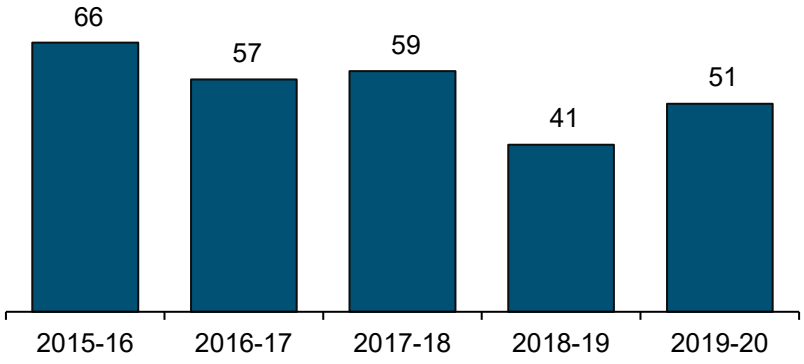


Outcomes achieved

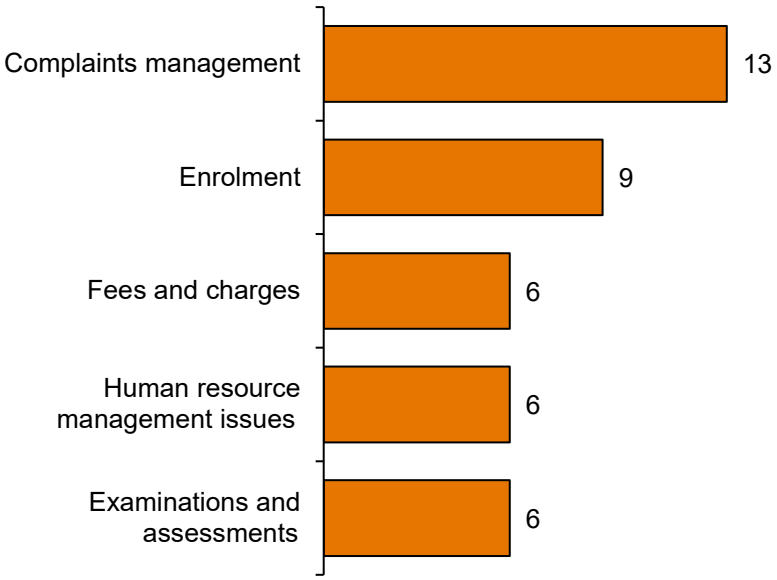
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to policy or procedure; and
- Staff training.

Education

Complaints received



Most common allegations



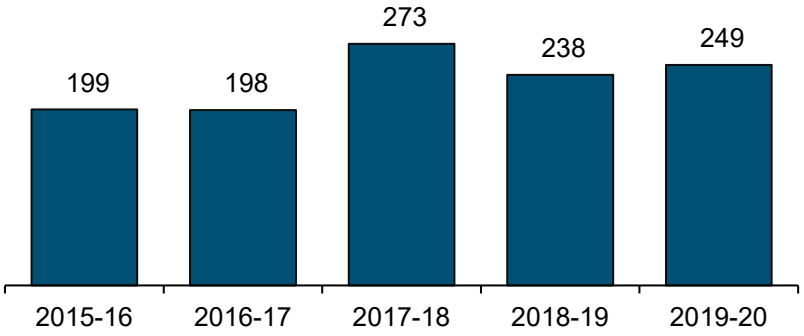
These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2018* relating to TAFE colleges and other public education agencies. Further details on these appeals are included later in this section.

Outcomes achieved

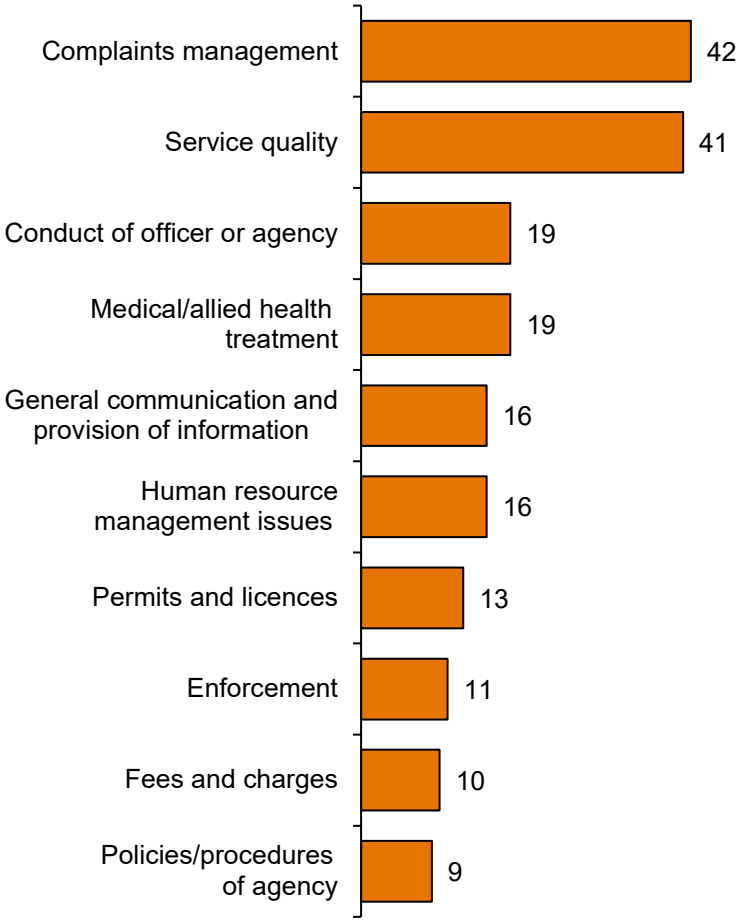
- Monetary charge refunded;
- Reversal or significant variation of original decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided; and
- Change to policy or procedure.

Other Public Sector Services

Complaints received



Most common allegations



Outcomes achieved

- Consider or reconsider a matter and make a decision;
- Reversal or significant variation of original decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to policy, procedure, business systems or practices;
- Update to publications or website;
- Conduct audit or review; and
- Improve recordkeeping.

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

Case Study

Decision reviewed in light of new policy

A person complained to the Ombudsman that a public authority had unreasonably refused to introduce a 40km/h school zone at a local school attended by their children.

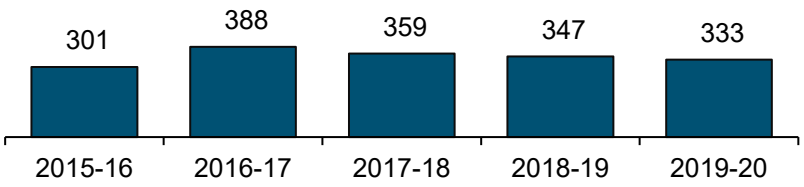
Following investigation by the Ombudsman, the public authority reviewed the matter in light of a new policy and commenced the actions required to initiate a school zone at the school frontage.

The local government sector

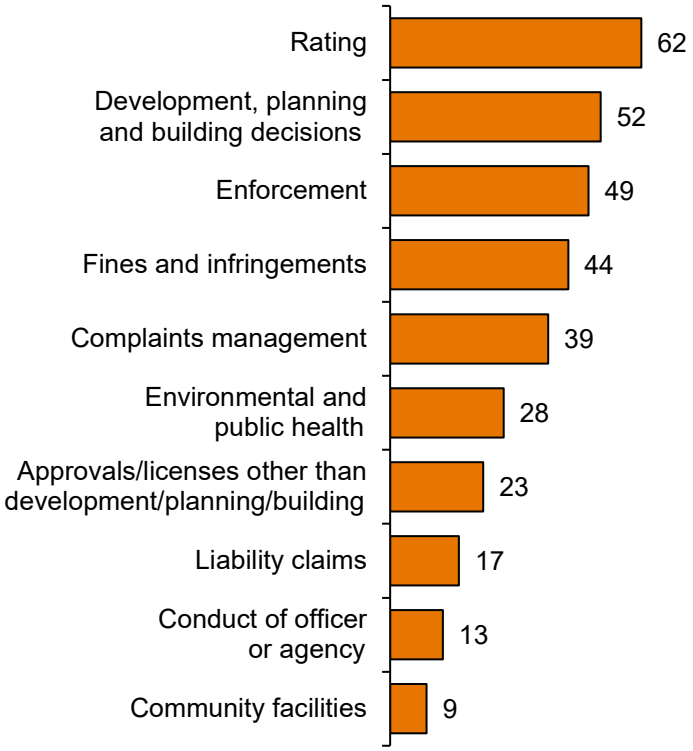
The following section provides further details about the issues and outcomes of complaints for the local government sector.

Local Government

Complaints received



Most common allegations



Outcomes achieved

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

Case Study

Action taken to address complaints about light pollution

A resident complained to the Ombudsman that a local government was not taking reasonable action to respond to complaints about a light display on a neighbouring property that was causing a nuisance.

Following investigation by the Ombudsman, the local government acknowledged that there had been a delay in responding to the resident's complaints. The local government agreed to inform the neighbour about the guidelines for light displays, proactively monitor future light displays to ensure compliance with the guidelines, develop an information sheet for the public to relay appropriate information about the guidelines and provide the resident with a designated point of contact for any future concerns.

Case Study

Overpayments refunded

A resident complained to the Ombudsman that a local government had been incorrectly charging them for two rubbish services on their rates notice instead of one.

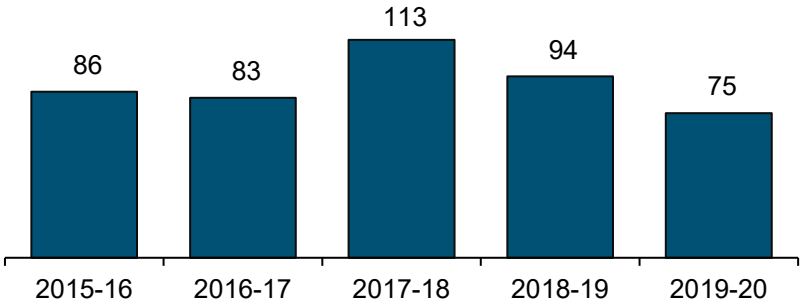
Following investigation by the Ombudsman, the local government refunded the resident for the years they had been incorrectly charged.

The university sector

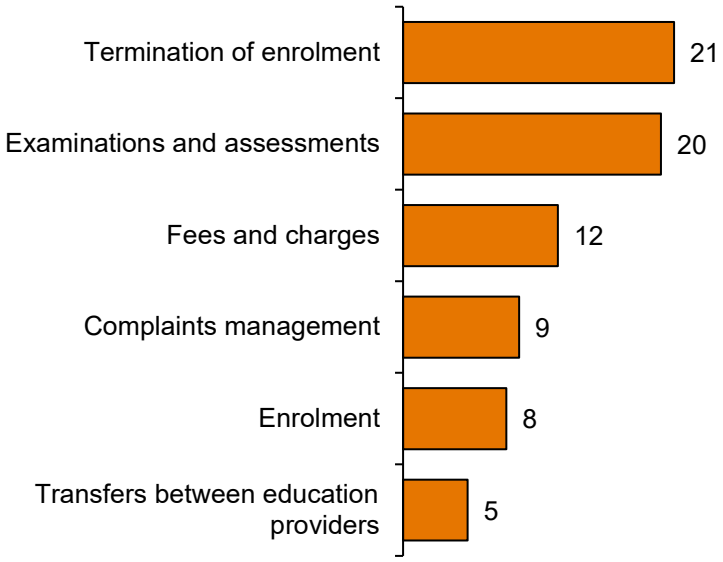
The following section provides further details about the issues and outcomes of complaints for the university sector.

Universities

Complaints received



Most common allegations



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

Outcomes Achieved

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

Case Study

Student's appeal to be re-heard

A student's university enrolment was terminated for unsatisfactory academic performance. The student sought a review of the decision and subsequently appealed, stating that they had health issues which impacted on their capacity to study during the relevant period of time. The Appeals Committee decided that the student's status would remain terminated as they had not maintained contact with support services during the previous year or provided evidence that their health issues had been resolved. The student complained to the Ombudsman.

The Ombudsman's investigation found that relevant materials regarding the student's health issues were not before the Appeals Committee when it made its decision.

As a result of the Ombudsman's investigation, the university agreed to have the student's appeal heard before the Appeals Committee again, and to have the Committee consider all of the evidence, including the letter from the medical practitioner.

Other Complaint Related Functions

Reviewing appeals by overseas students

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

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

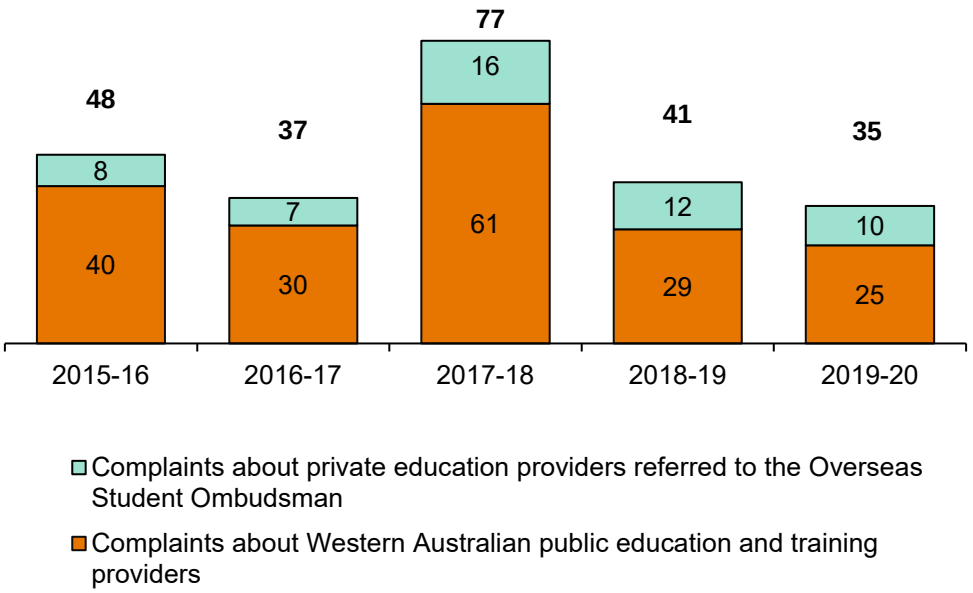
- Provides a free complaint resolution service;
- Is independent and impartial and does not represent either the overseas students or education and training providers; and
- Can make recommendations arising out of investigations.

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

Complaints lodged with the Office under the National Code

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

Complaints Received from Overseas Students under the National Code between 2015-16 and 2019-20



During 2019-20, the Office received 35 complaints from overseas students, including 25 complaints about public education and training providers. Of the 25 complaints about public education providers within the Ombudsman's jurisdiction, 21 complaints were about universities and four were about TAFE colleges or other education providers. The Office also received 10 complaints that, after initial assessment, were found to be about a private education provider. The Office referred these complainants to the Overseas Students Ombudsman.

The 25 complaints by overseas students about public education and training providers involved 27 separate allegations. There are more allegations than complaints because one complaint may cover more than one issue. The most common issues raised by overseas students were decisions about:

- Termination of enrolment (11);
- Fees and charges (5);
- Examinations and assessments (3);
- Transfers between education and training providers (2); and
- Enrolment (2).

During the year, the Office finalised 37 complaints about 42 issues.

Case Study

Enrolment reinstated and policies amended

An international student in a public high school had their enrolment cancelled by their school. The student's appeal against the decision was dismissed, and they subsequently complained to the Ombudsman that the cancellation was unfair.

The Ombudsman's investigation found that the school's decision to cancel their enrolment was made according to the provisions of the *National Code of Practice for Providers of Education and Training to Overseas Students 2018* but it did not follow the process for exclusion in the *School Education Act 1999* (**the Act**).

As a result of the Ombudsman's investigation, the school re-enrolled the student and the Department of Education agreed to amend its policies to state that the exclusion of any student enrolled in a public school must comply with the exclusion process set out in the Act.

Case Study

University refunds tuition fees

An international student enrolled in a course at a university, which included an English language bridging course. Before commencing study, the student requested to withdraw from the course as they wished to study in another state for personal reasons. The university denied the student's release. The student then withdrew from the university and requested a refund of all course tuition fees. The university refunded the main course tuition fees to the student but did not refund the English language bridging course tuition fees. The student complained to the Ombudsman.

As a result of the Ombudsman's investigation, the university reconsidered the matter, including the application of its English language bridging course refund policy and refunded the English language bridging course tuition fees to the student minus administration and enrolment fees.

Public Interest Disclosures

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

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

During the year, four disclosures were received.

Indian Ocean Territories

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

Terrorism

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

Requests for Review

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

In 2019-20, seven reviews were undertaken, representing one third of one per cent of the total number of complaints finalised by the Office. In all cases where a review was undertaken, the original decision was upheld.

Child Death Review

Overview

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

- Background;
- The role of the Ombudsman in relation to child death reviews;
- The child death review process;
- Analysis of child death reviews;
- Patterns, trends and case studies relating to child death reviews;
- Issues identified in child death reviews;
- Recommendations;
- 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:

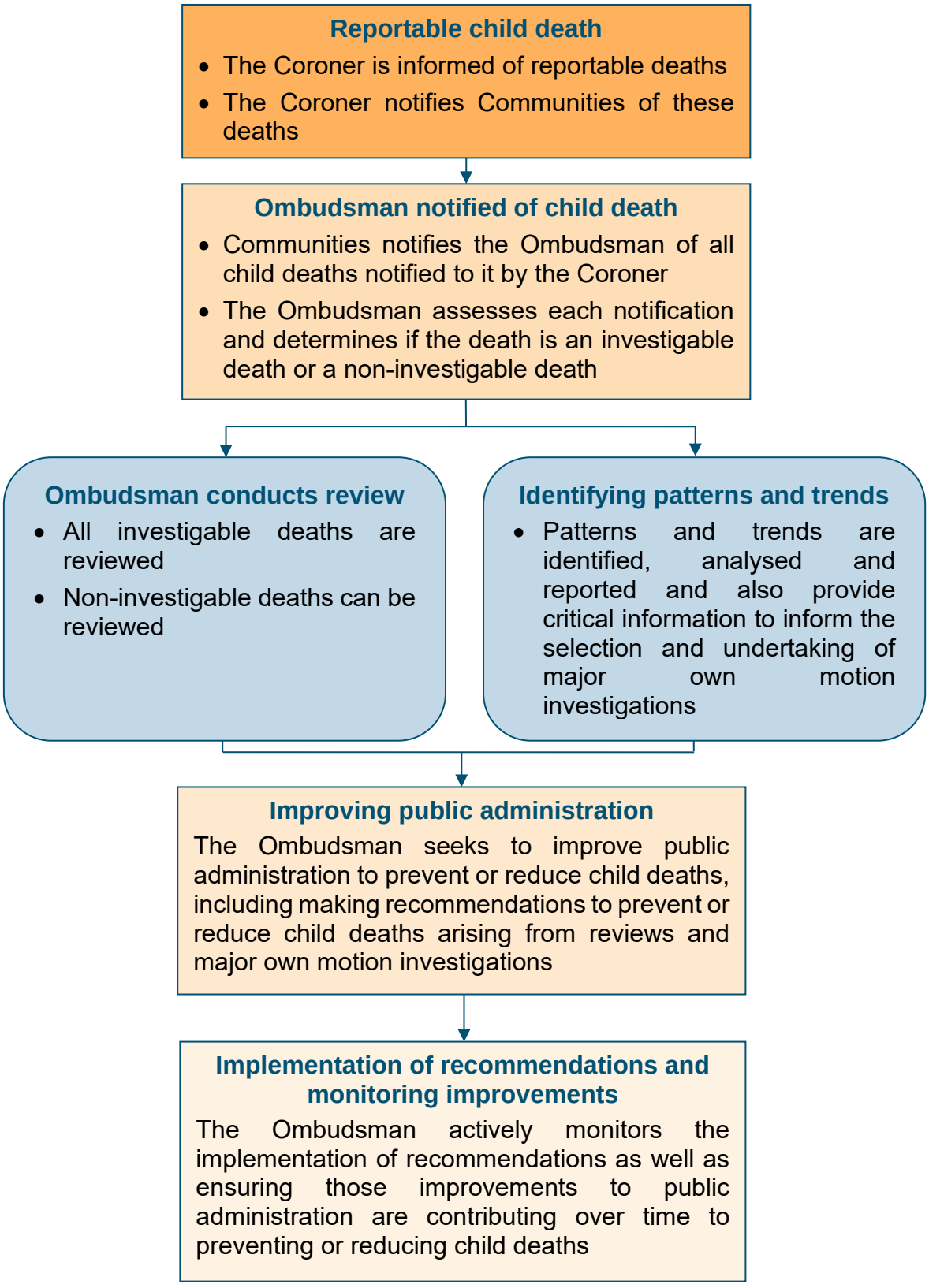
- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children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

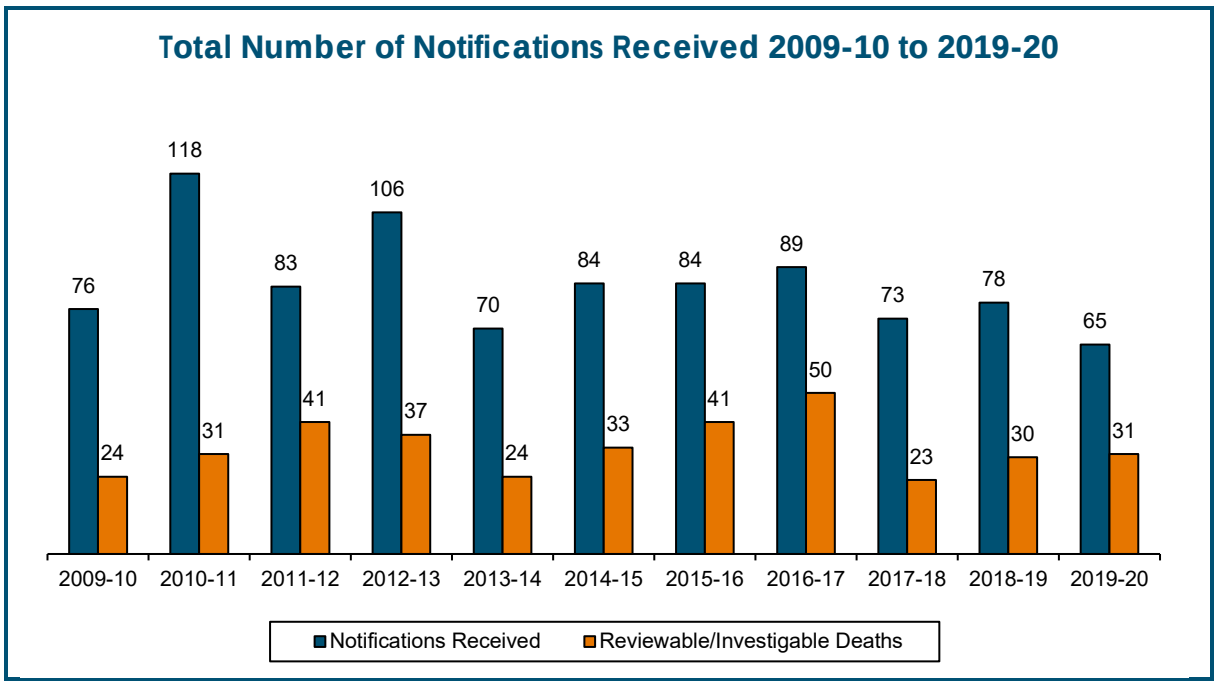
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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

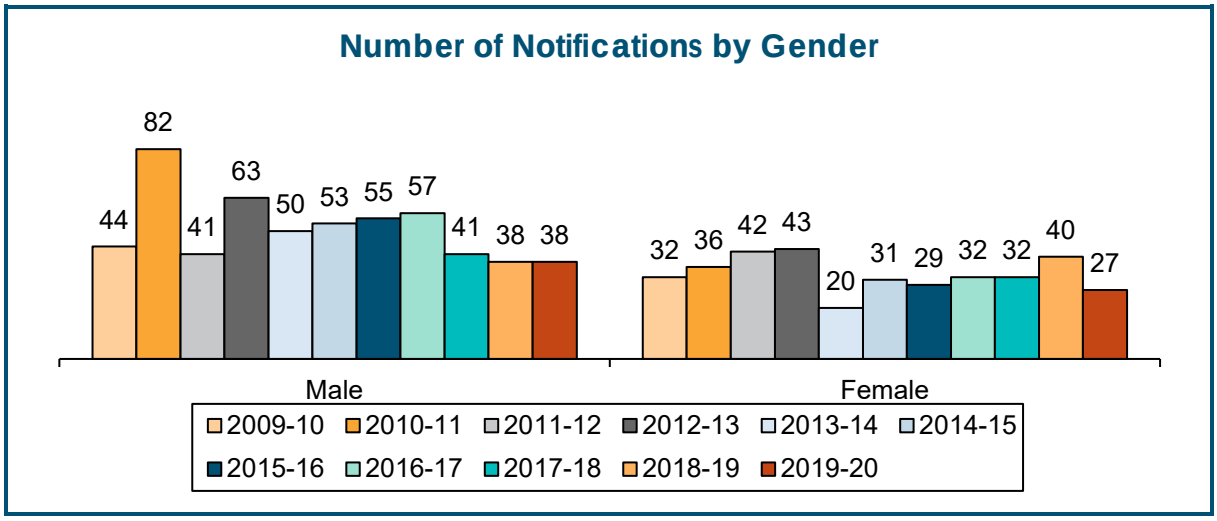
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

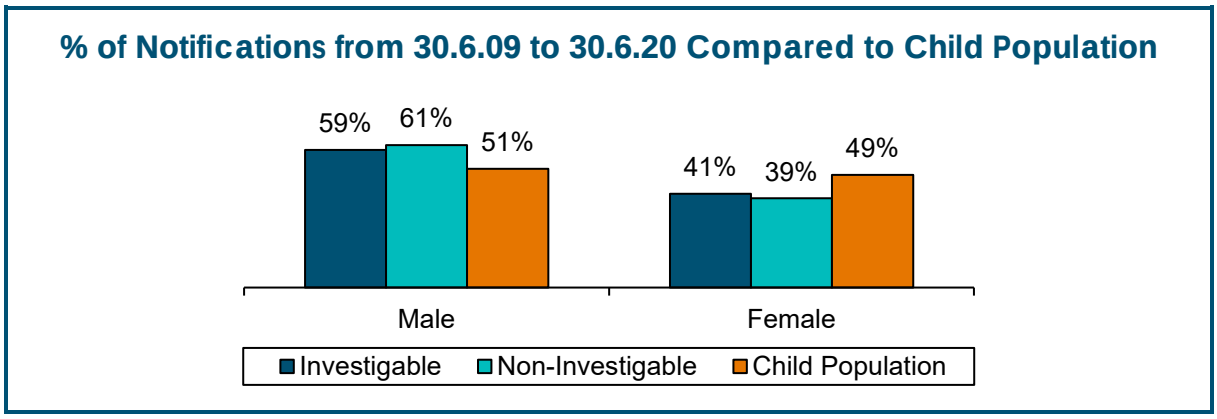
The following charts show:

- 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.

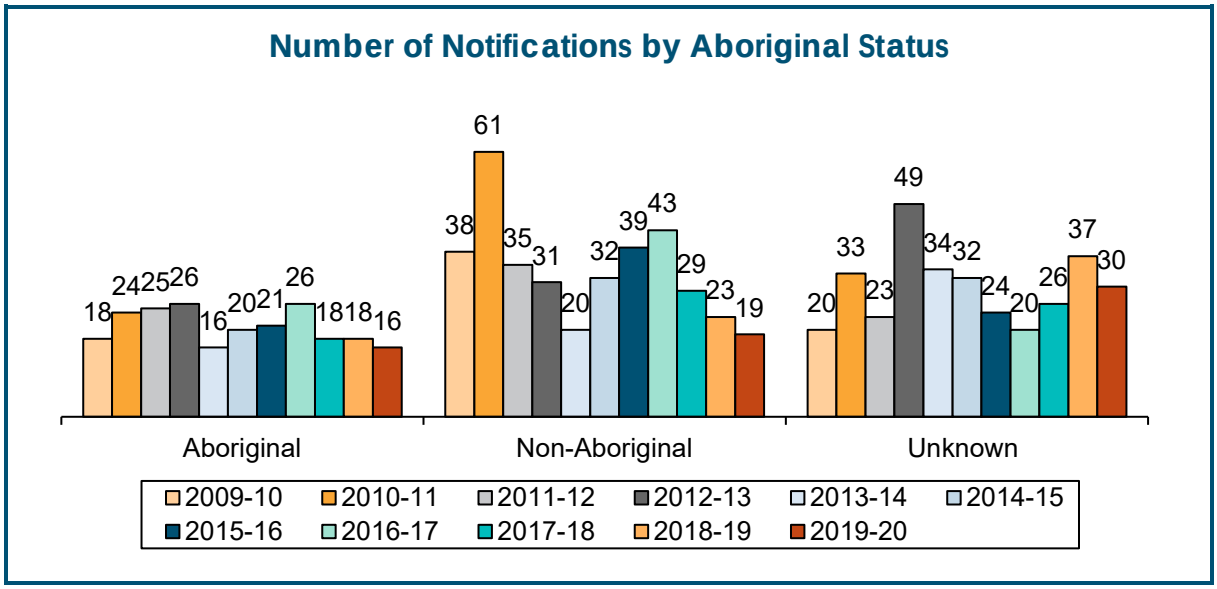


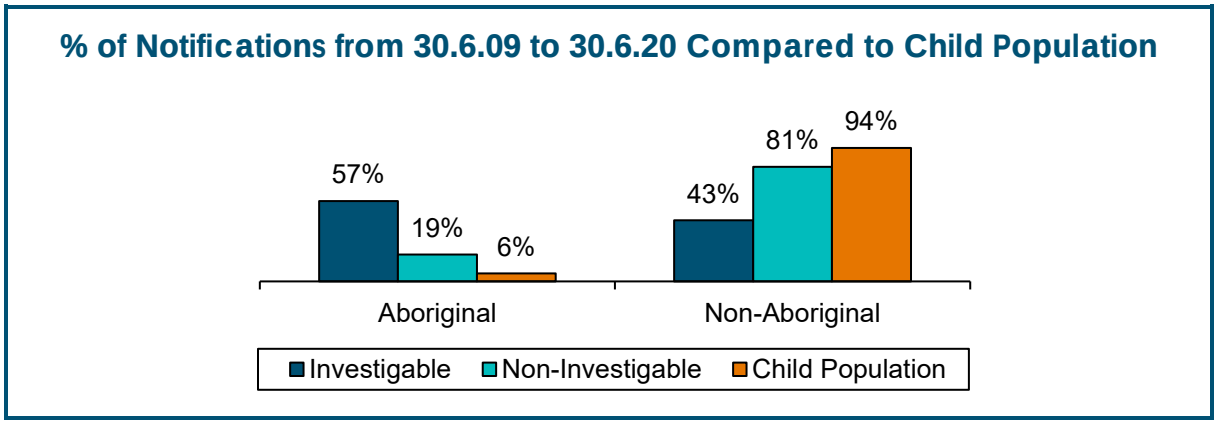


Further analysis of the data shows that, considering all 11 years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

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.





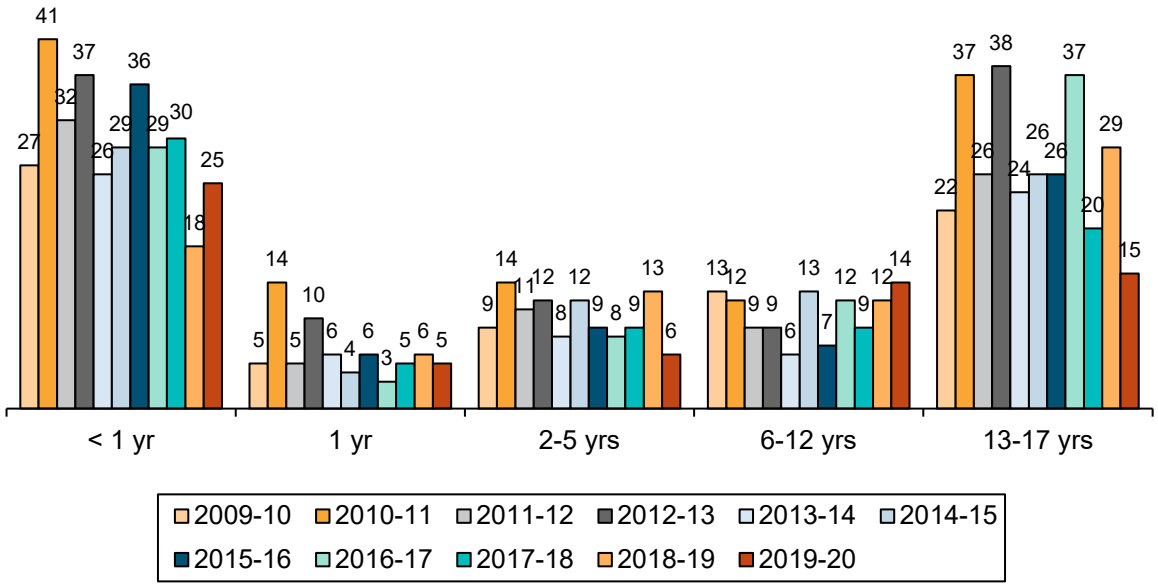
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

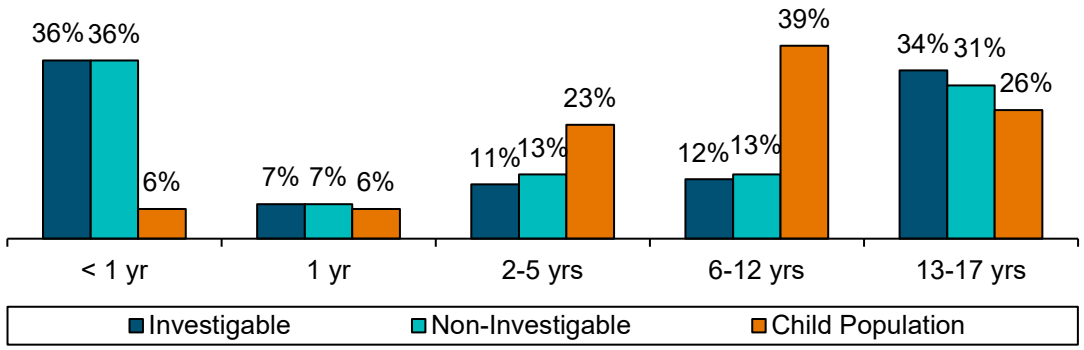
Age groups

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



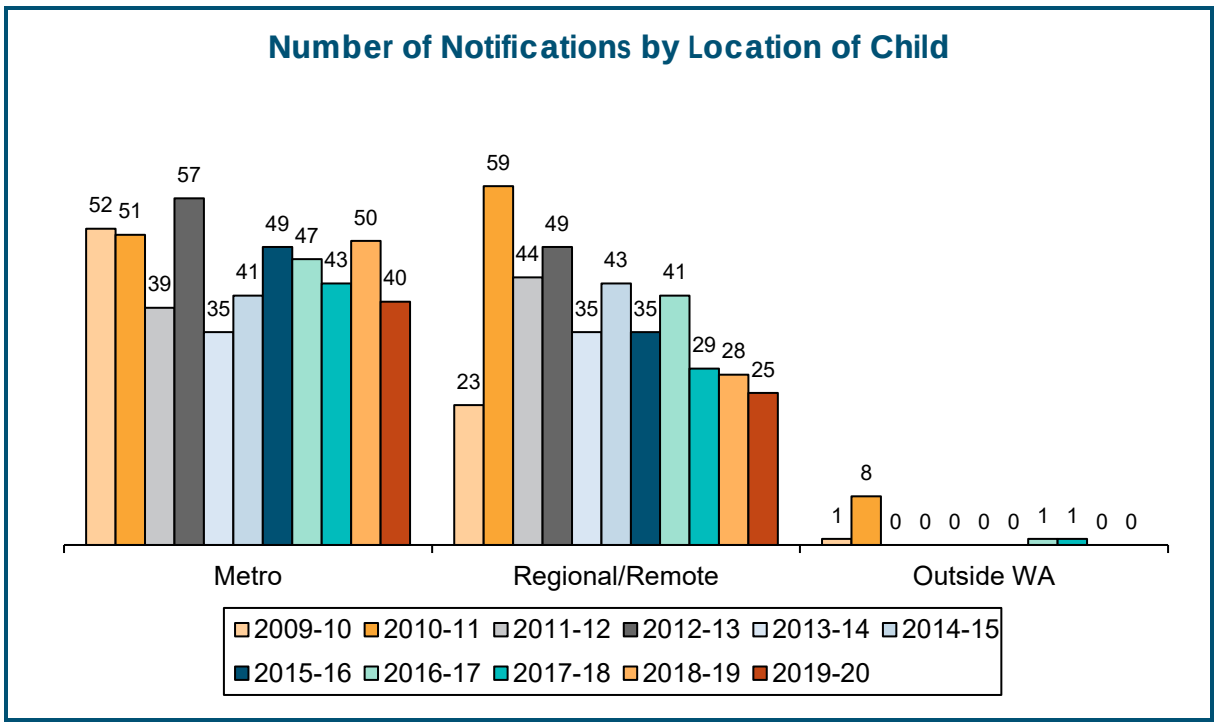
% of Notifications from 30.6.09 to 30.6.20 Compared to Child Population



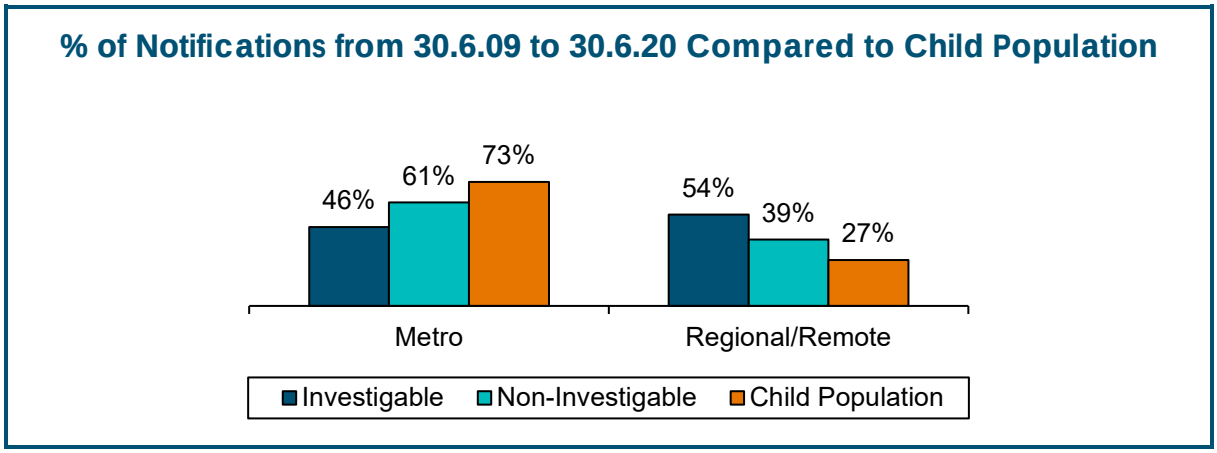
A more detailed analysis by age group is provided later in this section.

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

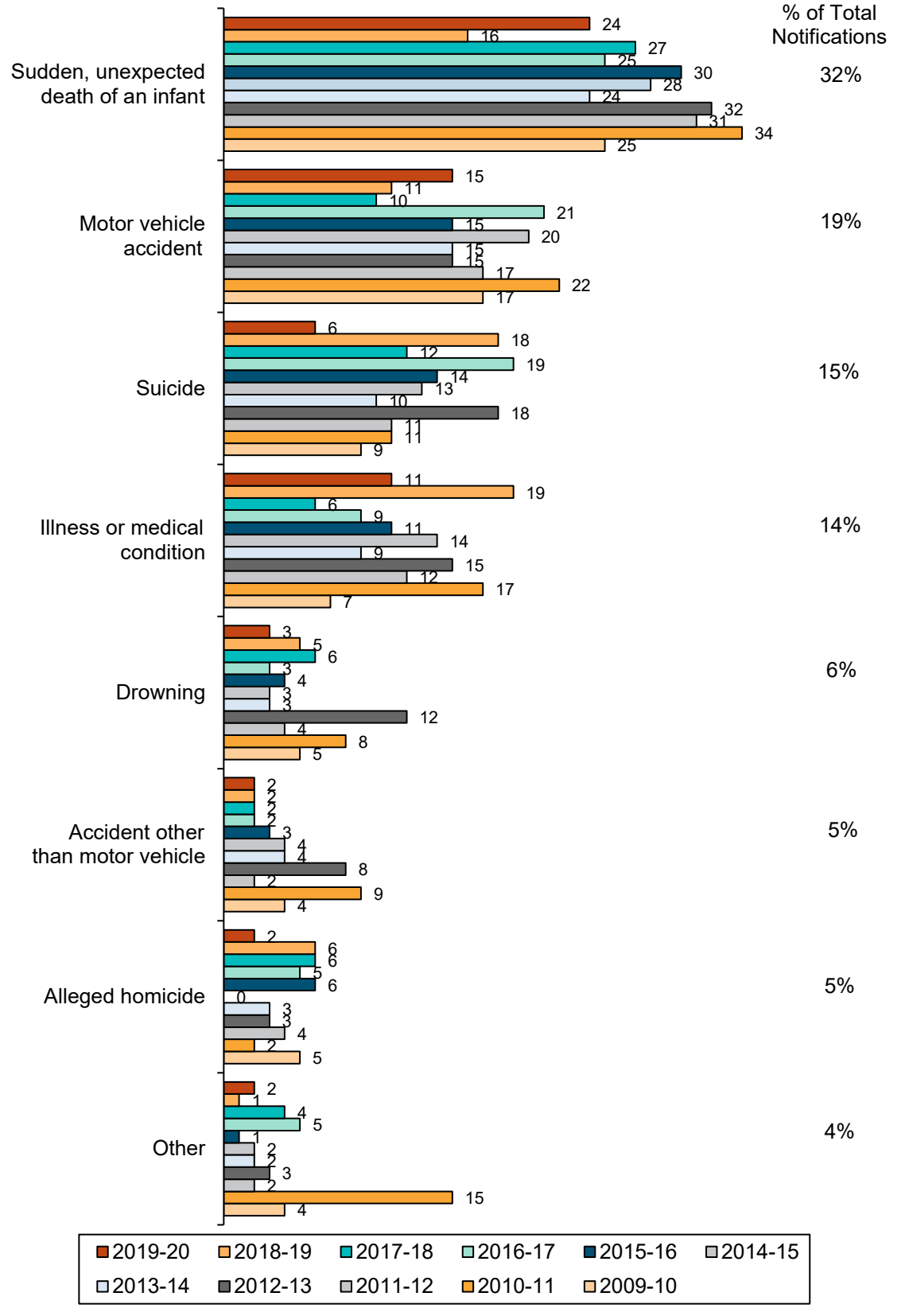
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally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



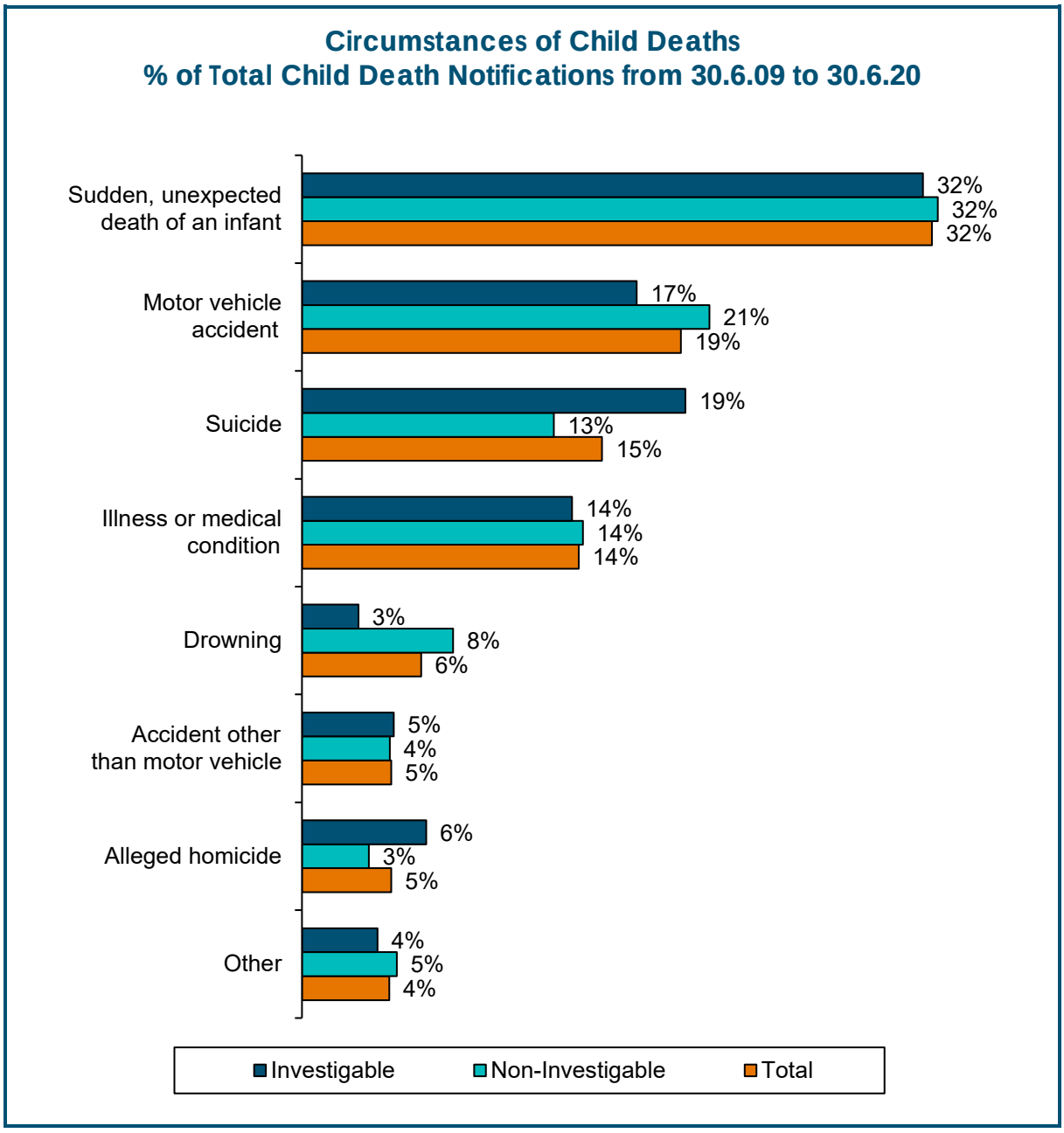
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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

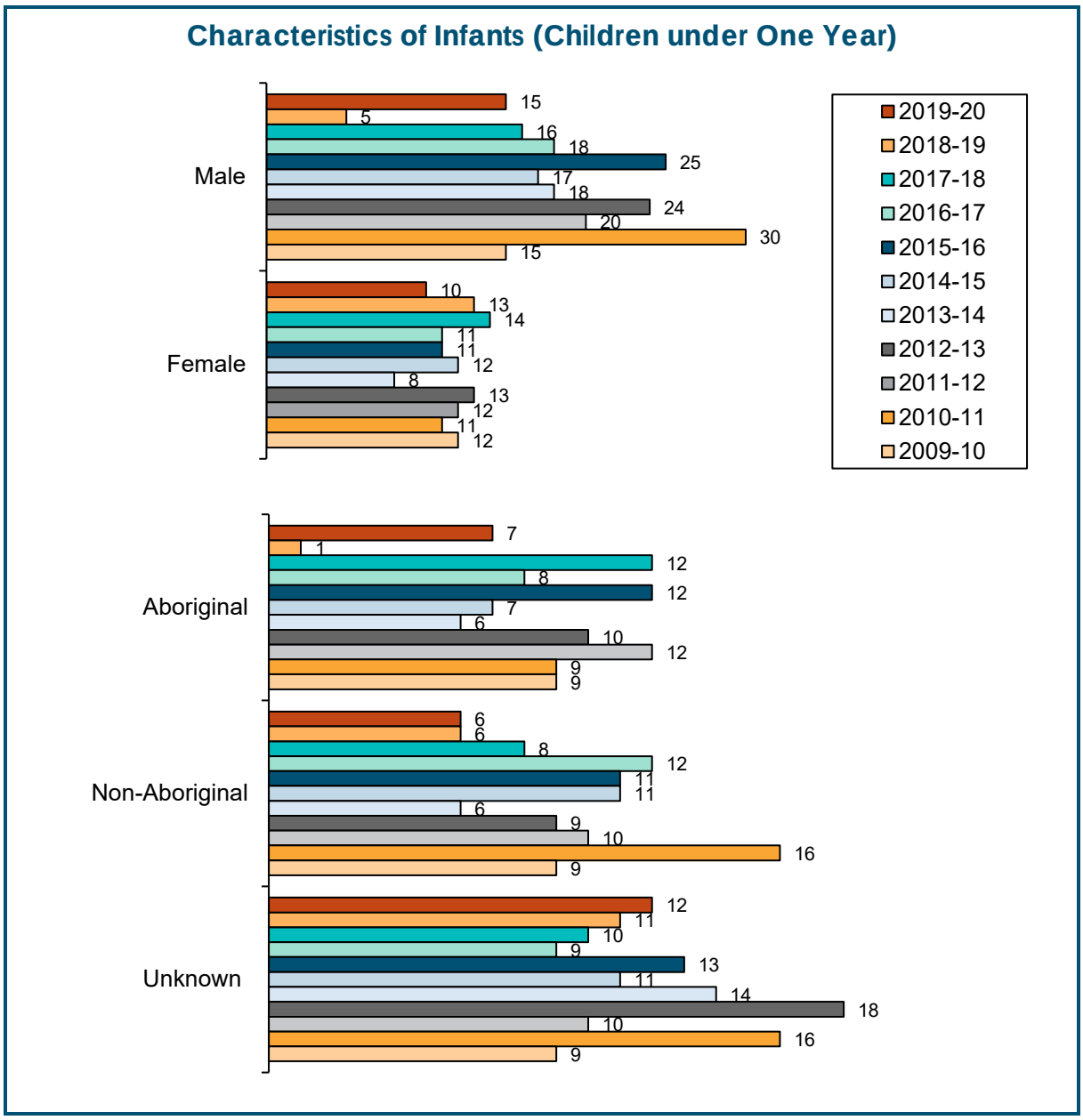
In child deaths notified to the Ombudsman in 2019-20, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

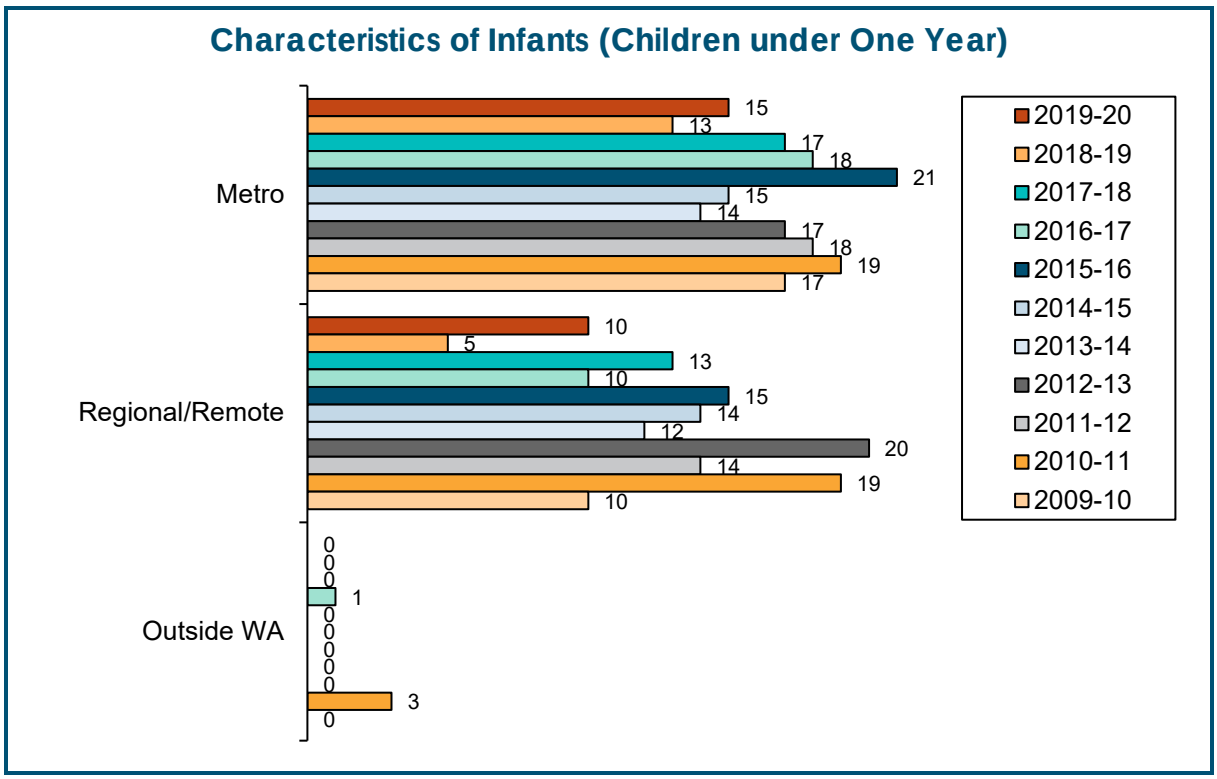
Analysis of children in particular age groups

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.



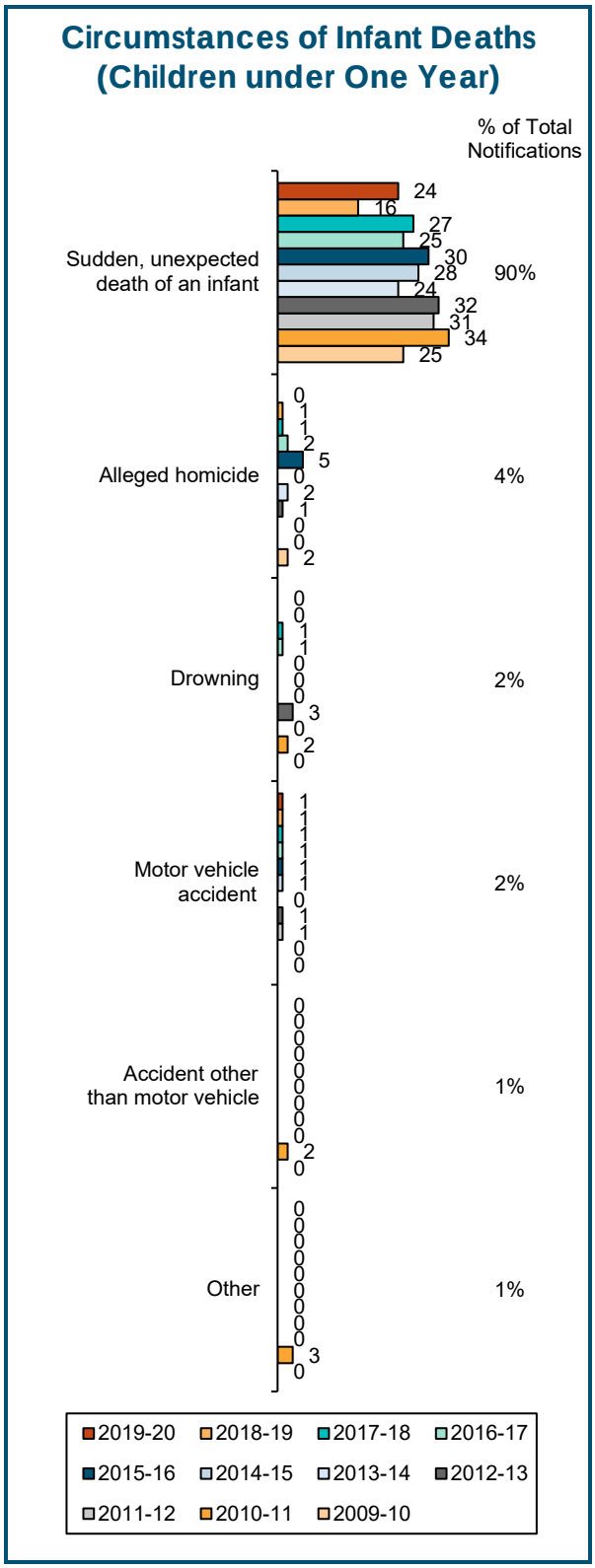


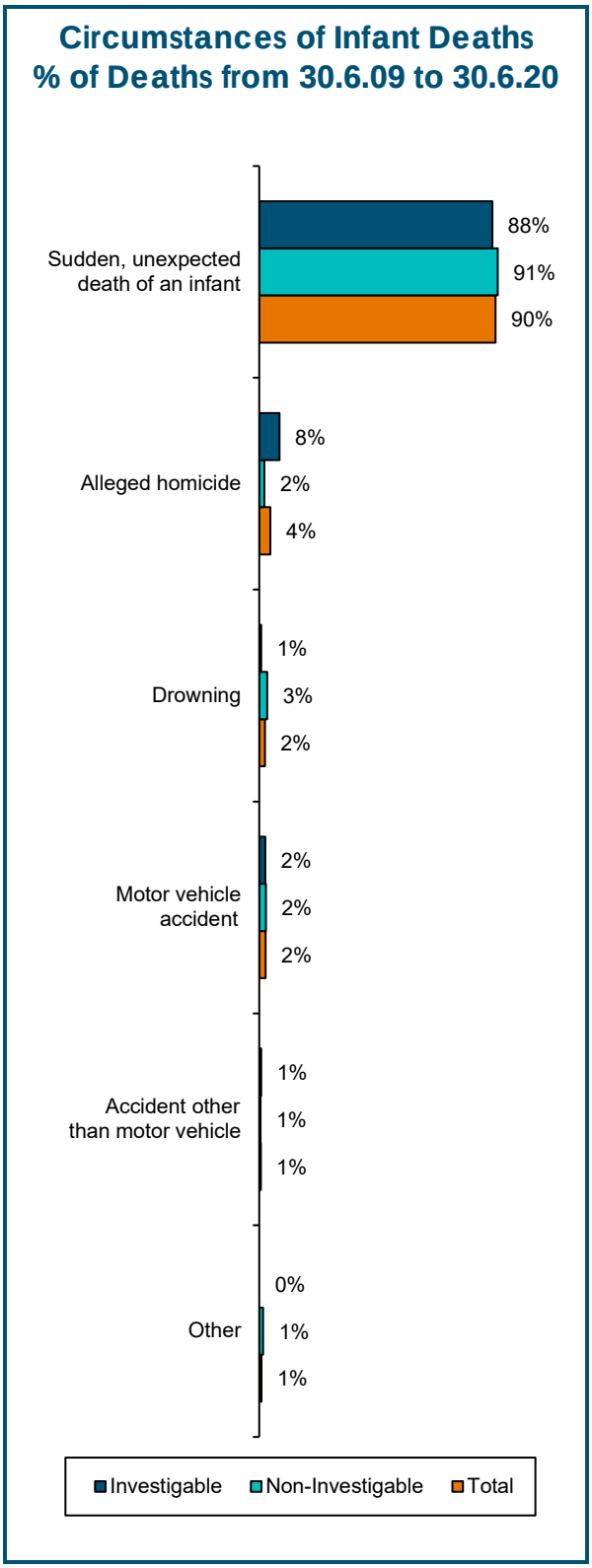
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.





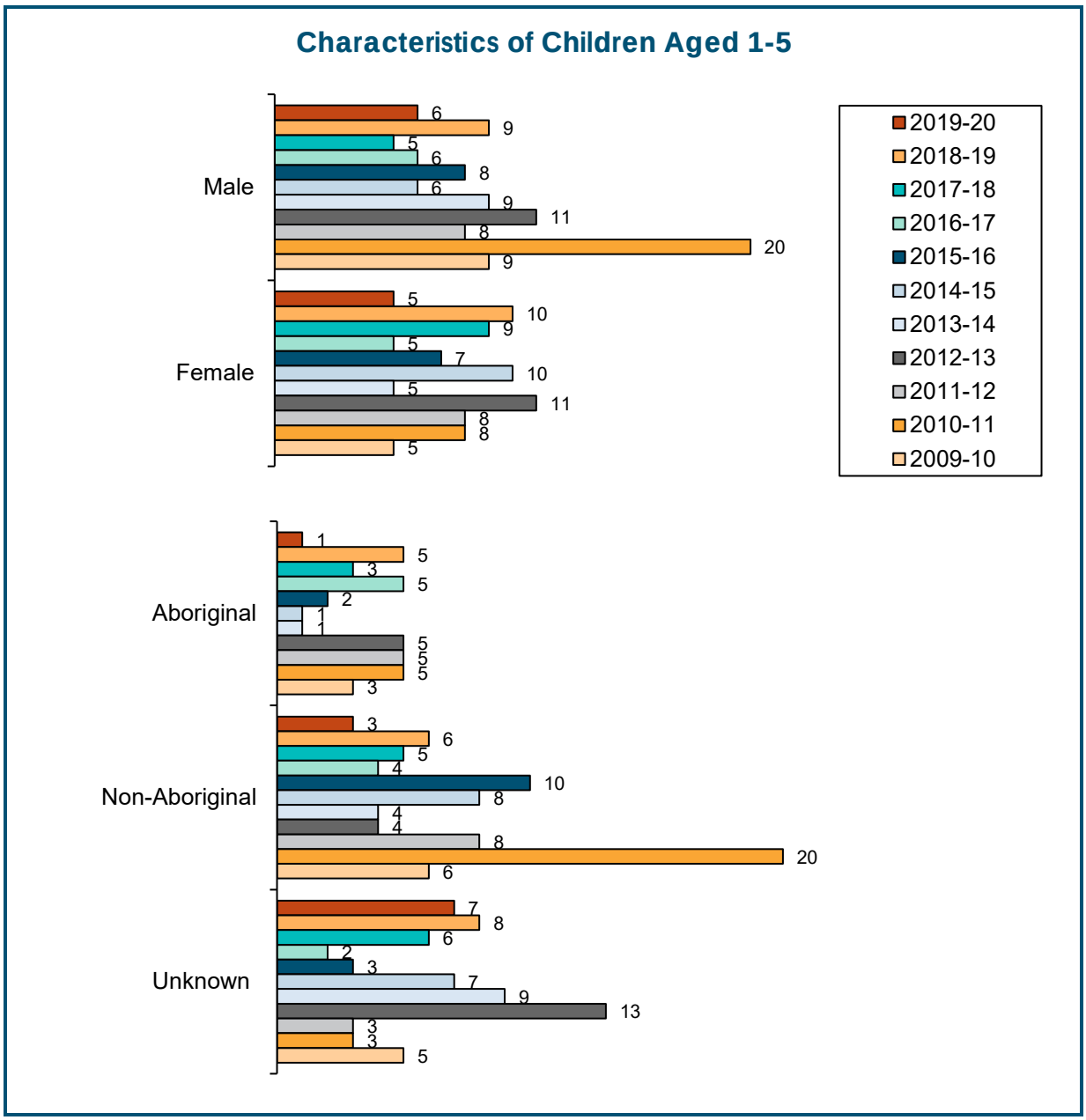
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

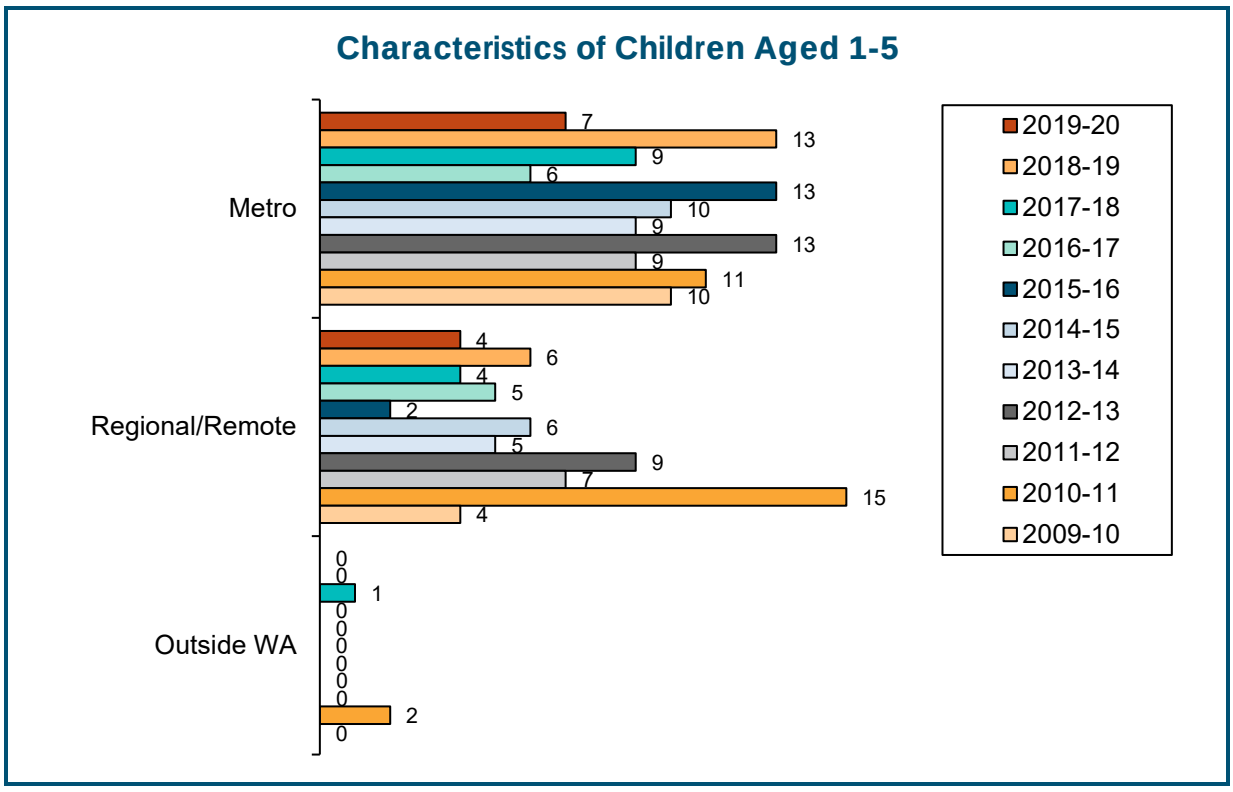
One hundred and thirty deaths of infants were determined to be investigable deaths.

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.



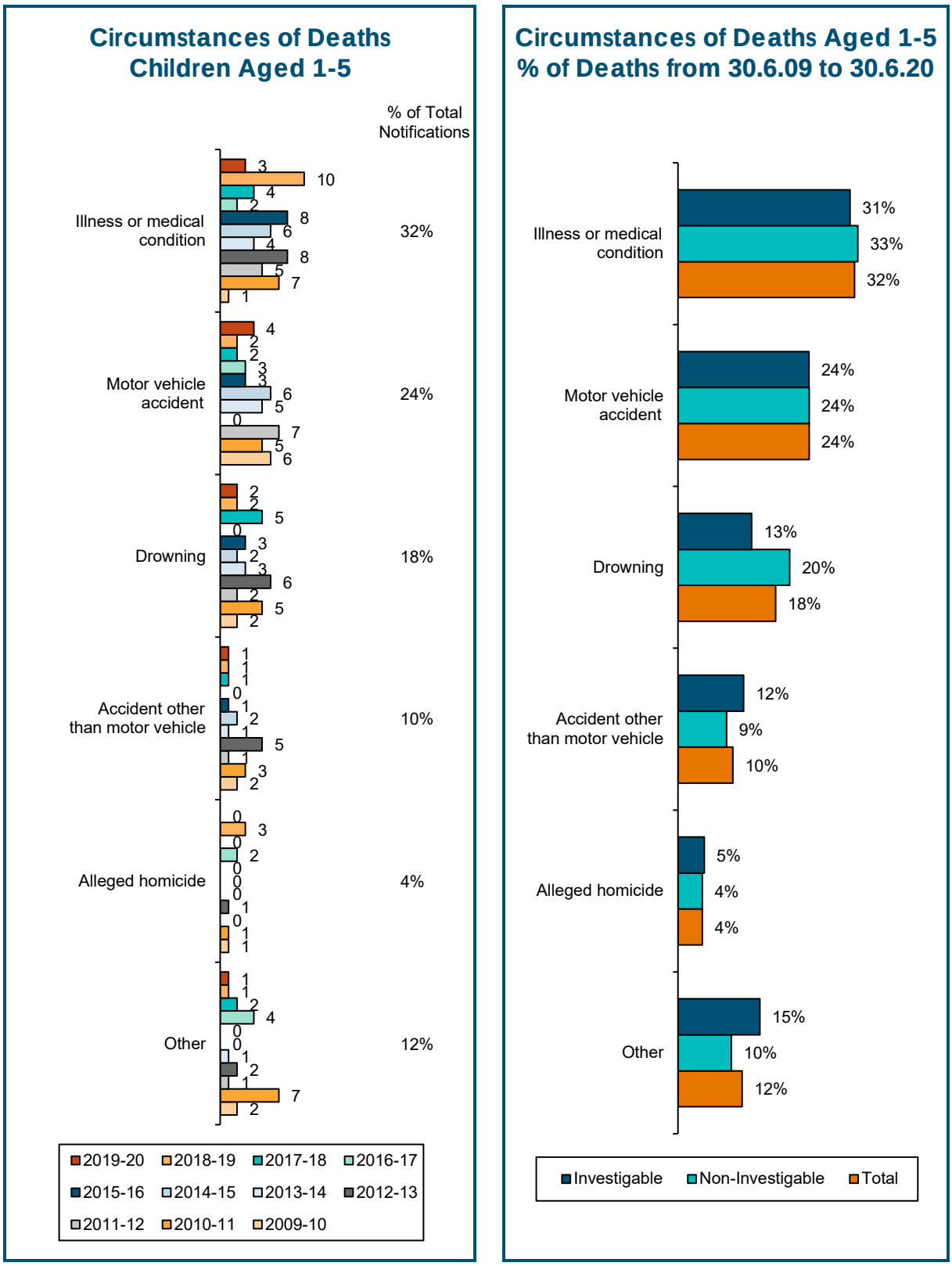


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).



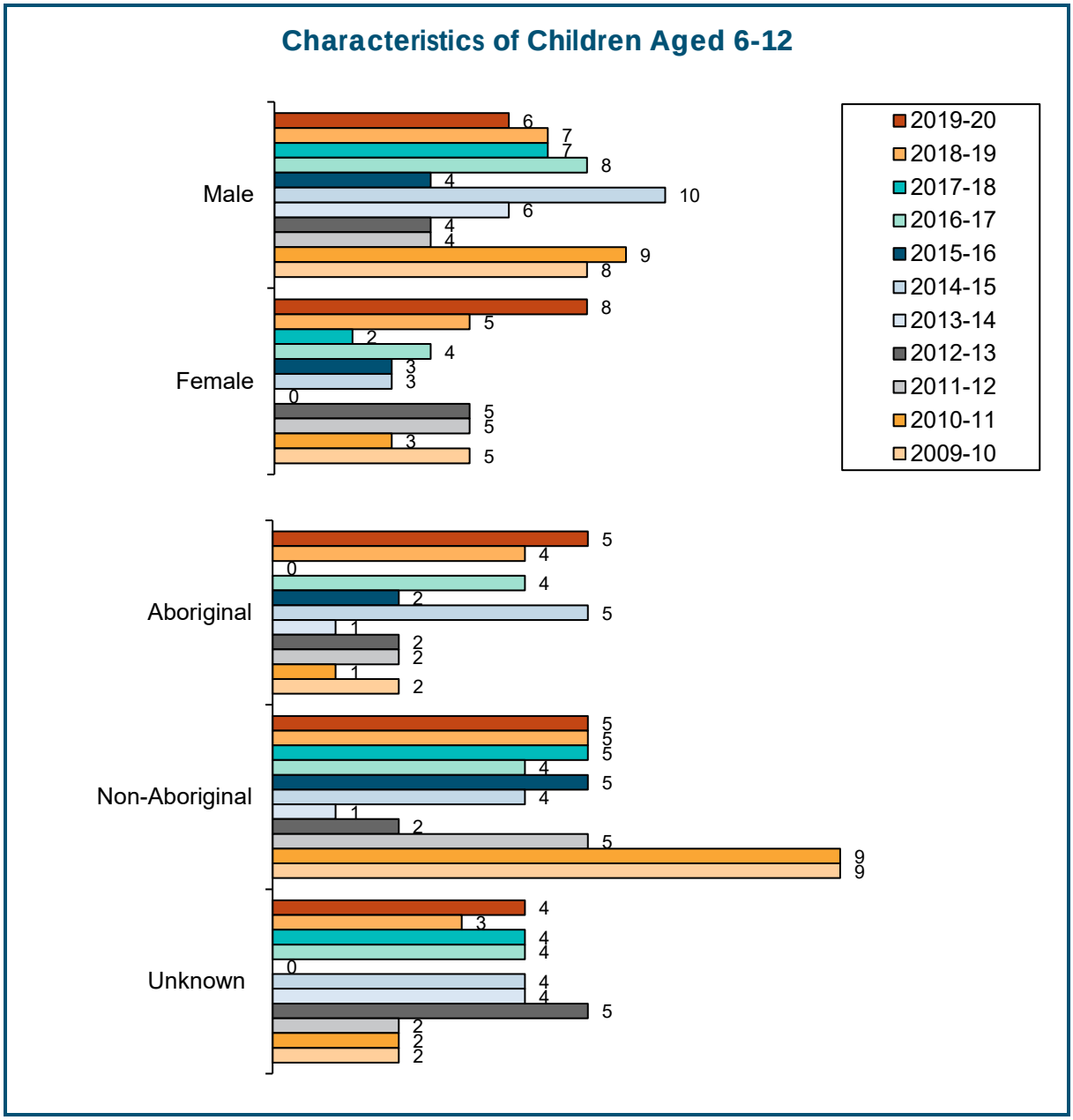
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

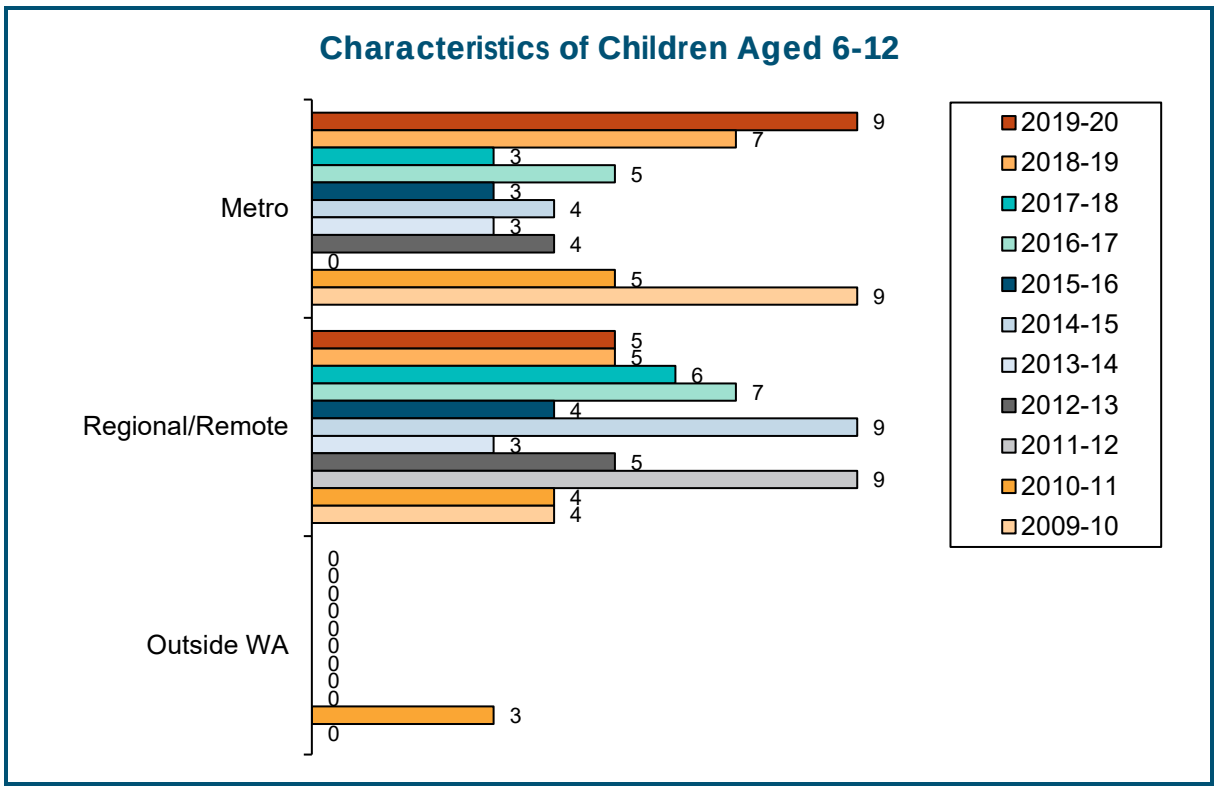
Sixty seven deaths of children aged 1 to 5 years were determined to be investigable deaths.

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.



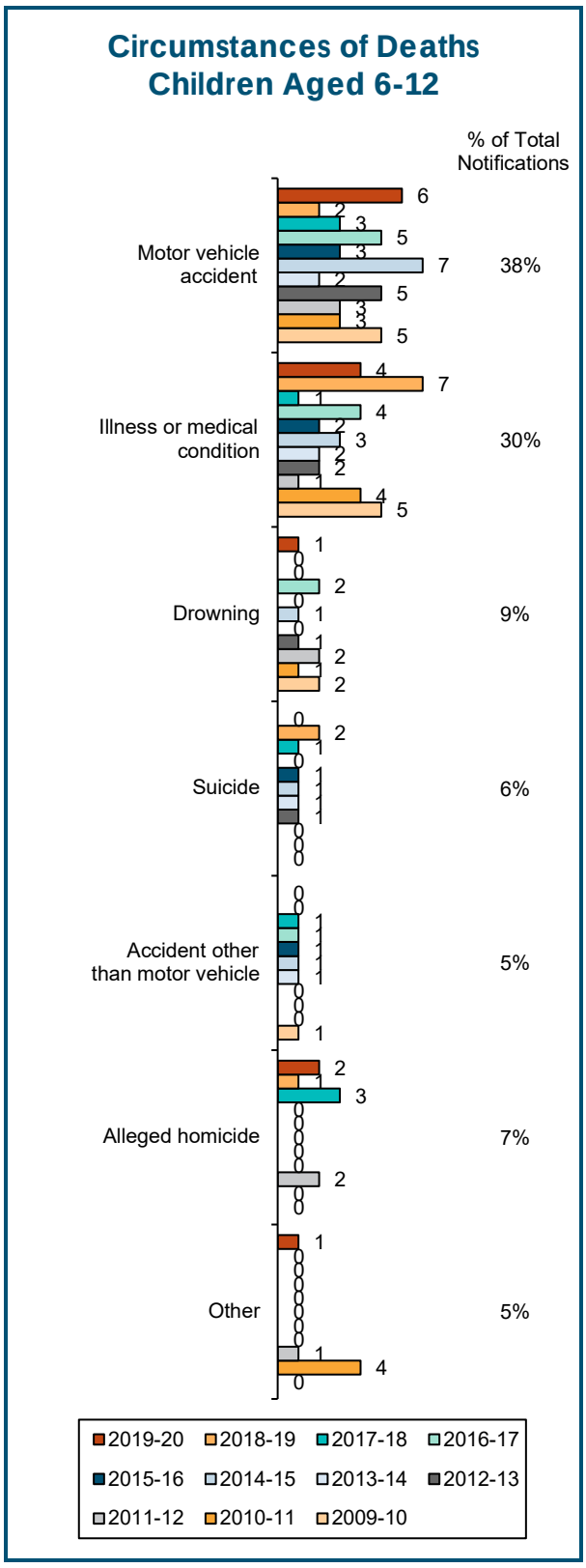


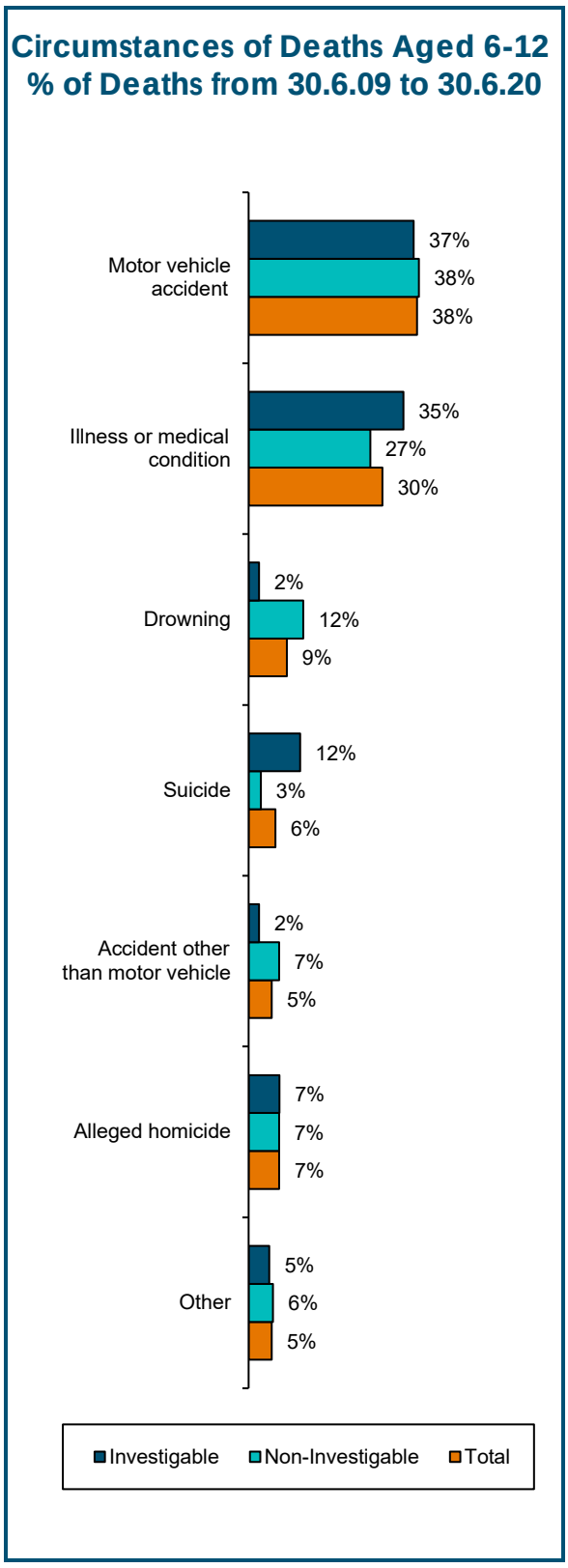
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).





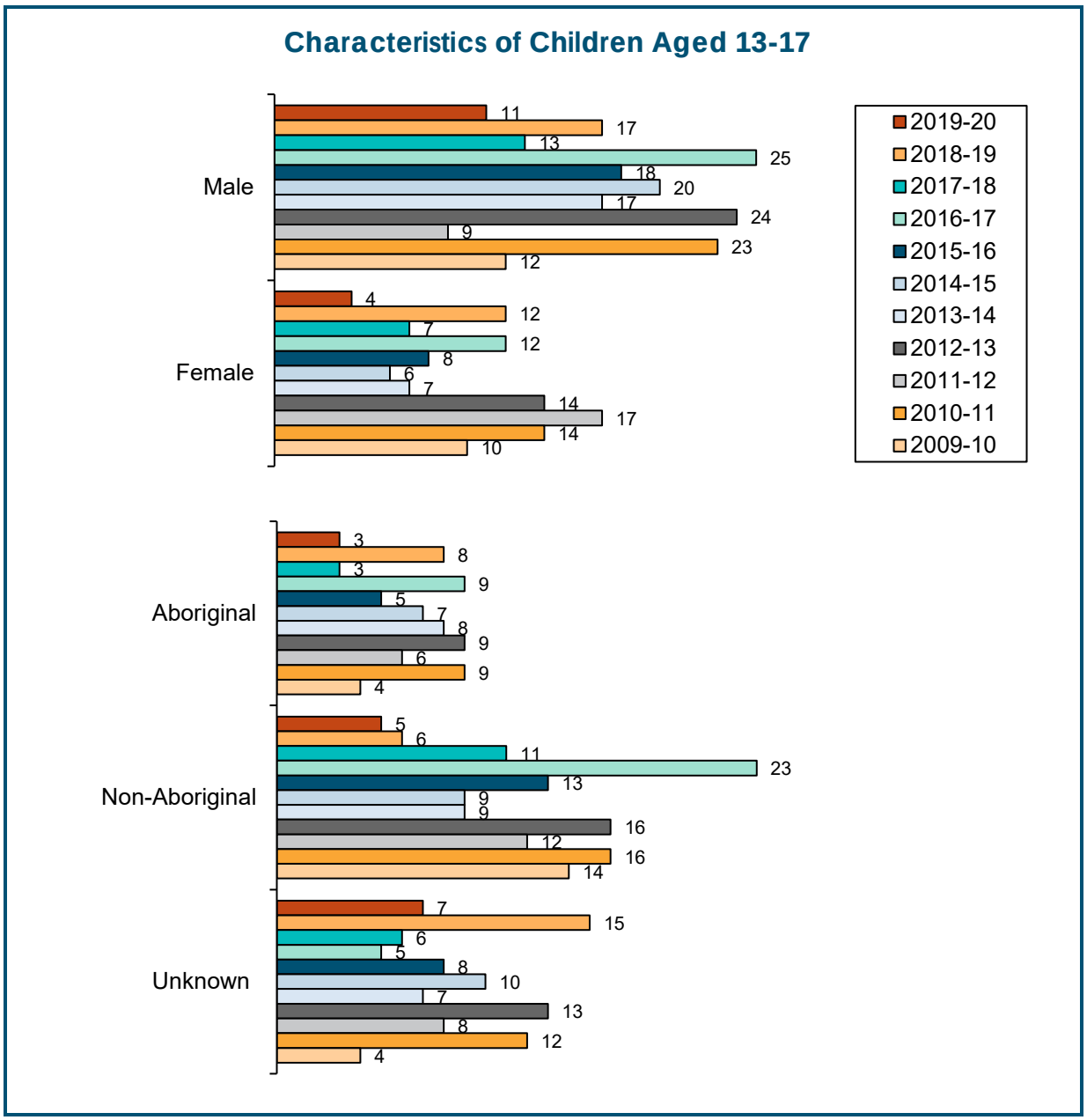
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

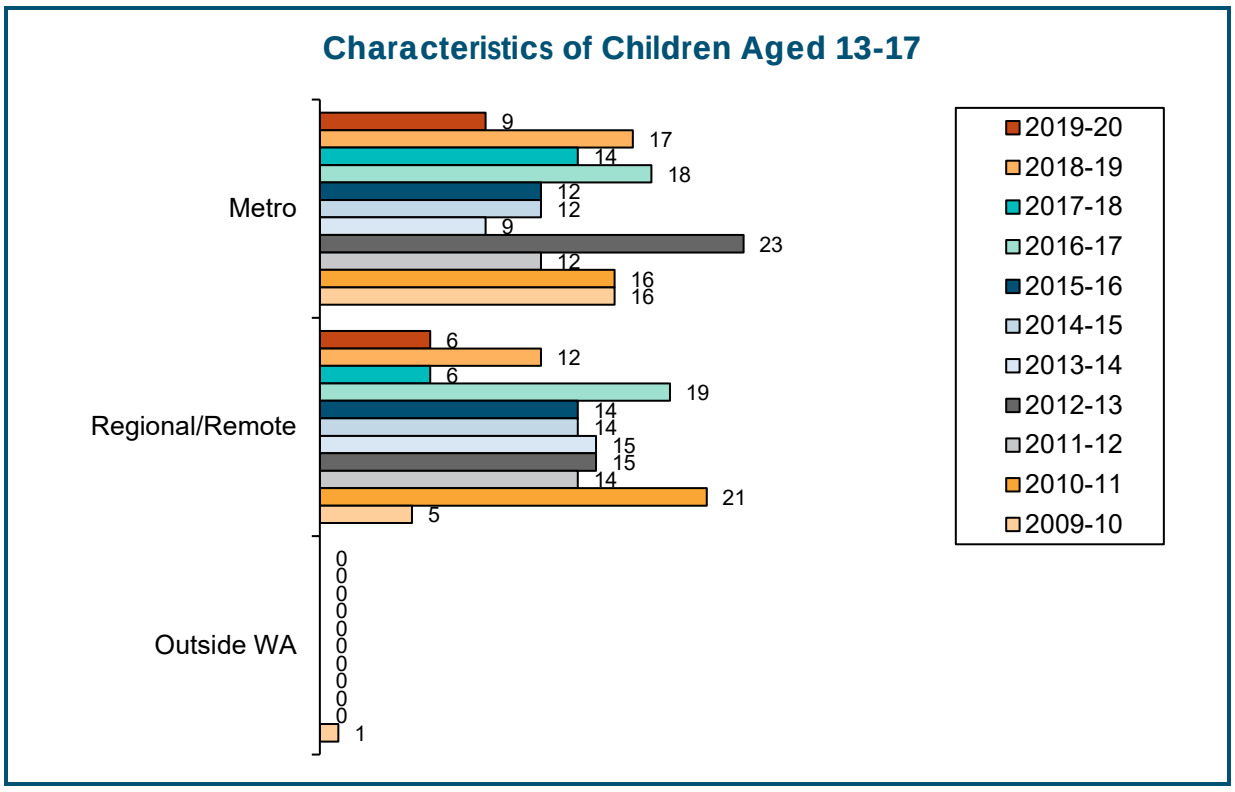
Forty three deaths of children aged 6 to 12 years were determined to be investigable deaths.

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.



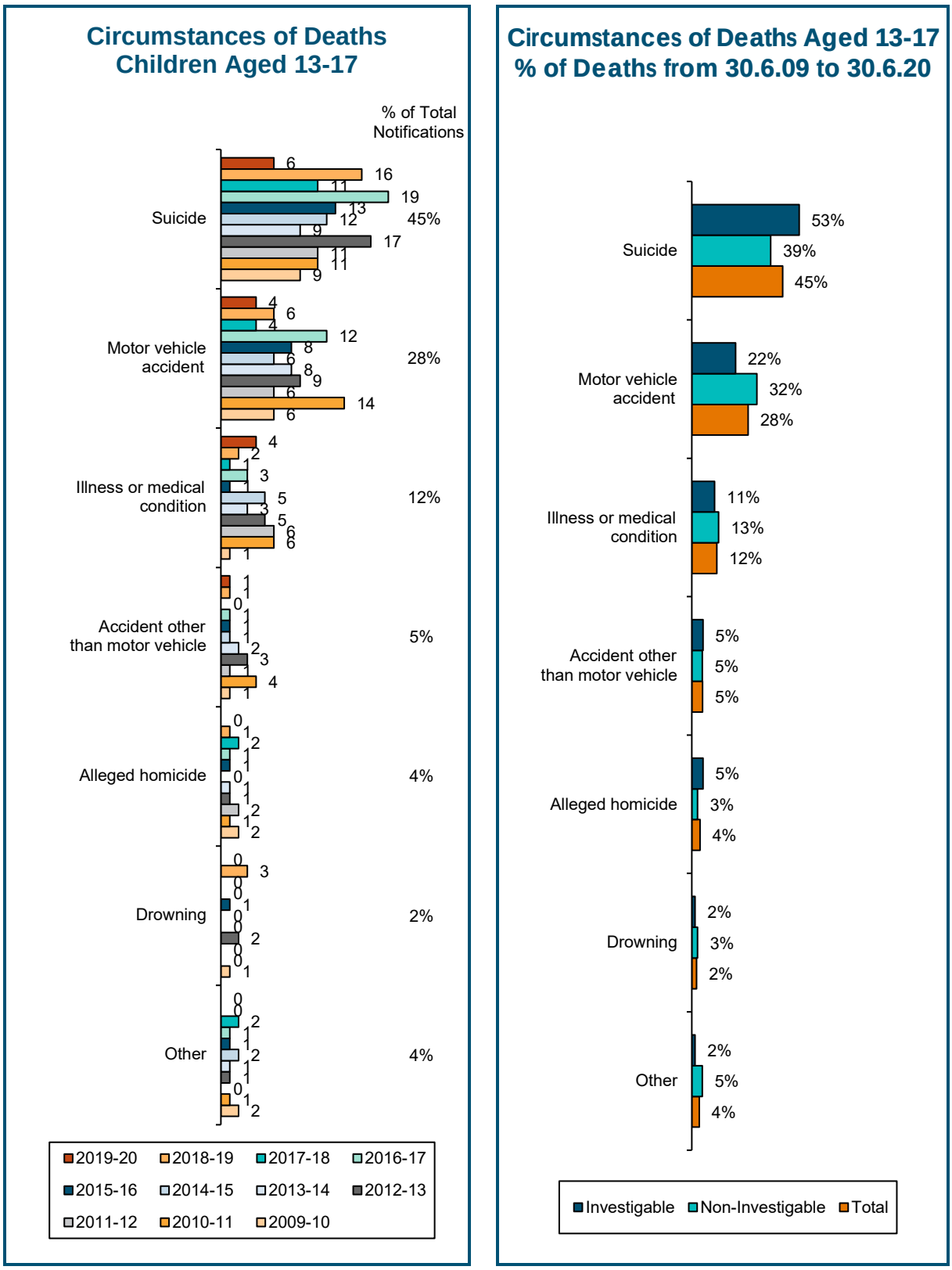


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.

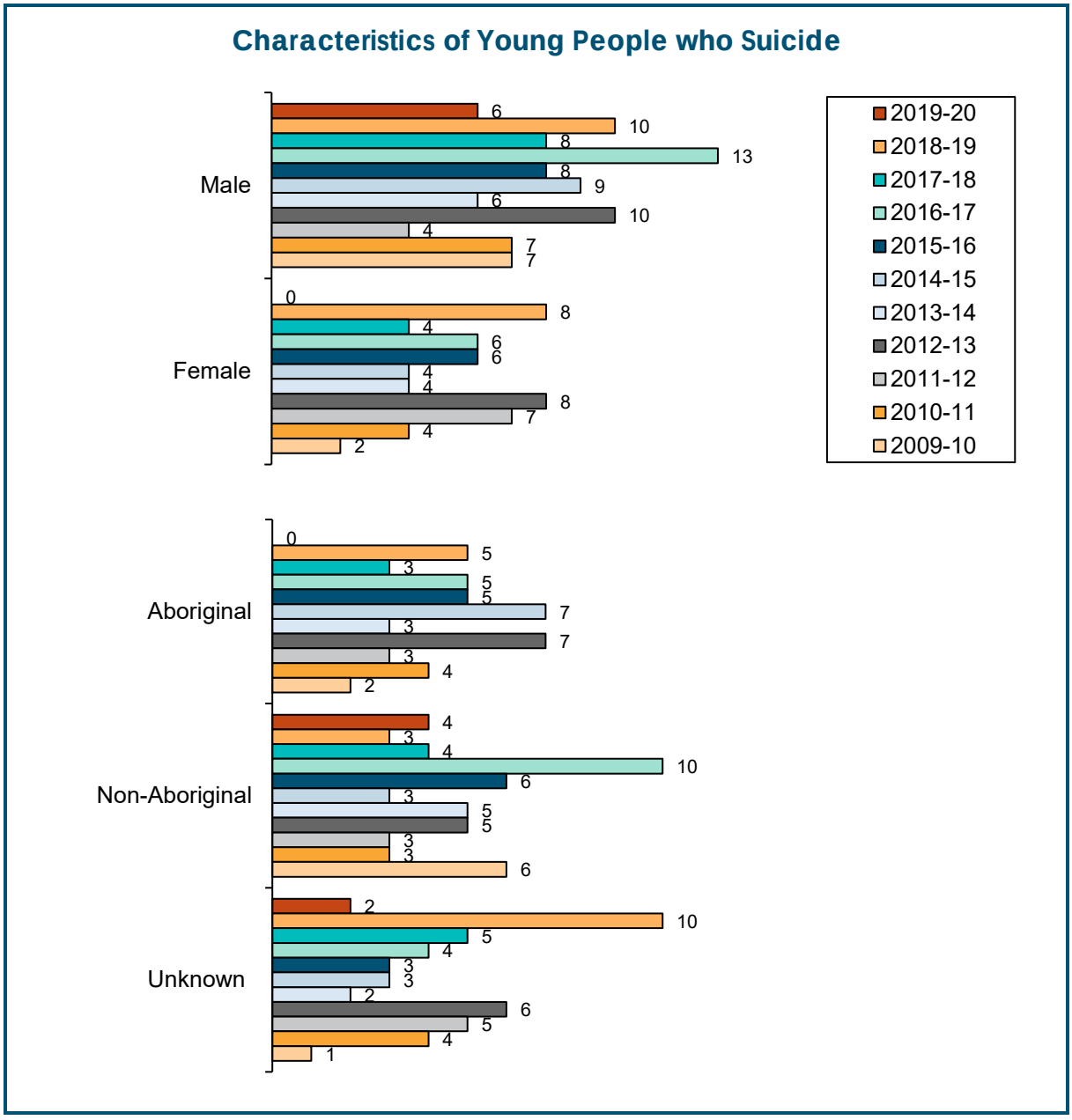
One hundred and twenty five deaths of children aged 13 to 17 years were determined to be investigable deaths.

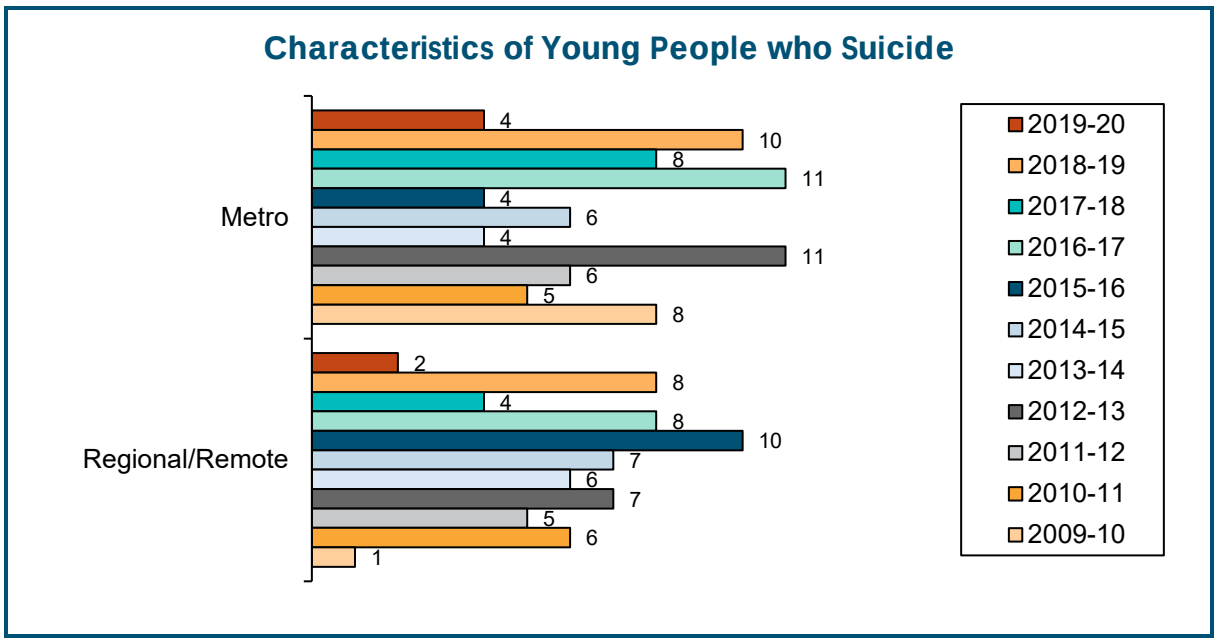
Suicide by young people

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:

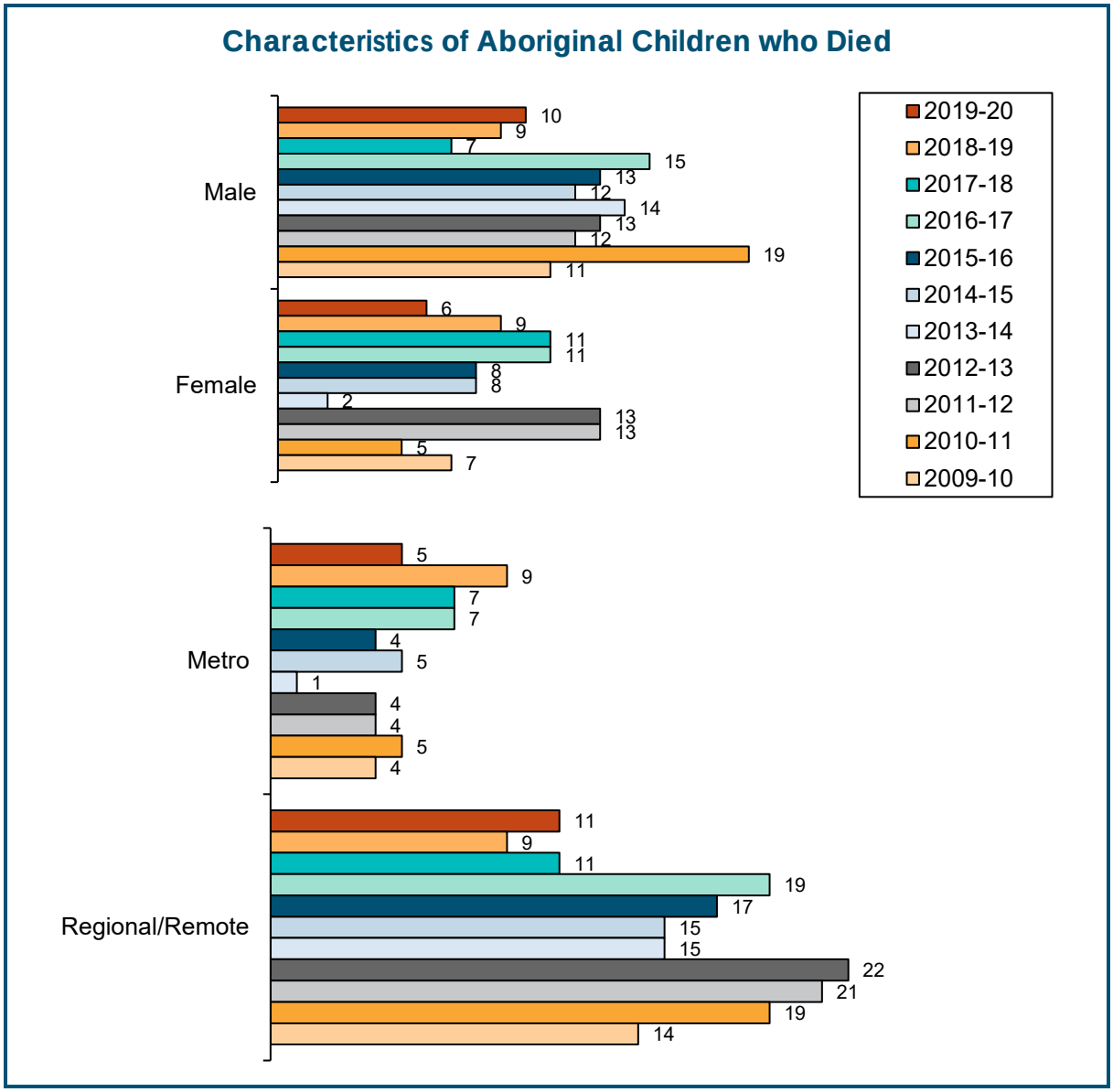
- Males – 56% of investigable deaths and 69% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 96 apparent suicides by young people where information on the Aboriginal status of the young person was available, 63% of the investigable deaths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

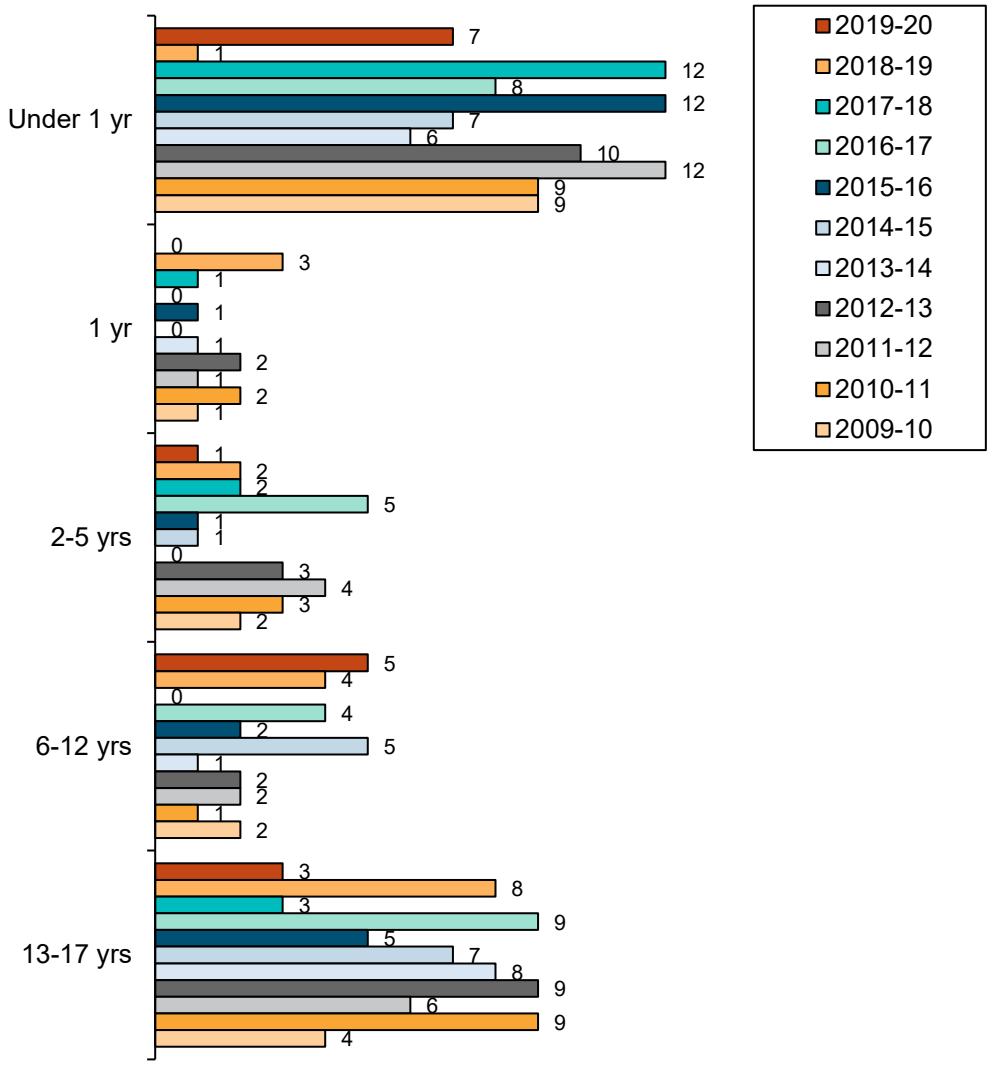
Of the 598 child death notifications received from 30 June 2009 to 30 June 2020, where the Aboriginal status of the child was known, 228 (38%) of the children were identified as Aboriginal.

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.

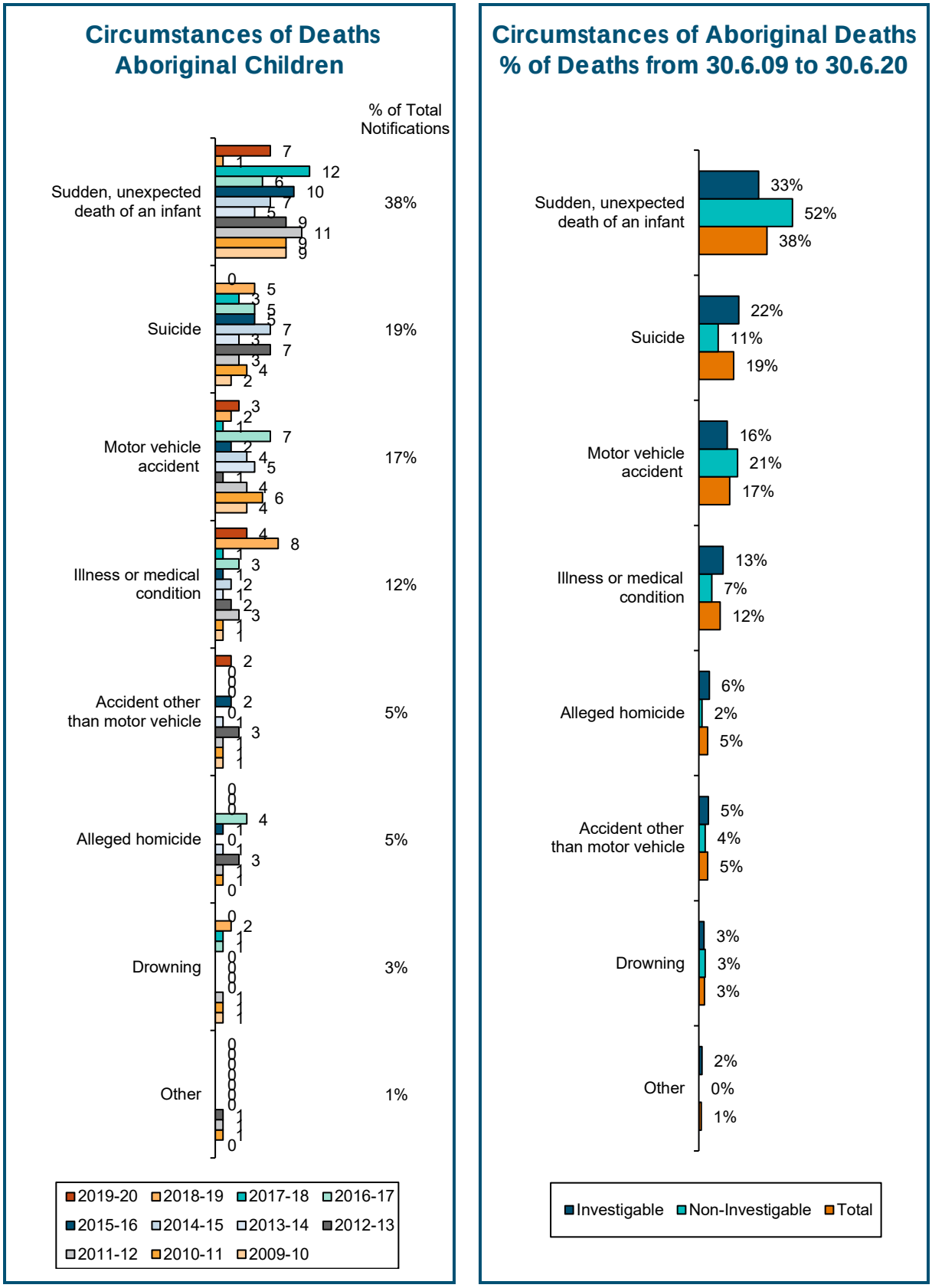


Characteristics of Aboriginal Children who Died



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.

Family and Domestic Violence Fatality Review

Overview

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

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

Background

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

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

The National Plan is endorsed by the Council of Australian Governments and supported by the *First Action Plan 2010-2013: Building a Strong Foundation*, which established the 'groundwork for the National Plan', and the *Second Action Plan 2013-2016: Moving Ahead* and the *Third Action Plan 2016-2019*, which build upon this work. The *Fourth Action Plan 2019-2022: Turning the Corner* (available at www.dss.gov.au), as the final action plan of the National Plan, sets out an 'agenda to achieve change by: improving existing initiatives, addressing gaps in previous action plans, providing a platform for future policy to reduce domestic, family and sexual violence'.

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

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

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

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

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

In 2017, the State Government released the *Stopping Family and Domestic Violence Policy*, which set out 21 new initiatives for responding to family and domestic violence.

This document superseded *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities* (**former State Strategy**) and the *Freedom from Fear Action Plan 2015*. Also in 2017, the first Minister for the Prevention of Family and Domestic Violence was appointed. In July 2020, the Department of Communities (**Communities**) released *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030* (**State Strategy**) and the associated *First Action Plan 2020-2022* (**First Action Plan**).

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

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

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

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

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

Information regarding the use of terms

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

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

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

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

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

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

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

(d) One of whom is a child who —

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

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

  or

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

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

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

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

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

(b) Is related to the person's —

  (i) Spouse or former spouse; or

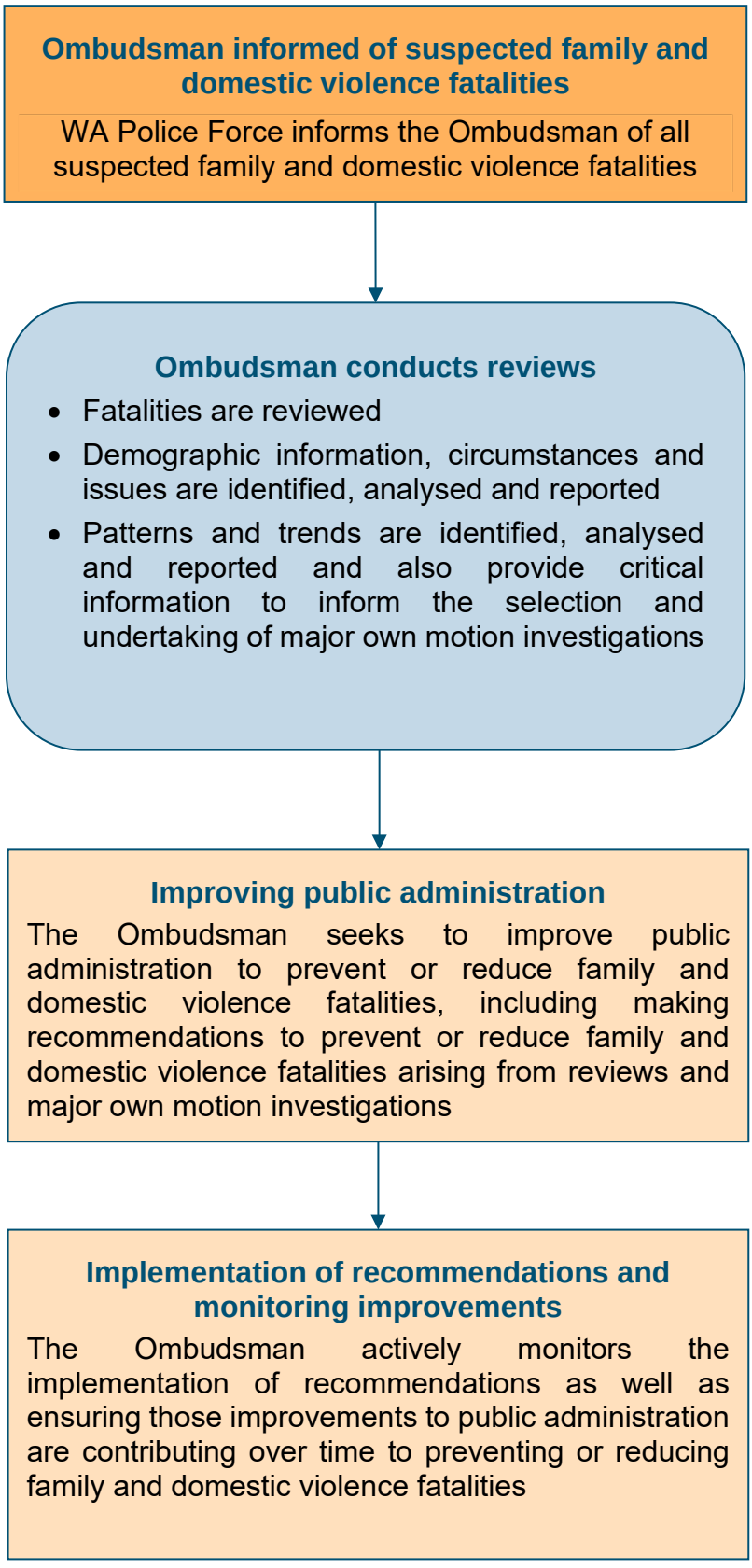
  (ii) De facto partner or former de facto partner.

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

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

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

The Family and Domestic Violence Fatality Review Process



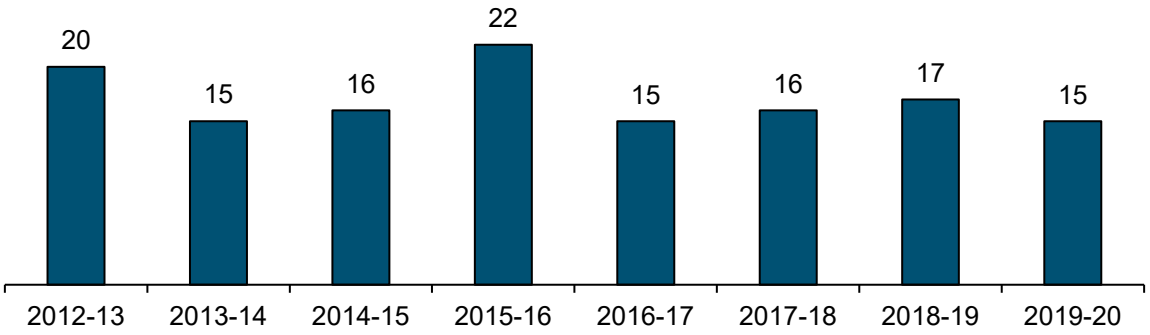
Analysis of Family and Domestic Violence Fatality Reviews

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

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

Number of family and domestic violence fatality reviews

In 2019-20, the number of reviewable family and domestic violence fatalities received was 15, compared to 17 in 2018-19, 16 in 2017-18, 15 in 2016-17, 22 in 2015-16, 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

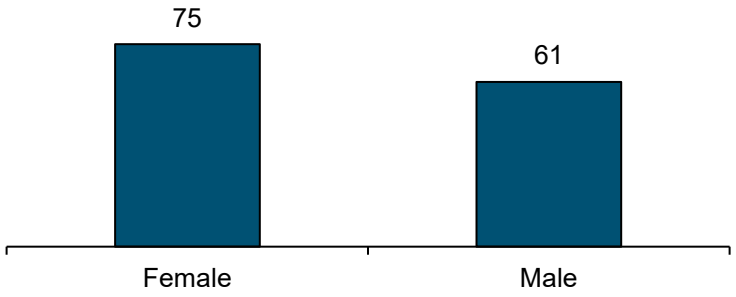


Demographic information identified from family and domestic violence fatality reviews

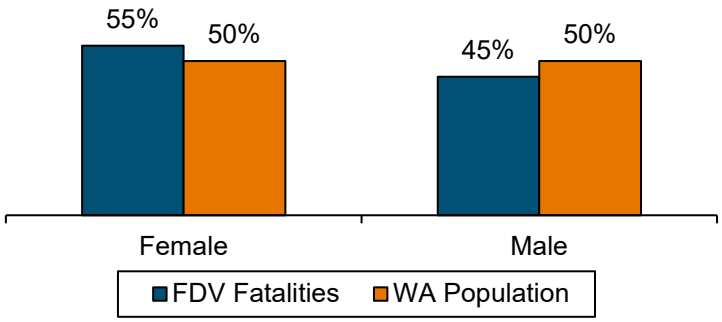
Information is obtained on a range of characteristics of the person who died, including gender, age group, Aboriginal status, and location of the incident in the metropolitan or regional areas.

The following charts show characteristics of the persons who died for the 136 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2020. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

Number of Persons who Died by Gender



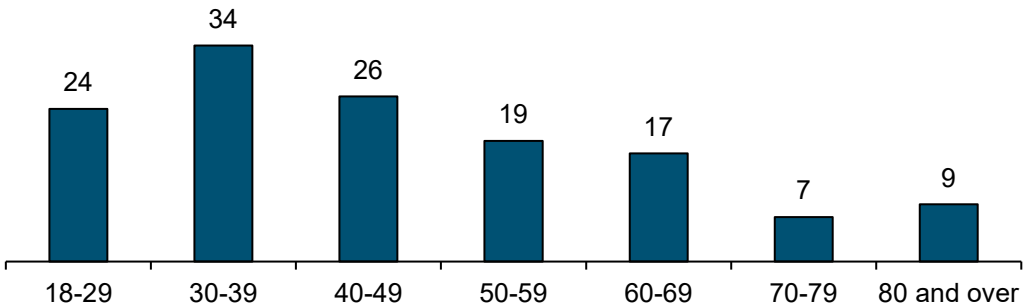
Gender of Persons who Died Compared to WA Population

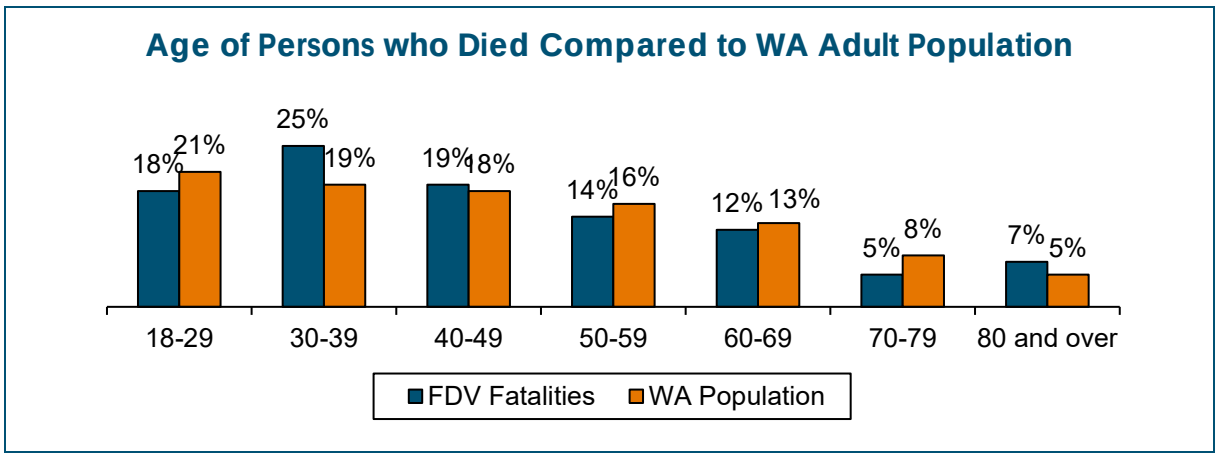


Compared to the Western Australian population, females who died in the eight years from 1 July 2012 to 30 June 2020, were over-represented, with 55% of persons who died being female compared to 50% in the population.

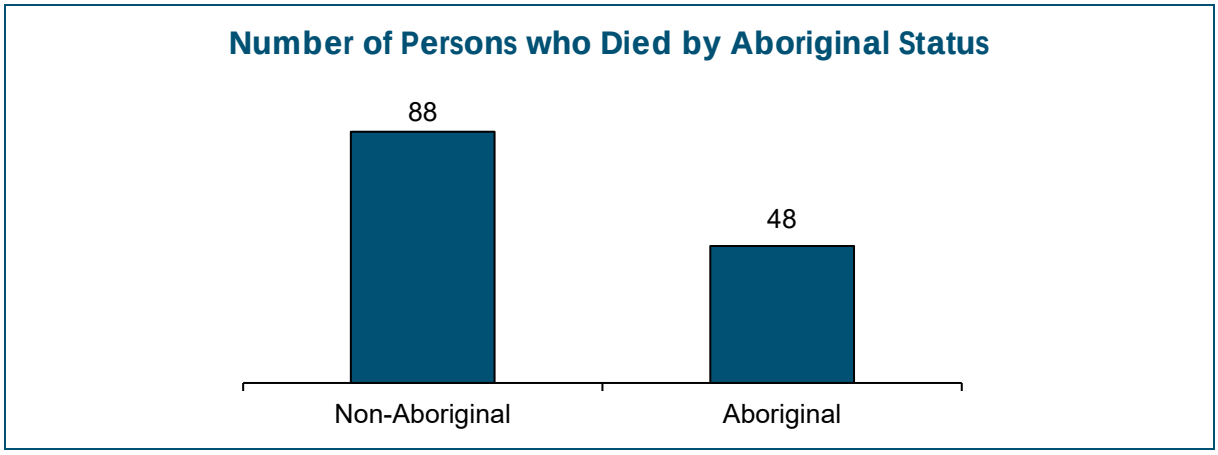
In relation to the 75 females who died, 70 involved a male suspected perpetrator, four involved a female suspected perpetrator, and one involved multiple suspected perpetrators of both genders. Of the 61 men who died, 10 were apparent suicides, 24 involved a female suspected perpetrator, 24 involved a male suspected perpetrator and three involved multiple suspected perpetrators of both genders.

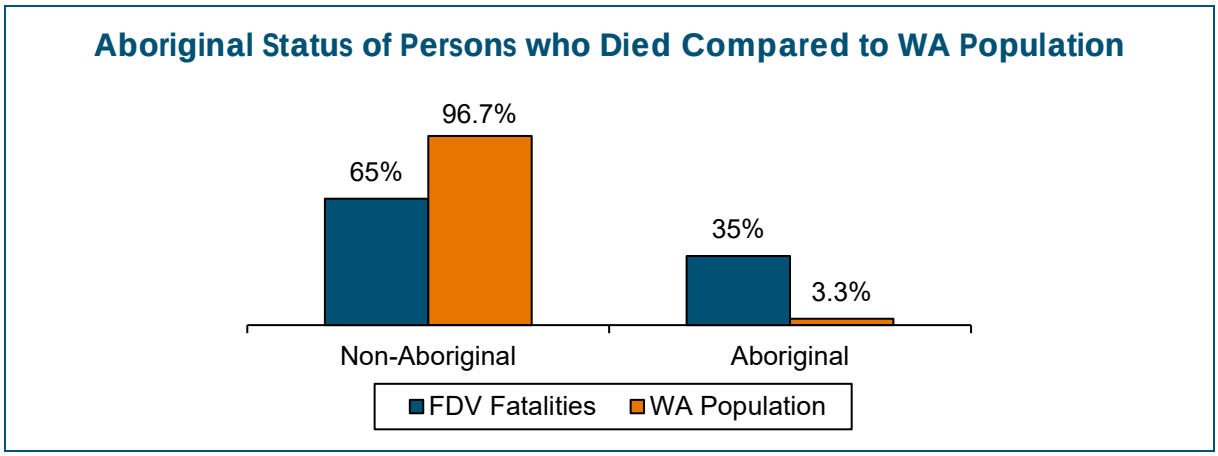
Number of Persons who Died by Age



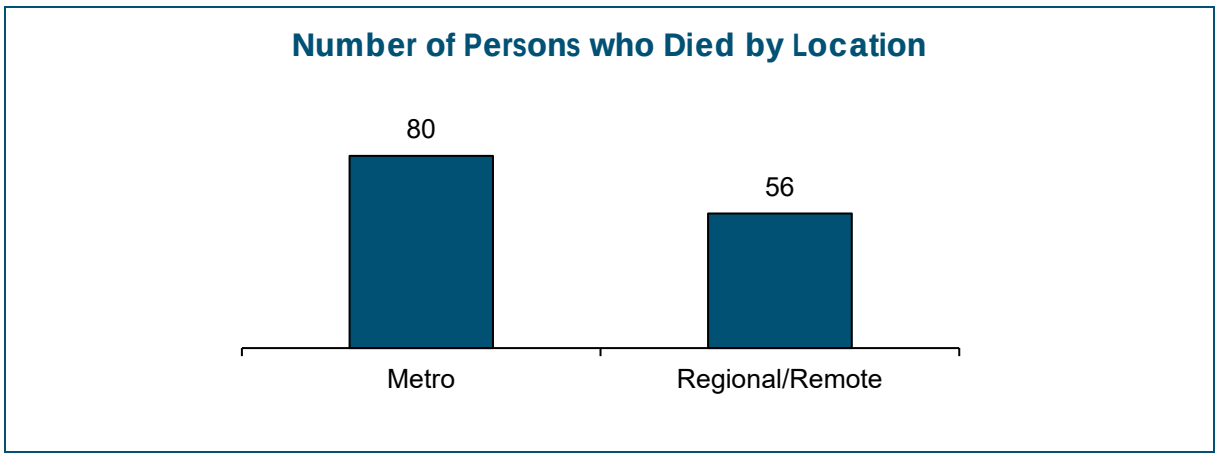


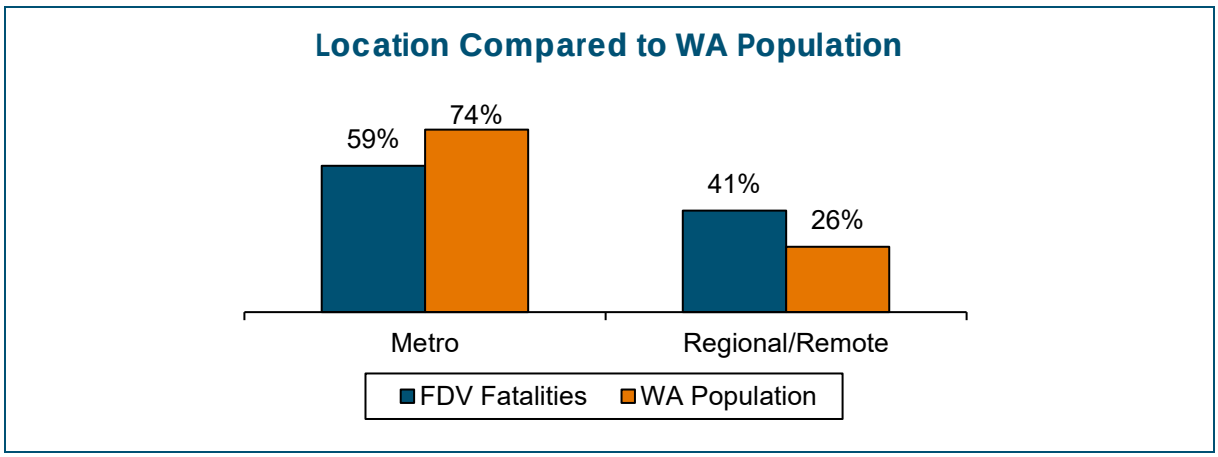
Compared to the Western Australian adult population, the age groups 30-39, 40-49 and 80 and over are over-represented, with 25% of persons who died being in the 30-39 age group compared to 19% of the adult population, 19% of persons who died being in the 40-49 age group compared to 18% of the adult population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





Compared to the Western Australian population, Aboriginal people who died were over-represented, with 35% of people who died in the eight years from 1 July 2012 to 30 June 2020 being Aboriginal compared to 3.3% in the population. Of the 48 Aboriginal people who died, 28 were female and 20 were male.





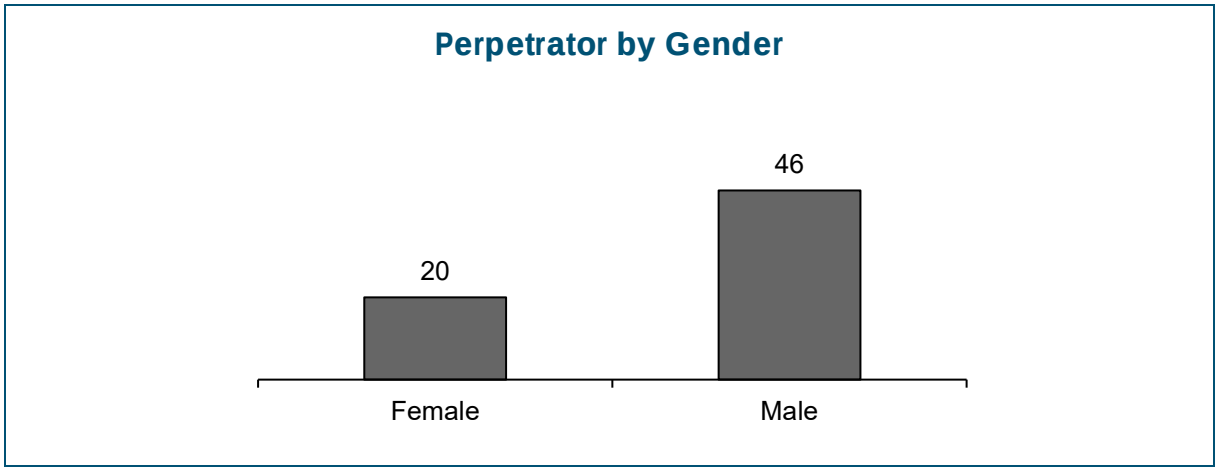
Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 41% of the people who died in the eight years from 1 July 2012 to 30 June 2020 living in regional or remote locations, compared to 26% of the population living in those locations.

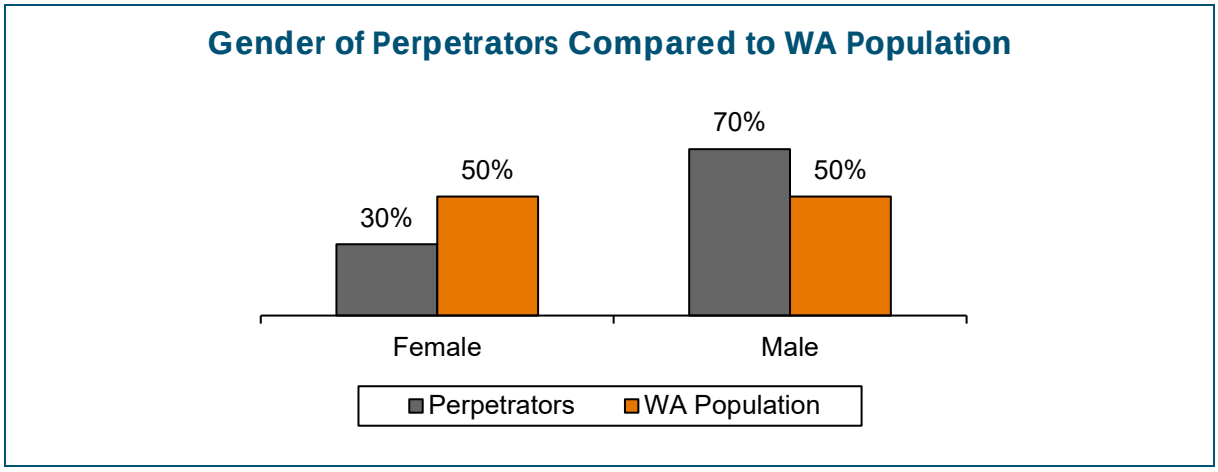
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2020 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2020.

Of the 136 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2020, coronial and criminal proceedings were finalised in relation to 66 perpetrators.

Information is obtained on a range of characteristics of the perpetrator including gender, age group and Aboriginal status. The following charts show characteristics for the 66 perpetrators where both the coronial process and the criminal proceedings have been finalised.

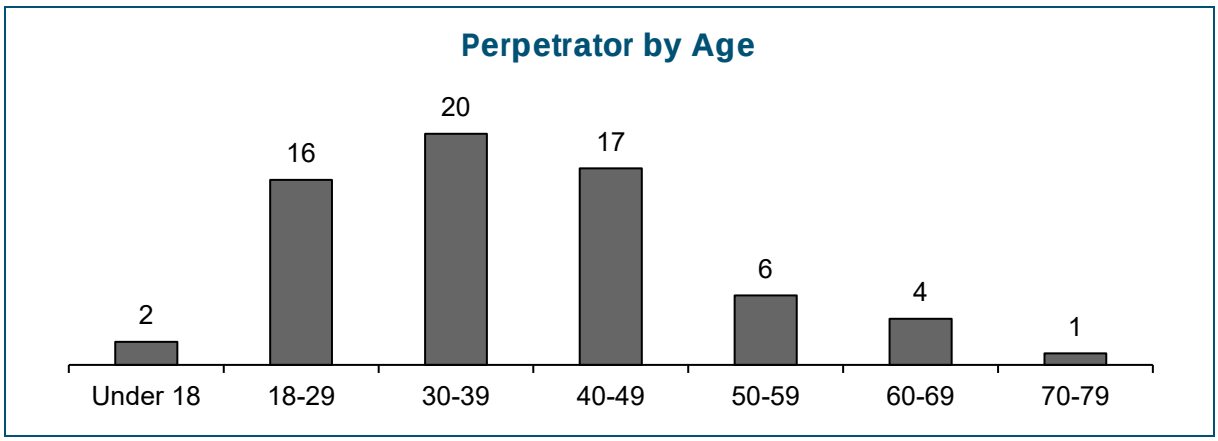


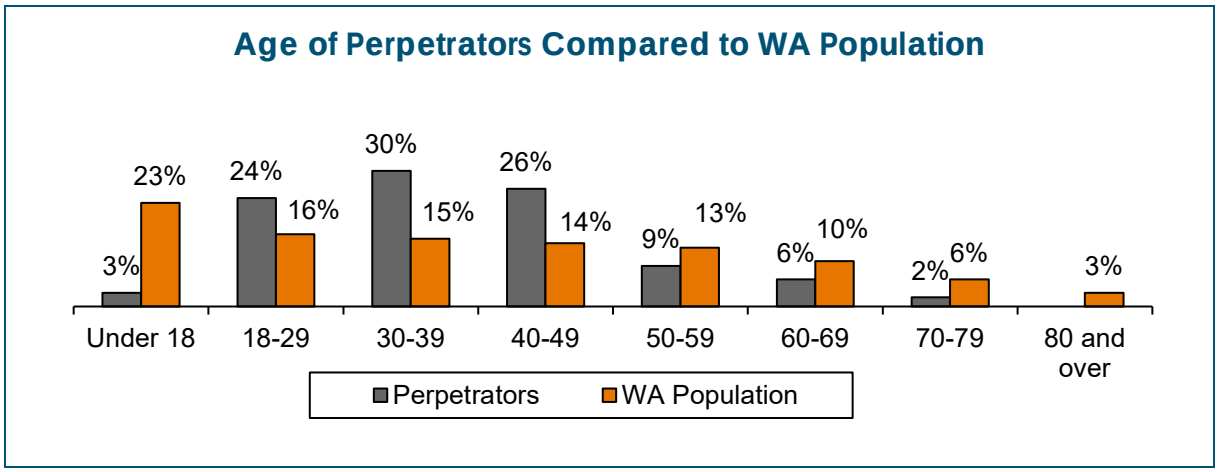


Compared to the Western Australian population, male perpetrators of fatalities in the eight years from 1 July 2012 to 30 June 2020 were over-represented, with 70% of perpetrators being male compared to 50% in the population.

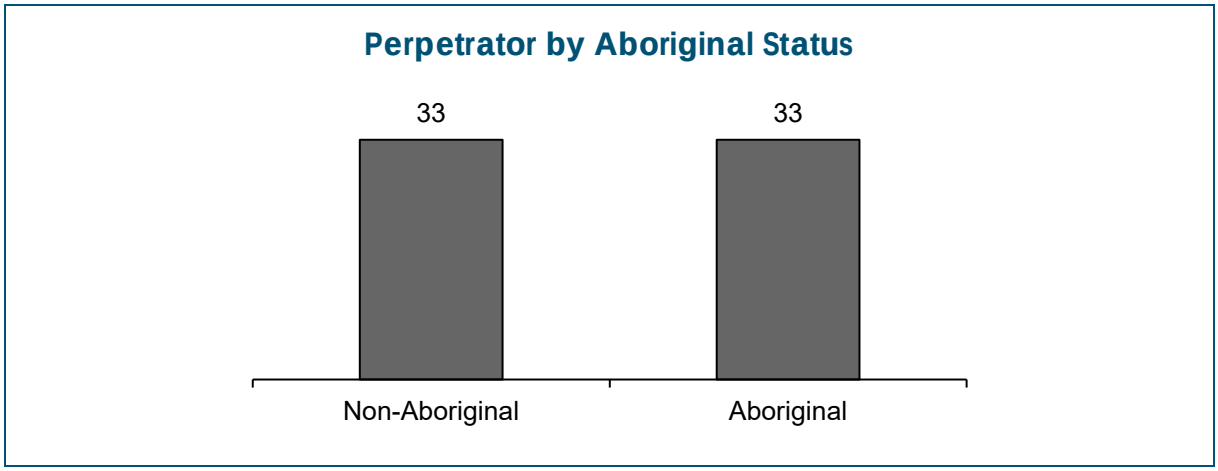
Fourteen males were convicted of manslaughter and 32 males were convicted of murder. Ten females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death and nine females were convicted of murder.

Of the 19 fatalities by the 20 female perpetrators, in 17 fatalities the person who died was male, and in two fatalities the person who died was female. Of the fatalities by the 46 male perpetrators, in 37 fatalities the person who died was female, and in nine fatalities the person who died was male.

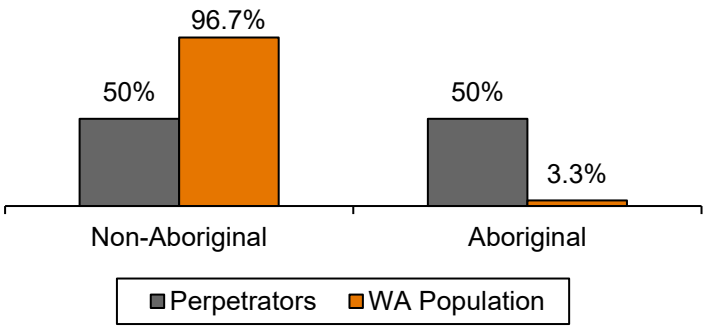




Compared to the Western Australian population, perpetrators of fatalities in the eight years from 1 July 2012 to 30 June 2020 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 24% of perpetrators being in the 18-29 age group compared to 16% in the population, 30% of perpetrators being in the 30-39 age group compared to 15% in the population, and 26% of perpetrators being in the 40-49 age group compared to 14% in the population.



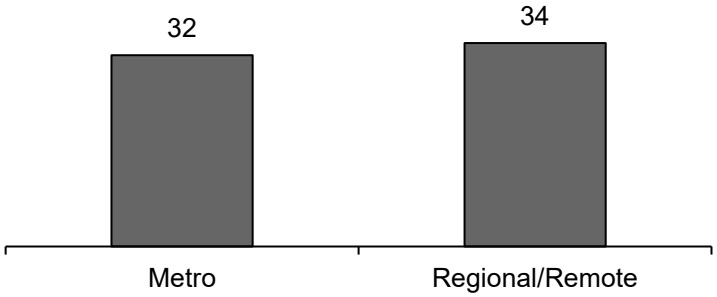
Aboriginal Status of Perpetrators Compared to WA Population



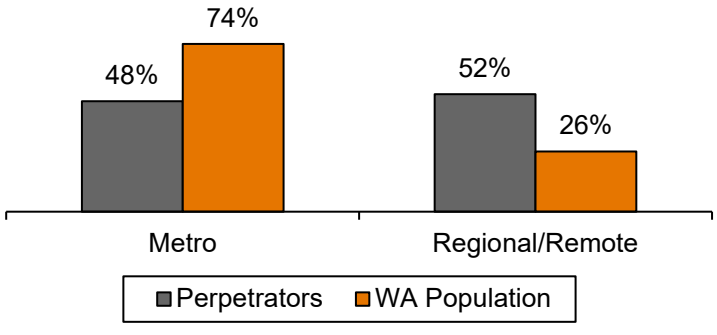
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the eight years from 1 July 2012 to 30 June 2020 were over-represented with 50% of perpetrators being Aboriginal compared to 3.3% in the population.

In 31 of the 33 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location



Perpetrators by Location Compared to WA Population



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

Compared to the Western Australian population, the people who died in the eight years from 1 July 2012 to 30 June 2020, who were living in regional or remote locations, were over-represented, with 52% of the people who died living in regional or remote locations compared to 26% of the population living in those locations.

Circumstances in which family and domestic violence fatalities have occurred

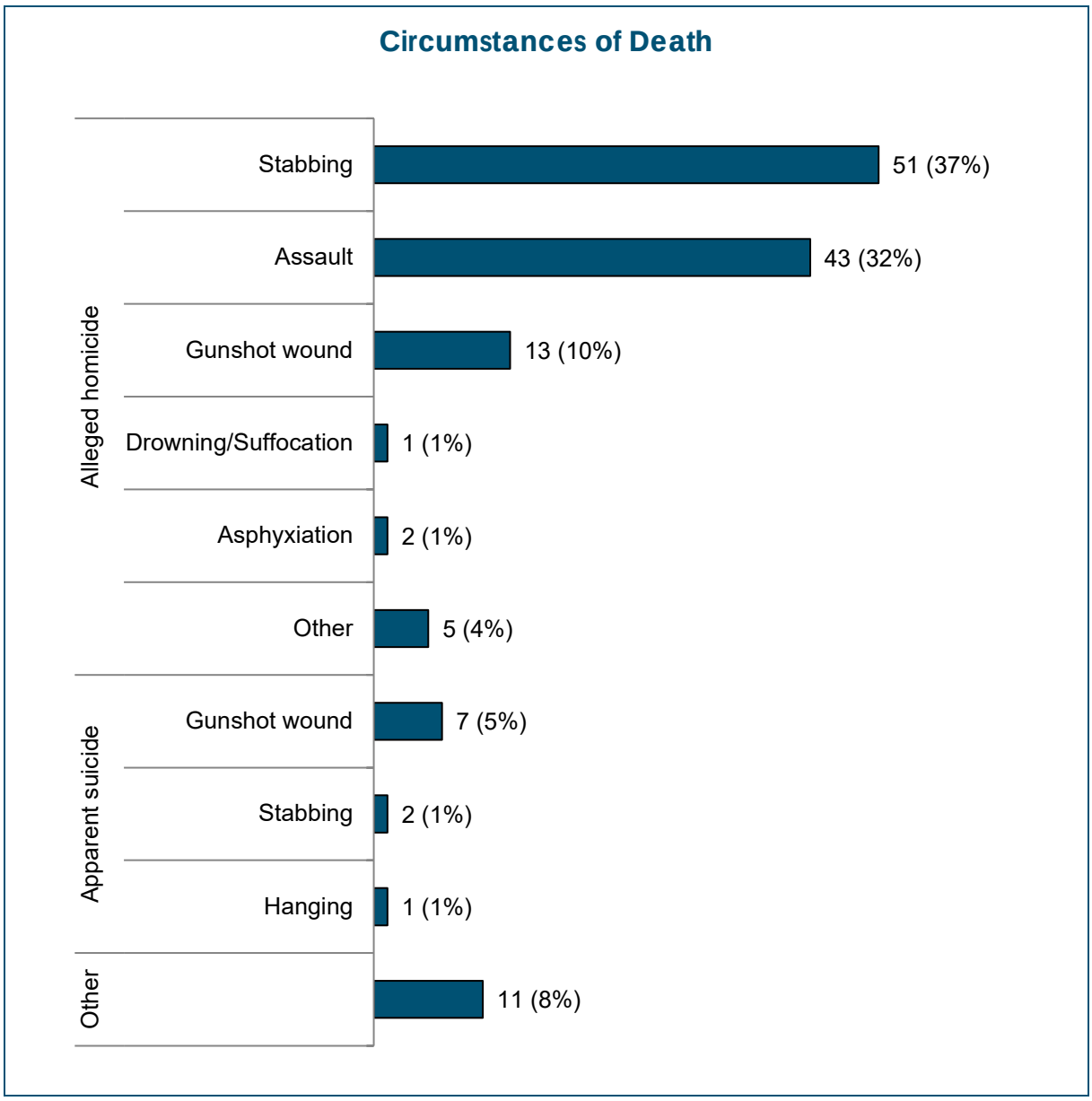
Information provided to the Office by WA Police Force about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

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

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

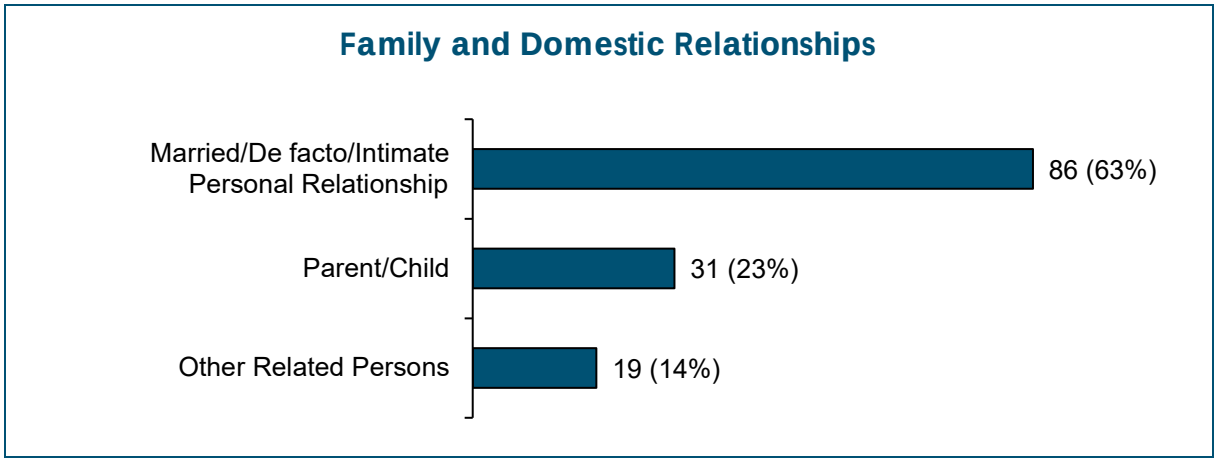
The principal circumstances of death in 2019-20 were alleged homicide by physical assault and stabbing.

The following chart shows the circumstance of death as categorised by the Ombudsman for the 136 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2020.



Family and domestic relationships

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



Of the 136 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2020:

- 86 fatalities (63%) involved a married, de facto or intimate personal relationship, of which there were 74 alleged homicides, eight apparent suicides and four in other circumstances. The 86 fatalities included 14 deaths that occurred in seven cases of alleged homicide/suicide and, in all seven cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. The eighth apparent suicide involved a male. Of the remaining 67 alleged homicides, 47 (70%) of the people who died were female and 20 (30%) were male;
- 31 fatalities (23%) involved a relationship between a parent and adult child, of which there were 23 alleged homicides, two apparent suicides and six in other circumstances. Of the 23 alleged homicides, eight (35%) of the people who died were female and 15 (65%) were male. Of these 23 fatalities, in 16 cases (70%) the person who died was the parent or step-parent and in seven cases (30%) the person who died was the adult child or step-child; and
- There were 19 people who died (14%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, seven (37%) were female and 12 (63%) were male.

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

State policy and planning to reduce family and domestic violence fatalities

The State Strategy states 'Communities is the lead agency coordinating strategy and policy direction in prevention of family and domestic violence in Western Australia'.

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

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

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

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

Type of relationships

The Ombudsman finalised 118 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2020.

For 75 (64%) of the finalised reviews of family and domestic violence fatalities, the fatality occurred between persons who, either at the time of death or at some earlier time, had been involved in a married, de facto or other intimate personal relationship. For the remaining 43 (36%) of the finalised family and domestic violence fatality reviews, the fatality occurred between persons where the relationship was between a parent and their adult child or persons otherwise related (such as siblings and extended family relationships).

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

For the 118 finalised reviews, the circumstances of the fatality were as follows:

- For the 75 intimate partner fatalities, 63 were alleged homicides, eight were apparent suicides, and four were other circumstances; and
- For the 43 non-intimate partner fatalities, 34 were alleged homicides, two were apparent suicides, and seven were other circumstances.

Intimate partner relationships

Of the 63 intimate partner relationship fatalities involving alleged homicide:

- There were 47 fatalities where the person who died was female and the suspected perpetrator was male, one where the person who died was female and there were multiple suspected perpetrators of both genders, 12 where the person who died was male and the suspected perpetrator was female, one where the person who died was male and the suspected perpetrator was male, and two where the person who died was male and there were multiple suspected perpetrators of both genders;
- There were 24 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In 16 of these fatalities the person who died was female and in eight the person who died was male;
- There were 31 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 11 at the residence of the person who died or the residence of the suspected perpetrator, seven at the residence of family or friends, and 14 at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 30 fatalities where the person who died lived in regional and remote areas, and in 21 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 43 non-intimate partner fatalities, there were 28 fatalities involving a parent and adult child and 15 fatalities where the parties were otherwise related.

Of the 34 non-intimate partner fatalities involving alleged homicide:

- There were seven fatalities where the person who died was female and the suspected perpetrator was male, four where the person who died was female and the suspected perpetrator was female, 17 where the person who died was male

and the suspected perpetrator was male, and six where the person who died was male and the suspected perpetrator was female;

- There were nine non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 13 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 14 at the residence of the person who died or the residence of the suspected perpetrator, and seven at the residence of family or friends or in a public place; and
- There were 11 fatalities where the person who died lived in regional and remote areas.

Prior reports of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reports of alleged family and domestic violence between the parties. In 37 (59%) of the 63 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2020, alleged family and domestic violence between the parties had been reported to WA Police Force and/or to other public authorities. In 10 (29%) of the 34 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2020, alleged family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities.

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

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

Of the 47 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, from the records available:

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

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

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

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

Subsequent to this recommendation, Action Item 4 of the First Action Plan intends to '[d]evelop a family and domestic violence dashboard that tracks and reports demand data, to support monitoring and analysis of current and emerging data trends and inform planning'. In relation to data collation about communities over-represented in family and domestic violence, and how this is used to inform evidence-based strategies tailored to addressing family and domestic violence in these communities, the Ombudsman will continue to monitor the implementation and effectiveness of the State Strategy, and First Action Plan for responding to Aboriginal family violence.

Identification of family and domestic violence incidents

Of the 47 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, WA Police Force was the agency to receive the majority of these reports. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, noted that DCPFS may become aware of family and domestic violence through a referral to DCPFS and subsequent assessment through the duty interaction process. Identification of family and domestic violence is integral to the agency being in a position to implement its family and domestic violence policy and processes to address perpetrator accountability and promote victim safety and support. However, the Ombudsman's reviews and own motion investigations continue to identify missed opportunities to identify family and domestic violence in interactions.

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

Provision of agency support to obtain a violence restraining order

Prior to 1 July 2017 in Western Australia, a person who experienced domestic violence by another person, whether or not they were related, could apply to the Magistrates Court for a protection order being a violence restraining order. In July 2017, family violence restraining orders were introduced in Western Australia. A family violence restraining order is governed under the *Restraining Orders Act 1997* and can be used to 'restrain' a 'family member' as defined by the *Restraining Orders Act 1997*.

As identified above, WA Police Force is likely to receive the majority of reports of family and domestic violence. WA Police Force attendance at the scene affords WA Police Force with the opportunity to provide victims with information and advice about:

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

Support to victims in reported incidences of family and domestic violence

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

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

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that WA Police Force had taken steps and/or proposed steps to be taken to give effect to these recommendations. Subsequent to these recommendations, Action Item 13(d) of the First Action Plan indicates the WA Police Force intends to undertake 'comprehensive family violence training that is reported in the WA Police Force Annual Report'. The Office will continue to monitor, and report on, the provision, by WA Police Force, of information and advice regarding family violence restraining orders.

Support to obtain a violence restraining order on behalf of children

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

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

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

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

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that in relation to Recommendations 44, 45, 46 and 47 DCPFS had taken steps and proposed steps to be taken to give effect to all these recommendations. The State Strategy identifies the need to '[s]upport the long-term recovery and wellbeing of children who have experienced family and domestic violence' as a Priority Action. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Support during the process of obtaining a family violence restraining order

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

> Recommendation 14: In developing and implementing future phases of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, DCPFS specifically identifies and incorporates opportunities for state

government departments and authorities to deliver information and advice about violence restraining orders, beyond the initial response by WAPOL.

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

Subsequent to this recommendation, in May 2020, in the context of concerns for increased family and domestic violence during COVID-19 restrictions, new laws were introduced to enable victims of family and domestic violence to apply for family violence restraining orders online through registered legal services which provide family violence assistance. This action is intended to make it more convenient and less stressful for victims to obtain family violence restraining orders.

The State Strategy identifies that victims of family and domestic violence 'often need information, social support and legal advice on a range of issues such as…restraining orders. Actions under the Strategy will focus on making this available at an early stage to support people's safety and wellbeing and help them make informed choices'. Action Item 17 of the First Action Plan intends to '[e]xplore options to improve early access to legal advice for victims and perpetrators of family and domestic violence'.

Support when a family violence restraining order has not been granted

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

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

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

Provision of support to victims experiencing family and domestic violence

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

> The purpose of risk assessment is to determine the risk and safety for the adult victim and children, taking into consideration the range of victim and perpetrator risk factors that affect the likelihood and severity of future violence.
>
> Risk assessment must be undertaken when family and domestic violence has been identified…

Risk assessment is conducted for a number of reasons including:

- evaluating the risk of re-assault for a victim;
- evaluating the risk of homicide;
- informing service system and justice responses;
- supporting women to understand their own level of risk and the risk to children and/or to validate a woman's own assessment of her level of safety; and
- establishing a basis from which a case can be monitored.

(pages 36-37)

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

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

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to all these recommendations. Subsequent to these recommendations, Action Item 12 of the First Action Plan intends to update the *Common Risk Assessment and Risk Management Framework* to '[s]trengthen approaches to risk management and information sharing'. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 37 (59%) of the 63 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2020, prior family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities. The Ombudsman's reviews identify where perpetrators have a history of reported violence, with one or more partners, and examines steps taken to hold perpetrators to account for their actions and support them to cease their violent behaviours, in accordance with the intent of the former State Strategy.

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

Fatalities with no prior reported family and domestic violence

Based on the information available to the Office, in 26 (41%) of the 63 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2020, the fatal incident was the only family and domestic violence between the parties that had been reported to WA Police Force and/or other public authorities. It is important to note, however, research indicating under-reporting of family and domestic violence. The Australian Bureau of Statistics' *Personal Safety Survey 2016* (www.abs.gov.au) collected information about help seeking behaviours, noting that:

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

and

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

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

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

Family violence involving Aboriginal people

Of the 118 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2020, Aboriginal Western Australians were over-represented, with 37 (31%) persons who died being Aboriginal. In all but two cases, the suspected perpetrator was also Aboriginal. There were 27 of these 37 fatalities where the person who died lived in a regional or remote area of Western Australia, of which 21 were intimate partner fatalities.

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

Contextual factors for family violence involving Aboriginal people

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

> …violence against women within the Indigenous Australian communities need[s] to be understood within the specific historical and cultural context of colonisation and systemic disadvantage. Any discussion of violence in contemporary Indigenous communities must be located within this historical context. Similarly, any discussion of "causes" of violence within the community must recognise and reflect the impact of

colonialism and the indelible impact of violence perpetrated by white colonialists against Indigenous peoples

… A meta-evaluation of literature…identified many "causes" of family violence in Indigenous Australian communities, including historical factors such as: collective dispossession; the loss of land and traditional culture; the fragmentation of kinship systems and Aboriginal law; poverty and unemployment; structural racism; drug and alcohol misuse; institutionalisation; and the decline of traditional Aboriginal men's role and status - while "powerless" in relation to mainstream society, Indigenous men may seek compensation by exerting power over women and children...

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

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

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

(Blagg, H, Bluett-Boyd, N and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 13).

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

This research report undertakes a critical inquiry into responses to family violence in a number of remote communities from the perspective of Aboriginal people who either work within the family violence space or have had experience of family violence. It explicitly foregrounds Indigenous knowledge of family violence, arguing that Indigenous knowledge departs from what we call in this report "mainstream knowledge" in a number of critical respects. The report is based on qualitative research in three sites in Australia: Fitzroy Crossing (Western Australia), Darwin (Northern Territory), and Cherbourg (Queensland). It supports the creation of a network of regionally based Indigenous family violence strategies owned and managed by Indigenous people and linked to initiatives around alcohol reduction, intergenerational trauma, social and emotional wellbeing, and alternatives to custody. The key theme running through our consultations was that innovative practice must be embedded in Aboriginal law and

> culture. This recommendation runs counter to accepted wisdom regarding intervention in family and domestic violence, which tends to assume that gender trumps other differences, and that violence against women results from similar forms of oppression, linked to gender inequalities and patriarchal forms of power. While not disputing the role of gender and coercion in underpinning much violence against Indigenous women, we, nonetheless, claim that a distinctively Indigenous approach to family violence necessitates exploring causal factors that reflect specifically Indigenous experiences of colonisation and its aftermath. (page 9)

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

A separate strategy to prevent and reduce Aboriginal family violence

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

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

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

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

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

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

> Recommendation 4: DCPFS, as the lead agency responsible for family and domestic violence strategic planning in Western Australia, develops a strategy that is specifically tailored to preventing and reducing Aboriginal family violence, and is linked to, consistent with, and supported by *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*.

> Recommendation 6: In developing a strategy tailored to preventing and reducing Aboriginal family violence, referred to at Recommendation 4, DCPFS actively invites and encourages the involvement of Aboriginal people in a full and active way at each stage and level of the process, and be comprehensively informed by Aboriginal culture.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to these recommendations. Subsequent to these recommendations, Action Item 5 of the First Action Plan intends to '[c]o-design the Aboriginal Family Safety Strategy with Aboriginal people and communities'. This Office will continue to monitor the implementation of this action item.

Limited use of violence restraining orders

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

In the report, the Ombudsman recommended that:

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

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DOTAG had taken steps and proposed steps to be taken to give effect to this recommendation. Subsequent to this recommendation, Action Item 25 of the First Action Plan intends to '[d]evelop a Department of Justice Aboriginal Family Safety Strategy'. The Office will continue to monitor, and report on, the steps being taken to implement this action item.

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

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

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

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

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

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

In the report, the Ombudsman recommended that:

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

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

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

Of the 37 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2020 involving Aboriginal people, 27 (73%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Sixteen (43%) of the Aboriginal people who died lived in the Kimberley region, which is home to 1.4% of all people and 19% of Aboriginal people in the Western Australian population.

As outlined above, *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to Recommendations 4 and 6 of the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015. These recommendations related to DCPFS developing 'a strategy that is specifically tailored to preventing and reducing Aboriginal family violence' that would encompass all regions of Western Australia and would ensure actively inviting and encouraging 'the involvement of Aboriginal people in a full and active way at each stage and level of the process' and being 'comprehensively informed by Aboriginal culture'. Subsequent to these recommendations, Item 5 of the First Action Plan intends to '[c]o-design the Aboriginal Family Safety Strategy with Aboriginal people and communities'.

Factors co-occurring with family and domestic violence

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

Co-occurrence with alcohol and other drug use

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

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

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

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

On the information available, relating to the 97 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2020, the Office's reviews identify where alcohol use and/or drug use are factors associated with the fatality, and where there may be a history of alcohol use and/or drug use.

	ALCOHOL USE		DRUG USE	
	Associated with fatal event	Prior history	Associated with fatal event	Prior history
Person who died only	4	5	3	8
Suspected perpetrator only	6	14	13	16
Both person who died and suspected perpetrator	31	33	10	16
Total	**41**	**52**	**26**	**40**

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

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

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

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

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

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

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

Co-occurrence of mental health issues

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

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

and

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

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

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

Case Study

Mr B fatally assaulted his intimate partner, Ms Y. Mr B has been convicted of murder. The WA Police Force and Communities had received multiple reports of family and domestic violence involving Mr B and Ms Y, and there had been associated intervention by the Family and Domestic Violence Response Team. The Ombudsman's review examined actions taken by the Family and Domestic Violence Response Team to assess Mr B's risk of violence and the development of an associated safety plan, and made the following recommendation:

> Within three months of the finalisation of this review, Communities provides a report to the Ombudsman outlining Communities' plan for monitoring and evaluation the Family and Domestic Violence Response Team function and operation to ensure this service is providing an efficient, effective and collaborative response to families impacted by family and domestic violence, is improving victim safety, and is addressing perpetrator accountability.

Issues Identified in Family and Domestic Violence Fatality Reviews

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

It is important to note that:

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

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

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following two recommendations were made by the Ombudsman in 2019-20 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. Within three months of the finalisation of this review, Communities provides a report to the Ombudsman outlining Communities' plan for monitoring and evaluation the Family and Domestic Violence Response Team function and operation to ensure this service is providing an efficient, effective and collaborative response to families impacted by family and domestic violence, is improving victim safety, and is addressing perpetrator accountability.
2. DOJ provides the Ombudsman with a report by 31 July 2020, that outlines, for the period 1 July 2019 to 30 June 2020:
    - The number of offenders who were sentenced for offences that occurred in the context of family and domestic violence;
    - How many of these offenders were assessed as eligible and recommended for family and domestic violence rehabilitation intervention (individual or group); and
    - How many of these offenders who were recommended for family and domestic violence rehabilitation intervention have since completed the intervention (individual or group).

The Ombudsman's *Annual Report 2020-21* will report on the steps taken to give effect to the two recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2018-19. The Ombudsman's *Annual Report 2021-22* will report on the steps taken to give effect to the two recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2019-20.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2017-18

The Ombudsman made nine recommendations about ways to prevent or reduce family and domestic violence fatalities 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: DOJ develops a family and domestic violence policy to direct and co-ordinate its commitment to achieving the Primary State Outcomes of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022*. Further, the family and domestic violence policy identifies the needs of Aboriginal people and includes specifically tailored strategies for preventing and reducing Aboriginal family violence which are linked to, and consistent with, *Western Australia's Family and Domestic Violence Prevention Strategy to 2022*.

Steps taken to give effect to the recommendation

This Office requested that DOJ inform the Office of the steps taken to give effect to the recommendation (It is noted that the *Western Australia's Family and Domestic Violence Prevention Strategy to 2022* that was in place at the time this recommendation was made, has since been rescinded. A new State Strategy: *10 Year Strategy for Reducing Family and Domestic Violence* is being developed). In response, DOJ provided a range of information in a letter to this Office dated 29 April 2020, containing a report prepared by DOJ.

In DOJ's report, DOJ relevantly informed this Office that:

> The Department has taken steps to give effect to the recommendation.
>
> The Department is in the process of developing an over-arching Family and Domestic Violence (FDV) Strategy (the Strategy) to achieve a more coordinated, integrated and evidence-based approach to FDV within the Department and the justice system.
>
> The aim of the Strategy is to:
> - create space to reflect on what we do, why we do it and whether it works;
> - identify the Department's priorities in the face of numerous competing external demands;
> - instill an evidence-based approach to FDV within the justice system;
> - become a key reference point for the Department when deciding how to allocate resources, how to respond to external stakeholder requests and how to navigate changes in Government policy at the State and Federal level;
> - constitute a public statement of values that neatly captures the Department's approach to FDV;
> - provide a mechanism for monitoring achievements and measuring success; and
> - contribute to a reduction in FDV offending and improved community safety outcomes.
>
> As part of the Department's commitment to Aboriginal self-determination and reconciliation, the Department will also develop a separate Aboriginal Family Safety Strategy. This work is being led by the Aboriginal Services Directorate within Strategic Reform and will dovetail with the overarching Strategy. The timeframe is yet to be determined, however, an Assistant Director Aboriginal Inclusion has been appointed to lead this work and has recently commenced.
>
> Subject to the COVID-19 situation, the Department intends that the overarching Strategy will be finalised by the end of 2020, taking into account:
> - the forthcoming State 10 Year FDV Strategy;
> - the Commonwealth's Fourth Action Plan under the National Plan to Reduce Violence Against Women (August 2019);

- the Commonwealth Government's response to the Australian Law Reform Commission's Family Law System Inquiry (March 2019); and
- the Legislative Assembly's Community Development and Justice Standing Committee's: *Inquiry into the Magistrates Court of Western Australia's Management of Matters involving Family and Domestic Violence* (due to report on 13 August 2020).

Further, in DOJ's report, DOJ relevantly informed this Office of the actions that had been taken to date, and are proposed, to implement this recommendation including that:

> In 2018, the Department established an internal working group to oversee the Strategy. The working group was refreshed in early 2020 and replaced by an FDV Steering Committee. According to the new Terms of Reference, the FDV Steering Committee will:
>
> 1) oversee the development and implementation the Strategy;
> 2) support the development of the Aboriginal Family Safety Strategy; and
> 3) serve as a forum for other FDV-related matters.
>
> From 2019 until present, the Department has undertaken the following steps towards delivery of the Strategy:
>
> - Completed a detailed mapping of all existing FDV-related projects, initiatives and services across the Department, including election commitments, legislative and non-legislative policy initiatives;
> - Conducted joint consultation with women prisoners in May 2019 (in the metropolitan area) with the Department of Communities, including Aboriginal and non-Aboriginal focus groups, to inform both the Strategy and the State 10 Year FDV Strategy;
> - Actively participated in the Reference Group for the development of the State 10 Year FDV Strategy (a key input for the Strategy);
> - Coordinated WA's participation in the Council of Attorneys-General Family Violence Working Group (another input for the Strategy) including four projects aimed at increasing integration between the child protection, family law and state courts involved in FDV matters;
> - Progressed a number of Government election commitments relating to FDV, all of which are key inputs for the Strategies referred to above; and
> - Recruited (and is in the process of recruiting) additional resources to deliver both Strategies referred to above.

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

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

Steps taken to give effect to the recommendation

This Office requested that DOJ inform the Office of the steps taken to give effect to the recommendation. In response, DOJ provided a range of information in a letter to this Office dated 29 April 2020, containing a report prepared by DOJ.

In DOJ's report, DOJ relevantly informed this Office that:

The Department has fully implemented the recommendation.

In early 2019, the Department successfully completed an IT project to transfer the police-initiated 'FDV flag' from the Integrated Courts Management System (ICMS) into the two main Corrective Services databases: the Total Offender Management System (TOMS) and the Community Business Information System (CBIS).

As of April 2020, the FDV flag will have been in place in both databases for a period of 12 months. The Department is now in the process of producing reports based on 12 months' worth of data to inform both FDV Departmental strategies (referred to in the above recommendation) and to assist with future management and rehabilitation of FDV offenders.

The FDV flag has also been added to the Department's *Corrective Services Reporting Portal* - a data dashboard launched in late 2019 that provides all staff with access to up to date statistical reports on offenders in custody and community corrections.

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

Recommendation 3: DOJ considers, as part of its current review into prisoner management, the management of prisoners serving an effective sentence of six months or less for an offence that occurred in the context of family and domestic violence who have been identified as a high risk of re-offending and develops strategies to promote perpetrator accountability and support these prisoners to cease their violent behaviour.

Steps taken to give effect to the recommendation

This Office requested that DOJ inform the Office of the steps taken to give effect to the recommendation. In response, DOJ provided a range of information in a letter to this Office dated 29 April 2020, containing a report prepared by DOJ.

In DOJ's report, DOJ relevantly informed this Office that:

The Department has taken steps to give effect to the recommendation.

As stated in the response to the [name deleted] fatality review, the Department is committed to identifying the most appropriate strategies for this cohort of prisoners which would promote accountability and support them to cease their violent behaviour.

Consideration has been given to this recommendation, however, the Department's immediate priority remains addressing the backlog of assessments for prisoners with a sentence longer than six months. As such, it is not viable at this time to increase the scope of assessments to include sentences of less than six months.

However, the Department is driving a number of longer-term justice reform initiatives that will assist in the management of this cohort [those prisoners serving an effective sentence of less than six months] and address some of the underlying drivers for short-term custody, such as the Parole In-reach Program, which will assist prisoners on short-term sentences (including FDV offenders) in accessing programs and securing parole, where it is safe to do so.

There also continue to be a number of voluntary services that are available to people on short-term sentences and remand across the State, facilitated by the Transitional

Managers at each site. This includes post-release referrals to residential facilities addressing FDV perpetration.

At the strategic level, the Department continues to explore options for the management of FDV offenders on short sentences and will incorporate this issue into the Strategies referred to above.

Further, in DOJ's report, DOJ relevantly informed this Office of the actions that had been taken to date to implement this recommendation including that:

The Department has taken the following steps to identify appropriate strategies for prisoners serving a sentence of six months or less for an offence that has occurred in the context of FDV:

- In August 2019, the Department completed an environmental scan of the effectiveness of correctional and throughcare programs offered to FDV offenders in custody for six months or less (finding that there is very limited evidence on effective interventions);
- In 2019, the Department commenced implementation of the Justice Reform Projects which aim to address and interrupt some of the underlying drivers of short-term custodial sentences, and increase access to rehabilitative programs, including for FDV offenders (funded in the 2019/2020 State Budget);
- In early 2020, the Department completed a review of the criminogenic program suite, which included consideration of interventions for short-term prisoners.

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

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

Steps taken to give effect to the recommendation

This Office requested that DOJ inform the Office of the steps taken to give effect to the recommendation. In response, DOJ provided a range of information in a letter to this Office dated 29 April 2020, containing a report prepared by DOJ.

In DOJ's report, DOJ relevantly informed this Office that:

The Department has taken steps to give effect to the recommendation.

The Department has provided previous quarterly updates to the Ombudsman on: 28 March 2017; 2 August 2018; and 11 January 2019.

The Department has been working to improve its FDV information release and sharing policies through the following projects:

- Collaboration with the Department of Communities and WA Police Force on the creation of a central secure database to share risk-relevant information about FDV perpetrators between Government agencies, including Corrective Services, and the Courts;

- Coordination of WA's participation in the development of the Commonwealth's 'National Family Violence Information Sharing Framework' (via the Council of Attorneys-General (CAG) Family Violence Working Group) to be operationalised by the end of 2020. The Framework - which includes corrections and youth justice information - is being developed in response to the Australian Law Reform Commission's Family Law System Inquiry (March 2019), and will improve information sharing between the Family Court of Western Australia, the child protection system, and other State Courts hearing family violence matters - to promote the safety of women and children; and
- The Electronic Monitoring trial for high risk FDV offenders currently being rolled out will also support enhanced information sharing between the Department, particularly Corrective Services, and Western Australia Police Force. The trial will increase victim safety by facilitating GPS tracking of high-risk FDV offenders who breach a Family Violence Restraining Order (FVRO) with a further act of family violence.

The role of the *Tripartite Schedule between the Department of Child Protection and Family Support, the Department of Corrective Services and Western Australia Police (August 2013)* is being reconsidered in the context of the above projects and the review will be progressed as part of the FDV Strategy. Legislative amendments to the *Children and Community Services Act 2004* (WA) in January 2016 have superseded some aspects of the Tripartite Schedule.

Further, in DOJ's report, DOJ relevantly informed this Office of the actions that had been taken to date to implement this recommendation including that:

The Department has taken the following steps to improve its information release and sharing policies to promote the safety of FDV victims:

- Attended executive meetings with the Department of Communities and WA Police Force in early 2020 regarding the creation of a risk-management information sharing framework for perpetrators and provided input to a forthcoming inter-agency workshop;
- Coordinated WA's participation in the development of the Commonwealth's 'National Information Sharing Framework' (see Council of Attorneys General decisions and communiques - June 2019 and November 2019);
- Commenced preparations for the Electronic Monitoring trial for high risk FDV offenders (see 2019/2020 State Budget allocation; recruitment of Project Manager and other resources in 2019; and recent passage of the *Family Violence Legislation Reform (COVID-19 Response) Act 2020* (WA) containing amendments to the Sentencing Act 1995 (WA) to support the trial, enacted on 7 April 2020).

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

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

Steps taken to give effect to the recommendation

This Office requested that DOJ inform the Office of the steps taken to give effect to the recommendation. In response, DOJ provided a range of information in a letter to this Office dated 29 April 2020, containing a report prepared by DOJ.

In DOJ's report, DOJ relevantly informed this Office that:

> The Department has taken steps to give effect to the recommendation.
>
> The Department has provided previous quarterly updates to the Ombudsman on: 28 March 2017; 2 August 2018; and 11 January 2019.
>
> The Department has established a project to improve timeframes for completion of Individual Management Plans (IMPs) and Treatment Assessments, led by the IMP Project Steering Committee. Subject to the COVID-19 crisis, the IMP Project is intended to reduce the backlog of IMPs and ensure that prisoners (including FDV perpetrators) are referred to appropriate treatment programs. This is being supported by increased clinical oversight of the assessment process.
>
> The Department is also currently implementing a dedicated FDV screening tool to assist with determining treatment needs for offenders in the community and custodial settings (the Domestic Violence Screening Instrument - Revised (DVSI-R)). Further details are provided below under Recommendation 6. Use of a dedicated FDV tool has the potential to further enhance data collection. Subject to the COVID-19 crisis, the Department proposes to commence the roll-out of the DVSI-R in adult custodial settings by mid-2020.
>
> The Department has also developed a specific criminogenic program for young FDV offenders at Banskia Hill Detention Centre. The comprehensive 'Disrupting Family Violence (Youth)' program and evaluation package was developed in 2019 in collaboration with international expert, Mr Ken McMaster, and is currently awaiting sufficient suitable candidates.
>
> At the strategic level, the Department is also focusing on improving the overall quality and effectiveness of its FDV programs in community and custodial settings. For example:

- An 'FDV Program Evaluation Framework ' has been developed (updated in 2019) in consultation with Stopping Family Violence Inc - the peak body in WA for Men's behaviour change programs - to optimise all FDV programs being facilitated by the Department and contracted NGO services, and ensure that the Department is delivering a product that is addressing offending behaviour and reducing recidivism.
- As a result of the 2019 Criminogenic Program Review referred to above, the Department will undertake a more comprehensive and specific review of its suite of FDV programs; and
- Investment in the interim will be focused on the Not Our Way (NOW) program for Aboriginal adult male FDV offenders, including completion of a process evaluation that commenced in November 2019 (working with Aboriginal men in regional areas to evaluate the program content and ensure it is culturally sound).

Further, in DOJ's report, DOJ relevantly informed this Office of the actions that had been taken to date to implement this recommendation including that:

> The Department has taken the following steps towards improving the rates of prisoners assessed for and accessing FDV programs:
> - Implementation of the FDV Flag within Corrections databases in 2019 to assist with data collection;
> - IMP Project Steering Committee established in 2019; temporary additional staff (eight treatment assessors, one education assessor and one assessment writer) have been engaged and extended to mid-2020; 10 public service staff commenced in November 2019 to provide additional support;
> - Development and implementation of the 'DVSI-R' screening tool - pilot conducted in 2019 in East Perth and Peel Community Corrections branches; and
> - Development of the FDV criminogenic 'Disrupting Family Violence' program and evaluation package for young FDV offenders at Banksia Hill Detention Centre in 2019.

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

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

Steps taken to give effect to the recommendation

This Office requested that DOJ inform the Office of the steps taken to give effect to the recommendation. In response, DOJ provided a range of information in a letter to this Office dated 29 April 2020, containing a report prepared by DOJ.

In DOJ's report, DOJ relevantly informed this Office that:

> The Department has taken steps to give effect to the recommendation.

The Department has provided previous quarterly updates to the Ombudsman on: 28 March 2017; 2 August 2018; and 11 January 2019.

The Department undertook a detailed review of FDV risk screening tools in 2018/19 and recommended use of the DVSI-R for the purpose of FDV screening and assessment in custody and community.

A decision was made to undertake a staged implementation of the DVSI-R.

The new DVSI-R tool is being implemented with the aim of better identifying risk of future harm and better tailoring FDV treatment needs to offenders. In particular the DVSI-R tool aims to identify:

- the likelihood of reoffending (both 'general' and FDV-related);
- the likelihood of further FDV behaviour (not just recidivism);
- potential for harm to a known victim or other victims;
- targets for treatment; and
- actions required to manage risk.

A pilot commenced in early 2019 with participants from the Family Violence List and then expanded to include Adult Community Corrections branches in East Perth and Peel. Subject to the unfolding COVID-19 situation, the Department plans to commence roll-out of the DVSI-R into all adult custodial facilities by mid-2020.

Further, the Department has increased clinical supervision and training for those conducting treatment assessments, to ensure accurate identification of FDV treatment needs at the point of assessment that are endorsed and monitored under a stronger clinical framework.

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

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

Steps taken to give effect to the recommendation

This Office requested that DOJ inform the Office of the steps taken to give effect to the recommendation. In response, DOJ provided a range of information in a letter to this Office dated 29 April 2020, containing a report prepared by DOJ.

In DOJ's report, DOJ relevantly informed this Office that:

The Department has taken steps to give effect to the recommendation.

The Department has provided previous quarterly updates to the Ombudsman on: 28 March 2017; 2 August 2018; and 11 January 2019.

The Department developed the Family Violence Legislation Reform Bill 2019 (WA), which was introduced to Parliament on 27 November 2019 and subsequently passed by Parliament on 25 June 2020. The *Family Violence Legislation Reform Act 2020*

(WA) amends nine pieces of legislation across six Ministerial portfolios to improve safety outcomes for FDV victims. The Act includes amendments to the:

- *Restraining Orders Act 1997* (WA) to enhance victim safety and make it easier for victims to obtain protection from violence, through online FVRO applications and SMS notification to victims once an FVRO has been served;
- *Sentence Administration Act 2003* (WA) to require the Prisoners Review Board (the Board) to consider imposing an electronic monitoring requirement as part of a parole order or a re-entry release order (RRO) if a prisoner has been serving imprisonment for a family violence offence and the prisoner is a declared serial family violence offender; and
- *Sentencing Act 1995* (WA) to allow for improved locational tracking and electronic monitoring of high-risk offenders (supporting the Electronic Monitoring trial referred to above under Recommendation 4).

These amendments will assist in promoting the safety of FDV victims and the community.

In addition to the proposed amendments contained in the Act, the Department's Victim Notification Register (VNR) provides information about the management of an offender to FDV victims once the offender is under the supervision of the Corrective Services. (The eligibility criteria for joining the VNR were significantly expanded for FDV victims in June 2017 via the *Restraining Orders* and *Related Legislation Amendment (Family Violence) Act 2016* (WA)).

The Department will also give further consideration to this recommendation as part of the development and implementation of the Departmental Strategies

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

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

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 Communities' report, Communities relevantly informed this Office that:

This recommendation has been actioned

Family and Domestic Violence Response Teams Review and Redesign Project
Communities is reviewing and redesigning the Family and Domestic Violence Response Teams (FDVRT).

The FDVRT review will focus on eight areas which have been devised by the Planning Group and are based on known issues and feedback from stakeholders, including the Ombudsman's Office. Area 6 comprises 'Connections to Aboriginal communities', including:

a) To what extent are Aboriginal Community Controlled Organisations involved with FDVRTs?
b) Is the FDVRT model meeting the needs of Aboriginal people?
c) How effective is the FDVRT model in meeting the needs of remote Aboriginal communities?

Department of Communities Voluntary Action

Communities will consider the below voluntary actions to inform the FDVRT Review and Redesign Project:

- Recording: provision to record 'outcomes' in the FVIR from partner agencies, following responses to victims and perpetrators of family and domestic violence;
- Assessment: targeted training for FDVRT partner agencies to improve compliance with the assessment processes within the Common Risk Assessment Risk Management Framework;
- Staffing: a fulltime position across the state for all Community Response Services;
- Multi Agency Case Management: all FVIR assessed as Category 1 will be considered for a MACM to manage levels of risk to the adult and child victim; and
- *FDVRT Operating procedures*: clearer direction in relation to the roles and responsibilities, particularly the role of the SCPW-FDV as representing Communities in the FDVRT.

It is noted that in the context of another Ombudsman family and domestic violence fatality review, Communities informed this Office, in a letter dated 9 October 2019, that '[t]he adequacy and functionality of the FVIR Triage Application overall, including its capability to capture and report on critical information including cultural background, will be considered as part of the review of the FDVRTs'.

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

Recommendation 9: Communities provides the Ombudsman with a report on the steps taken to give effect to Recommendations 4, 5 and 6 [made in November 2015, as set out below] of the Ombudsman's major own motion investigation report *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* by [nominated date].

Recommendation 4

The Department, as the lead agency responsible for family and domestic violence strategic planning in Western Australia, develops a strategy that is specifically tailored to preventing and reducing Aboriginal family violence, and is linked to, consistent with, and supported by *Western Australia's Family and Domestic Violence Prevention strategy to 2022: Creating Safer Communities.*

Recommendation 5

The Department, in developing the Aboriginal family violence strategy referred to at recommendation 4, incorporates strategies that recognise and address the co-occurrence of alcohol use and Aboriginal family violence.

Recommendation 6

In developing a strategy tailored to preventing and reducing Aboriginal family violence, referred to at Recommendation 4, the Department actively invites and encourages the involvement of Aboriginal people in a full and active way at each stage and level of the process, and be comprehensively informed by Aboriginal culture.

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 Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned**
>
> **10 Year Strategy for Reducing Family and Domestic Violence**
> Communities drafted Western Australia's 10 Year Strategy for Reducing Family and Domestic Violence (the Strategy). The strategy sets out a whole of government and community plan for preventing and responding to family and domestic violence. The final draft Strategy was endorsed by Cabinet in December 2019 via the Community Safety and Family Support Cabinet Sub Committee. Timing for release of the Strategy is yet to be confirmed. Communities has commenced planning for the first Action Plan of the Strategy.

Communities has informed this Office that it is developing an Aboriginal Family Safety Strategy in partnership with Aboriginal people and communities. The dedicated Aboriginal family safety strategy will sit alongside the State Strategy, creating a more equitable and culturally appropriate roadmap for reducing family and domestic violence in WA. Action Item 5 of the First Action Plan intends to '[c]o-design the Aboriginal Family Safety Strategy with Aboriginal people and communities'.

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

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

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of family and domestic violence fatalities. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2019-20, timely review processes have resulted in 38% of reviews being completed within three months and 62% of reviews completed within 12 months.

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

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

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

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

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

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

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

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

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

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

The Office has now concluded its review of the (now) Department of Communities' (**Communities**) review report. The Office has considered the *Family and Domestic Violence Practice Guidance Review Report* and that Communities has conducted a project to review its family and domestic violence practice guidance. The focus of the review conducted by Communities was to identify and recommend amendments to Communities' family and domestic violence practice guidance. The review did not include any actions 'to identify barriers to the effective implementation of relevant

family and domestic violence policies and practice guidance'. Further, while Communities identified several issues which potentially relate to barriers to effective implementation, a range of Communities' 'proposed actions' to overcome these potential barriers were not considered to be appropriate.

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

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

> Communities acknowledges this finding and confirms it is a priority for Communities to address and implement the intent of the recommendation. It was the intent of the *Family and Domestic Violence Practice Guidance Review Report* (the report) and the *Family and Domestic Violence Practice Guidance Implementation* to do so. The report did help to identify a range of issues that limit the implementation of policy and practice guidance, and Communities has undertaken numerous activities and processes to address these. These include:
>
> - new toolkits for assessment and safety planning in cases of emotional abuse - family and domestic violence, which aim to support child protection workers to form an evidence-based professional judgement, and include practice examples of how to gather information to inform assessments, analyse the information, and practice examples of safety planning;
> - mandatory training concerning family and domestic violence for new and current employees to have a focus on effectively engaging perpetrators, including assessments within the training and in the field;
> - workshops and presentations with Team Leader and Senior Practice Development Officer groups to encourage strong leadership within districts of the policy and practice guidance;
> - case consultation with child protection workers to provide opportunities for staff to reflect on and plan their practice;
> - a centralised intake model in July 2017, including a 'threshold tool' to provide a consistent response to child protection referrals;
> - a partnership with Curtin University, the University of Melbourne and the Safe and Together Institute in order to integrate techniques in working with perpetrators into practice; and
> - a practice audit is currently being undertaken to assess the implementation to date of the family and domestic violence practice guidance, and to establish a baseline from which further audits or reviews of practice can be measured. The audit examines 50 cases (three from each district) at various stages of Communities' Child Protection and Family Support division involvement, identifies areas for practice improvement and provides opportunities to work with districts to improve understanding of key issues in the intersection between child protection and family and domestic violence.

Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

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

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

Stakeholder Liaison

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

The Ombudsman's Advisory Panel

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

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

The Panel met 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 WA Police Force, the Department of Communities, the Department of Health, the Department of Education, and the Department of Justice 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 those who are at risk of family and domestic violence or who have experienced family and domestic violence. Important stakeholders, with which the Office liaised as part of the family and domestic violence fatality review function in 2019-20, included:

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

Aboriginal and regional communities

In 2016, the Ombudsman 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.
- 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. Through the leadership 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 family and domestic violence fatality review function with Aboriginal and regional communities, including by communicating with:

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

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

Own Motion Investigations and Administrative Improvement

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

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

Improvements from Complaints and Reviews

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

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

Own Motion Investigations

One of the ways that the Office endeavours to improve public administration is to undertake investigations of systemic and thematic patterns and trends arising from

complaints made to the Ombudsman and from child death and family and domestic violence fatality reviews. These investigations are referred to as own motion investigations.

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

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

Selecting topics for own motion investigations

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

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

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

Own Motion Investigations in 2019-20

In 2019-20, significant work was undertaken on:

- The Office's major own motion investigation into ways that State Government departments and authorities can prevent or reduce suicide by children and young people, to be tabled in Parliament in 2020;
- An investigation into family and domestic violence and suicide, to be tabled in Parliament in 2021; and
- An investigation into homelessness, to be tabled in Parliament in 2021.

Monitoring the implementation of recommendations

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

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*

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

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

During 2019-20, significant work was undertaken on a report by the Office on the steps taken to give effect to the 22 recommendations arising from the findings of this report.

The report will be tabled in Parliament in 2020.

Continuous Administrative Improvement

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

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

Guidance for Public Authorities

The Office provides publications, workshops, assistance and advice to public authorities regarding their decision making and administrative practices and their

complaint handling systems. This educative function assists with building the capacity of public authorities and subsequently improving the standard of administration.

Publications

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

Workshops for public authorities

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

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

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

Working collaboratively

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

Inspection and Monitoring Functions

Telecommunications interception records

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

Collaboration and Access to Services

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

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

Working Collaboratively

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

International Ombudsman Institute

Background:

The International Ombudsman Institute (**IOI**), established in 1978, is the global organisation for the cooperation of more than 200 independent Ombudsman institutions from more than 100 countries worldwide. The IOI is organised in six regional chapters (Africa, Asia, Australasia & Pacific, Europe, the Caribbean & Latin America and North America).

The Office's involvement:

The Office is a member of the IOI. The IOI is governed by a World Board, of which the Ombudsman has served as the Second Vice-President since 2016. Before this, the Ombudsman served as Treasurer of the IOI from 2014 to 2016 and President of the Australasian and Pacific Ombudsman Region (**APOR**) of the IOI from 2012 to 2014. Since February 2020, the Ombudsman is the President-elect of the IOI.

2019-20 initiatives:

In September 2019, the Office delivered investigator training in Fiji as part of a programme led by the Office of the New Zealand Ombudsman. Training was delivered to Ombudsman representatives from the Pacific Island nations of Cook

Islands, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. The programme was supported through a funding grant provided by the IOI. Assistant Ombudsman, Marcus Claridge delivered material on multiple stages of the complaint investigation process alongside representatives from the Victorian and Australian Commonwealth Ombudsman offices. The United Nations Development Programme, the United Nations Office on Drugs and Crime and the Office of the United Nations High Commissioner for Human Rights also presented to participants.

In September 2019, the Ombudsman welcomed the Chief Ombudsman of Thailand, General Viddhavat Rajatanun, who led a high level delegation from the Office of the Ombudsman Thailand, to sign a Memorandum of Understanding (**MOU**) on Bilateral Cooperation between the Ombudsman Thailand and the Office.

The Chief Ombudsman of Thailand was accompanied by Mr Boon Tapanadul, Ombudsman, Mr Somsak Suwansujarit, Ombudsman, and Mr Raksagecha Chaechai, Secretary-General. The MOU on Bilateral Cooperation was the first such agreement for the Office and the first outside of Asia for the Ombudsman Thailand.

The signing of the MOU on Bilateral Cooperation marks a significant step toward closer cooperation and collaboration between the two Ombudsman institutions and fosters further international cooperation in the field of complaint handling, good governance and Ombudsmanship. During the delegation's visit to Perth, formal bilateral discussions were held between the Ombudsman Thailand and the Office and an official high-level program of visits was undertaken to other Western Australian integrity agencies.

From 10 to 15 February 2020, the Ombudsman and Assistant Ombudsman, Rebecca Poole, attended an international seminar in Bangkok, Thailand. The international seminar, *Ombudsman in a Changing World: Resilience amidst Challenges*, was hosted by the Chief Ombudsman of Thailand on the occasion of the 20th anniversary of the establishment of the Office of the Ombudsman Thailand. The Ombudsman was a speaker in the first plenary session, *Ombudsman in a changing world: paradigm shift and challenges*, and chaired the closing plenary session, *Future of Ombudsmanship in a changing world: adaptation and cooperation techniques*.

While in Thailand, the Ombudsman met with Mr Allan McKinnon PSM, Australian Ambassador to Thailand, and attended a reception hosted by His Excellency Taha Macpherson, New Zealand Ambassador to Thailand, and Peter Boshier, Chief Ombudsman of New Zealand, to recognise and celebrate the growing role of the Ombudsman in the Asia-Pacific Region.

In February 2020, the Ombudsman was elected President of the IOI. This is the first time in the 42-year history of the IOI that an Australian has been elected President. It is also the first time that a President has been elected by IOI members. Historically, Presidents were elected by the IOI World Board. A new voting system, applicable for the first time in the 2020 election, provided the opportunity for every IOI member globally to vote for the position of President. The Ombudsman will commence his term as President at the rescheduled 12th quadrennial IOI World Conference and General Assembly in Dublin, Ireland.

Information sharing with Ombudsmen from other jurisdictions

Background:

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

2019-20 initiatives:

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

Australia and New Zealand Ombudsman Association

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

Background:

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

The Office's involvement:

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

Providing Access to the Community

Communicating with complainants

The Office provides a range of information and services to assist specific groups, and the public more generally, to understand the role of the Ombudsman and the complaint process. Many people find the Office's enquiry service and complaint clinics held during regional visits assist them to make their complaint. Other initiatives in 2019-20 include:

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

Access to the Ombudsman's services

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

- Access to the Office through a Freecall number, which is free from landline phones;
- Access to the Office through email and online services. The importance of email and online access is demonstrated by its use this year in 72% of all complaints received;
- Information on how to make a complaint to the Ombudsman is available in 15 languages and features on the homepage of the Ombudsman's website. People may also contact the Office with the assistance of an interpreter by using the Translating and Interpreting Service;
- The Office's accommodation, building and facilities provide access for people with disability, including lifts that accommodate wheelchairs and feature braille on the access buttons and people with hearing and speech impairments can contact the Office using the National Relay Service;
- The Office's Regional Awareness and Accessibility Program and Youth Awareness and Accessibility Program target awareness and accessibility for regional and Aboriginal Western Australians as well as children and young people;
- The Office attends events to raise community awareness of, and access to, its services, such as the Financial Counsellors' Association of WA conference in October 2019 and Homeless Connect Perth in November 2019; and
- The Office's visits to adult prisons and the juvenile detention centre provide an opportunity for adult prisoners and juvenile detainees to meet with representatives of the Office and lodge complaints in person.

Ombudsman website

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

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

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

The website continues to be a valuable resource for the community and public sector as shown by the increased use of the website this year. In 2019-20:

- The total number of visits to the website was 144,228. This is a 50% increase on the number of visits in 2015-16;
- The top two most visited pages (besides the homepage and the Contact Us page) on the site were *Making a complaint* and *What you can complain about*; and
- The Office's *Effective Handling of Complaints Made to Your Organisation Guidelines* and *Procedural Fairness Guidelines* were the two most viewed documents.

The total number of visits to the website in 2019-20 was 144,228.

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

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

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

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

The segment allows the public to communicate a range of concerns with the Ombudsman. The segment also allows the Office to communicate key messages about the Ombudsman and Energy and Water Ombudsman jurisdictions, the outcomes that can be achieved for members of the public and how public administration can be improved. The Ombudsman appeared on the 'Ask the Ombudsman' segment in September and October 2019.

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2019-20. A regional visit was conducted to Kalgoorlie and Leonora in the Goldfields-Esperance Region in December 2019. The visit included activities such as:

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

The Program is an important way for the Office to raise awareness of, access to, and use of, its services for regional and Aboriginal Western Australians. The visit to Kalgoorlie and Leonora was coordinated with the Western Australian Energy and Water Ombudsman, the Commonwealth Ombudsman, the Health and Disability Services Complaints Office and the Equal Opportunity Commission.

The Program enables the Office to:

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

Ombudsman staff presented workshops on *Good Decision Making* and *Effective Complaint Handling* to state and local government officers in Kalgoorlie on 4 December 2019.

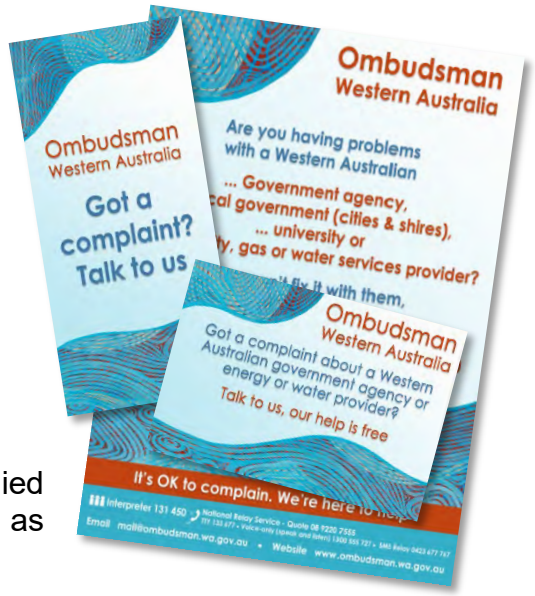
The Program also provides a valuable opportunity for staff to strengthen their understanding of the issues affecting people in regional and Aboriginal communities.

Aboriginal engagement

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

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

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



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

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

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

Youth Awareness and Accessibility Program

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

The Office continued its proactive visiting program to vulnerable groups of children in the child protection system. During 2019-20, the Office visited two family group homes and one residential group home in the Kalgoorlie-Esperance Region in December 2019.

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

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

Prison Program

The Office continued the Prison Program during 2019-20. Four visits were made to prisons and the juvenile detention centre to raise awareness of the role of the Ombudsman and enhance accessibility to the Office for adult prisoners and juvenile detainees in Western Australia.

Speeches and Presentations

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

Ombudsman's speeches and presentations

- *Practices and recent developments of the International Ombudsman Institute*, presentation to the 31st Australasian and Pacific Ombudsman Region Conference in September 2019;
- *The Ombudsman*, presented to University of Western Australia Foundations of Public Law students in October 2019;
- *A law and economics analysis of government accountability*, presented to students as part of the University of Western Australia's advanced administrative law subject 'Government Accountability – Law and Practice', and chaired the closing session panel discussion, in February 2020; and
- *Ombudsman in a changing world: paradigm shift and challenges*, presented to the International Seminar Commemorating the 20th Anniversary of the establishment of the Ombudsman Thailand in February 2020 and chaired the closing plenary session, *Future of Ombudsmanship in a changing world: adaptation and cooperation techniques*.

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

Speeches and presentations by other staff

- *Theories of society, government and rule making* and *Theories of Accountability and Integrity*, presented by the Deputy Ombudsman to students as part of the University of Western Australia's advanced administrative law subject 'Government Accountability – Law and Practice' in January 2020;
- *Integrity in government and its agencies*, presented by the Principal Analyst to students as part of the University of Western Australia's advanced administrative law subject 'Government Accountability – Law and Practice' in January 2020;
- *Keeping Accountability Agencies Accountable*, presented by the Principal Analyst and Principal Project Officer to students as part of the University of Western Australia's advanced administrative law subject 'Government Accountability – Law and Practice' in February 2020; and
- *The Role and Functions of the Ombudsman*, presented by the Senior Assistant Ombudsman Complaint Resolution to staff of the City of Kwinana, City of Perth, City of Bayswater, Shire of Northam, Shire of Mundaring, City of Cockburn and City of Swan between October 2019 and February 2020.

Liaison with Public Authorities

Liaison relating to complaint resolution

The Office liaised with a range of bodies in relation to complaint resolution in 2019-20, including:

- The Department of Justice;
- The Department of Communities;
- The Corruption and Crime Commission; and
- Western Australia Police Force.

Liaison relating to reviews and own motion investigations

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

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

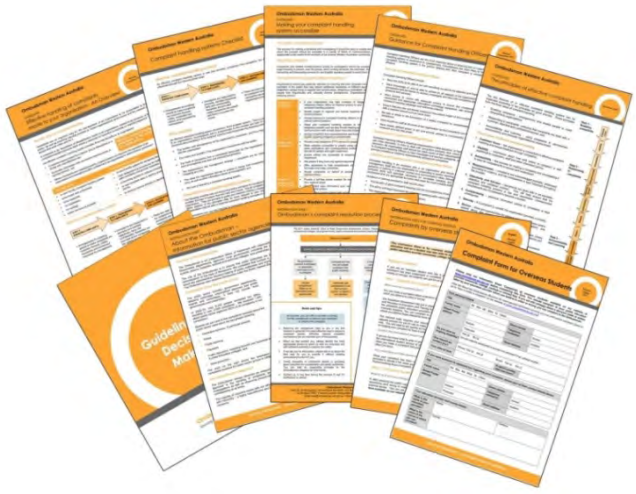
Liaison relating to inspection and monitoring functions

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

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

Publications

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



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