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;
- Timely handling of notifications and reviews;
- 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:

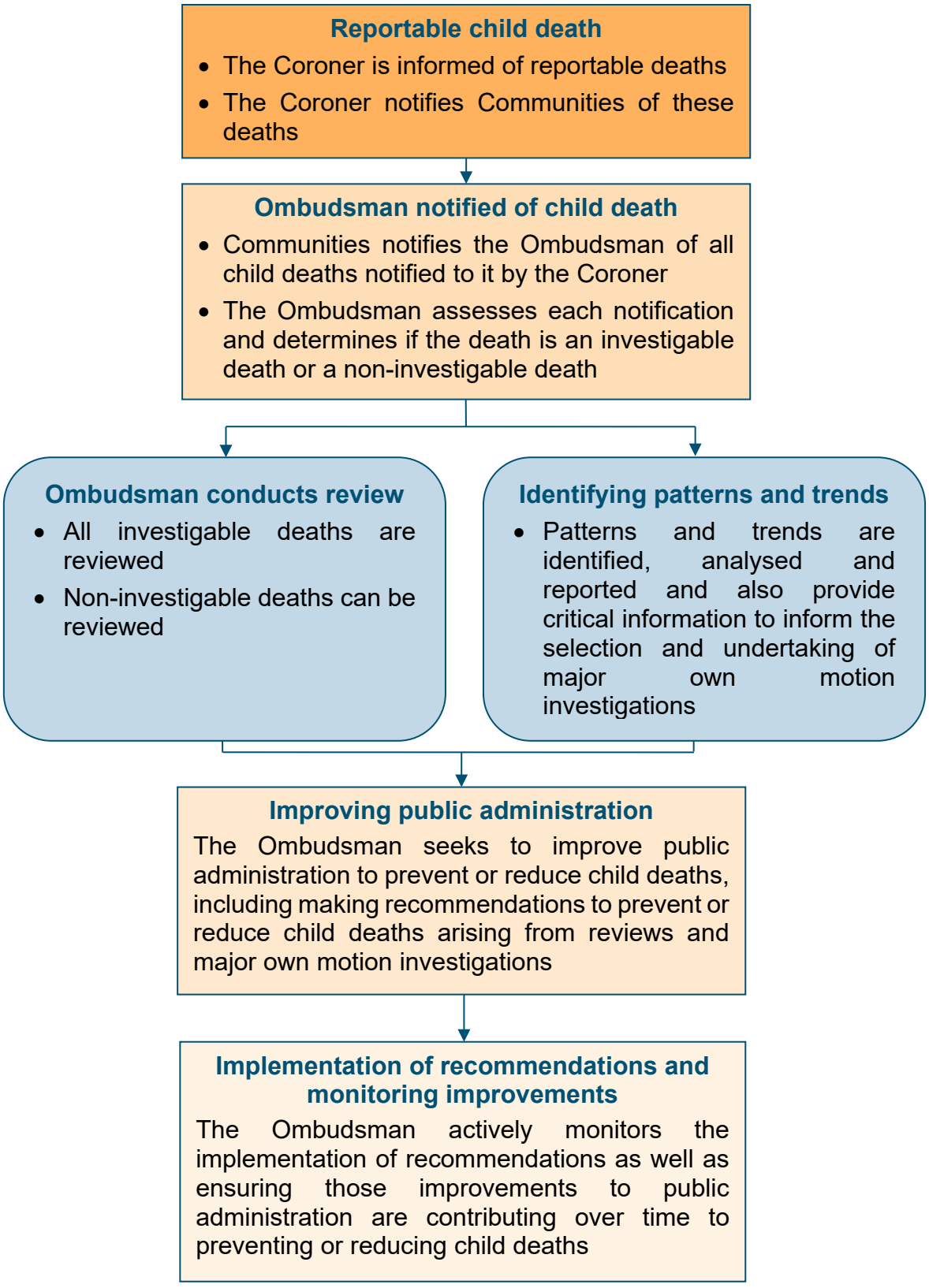
- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children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

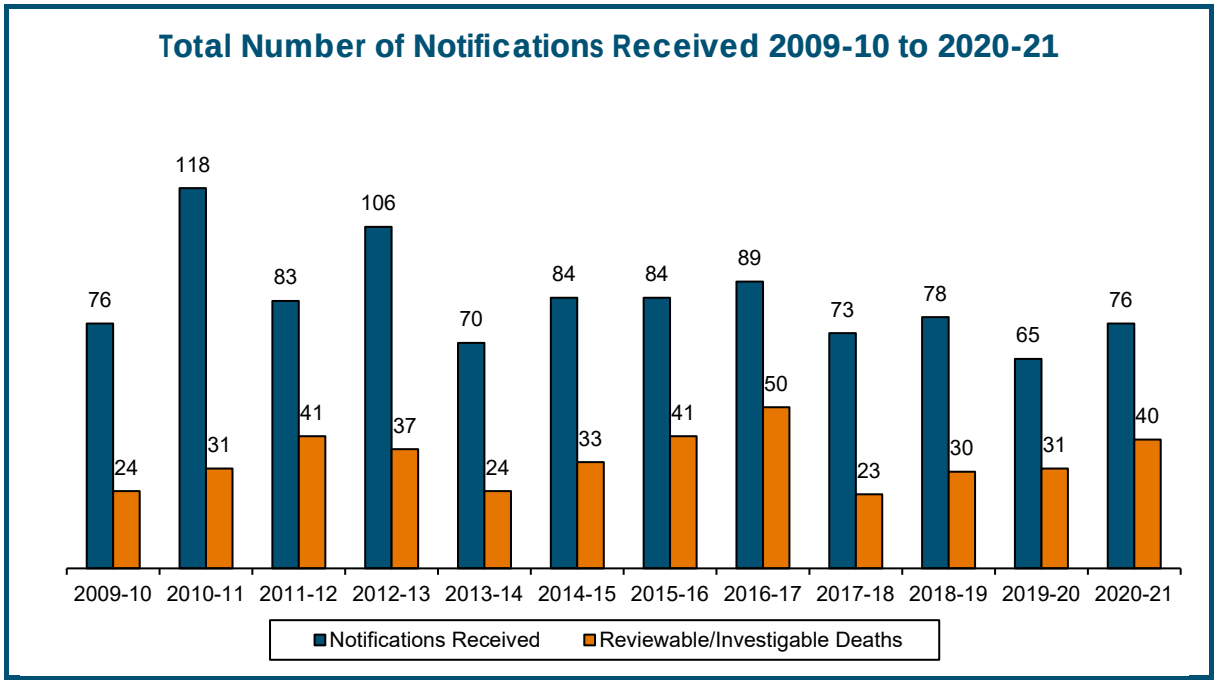
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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 2020-21, there were 40 child deaths that were investigable and subject to review from a total of 76 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 18 years from 2003-04 to 2020-21. 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	140	67	38	31
2020-21	133	77	46	40

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

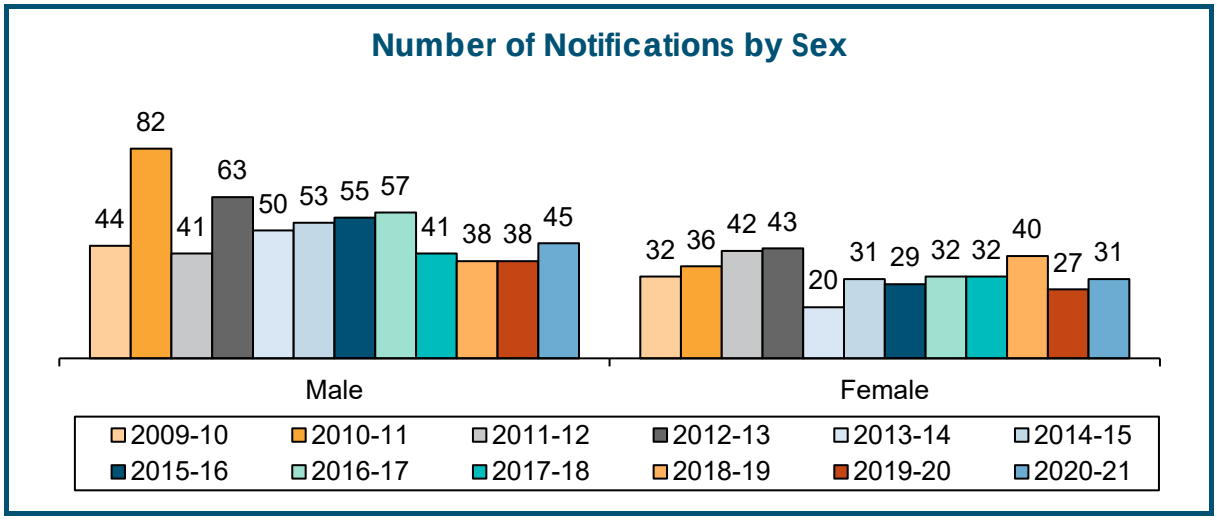
Information is obtained on a range of characteristics of the children who have died including sex, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

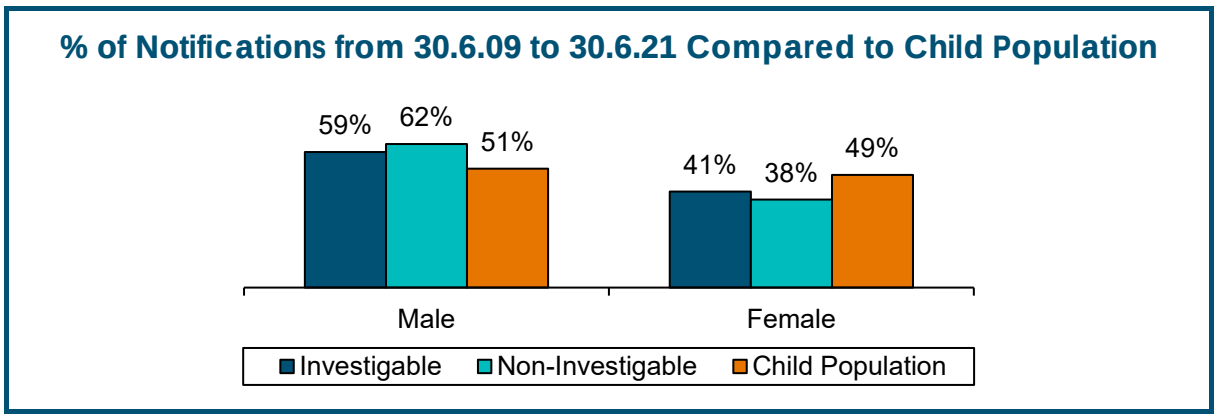
The following charts show:

- The number of children in each group for each year from 2009-10 to 2020-21; and
- For the period from 30 June 2009 to 30 June 2021, 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

Information is collated on a child's sex (male or female) as identified in agency documentation provided to this Office. As shown in the following charts, considering all 12 years, male children are over-represented compared to the population for both investigable and non-investigable deaths.

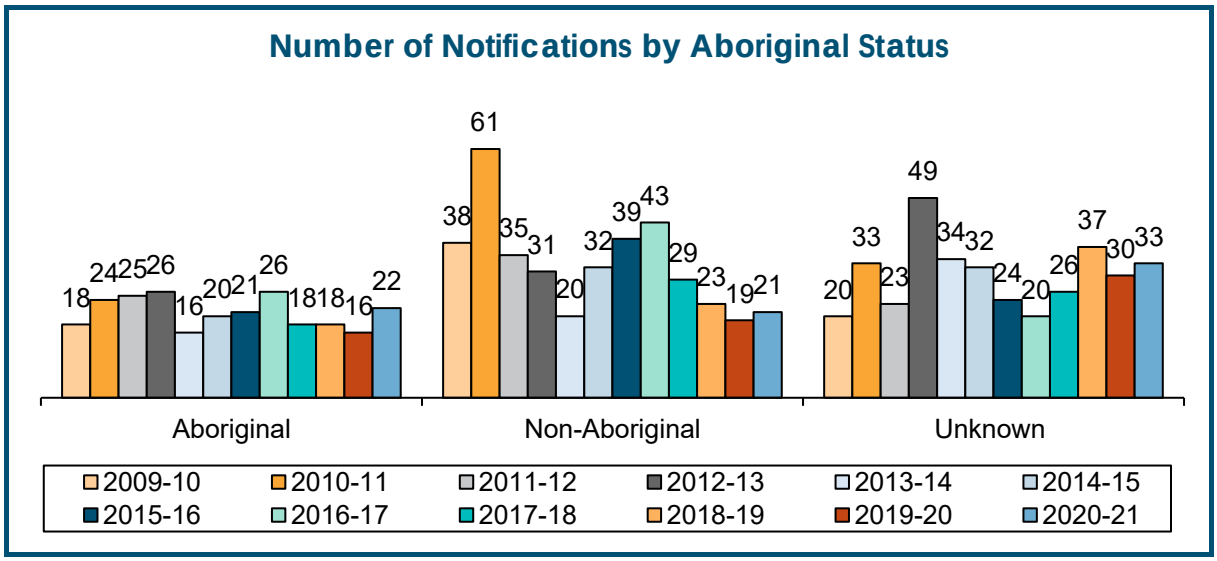


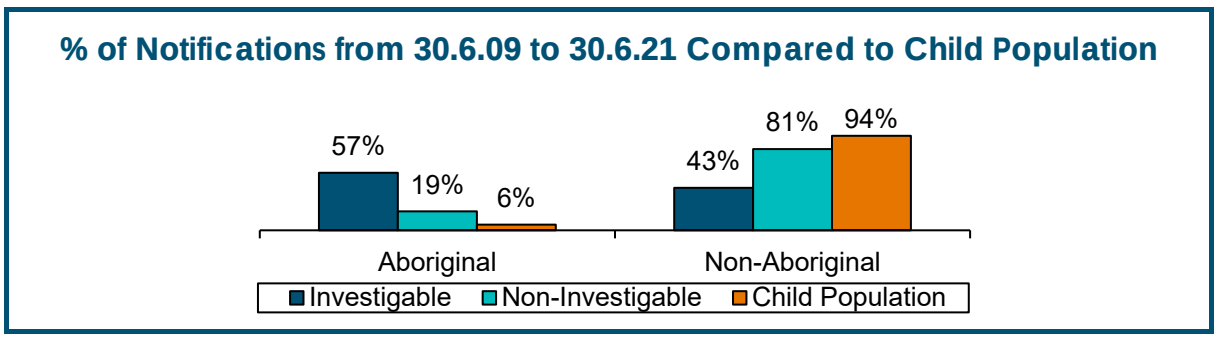


Further analysis of the data shows that, considering all 12 years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

Aboriginal status

Information on Aboriginal status is collated where a child, or one/both of their parents, identify as Aboriginal to agencies they have contact with, and this is recorded in the documentation provided to this Office. As shown in the following charts, Aboriginal children are over-represented compared to the population in all deaths and more so for investigable deaths.



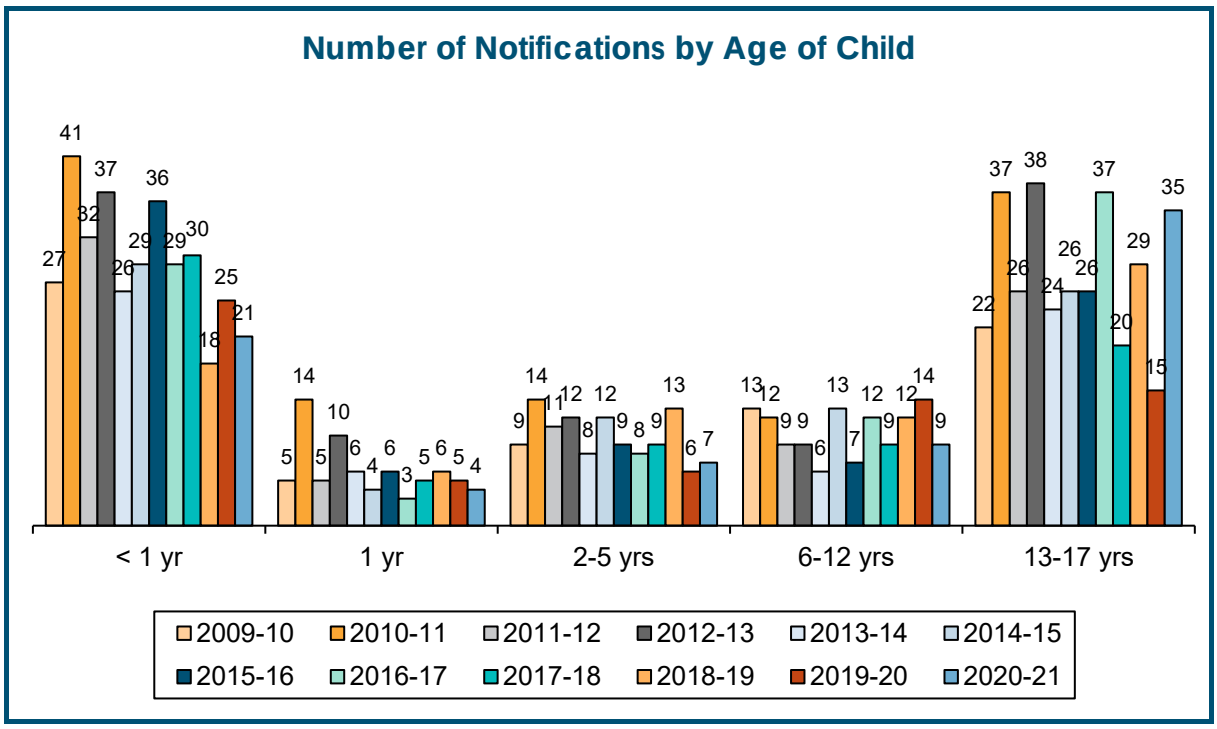


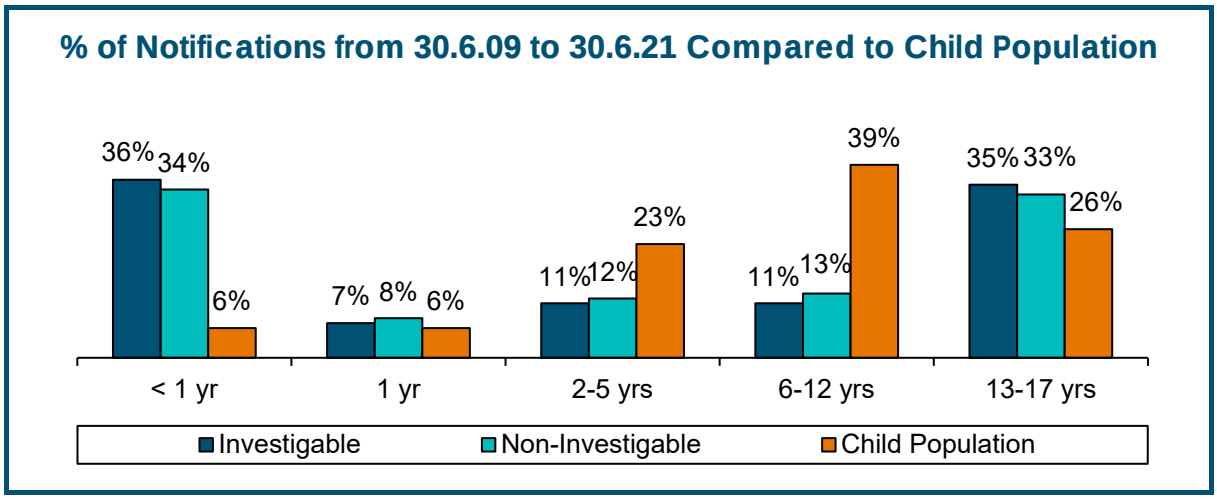
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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

Age groups

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

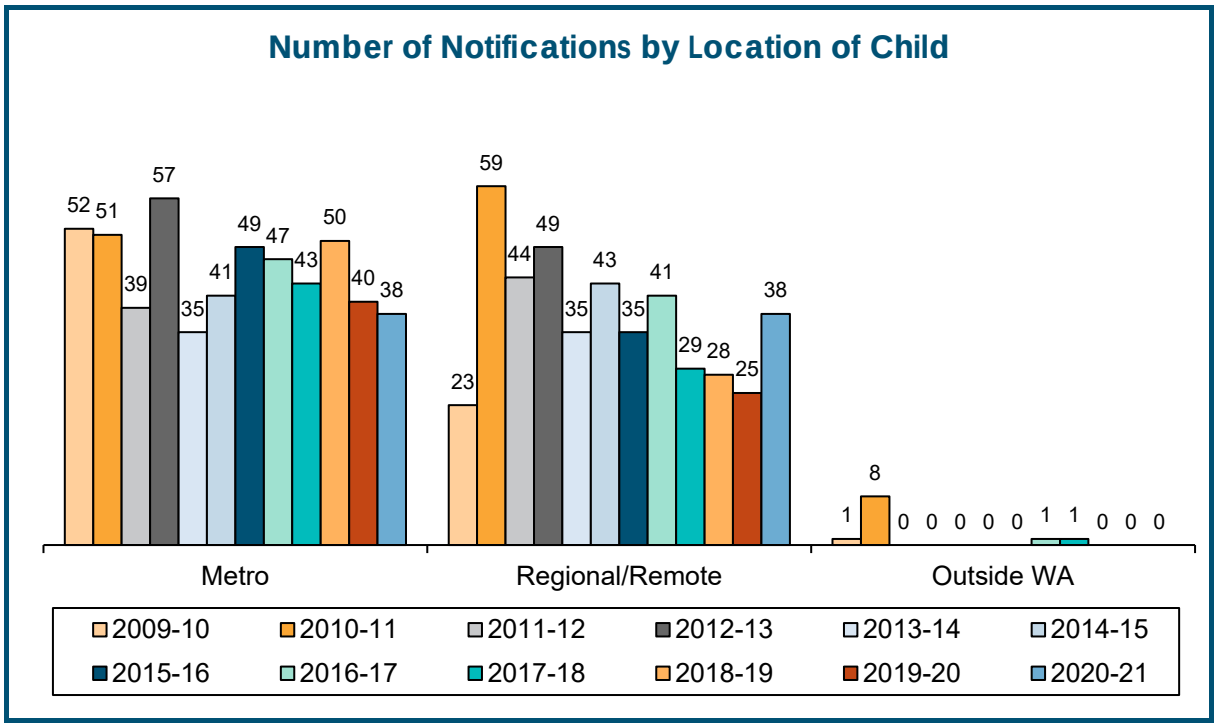




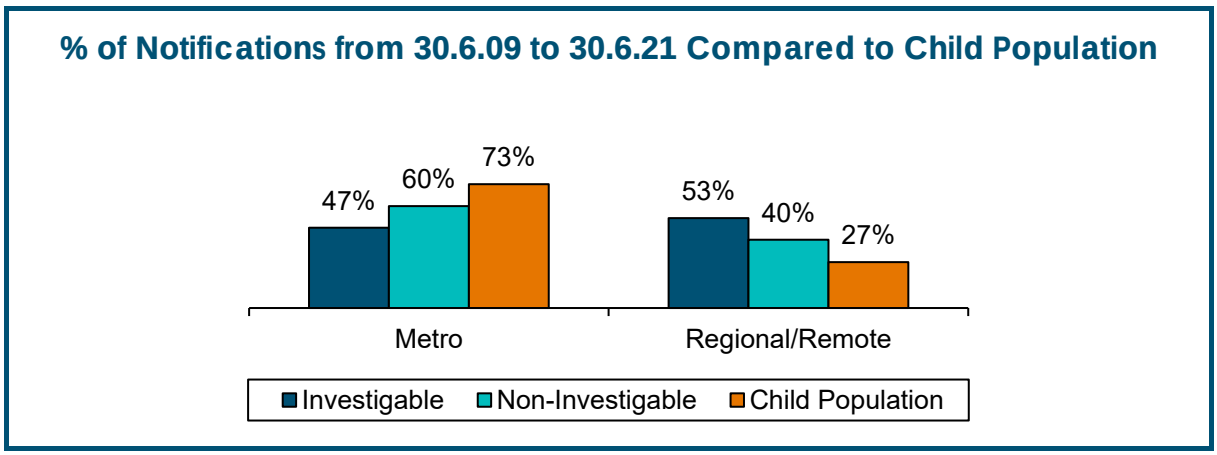
A more detailed analysis by age group is provided later in this section.

Location of residence

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



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



Further analysis of the data shows that 75% 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

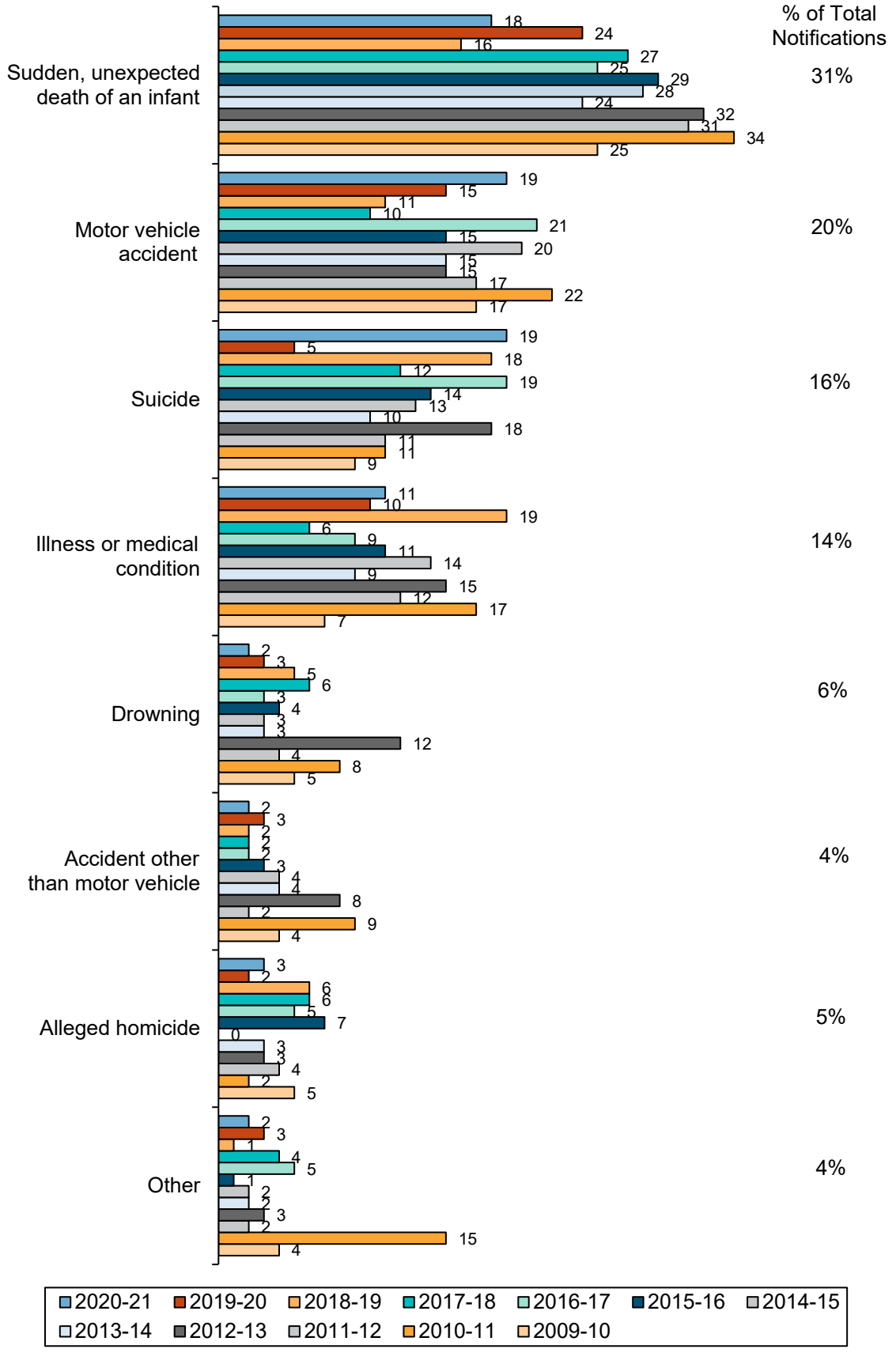
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally 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 2021.

Circumstances of Child Deaths



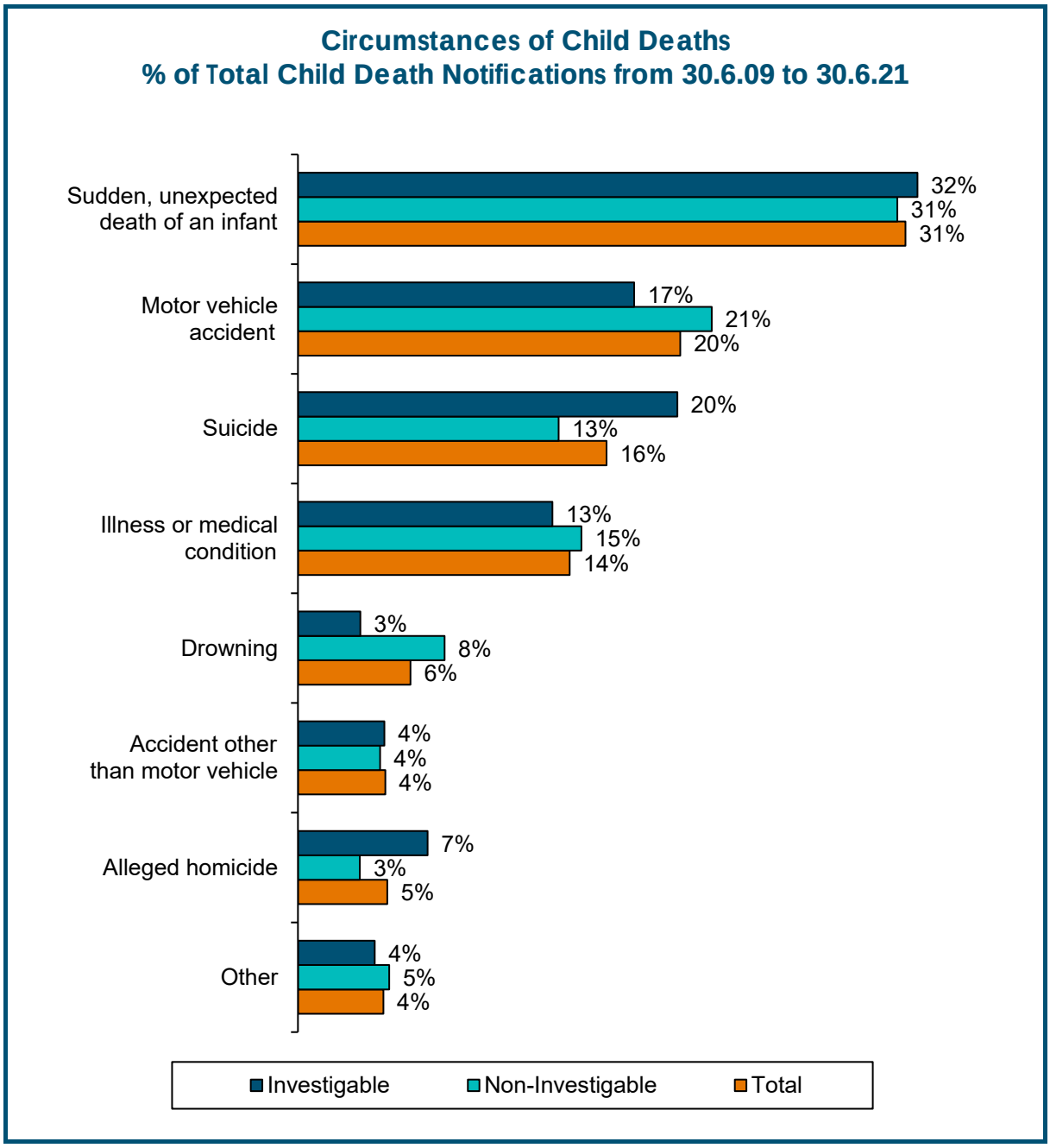
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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 1,002 child death notifications received in the 12 years from 30 June 2009 to 30 June 2021 are:

- Sudden, unexpected deaths of infants, representing 31% of the total child death notifications from 30 June 2009 to 30 June 2021 (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, 35% in 2015-16, 28% in 2016-17, 37% in 2017-18, 21% in 2018-19, 37% in 2019-20 and 24% in 2020-21); and
- Motor vehicle accidents, representing 20% of the total child death notifications from 30 June 2009 to 30 June 2021 (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, 23% in 2019-20 and 25% in 2020-21).

The following chart provides a breakdown of the circumstances of death for child death notifications for investigable and non-investigable deaths.



There are three areas where the circumstance of death shows a higher proportion for investigable deaths than for deaths that are not investigable. These are:

- Sudden, unexpected death of an infant;
- 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		7	4	29	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	3	15	10		2	3	24	5	3
2020-21	2	19	11		3	2	18	19	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 2021.

Social or Environmental Factor	% of Finalised Reviews from 30.6.09 to 30.6.21
Family and domestic violence	74%
Parenting	60%
Drug or substance use	49%
Alcohol use	46%
Parental mental health issues	30%
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 over a third of the cases.
- Where alcohol use was present:
  - Parenting was a co-existing factor in nearly three quarters of the cases;
  - Family and domestic violence was a co-existing factor in over eight in 10 cases;
  - Drug or substance use was a co-existing factor in two thirds of the cases; and
  - Homelessness was a co-existing factor in a third of the cases.

Reasons for contact with Communities

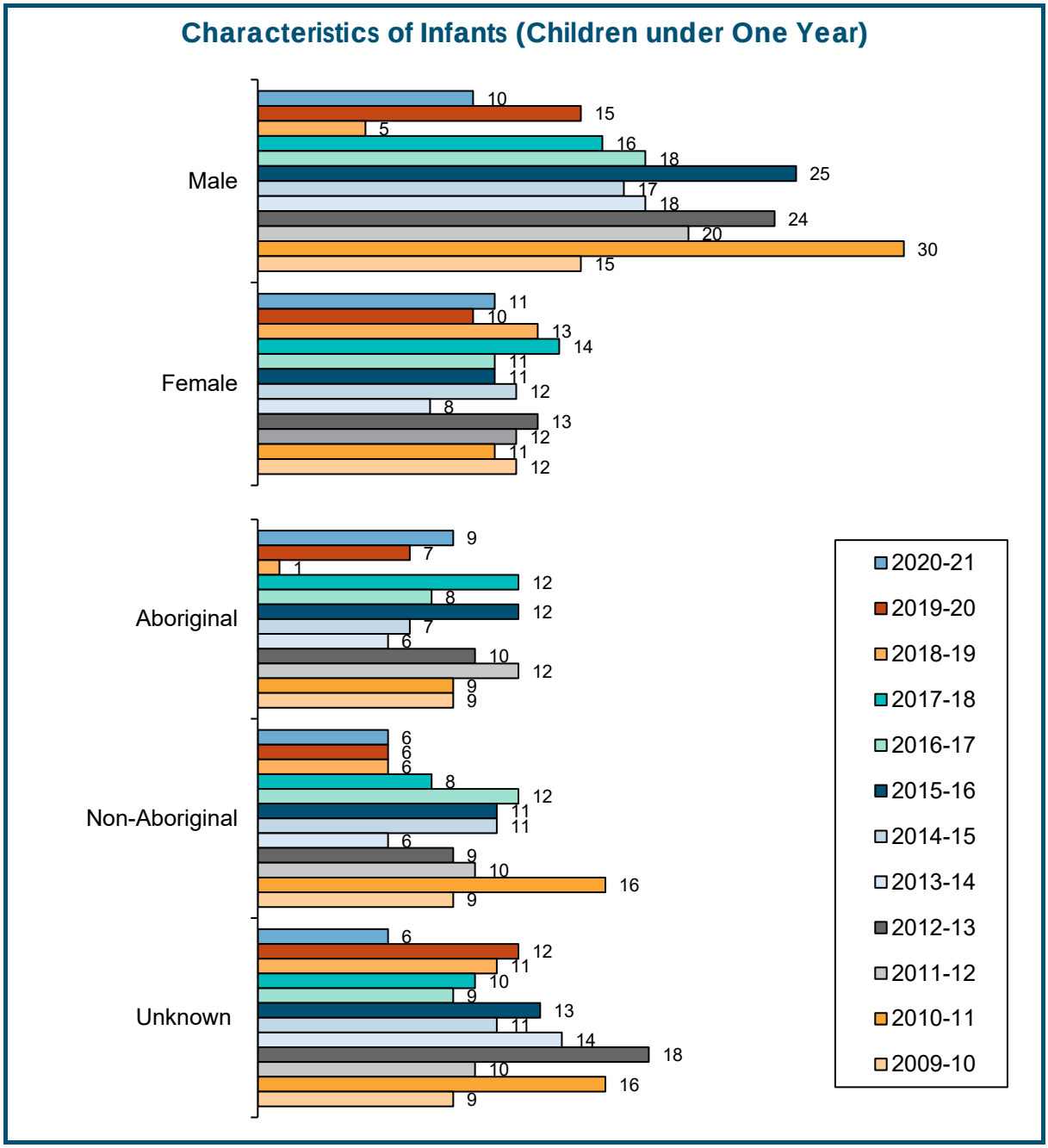
In child deaths notified to the Ombudsman in 2020-21, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

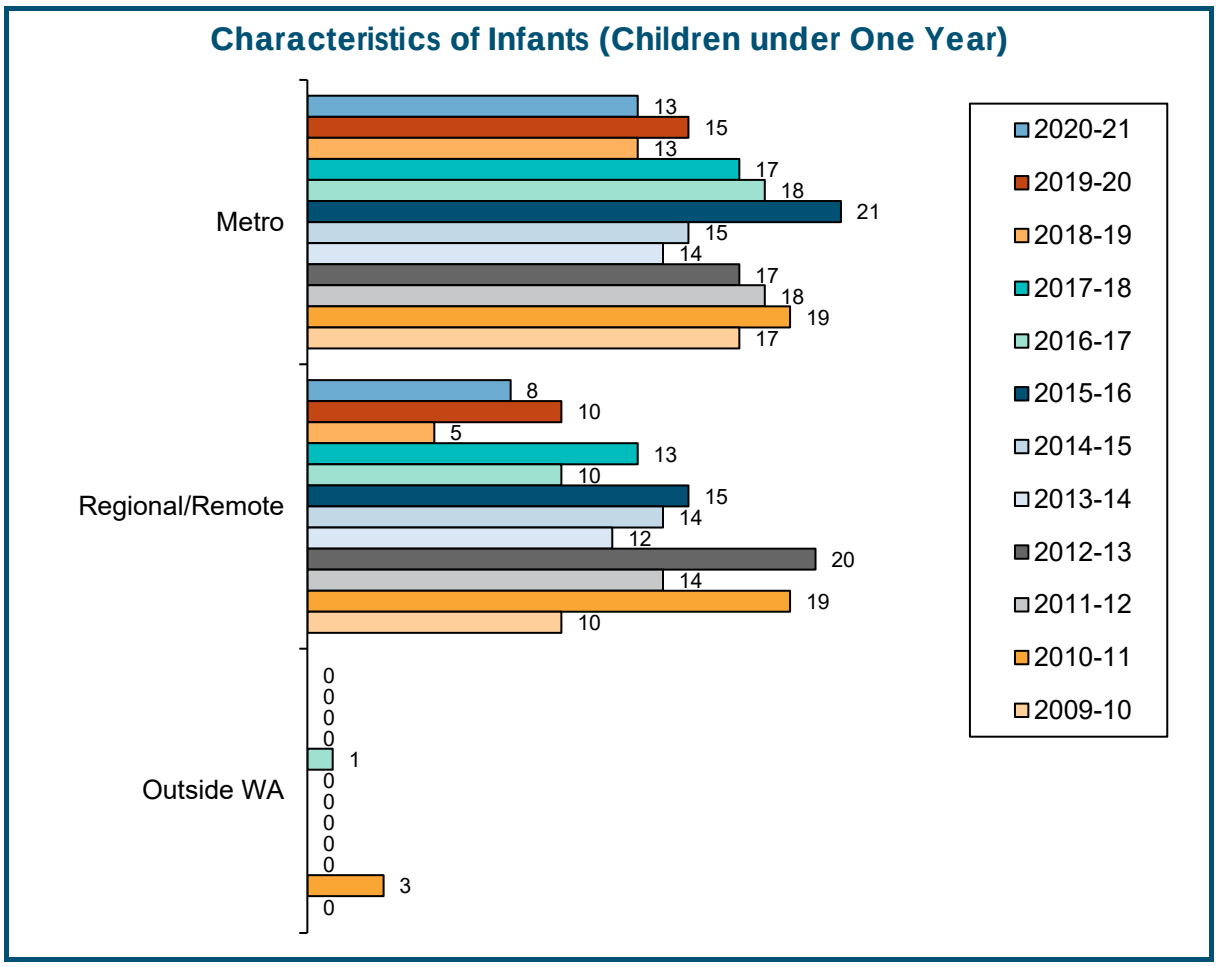
Analysis of children in particular age groups

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 1,002 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2021, there were 351 (35%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.



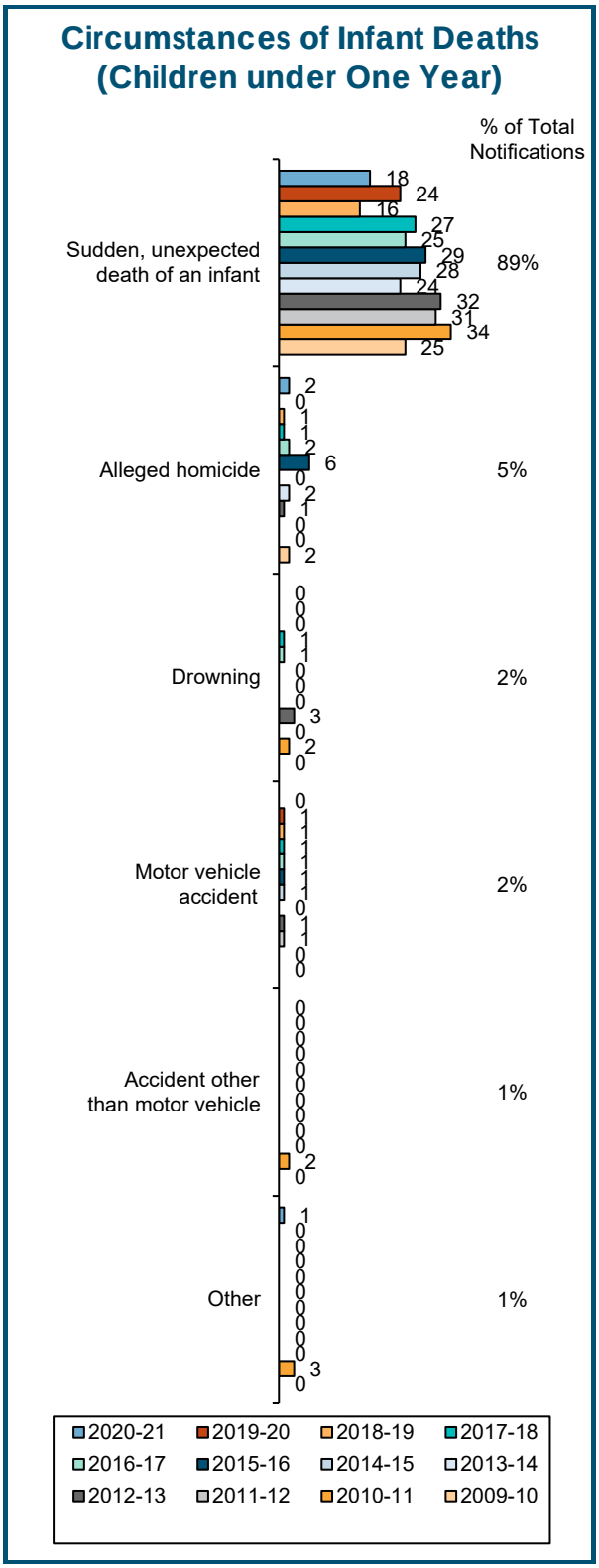


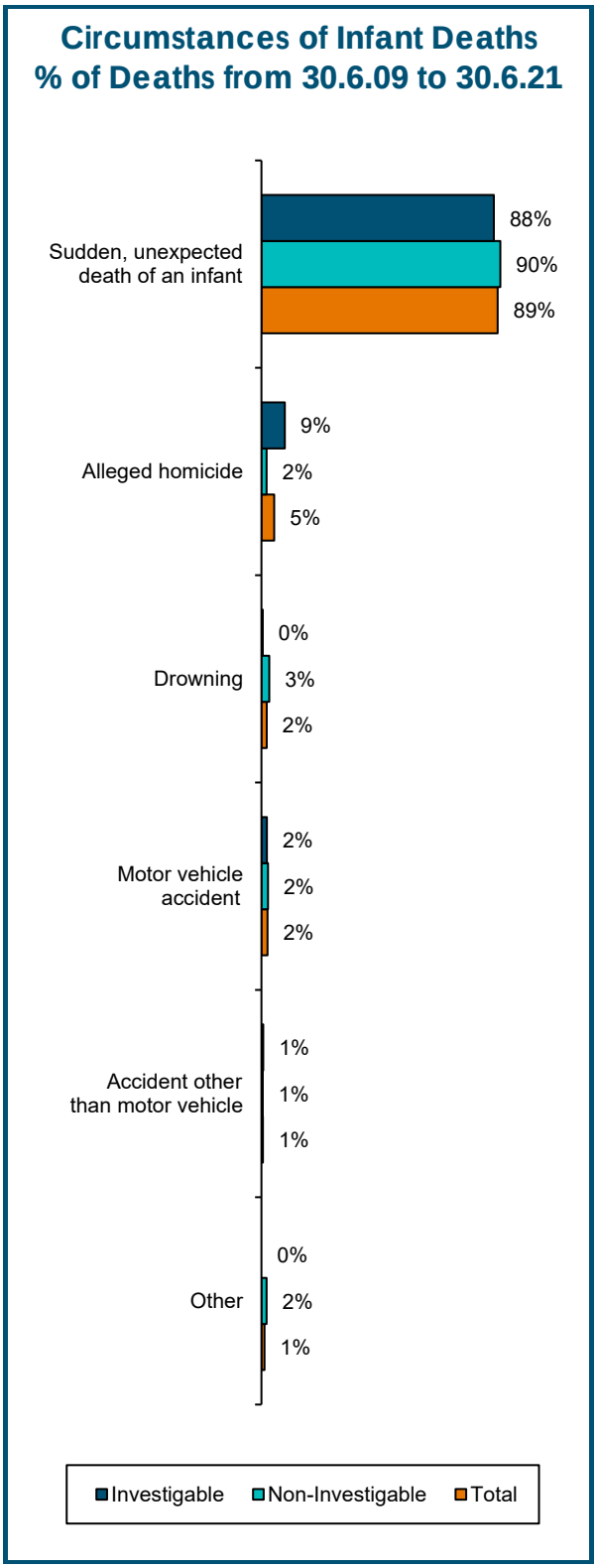
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 62% 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 29% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 51% of investigable infant deaths and 38% of non-investigable deaths of infants, living in Western Australia, were children living in regional or remote locations compared to 27% in the child population.

An examination of the patterns and trends of the circumstances of infant deaths showed that of the 351 infant deaths, 313 (89%) were categorised as sudden, unexpected deaths of an infant and the majority of these (202) 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.





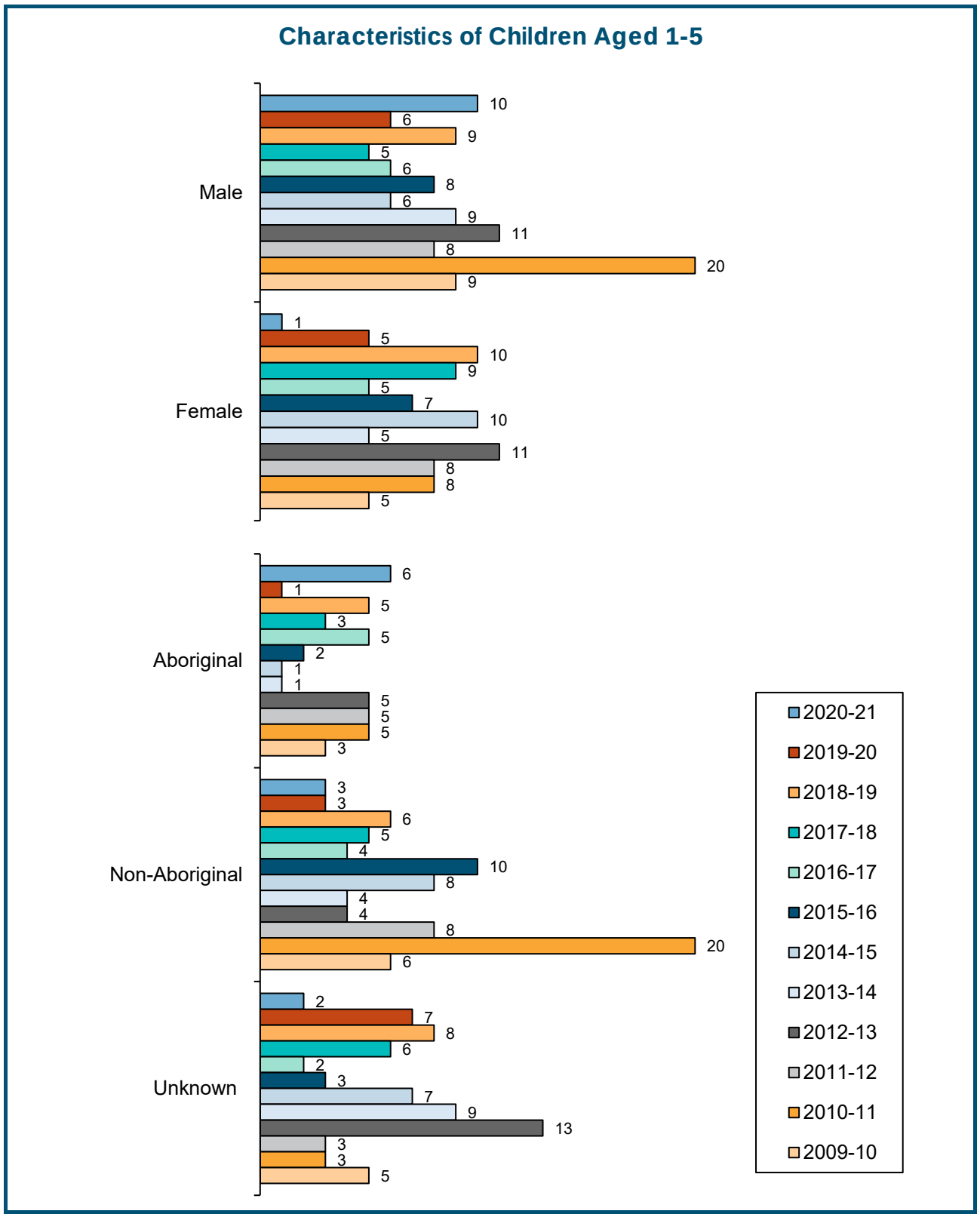
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

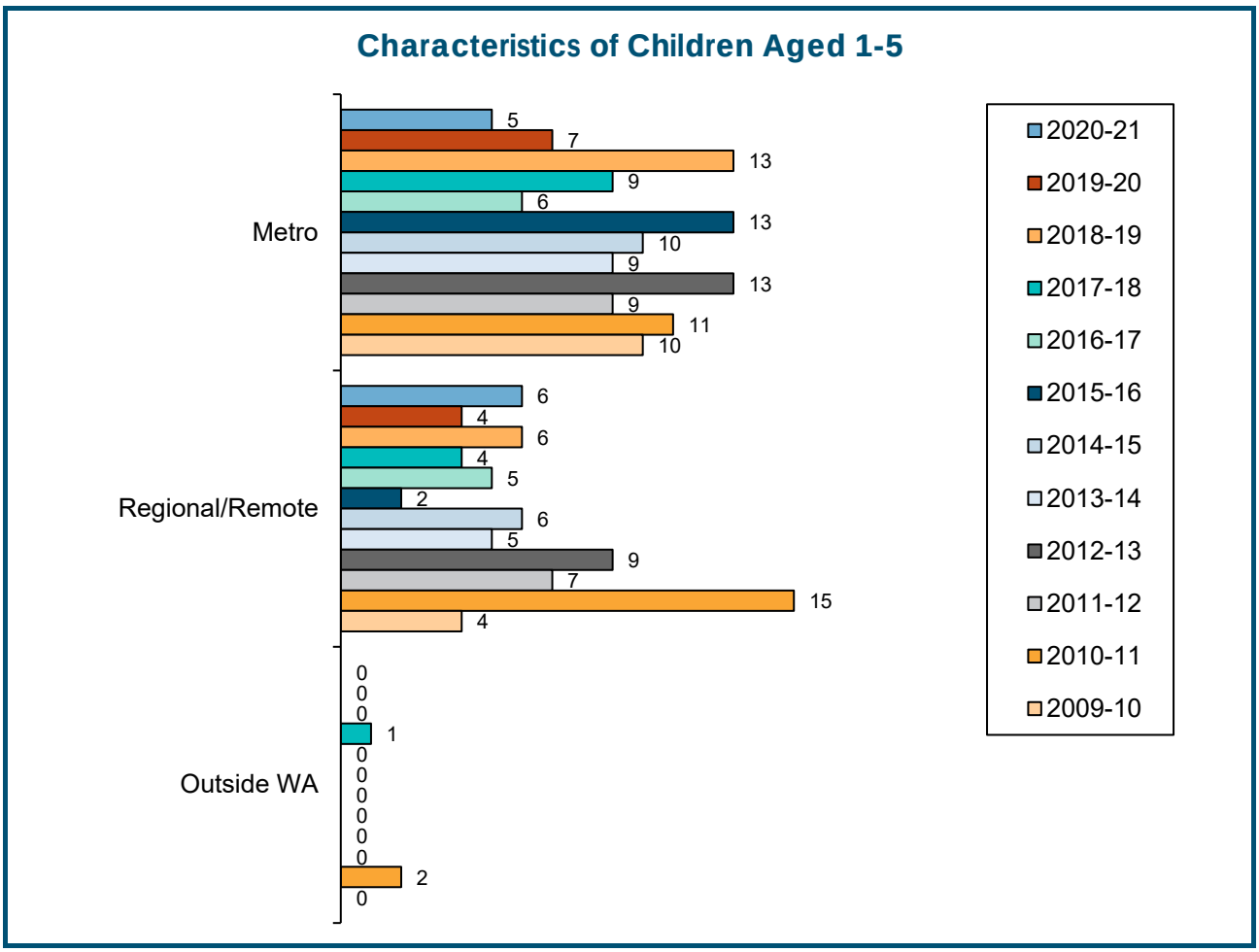
One hundred and forty seven deaths of infants were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 1,002 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2021, there were 191 (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 – 58% of investigable deaths and 55% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Aboriginal children – 54% of investigable deaths and 15% 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 – 43% of investigable deaths and 36% 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 (34%), followed by motor vehicle accidents (24%) and drowning (17%).

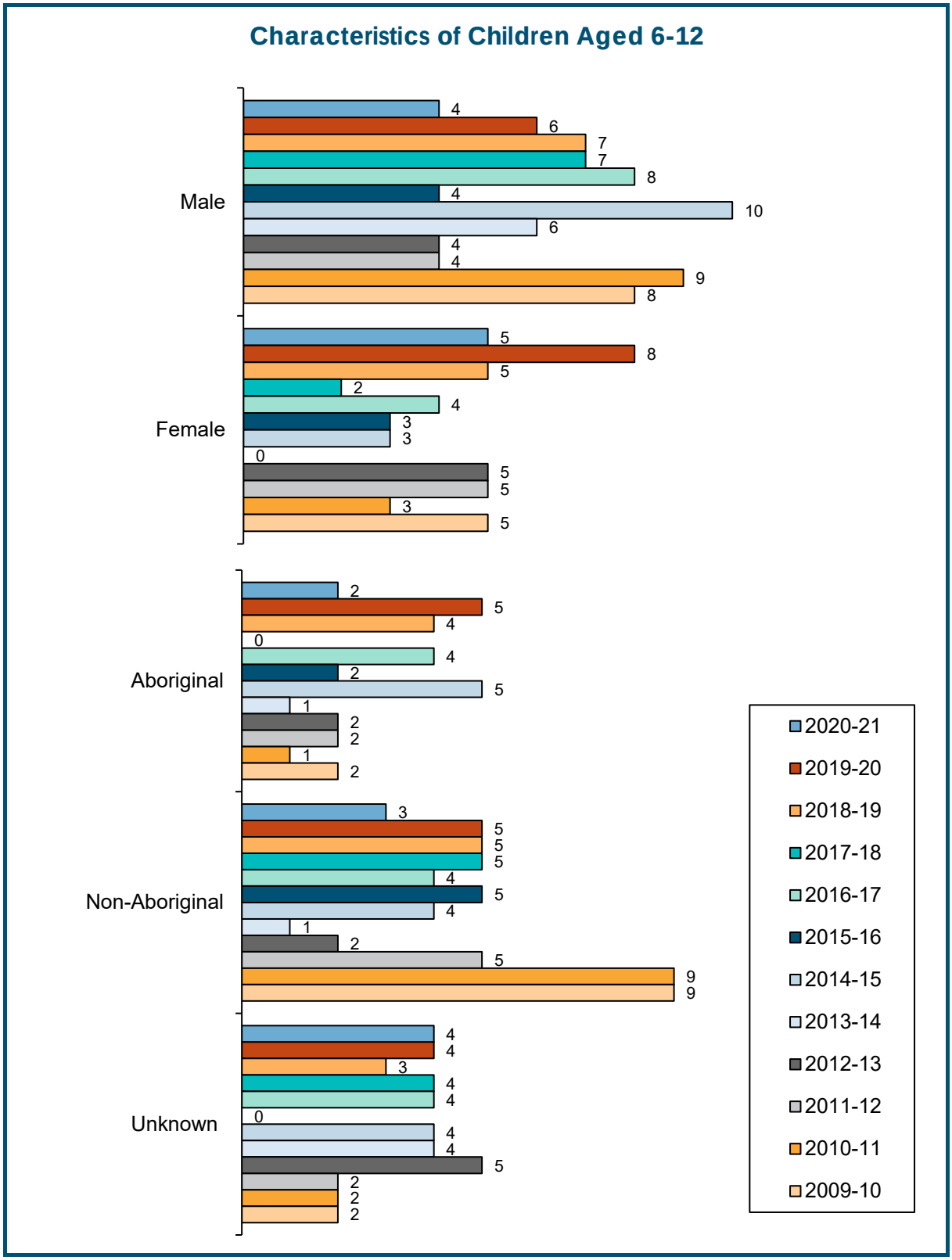
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

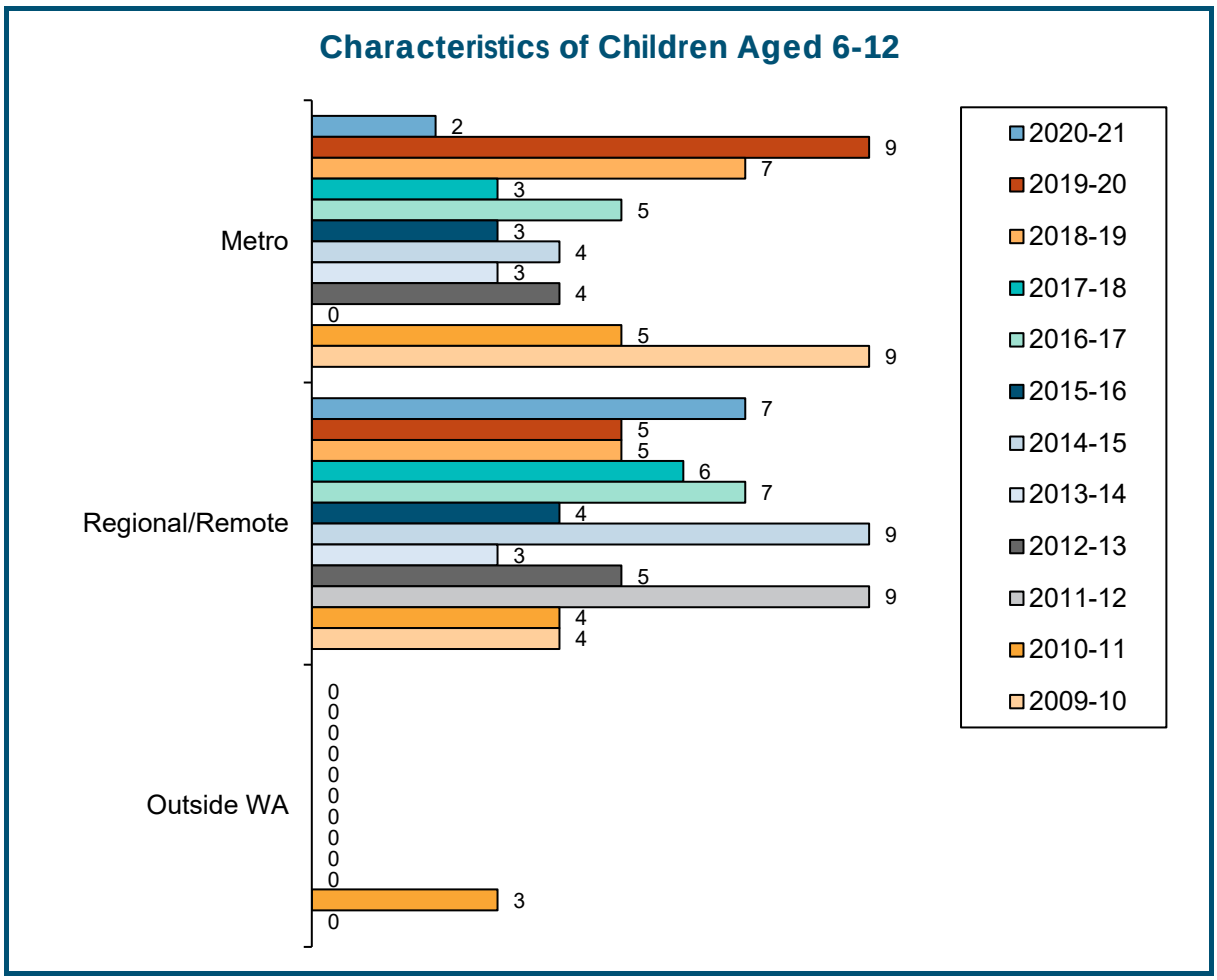
Seventy two deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of children aged 6 to 12 years

Of the 1,002 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2021, there were 125 (12%) related to children aged from 6 to 12 years.

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



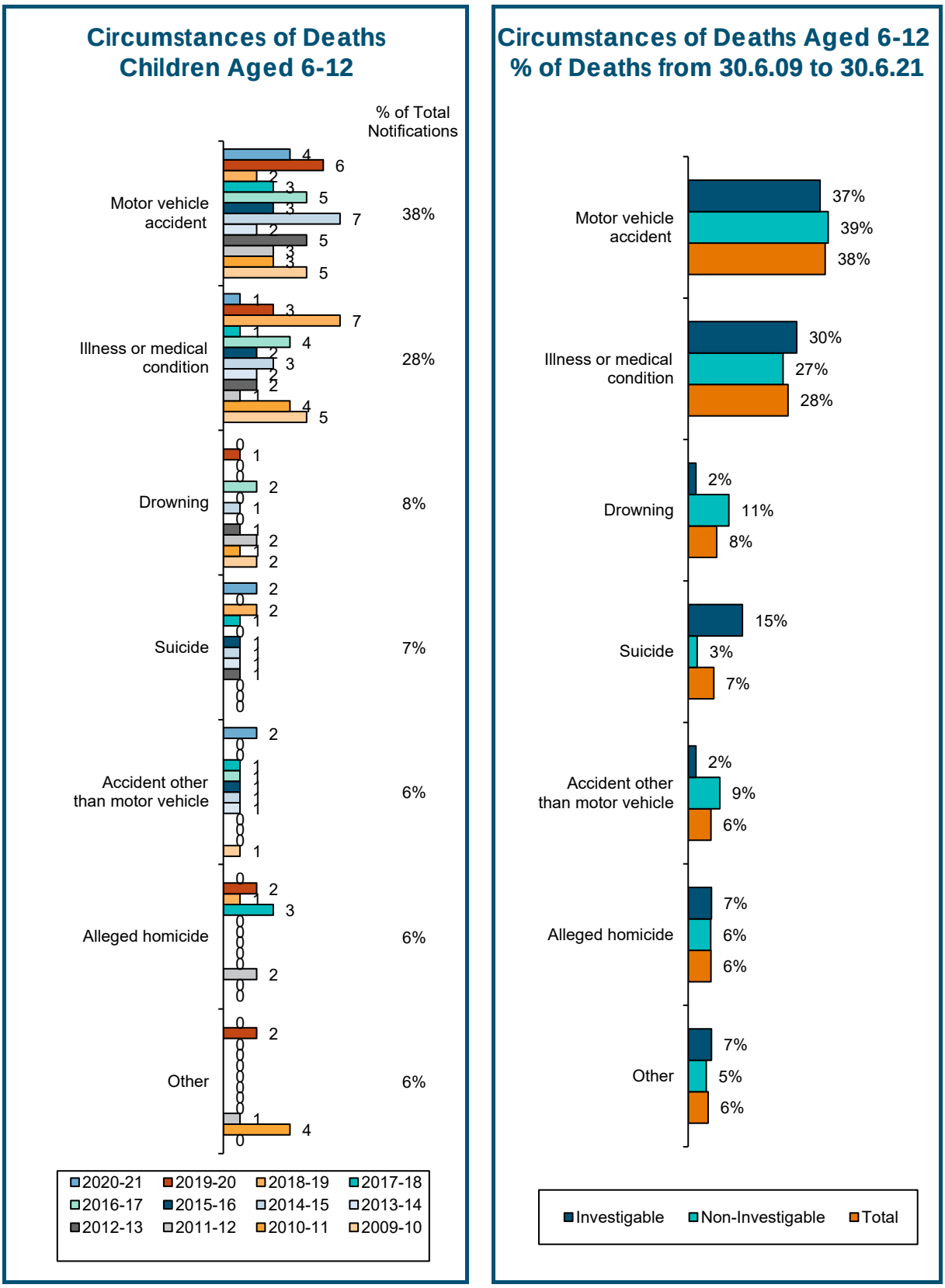


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 50% of investigable deaths and 68% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population;
- Aboriginal children – 56% of investigable deaths and 15% 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 50% of non-investigable deaths of children aged 6 to 12, living in Western Australia, were children living in regional or remote locations compared to 27% in the child population.

As shown in the following chart, motor vehicle accidents are the most common circumstance of death for this age group (38%), followed by illness or medical condition (28%) and drowning (8%).



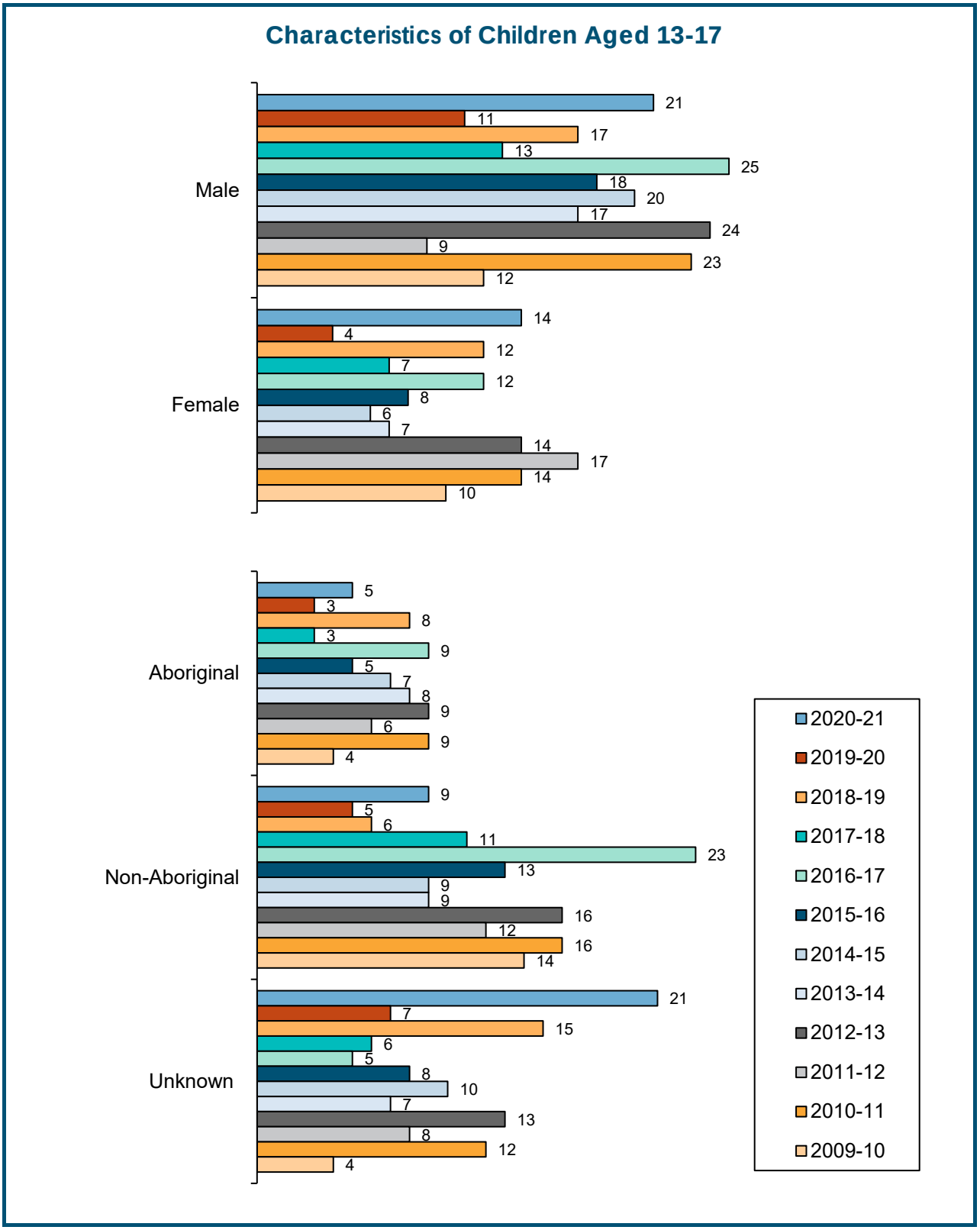
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

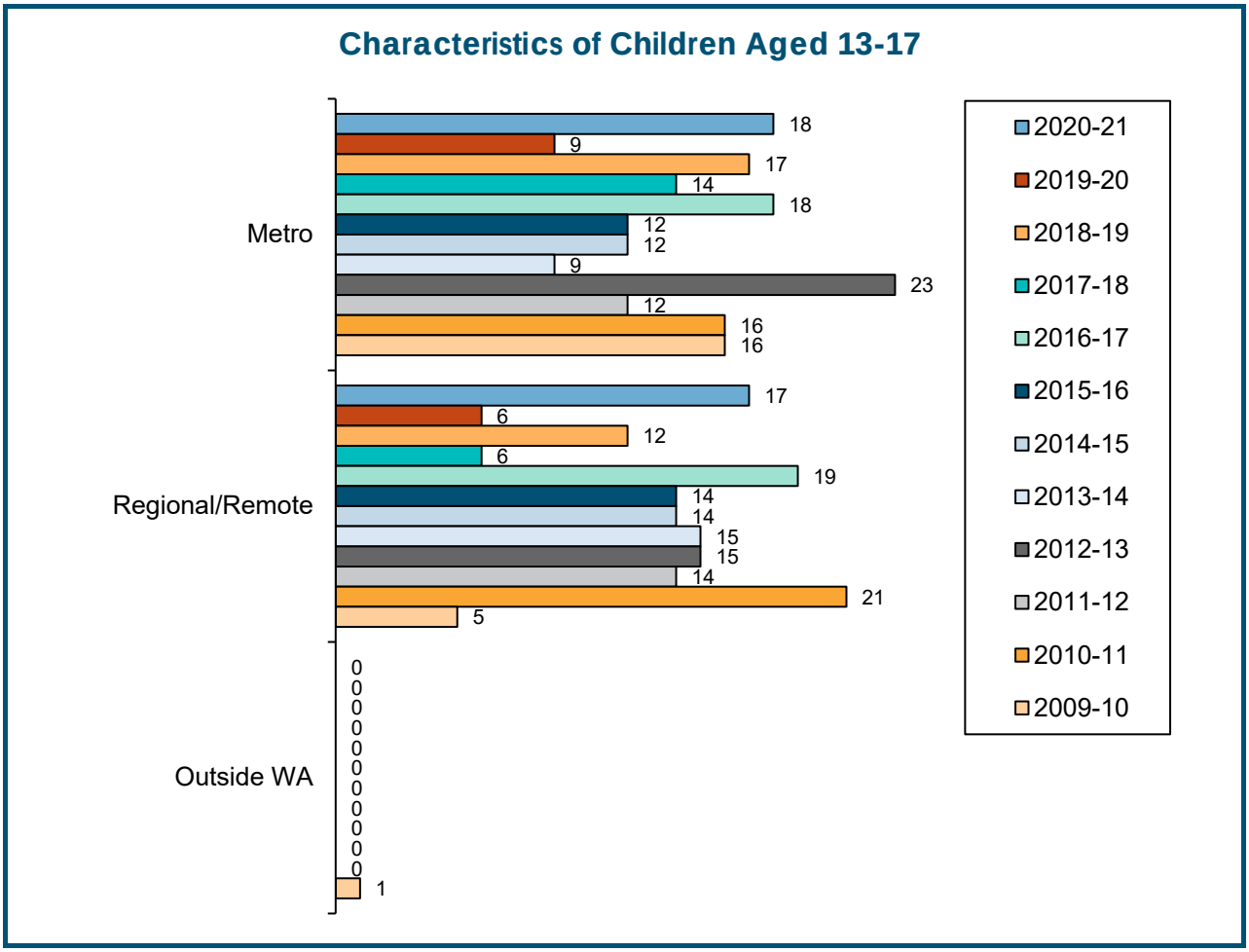
Forty six deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of children aged 13 – 17 years

Of the 1,002 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2021, there were 335 (33%) related to children aged from 13 to 17 years.

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



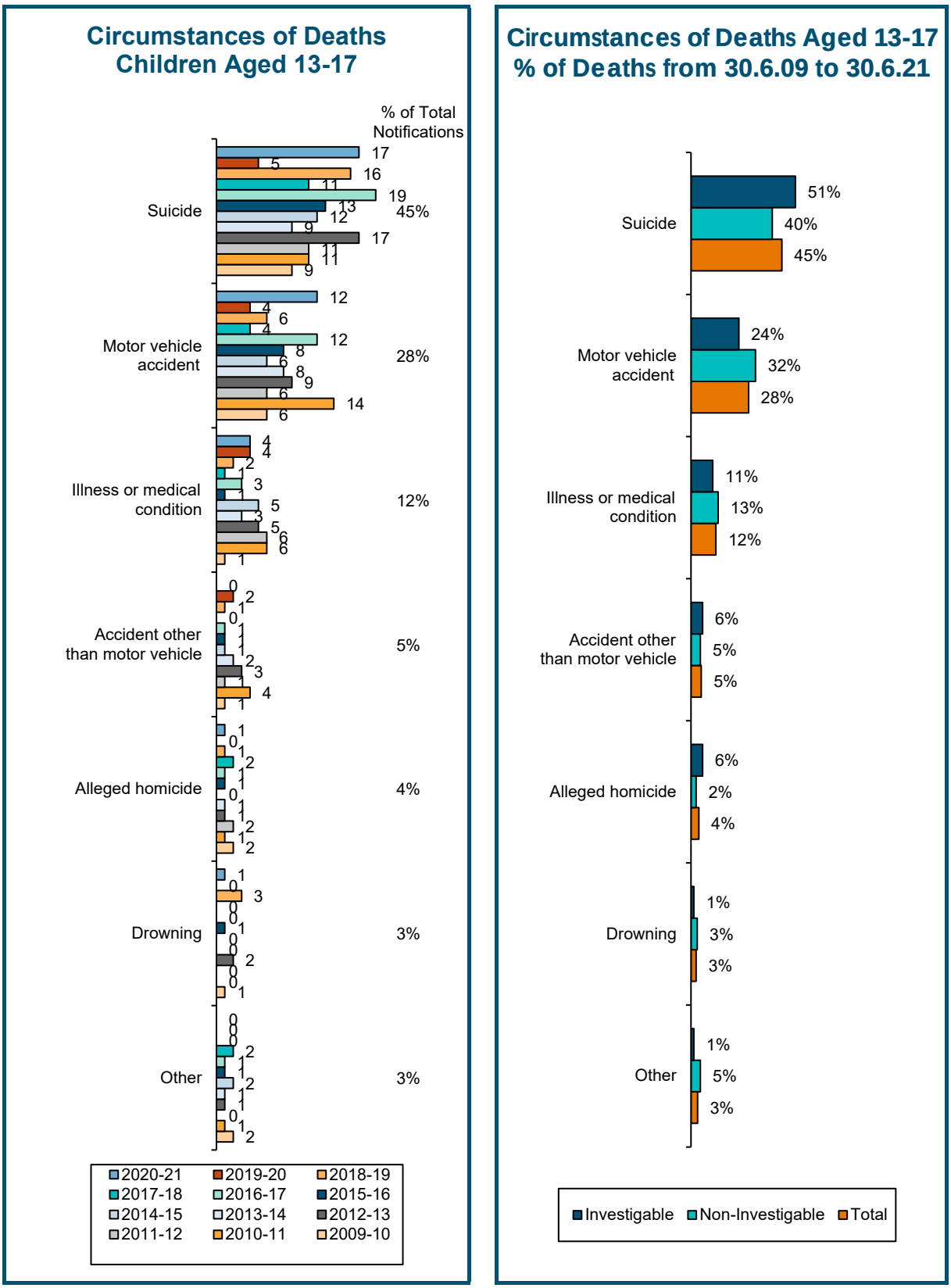


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 58% of investigable deaths and 66% of non-investigable deaths of children aged 13 to 17 were male compared to 51% in the child population;
- Aboriginal children – 53% of investigable deaths and 13% of non-investigable deaths of children aged 13 to 17 were Aboriginal compared to 6% in the child population; and
- Children living in regional or remote locations – 56% of investigable deaths and 41% of non-investigable deaths of children aged 13 to 17, living in Western Australia, were living in regional or remote locations compared to 27% in the child population.

As shown in the following chart, suicide is the most common circumstance of death for this age group (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.

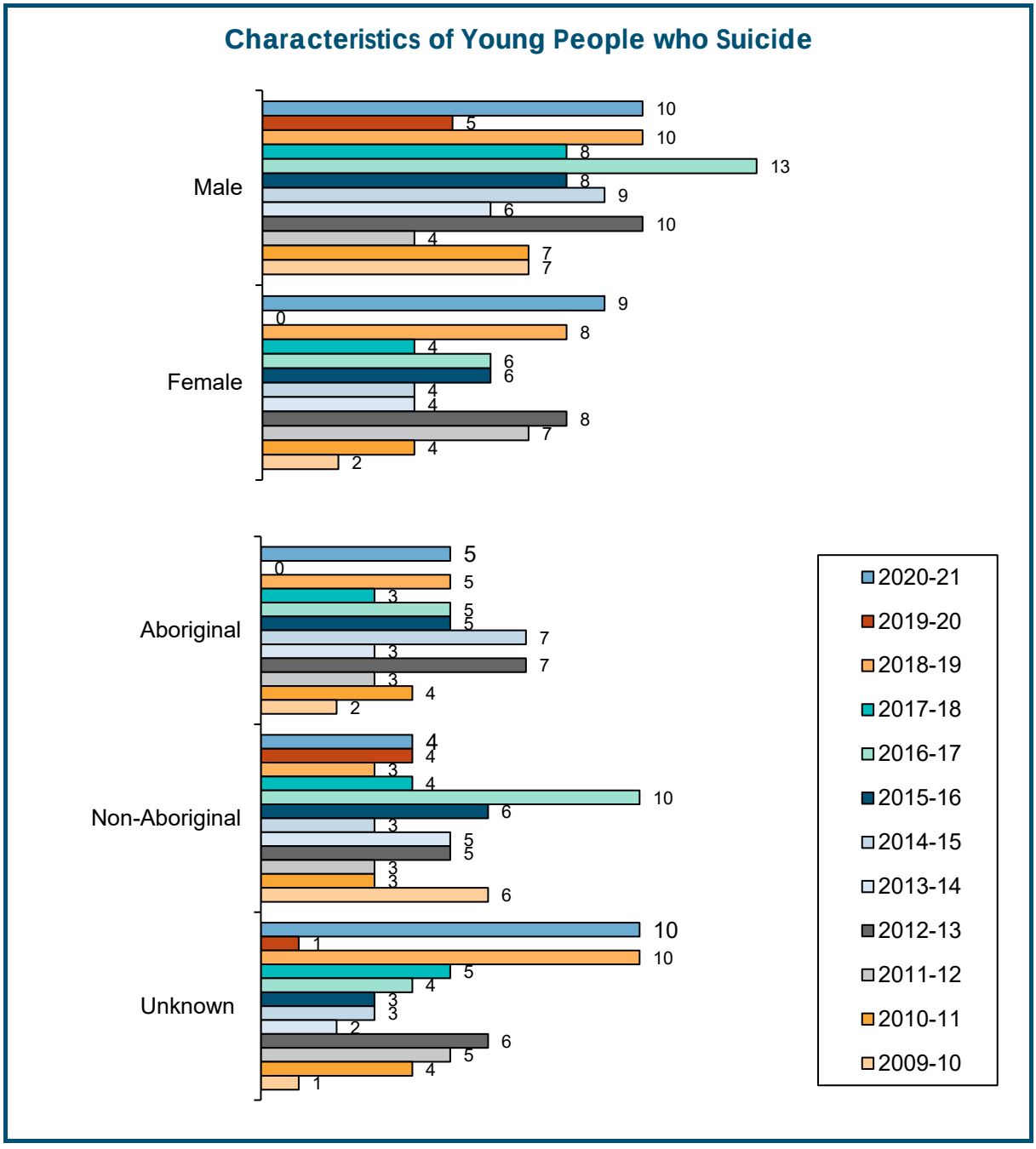
One hundred and forty deaths of children aged 13 to 17 years were determined to be investigable deaths.

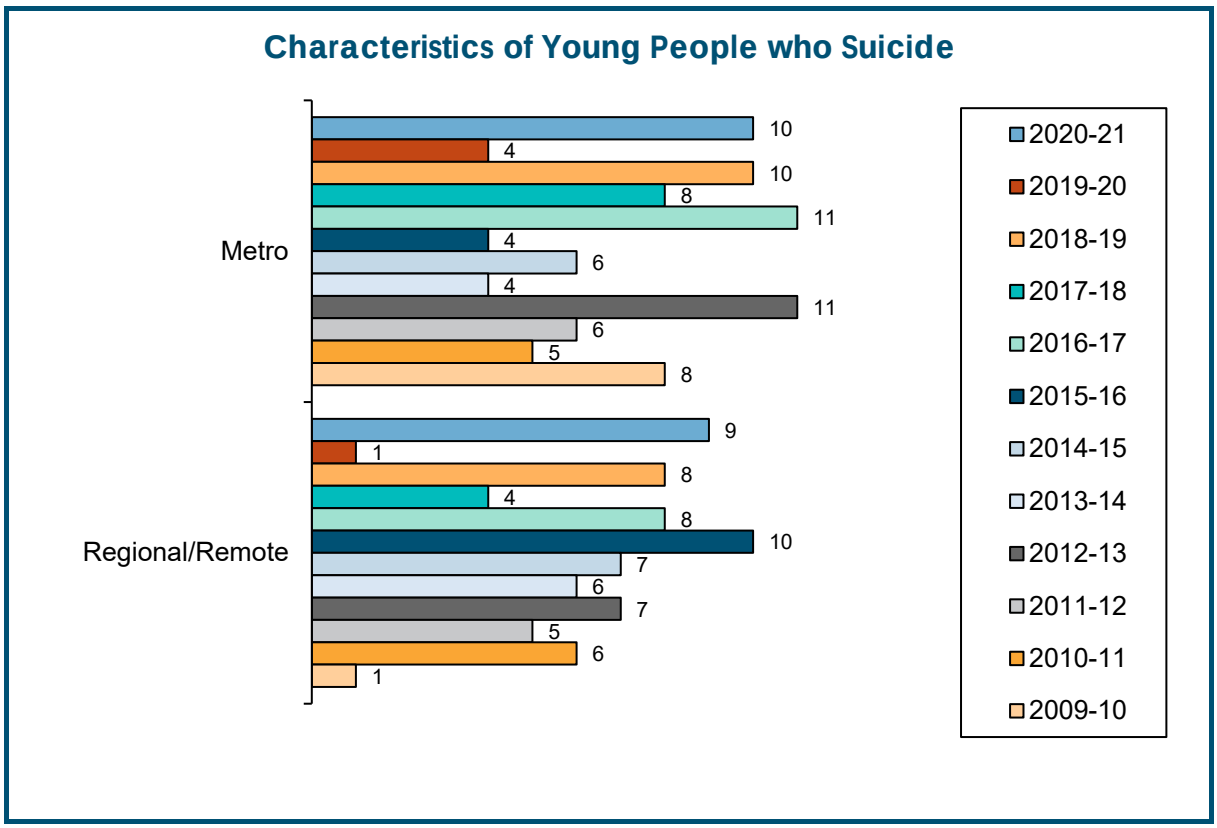
Suicide by young people

Of the 159 young people who apparently took their own lives from 30 June 2009 to 30 June 2021:

- Nine were under 13 years old;
- Nine were 13 years old;
- Fifteen were 14 years old;
- Thirty five were 15 years old;
- Forty one were 16 years old; and
- Fifty were 17 years old.

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





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

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

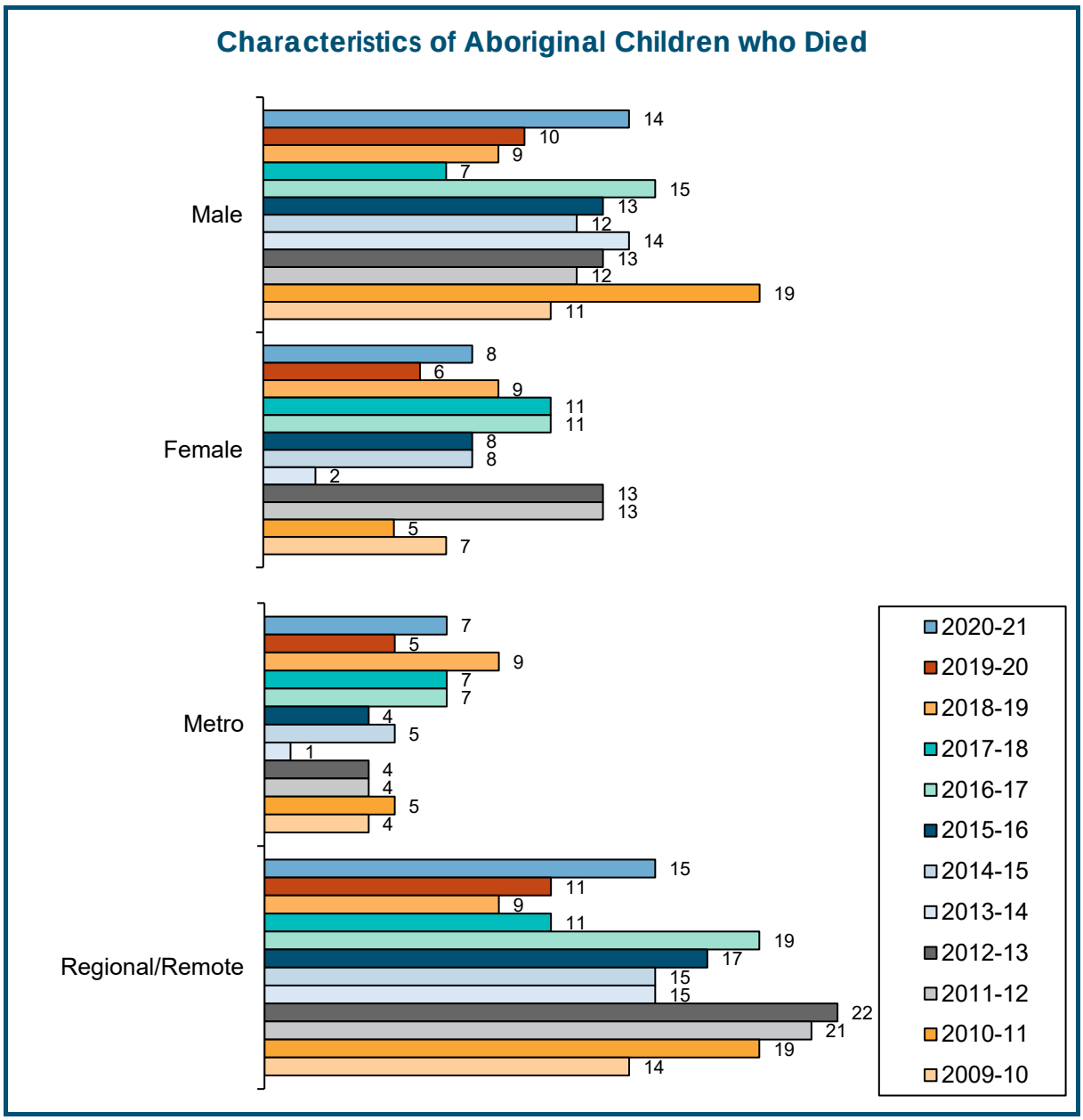
- Males – 53% of investigable deaths and 69% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 105 apparent suicides by young people where information on the Aboriginal status of the young person was available, 64% of the investigable deaths and 16% 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 58% of investigable suicides by young people and 33% 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

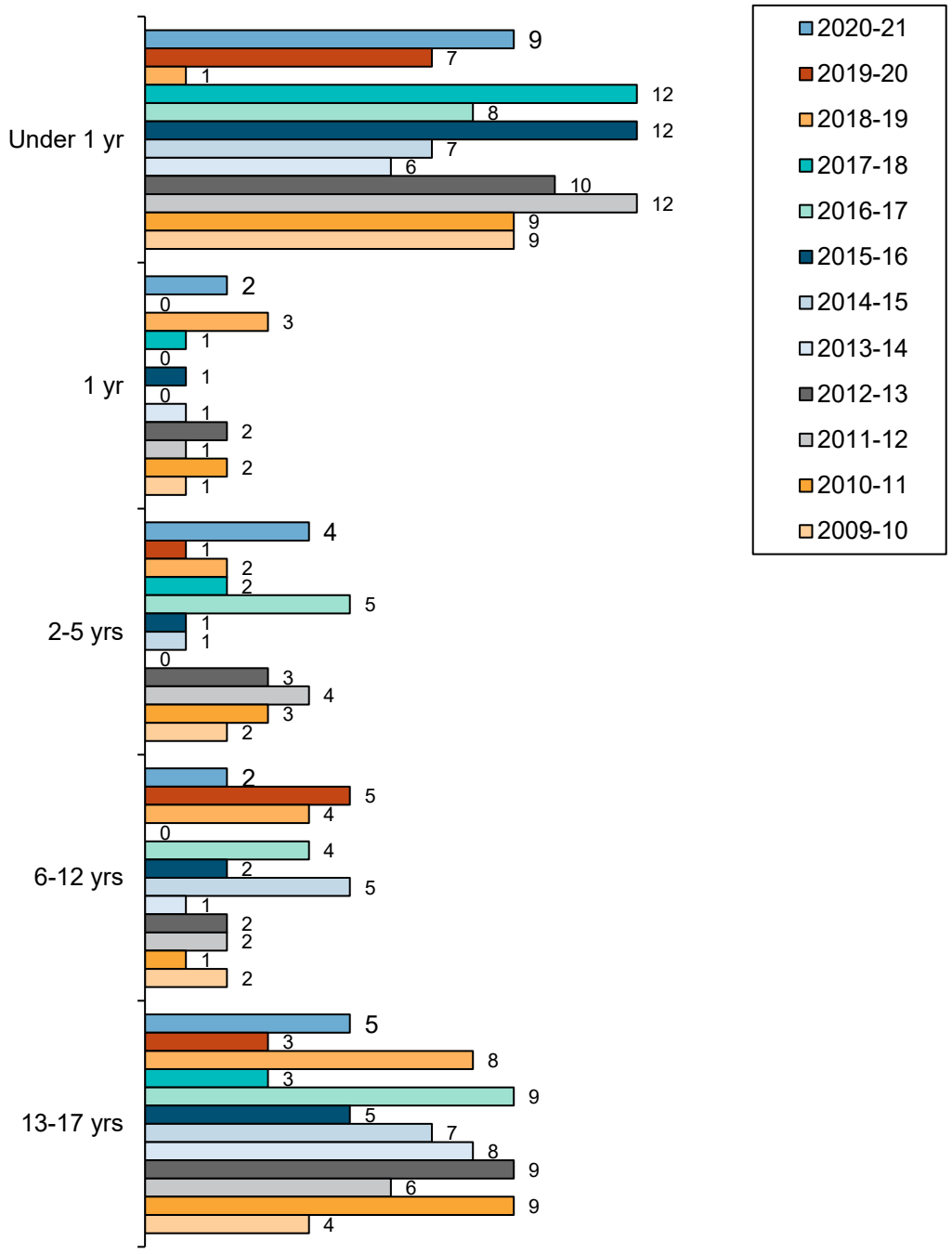
Of the 641 child death notifications received from 30 June 2009 to 30 June 2021, where the Aboriginal status of the child, or their parent/s, was recorded by agencies they had contact with in documentation provided to this Office, 250 (39%) of the children were identified as Aboriginal.

For the notifications received, the following chart demonstrates:

- Over the 12 year period from 30 June 2009 to 30 June 2021, the majority of Aboriginal children who died were male (60%). For 2020-21, 64% 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 12 year period, 75% of Aboriginal children who died lived in regional or remote communities.

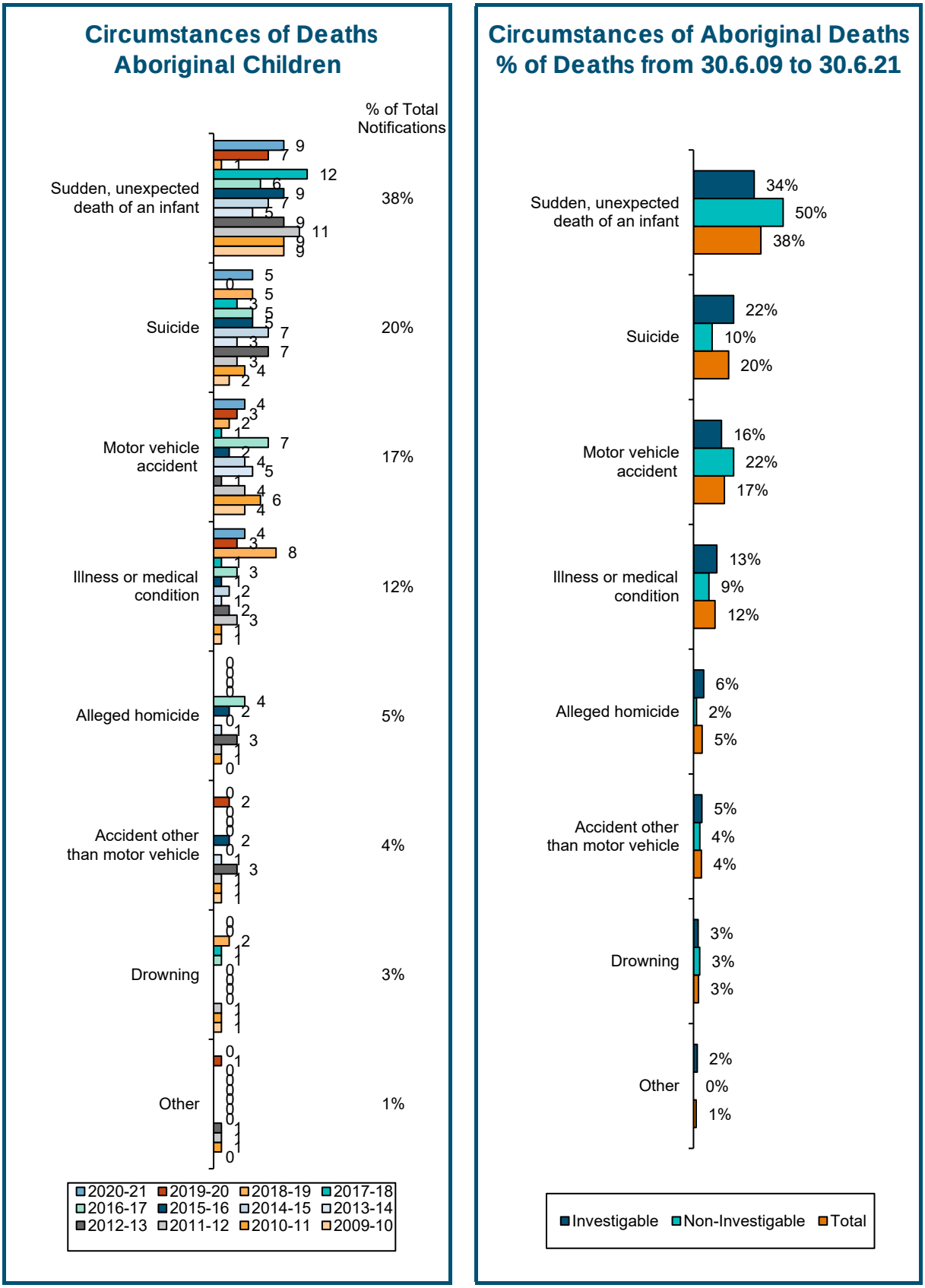


Characteristics of Aboriginal Children who Died



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 (20%), and motor vehicle accidents (17%) are the largest circumstance of death categories for the 250 Aboriginal child death notifications received in the 12 years from 30 June 2009 to 30 June 2021.



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 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 safety and wellbeing concerns for Baby A reported to Communities, indicating Baby A was a high-risk infant. Noting that Baby A had been managed on the Monitored List, this Office examined the governance processes associated with the Monitored List and the Ombudsman made the following recommendation:

> Communities provides a report to the Ombudsman within six months of the finalisation of this child death review outlining actions taken and/or proposed by Communities' 'working party' established to review executive governance and oversight processes for children placed on the Monitored List, inclusive of children not in the Chief Executive Officer's care.

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.

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.

Further details of *A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce deaths of children by drowning* are provided in the Own Motion Investigations and Administrative Improvement section of this Annual Report.

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

Child B died following solvent use.

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

> That Communities provides a report to the Ombudsman, within four months of the finalisation of this review, detailing Communities' strategies and/or practice guidelines for recognising and responding to reports of alcohol, drug and volatile substance use by children and young people.

Deaths of primary school aged children from motor vehicle accidents

In 2020-21, the Ombudsman received four notifications of the deaths of children aged six to 12 years in the circumstances of motor vehicle accidents. All four of these deaths occurred in regional or remote 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 2014 Investigation**). The report made 22 recommendations about ways to prevent or reduce suicide by young people, all of which were accepted by the agencies involved.

Preventing suicide by children and young people 2020, tabled in Parliament in September 2020, identified that steps have been taken to give effect to the Ombudsman's recommendations from the 2014 Investigation and examined a further 79 deaths by suicide that occurred following the 2014 Investigation. Further details are provided in the Own Motion Investigations and Administrative Improvement section of this Annual Report.

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 to promote child safety and wellbeing.
- 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 assessing whether a family care arrangement is appropriate for the safety and wellbeing of an infant subject to a child safety investigation.
- Not adequately meeting policies and procedures relating to Safety and Wellbeing Assessments and safety planning.
- Not adequately meeting policies and procedures relating to *Intensive Family Support*.
- Not adequately meeting policies and procedures relating to high-risk infants.
- Not adequately meeting policies and procedures relating to pre-birth planning.
- Not adequately meeting policies and procedures relating to use of the Interaction Tool.
- 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 assessment and safety planning to promote the best interests of a young person in the context of youth alcohol, drug and solvent use.
- Need for clear strategies or practice guidelines informing child protection workers how to promote the safety and wellbeing of children and young people using alcohol and other drugs.
- Missed opportunities to promote infant safe sleeping by providing appropriate information.
- Not taking action to promote child safety and wellbeing in the context of homelessness.
- Not adequately meeting policies and procedures relating to management of the Monitored List.
- Missed opportunities to achieve sustained improvement where issues and associated actions are identified by internal review processes.
- 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 2020-21 arising from child death reviews (certain recommendations may be de-identified to ensure confidentiality).

1. That Communities provides a report to the Ombudsman, within four months of the finalisation of this review, detailing Communities' strategies and/or practice guidelines for recognising and responding to reports of alcohol, drug and volatile substance use by children and young people.

2. Communities provides the Ombudsman with a copy of the Australian Centre for Child Protection 'independent evaluation of the Interaction Tool' and/or a report outlining the findings and outcomes of the independent evaluation of the Centralised Intake Model, Interaction Tool and its state-wide implementation, when available.

3. WA Country Health Service (**WACHS**) considers the findings of this child death review of Infant A, along with the findings of the child death reviews of Infant B and Infant C and actions taken by WACHS to implement the Ombudsman's associated June 2018 recommendations, to determine whether further action is required to:
   - Ensure that where risk indicators for an unborn child/infant are identified, appropriate assessments are undertaken and documented in accordance with the Department of Health Guidelines for Protecting Children 2015 (revised May 2017, or any subsequent revisions);
   - Ensure that where inquiries or referrals are made with Communities, all relevant risk information is shared;
   - Improve understanding of the provisions under the *Child and Community Services Act 2004* (**CCS Act**) to protect health service providers from liability when they disclose confidential information related to the wellbeing of an unborn child/infant; and
   - Improve knowledge of Communities' referral assessment processes (including what information is considered under the 22 prompts of the Interaction tool and the Casework Practice Manual section 2.2.18 High-risk infants) and the threshold for Communities in determining that action is required under the CCS Act, to promote effective communication and collaboration by WACHS in ensuring an unborn child/infant is safe from harm.

4. The Department of Justice provides the Ombudsman with a report by 30 June 2021, outlining the outcomes of the quality assurance project to assess compliance with Chapter 19 of the Adult Community Corrections Handbook in the management of Community Based Orders to ensure:
   - Referrals are made to Communities where children are at risk;
   - Proactive information sharing with Communities to protect the safety of an adult victim of family and domestic violence; and
   - Collaborative case management where continued concerns are held for the safety of children or an adult victim of family and domestic violence.

5. That Communities considers whether any action is required to ensure, when a family arranged placement occurs during a Child Safety Investigation, that action is taken to assess the appropriateness of the family arranged placement in the child's best interests, provide associated safety planning and supports to this placement including consideration of whether a protection order (supervision) is required and reports back to the Ombudsman on the outcome of this consideration by 30 April 2021.

6. Communities provides a report to the Ombudsman within six months of the finalisation of this child death review outlining actions taken and/or proposed by Communities' 'working party' established to review executive governance and oversight processes for children placed on the Monitored List, inclusive of children not in the Chief Executive Officer's care.

Steps taken to give effect to the recommendations arising from child death reviews in 2018-19

The Ombudsman made 13 recommendations about ways to prevent or reduce child deaths in 2018-19. 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: Communities takes all necessary steps to ensure that administrative processes associated with assessment of child wellbeing reports do not prevent Communities from seeking information from other relevant government and non-government agencies.

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 14 April 2021, containing a report prepared by Communities.

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

> **This recommendation has been actioned**
>
> Communities has undertaken a four month pilot of the expansion of activities when a report of concern is received (Duty Interaction) including wider consultation to gather information to inform Communities assessment and decision to progress to the next stage of intake (Initial Inquiries).
>
> Communities commissioned an independent evaluation of the interaction tool to examine its application and appropriateness.
>
> Communities has been working to continually refine and improve the Interaction Tool. This includes:
>
> - Change the look of the tool and language of some of the items to promote clarity

- Working towards better integration of the Interaction Tool in Communities recording platform ASSIST to streamline processes and improve access to the information.

As a quality assurance mechanism, a random sample of child protection interactions are screened daily as a quality assurance and continual improvement process to identify themes and issues for the ongoing training, development and upskilling of staff.

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

A discussion paper has been prepared for Communities Executive Team to consider the pilot findings.

The Australian Centre for Child Protection (ACCP) was contracted to undertake the evaluation of the Interaction Tool. The evaluation outcomes are being used to inform the development of the revised version of the Interaction Tool.

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

Recommendation 2: Communities Regional District reiterates to staff what their responsibilities are in applying a trauma informed and culturally appropriate approach when working with Aboriginal children and young people, to promote the safety and wellbeing of, and improve outcomes for, Aboriginal children, families and communities when they come into contact with Communities, in accordance with the purpose of the *Aboriginal Services and Practice Framework 2016-2018.*

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 14 April 2021, containing a report prepared by Communities.

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

This recommendation has been actioned

On 30 November 2020 a second Aboriginal Practice Leader (APL) commenced work in the Regional District. The second APL's portfolio includes the Intensive Family Support Team, the Reunification Team, and the Regional District generic team. Recruitment for a second Senior Practice Development Officer (SPDO) is currently underway.

The Regional District currently employs 16 Aboriginal staff.

Late in 2020 the Regional Executive Director met with the Aboriginal staff group to seek their views on operations.

All staff in the Regional District have completed a one-day, Cultural Competency training, delivered by the Aboriginal Language Centre. All staff who are new to the Regional District attend the workshop as it is made available.

Since the beginning of 2020, the Regional District has internally delivered monthly Cultural Awareness Workshops to staff. Workshops are developed and delivered collaboratively by Aboriginal Practice Leaders (APL), the Regional Coordinator and other leadership staff. Workshop themes are developed in accordance to staff feedback.

On 23 and 24 February 2021, the Impact of Trauma learning program was delivered in the Regional District, this learning program continues to be delivered annually.

Three staff from the Regional District are undertaking the University of South Australia Professional Certificate in Understanding Childhood Trauma.

In 2020, the Aboriginal Language Centre translated a number of Affidavits into Aboriginal languages for families. The Aboriginal Language Centre is also working to provide the Safe Infant Sleeping brochure interpreted into seven Aboriginal languages. It is anticipated that this work will be completed by mid-2021.

In 2021, staff working in the Reunification team commenced using Blurred Borders resources with families. The Resource Kits use visual art and storytelling to help explain, in a culturally accessible way, the key legal concepts around: bail and the criminal process, and family violence.

The two Regional District Psychologists work closely with the APLs to develop case specific, trauma informed responses to children in care, which includes travelling to jointly meet with carers.

Trauma profiles are developed for all young people residing at the Residential Group Home by a Regional District Psychologist, the profiles are then circulated to case workers and Team Leaders.

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

Recommendation 3: That DOE's Statewide Services, with input from the Aboriginal Education Teaching and Learning Directorate, reviews the findings of this child death review, through the lens of the *Aboriginal Cultural Standards Framework (2015),* and works with the Regional School staff and school community to develop a plan to provide 'strengthened support and intervention for students' in accordance with Department's *New Initiatives in Aboriginal Education (2017)* and *Aboriginal Cultural Standards Framework (2015)* to improve school attendance and students' social wellbeing, and to optimise academic outcomes.

Steps taken to give effect to the recommendation

This Office requested that DOE inform the Office of the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 26 March 2021, containing a report prepared by DOE and copies of the *Plan for Regional School, Regional School 2019 Annual Report, Regional School 2021-2023 Strategic Plan, Regional School Strategic Intent 2021-2023, and Behaviour Expectations at Regional School Matrix.*

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

The Regional School continues the work commenced in 2018, to embed the Aboriginal Cultural Standards Framework at the school. An updated plan for the Regional School has been provided.

The Regional School Annual Report reflects on improvements in the school's priority areas of attendance and student progress and achievement. The report provides information on partnerships with community organisations.

Embedding the Aboriginal Cultural Standards Framework, with year-on-year progress towards cultural responsiveness/representation, is noted in the Regional School Strategic Plan 2021-2023.

The plan includes the following priority areas:

- Connected students: Self, School, Culture, Future;
- Relationships and partnership; and
- Highly effective teaching and leadership.

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

Recommendation 4: DOE reviews and revises the current plan to implement the Expert Review Group 10 'prescribed improvement strategies', in association with the Regional School staff and school community, the Regional Executive Director and the DOE's Statewide Services, including the Aboriginal Education Teaching and Learning Directorate, as appropriate, to ensure timely and effective improvement in relation to the 12 'major findings' identified by the Expert Review Group in 2013.

Steps taken to give effect to the recommendation

This Office requested that DOE inform the Office of the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 26 March 2021, containing a report prepared by DOE.

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

In February 2021, a Public School Review was undertaken at the Regional School, superseding the 2013 Expert Review Group report. The report's areas of focus are interlinked with the Aboriginal Cultural Standards Framework and examine relationships and partnerships, learning environment, leadership, use of resources, teaching quality and student achievement and progress.

The Regional School will be reviewed again in Term 1, 2022. The review will focus on the Learning Environment and Teaching Quality domains only. The next Public School Review, inclusive of all domains, will be scheduled for Term 1, 2024.

Strong and robust relationships have been established. The Regional School has embarked on an improvement journey. The goal is for all strategic and operational documents and practices to align and have a student footprint: 'Connected students: self, school, culture, future'. The review team noted that the school has made positive changes in response to attendance trends, building culturally appropriate classroom environments and developing pathways for every student. The review team also validated that NAPLAN student performance shows an upward trend.

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

Recommendation 5: DOE provides the Ombudsman with a report by 1 March 2019 on the outcomes of recommendations 3 and 4.

Steps taken to give effect to the recommendation

DOE provided this Office with a letter dated 1 March 2019, in which DOE relevantly informed this Office of the progress taken to implement recommendations 3 and 4. Further information, as outlined above, was provided by DOE in a letter to this Office dated 26 March 2021.

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

Recommendation 6: Communities, in collaboration with DOE, reviews the *Memorandum of Understanding Between the Department for Child Protection and Family Support and Department of Education (2013)* associated with the administration of the *Students Whose Whereabouts is Unknown* List to consider processes for the interagency identification and management of children on the *Students Whose Whereabouts is Unknown* List, including those who are in the care of the Communities' Chief Executive Officer and/or those who have come to the attention of Communities in the circumstances of reported child safety and wellbeing concerns, in order to locate these children on the *Students Whose Whereabouts is Unknown* List and collectively promote their best interests and re-engagement with education where indicated.

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 14 April 2021, containing a report prepared by Communities.

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

> **This recommendation has been actioned**
>
> Communities worked with the Department of Education (DOE) to review and update the Schedule between Communities and DOE [which is an addendum to the MOU between Communities and DOE 2021]. This included review of the processes to manage the changes to the Students Whereabouts Unknown List (as contained in the Schedule).
>
> The Schedule has been strengthened to include Student Whereabouts Unknown who are not in the CEO's care but who come to the attention of Communities.
>
> The MOU and Schedule have been completed and are operational.
>
> Communities practice guidance has been updated to reflect the directions included in the revised schedule.

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

Recommendation 7: DOE, in collaboration with Communities, reviews the *Memorandum of Understanding Between the Department for Child Protection and Family Support and Department of Education (2013)* associated with the administration of the *Students Whose Whereabouts is Unknown* List to consider processes for the interagency identification and management of children on the *Students Whose Whereabouts is Unknown* List, including those who are in the care of the Communities' Chief Executive Officer and/or those who have come to the attention of Communities in the circumstances of reported child safety and wellbeing concerns, in order to locate these children on the *Students Whose Whereabouts is Unknown* List and collectively promote their best interests and re-engagement with education where indicated.

Steps taken to give effect to the recommendation

This Office requested that DOE inform the Office of the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 26 March 2021, containing a report prepared by DOE and a copy of the *Memorandum of Understanding between the Department of Communities and the Department of Education (2021)* and *Schedule 1*.

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

> The Department of Education has worked with the Department of Communities to review the Memorandum of Understanding (MOU) between the Department for Child Protection and Family Support and Department of Education (2013). In January 2021, a new MOU between the Department of Education and Department of Communities came into effect.
>
> On 12 January 2021, the Department of Education entered into a new Memorandum of Understanding (MOU) with the Department of Communities to consider the range of services amalgamated under Communities and identify opportunities to streamline the integration of support for vulnerable children and young people.
>
> The MOU acknowledges that the safeguarding and promoting the wellbeing of children is shared responsibility between parents, families, communities and across government and non-government agencies.
>
> Section 8 outlines each department's individual and joint responsibilities in planning for school-aged children whose whereabouts are unknown.
>
> Section 8.3 provides greater opportunity for collaborative efforts to identify the whereabouts of children who have come to the attention of the Department of Communities in the circumstances of reported child safety and wellbeing concerns.

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

Recommendation 8: DOE provides the Ombudsman with a report within 12 months of the finalisation of this child death review outlining actions taken to give effect to draft recommendation 7 and processes, proposed and/or implemented, associated with monitoring the effectiveness of revised interagency practices to locate children on the *Students Whose Whereabouts is Unknown* List.

Steps taken to give effect to the recommendation

DOE provided this Office with a letter dated 10 January 2020, in which DOE relevantly informed this Office of the progress taken to implement recommendation 7. Further information, as outlined above, was provided by DOE in a letter to this Office dated 26 March 2021, which also informed this Office:

> The Department will continue to work with other agencies and organisations to locate students whose whereabouts were unknown and reduce the number not participating in education or approved options.

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

Recommendation 9: Given the issues identified with undertaking assessment and safety planning to administer the responsibilities under the *Children and Community Services Act 2004* in relation to the protection and wellbeing of a child, in this review, Communities provides the Ombudsman with a report by 30 September 2019 that outlines what steps will be undertaken by Communities to ensure critical decision making in assessment and safety planning is:

- **Consistent and compliant with the provisions and intent of the *Children and Community Services Act 2004;***
- **Informed by evidenced-based knowledge and skills related to child protection work; and**
- **Operationalised by an effective and efficient policy and procedural framework.**

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 26 September 2019, in which the Department relevantly informed this Office of initial steps taken and proposed steps. This Office requested further information 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 14 April 2021, containing a report prepared by Communities.

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

> **This recommendation has been actioned**
>
> **Introduction of Centralised Intake and the Interaction Tool**
>
> Refer to recommendation 1.

Pre-Birth Planning Project

A dedicated project for improving the quality and consistency of pre-birth planning processes, commenced in 2018-19.

Casework practice manual redevelopment project:

In 2019, Service Delivery commenced a trial of the Livepro Knowledge Management Platform, to provide a more accessible format for the provision of practice guidance. The objectives of the trial include:

- implement an effective and efficient way of delivering policy and practice guidance through technology to child protection staff in metro, regional and remote areas;
- develop efficient, clear and up to date information for child protection workers that is consistent with legislation and policy requirements;
- reduce the length of Casework Practice Manual (CPM) entries (where possible and appropriate);
- improve the search functionality; and
- identify barriers to staff accessing the CPM and develop appropriate solutions.

The trial of the Livepro platform for frontline staff concluded in January 2021, and due to budget restraints the platform is no longer being used.

From mid-2020 Communities, using outcomes from the trial, commenced exploring ways to improve the existing CPM on SharePoint.

These improvements include the use of active language and icons to highlight important information and incorporating related resources containing practice guidance into the content of entries. The CPM entries are being restructured to change the chapters in line with the Livepro platform to present guidance in a concise and easily understood way.

Work continues to prioritise reviewing existing entries to ensure information is aligned to changes and additions to Communities' policy framework.

Training and Professional Development

Communities continues to strengthen child protection training programs to ensure child protection workers are supported to increase their theoretical knowledge and practice skills to guide professional judgement in assessing and responding to co-occurring risk factors such as alcohol and other drugs, mental health and family and domestic violence. Particular attention has been paid to the following:

- Critical decision making in assessment and safety planning, which is informed by evidence-based knowledge and skills related to child protection work.
- Safety planning is informed by theoretical knowledge and practice skills associated with drug and alcohol use when parenting an infant.
- Team Leaders are receiving the relevant formal learning opportunities for governance of pre-birth planning and the Signs of Safety framework.
- Determine what mandatory formal learning and regular updates are required to ensure Team Leaders are supported to be proficient in approving critical decisions in child protection assessment and safety planning.
- Programs for team leaders, managers and supervisors related to undertaking Child Safety Investigations, implementing Signs of Safety practice and safety planning.

Training for new child protection workers (Orientation Program) is mapped to National Competencies; this will also be the case for the child protection Team Leader's development program. As per the previous report, Communities will be able to record demonstrated competencies as they relate to learning outcomes and objectives.

Purchase of an e-learning module on the intersection between family and domestic violence, alcohol and other drugs and mental health is in train.

Communities is contracting local Alcohol and other Drug service providers to deliver training on working with young people affected by volatile substance abuse. Team Leaders will be able to attend this training, which will initially be offered in Kalgoorlie and Geraldton.

Proposed

Revise the existing Assessment and Safety planning course to strengthen the focus on family and domestic violence (and its intersections with AOD and mental health), potentially partnering with the Department of Health.

To complement the revised Assessment and Safety Planning course, Communities will work with the Department of Health, Telethon Institute and the Mental Health Commission to develop further training on alcohol and drug use where mental health and cognitive disabilities are co-morbidities. This will include topics such as substance abuse during pregnancy and while breast feeding, substance abuse and its impact on parenting capabilities, substance: abuse and safe sleeping, and decision making in the best interests of the child.

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

Recommendation 10: Given the issues identified with the use of Signs of Safety (and for the application of/compliance with the *Signs of Safety Child Protection Practice Framework*), in this review and other reviews undertaken by the Ombudsman, and given that the *Signs of Safety Child Protection Practice Framework* has now been in place for ten years, and also given the University of South Australia Australian Centre for Child Protection Report and Framework Assessment of the Signs of Safety policies and administrative frameworks to operationalise reloaded projects, Communities provides the Ombudsman with a report by 30 September 2019 that outlines what steps will be undertaken by Communities to ensure that the 'Signs of Safety Reloaded' project provides an optimal policy and administrative framework to operationalise Communities' responsibilities under the *Children and Community Services Act 2004*.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 26 September 2019, in which Communities relevantly informed this Office that:

> …Communities focus over the next 12 months will include supporting and consolidating practice improvements, particularly in the areas of Child Safety Investigations, and gathering evidence and information about use of Signs of Safety Child Protection Practice Framework, to be reported in the first Signs of Safety Monitoring Report in 2020. The information gathered through these monitoring processes will be considered by Communities service delivery executive, to inform decisions about next steps including further planning and review.

This Office requested further information 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 14 April 2021, containing a report prepared by Communities.

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

> **This recommendation has been actioned**
>
> Communities is committed to ensuring the Signs of Safety framework provides an optimal policy and administrative framework to operationalise the responsibilities under the *Children and Community Services Act 2004*. Communities is working towards developing integrated operational data collection and analysis that provides evidence to inform decision making. To help achieve this, Communities is developing a single consolidated child protection monitoring framework. This would enable:
>
> - a more comprehensive overview of child protection activities;
> - an integrated view across programs and services;
> - the ability to modify monitoring activities to incorporate new or revised programs and services; and
> - a more streamlined governance process for child protection monitoring activities.
>
> A substantial number of projects designed to improve child protection responses have been delivered or are underway, including;
>
> - Centralised Intake and the introduction of the Interaction Tool, that has been evaluated and improvements to the tool implemented.
> - The CPM redevelopment
> - Regular updates to CPM entries, including a review of the family and domestic violence guidelines and policy
> - Pre-Birth Planning Project
> - Changes to Communities investigation processes with the introduction of Child Safety Investigations
> - Team Leader Pathways project and the implementation of the Let's Talk Performance Management System
> - Reviewed and revised training programs
> - One Learning Management System
> - Programs for team leaders, managers and supervisors related to undertaking safety and wellbeing assessments, implementing Signs of Safety practice and safety planning.
>
> **Signs of Safety Knowledge Hub**
>
> The Signs of Safety Knowledge Hub provides Communities staff with a wide range of case examples, support tools, practice resources and training information, as well as being a platform to share ideas and learning on Signs of Safety child protection practice.

Signs of Safety Gathering 2021

The sixth WA Signs of Safety Gathering has been scheduled for 26-28 October 2021. The theme of the Gathering is 'Hearing Our Voices'. The Signs of Safety Gathering provides an opportunity for participants to share and reflect on child protection workers practice with families where there are complex and challenging issues, keeping the child central to all planning and decision making. The Gathering includes participants from other government and non-government agencies, with invitations extended to national and international practitioners.

Signs of Safety 100 days of training

Referred to as '100 days of training'. The training will be focused on safety planning bootcamps across each of Communities child protection districts covering 30 staff from each district.

Aboriginal Family Led Decision Making Project.

Communities has commenced planning to implement a pilot of Aboriginal Family Led Decision Making. This project is led by and co-designed with Aboriginal stakeholders in partnership with Communities. An Implementation Group has been established to guide, co-design and make decisions on various aspects of the pilot. The Group consists entirely of Aboriginal leaders (10), with support from Communities staff. It is envisaged that the pilot will commence in the second half of 2021, whilst recognising the need for culturally appropriate decision-making processes which may impact on commencement date.

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

Integrated Operational Data Collection and Analysis

A desktop review of existing and proposed monitoring activities has commenced…

Signs of Safety 100 Days of Training

The first bootcamp was held with the Perth District in March 2021, the workshops are part of an extensive Child Protection Practice Leadership Development Program, which will deliver a range of learning sessions to child protection workers and leadership teams over the coming months. Eight workshops have been scheduled over the next six months for members of the Communities Leadership Team, Executive Directors and Regional Executive Directors to achieve greater understanding of front-line work.

Background to this recommendation

Communities implemented the Signs of Safety Framework in 2008. Communities commissioned an evaluation of the Signs of Safety Framework, undertaken by the University of South Australia Australian Centre for Child Protection (**ACCP**), which in 2018 identified the two key determinants of the evaluation outcomes as being the 'insufficient Signs of Safety framework' and the 'problems with staying true to the Signs of Safety framework (fidelity) and implementation'. The ACCP noted that the Signs of Safety Framework is underpinned by the theoretical framework of Solution Focused Brief Therapy and states there is no evidence base indicating that the adoption of brief therapy in a child protection setting reduces child abuse and neglect.

In response to the ACCP evaluation, Communities commenced the 'Signs of Safety Reloaded' project intended to address the issues identified by the ACCP. In November 2018, Communities informed this Office of the associated Monitoring Framework project and provided a draft copy of the project document dated July 2018. This draft Monitoring Framework stated that the monitoring would commence on '1 January 2019 and be reported annually by calendar year for a five-year period'. Communities also, at that time, informed this Office of a number of steps over the next five years to improve the implementation of the Signs of Safety Framework.

At the time of making this recommendation in June 2019, it was noted that ten years after the inception of the Signs of Safety Framework, there were ongoing issues with the fidelity of the framework and, as noted by the ACCP, limited evidence that Signs of Safety is demonstrating that it is the optimal tool to operationalise the Department's responsibilities under the CCS Act.

Information provided to this Office by Communities, as summarised above, indicates actions to train and support staff in implementing the Signs of Safety framework. While it is noted that, as initially commenced in 2018, this Office has been informed that 'Communities is working towards developing integrated operational data collection and analysis that provides evidence to inform decision making' and is 'developing a single consolidated child protection monitoring framework', these tasks have not been completed since this recommendation was made in June 2018.

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

Recommendation 11: Communities ensures that, during the course of supervision provided (in accordance with Chapter 4.1.7 of Communities' *Casework Practice Manual*) in 2019, all child protection workers are supported in relation to developing their theoretical knowledge and practice skills regarding drug/alcohol assessment and safety planning to guide professional judgement in administering Communities' responsibilities in accordance with the *Children and Community Services Act 2004*, including identifying further learning strategies and professional development when appropriate.

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 14 April 2021, containing a report prepared by Communities.

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

> **This recommendation has been actioned**
>
> During practice supervision, all child protection workers are supported in developing their theoretical knowledge and practice skills – particularly regarding drug/alcohol assessment and safety planning - including identifying further learning strategies and professional development.
>
> Communities is in the process of introducing a new performance management process 'Let's Talk'. Let's Talk is to replace the performance planning and review systems of the legacy agencies now amalgamated to form Communities.

> The Let's Talk process follows a performance cycle beginning with planning conversations that outline work objectives and professional development requirements. The Let's Talk sessions are documented in a performance agreement between the supervisor and the staff member.
>
> Let's Talk does not replace clinical/case supervision for child protection staff, however professional development needs for staff will now be included in the new process.

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

> …Implementation of Let's Talk Supervision program by July 2021

This Office requested further information of the steps taken to give effect to the recommendation. In response, further information was provided by Communities in an email to this Office dated 26 May 2021, which informed this Office:

> The Department of Communities (Communities) acknowledges that in implementing the recommendation arising from the child death review in 2019, Districts were directed to undertake and record supervisions in accordance with the case practice guidelines. However in 2018 Communities Reaching Forward Performance Management Reporting platform was disabled with a replacement Performance Management system referred to as the Let's Talk, this system is currently being implemented. Although supervisors have been undertaking conversations in accordance with the practice guidelines in relation to alcohol and other drugs as a harm type, these conversations were not consistently recorded. Therefore, Communities has determined to repeat the task and will do so by 31 December 2021. Communities will provide the Ombudsman with appropriate documentation to evidence the implementation of the recommendation in early 2022.

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

Recommendation 12: When developing a Team Leader Program for Communities' *Child Protection Learning Pathway*, Communities considers the findings of this case and data on team leader formal learning participation (as provided for this review), and determines what mandatory formal learning and regular updates are required to ensure team leaders are supported to be proficient in undertaking the delegated responsibilities in approving critical decisions in child protection assessment and safety planning.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 26 September 2019, in which the Department relevantly informed this Office that:

> …A project has been initiated to develop a clear learning pathway, including associated learning and development materials, to ensure Team Leaders have the requisite skills and knowledge for leading and managing teams, providing effective supervision and supporting critical decision making that is consistent with the objects and provisions of the *Children and Community Services Act 2004.* The project scope is currently being refined…

This Office requested further information of steps taken to give effect to the recommendation. In response, Communities provided a range of information in a

letter to this Office dated 14 April 2021, containing a report prepared by Communities.

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

> **This recommendation has been actioned**
>
> **Team Leader Program**
>
> A project to develop a learning and development program specifically for Team Leaders is underway. The content and competency-based assessment process will be based on existing National Competencies. Particular attention will be paid to the content of the Graduate Certificate of Statutory Child Protection. A Project Board of subject matter experts meets monthly to oversee this project.
>
> In developing the Team Leader Program, particular attention has been paid to the following:
>
> - Team Leaders are receiving the relevant formal learning opportunities for governance of pre-birth planning and the Signs of Safety framework.
> - Determine what mandatory formal learning and regular updates are required to ensure Team Leaders are supported to be proficient in approving critical decisions in child protection assessment and safety planning.
> - Programs for team leaders, managers and supervisors related to undertaking safety and wellbeing assessments, implementing Signs of Safety practice and safety planning.
>
> The Project Board will consider mandatory formal learning and updates in 2021, noting that this may be refined following the development of a competency framework and training needs analysis, as the project progresses.
>
> The following professional development opportunities are offered to child protection workers, including Team Leaders:
>
> - Pre-Birth Planning and Pre-Birth Facilitation training was attended by Team Leaders in 2020, with further workshops to be scheduled.
> - Responding to High Risk Infants was delivered in 2020, with further workshops scheduled for 2021.
> - Team Leaders have been actively attending Quality Assuring Child Safety Investigations training throughout 2021. This compliments the Child Safety Investigation training that was delivered in 2019.
> - Signs of Safety training is being progressively delivered throughout the State (February – September 2021). This program focuses on improved practice development and leadership. Sessions designed to support leadership in building the focus on child protection practice will also be held.
> - A Signs of Safety Knowledge Hive is hosted on Communities intranet, including practice resources.
> - Supervision and Performance Improvement Skills for Team Leaders was delivered throughout 2020, with further courses to be scheduled.
> - An introduction to Alcohol and Other Drugs e-learning course.
> - Case practice clinics, examining 'live' cases are regularly held. These can include cases where family and domestic violence, mental health and AOD are presenting issues.
> - Communities is partnering with the Telethon Institute to deliver training on Foetal and Alcohol Syndrome Disorder, with sessions scheduled for April 2021. Team Leaders will be given priority status as enrolments are received.
> - The content of the child protection Orientation Program was revised in 2020, with some Team Leaders subsequently attending tutorials. Written content, in the form

of learner guides and workbooks, is available to all Team Leaders. Relevant modules include:

- Intensive Family Support
- Child Safety Investigations Trajectory and Safety Planning
- Managing High Risk Cases
- Child Protection Decision Making (workshop)
- Aboriginal Cultural Safety

Proposed

- Revise the existing Assessment and Safety planning course to strengthen the focus on family and domestic violence (and its intersections with AOD and mental health), potentially partnering with the Department of Health.
- To complement the above dot point, work with the Department of Health, Telethon Institute and the Mental Health Commission to develop further training on alcohol and drug use where mental health and cognitive disabilities are co-morbidities. This will include topics such as substance abuse during pregnancy and while breast feeding, substance abuse and its impact on parenting capabilities, substance abuse and safe sleeping, and decision making in the best interests of the child.
- Deliver AOD Core training and AOD Motivational Interviewing training, tailoring the content to meet Team Leaders' needs.
- Rework relevant content in the child protection Orientation Program so that it is targeted at Team Leaders.
- Expand the scope and content of training delivered by local AOD service providers.

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

Recommendation 13: Communities provides a report to the Ombudsman on the completion of recommendation 12 by 30 September 2019.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 26 September 2019, in which Communities relevantly informed this Office of the progress to implement Recommendation 12. Further information, as outlined above, was provided by Communities in a letter to this Office dated 14 April 2021.

While a report was appropriately provided as required by Recommendation 13, it is noted that, as outlined in Communities' response to Recommendation 12 above, the development of a Team Leader Program for Communities' *Child Protection Learning Pathway* is not yet completed.

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 2020-21, timely review processes have resulted in 71% of all reviews being completed within six months.

Expanded child death review function

During 2020-21, 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.

Preventing suicide by children and young people 2020

About the report

As part of the Ombudsman's responsibility to review the deaths of Western Australian children, on 24 September 2020, *Preventing suicide by children and young people 2020* was tabled in Parliament. The report is comprised of three volumes:

- Volume 1 an executive summary;
- Volume 2 an examination of the steps taken to give effect to the recommendations arising from the report of the Ombudsman's 2014 major own motion investigation, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (**the 2014 Investigation**); and
- Volume 3, the report of the Ombudsman's 2020 major own motion investigation, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people* (**the 2020 Investigation**).

Arising from the 2014 Investigation, the Ombudsman made 22 recommendations about ways that State government departments and authorities can prevent or reduce suicide by young people directed to the Mental Health Commission, the (then) Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education broadly aimed at:

- developing differentiated strategies for suicide prevention relevant to each of the four groups of young people who died by suicide for inclusion in the Western Australian Suicide Prevention Strategy (Recommendations 1, 2 and 3);
- improving service delivery and the rate at which operational policy is implemented into practice within the Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education (Recommendations 4 - 21); and

- promoting inter-agency collaboration between the Mental Health Commission, Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education, through consideration of a joint case management approach and shared tools for use with young people experiencing multiple risk factors associated with suicide (Recommendation 22).

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

Objectives

The objectives of Volume 2 of the September 2020 report *Preventing suicide by children and young people 2020* were to consider (in accordance with the *Parliamentary Commissioner Act 1971*):

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

Volume 2 also considered whether the steps taken, proposed to be taken or reasons for taking no steps:

- seem to be appropriate; and
- have been taken within a reasonable time of the making of the recommendations.

After reviewing information arising from the reviews of the lives of children and young people who died by suicide following the 2014 Investigation along with current literature on suicide by children and young people, the Ombudsman decided to commence a new own motion investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people.

The objectives of the 2020 Investigation were to:

- further develop and build upon the detailed understanding of the nature and extent of involvement between the children and young people who died by suicide and State government departments and authorities;
- identify any continuing, new or changed patterns and trends in the demographic characteristics and social circumstances of the children and young people who died by suicide; circumstances of the deaths by suicide; risk factors associated with suicide experienced by the children and young people; and their contact with State government departments and authorities; and
- based on this understanding, identify ways that State government departments and authorities can prevent or reduce suicide by children and young people, and make recommendations to these departments and authorities accordingly.

Methodology

As detailed in Volume 2 of the Report, in order to inform its consideration of whether the steps taken to give effect to the recommendations of the 2014 Investigation, the Office:

- sought from the (then) Mental Health Commissioner, the (then) Director General of the Department for Child Protection and Family Support, the Director General of the Department of Health, and the (then) Director General of the Department of

Education a report on the steps taken that had been taken, or were proposed to be taken, to give effect to the recommendations arising from the 2014 Investigation;

- where further information, clarification or validation was required, met with the relevant State government departments and authorities and collected additional information relevant to suicide by young people in Western Australia;
- reviewed and considered the information provided by the Mental Health Commission, the (then) Department for Child Protection and Family Support, the Department of Health and the Department of Education and the additional information, clarification or validation obtained by the Office; together with relevant current national and international literature regarding suicide by children and young people and the associated risk factors;
- developed a draft report;
- provided the draft report to relevant State government departments and authorities for their consideration and response; and
- developed a final report including findings and recommendations.

Additionally, in order to undertake the 2020 Investigation contained in Volume 3 of the Report, the Office:

- conducted a review of relevant national and international literature regarding suicide by children and young people;
- consulted with government and non-government organisations;
- collected data from State government departments and authorities about each of the 79 children and young people who died by suicide during the 2020 Investigation period (**the 79 children and young people**);
- analysed the data relating to the 79 children and young people using qualitative and quantitative techniques to develop draft findings;
- consulted relevant stakeholders regarding the results of the Office's analysis as well as engaging external professionals with expertise regarding suicide by children and young people to critically comment and review the data collection, analysis and draft findings;
- developed a preliminary view and provided it to relevant State government departments and authorities for their consideration and response; and
- developed a final view including findings and recommendations.

Summary of Findings: Giving effect to the recommendations arising from the 2014 Investigation

The Office is very pleased that in relation to all of the recommendations arising from the 2014 Investigation, the Mental Health Commission, Department of Health, Department of Education and the (then) Department for Child Protection and Family Support had either taken steps, or propose to take steps (or both) to give effect to the recommendations. In no instances did the Office find that no steps had been taken to give effect to the recommendations.

As detailed in Volume 2 of the report, of the 25 recommendations arising from the 2014 Investigation:

- three recommendations were directed to the Mental Health Commission and steps have been taken to give effect to all three recommendations;

- five recommendations were directed to the Department of Health and steps have been taken (and in some cases, are also proposed to be taken) to give effect to all five recommendations;
- six recommendations were directed to the (then) Department for Child Protection and Family Support and steps have been taken (and in some cases, are also proposed to be taken) to give effect to four recommendations and steps are proposed to be taken to give effect to two recommendations;
- seven recommendations were directed to the Department of Education and steps have been taken (and in some cases, are also proposed to be taken) to give effect to six recommendations and steps are proposed to be taken to give effect to one recommendation;
- one recommendation was directed to the Mental Health Commission, working together with the Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education, and steps have been taken to give effect to this recommendation.

Summary of Findings: the 2020 Investigation

Arising from the findings of the 2020 Investigation, the Ombudsman made seven recommendations to four government agencies about preventing suicide by children and young people, including the development of a suicide prevention plan for children and young people to focus and coordinate collaborative and cooperative State Government efforts.

The Ombudsman is very pleased that each agency has agreed to these recommendations and has, more generally, been positively engaged with the 2020 Investigation. These recommendations are notable not by their number, but by the fact that the Ombudsman has sought to make highly targeted, achievable recommendations regarding critical issues. Further the Ombudsman has ensured that the recommendations do not duplicate the work of other investigations and inquiries.

The new information gathered, presented and comprehensively analysed in the 2020 Investigation will be, the Ombudsman believes, a very valuable repository of knowledge for government agencies, non-government organisations and other institutions in the vital work that they undertake in developing and assessing the efficacy of future suicide prevention efforts in Western Australia.

Preventing suicide by children and young people is a shared responsibility requiring collaboration, cooperation and a common understanding of past deaths, risk assessment and responsibilities. The complex and dynamic nature of the risk and protective factors associated with suicide requires a varied and localised response, informed by data about self-harm and suicide, and other indicators of vulnerability experienced by our children and young people. Ultimately, suicide by children and young people will not be prevented by a single program, service or agency working in isolation. Preventing suicide by children and young people must be viewed as part of the core, everyday business of each agency working with children and young people.

The 115 children and young people who died by suicide considered as part of the Ombudsman's 2014 and 2020 Investigations will not be forgotten by their parents, siblings, extended family, friends, classmates and communities. The Ombudsman extends his deepest personal sympathy to all that continue to grieve their immeasurable loss.

It is the Ombudsman's sincerest hope that the extensive new information in this report about suicide by children and young people, and its recommendations, will contribute to preventing these most tragic deaths in the future.

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

The full report, *Preventing suicide by children and young people 2020* is available at: www.ombudsman.wa.gov.au/suicidebychildrenandyoungpeoplereport2020.

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;
- *Investigation into ways to prevent or reduce deaths of children by drowning*, which was tabled in Parliament in November 2017; and
- *Preventing suicide by children and young people 2020*, which was tabled in Parliament in September 2020.

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 2020-21.

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 2020-21 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;
  - 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 Consultant 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 Consultant in this important work, and in 2020-21, the Ombudsman created a critical new executive position, Senior Assistant Ombudsman Aboriginal Engagement and Collaboration, which will be advertised in July 2021.

Significant work was undertaken throughout 2020-21 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.