Our Performance in 2020-21

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

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

Summary of Performance

Key Performance Indicators

Key Effectiveness Indicators

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

Key Effectiveness Indicators	2019-20 Actual	2020-21 Target	2020-21 Actual	Variance from Target
Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies	100%	100%	**100%**	Nil
Number of improvements to practices or procedures as a result of Ombudsman action	72	100	**109**	+9

Another important role of the Ombudsman is to enable remedies to be provided to people who make complaints to the Office where service delivery by a public authority may have been inadequate. The remedies may include reconsideration of decisions, more timely decisions or action, financial remedies, better explanations and apologies. In 2020-21, there were 179 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman.

Comparison of Actual Results and Budget Targets

Public authorities have accepted every recommendation made by the Ombudsman, matching the actual results of the past four years and meeting the 2020-21 target.

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

The 2020-21 actual number of improvements to practices and procedures of public authorities as a result of Ombudsman action (109) is higher than the 2020-21 target (100) and the 2019-20 actual (72) as there are fluctuations in improvements from year to year, related to the number, nature and outcomes of investigations finalised by the Office in any given year.

Key Efficiency Indicators

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

Key Efficiency Indicators	2019-20 Actual	2020-21 Target	2020-21 Actual	Variance from Target
Percentage of allegations finalised within three months	95%	95%	**96%**	+1%
Percentage of allegations finalised within 12 months	100%	100%	**100%**	Nil
Percentage of allegations on hand at 30 June less than three months old	92%	90%	**87%**	-3%
Percentage of allegations on hand at 30 June less than 12 months old	99%	100%	**100%**	Nil
Average cost per finalised allegation	$1,858	$1,890	**$1,885**	-$5
Average cost per finalised notification of death	$17,926	$17,500	**$17,565**	+$65
Cost of monitoring and inspection functions	$408,008	$415,000	**$407,486**	-$7,514

Comparison of Actual Results and Budget Targets

The 2020-21 actual results for the Key Efficiency Indicators met, or were comparable to, the 2020-21 target. Overall, 2020-21 actual results represent sustained efficiency of complaint resolution over the last five years.

The average cost per finalised allegation in 2020-21 ($1,885) is comparable with the 2020-21 target ($1,890) and the 2019-20 actual ($1,858). Since 2007-08, the efficiency of complaint resolution has improved significantly with the average cost per finalised allegation reduced by a total of 36% from $2,941 in 2007-08 to $1,885 in 2020-21.

The average cost per finalised notification of death ($17,565) is comparable with the 2020-21 target ($17,500) and the 2019-20 actual ($17,926).

The cost of monitoring and inspection functions ($407,486) is comparable with 2020-21 target ($415,000) and the 2019-20 actual ($408,008).

For further details, see the Key Performance Indicator section.

Summary of Financial Performance

The majority of expenses for the Office (78%) relate to staffing costs. The remainder is primarily for accommodation, communications and office equipment.

Financial Performance	2019-20 Actual ('000s)	2020-21 Target ('000s)	2020-21 Actual ('000s)	Variance from Target ('000s)
Total cost of services (sourced from Statement of Comprehensive Income)	$11,332	$11,544	**$11,713**	+$169
Income other than income from State Government (sourced from Statement of Comprehensive Income)	$2,493	$2,672	**$2,498**	-$174
Net cost of services (sourced from Statement of Comprehensive Income)	$8,840	$8,872	**$9,216**	+$344
Total equity (sourced from Statement of Financial Position)	$1,226	$867	**$570**	-$297
Net increase/decrease in cash held (sourced from Statement of Cash Flows)	$383	-$358	**-$567**	-$209
Staff Numbers	**Number**	**Number**	**Number**	**Number**
Full time equivalent (FTE) staff level at 30 June	66	70	**70**	Nil

Comparison of Actual Results and Budget Targets

All 2020-21 actual results are comparable to the 2020-21 targets.

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

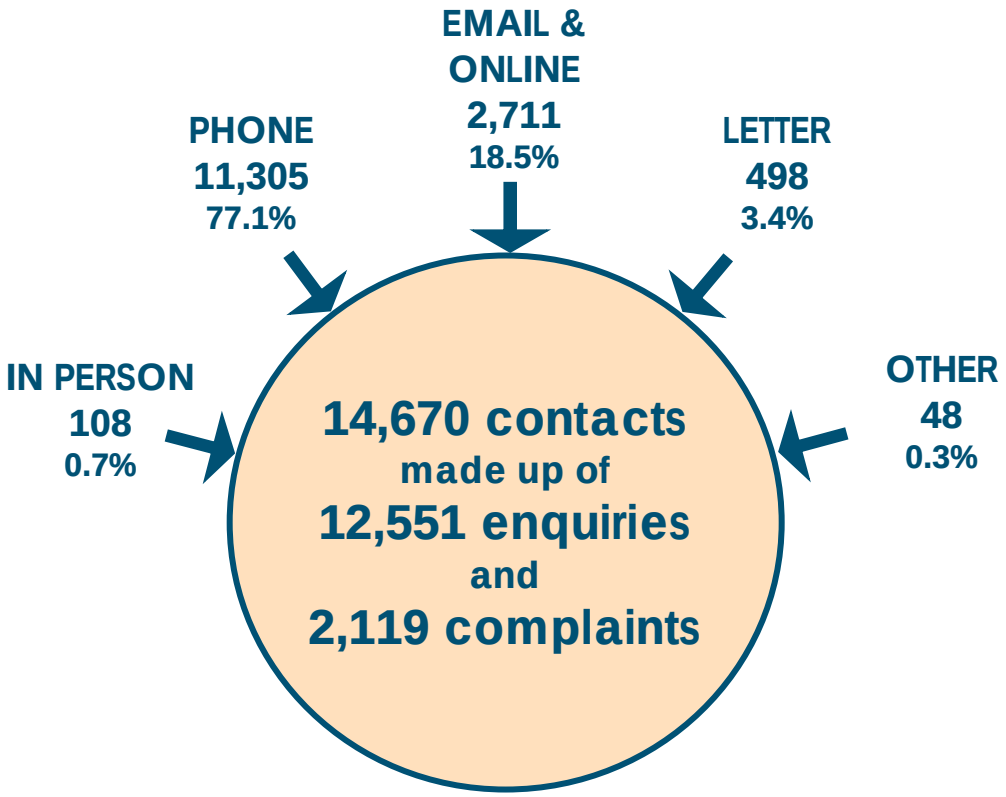
Complaint Resolution

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

Contacts

In 2020-21, the Office received 14,670 contacts from members of the public consisting of:

- 12,551 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 2,119 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

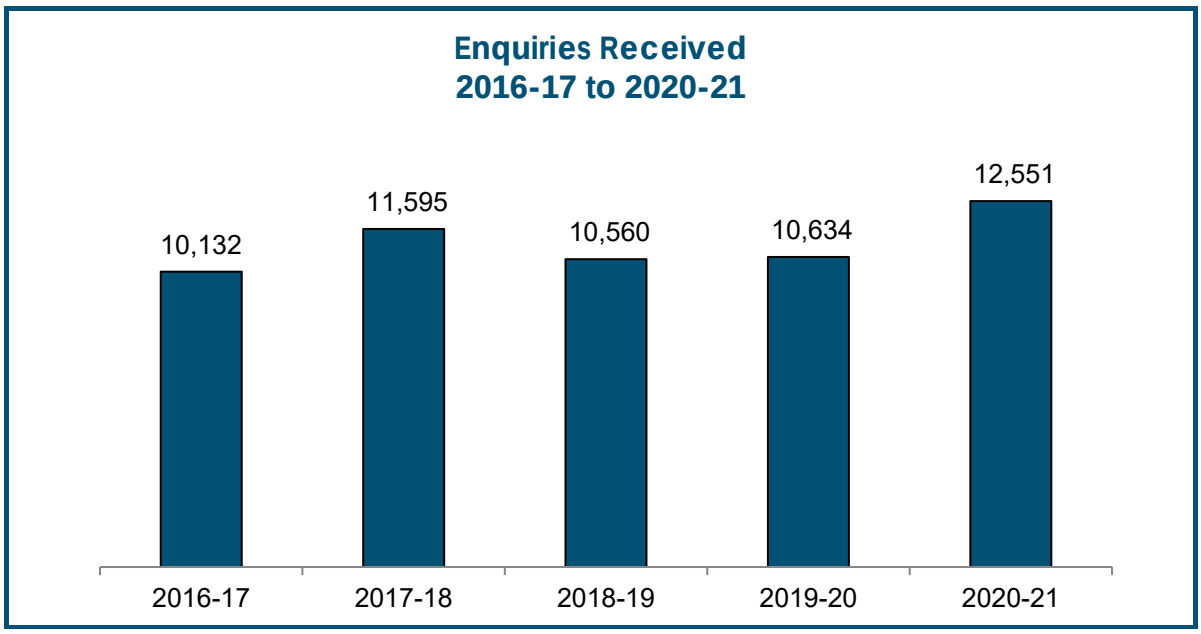


Enquiries Received

There were 12,551 enquiries received during the year.

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

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

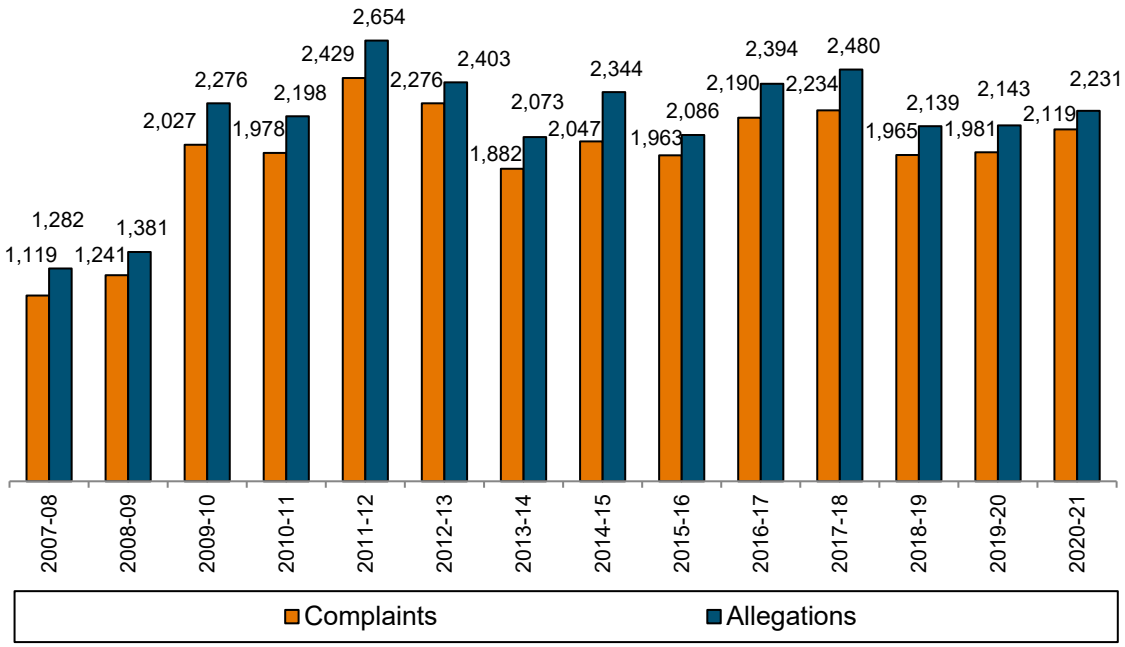


Enquirers are encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

Complaints Received

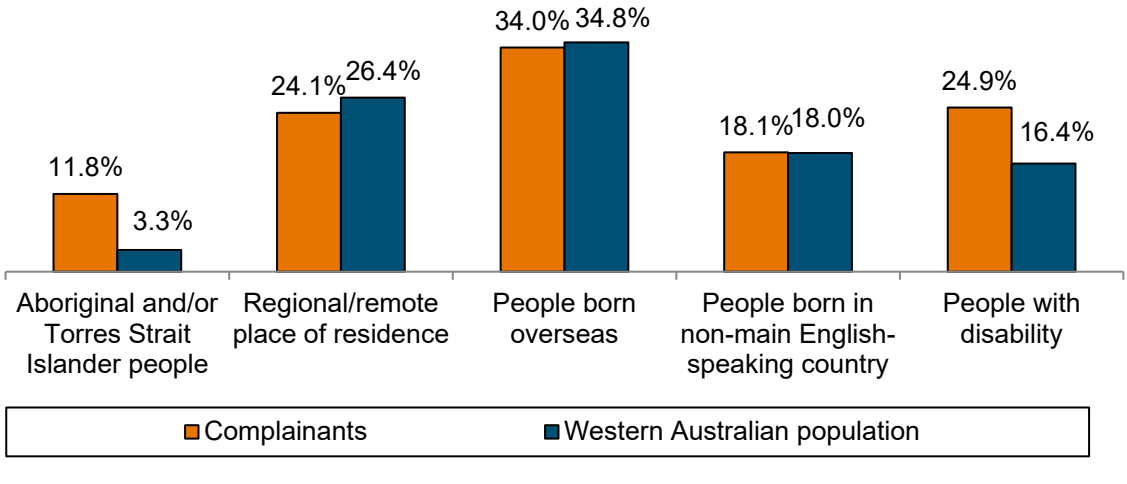
In 2020-21, the Office received 2,119 complaints, with 2,231 separate allegations, and finalised 2,062 complaints. There are more allegations than complaints because one complaint may cover more than one issue.

Total Number of Complaints and Allegations Received 2007-08 to 2020-21



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

Characteristics of Complainants in 2020-21

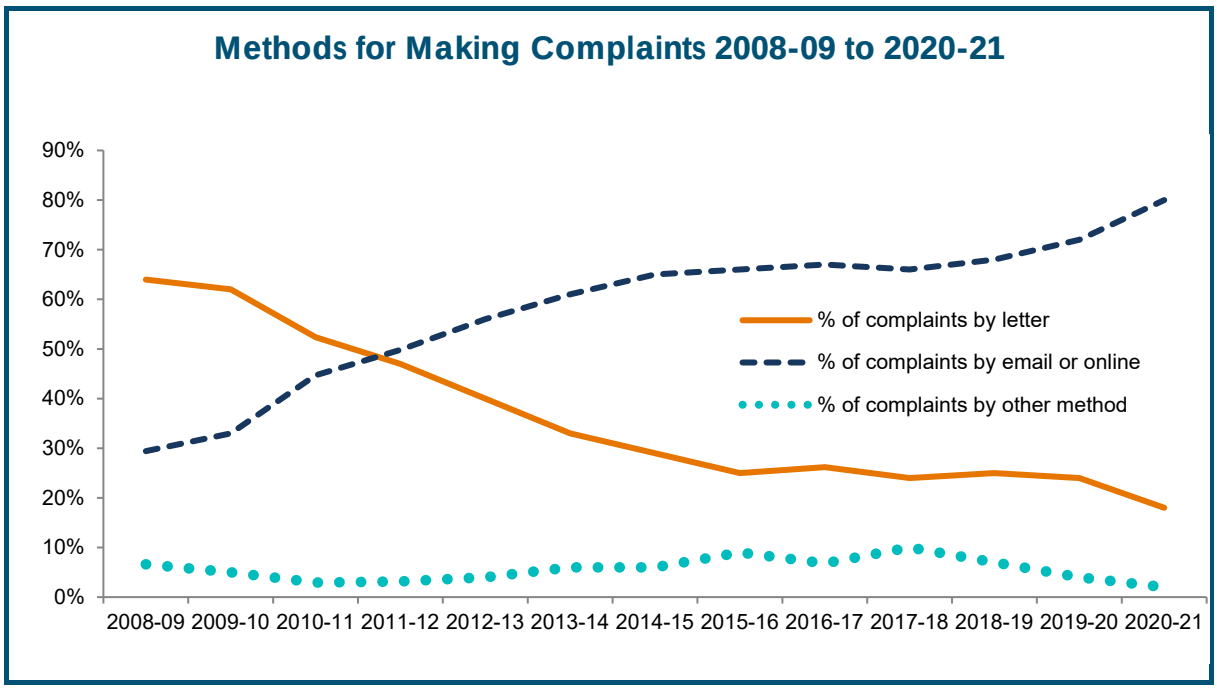


NOTE: Non-main English-speaking countries as defined by the Australian Bureau of Statistics are countries other than Australia, the United Kingdom, the Republic of Ireland, New Zealand, Canada, South Africa and the United States of America. Being from a non-main English-speaking country does not imply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

How Complaints Were Made

Over the last 13 years, the use of email and online facilities to lodge complaints has increased and the proportion of people who lodge complaints by letter has declined.

In 2020-21, 80% of complaints were lodged by email or online, compared to 18% by letter and two per cent by other methods including during regional visits and in person.



Resolving Complaints

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

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

Time Taken to Resolve Complaints

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

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

Building on the program, the Office developed and commenced a new organisational structure and processes in 2011-12 to promote and support early resolution of complaints. There have been further enhancements to complaint handling processes in 2020-21, in particular in relation to the early resolution of complaints.

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

In 2020-21:

- The percentage of allegations finalised within 3 months was 96%; and
- The percentage of allegations on hand at 30 June less than 3 months old was 87%.

96% of allegations were finalised within 3 months.

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

- The average age of complaints has decreased from 173 days to 45 days; and
- Complaints older than 6 months have decreased from 40 to 9.

Complaints Finalised in 2020-21

There were 2,062 complaints finalised during the year and, of these, 1,464 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 927 were finalised at initial assessment, 481 were finalised after an Ombudsman investigation and 56 were withdrawn.

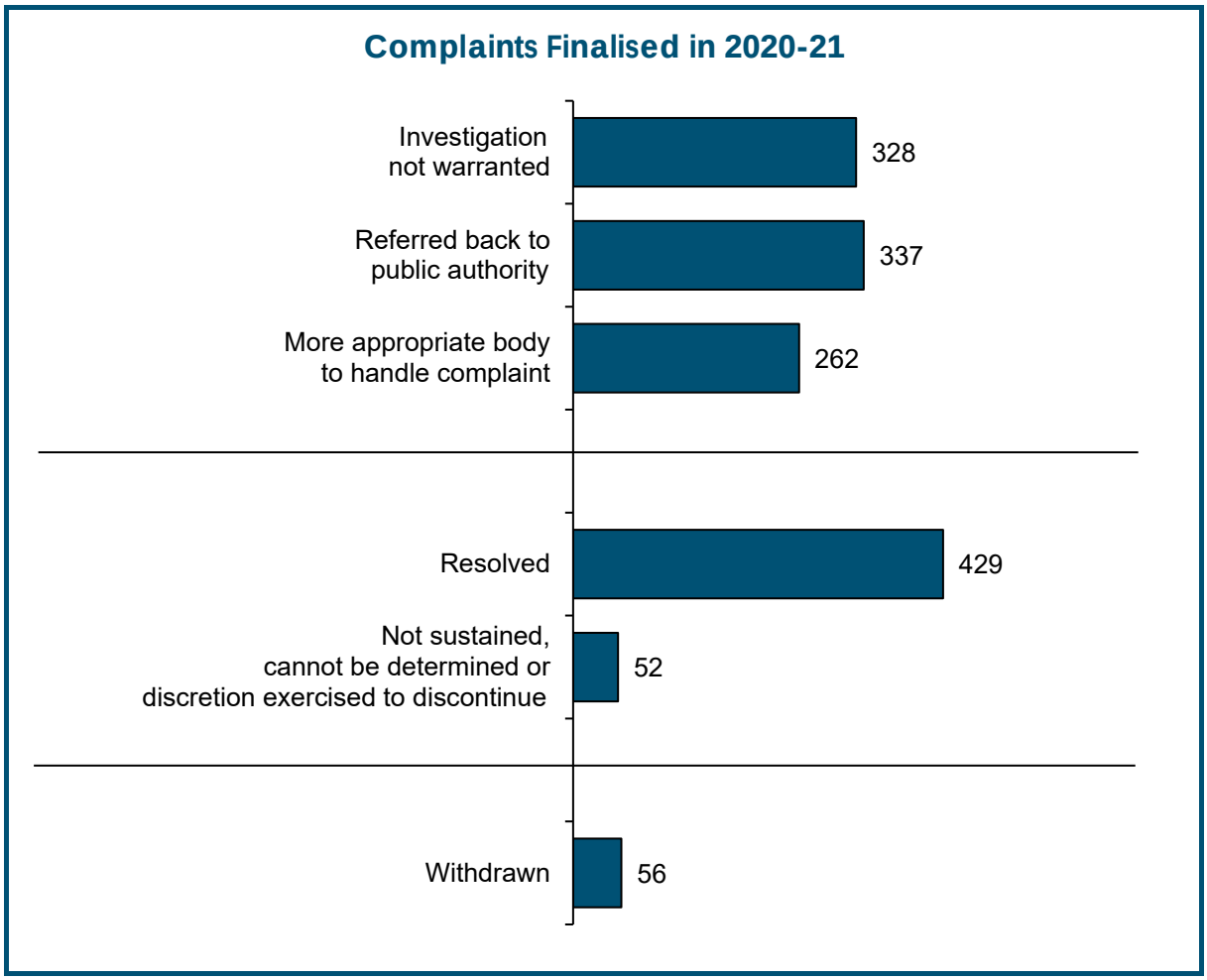
Complaints finalised at initial assessment

Over a third (36%) of the 927 complaints finalised at initial assessment were referred back to the public authority to provide it with an opportunity to resolve the matter before investigation by the Ombudsman. This is a common and timely approach and often results in resolution of the matter. The person making the complaint is asked to contact the Office again if their complaint remains unresolved. In a further 262 (28%) of the complaints finalised at initial assessment, it was determined that there was a more appropriate body to handle the complaint. In these cases, complainants are provided with contact details of the relevant body to assist them.

Complaints finalised after investigation

Of the 481 complaints finalised after investigation, 86% were resolved through the Office's early resolution approach. This involves Ombudsman staff contacting the public authority to progress a timely resolution of complaints that appear to be able to be resolved quickly and easily. Public authorities have shown a strong willingness to resolve complaints using this approach and frequently offer practical and timely remedies to resolve matters in dispute, together with information about administrative improvements to be put in place to avoid similar complaints in the future.

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

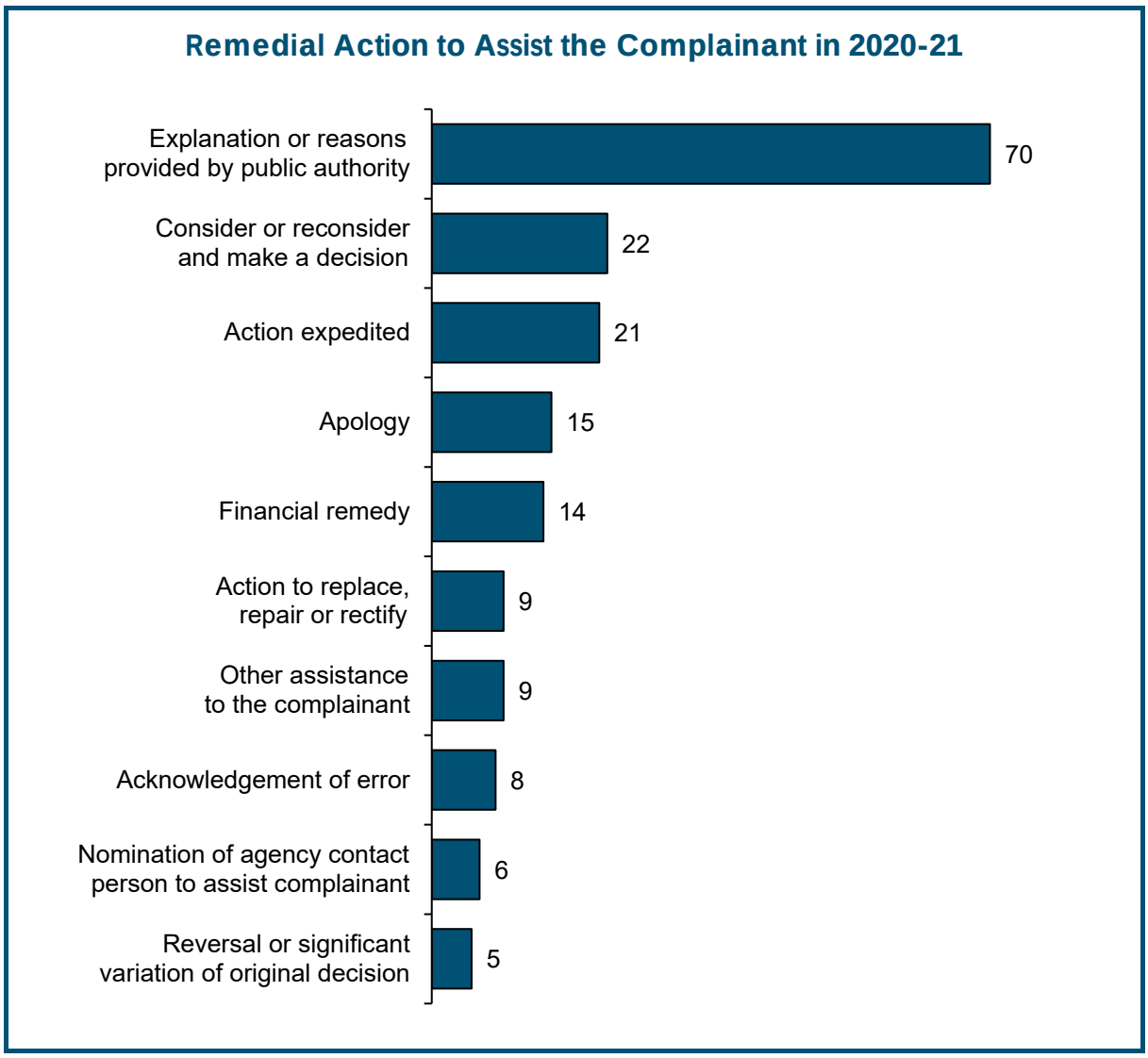


Note: Investigation not warranted includes complaints where the matter is not in the Ombudsman's jurisdiction.

Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2020-21, there were 179 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman. In some cases, there is more than one action to resolve a complaint. For example, the public authority may apologise and reverse their original decision. In a further 52 instances, the Office referred the complaint to the public authority following its agreement to expedite examination of the issues and to deal directly with the person to resolve their complaint. In these cases, the Office follows up with the public authority to confirm the outcome and any further action the public authority has taken to assist the individual or to improve their administrative practices.

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



Case Study

Charges reviewed and waived

A tenant was charged by a public authority for repairs and maintenance after the tenant had vacated the property. The tenant complained to the public authority about the charges. The public authority reviewed the matter and as a result of the review waived some of the charges. The tenant complained to the Ombudsman that they were not responsible for some of the remaining charges.

Following an investigation by the Ombudsman, the public authority further reviewed the charges and considered the application of its policies relating to tenant liability. As a result of its further review, the public authority waived a further amount of the disputed charges.

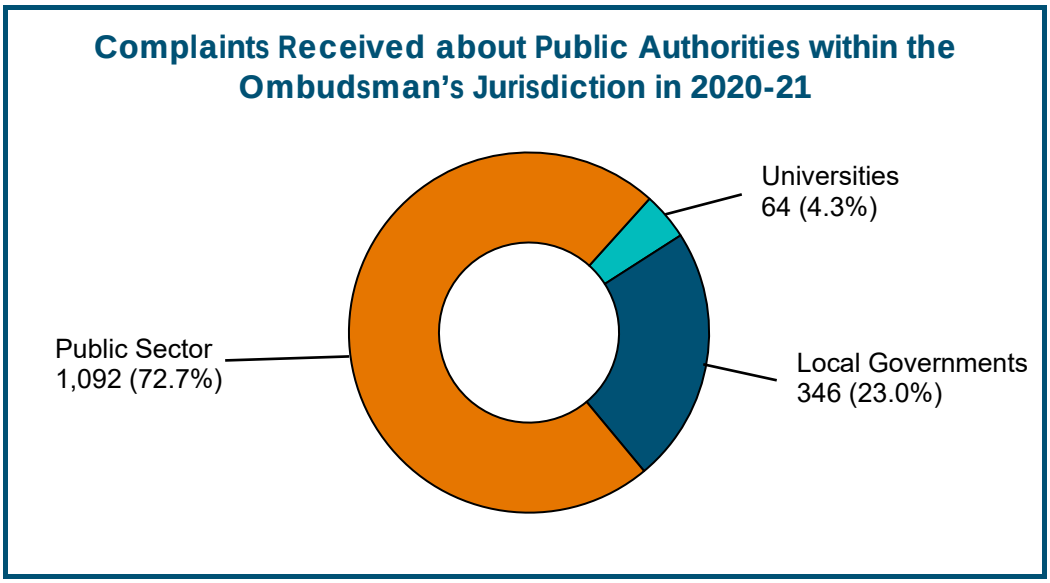
Outcomes to improve public administration

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

About the Complaints

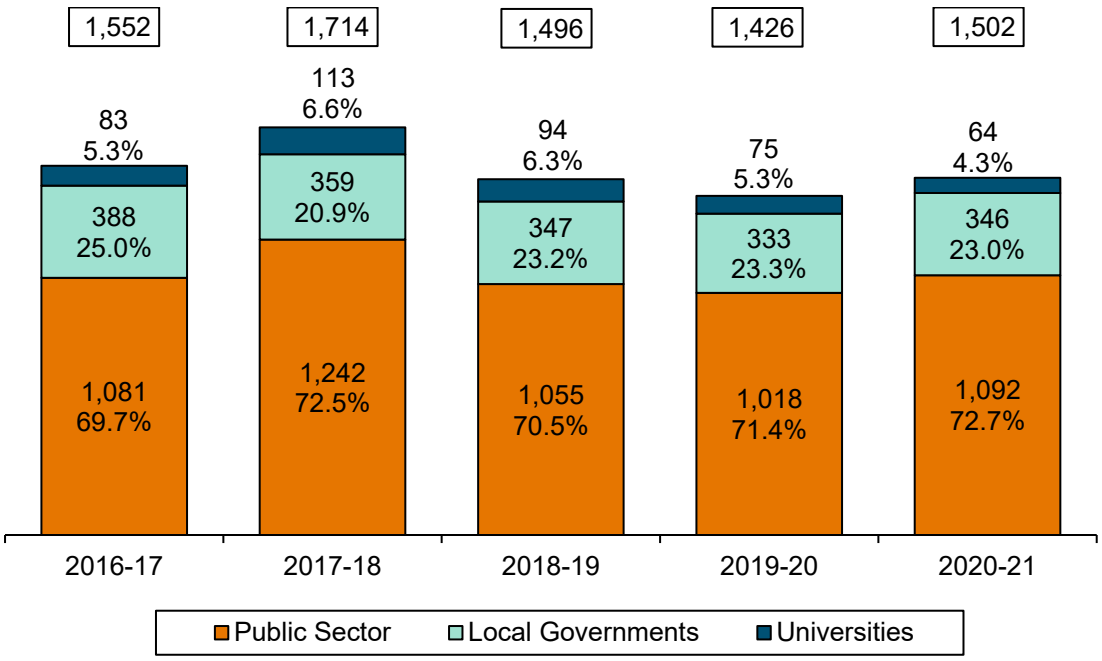
Of the 2,119 complaints received, 1,502 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 617 complaints were about bodies outside the Ombudsman's jurisdiction. In these cases, Ombudsman staff provided assistance to enable the people making the complaint to take the complaint to a more appropriate body.

Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (1,092 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (346 complaints); and the university sector (64 complaints).



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

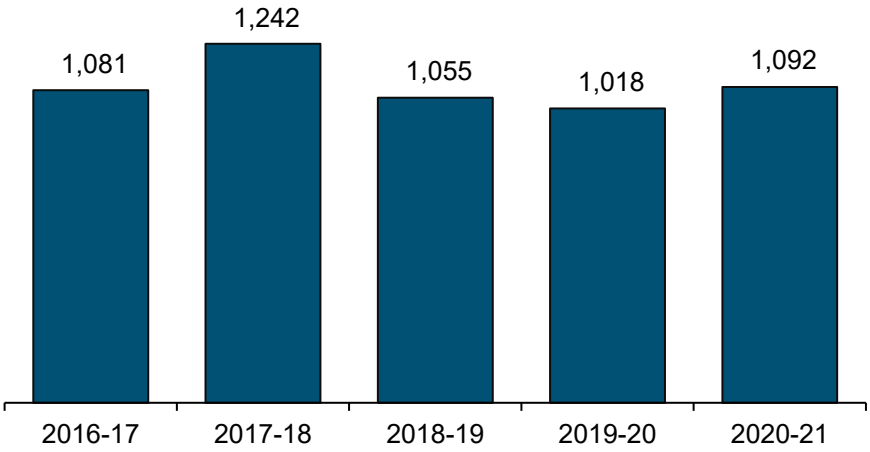
Complaints Received about Public Authorities within the Ombudsman's Jurisdiction between 2016-17 and 2020-21



The Public Sector

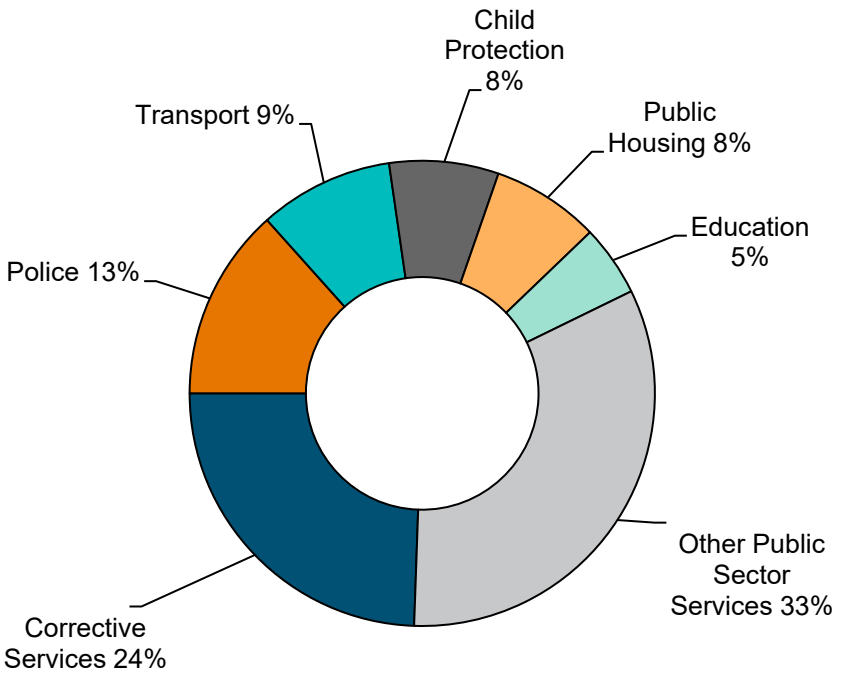
In 2020-21, there were 1,092 complaints received about the public sector and 1,053 complaints were finalised. The number of complaints about the public sector as a whole since 2016-17 is shown in the chart below.

Complaints Received about the Public Sector between 2016-17 and 2020-21



Public sector agencies deliver a very diverse range of services to the Western Australian community. In 2020-21, complaints were received about key services as shown in the following chart.

Complaints Received about the Public Sector in 2020-21



Of the 1,092 complaints received about the public sector in 2020-21, 67% were about six key service areas covering:

- Corrective services, in particular prisons (267 or 24%);
- Police (146 or 13%);
- Transport (102 or 9%);
- Child protection (83 or 8%);
- Public housing (82 or 8%); and
- Education, including public schools and TAFE colleges (54 or 5%). Information about universities is shown separately under the university sector.

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

Outcomes of complaints about the public sector

In 2020-21, there were 157 actions taken by public sector bodies as a result of Ombudsman action following a complaint. These resulted in 118 remedies being provided to complainants and 39 improvements to public sector practices.

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

Case Study

Decision to decline application for assistance overturned

A person applied for assistance from a public authority. The public authority declined the application based on the person's previous history with the public authority. The person sought a review of the decision on the basis that their current situation was different as they were receiving support for relevant health conditions, but the public authority upheld the original decision. The person complained to the Ombudsman that the public authority's decision was unreasonable as it did not appropriately consider the changes to the person's situation.

Following an investigation by the Ombudsman, the public authority further reviewed the matter and overturned its decision in the person's favour and approved their application for assistance on the condition that the person continues to engage with support services.

Case Study

Decision review results in withdrawal of infringement

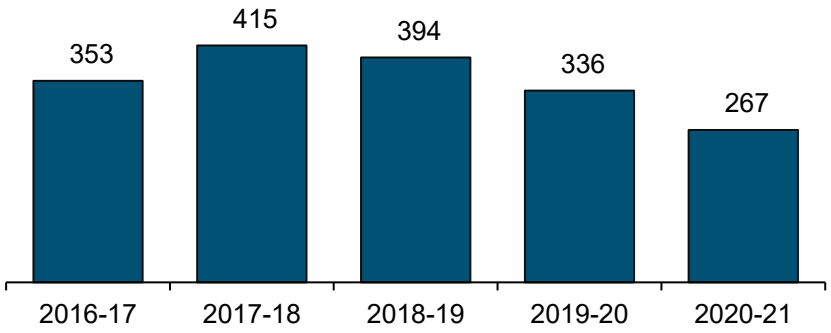
A person complained to the Ombudsman that they had received an infringement from a public authority for failing to meet the requirements of a professional licence. The person complained that this was unreasonable as they had never worked in the profession and had assumed their licence had lapsed.

Following an investigation by the Ombudsman, the public authority reviewed the matter, authorised the withdrawal of the infringement notice and apologised to the person for any distress experienced.

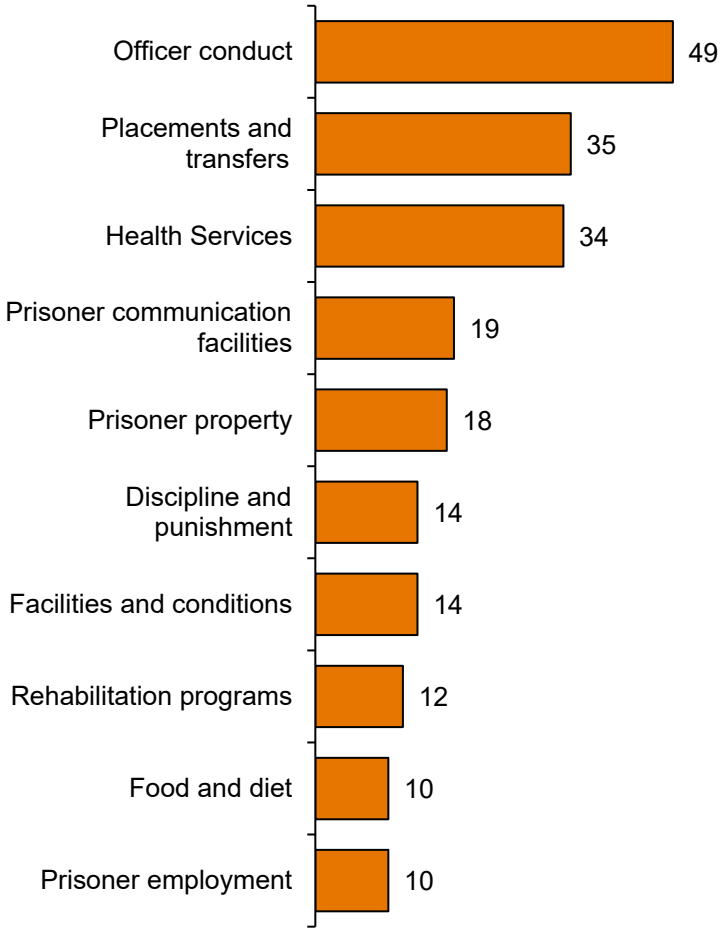
Public sector complaint issues and outcomes

Corrective Services

Complaints received



Most common allegations

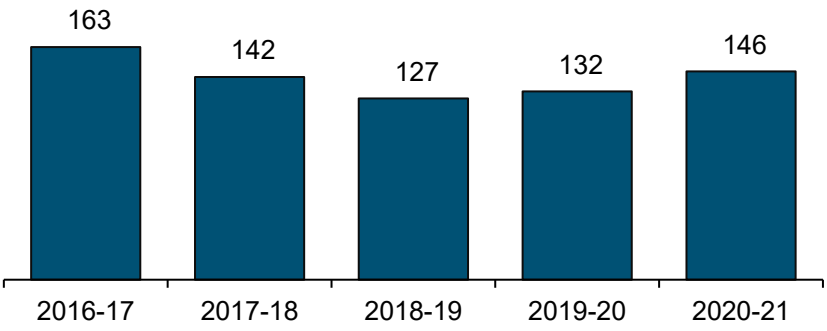


Outcomes achieved

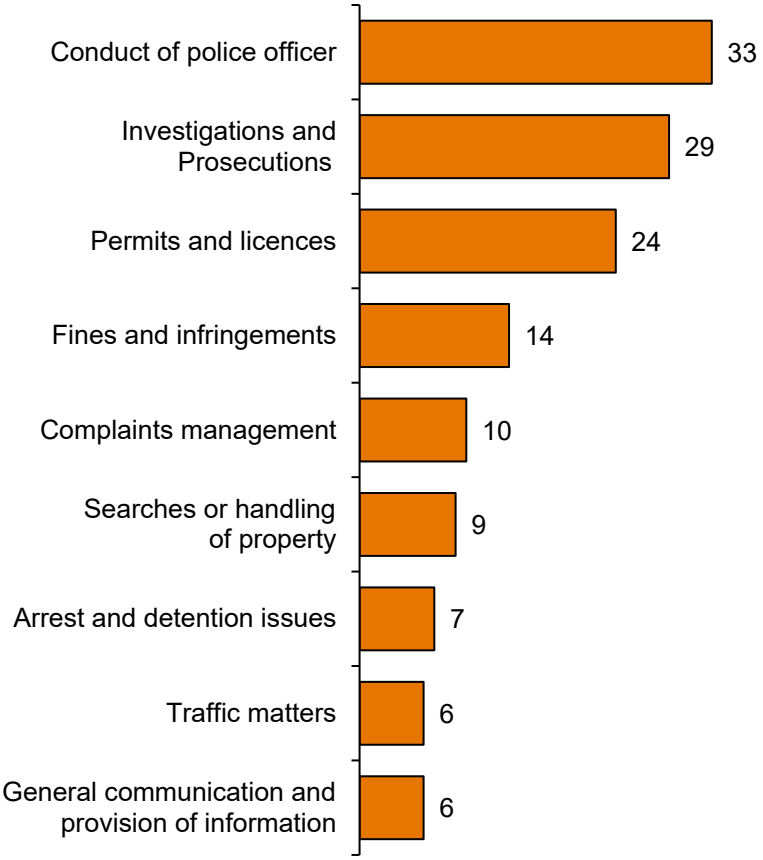
- Financial payment;
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Action expedited;
- Explanation given or reasons provided; and
- Staff training.

Police

Complaints received



Most common allegations

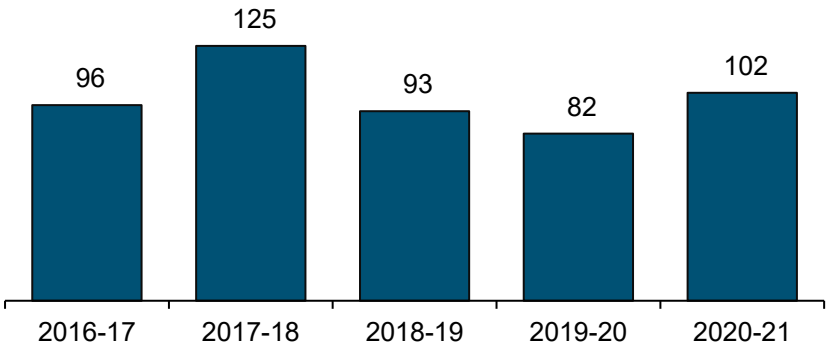


Outcomes achieved

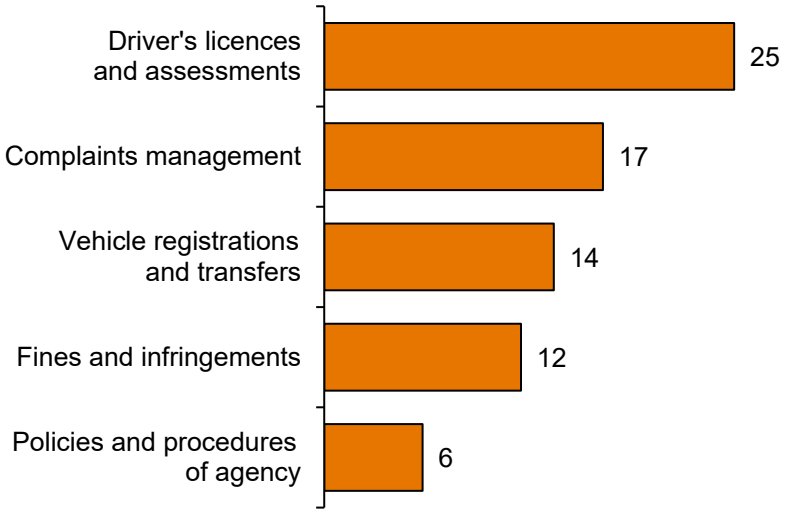
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision; and
- Explanation given or reasons provided.

Transport

Complaints received



Most common allegations

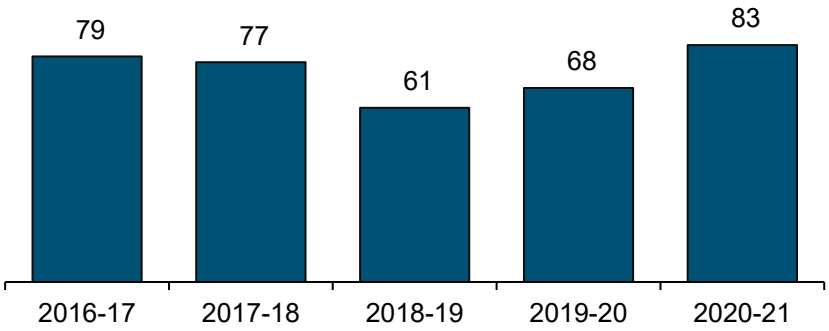


Outcomes achieved

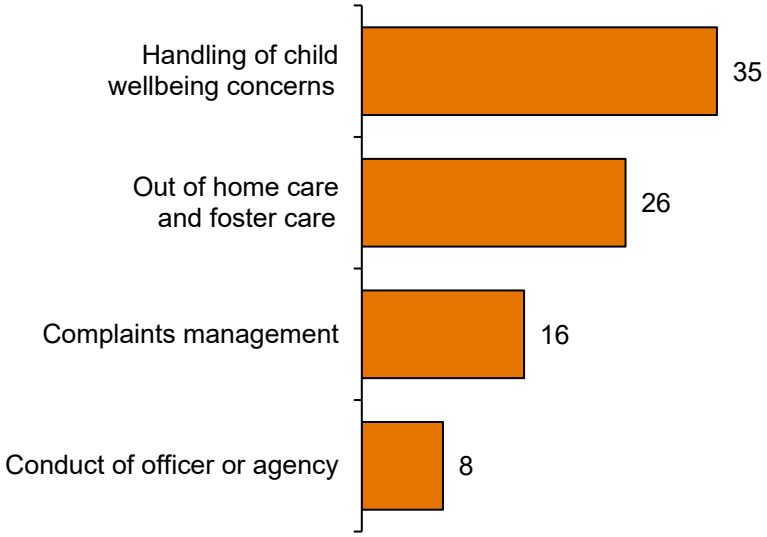
- Monetary charge reduced;
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology;
- Acknowledgement of error;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to business systems or practices;
- Update to publications or website;
- Conduct audit or review;
- Improve record keeping;
- Staff training.

Child Protection

Complaints received



Most common allegations

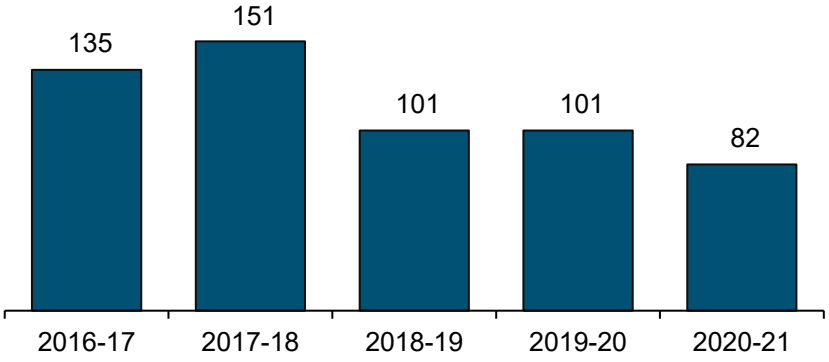


Outcomes achieved

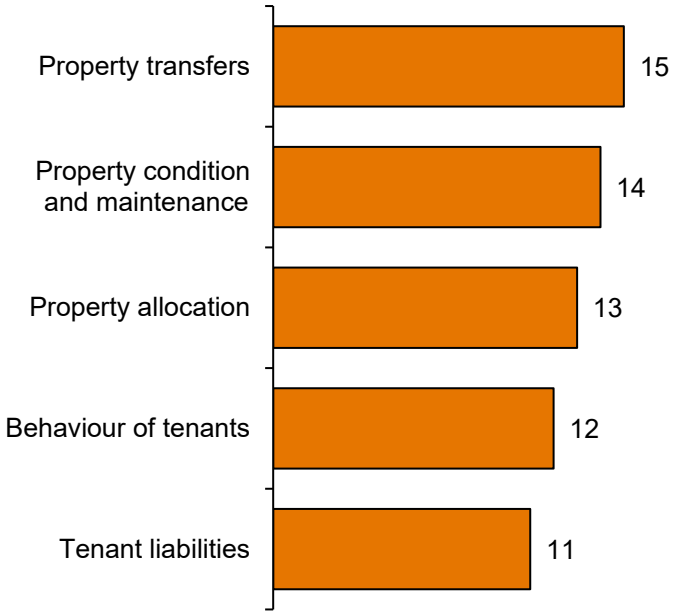
- Acknowledgment of error;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy, procedure, business systems or practices;
- Conduct audit or review; and
- Staff training.

Public Housing

Complaints received



Most common allegations

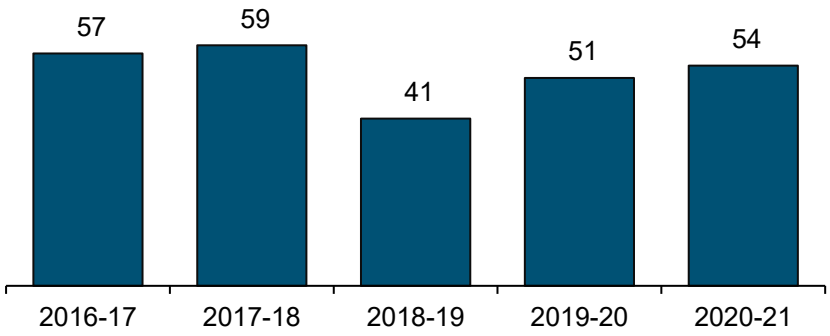


Outcomes achieved

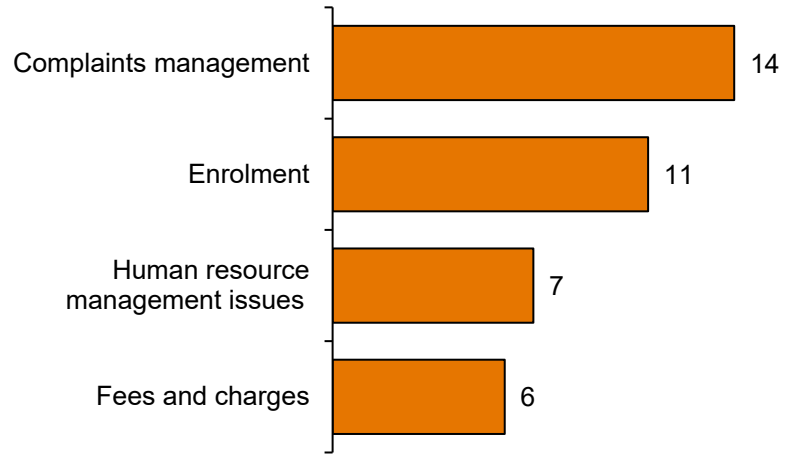
- Monetary charge reduced, refunded or rebate given;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Acknowledgement of error;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to business systems or practices;
- Conduct audit or review; and
- Staff training.

Education

Complaints received



Most common allegations



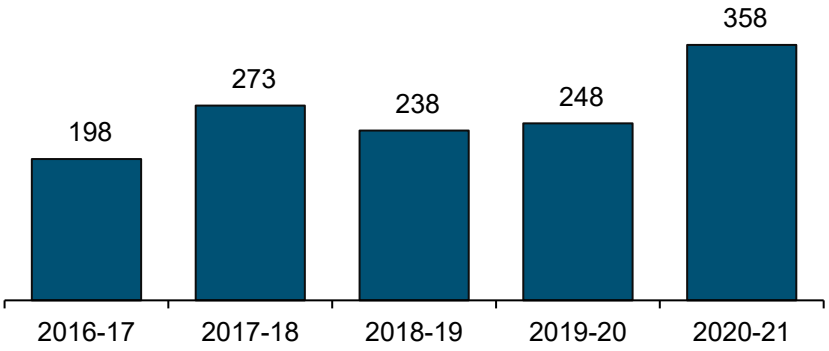
These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2018* relating to TAFE colleges and other public education agencies. Further details on these appeals are included later in this section.

Outcomes achieved

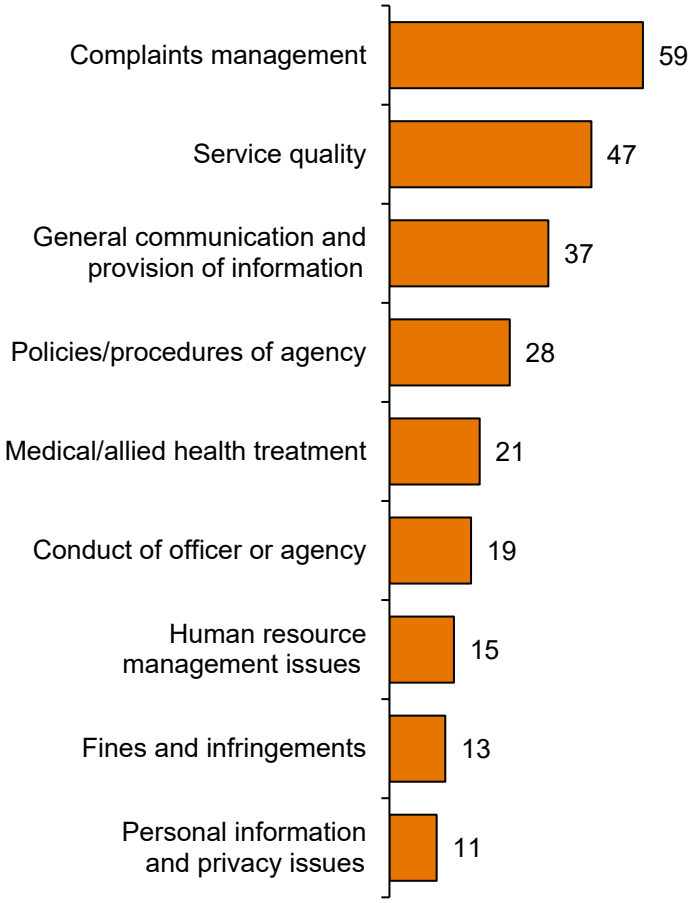
- Apology given;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to policy or procedure;
- Update to publications or website; and
- Conduct audit or review.

Other Public Sector Services

Complaints received



Most common allegations



Outcomes achieved

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

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

Case Study

Action taken to improve the handling of permit applications

A person complained to the Ombudsman that a public authority issued an incorrect permit to their business resulting in additional costs to their business.

Following an investigation by the Ombudsman, the public authority acknowledged that an error had been made with regard to issuing the permit and agreed to provide an apology for any confusion this may have caused. To prevent a reoccurrence of a similar error, the public authority updated its permit assessment tool to provide detailed references to its policy, provided additional training to staff and reviewed the assessment process to ensure it clearly aligns with its policy.

Case Study

Personal information corrected

A person complained to a public authority that it had not recorded the person's name correctly in its database, which resulted in problems with identity verification for other services. The public authority said that their system did not support the format of the person's name. The person complained to the Ombudsman.

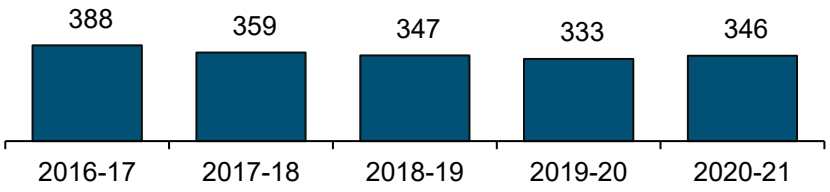
Following an investigation by the Ombudsman, the public authority made a manual adjustment to the person's name and contacted the person to inform them their name had been corrected.

The local government sector

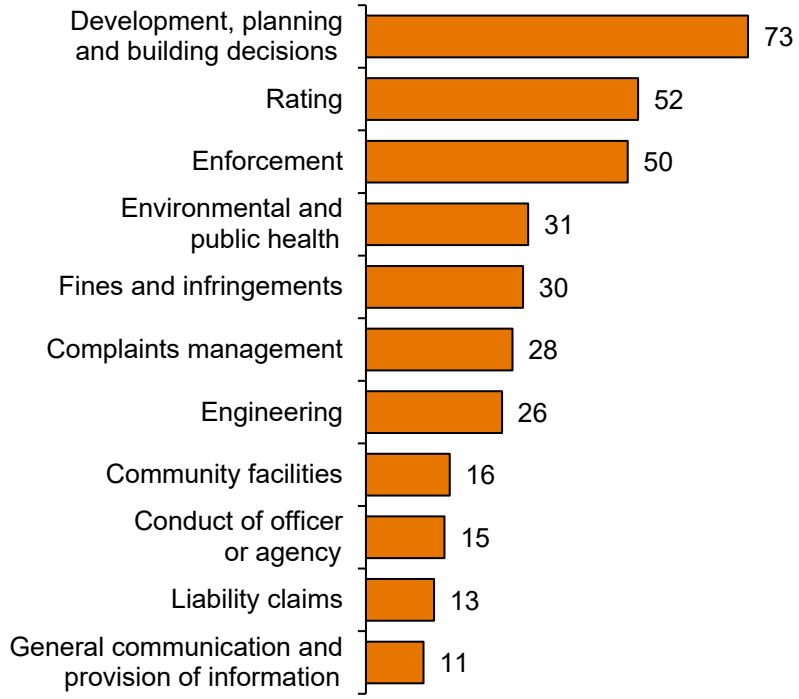
The following section provides further details about the issues and outcomes of complaints for the local government sector.

Local Government

Complaints received



Most common allegations



Outcomes achieved

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

Case Study

Refund and review following overpayment

A resident complained to the Ombudsman that a local government incorrectly charged the resident the full waste service charge for their property instead of applying the pensioner discount, despite the local government being aware that the resident held a pensioner concession for a number of years and applying the relevant concession to their rates over that time.

Following an investigation by the Ombudsman, the local government agreed to refund the overcharged amount and review the internal process for activating waste charge rebates on individual ratepayers.

Case Study

Action taken to improve pool barrier inspection process

A resident complained to the Ombudsman that a local government incorrectly determined a pool barrier fence to be compliant prior to the resident purchasing a property. After purchasing the property, it was found that the pool barrier fence had extensive rust and required replacing.

Following an investigation by the Ombudsman, the local government implemented a new electronic program which maintains pool inspection records and correspondence to support the pool inspection process; a checklist for identifying and recording relevant pool barrier faults at each pool inspection; a requirement for photographs to be taken at pool inspections; competency training of new pool inspectors; and would consider regular refresher training of pool inspectors.

Case Study

Apology and explanation regarding assessment of development application

A resident complained to the Ombudsman that a local government's decision to approve a neighbour's development application was unreasonable as the resident believed the structure was not compliant with relevant codes.

The Ombudsman's investigation of the complaint found that the local government had changed the classification of the development during the assessment process, which meant the approval was in compliance with the relevant codes, however had not informed the resident of the change in classification.

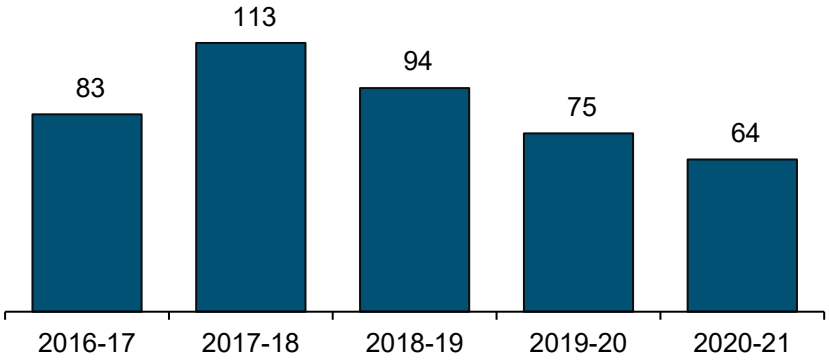
Following the Ombudsman's investigation, the local government agreed to write to the resident to explain the decision to approve the development and apologise for not informing the resident of the change in classification during the assessment process. The local government also agreed to improve its processes for future development applications by keeping detailed records of reasons for decision and, where consultation process have been completed, informing affected residents about any subsequent change in its assessment process.

The university sector

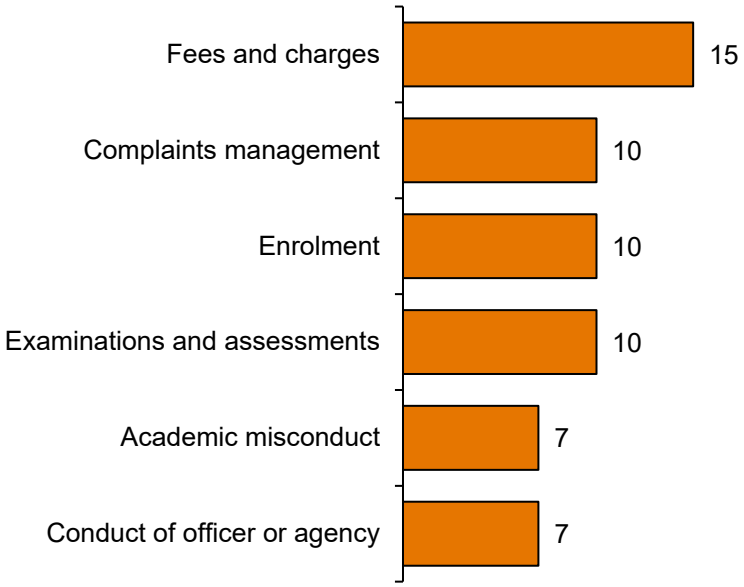
The following section provides further details about the issues and outcomes of complaints for the university sector.

Universities

Complaints received



Most common allegations



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

Outcomes Achieved

- Financial payment or 'act of grace' payment;
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Acknowledgement of error;
- Explanation given or reasons provided;
- Change to policy, procedure, business systems or practices; and
- Staff training.

Other Complaint Related Functions

Reviewing appeals by overseas students

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

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

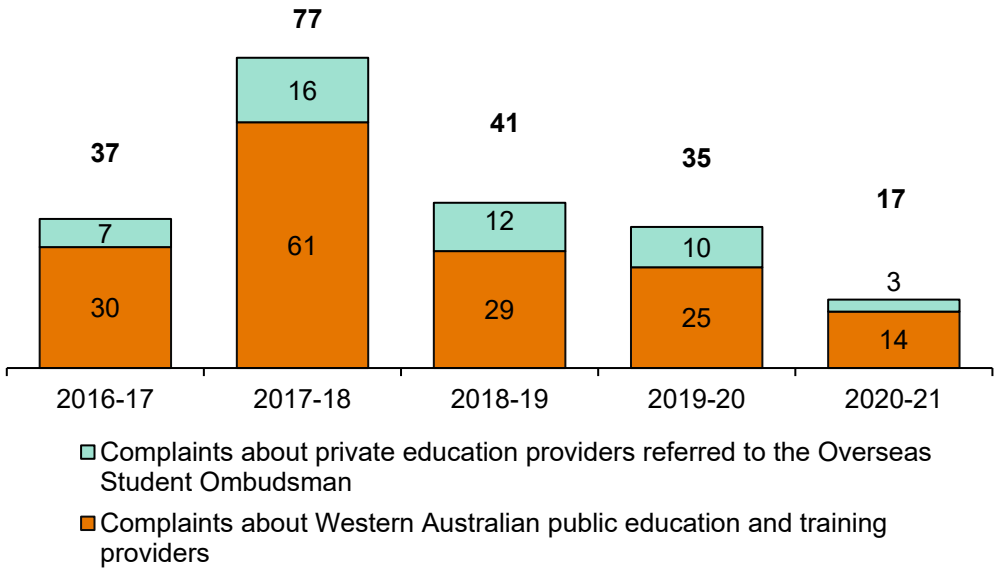
- Provides a free complaint resolution service;
- Is independent and impartial and does not represent either the overseas students or education and training providers; and
- Can make recommendations arising out of investigations.

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

Complaints lodged with the Office under the National Code

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

Complaints Received from Overseas Students under the National Code between 2016-17 and 2020-21



During 2020-21, the Office received 17 complaints from overseas students, including 14 complaints about public education and training providers. Of the 14 complaints about public education providers within the Ombudsman's jurisdiction, 13 complaints were about universities and one was about another education provider. The Office also received three complaints that, after initial assessment, were found to be about a private education provider. The Office referred these complainants to the Overseas Students Ombudsman.

The 14 complaints by overseas students about public education and training providers involved 14 separate allegations. The most common issues raised by overseas students were decisions about:

- Fees and charges (5);
- Termination of enrolment (3); and
- Examinations and assessments (2).

During the year, the Office finalised 20 complaints by overseas students.

Case Study

Full refund of tuition fees

An international student complained that a university's decision not to provide them with a full refund for their English Language Bridging units, after the student withdrew from their studies due to medical issues, was unreasonable.

Following investigation by the Ombudsman, the university agreed to initiate a refund of the balance of fees paid by the student, meaning that they would receive a full refund.

Public Interest Disclosures

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

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

During the year, five disclosures were received.

Indian Ocean Territories

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

Terrorism

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

Requests for Review

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

In 2020-21, seven reviews were undertaken, representing one third of one per cent of the total number of complaints finalised by the Office. In all cases where a review was undertaken, the original decision was upheld.

Child Death Review

Overview

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

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

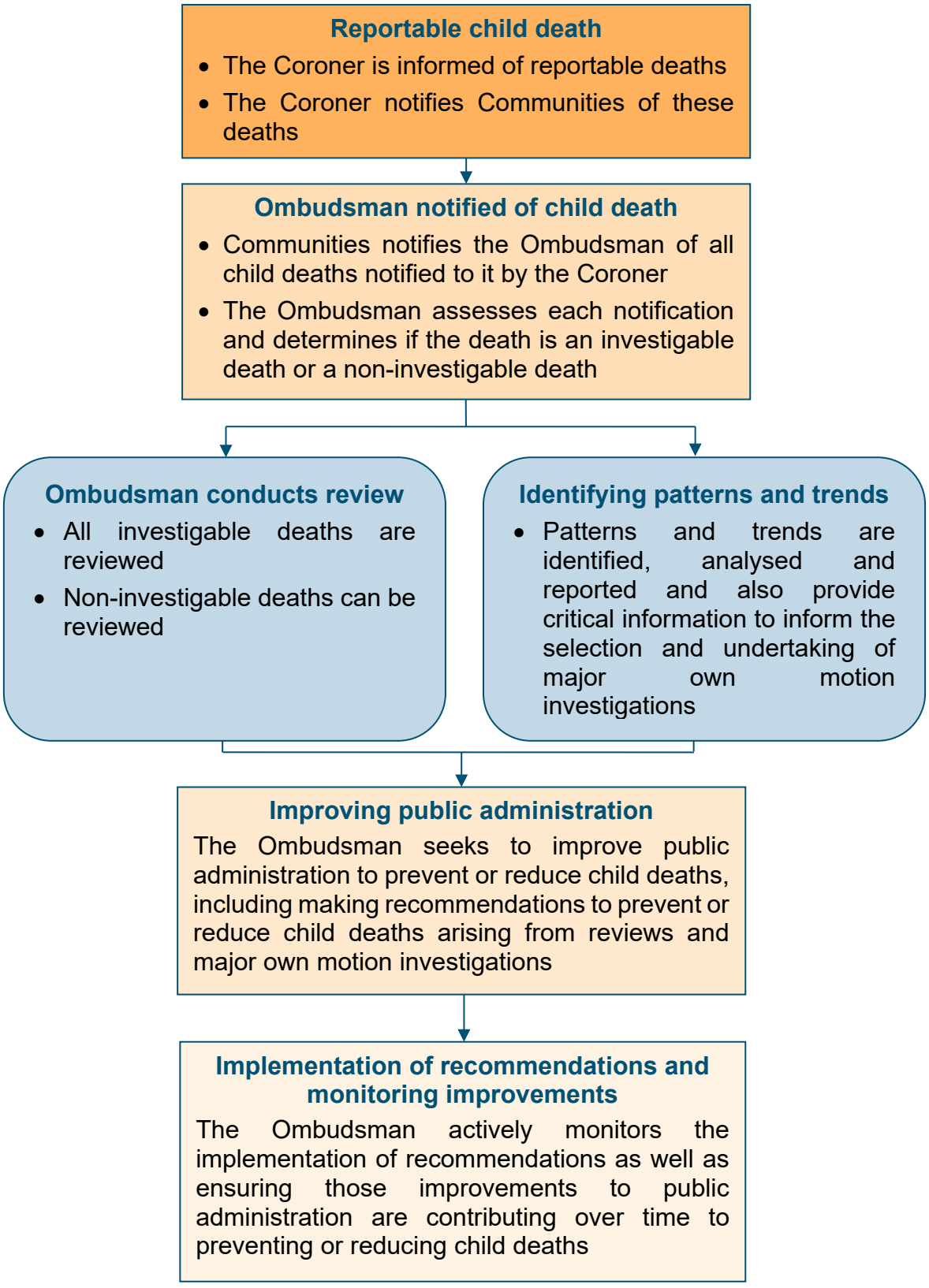
- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children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

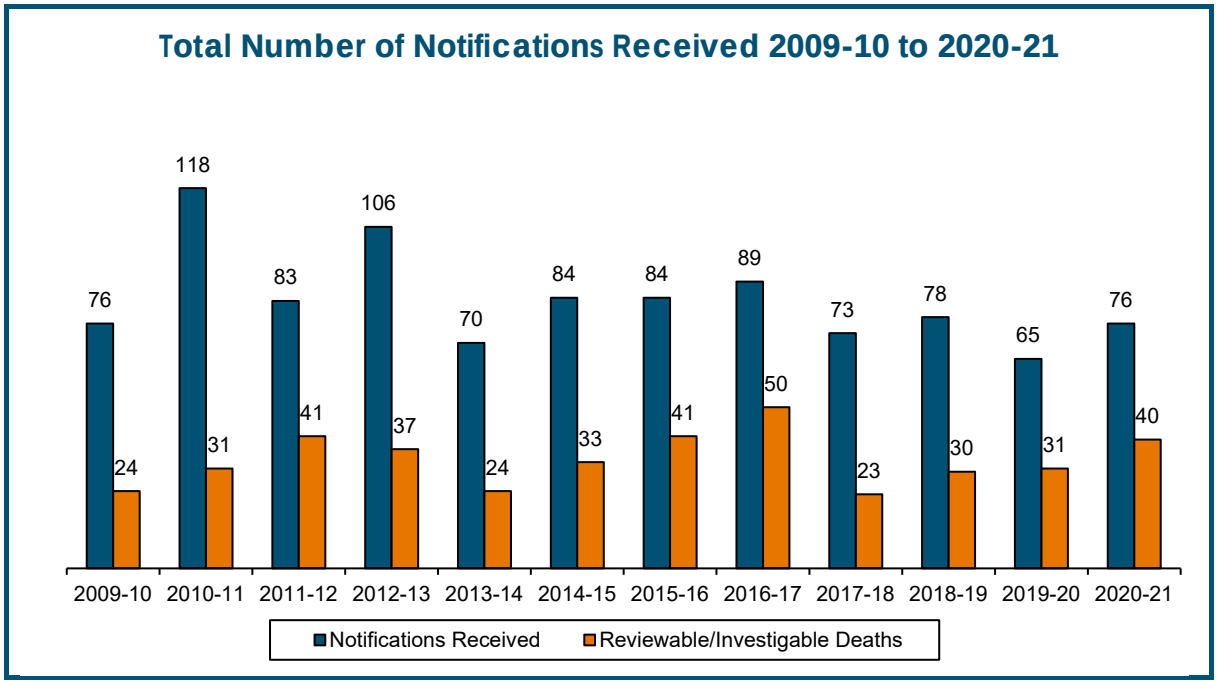
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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

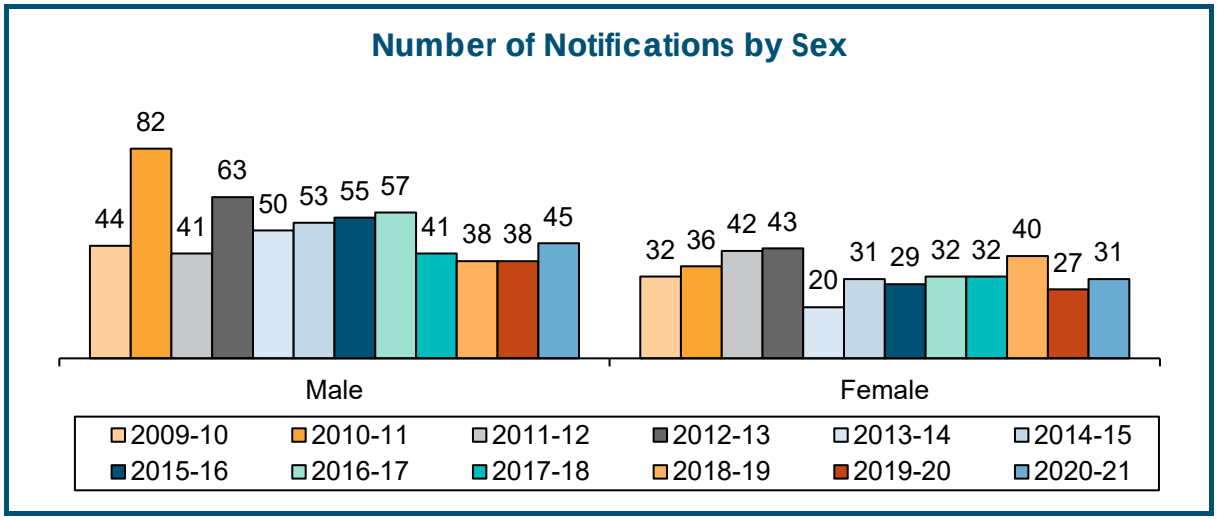
Information is obtained on a range of characteristics of the children who have died including sex, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

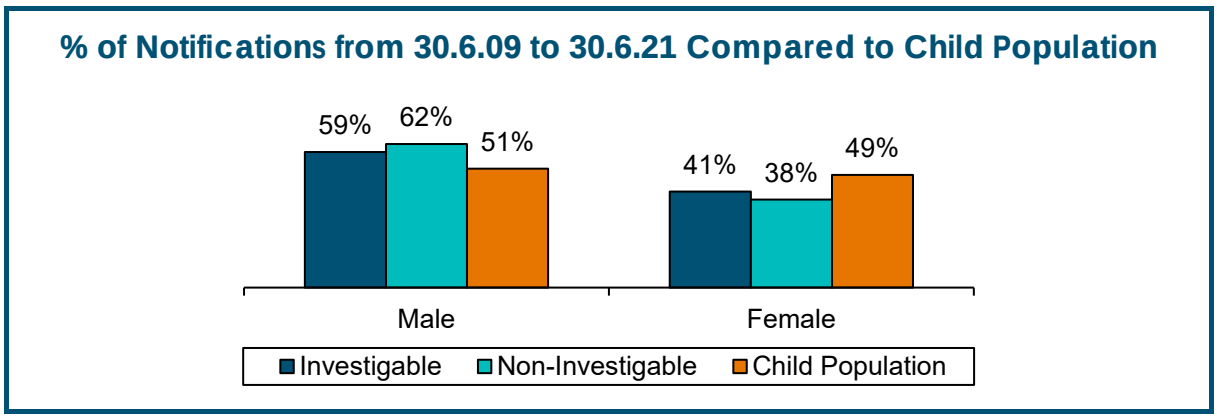
The following charts show:

- 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.

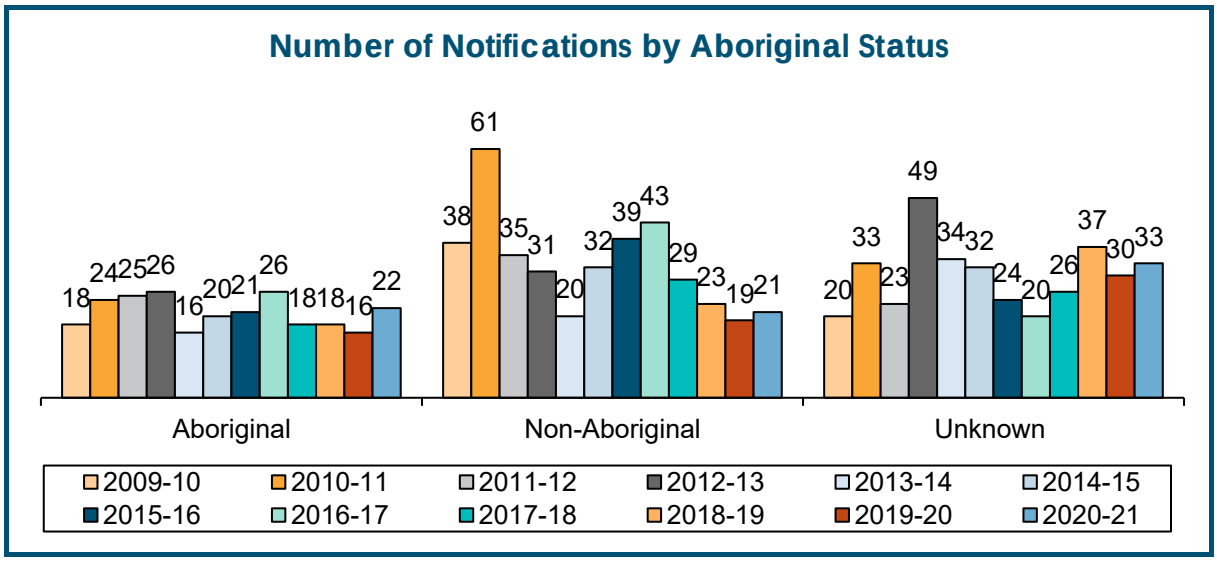


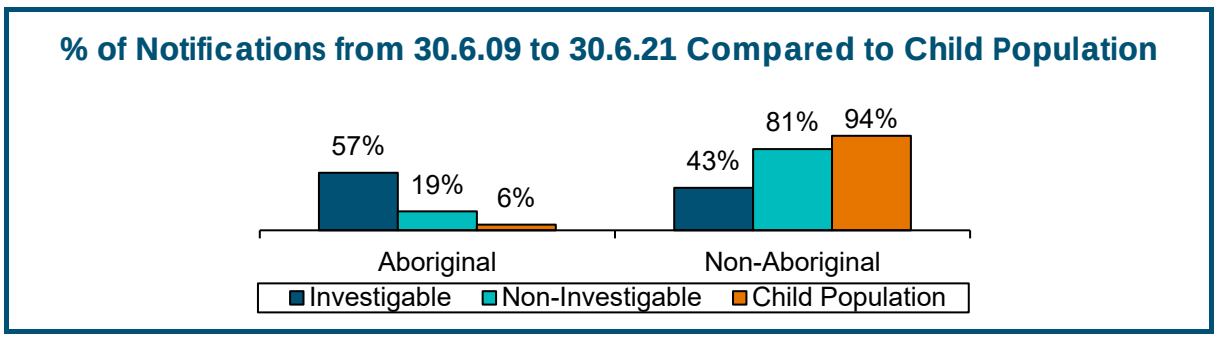


Further analysis of the data shows that, considering all 12 years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

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.



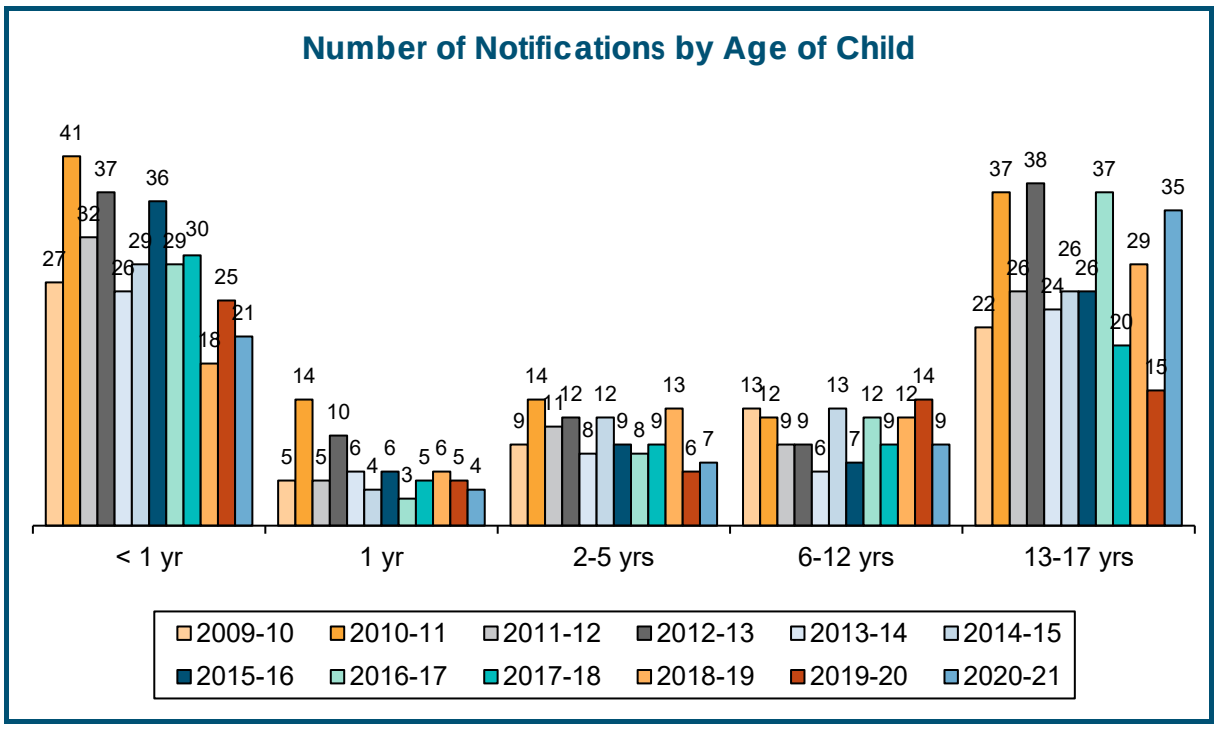


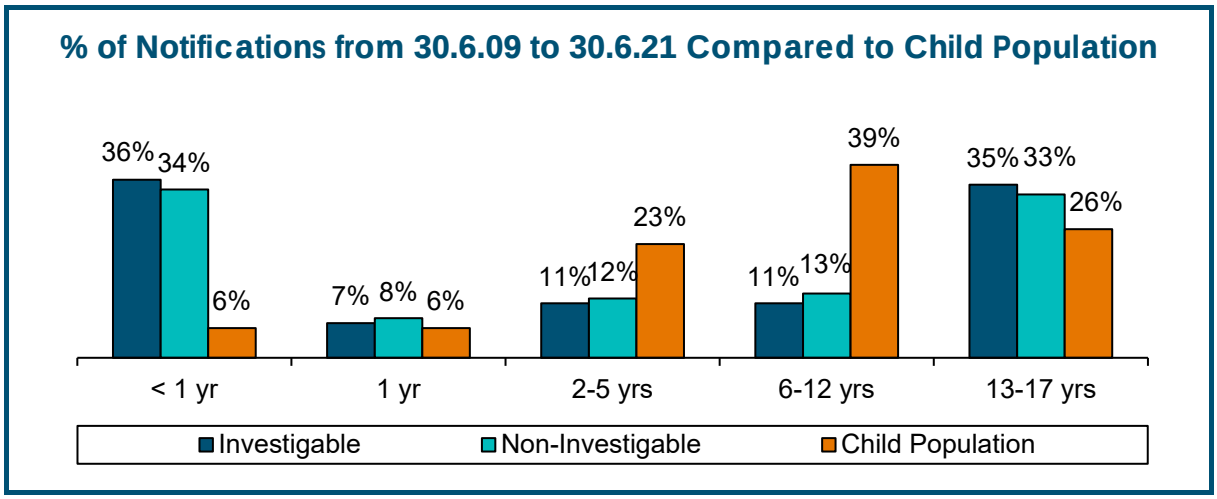
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

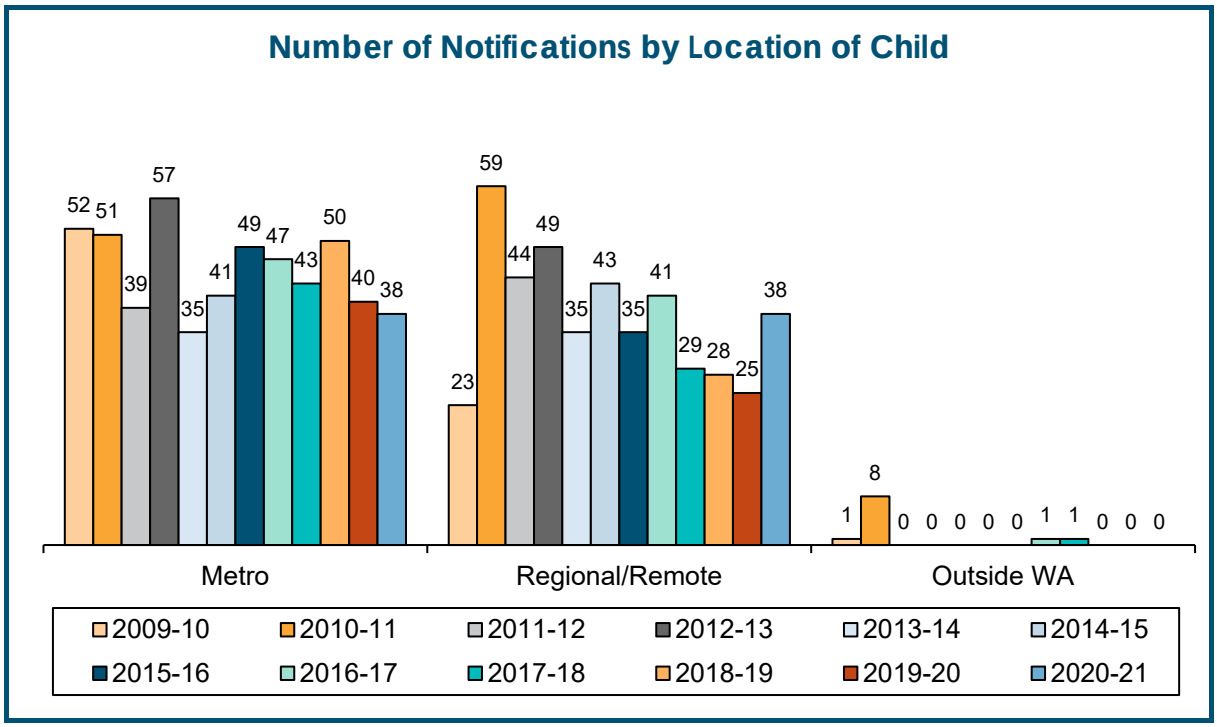




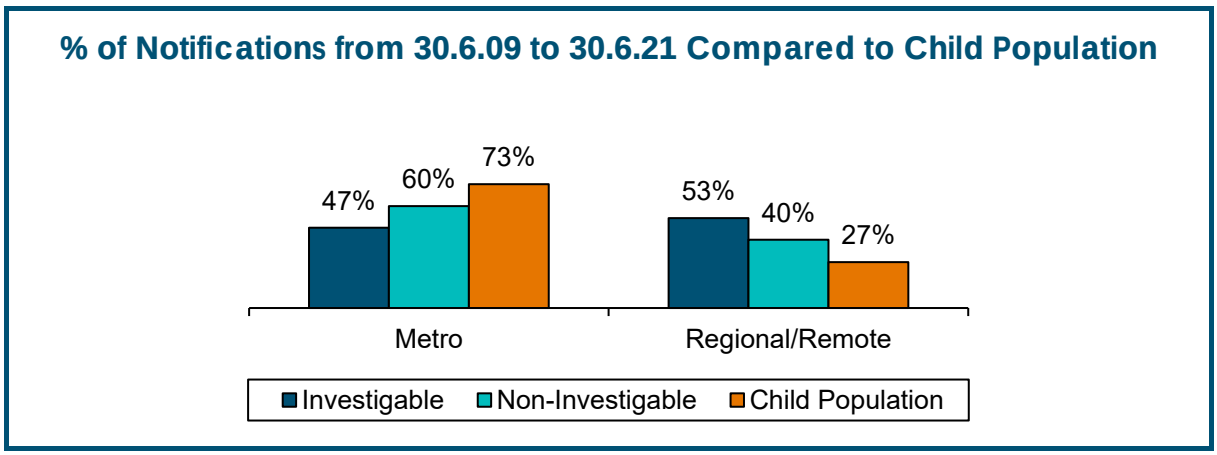
A more detailed analysis by age group is provided later in this section.

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

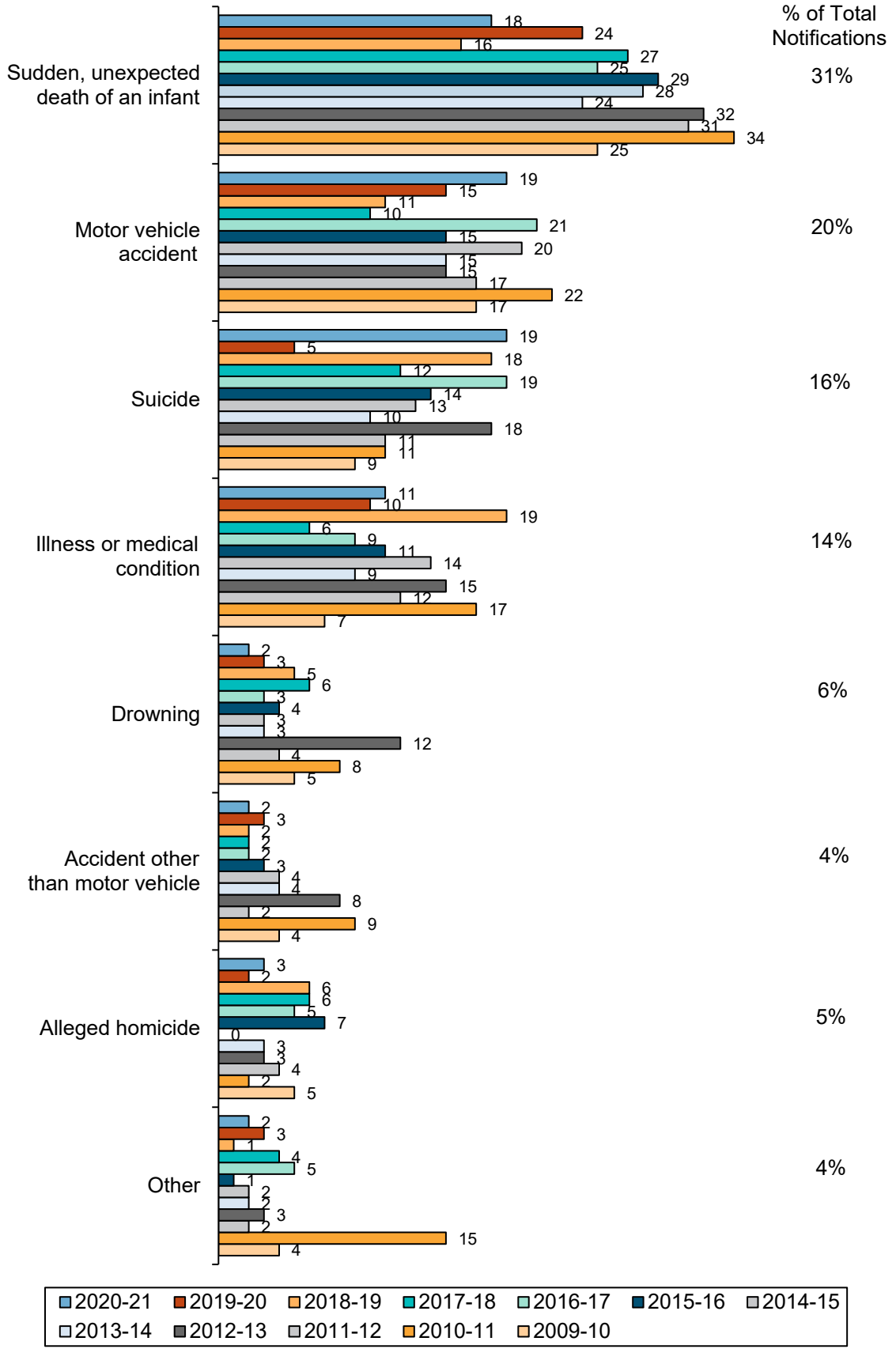
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally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



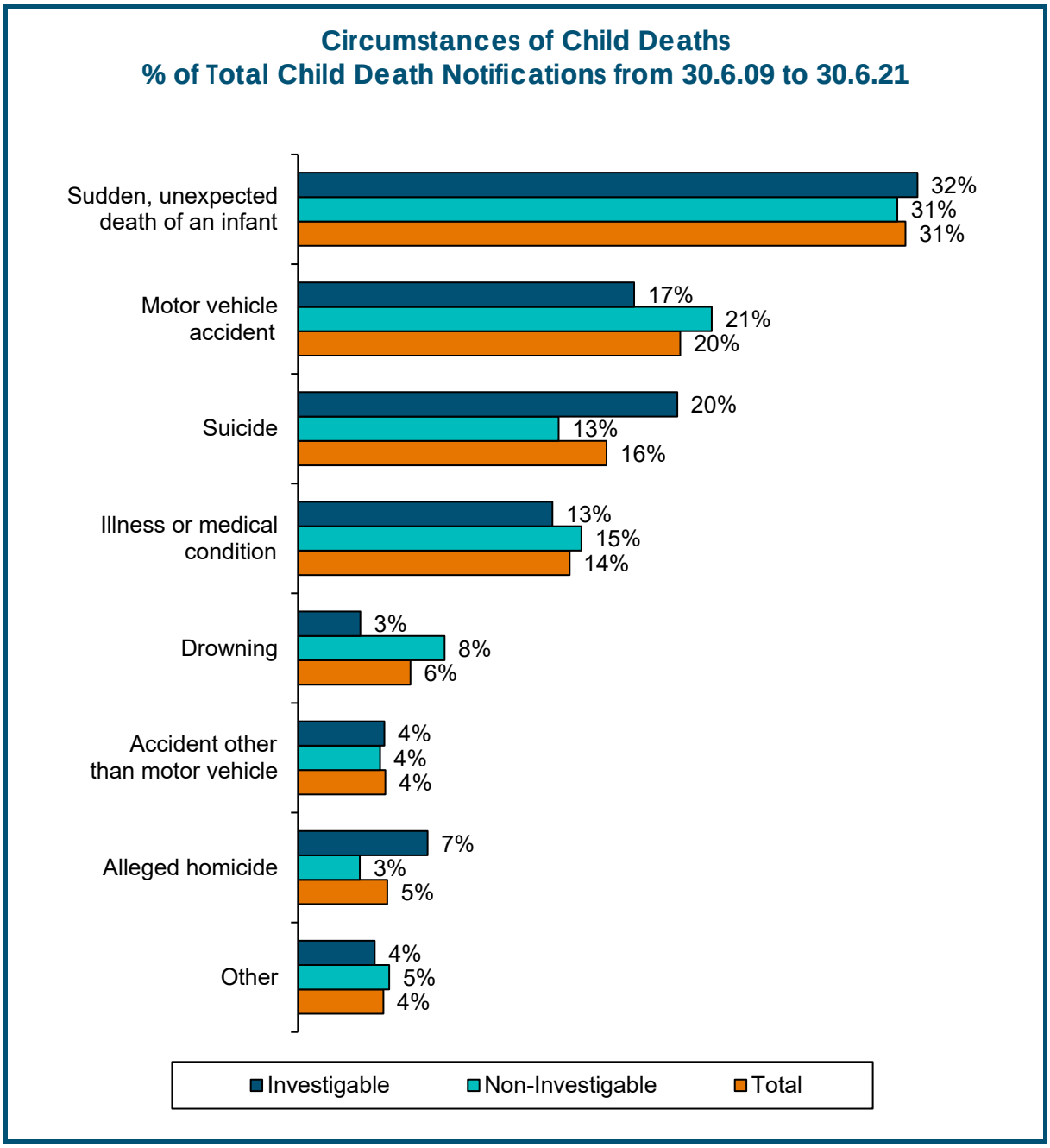
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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

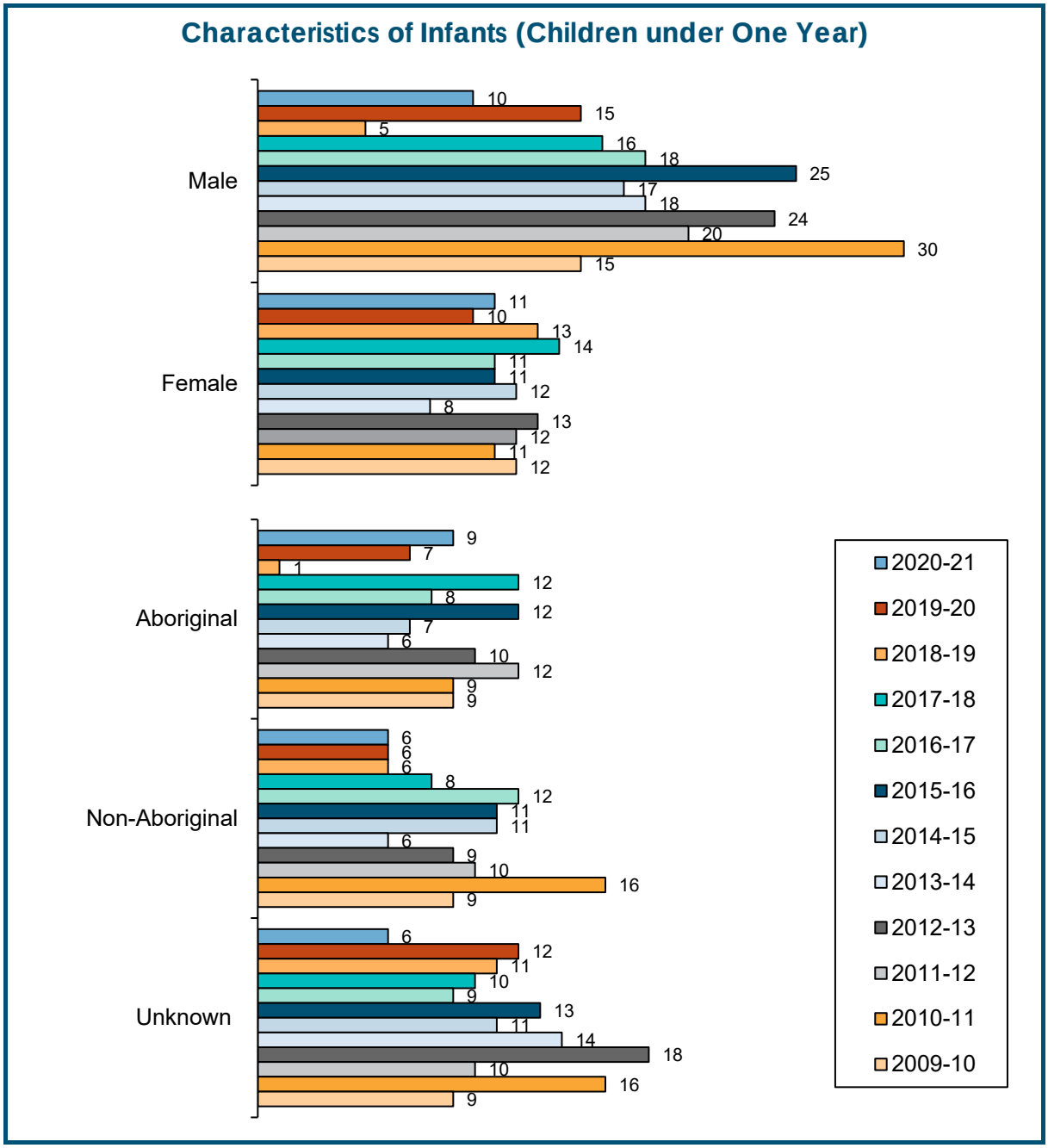
In child deaths notified to the Ombudsman in 2020-21, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

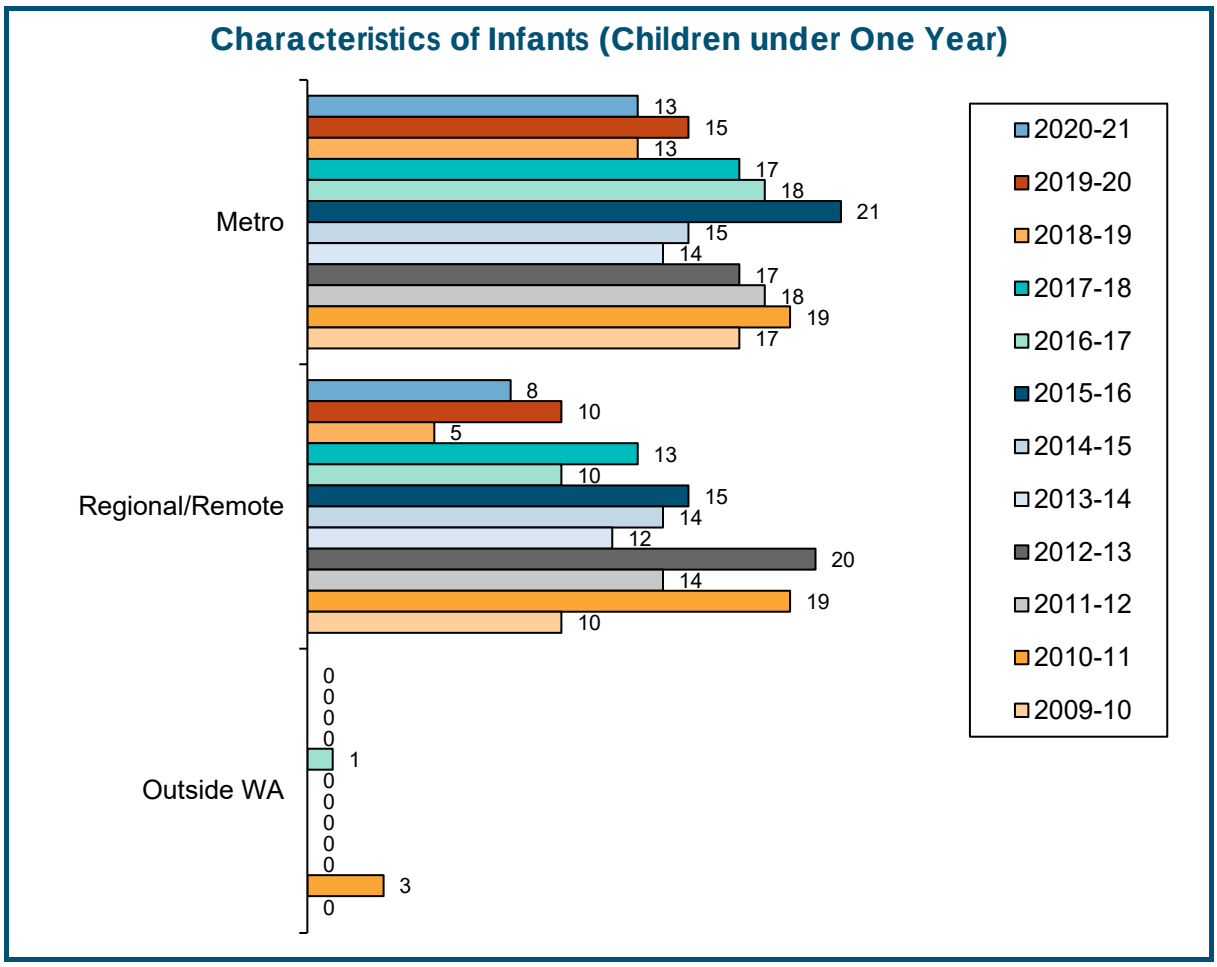
Analysis of children in particular age groups

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.



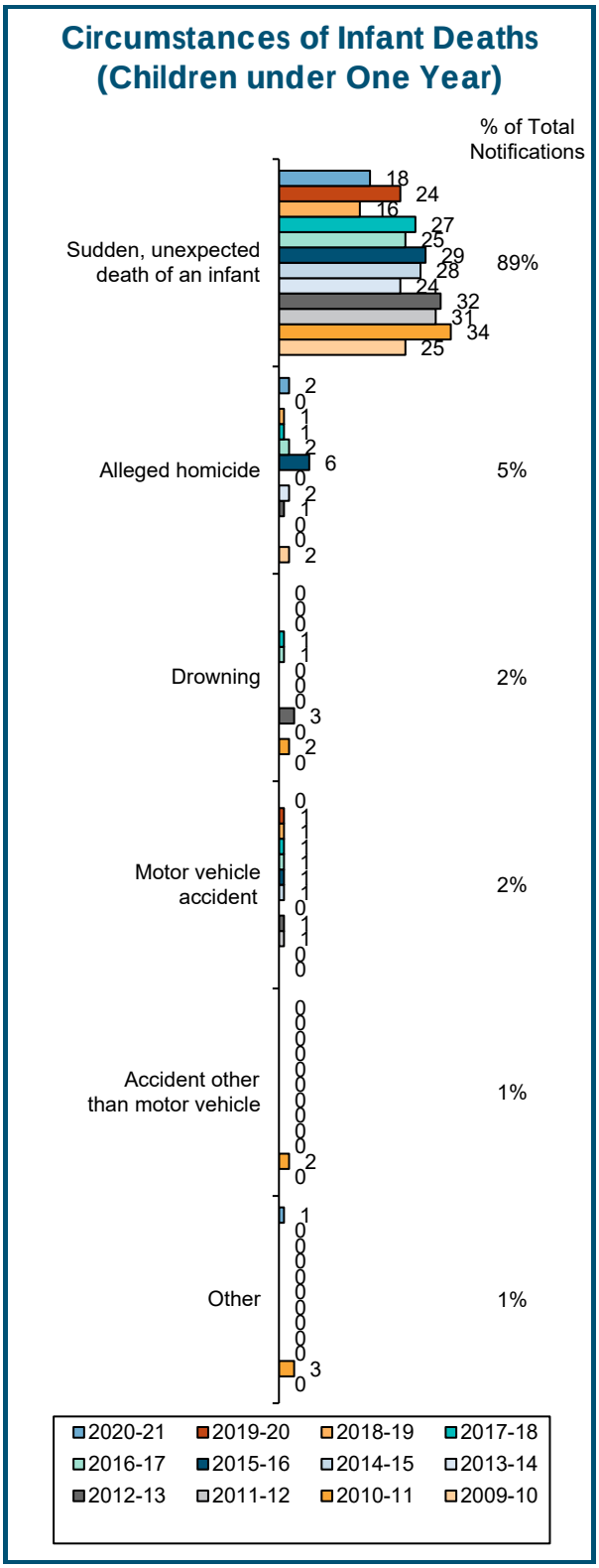


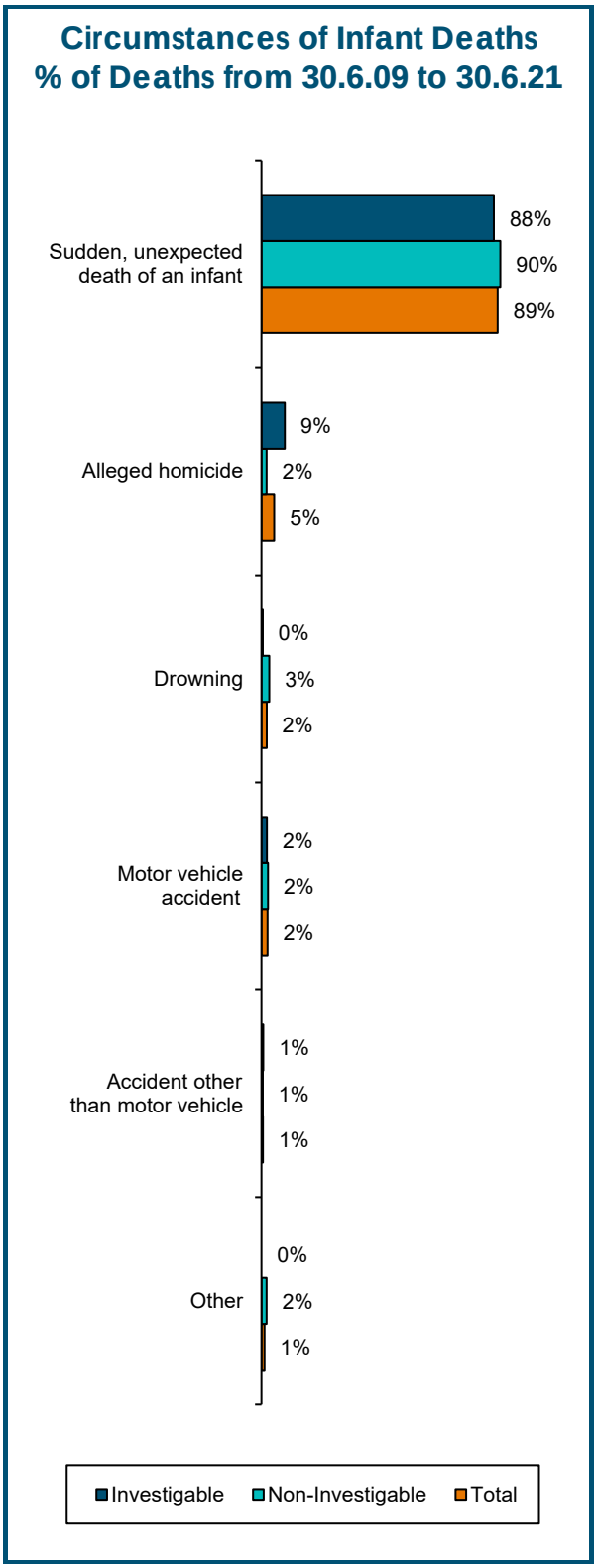
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.





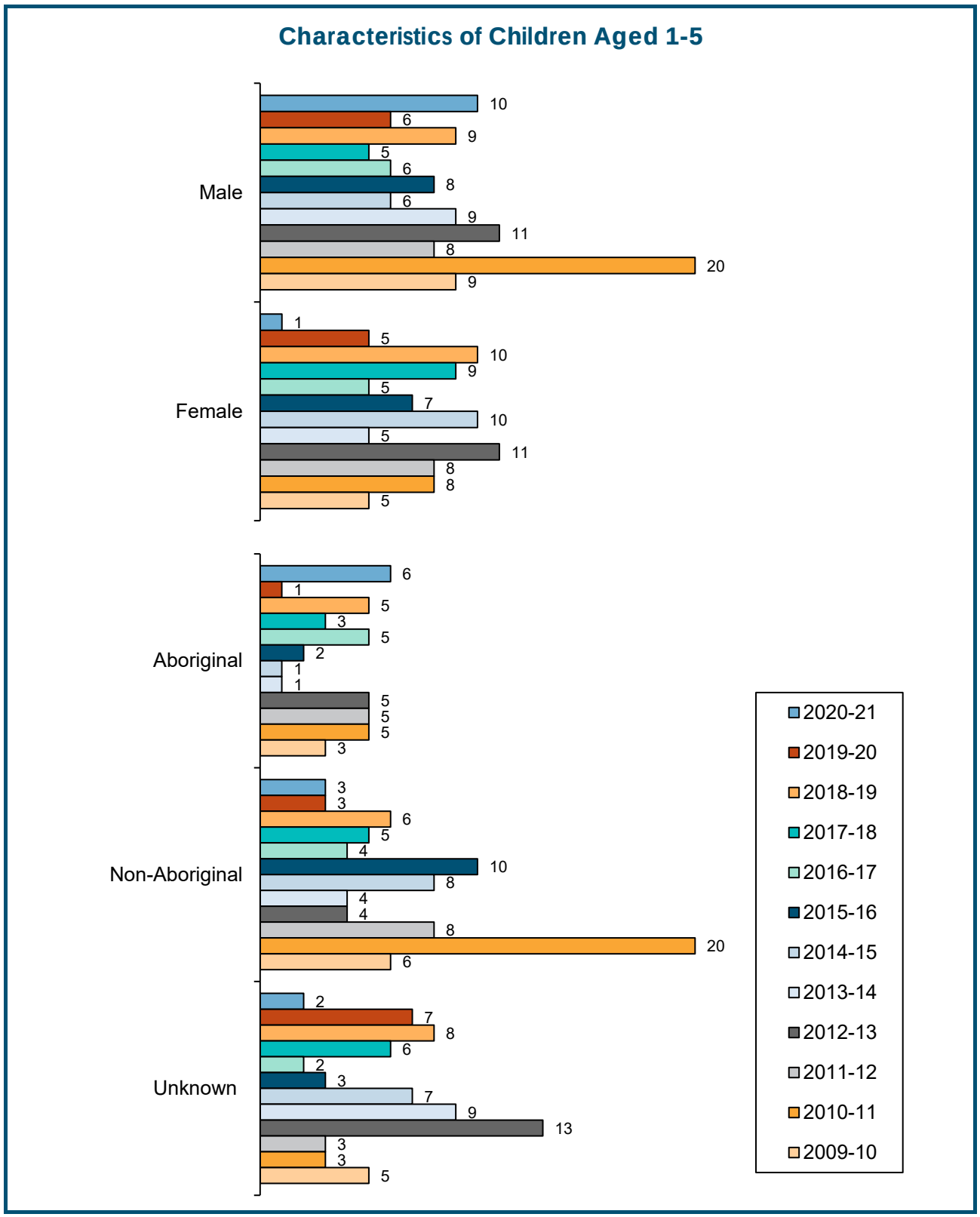
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

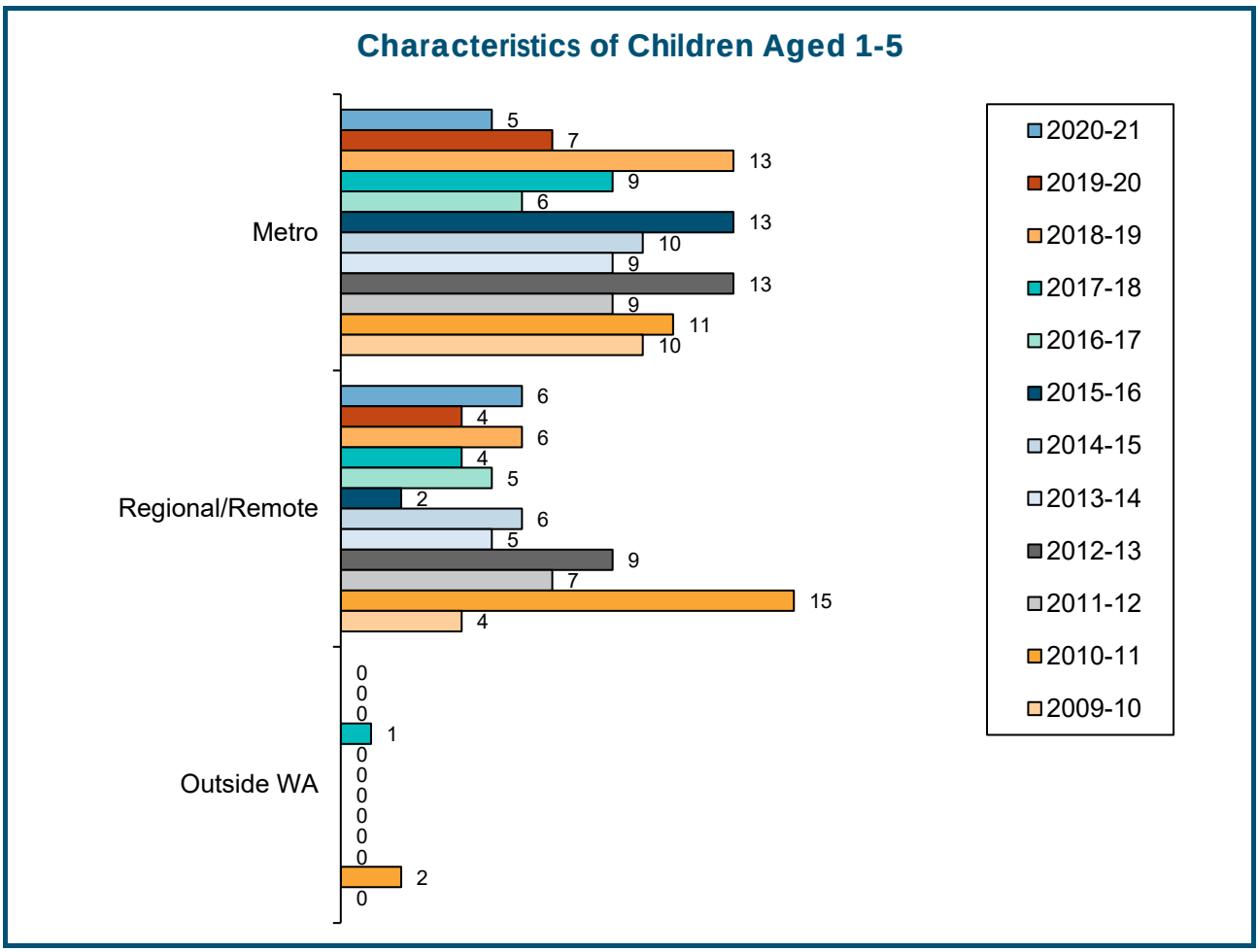
One hundred and forty seven deaths of infants were determined to be investigable deaths.

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%).

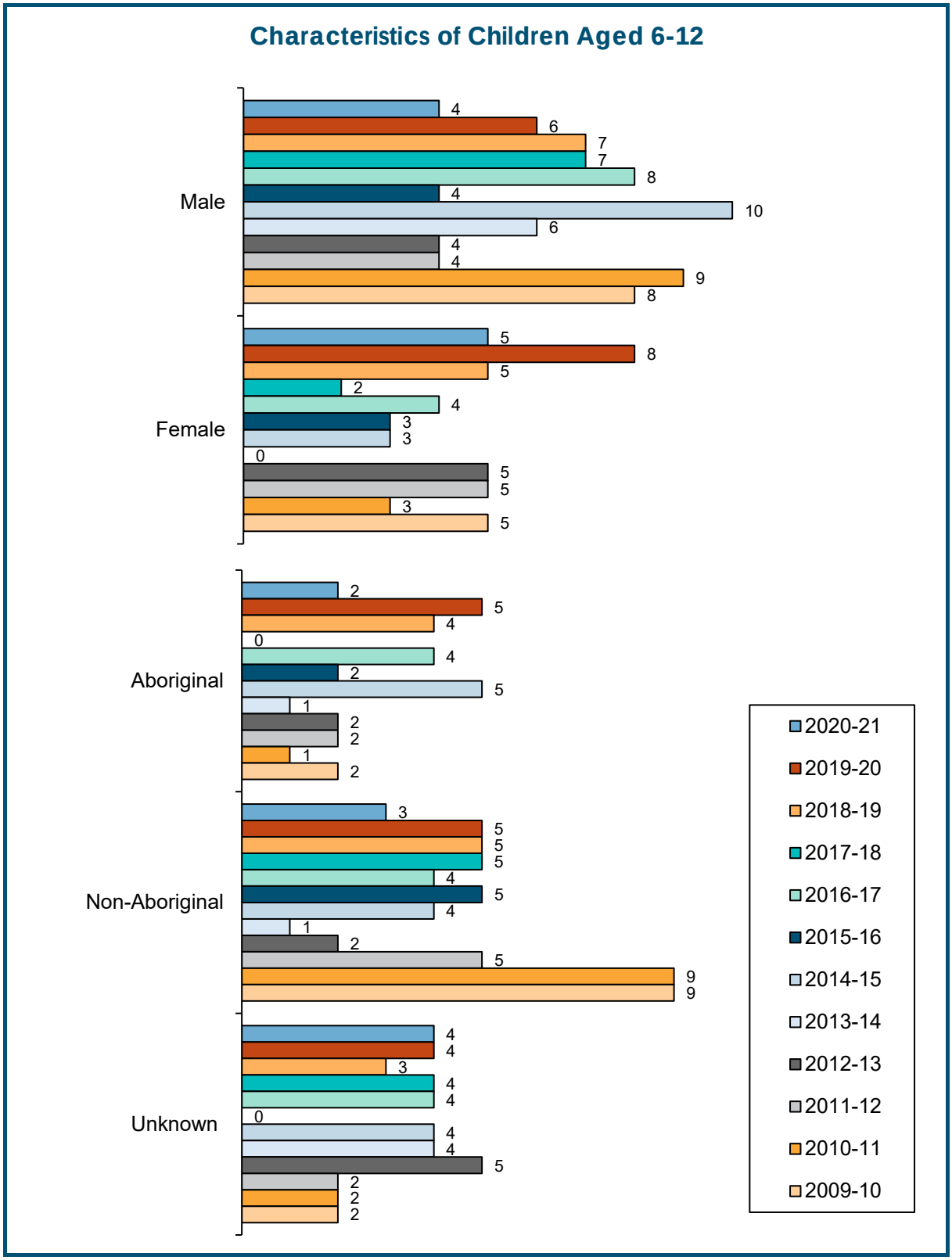
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

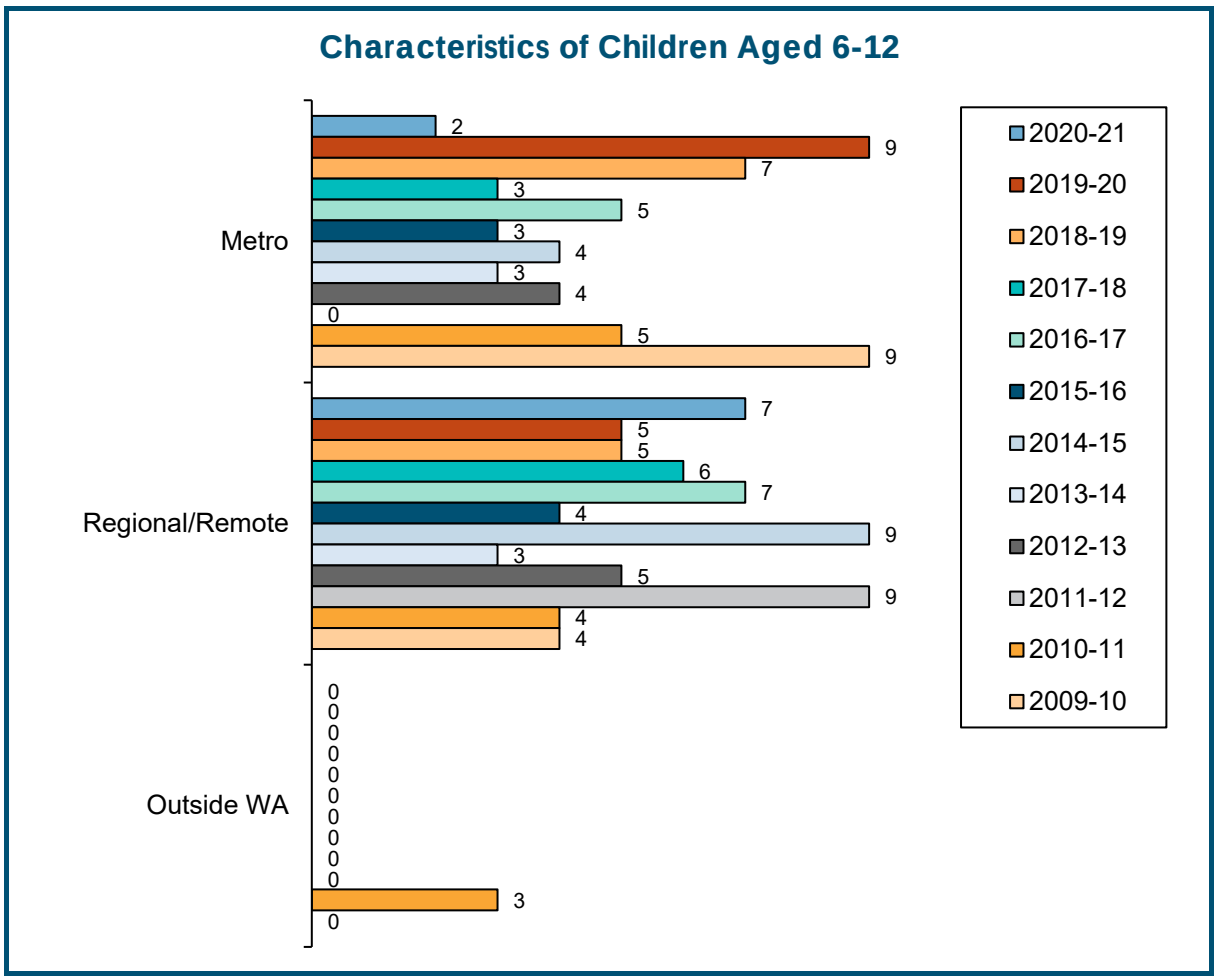
Seventy two deaths of children aged 1 to 5 years were determined to be investigable deaths.

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.



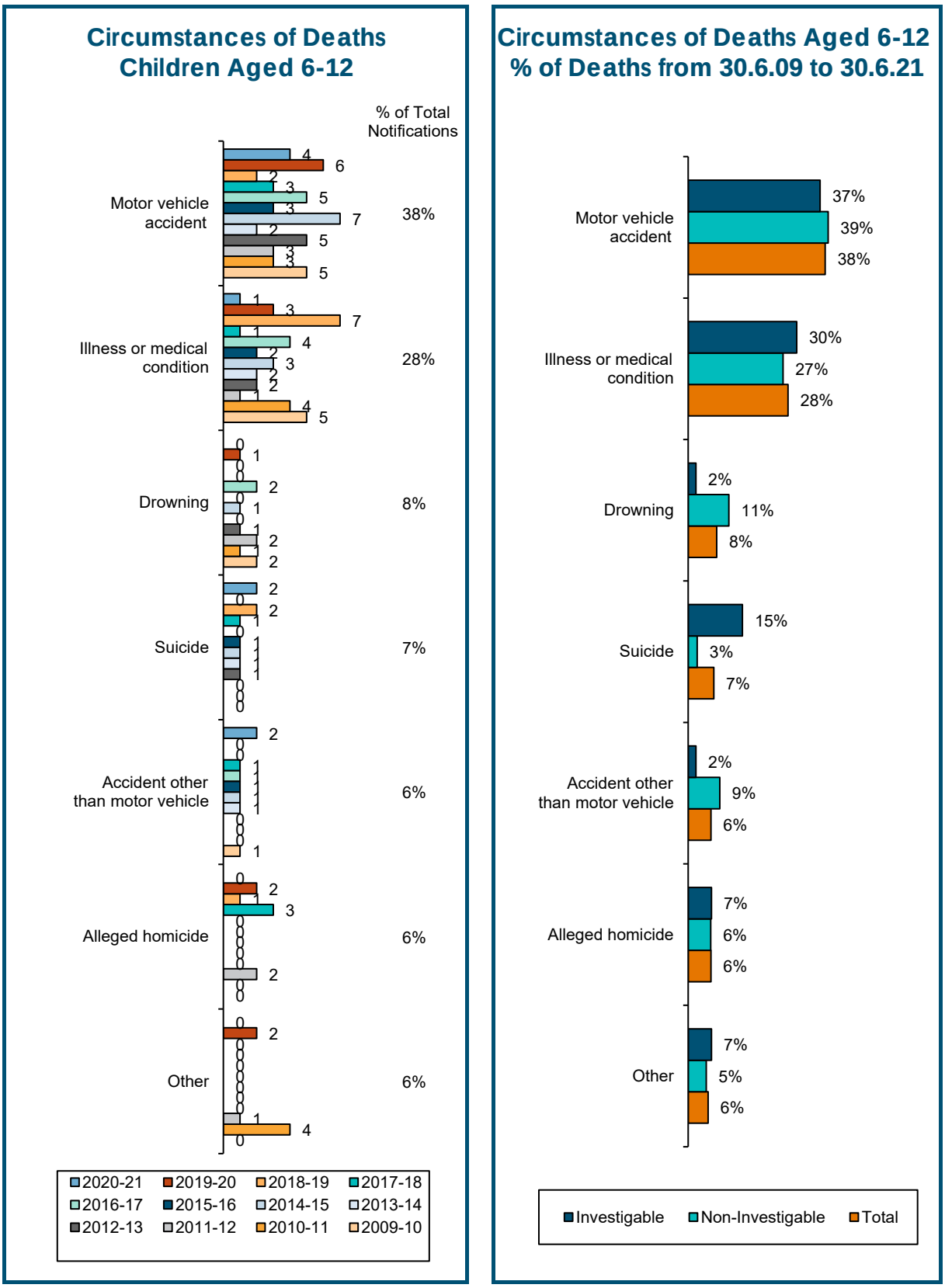


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).



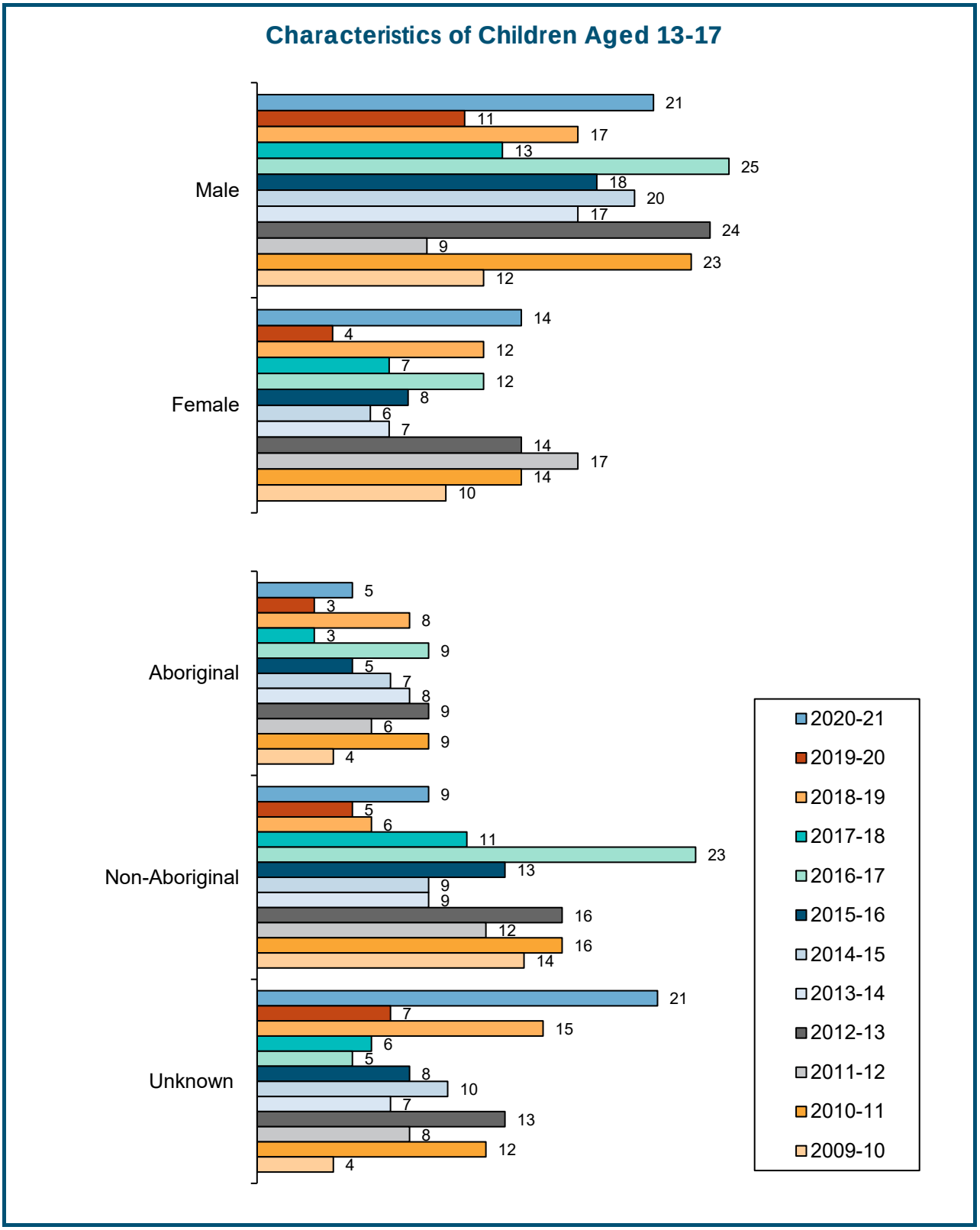
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

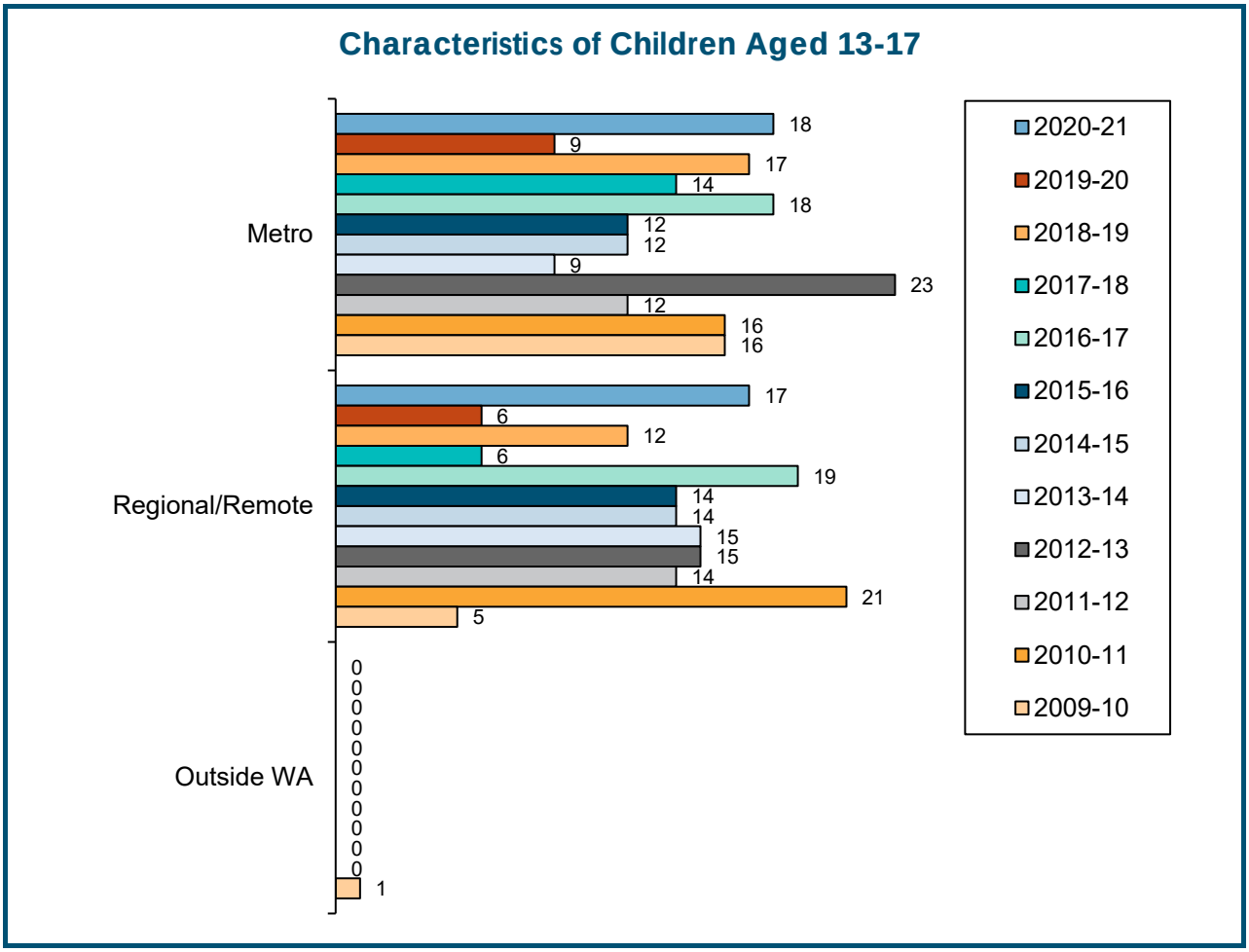
Forty six deaths of children aged 6 to 12 years were determined to be investigable deaths.

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.



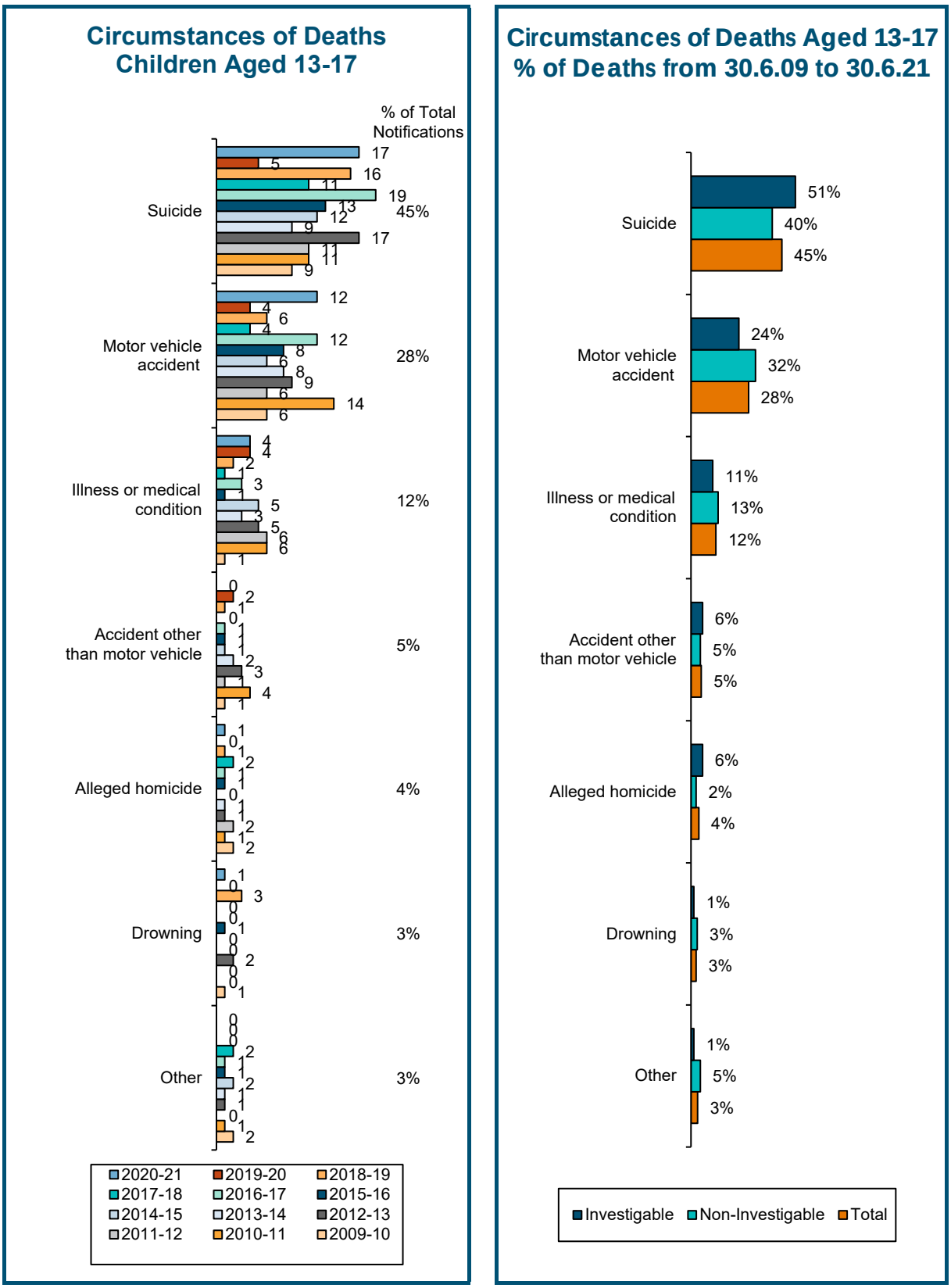


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.

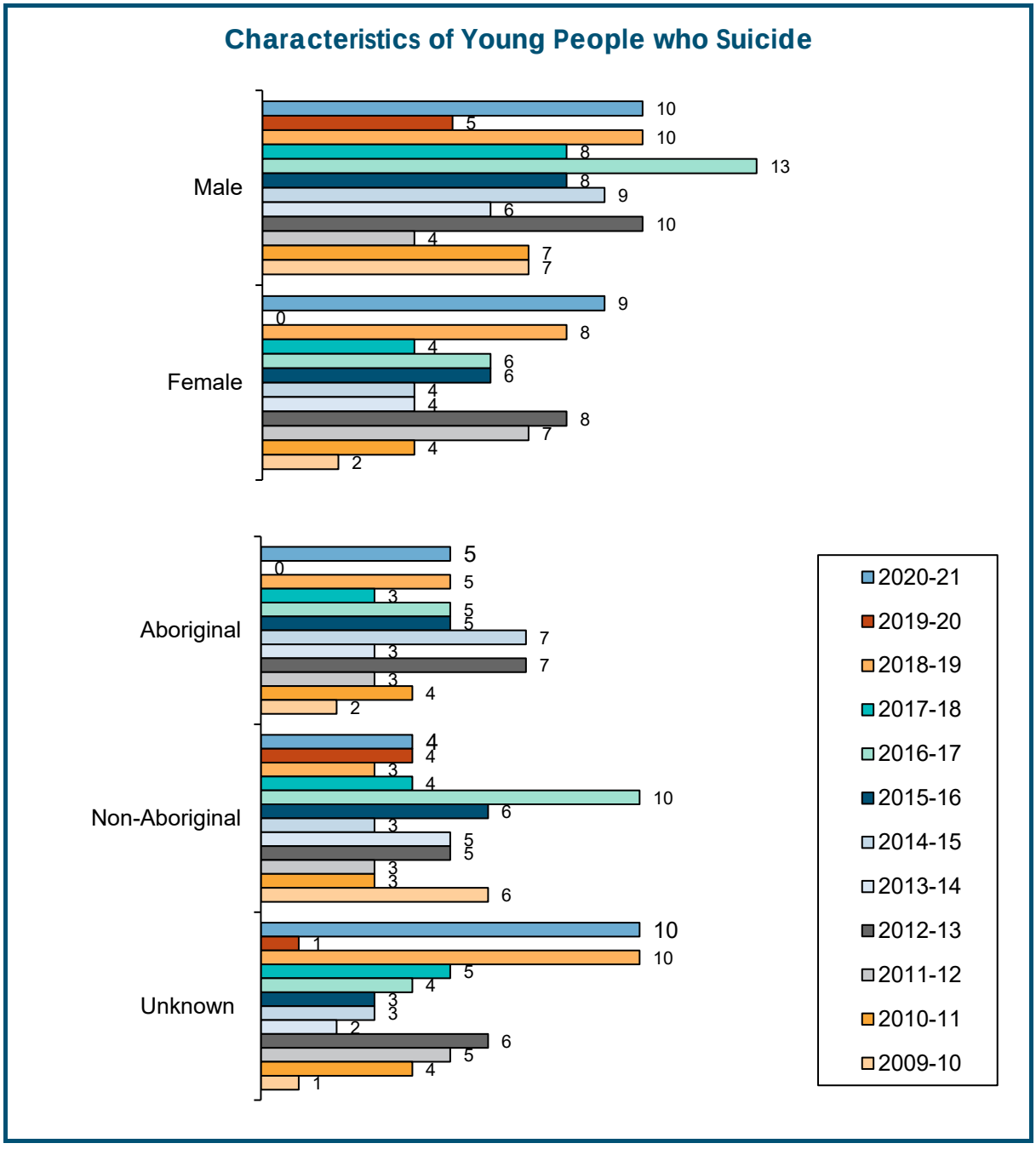
One hundred and forty deaths of children aged 13 to 17 years were determined to be investigable deaths.

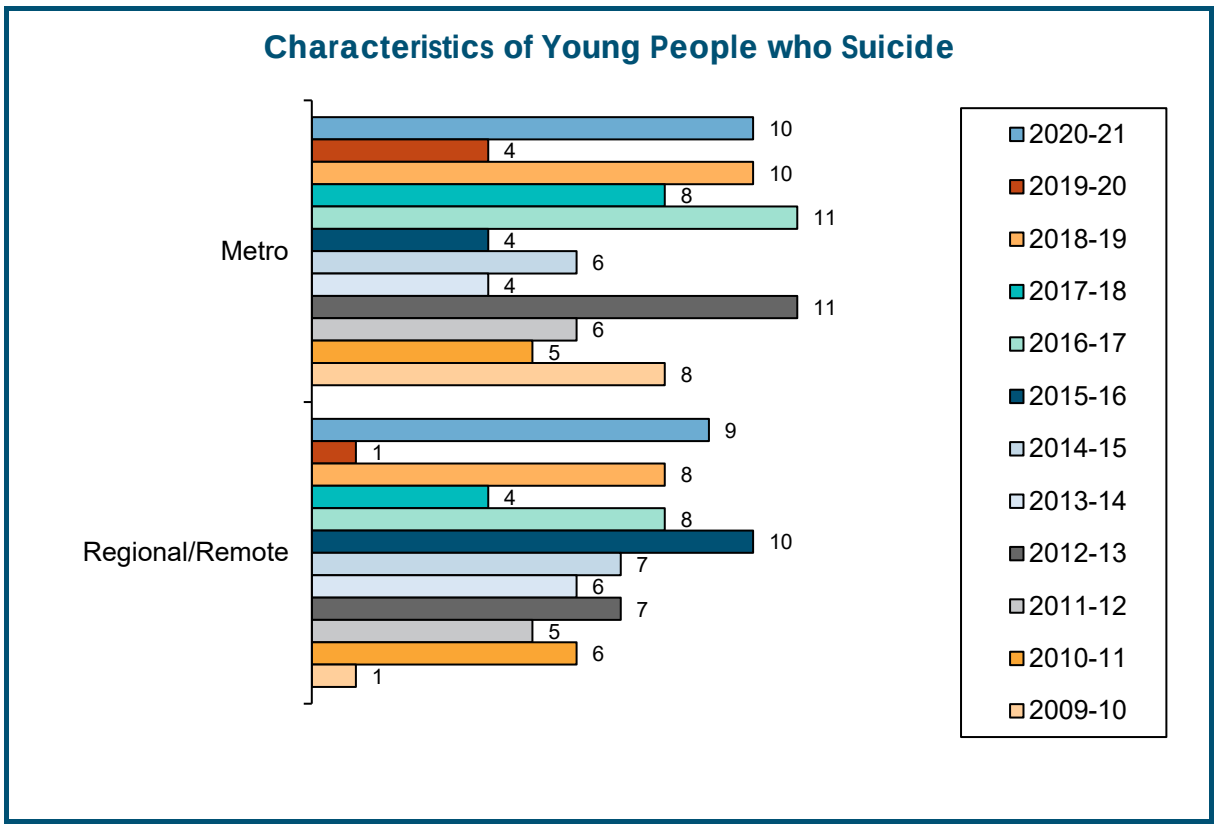
Suicide by young people

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:

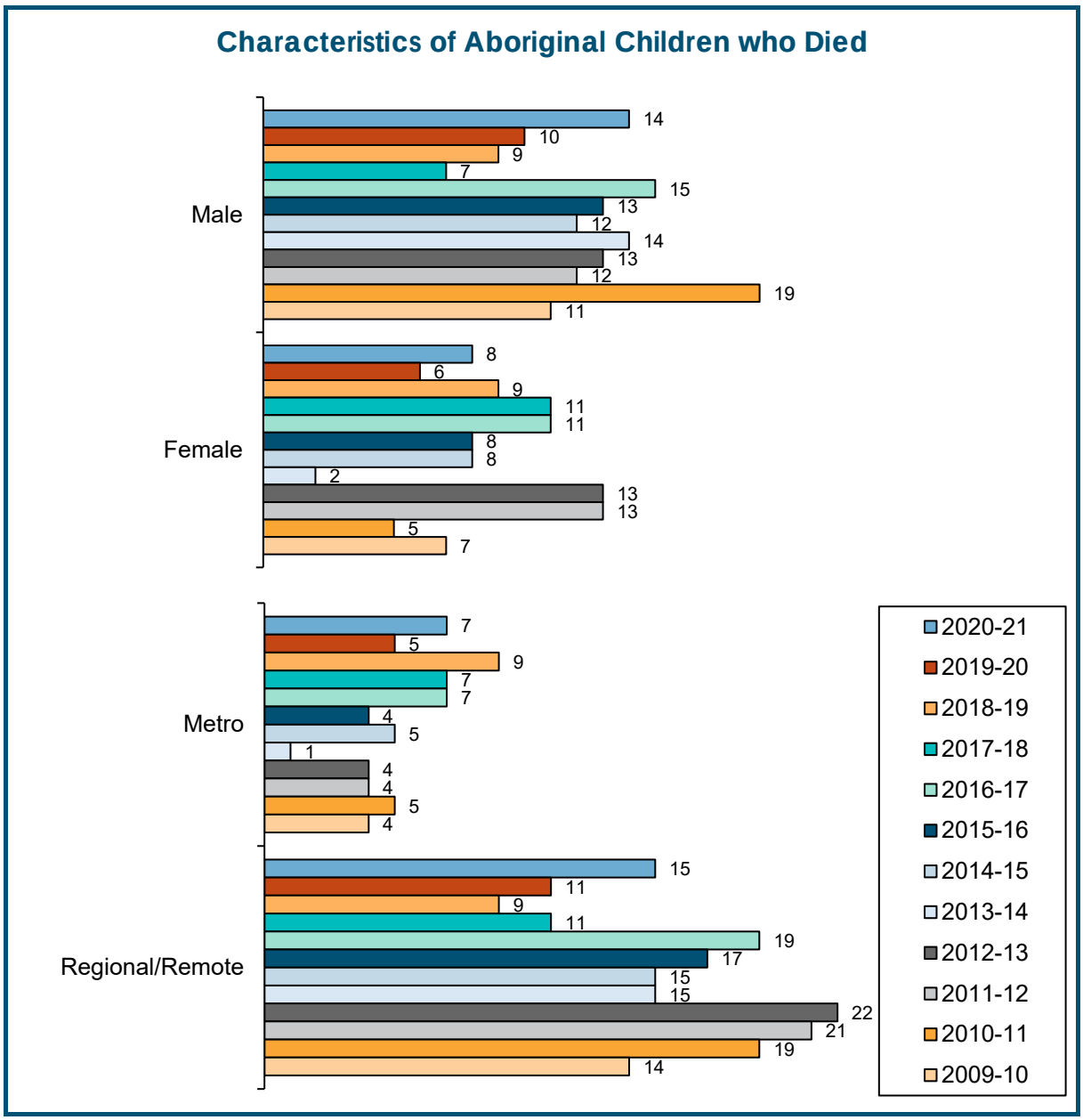
- Males – 53% of investigable deaths and 69% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 105 apparent suicides by young people where information on the Aboriginal status of the young person was available, 64% of the investigable deaths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

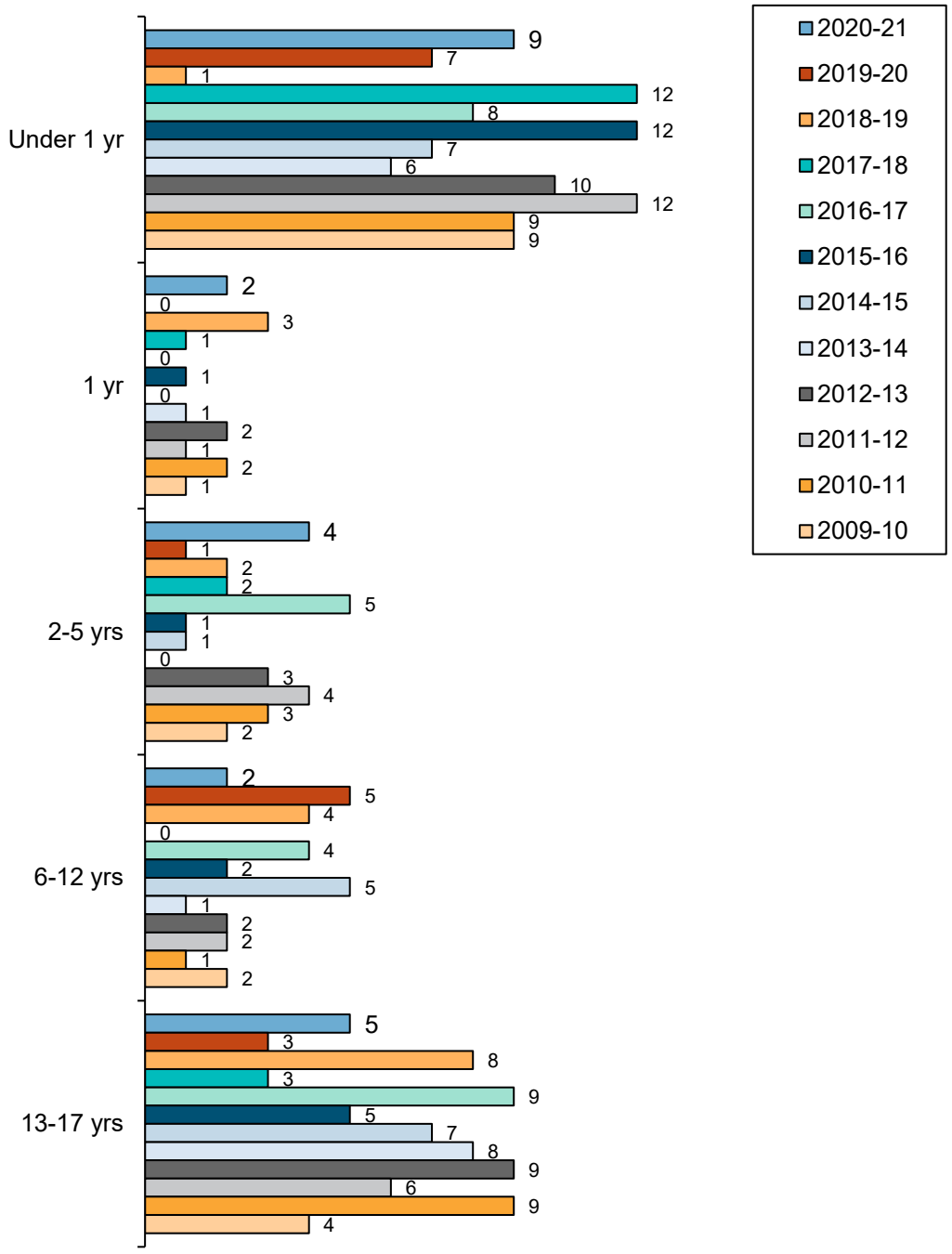
Of the 641 child death notifications received from 30 June 2009 to 30 June 2021, where the Aboriginal status of the child, or their parent/s, was recorded by agencies they had contact with in documentation provided to this Office, 250 (39%) of the children were identified as Aboriginal.

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.

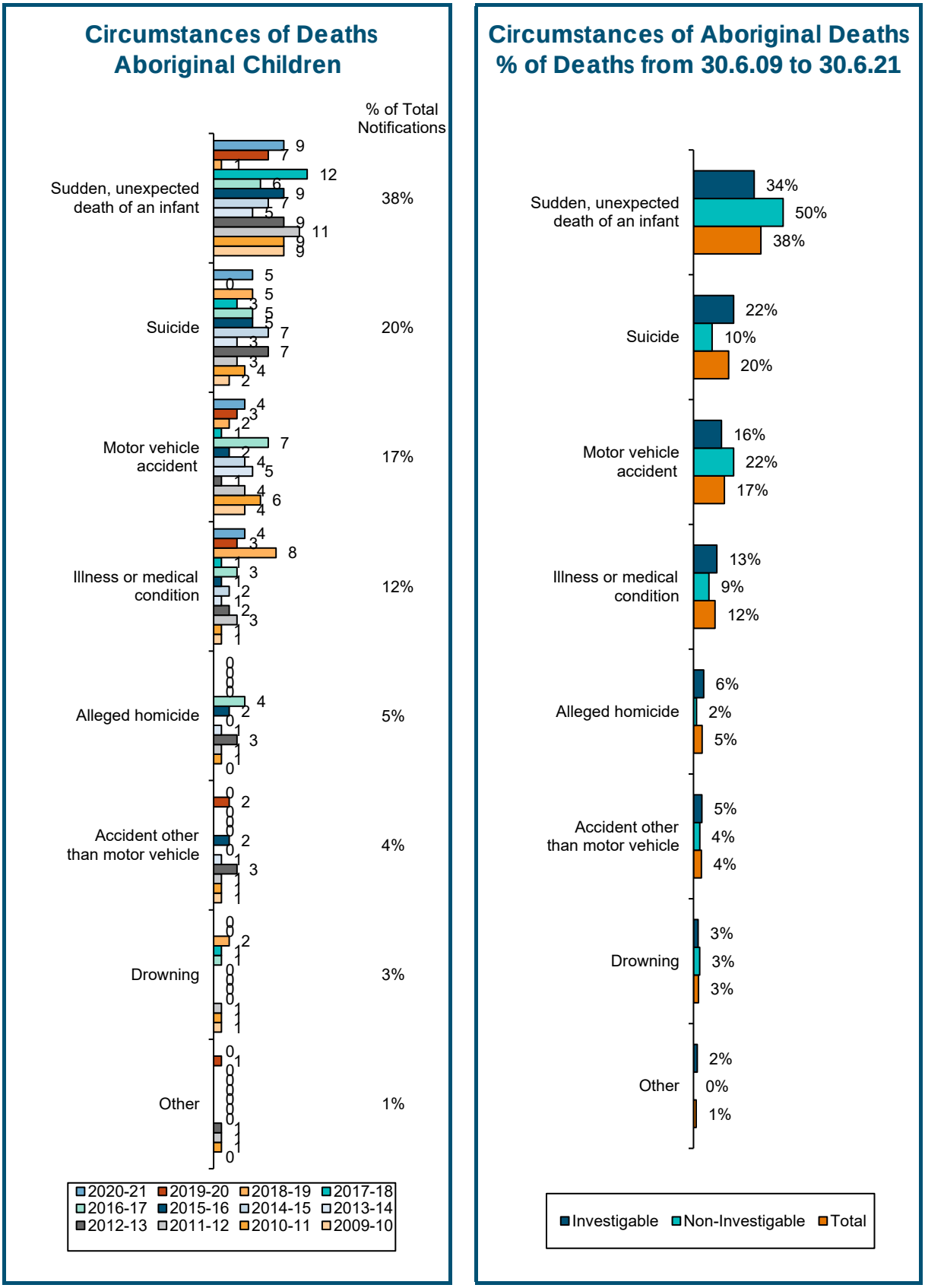


Characteristics of Aboriginal Children who Died



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.

Family and Domestic Violence Fatality Review

Overview

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

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

Background

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

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

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

The *Annual Action Plan 2009-10*, associated with the *WA Strategic Plan for Family and Domestic Violence 2009-13*, identified a range of strategies to reduce family and domestic violence including a 'capacity to systematically review family and domestic violence deaths and improve the response system as a result' (page 2). The *Annual Action Plan 2009-10* set out 10 key actions to progress the development and implementation of the integrated response in 2009-10, including the need to '[r]esearch models of operation for family and domestic violence fatality review committees to determine an appropriate model for Western Australia' (page 2).

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

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

In 2017, the State Government released the *Stopping Family and Domestic Violence Policy*, which set out 21 new initiatives for responding to family and domestic violence. This document superseded *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities* (**former State Strategy**) and the *Freedom from Fear Action Plan 2015*. Also in 2017, the first Minister for the Prevention of Family and Domestic Violence was appointed. In July 2020, the Department of Communities (**Communities**) released *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030* (**State Strategy**) and the associated *First Action Plan 2020-2022* (**First Action Plan**). The State Strategy's stated purpose is to 'guide a whole-of-community response to family and domestic violence in Western Australia from 2020-2030' and sets out the following guiding principles:

- People in Western Australia should be safe in their relationships and their homes;
- The safety and wellbeing of victims is the first priority;
- Children and young people exposed to domestic violence are victims;
- Perpetrators are solely responsible for their actions – victims must not be blamed;
- Women's safety is linked to gender equality;
- Everyone has a role in stopping family and domestic violence;
- Effective solutions are locally tailored, culturally safe and trauma informed;
- Men and boys are integral to the solution; and
- There is 'no wrong door approach' to service delivery.

The Ombudsman's family and domestic violence fatality reviews examine stakeholder implementation of the State Strategy, to prevent or reduce the risks associated with family and domestic violence fatalities.

It is essential to the success of the family and domestic violence fatality review role that the Office identified and engaged with a range of key stakeholders in the

implementation and ongoing operation of the role. It is important that stakeholders understand the role of the Ombudsman, and the Office understands the critical work of all key stakeholders.

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

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

The Office has also accepted invitations to speak at relevant seminars and events to explain its role in regard to family and domestic violence fatality reviews and since 1 July 2012, has participated as a Member of the Australian Domestic and Family Violence Death Review Network.

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

Information regarding the use of terms

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

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

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

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

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

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

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

(d) One of whom is a child who —

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

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

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

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

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

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

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

(b) Is related to the person's —

(i) Spouse or former spouse; or

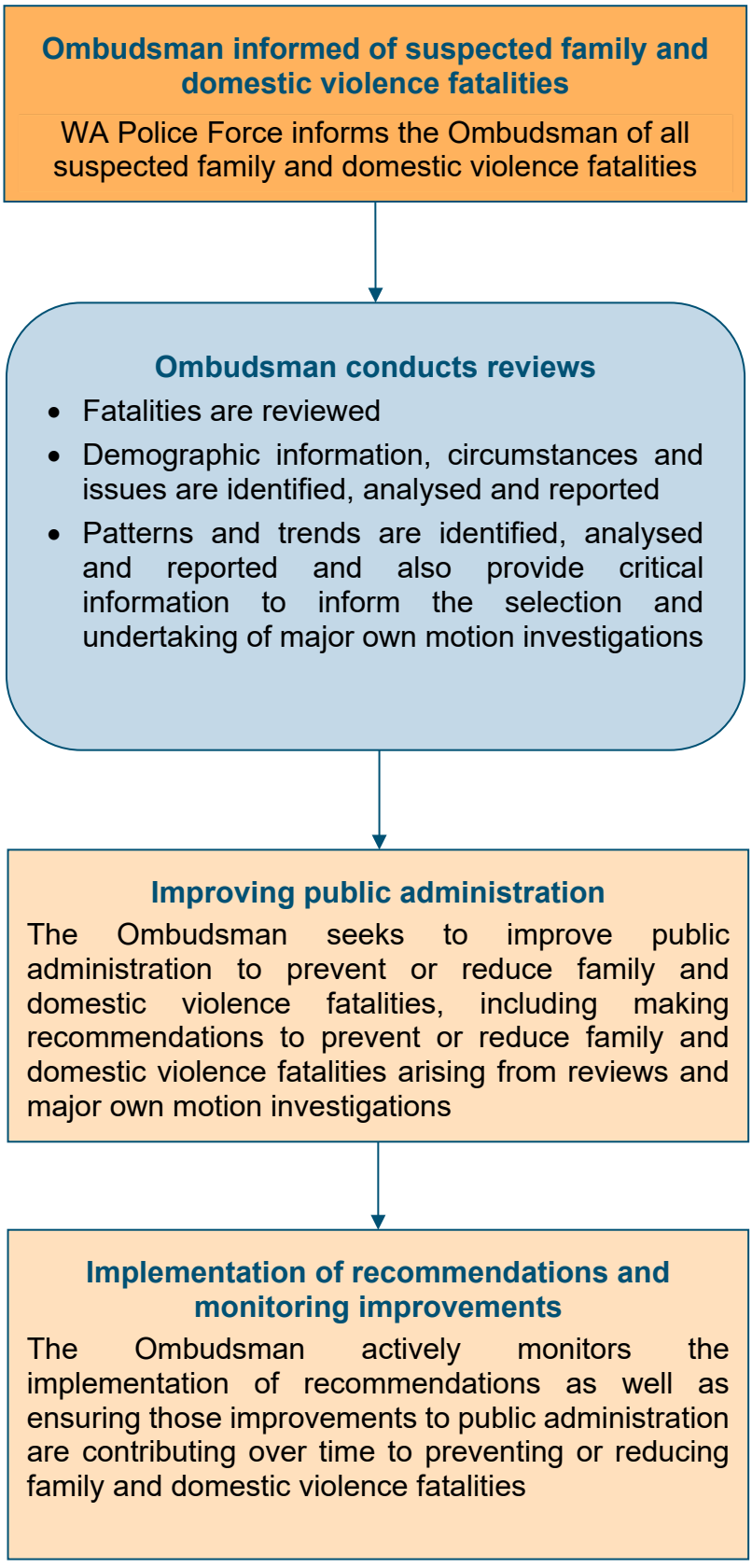
(ii) De facto partner or former de facto partner.

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

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

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

The Family and Domestic Violence Fatality Review Process



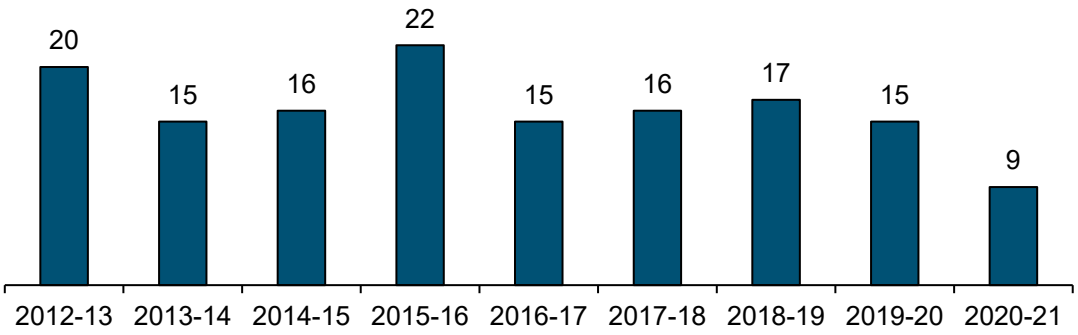
Analysis of Family and Domestic Violence Fatality Reviews

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

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

Number of family and domestic violence fatality reviews

In 2020-21, the number of reviewable family and domestic violence fatalities received was nine, compared to 15 in 2019-20, 17 in 2018-19, 16 in 2017-18, 15 in 2016-17, 22 in 2015-16, 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

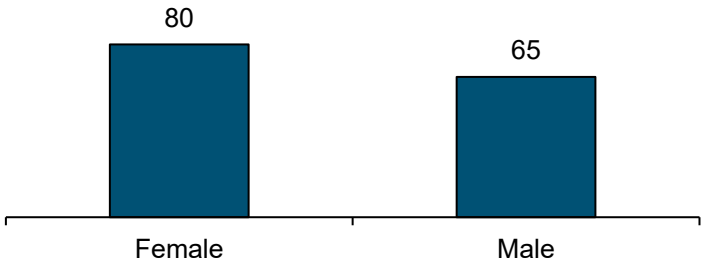


Demographic information identified from family and domestic violence fatality reviews

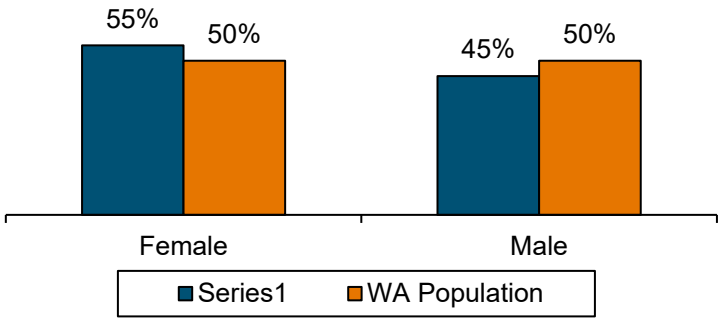
Information is obtained on a range of characteristics of the person who died, including sex, age group, Aboriginal status, and location of the incident in the metropolitan or regional areas.

The following charts show characteristics of the persons who died for the 145 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2021. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

Number of Persons who Died by Sex



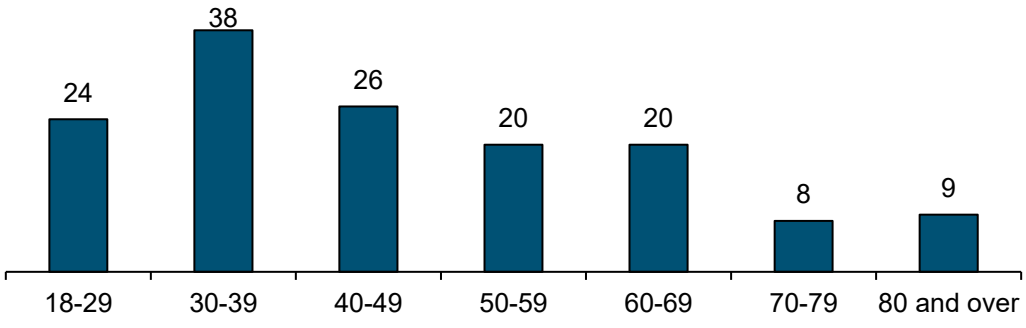
Sex of Persons who Died Compared to WA Population

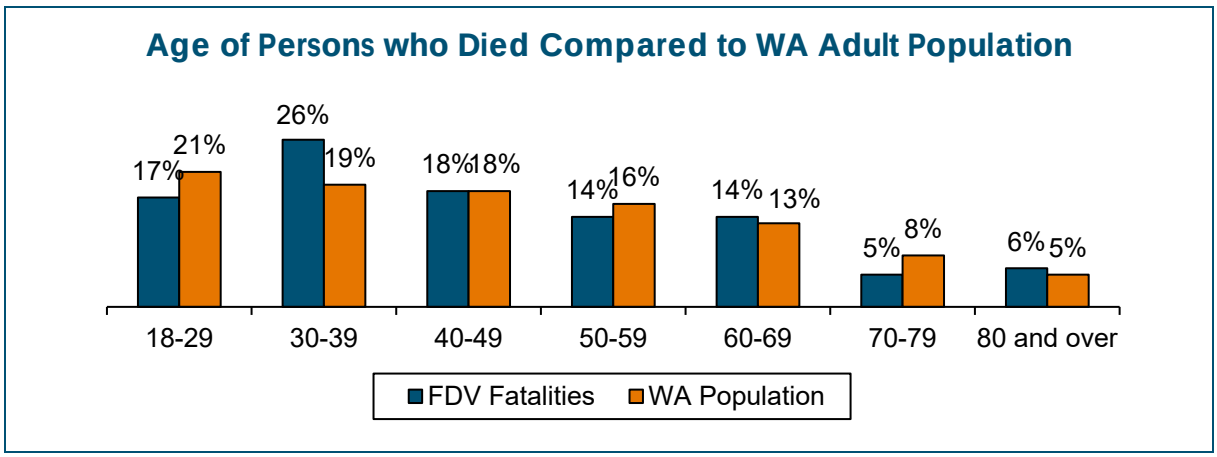


Information is collated on the sex of the deceased, and the suspected perpetrator, as identified in agency documentation provided to this Office. Compared to the Western Australian population, females who died in the nine years from 1 July 2012 to 30 June 2021, were over-represented, with 55% of persons who died being female compared to 50% in the population.

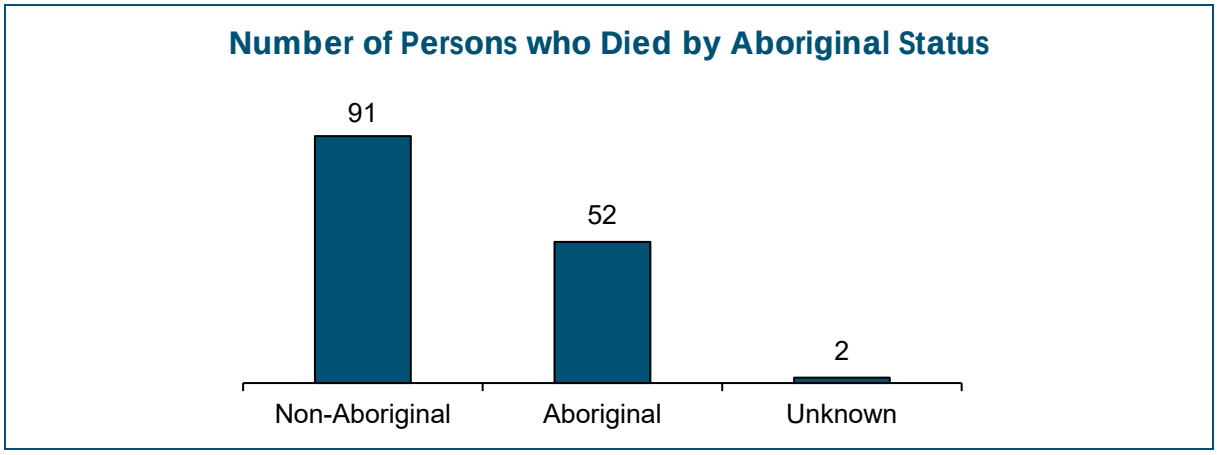
In relation to the 80 females who died, 75 involved a male suspected perpetrator and five involved a female suspected perpetrator. Of the 65 men who died, 10 were apparent suicides, 25 involved a female suspected perpetrator, 27 involved a male suspected perpetrator and three involved multiple suspected perpetrators of both sexes.

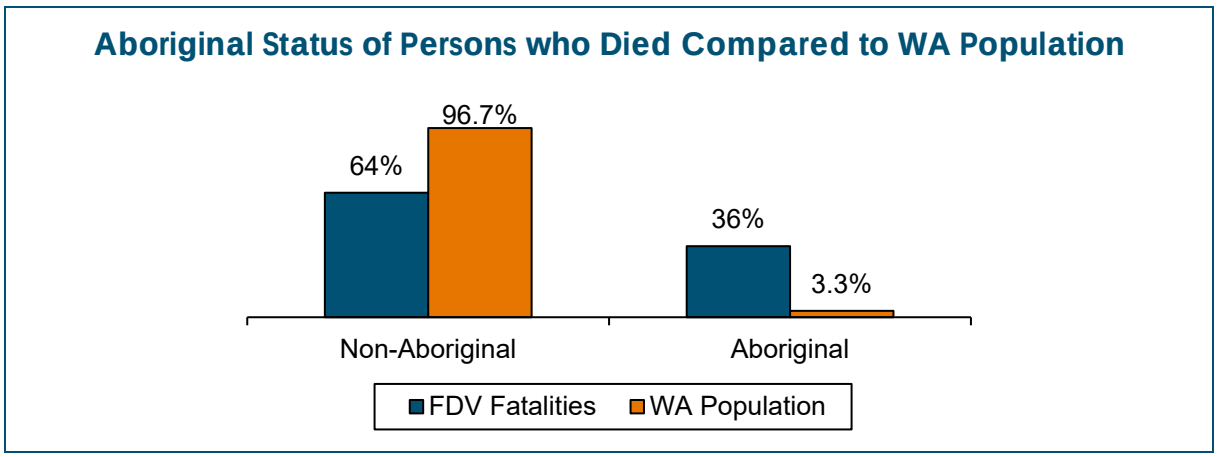
Number of Persons who Died by Age





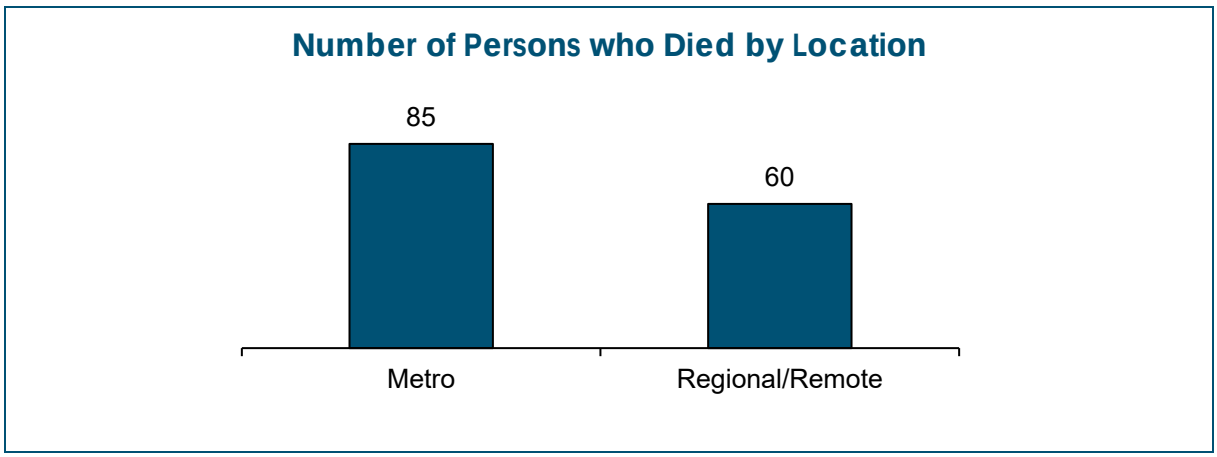
Compared to the Western Australian adult population, the age groups 30-39, 60-69 and 80 and over are over-represented, with 26% of persons who died being in the 30-39 age group compared to 19% of the adult population, 14% of persons who died being in the 60-69 age group compared to 13% of the adult population and six per cent of persons who died being in the 80 and over age group compared to five per cent of the adult population.

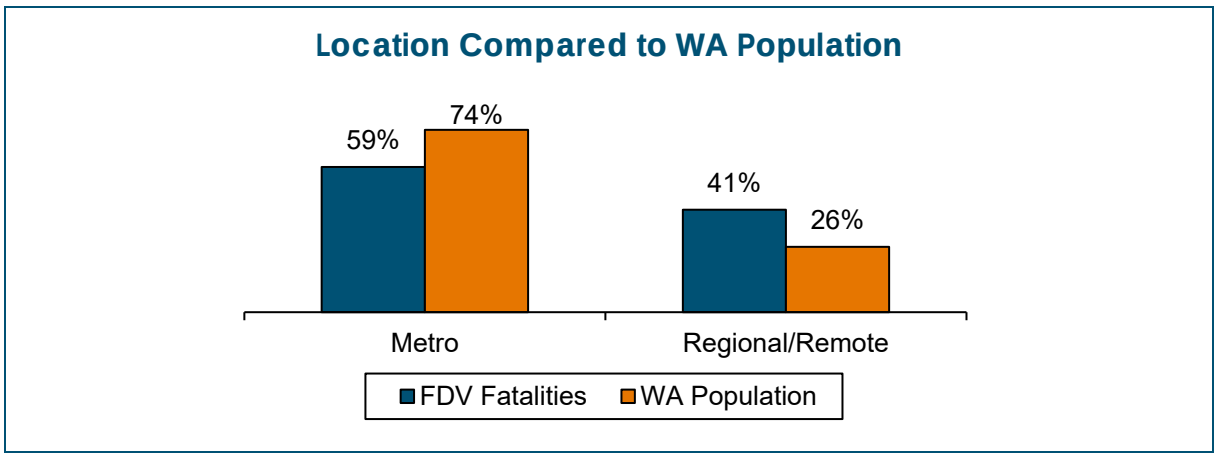




Note: In the above chart, percentages are based on those where Aboriginal status is known.

Information on Aboriginal status is collated where the deceased, and suspected perpetrator, identify as Aboriginal to agencies they have contact with, and this is recorded in the documentation provided to this Office. Compared to the Western Australian population, Aboriginal people who died were over-represented, with 36% of people who died in the nine years from 1 July 2012 to 30 June 2021 being Aboriginal compared to 3.3% in the population. Of the 52 Aboriginal people who died, 31 were female and 21 were male.





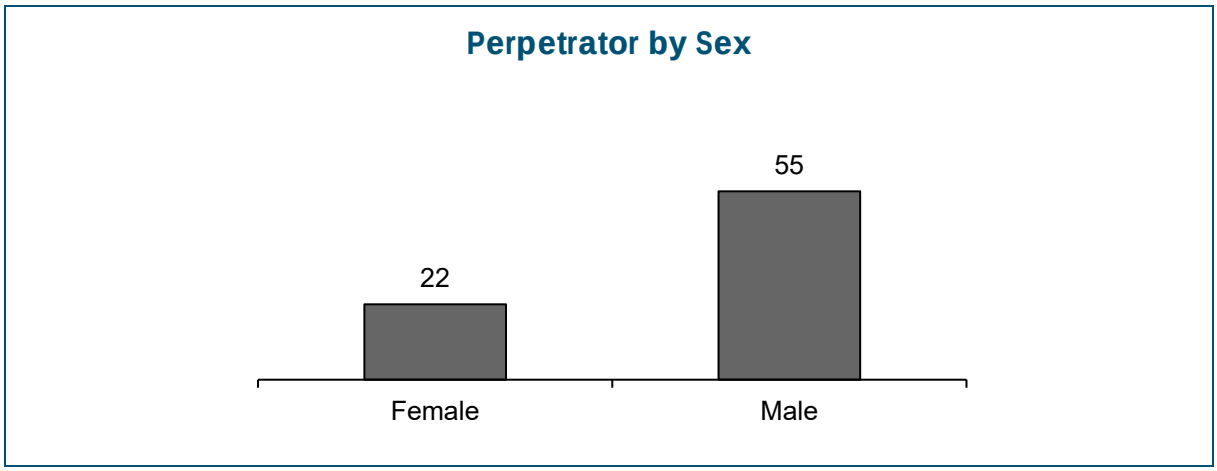
Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 41% of the people who died in the nine years from 1 July 2012 to 30 June 2021 living in regional or remote locations, compared to 26% of the population living in those locations.

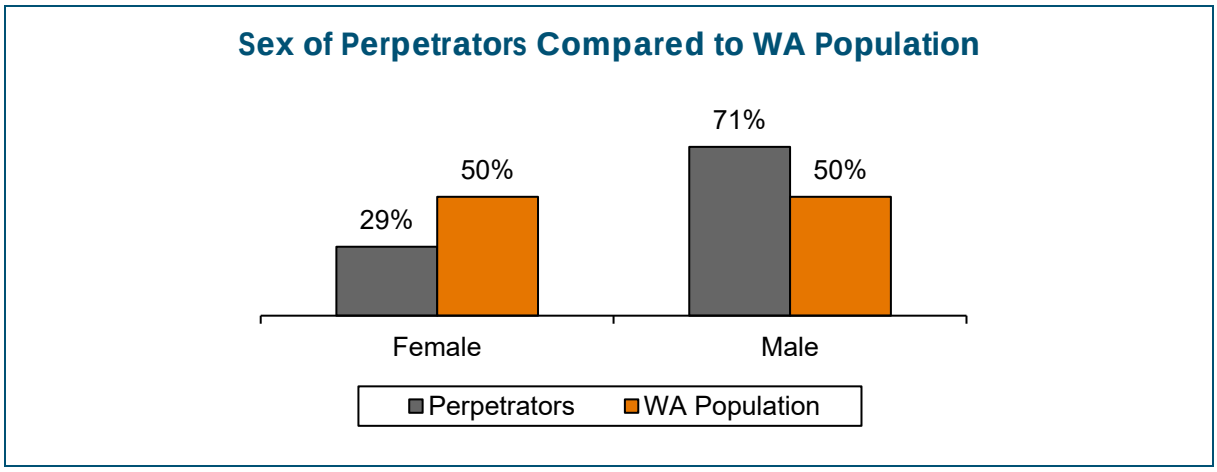
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2021 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2021.

Of the 145 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2021, coronial and criminal proceedings were finalised in relation to 77 perpetrators.

Information is obtained on a range of characteristics of the perpetrator including sex, age group and Aboriginal status. The following charts show characteristics for the 77 perpetrators where both the coronial process and the criminal proceedings have been finalised.

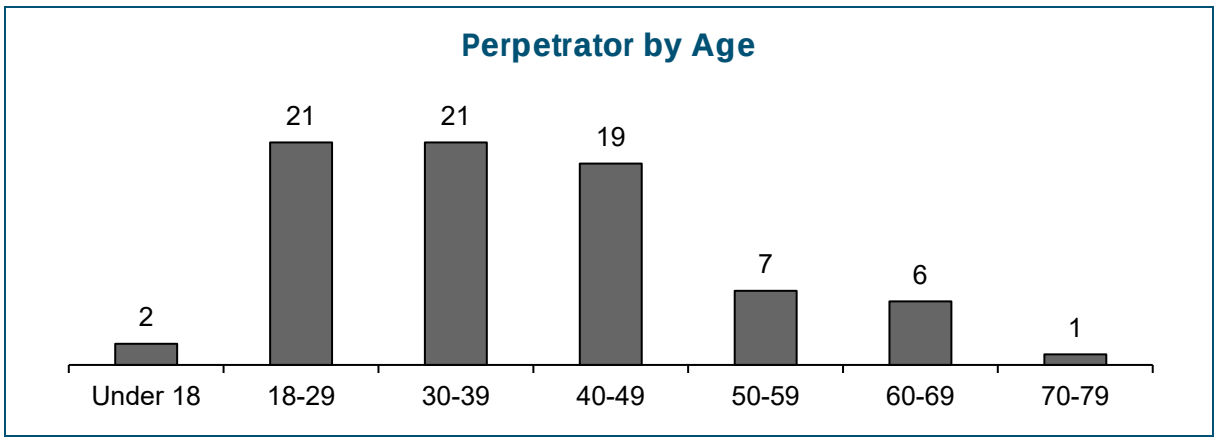


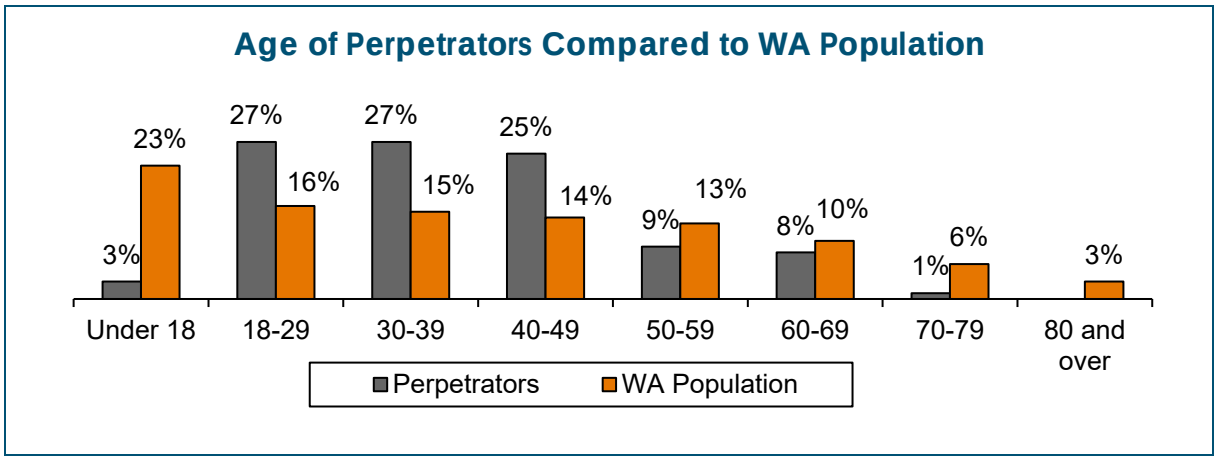


Compared to the Western Australian population, male perpetrators of fatalities in the nine years from 1 July 2012 to 30 June 2021 were over-represented, with 71% of perpetrators being male compared to 50% in the population.

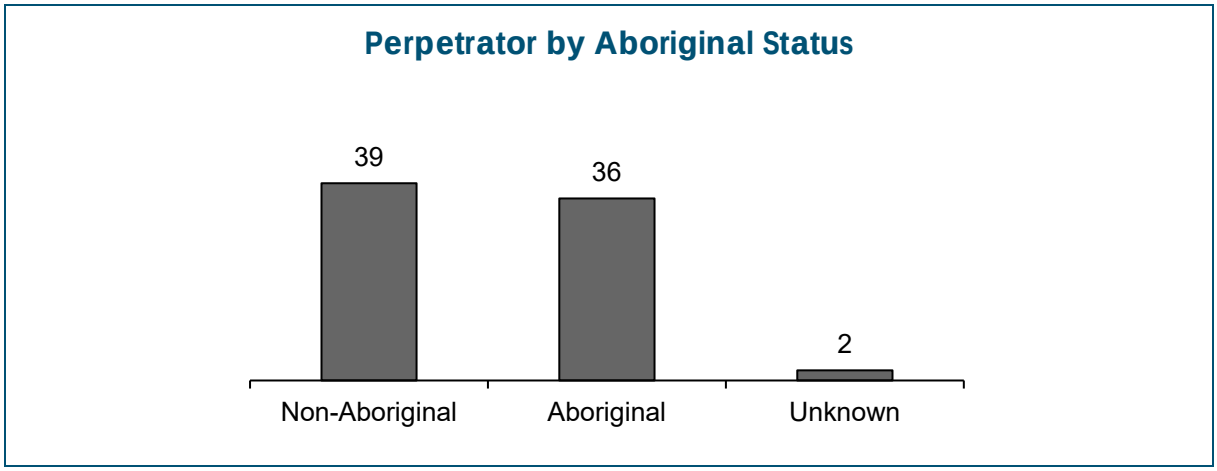
Seventeen males were convicted of manslaughter, 38 males were convicted of murder. Eleven females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death and 10 females were convicted of murder.

Of the 21 fatalities by the 22 female perpetrators, in 20 fatalities the person who died was male, and in one fatality the person who died was female. Of the 56 fatalities by the 55 male perpetrators, in 42 fatalities the person who died was female, and in 14 fatalities the person who died was male.

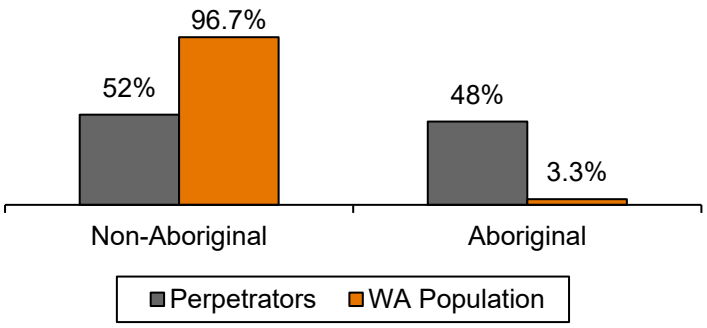




Compared to the Western Australian population, perpetrators of fatalities in the nine years from 1 July 2012 to 30 June 2021 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 27% of perpetrators being in the 18-29 age group compared to 16% in the population, 27% of perpetrators being in the 30-39 age group compared to 15% in the population, and 25% of perpetrators being in the 40-49 age group compared to 14% in the population.



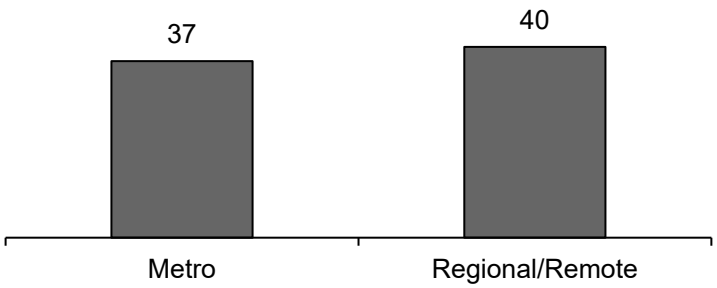
Aboriginal Status of Perpetrators Compared to WA Population



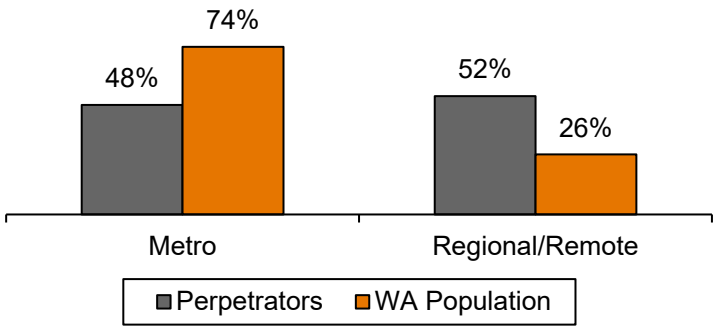
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the nine years from 1 July 2012 to 30 June 2021 were over-represented with 48% of perpetrators (where Aboriginal status was recorded in information provided to this Office) being Aboriginal compared to 3.3% in the population.

In 33 of the 36 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location



Perpetrators by Location Compared to WA Population



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

Compared to the Western Australian population, the people who died in the nine years from 1 July 2012 to 30 June 2021, who were living in regional or remote locations, were over-represented, with 52% of the people who died living in regional or remote locations compared to 26% of the population living in those locations.

Circumstances in which family and domestic violence fatalities have occurred

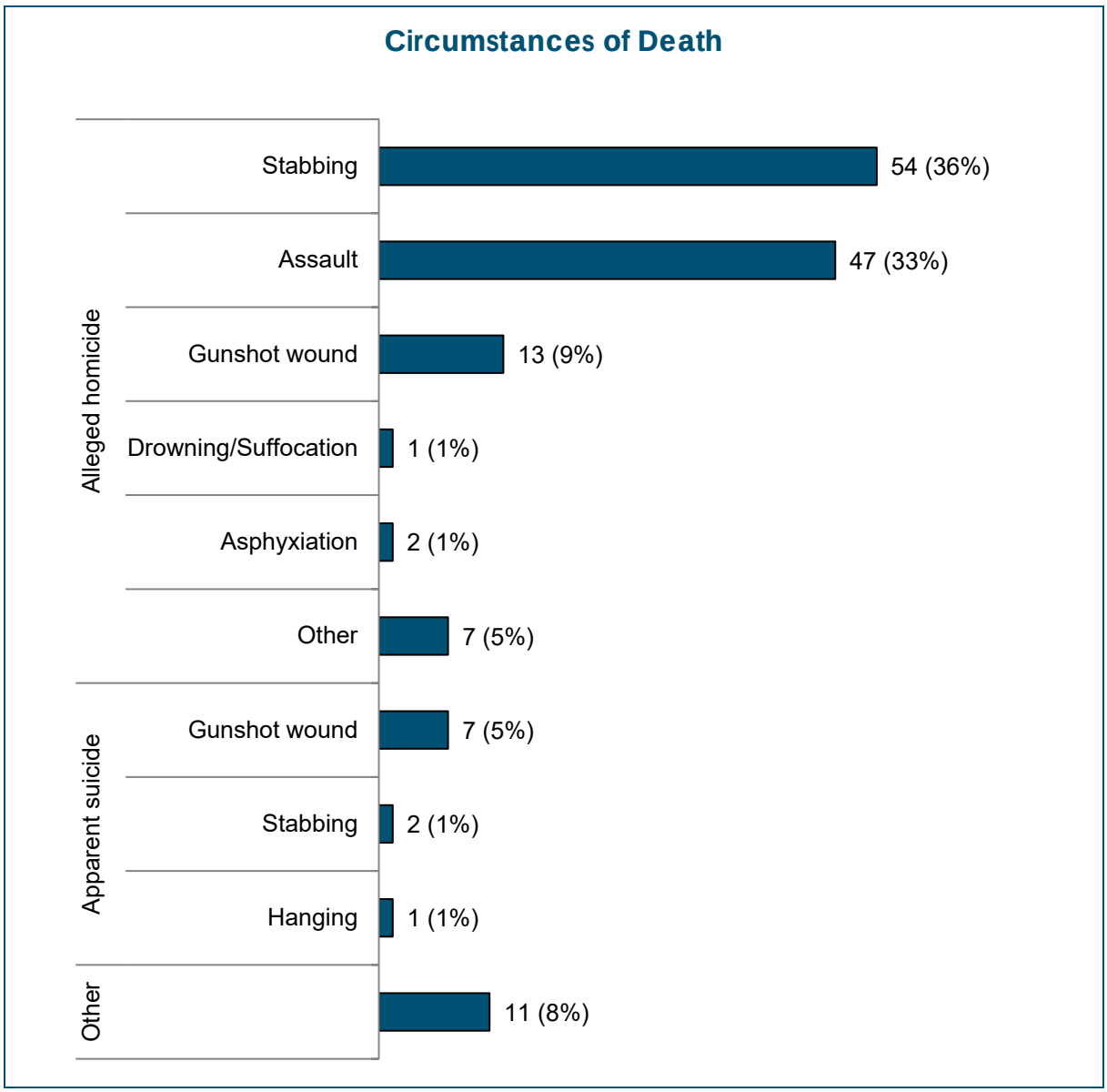
Information provided to the Office by WA Police Force about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

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

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

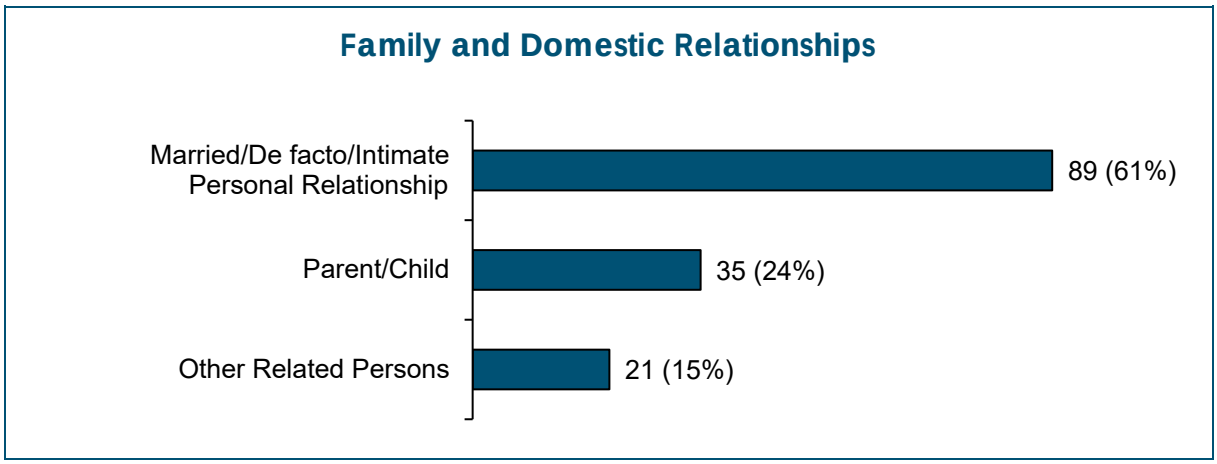
The principal circumstances of death in 2020-21 were alleged homicide by physical assault and stabbing.

The following chart shows the circumstance of death as categorised by the Ombudsman for the 145 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2021.



Family and domestic relationships

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



Of the 145 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2021:

- 89 fatalities (61%) involved a married, de facto or intimate personal relationship, of which there were 77 alleged homicides, eight apparent suicides and four in other circumstances. The 89 fatalities included 14 deaths that occurred in seven cases of alleged homicide/suicide and, in all seven cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. The eighth apparent suicide involved a male. Of the remaining 70 alleged homicides, 49 (70%) of the people who died were female and 21 (30%) were male;
- 35 fatalities (24%) involved a relationship between a parent and adult child, of which there were 27 alleged homicides, two apparent suicides and six in other circumstances. Of the 27 alleged homicides, 10 (37%) of the people who died were female and 17 (63%) were male. Of these 27 fatalities, in 20 cases (74%) the person who died was the parent or step-parent and in seven cases (26%) the person who died was the adult child or step-child; and
- There were 21 people who died (15%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, eight (38%) were female and 13 (62%) were male.

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

State policy and planning to reduce family and domestic violence fatalities

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

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

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

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

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

Type of relationships

The Ombudsman finalised 133 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2021.

For 84 (63%) of the finalised reviews of family and domestic violence fatalities, the fatality occurred between persons who, either at the time of death or at some earlier time, had been involved in a married, de facto or other intimate personal relationship. For the remaining 49 (37%) of the finalised family and domestic violence fatality reviews, the fatality occurred between persons where the relationship was between a parent and their adult child or persons otherwise related (such as siblings and extended family relationships).

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

For the 133 finalised reviews, the circumstances of the fatality were as follows:

- For the 84 intimate partner fatalities, 72 were alleged homicides, eight were apparent suicides, and four were other circumstances; and
- For the 49 non-intimate partner fatalities, 40 were alleged homicides, two were apparent suicides, and seven were other circumstances.

Intimate partner relationships

Of the 72 intimate partner relationship fatalities involving alleged homicide:

- There were 53 fatalities where the person who died was female and the suspected perpetrator was male, 16 where the person who died was male and the suspected perpetrator was female, one where the person who died was male and the suspected perpetrator was male, and two where the person who died was male and there were multiple suspected perpetrators of both sexes;
- There were 28 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In 19 of these fatalities the person who died was female and in nine the person who died was male;
- There were 35 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 12 at the residence of the person who died or the residence of the suspected perpetrator, eight at the residence of family or friends, and 17 at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 35 fatalities where the person who died lived in regional and remote areas, and in 26 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 49 non-intimate partner fatalities, there were 32 fatalities involving a parent and adult child and 17 fatalities where the parties were otherwise related.

Of the 40 non-intimate partner fatalities involving alleged homicide:

- There were 10 fatalities where the person who died was female and the suspected perpetrator was male, four where the person who died was female and the suspected perpetrator was female, 20 where the person who died was male and the suspected perpetrator was male, and six where the person who died was male and the suspected perpetrator was female;
- There were 11 non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 16 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 16 at the residence of the person who died or the residence of the suspected perpetrator, and eight at the residence of family or friends or in a public place; and
- There were 14 fatalities where the person who died lived in regional and remote areas.

Prior reports of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reports of alleged family and domestic violence between the parties. In 44 (61%) of the 72 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2021, alleged family and domestic violence between the parties had been reported to WA Police Force and/or to other public authorities. In 13 (33%) of the 40 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2021, alleged family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities.

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

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

Of the 57 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, from the records available:

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

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

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

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

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

Identification of family and domestic violence incidents

Of the 57 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, WA Police Force was the agency to receive the majority of these reports. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, noted that DCPFS may become aware of family and domestic violence through a referral to DCPFS and subsequent assessment through the duty interaction process. Identification of family and domestic violence is integral to the agency being in a position to implement its family and domestic violence policy and processes to address perpetrator accountability and promote victim safety and support. However, the Ombudsman's reviews and own motion investigations continue to identify missed opportunities to identify, and respond to, family and domestic violence in interactions.

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

Provision of agency support to obtain a violence restraining order

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

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

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

Support to victims in reported incidences of family and domestic violence

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

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

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

Support to obtain a violence restraining order on behalf of children

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

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

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

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

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that in relation to Recommendations 44, 45, 46 and 47 DCPFS had taken steps and proposed steps to be taken to give effect to all these recommendations. The State Strategy identifies the need to '[s]upport the long-term recovery and wellbeing of children who have experienced family and domestic violence' as a Priority Action. Communities' *Casework Practice Manual 2.3.3 Family violence restraining orders* provides practice guidance for 'child protection workers about applying for a Family Violence Restraining Order (FVRO) on behalf of a child or supporting adult victims to seek FVROs that include themselves and their children'. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Support during the process of obtaining a family violence restraining order

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

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

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

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

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

Support when a family violence restraining order has not been granted

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

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

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

Provision of support to victims experiencing family and domestic violence

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

> The purpose of risk assessment is to determine the risk and safety for the adult victim and children, taking into consideration the range of victim and perpetrator risk factors that affect the likelihood and severity of future violence.

Risk assessment must be undertaken when family and domestic violence has been identified…

Risk assessment is conducted for a number of reasons including:

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

(pages 36-37)

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

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

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

Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 44 (61%) of the 72 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2021, prior family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities. The Ombudsman's reviews identify where perpetrators have a history of reported violence, with one or more partners, and examines steps taken to hold perpetrators to account for their actions and support them to cease their violent behaviours, in accordance with the intent of the former State Strategy.

The Ombudsman's reviews have examined processes for the rehabilitation of perpetrator behaviours, where perpetrators of family and domestic violence are imprisoned. In 2020-21, the Ombudsman's reviews have also examined opportunities to improve information sharing across agencies, to address perpetrator behaviours.

Fatalities with no prior reported family and domestic violence

Based on the information available to the Office, in 28 (39%) of the 72 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2021, the fatal incident was the only family and domestic violence between the parties that

had been reported to WA Police Force and/or other public authorities. It is important to note, however, research indicating under-reporting of family and domestic violence. The Australian Bureau of Statistics' *Personal Safety Survey 2016* (www.abs.gov.au) collected information about help seeking behaviours, noting that:

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

and

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

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

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

Family violence involving Aboriginal people

Of the 133 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2021, Aboriginal Western Australians were over-represented, with 44 (33%) persons who died being Aboriginal. In all but three cases, the suspected perpetrator was also Aboriginal. There were 34 of these 44 fatalities where the person who died lived in a regional or remote area of Western Australia, of which 26 were intimate partner fatalities.

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

Contextual factors for family violence involving Aboriginal people

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

> …violence against women within the Indigenous Australian communities need[s] to be understood within the specific historical and cultural context of colonisation and systemic disadvantage. Any discussion of violence in contemporary Indigenous communities must be located within this historical context. Similarly, any discussion of "causes" of violence within the community must recognise and reflect the impact of colonialism and the indelible impact of violence perpetrated by white colonialists against Indigenous peoples
>
> … A meta-evaluation of literature…identified many "causes" of family violence in Indigenous Australian communities, including historical factors such as: collective dispossession; the loss of land and traditional culture; the fragmentation of kinship systems and Aboriginal law; poverty and unemployment; structural racism; drug and alcohol misuse; institutionalisation; and the decline of traditional Aboriginal men's role and status - while "powerless" in relation to mainstream society, Indigenous men may seek compensation by exerting power over women and children...
>
> (Blagg, H, Bluett-Boyd, N, and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 3).

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

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

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

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

The Ombudsman's reviews and report have identified that Aboriginal victims want the violence to end, but not necessarily always through the use of family violence restraining orders. The Ombudsman's reviews have also examined agency action to facilitate co-design of locally based solutions to promote Aboriginal family and community safety. In 2020-21, the Ombudsman has made four recommendations that seek to support community led solutions.

A separate strategy to prevent and reduce Aboriginal family violence

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

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

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

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

Thirdly, the findings set out in the report demonstrate how the unique factors associated with Aboriginal family violence have resulted in important aspects of the

use of violence restraining orders by Aboriginal people which are different from those of non-Aboriginal people.

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

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

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

Limited use of violence restraining orders

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

In the report, the Ombudsman recommended that:

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

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

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

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

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

The findings from the Ombudsman's family and domestic violence fatality reviews and the own motion investigations will contribute to the development of Action Item 25 of the First Action Plan, and the Office will continue to monitor, and report on, the steps being taken to implement Recommendation 16 from the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015.

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

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

In the report, the Ombudsman recommended that:

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

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

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

Of the 44 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2021 involving Aboriginal people, 34 (77%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Eighteen (41%) of the Aboriginal people who died lived in the Kimberley region, which is home to 1.4% of all people and 19% of Aboriginal people in the Western Australian population.

As outlined above, *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to Recommendations 4 and 6 of the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015. These recommendations related to DCPFS developing 'a strategy that is specifically tailored to preventing and reducing Aboriginal family violence' that would encompass all regions of Western Australia and would ensure actively inviting and encouraging 'the involvement of Aboriginal people in a full and active way at each stage and level of the process' and being 'comprehensively informed by Aboriginal culture'. Subsequent to these recommendations, Item 5 of the First Action Plan intends to '[c]o-design the Aboriginal Family Safety Strategy with Aboriginal people and communities'. The Ombudsman's reviews have also examined agency action to facilitate co-design of locally based solutions to promote Aboriginal family and community safety. In 2020-21, the Ombudsman has made four recommendations that seek to support community led solutions.

Case Study

Family violence response in remote Aboriginal communities

The Ombudsman has reviewed a cohort of intimate partner homicides that involve Aboriginal people from a remote community in Western Australia. These reviews have examined how State Government agencies are engaging with the Remote Aboriginal Community to develop community led solutions to promote family and community safety.

Communities subsequently informed this Office that, in partnership with WA Police Force, a Joint Response Team (JRT) had commenced visiting the Remote Aboriginal Community to develop strategies to promote safety.

Factors co-occurring with family and domestic violence

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

Co-occurrence with alcohol and other drug use

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

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

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

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

On the information available, relating to the 112 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2021, the Office's reviews identify where alcohol use and/or drug use are factors associated with the fatality, and where there may be a history of alcohol use and/or drug use.

	ALCOHOL USE		DRUG USE	
	Associated with fatal event	Prior history	Associated with fatal event	Prior history
Person who died only	5	5	4	9
Suspected perpetrator only	9	15	18	21
Both person who died and suspected perpetrator	37	42	12	21
Total	**51**	**62**	**34**	**51**

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

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

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

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

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

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

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

Western Australian Alcohol and Drug Interagency Strategy 2018-2022, and the State Strategy to reduce family and domestic violence, in responding to family and domestic violence and co-occurrence with alcohol and drugs.

Co-occurrence of mental health issues

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

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

and

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

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

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

Issues Identified in Family and Domestic Violence Fatality Reviews

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

It is important to note that:

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

- Not working directly with remote Aboriginal community to facilitate local solutions to family violence that are co-designed, and led, by Aboriginal people to promote safety.
- Missed opportunities to develop culturally informed safety planning and consult with Aboriginal experts.
- Not undertaking sufficient action to confirm the cultural safety of a family and domestic violence model in use across the diverse population of Aboriginal people in Western Australia.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities to provide perpetrator rehabilitation support.
- Missed opportunities to address family and domestic violence victim safety.
- Missed opportunity to facilitate safe accommodation.
- Missed opportunity to assess risk of harm and develop strategies to reduce or prevent family and domestic violence in the context of mental health issues and/or drug and alcohol use.
- Not undertaking sufficient family and inter-agency communication to enable effective case management and collaborative responses.
- Not adequately meeting policy and procedures of the Family and Domestic Violence Response Team.
- Not taking action consistent with legislative responsibilities of the *Children and Community Services Act 2004*, and associated policy, to determine whether children were in need of protection or whether action was required to safeguard child wellbeing.
- Not adequately meeting policies and procedures relating to the Aboriginal and Torres Strait Islander child placement principle, permanency planning and cultural care planning.
- Missed opportunity to develop safety planning to reduce the risk of an escalation of family and domestic violence, when children are taken into the care of the Chief Executive Officer.

- Missed opportunity to ensure governance, monitoring and evaluation of a family and domestic violence five-year initiative were in place to achieve positive outcomes.
- Inaccurate recordkeeping.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following eight recommendations were made by the Ombudsman in 2020-21 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. In the context of Communities' commitment to the development of Aboriginal led, co-designed, local solutions to reduce family and domestic violence and promote safety, Communities provides a report to the Ombudsman by 31 December 2020 on the progress of the engagement with the Remote community to develop strategies to promote safety for women, children and families.

2. DOJ provides a report to the Ombudsman by 31 March 2021 on:
   - the progress of discussions with the Western Australia Police Force to promote DOJ's timely access to Family Violence Incident Reports when managing family and domestic violence offenders on Community Based Orders; and
   - the outcomes of the process evaluation of the Domestic Violence Screening Instrument (DVSI - R) for use with family and domestic violence offenders on Community Based Orders.

3. Communities considers if any action is required to ensure safety planning for the parents' wellbeing is undertaken to address the potential escalation of FDV risk when a child is taken into the Chief Executive Officer's care in the context of FDV, in accordance with Section 2.3.5 Safety planning for emotional abuse - FDV of the Department's Casework Practice Manual, and reports back to the Ombudsman on the outcome of this consideration by 30 April 2021.

4. Communities, with input from Regional Aboriginal communities including Aboriginal Community Controlled Organisations, reviews the five Tjallara Consulting documents on the Law and Culture Community Engagement Framework to consider their value for engagement with Aboriginal communities in the Regional district to co-design strategies to promote Aboriginal family and community safety and, informs the Ombudsman on the outcome by 30 September 2021.

5. That, for the period 2020-2022 prior to the co-design of the Aboriginal Family Safety Strategy, in its development of an FDV-Informed Approach underpinned by Safe & Together principles and core components, Communities:
   - requests the Aboriginal Cultural Council, in accordance with its remit of 'offering advice from an Aboriginal perspective, ensuring policy and practice development is informed with a cultural viewpoint', provide Communities with advice about the cultural safety of the Safe & Together Model for use across the diverse population of Aboriginal people, families and communities in

Western Australia, including whether further action is required to 'validate' of 'adapt' the model to ensure cultural safety; and

- provides this Office with a report on the advice provided by the Aboriginal Cultural Council and, if relevant, information about how Communities will address that advice.

6. Communities reiterates to the Regional District (including the Crisis Care Unit and after hour services) the role of Communities in facilitating access for Aboriginal people to safe, short stay accommodation options.

7. That, by 1 November 2021, the WA Police Force provides to the Ombudsman a report co-signed by the Department of Communities and a representative of the Remote Aboriginal Community, which details:
   - the dates and outcomes of Joint Response Team (**JRT**) visits to the Remote Aboriginal Community;
   - the measures identified by the community, in discussion with the JRT, to improve family and community safety in the Remote Aboriginal Community;
   - who is responsible for the measures and the anticipated completion date; and
   - an update on the implementation of the measures to date.

8. That Communities works with the WA Police Force (the lead agency for the JRT) to provide to the Ombudsman by 1 November 2021 a report, co-signed by a representative of the Remote Aboriginal Community, which details:
   - the dates and outcomes of JRT visits to the Remote Aboriginal Community;
   - the measures identified by the community, in discussion with the JRT, to improve family and community safety in the Remote Aboriginal Community;
   - who is responsible the measures and the anticipated completion date; and
   - an update on the implementation of the measures to date.

The Ombudsman's *Annual Report 2021-22* will report on the steps taken to give effect to the two recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2019-20. The Ombudsman's *Annual Report 2022-23* will report on the steps taken to give effect to the eight recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2020-21.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2018-19

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

Steps taken to give effect to the recommendation

This Office requested that EMHS inform the Office of the steps taken to give effect to the recommendation. In response, EMHS provided a range of information in a letter to this Office dated 31 March 2021.

In EMHS' letter, EMHS relevantly informed this Office that:

> In previous correspondence with your office EMHS indicated it was developing local policies in accordance with the requirements of the *WA Health Clinical Care of People with Mental Health Problems Who May Be at Risk of Becoming Violent or Aggressive Policy* (MP 0101/18). An amendment to MP0101/18 in July 2019 by the system manager negated the requirement for local policy development.
>
> With the adoption of MP0101/18, EMHS mental health services have established processes for core policy requirements including for; the review of clinical documentation and violent and aggressive incidents, the establishment of clinical supervision systems, and access to relevant clinical training systems to ensure minimisation of aggressive incidents and de-escalation techniques.
>
> While routine oversight of these processes is via local safety and quality structures and morbidity and mortality review committees, the EMHS has not yet undertaken a single policy compliance assessment across the health service against MP 0101/18. As such, I have instructed that this be undertaken as a matter of priority with the development of actions to address any gaps in current policy compliance.
>
> Completion of the assessment and implementation of any findings will be overseen by the EMHS Mental Health Leads Group, with status reporting to the EMHS Area Executive Group.
>
> In addition, I have appointed a Psychiatrist as a Mental Health Clinical Lead to drive the consistent application of mental health policy across the health service, inclusive of the application of MP0101/18.

Consideration of the issues identified in the review have been taken through the amendment by the Department of Health System Manager to MP0101/18 in July 2019.

It is noted from the additional information provided by EMHS that steps are being taken to improve the assessment of risk and response to violent and aggressive incidents.

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

Recommendation 2: As DOJ develops its agency family and domestic violence strategy, DOJ considers this case in:

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

Steps taken to give effect to the recommendation

This Office requested that DOJ inform the Office of the steps taken to give effect to the recommendation. In response, DOJ provided a range of information in a letter to this Office dated 25 March 2021, containing a report prepared by DOJ 'setting out information on steps taken and proposed to give effect to each limb of the recommendation'.

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

> Developing specific strategies to ensure the provision of effective rehabilitation and treatment services for young offenders convicted of offences that occurred within the context of family and domestic violence to assist these young offenders to cease their violent behaviour:
>
> **The Department has taken steps to give effect to this recommendation.**
>
> The Department is ensuring that all young people convicted of offences in the context of Family and Domestic Violence (FDV) are identified for treatments and intervention as early as possible.
>
> - Young people that have committed violent offences inclusive of FDV offences – receive offence specific one-on-one counselling with Youth Justice Psychological Services. This is provided to young offenders both in custody and the community.
> - The Department currently provides introductory level (short-duration) therapeutic modules for young offenders that identify as either a victim or perpetrator of FDV offences.
>
> In 2019, the Department purchased an intensive (longer duration) group based intervention Disrupting Family Violence for young male perpetrators of FDV offences or those with identified FDV treatment needs.

- However, the Disrupting Family Violence program has not been rolled out in custody or the community, due to insufficient numbers of young people meeting the program criteria.

In recognising these challenges, the Department has identified the need for an intermediate FDV program that is culturally secure and targets the criminogenic needs of young people committing FDV specific offences, whilst maximising the number of participants in either custody or the community.

The Department proposes to take further steps to give effect to the recommendation.

- In 2021, the Department is progressing work towards design, development and trialing of a FDV program that meets the identified needs of young people that require a more intensive intervention than Healthy Relationships, but cannot participate in the Disrupting Family Violence program.

The Department will continue to monitor progress against this recommendation.

Developing strategies to promote the safety of young victims of family and domestic violence:

The Department has taken steps to give effect to the recommendation, and proposes to take further steps.

Through the Kimberley Juvenile Justice Strategy (KJJS), the Department is supporting a number of community-based initiatives aimed at diverting young people from the justice system, including those who are experiencing or witnessing FDV.

The Department's Corrective Services Division is currently reviewing a number of policies and procedures encompassing case management and reporting requirements for youth justice staff in supervising young people subject to bail and/or community based supervision orders.

- For example, the Reporting and Collaborative Practices Alleged Assault, Harm and/or Neglect Procedure sets out obligations for youth justice staff to report to the Department of Communities (Child Protection and Family Support) and Western Australia Police Force depending on the nature of the harm.
- This procedure is being reviewed in regard to responses and supports for young people disclosing as being a victim of/or witnessing FDV within their family or home environment.

The Department will continue to look to opportunities for promoting the safety of young FDV victims including where perpetrated by a young offender, and will consider during the development of the Department's overarching FDV Strategy and the separate Aboriginal Family Safety Strategy.

Ensuring rehabilitation pathways for Aboriginal youth have been co-designed by Aboriginal people and accord with cultural protocols relating to gender in program delivery:

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

During 2021, the Department will seek to engage an Aboriginal Psychologist to work in collaboration with Youth Justice Psychological Services to co-design, develop and trial a FDV program that meets the identified needs of the young people who require

a more intensive intervention (than Healthy Relationships), but cannot participate in the Disrupting Family Violence program (as outlined above).

The Department will also be tendering for Youth Justice Services programs in 2021-2022 under the Delivering Community Services in Partnership Policy. As part of the process a full co-design process will be initiated to enable the sector, including Aboriginal service providers' feedback, to be implemented into the final specifications.

The Department will continue to consider the need for co-designed programs for Aboriginal youth as part of its overarching FDV Strategy, which is currently in development.

The Department will continue to monitor progress against this recommendation.

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

It is now a Department requirement for all young people sentenced (to community based supervision or detention) for offences in the context of FDV – to be automatically referred for intervention by the Youth Justice Psychological Services.

- This will assist in gathering data and specific cohort information to better determine the need and type of interventions required for young people committing violent offences inclusive of FDV specific offending.
- Prior to this, the Department was reliant on manual tracking of young people with violent offences.

The Department engaged an international expert to develop the Disrupting Family Violence program. This provides an intensive 14 week (42 session) group based intervention for young males (14 years and above).

- This program is yet to be delivered in custody or the community due to insufficient numbers of young people meeting the program criteria.
- A key challenge is the length of the young peoples' order or period of detention.

The Department is continuing to roll-out its Healthy Relationships program to young people who have had an exposure to FDV or unhealthy relationships.

- Over the past 10 years, the Department has been delivering the Healthy Relationships program to young people in custody. This eight-session therapeutic program aims to provide an understanding of what constitutes healthy and unhealthy relationships.
- The Healthy Relationships program is in the process of being rolled out and trialed for young people subject to community based supervision orders.
- This program is an introductory level cognitive behaviour therapy based program for young people that identify either as a victim or perpetrator.
- The Department is exploring opportunities to evaluate the Healthy Relationships program.

The KJJS incorporates a range of initiatives that provide a gateway for identification and supports for young people and their families, including those who are experiencing or witnessing family violence.

- For example, night patrols by local community members to take street present young people to a safe place together with a follow up service where referrals are made to relevant service providers.
- In addition, there are a number of place based activities delivered by Aboriginal-

led organisations and local government that focus on cultural healing, structured learning, training and supports for at-risk young people.

and:

- The Department provides a range of programs to young people in the community and in custody across Western Australia. These programs seek to address health, rehabilitative, recreational, cultural and educational needs and are delivered by either Department staff or external service providers.
- The Department previously undertook a tender process in 2016, for service delivery to young people across regions in Western Australia. Tenders were required to demonstrate the cultural competence of their proposed services relevant to Aboriginal and Culturally and Linguistically Diverse young people.

Further, in DOJ's letter, DOJ relevantly informed this Office that:

> Moreover, the initiatives and issues identified in the report will be taken into account during the development of the Department's overarching FDV Strategy and Aboriginal Family Safety Strategy…

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 family and domestic violence fatalities and in the undertaking of major own motion investigations.

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of family and domestic violence fatalities. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2020-21, timely review processes have resulted in 41% of all reviews being completed within six months and 68% of reviews completed within 12 months.

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

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

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

> Taking into account the findings of this investigation, DCPFS:
>
> - conducts a review to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance;

- develops an associated action plan to overcome identified barriers; and
- provides the resulting review report and action plan to this Office within 12 months of the tabling in the Western Australian Parliament of the report of this investigation.

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

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

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

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

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

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

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

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

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

> Communities acknowledges this finding and confirms it is a priority for Communities to address and implement the intent of the recommendation. It was the intent of the *Family and Domestic Violence Practice Guidance Review Report* (the report) and the *Family*

and Domestic Violence Practice Guidance Implementation to do so. The report did help to identify a range of issues that limit the implementation of policy and practice guidance, and Communities has undertaken numerous activities and processes to address these. These include:

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

Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

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

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through the Ombudsman's Advisory Panel (**the Panel**), and other mechanisms, working with public authorities and communities where individuals may be at risk of family and domestic violence to consider safety issues and potential areas for improvement, and to highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information, where appropriate, with other accountability and oversight agencies including Ombudsmen and family and domestic violence fatality review bodies in other States to facilitate consistent approaches and shared learning;

- Engaging with other family and domestic violence fatality review bodies in Australia through membership of the Australian Domestic and Family Violence Death Review Network (**the Network**). The Network is currently working in partnership with the Australia's National Research Organisation for Women's Safety (**ANROWS**) to provide an update on the *Australian Domestic and Family Violence Death Review Network Data Report 2018*. This collaboration is also working to develop analysis of the common risk factors in family and domestic violence homicides in Australia based on the breadth of information that is available to the Network. Additionally, the collaboration will develop a national dataset of the characteristics of the deaths of children by parents to inform prevention initiatives at a national level;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

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

The Ombudsman's Advisory Panel

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

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

The Panel met two times in 2020-21.

Key stakeholder relationships

There are a number of public authorities and other bodies that interact with or deliver services to those who are at risk of family and domestic violence or who have experienced family and domestic violence. Important stakeholders, with which the Office liaised as part of the family and domestic violence fatality review function in 2020-21, included:

- The Coroner;
- Relevant public authorities including:
  - WA Police Force;
  - The Department of Health;
  - Health Service Providers;

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

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

Aboriginal and regional communities

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

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

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

Own Motion Investigations and Administrative Improvement

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

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

Improvements from Complaints and Reviews

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

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

Own Motion Investigations

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

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

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

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

Selecting topics for own motion investigations

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

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

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

Own Motion Investigations in 2020-21

In 2020-21, significant work was undertaken on:

- The Office's major own motion investigation *Preventing suicide by children and young people 2020*, which was tabled in Parliament in September 2020;
- A report on giving effect to the recommendations arising from *Preventing suicide by children and young people 2020*, to be tabled in Parliament in 2021-22;
- An investigation into family and domestic violence and suicide, to be tabled in Parliament in 2021-22; and
- An investigation into services provided to children and young people with disordered eating, to be tabled in Parliament in 2022.

Preventing suicide by children and young people 2020

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**).

The 2014 Investigation examined the deaths of 36 young people aged 14 to 17 years. Arising from his findings, the Ombudsman made 22 recommendations to four agencies, namely, the Mental Health Commission, Department of Health, Department of Education and the (then) Department for Child Protection and Family Support, all of which were accepted by these agencies. The Ombudsman was very pleased to report to Parliament that he found that steps have been taken or are proposed to be taken (or both) for each of the 22 recommendations of the 2014 Investigation as set out in Volume 2 of the report.

The 2020 Investigation examined a further 79 deaths by suicide that occurred following the 2014 Investigation, as set out in Volume 3. The 2020 Investigation examined what is known about suicide and self-harm by Western Australian children and young people, the research literature, current strategic frameworks, and data obtained during our investigation. Significantly, it also collates State-wide suicide and self-harm data relating to Western Australian children and young people over the 9 years from 1 July 2009 to 30 June 2018 for the first time, including:

- deaths by suicide; and
- hospital admissions and emergency department attendances for self-harming and suicidal behaviour.

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.

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

The Office is monitoring the steps taken to give effect to the recommendations of *Preventing suicide by children and young people 2020* and in accordance with the Ombudsman's commitment to Parliament, will report on the results of our monitoring in 2021.

Monitoring the implementation of recommendations

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

Giving effect to the recommendations arising from the Ombudsman's *Investigation into ways to prevent or reduce deaths of children by drowning*

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

On 23 November 2017, the Office tabled in Parliament the report of a major own motion investigation, *Investigation into ways to prevent or reduce deaths of children by drowning* (**the Investigation**).

As a result of the investigation, the Office made 25 recommendations about ways to prevent or reduce deaths of children by drowning. The Department of Mines, Industry Regulation and Safety and the Building Commissioner agreed to these recommendations.

The full report *Investigation into ways to prevent or reduce deaths of children by drowning* is available at: www.ombudsman.wa.gov.au/drowningsreport.

Importantly, the Ombudsman indicated that the Office would actively monitor the implementation of these recommendations and report to Parliament on the results of the monitoring within 12 months of the tabling of the investigation.

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

The Ombudsman found that the Department of Mines, Industry Regulation and Safety (**the Department**) through the Building Commissioner and its Consumer Protection division (now within the Department's Industry Regulation and Consumer Protection division) had either taken steps, or proposed 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. The full report *A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce child deaths by drowning* is available at: www.ombudsman.wa.gov.au/Improving_Admin/AI_Reports.htm#Drownings-follow-up-report-2018.

On 20 May 2021, the Department published a decision paper entitled, *Swimming Pool and Safety Barrier Control* (**the Decision Paper**) (available at www.commerce.wa.gov.au/publications/decision-paper-swimming-pool-and-safety-barrier-control).

The Decision Paper addresses 23 of the Ombudsman's 25 recommendations – 20 of which were made to the Building Commissioner and three directed to the Building Commissioner in collaboration with the Department's Consumer Protection division. The remaining two recommendations (Recommendations 1 and 2) are being

addressed through other work within the Department and were not considered by the Decision Paper.

The Decision Paper includes 16 decisions and states that:

> These decisions are based on the principles of best practice regulation and take full account of the Ombudsman's recommendations and the extensive feedback received in Stages 1 and 2 of the review process.

The approach taken by the Department continues to represent a best practice response to an Ombudsman's investigation. This is particularly noteworthy considering that the issue is about preventing child deaths and the large number of stakeholders that required consultation and coordination.

The Office is pleased to note the continued implementation of the recommendations arising from, *Investigation into ways to prevent or reduce deaths of children by drowning* and this Decision Paper is strongly welcomed.

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

Continuous Administrative Improvement

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

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

Guidance for Public Authorities

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

Publications

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

Workshops for public authorities

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

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

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

Working collaboratively

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

Inspection and Monitoring Functions

Telecommunications interception records

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

Collaboration and Access to Services

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

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

Working Collaboratively

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

International Ombudsman Institute

Background:

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

The Office's involvement:

The Office is a member of the IOI. The IOI is governed by a World Board, of which the Ombudsman has served as the President since May 2021, following a term as the Second Vice-President between 2016 and 2021. Before this, the Ombudsman served as Treasurer of the IOI from 2014 to 2016 and President of the Australasian and Pacific Ombudsman Region (**APOR**) of the IOI from 2012 to 2014.

2020-21 initiatives:

In May 2021, the Ombudsman commenced his four-year term as President of the International Ombudsman Institute at the Closing Ceremony of the 12th quadrennial

World Conference of the Institute held (virtually) in Dublin. The Ceremony was attended by the Honourable Gary Gray AO, Australian Ambassador to Ireland.

This marks the first time in the 43-year history of the Institute that an Australian has been elected President. Among his first priorities will be strong engagement with the United Nations following the recent adoption by the General Assembly of the resolution, *The role of Ombudsman and mediator institutions in the promotion and protection of human rights, good governance and the rule of law*. It is also the first time a President was elected by vote of the entire membership of the IOI (of over 200 Ombudsman institutions). Previously, the position of President was elected by members of the Board of the IOI. The Ombudsman received 94% of the vote.

In June 2021, the Ombudsman, as President of the IOI, delivered an opening address to the 3rd Latin American Restorative Justice Congress, held virtually. The Congress was held over three days, with more than 60 presenters from 15 countries, including Argentina, Chile, Colombia, Mexico, Brazil, Peru, Australia, Honduras, Uruguay, Bolivia, Guatemala, the Dominican Republic and Great Britain. More than 4,000 people registered for the Congress.

In June 2021, the Ombudsman attended the virtual presentation of the 2020 Annual Report of the Human Rights Commission of Mexico City. The Ombudsman, as President of the IOI, was invited as a special guest to the presentation by the President of the Human Rights Commission of Mexico City, Ms Nashieli Ramírez Hernández.

The virtual presentation was held in the presence of the Head of Government of Mexico City, the President of the Superior Court of Justice of Mexico City, the members of the Human Rights Commission of Congress and representatives from civil society organisations. The presentation also included a speech by Dr Raúl Lamberto, Ombudsman of the Province of Santa Fe and Regional President, IOI Caribbean and Latin America region.

Information sharing with Ombudsmen from other jurisdictions

Background:

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

2020-21 initiatives:

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

Australia and New Zealand Ombudsman Association

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

Background:

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

The Office's involvement:

The Office is a member of ANZOA. The Office periodically provides general updates on its activities and also has nominated representatives who participate in interest groups in the areas of Indigenous engagement, complaints management, corporate services and people and development, systemic issues, data and analytics, vulnerable consumers, and public relations and communications.

Providing Access to the Community

Communicating with complainants

The Office provides a range of information and services to assist specific groups, and the public more generally, to understand the role of the Ombudsman and the complaint process. Many people find the Office's enquiry service and drop-in clinics held during regional visits assist them to make their complaint. Other initiatives in 2020-21 include:

- Regular updating of the Ombudsman's publications and website to provide easy access to information for people wishing to make a complaint and those undertaking the complaint process;
- Ongoing promotion of the role of the Office and the type of complaints the Office handles through presentations and participating in events in the community; and
- The Office's Youth Awareness and Accessibility Program and Prison Program.

Access to the Ombudsman's services

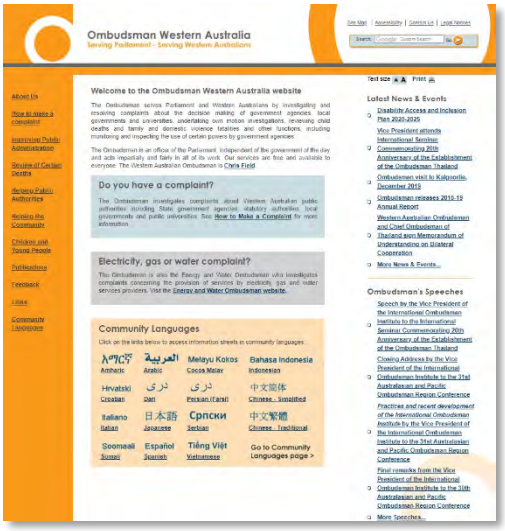
The Office continues to implement a number of strategies to ensure its complaint services are accessible to all Western Australians. These include access through online facilities as well as more traditional approaches by letter and through visits to the Office. The Office also holds drop-in clinics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

- Access to the Office through a Freecall number, which is free from landline phones;
- Access to the Office through email and online services. The importance of email and online access is demonstrated by its use this year in 80% of all complaints received;
- Information on how to make a complaint to the Ombudsman is available in 17 languages in addition to English and features on the homepage of the Ombudsman's website. People may also contact the Office with the assistance of an interpreter by using the Translating and Interpreting Service;
- The Office's accommodation, building and facilities provide access for people with disability, including lifts that accommodate wheelchairs and feature braille on the access buttons and people with hearing and speech impairments can contact the Office using the National Relay Service;
- The Office's Regional Awareness and Accessibility Program and Youth Awareness and Accessibility Program target awareness and accessibility for regional and Aboriginal Western Australians as well as children and young people;

- The Office attends events to raise community awareness of, and access to, its services, such as the Wagin Woolorama Agricultural Show in March 2021; and
- The Office's visits to adult prisons and the juvenile detention centre provide an opportunity for adult prisoners and juvenile detainees to meet with representatives of the Office and lodge complaints in person.

Ombudsman website

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



- Members of the public on the complaint handling services provided by the Office as well as links to other complaint bodies for issues outside the Ombudsman's jurisdiction;
- Public authorities on decision making, complaint handling and conducting investigations;
- Children and young people as well as information for non-government organisations and government agencies that assist children and young people, including downloadable print material tailored for children and young people. The youth pages can be accessed at www.ombudsman.wa.gov.au/youth;
- Access to the Ombudsman's reports such as *Preventing suicide by children and young people 2020*;
- The latest news on events and collaborative initiatives such as the Regional Awareness and Accessibility Program; and
- Links to other key functions undertaken by the Office such as the Energy and Water Ombudsman website and other related bodies including other Ombudsmen and other Western Australian accountability agencies.

The website continues to be a valuable resource for the community and public sector as shown by the increased use of the website this year. In 2020-21:

- The total number of visits to the website was 105,165;
- The top two most visited pages (besides the homepage and the Contact Us page) on the site were *Making a complaint* and *What you can complain about*; and
- The Office's *Effective Handling of Complaints Made to Your Organisation Guidelines* and *Procedural Fairness Guidelines* were the two most viewed documents.

The total number of visits to the website in 2020-21 was 105,165.

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

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2020-21. A regional visit was conducted to Northam and Merredin in the Wheatbelt Region in March 2021 and the Indian Ocean Territories in June 2021. The visits include activities such as:

- Information stalls and drop-in clinics, which provided an opportunity for members of the local community to raise their concerns face-to-face with the staff of the Office;
- Meetings with the Aboriginal community to discuss government service delivery and where the agencies may be able to assist;
- Liaison with community, advocacy and consumer organisations; and
- Liaison with public authorities.

The Program is an important way for the Office to raise awareness of, access to, and use of, its services for regional and Aboriginal Western Australians and people living and working in the Indian Ocean Territories. The visits were coordinated with the Western Australian Energy and Water Ombudsman, the Health and Disability Services Complaints Office and the Equal Opportunity Commission, with the Wheatbelt visit also coordinated with the Commonwealth Ombudsman, and the Indian Ocean Territory visit coordinated with the Department of Mines, Industry Regulation and Safety (Consumer Protection).

The Office held events in Northam and Merredin in March 2021, in collaboration with the Commonwealth Ombudsman, Equal Opportunity Commission, and Health and Disability Services Complaints Office.

Principal Investigating Officer, Deidre Govindan, and Principal Project Officer, Lindon McKenna, held events in the Indian Ocean Territories in June 2021 in collaboration with the Equal Opportunity Commission, Health and Disability Services Complaints Office and Consumer Protection.

The Office also:

- Held an information stall at the Wagin Woolorama Agricultural Show in March 2021; and
- Hosted a webinar, *Independent Agency Forum for Service Providers* for community service organisations and Aboriginal organisation across the Pilbara Region in May 2021. The webinar was delivered in collaboration with the Commonwealth Ombudsman, Corruption and Crime Commission, Health and Disability Services Complaints Office and the Equal Opportunity Commission.

The Office held an information stall at the Wagin Woolorama Agricultural Show in March 2021.

The Program enables the Office to:

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

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

Aboriginal engagement

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

In 2018, the Office established two additional Aboriginal positions and in 2021, created a critical new executive position, Senior Assistant Ombudsman Aboriginal Engagement and Collaboration (all of which are identified s. 50(d) positions under the *Equal Opportunity Act 1984*).

The Office also engaged an Aboriginal artist to produce an artwork for the Office. The artwork is featured on the cover of this report and has been used as a theme for new publications.

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

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

- Aboriginal community information sessions as part of its Regional Awareness and Accessibility Program; and
- Consultation with the Aboriginal community for major investigations and reports. See further details in the Own Motion Investigations and Administrative Improvement section.

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

Youth Awareness and Accessibility Program

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

In 2020-21, the Office produced a poster for children and young people translated into 15 community languages.

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

The Office also has colouring-in versions of its postcard, which were popular with children visiting the Office's information stall at the Wagin Woolorama Agricultural Show in March 2021.

Speeches and Presentations

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

Ombudsman's speeches and presentations

- *Role of the State/Guarantee of Rights in Exceptional Situations* presented to the eleventh assembly and seminar of the Instituto Latinoamericano del Ombudsman - Defensorias del Pueblo in November 2020;
- *The Ombudsman's role during and post COVID-19 pandemic* presented to the International Webinar Commemorating 21st Anniversary of the Establishment of the Thai Ombudsman, Bangkok, in April 2021;
- *Victims of gender-based violence or discrimination* presented to the 12th International Ombudsman Institute World Conference in May 2021;
- *Closing address* to the 12th International Ombudsman Institute World Conference in May 2021; and
- *Opening Ceremony Address* to the Third Latin American Congress on Restorative Justice in June 2021.

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

Speeches and presentations by other staff

- *The Role and Functions of the Ombudsman*, presented by the Director Complaint Resolution to staff of the City of Wanneroo in August 2020;
- *The Role of the Ombudsman*, presented by the Senior Assistant Ombudsman Reviews, Senior Assistant Ombudsman Complaint Resolution and Senior Assistant Ombudsman Own Motion Investigations and Monitoring to lawyers at the Women's Legal Service WA in November 2020;
- *The Role of the Ombudsman*, presented by the Principal Project Officer in collaboration with the Health and Disability Services Complaints Office to clients of the Lorikeet Centre in November 2020;
- *The Role of the Ombudsman*, presented by the the Senior Assistant Ombudsman Reviews and the Principal Aboriginal Consultant to the Family Inclusion Network of Western Australia Inc in April 2021; and
- *The Ombudsman's Fatality Reviews*, presented by the Senior Assistant Ombudsman Reviews to staff of the WA Police Force in May 2021.

Liaison with Public Authorities

Liaison relating to complaint resolution

The Office liaised with a range of bodies in relation to complaint resolution in 2020-21, including:

- The Department of Communities;
- The Department of Education;
- The Department of Justice; and
- The Corruption and Crime Commission.

Liaison relating to reviews and own motion investigations

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

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

Liaison relating to inspection and monitoring functions

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

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

Publications

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

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