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:

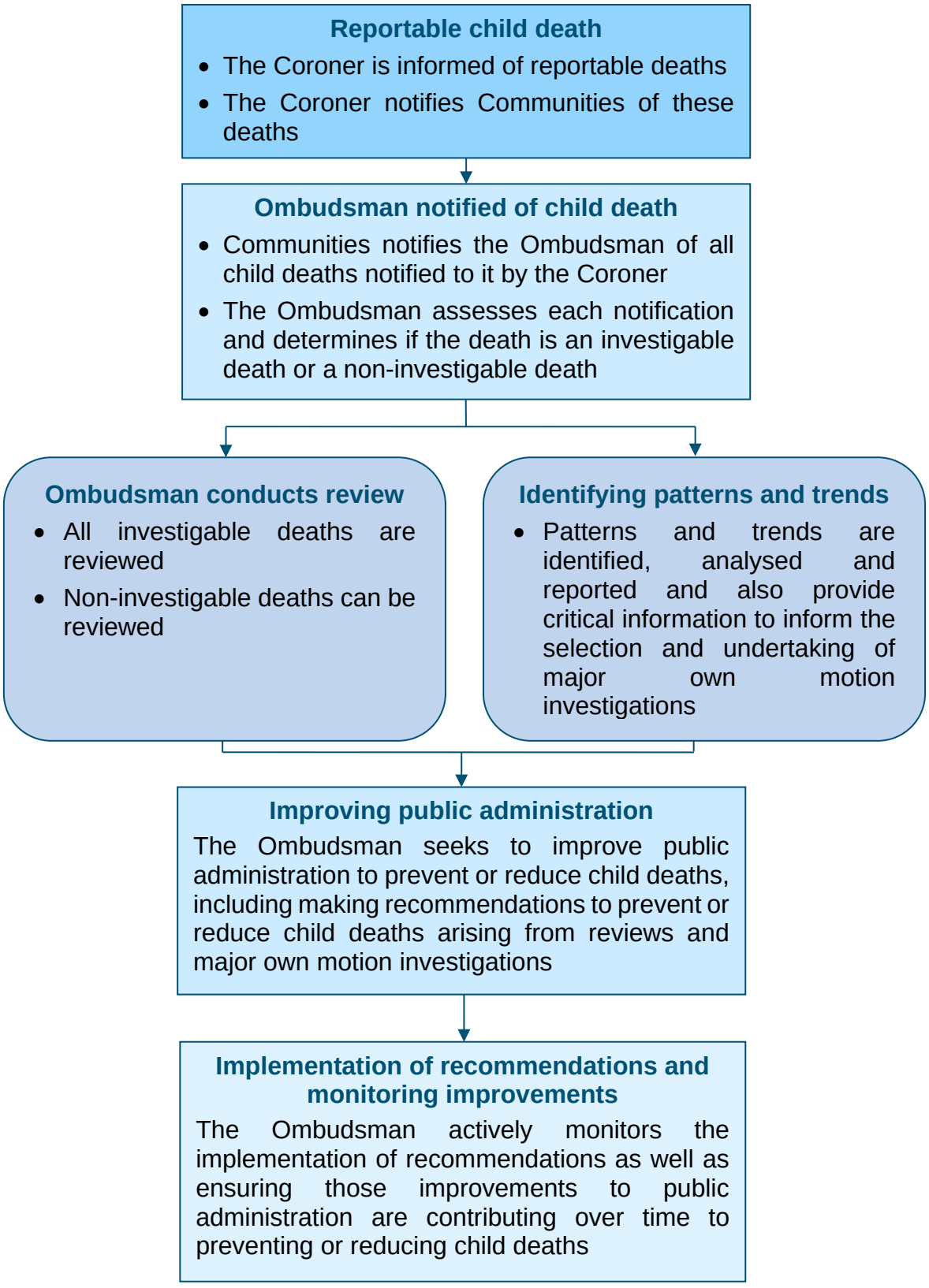
- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children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

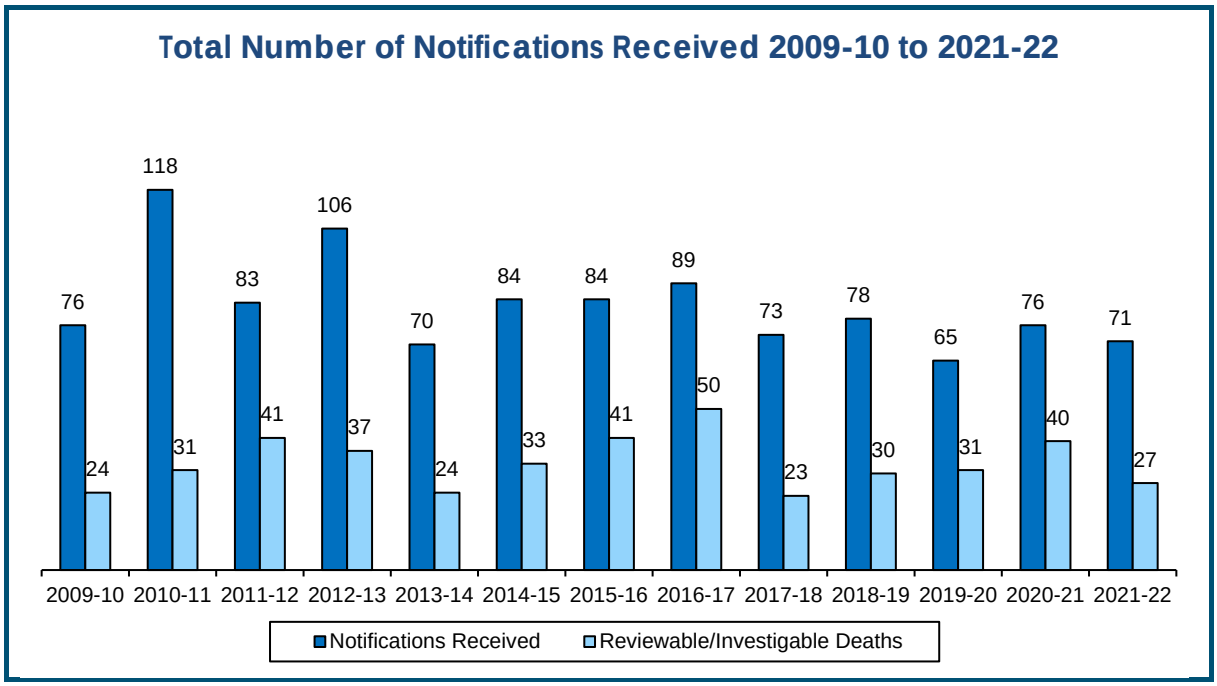
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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 2021-22, there were 27 child deaths that were investigable and subject to review from a total of 71 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 19 years from 2003-04 to 2021-22. 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	139	77	46	40
2021-22	146	68	36	27

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

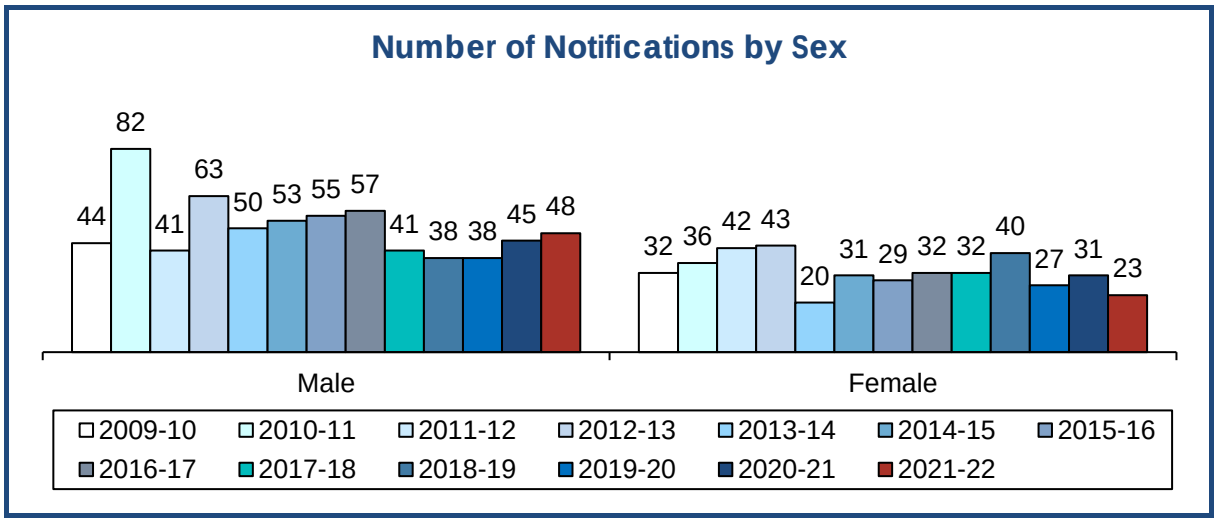
Information is obtained on a range of characteristics of the children who have died including sex, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

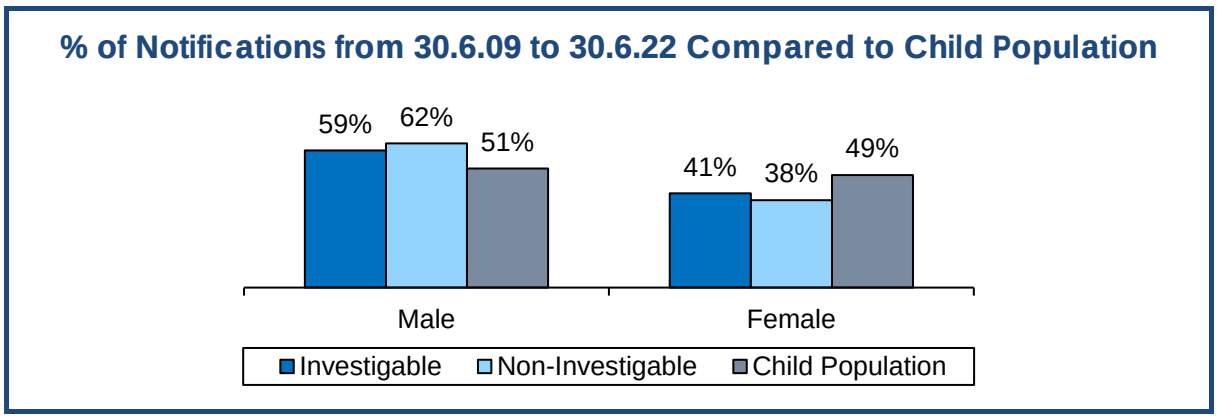
The following charts show:

- The number of children in each group for each year from 2009-10 to 2021-22; and
- For the period from 30 June 2009 to 30 June 2022, 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 13 years, male children are over-represented compared to the population for both investigable and non-investigable deaths.

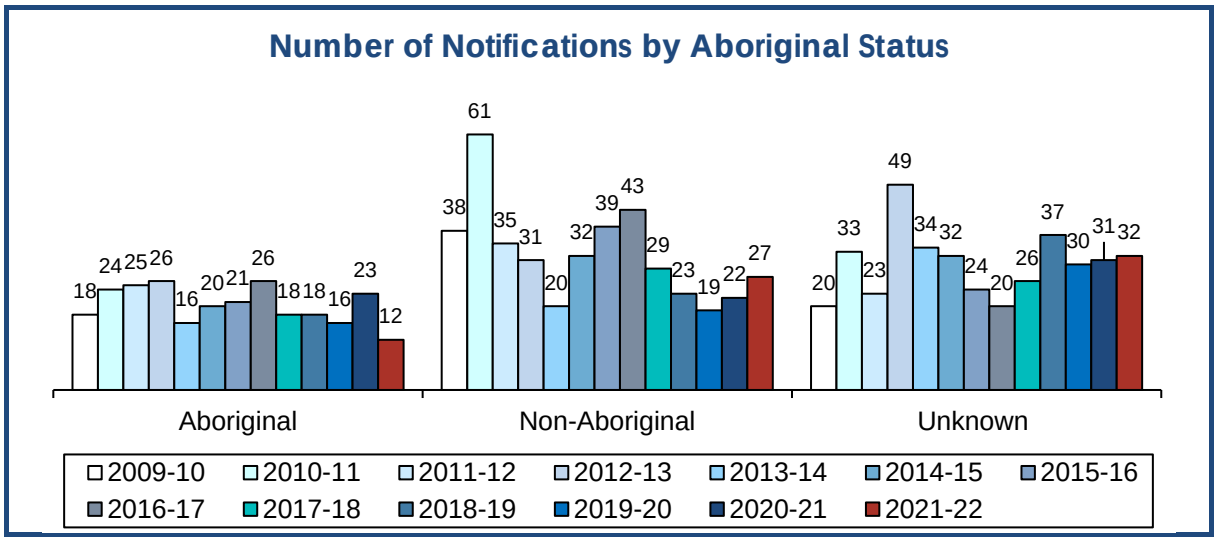


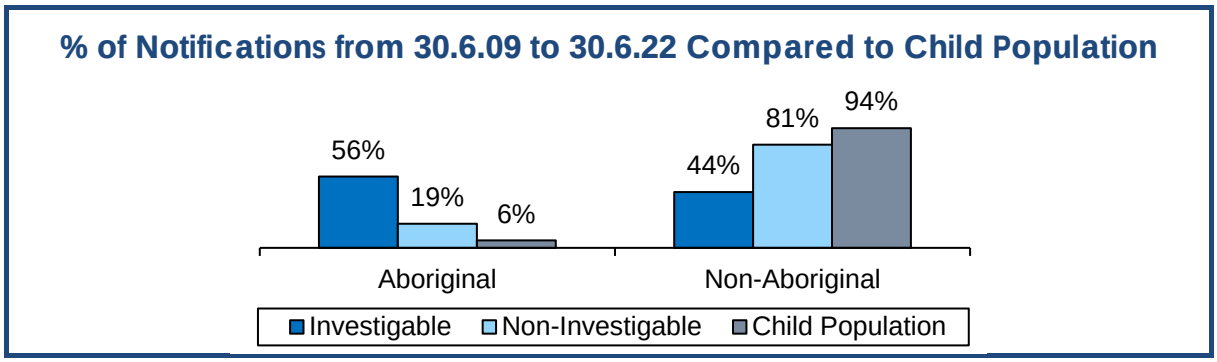


Further analysis of the data shows that, considering all 13 years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

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.



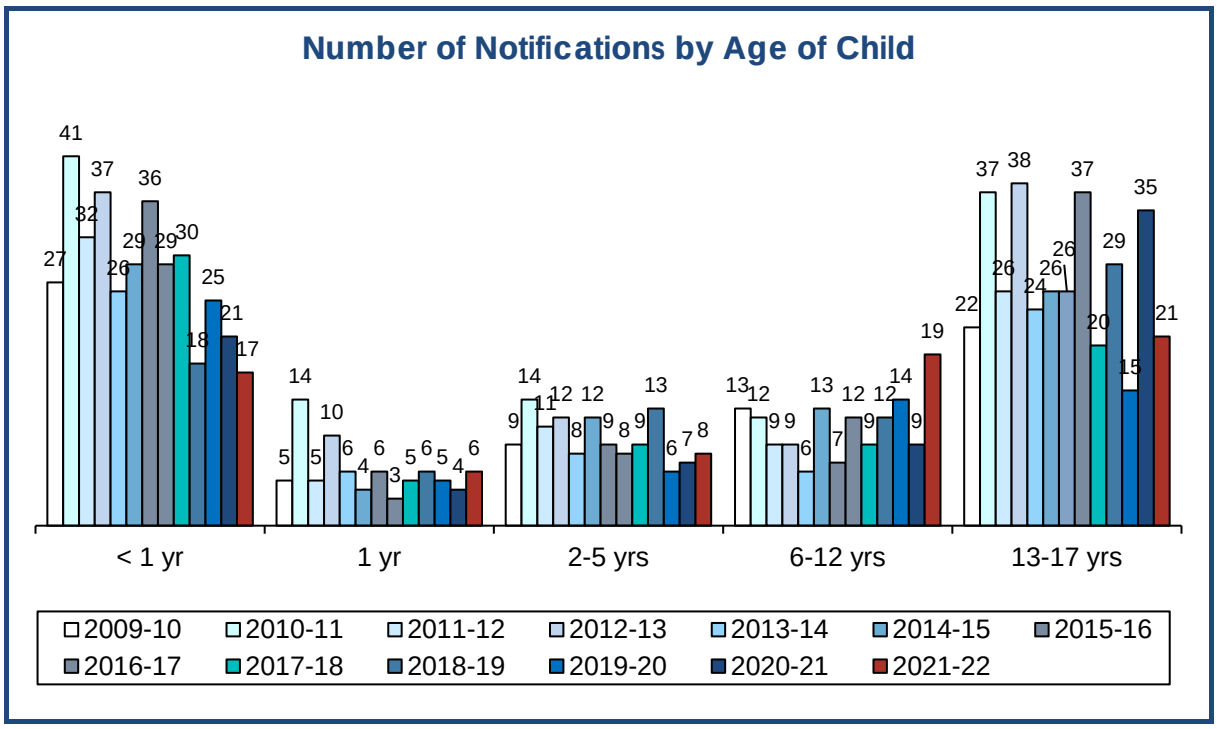


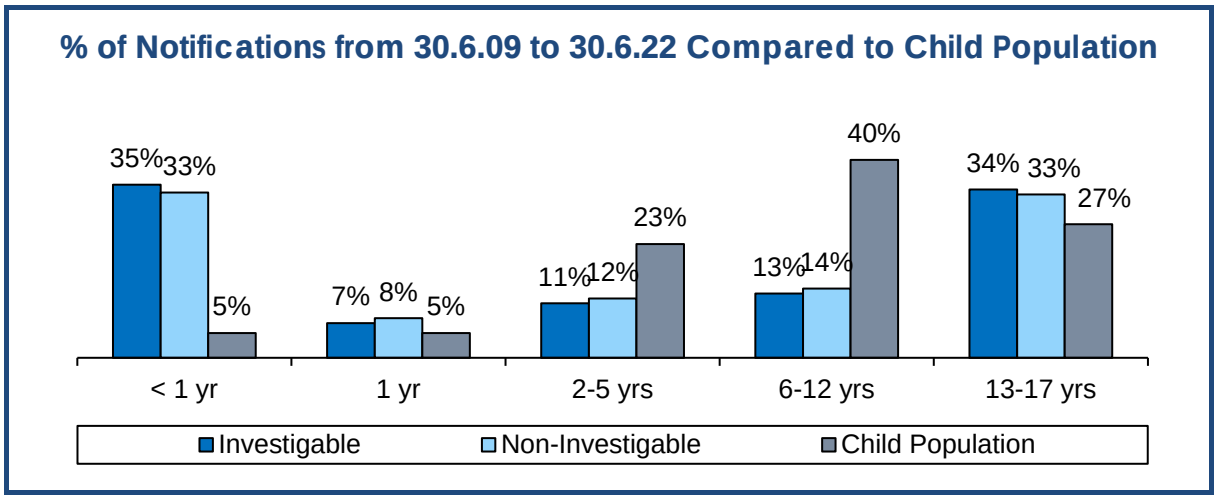
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

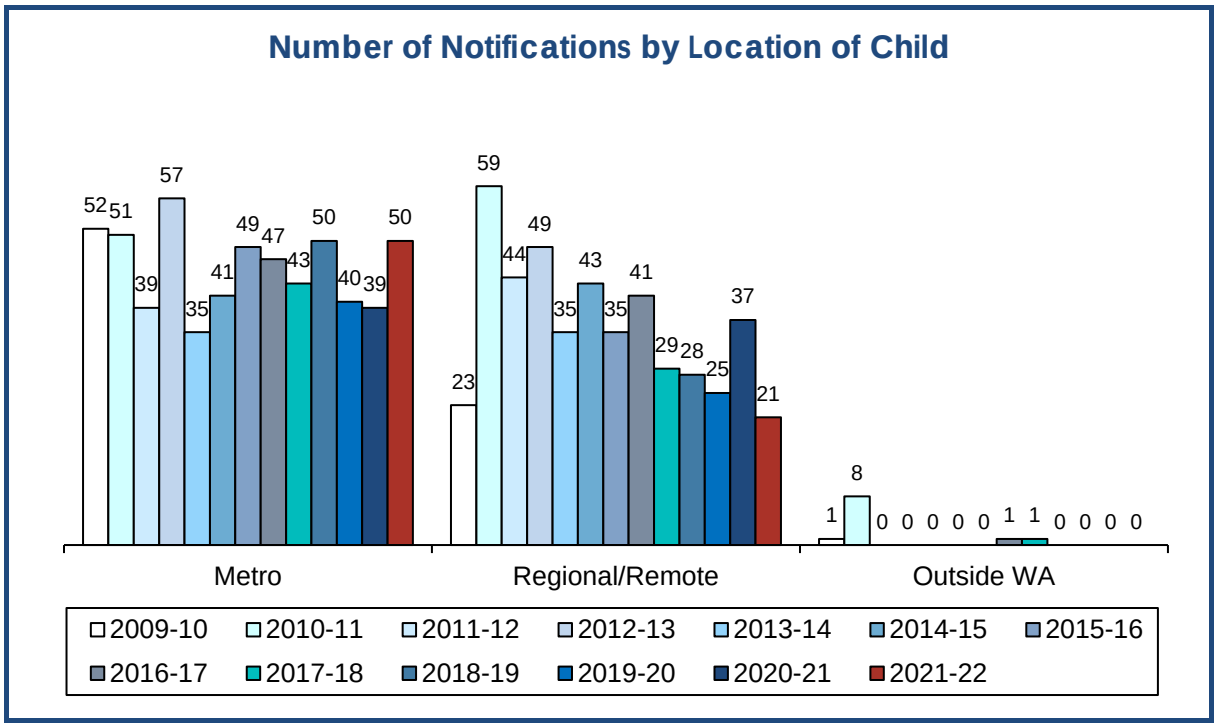




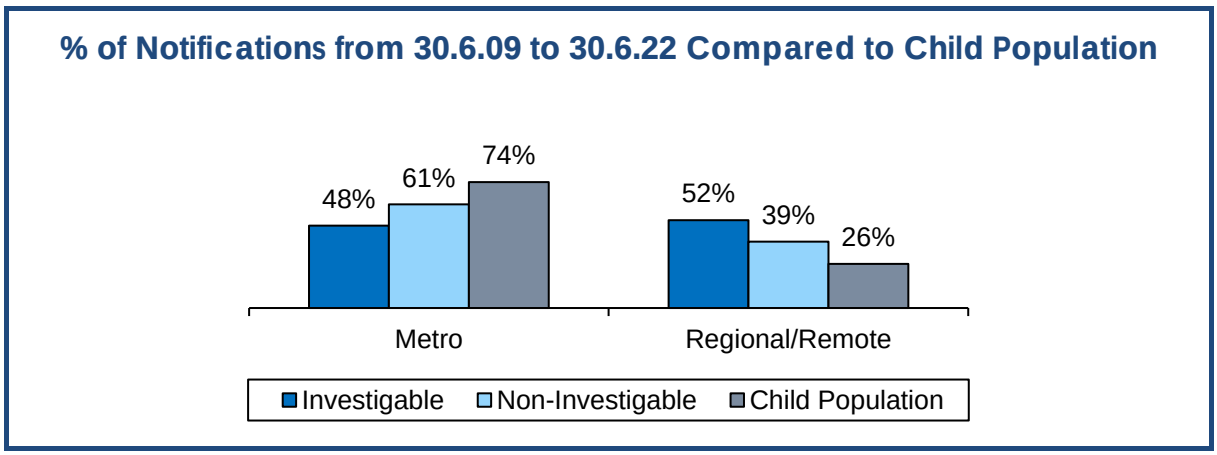
A more detailed analysis by age group is provided later in this section.

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

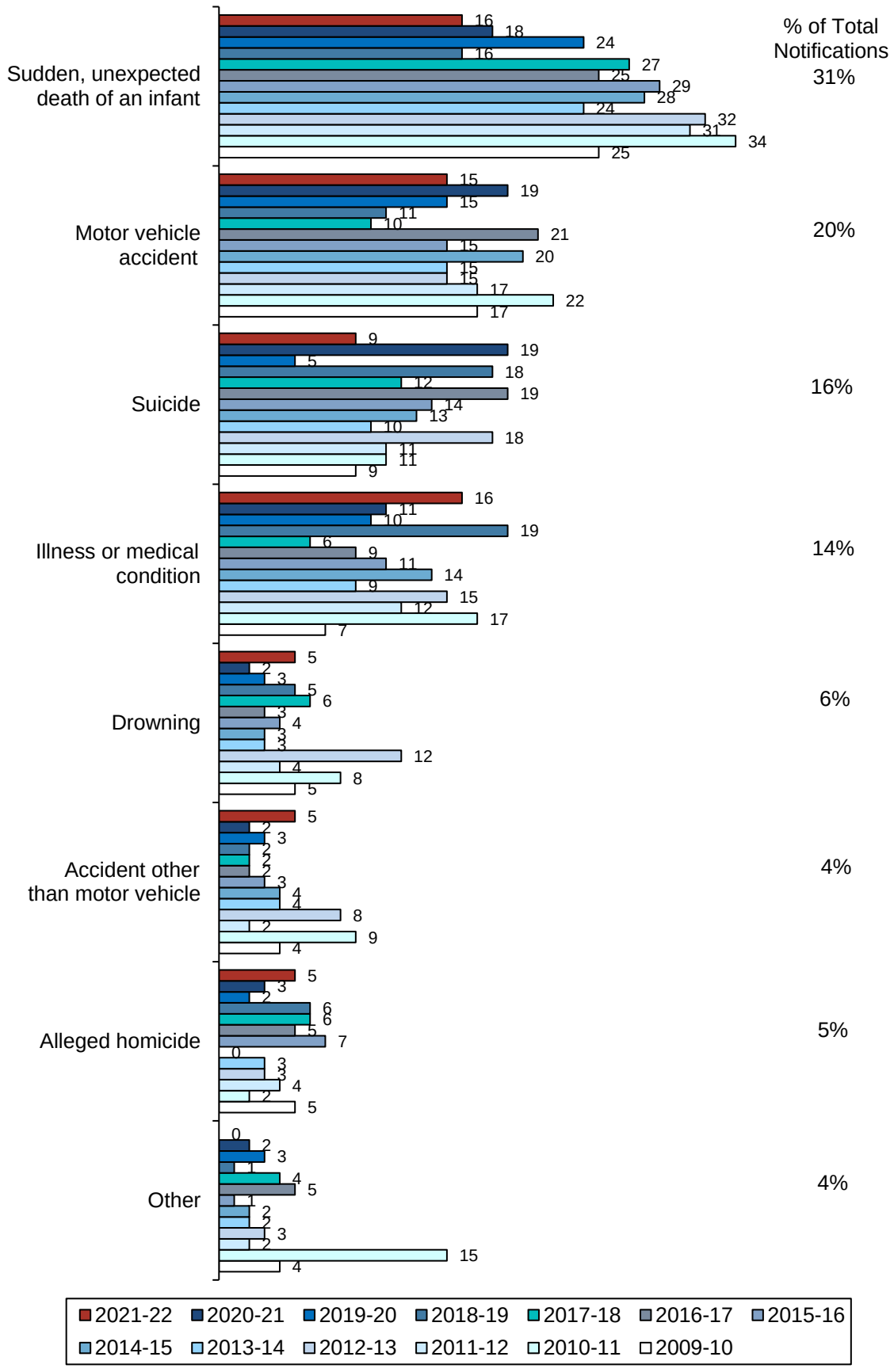
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally 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 2022.

Circumstances of Child Deaths



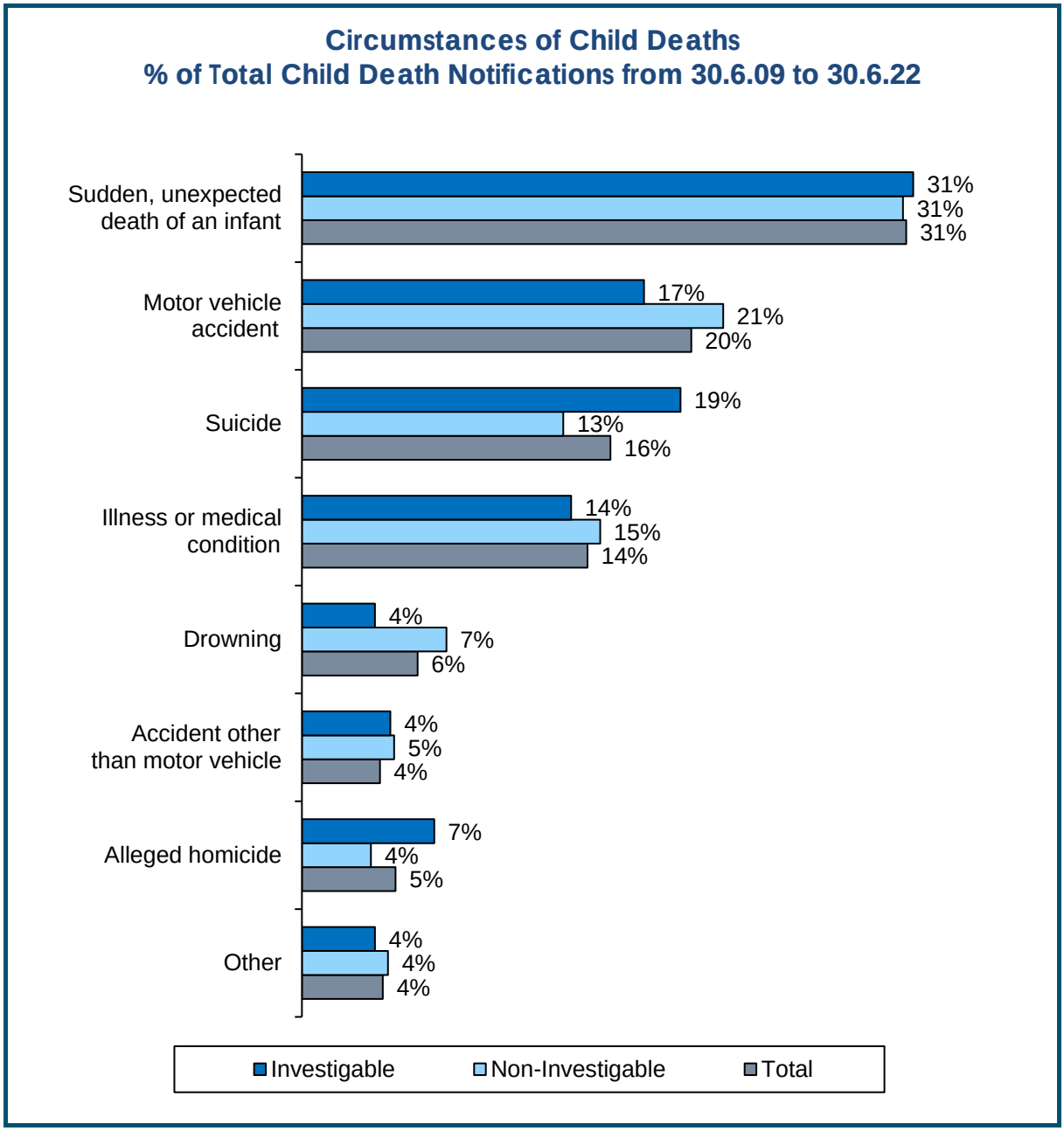
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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 1,073 child death notifications received in the 13 years from 30 June 2009 to 30 June 2022 are:

- Sudden, unexpected deaths of infants, representing 31% of the total child death notifications from 30 June 2009 to 30 June 2022 (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, 24% in 2020-21 and 23% in 2021-22); and
- Motor vehicle accidents, representing 20% of the total child death notifications from 30 June 2009 to 30 June 2022 (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, 25% in 2020-21 and 21% in 2021-22).

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



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

- Suicide; and
- Alleged homicide.

Longer term trends in the circumstances of death

The CDRC also collated information on child deaths, using similar definitions, for the deaths it reviewed. The following tables show the trends over time in the circumstances of death. It should be noted that the Ombudsman's data shows the information for all notifications received, including deaths that are not investigable, while the data from the CDRC relates only to completed reviews.

Child Death Review Committee up to 30 June 2009 – see Note 1

The figures on the circumstances of death for 2003-04 to 2008-09 relate to cases where the review was finalised by the CDRC during the financial year.

Year	Accident – Non-vehicle	Accident - Vehicle	Acquired Illness	Asphyxiation /Suffocation	Alleged Homicide (lawful or unlawful)	Immersion/ Drowning	SUDI *	Suicide	Other
2003-04	1	1	1	1	2	3	1		
2004-05		2	1	1	3	1	2		
2005-06	1	5			2	3	13		
2006-07	1	2	2				4	1	
2007-08	2	1			1	1	2	3	4
2008-09						1	6	1	

* Sudden, unexpected death of an infant – includes Sudden Infant Death Syndrome

Ombudsman from 30 June 2009 – see Note 2

The figures on the circumstances of death from 2009-10 relate to all notifications received by the Ombudsman during the year including cases that are not investigable and are not known to Communities. These figures are much larger than previous years as the CDRC only reported on the circumstances of death for the cases that were reviewable and that were finalised during the financial year.

Year	Accident Other Than Motor Vehicle	Motor Vehicle Accident	Illness or Medical Condition	Asphyxiation /Suffocation	Alleged Homicide	Drowning	SUDI *	Suicide	Other
2009-10	4	17	7		5	5	25	9	4
2010-11	9	22	17		2	8	34	11	15
2011-12	2	17	12		4	4	31	11	2
2012-13	8	15	15		3	12	32	18	3
2013-14	4	15	9		3	3	24	10	2
2014-15	4	20	14		0	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
2021-22	5	15	16		5	5	16	9	0

* 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 2022.

Social or Environmental Factor	% of Finalised Reviews from 30.6.09 to 30.6.22
Family and domestic violence	75%
Parenting	62%
Drug or substance use	51%
Alcohol use	47%
Parental mental health issues	31%
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 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 nearly two-thirds 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 three quarters of the cases;
  - Family and domestic violence was a co-existing factor in nearly nine in 10 cases;
  - Drug or substance use was a co-existing factor in over two thirds of the cases; and
  - Homelessness was a co-existing factor in over a third of the cases.

Reasons for contact with Communities

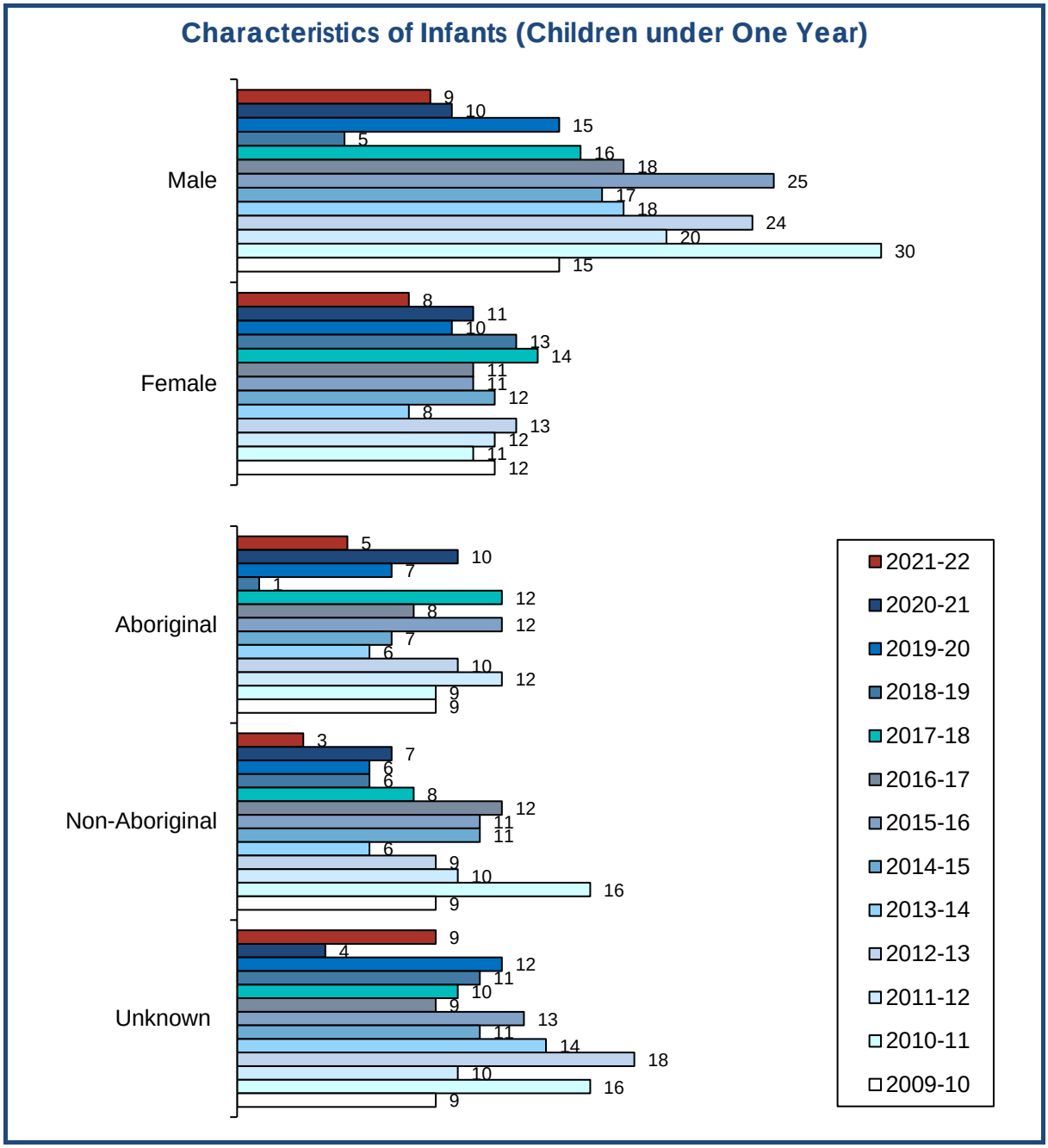
In child deaths notified to the Ombudsman in 2021-22, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

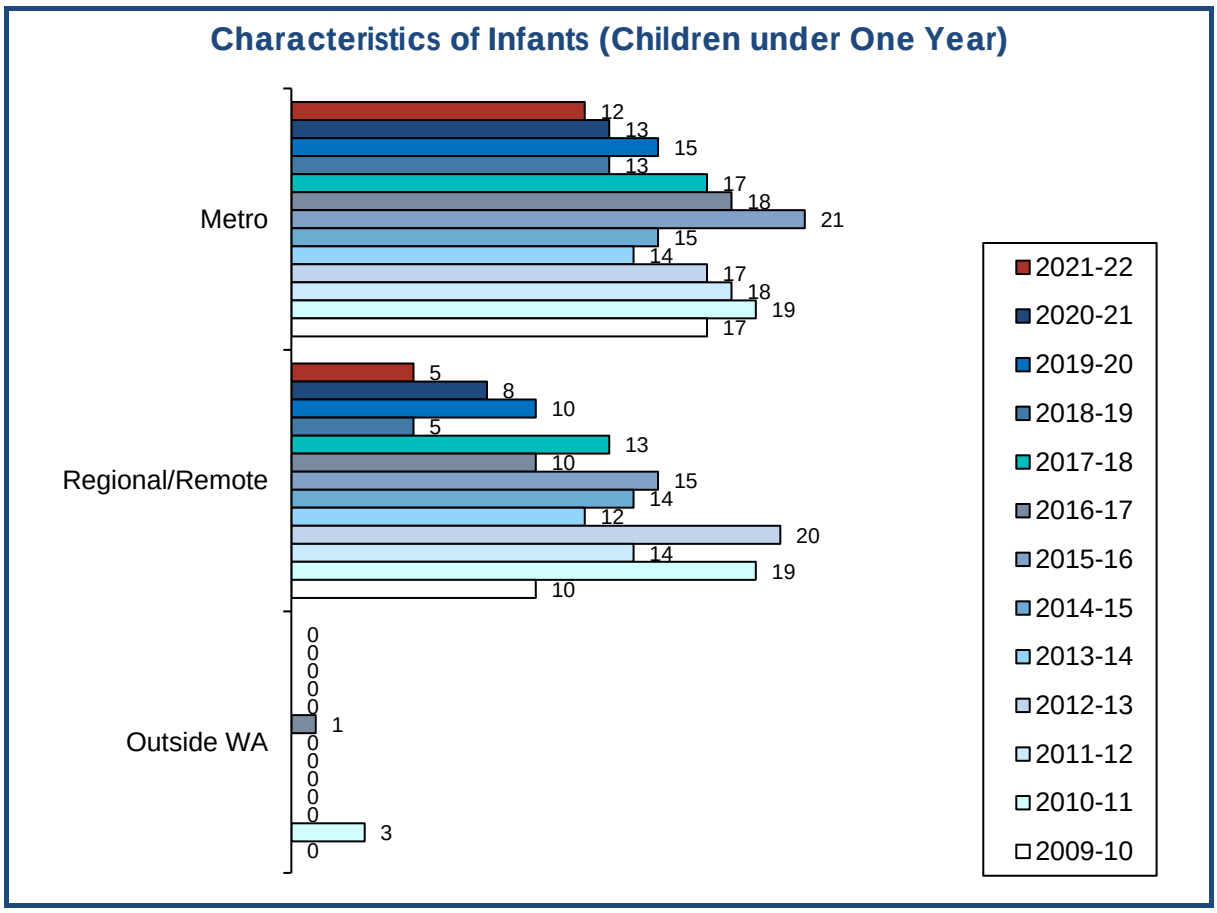
Analysis of children in particular age groups

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 1,073 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2022, there were 368 (34%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.



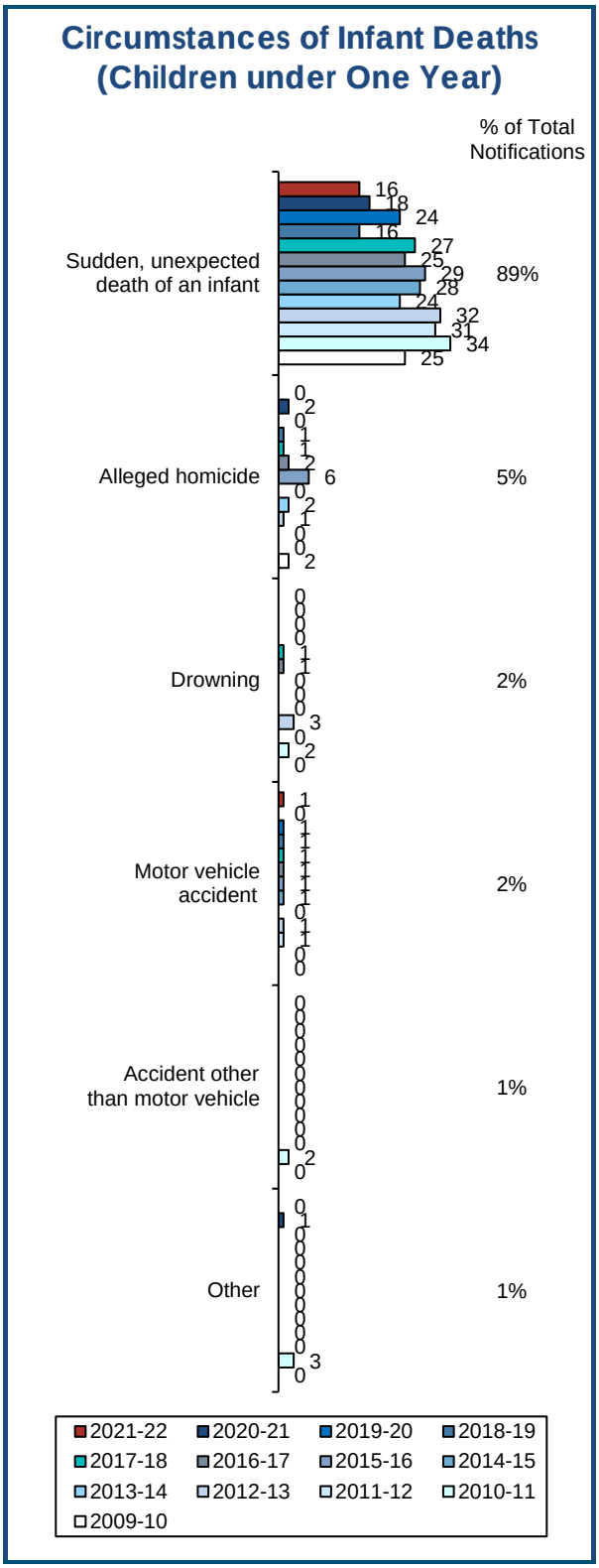


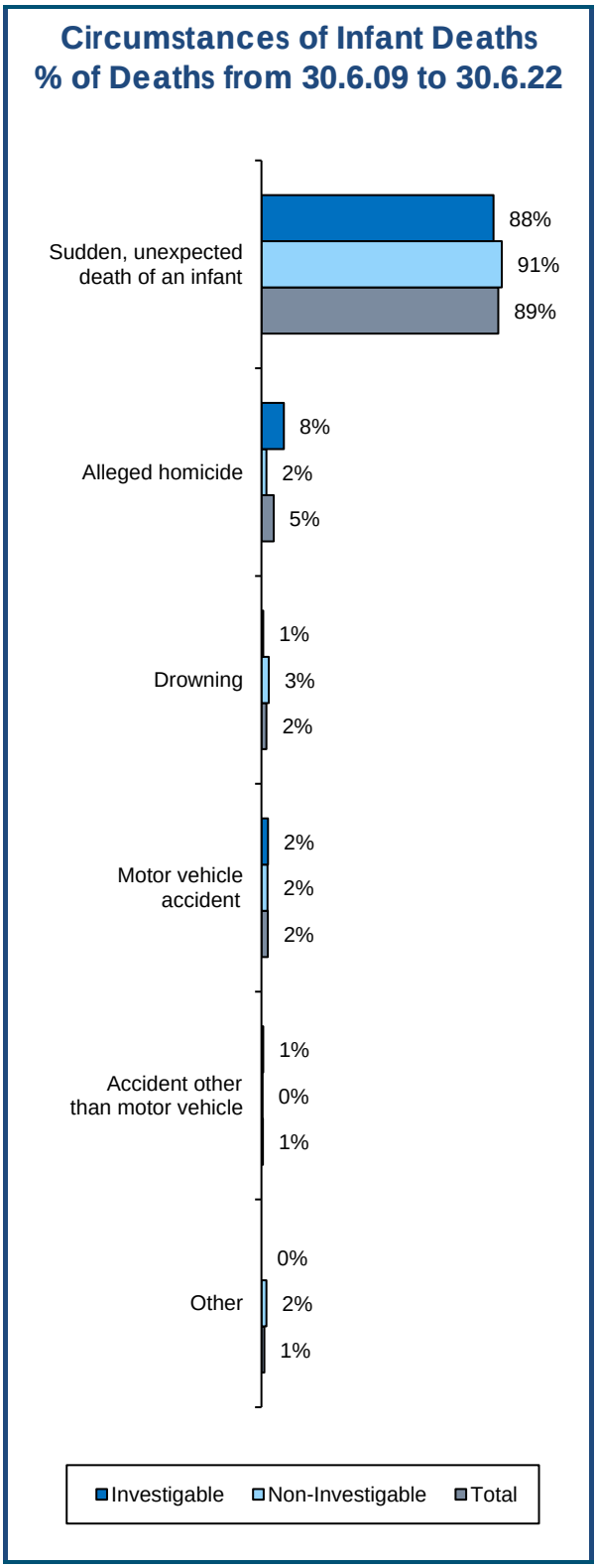
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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 59% 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 – 52% of investigable infant deaths and 36% of non-investigable deaths of infants, living in Western Australia, were children living in regional or remote locations compared to 26% in the child population.

An examination of the patterns and trends of the circumstances of infant deaths showed that of the 368 infant deaths, 329 (89%) were categorised as sudden, unexpected deaths of an infant and the majority of these (207) 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.

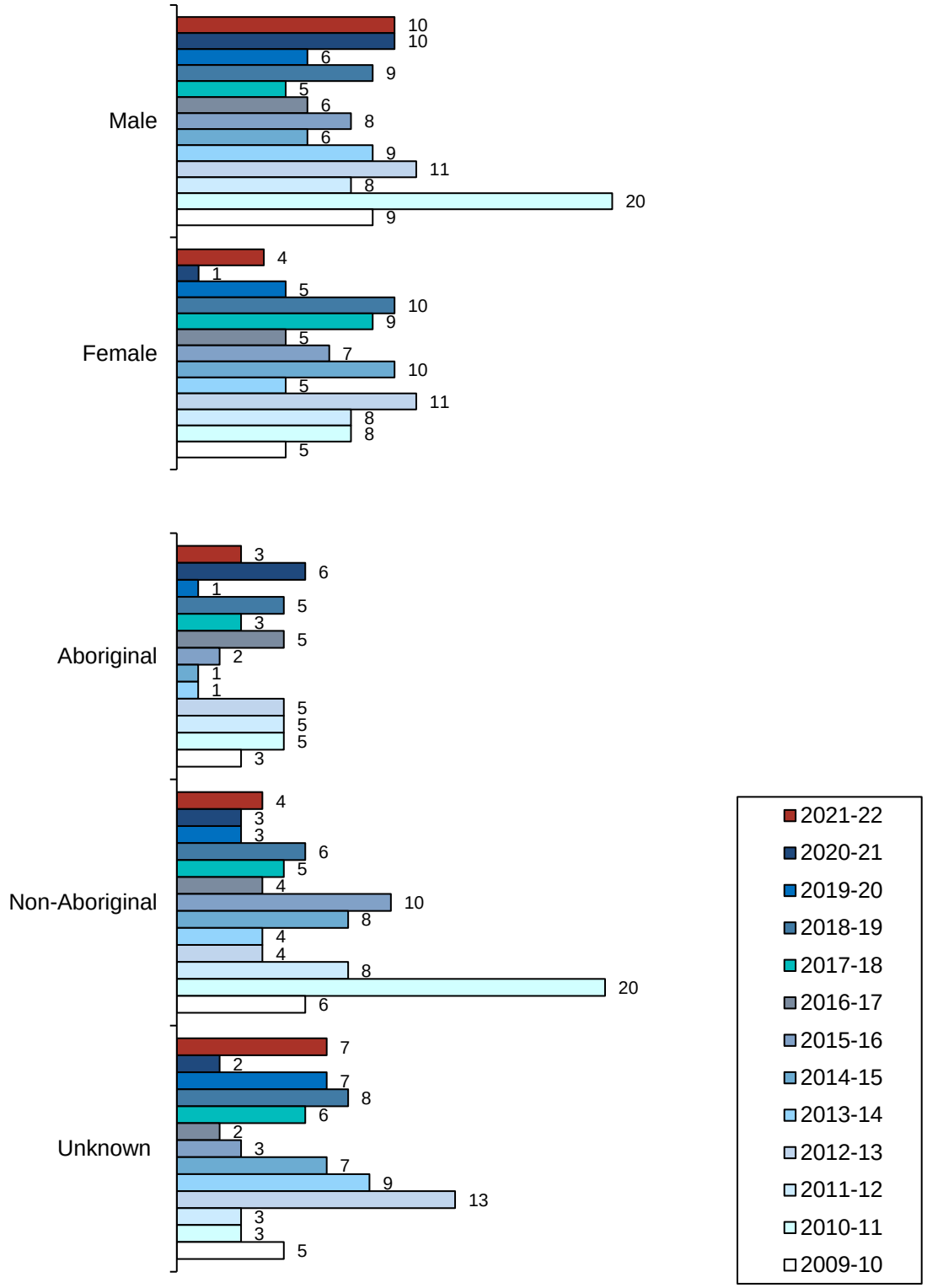
One hundred and fifty three deaths of infants were determined to be investigable deaths.

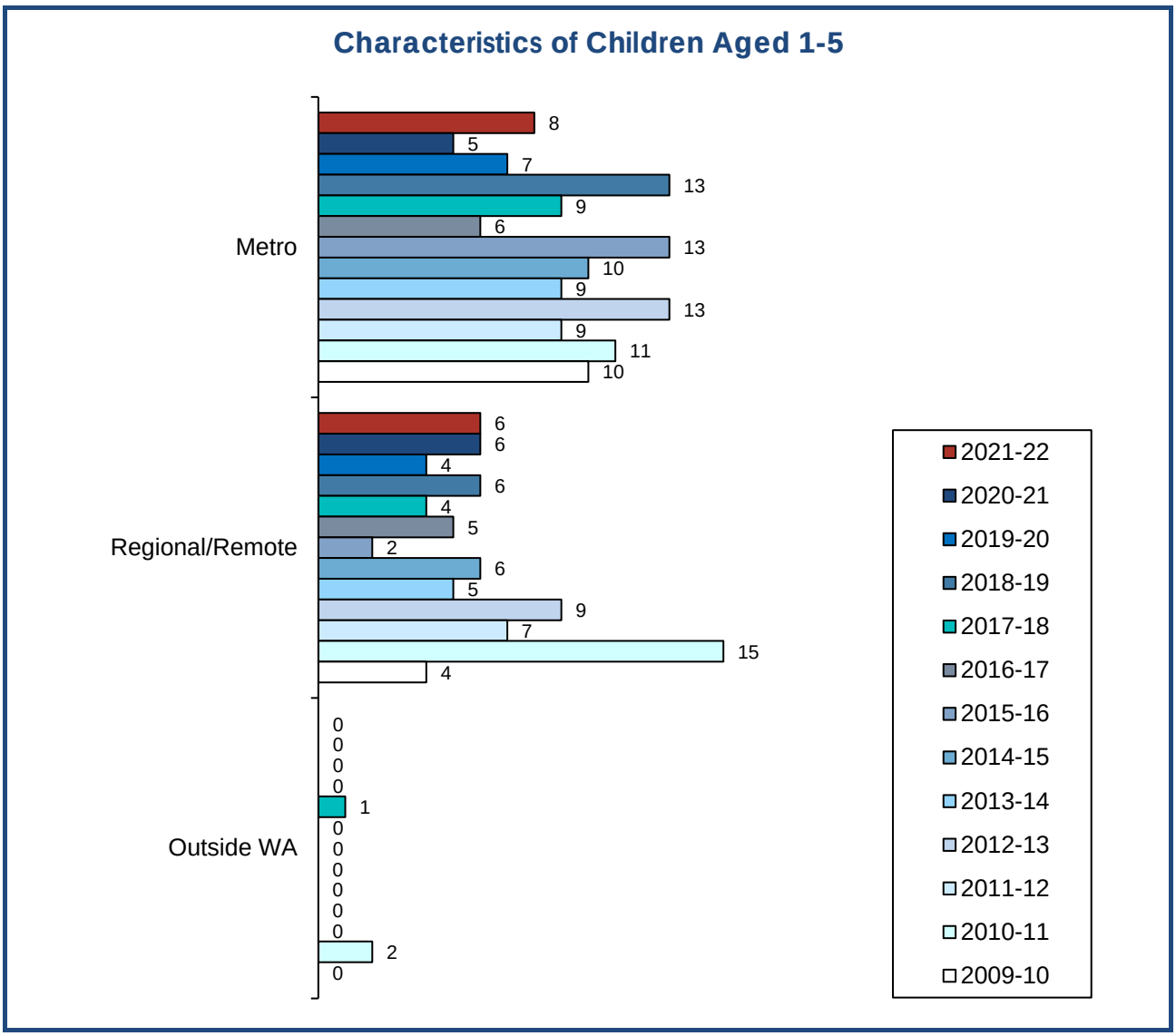
Deaths of children aged 1 to 5 years

Of the 1,073 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2022, there were 205 (19%) related to children aged from 1 to 5 years.

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

Characteristics of Children Aged 1-5



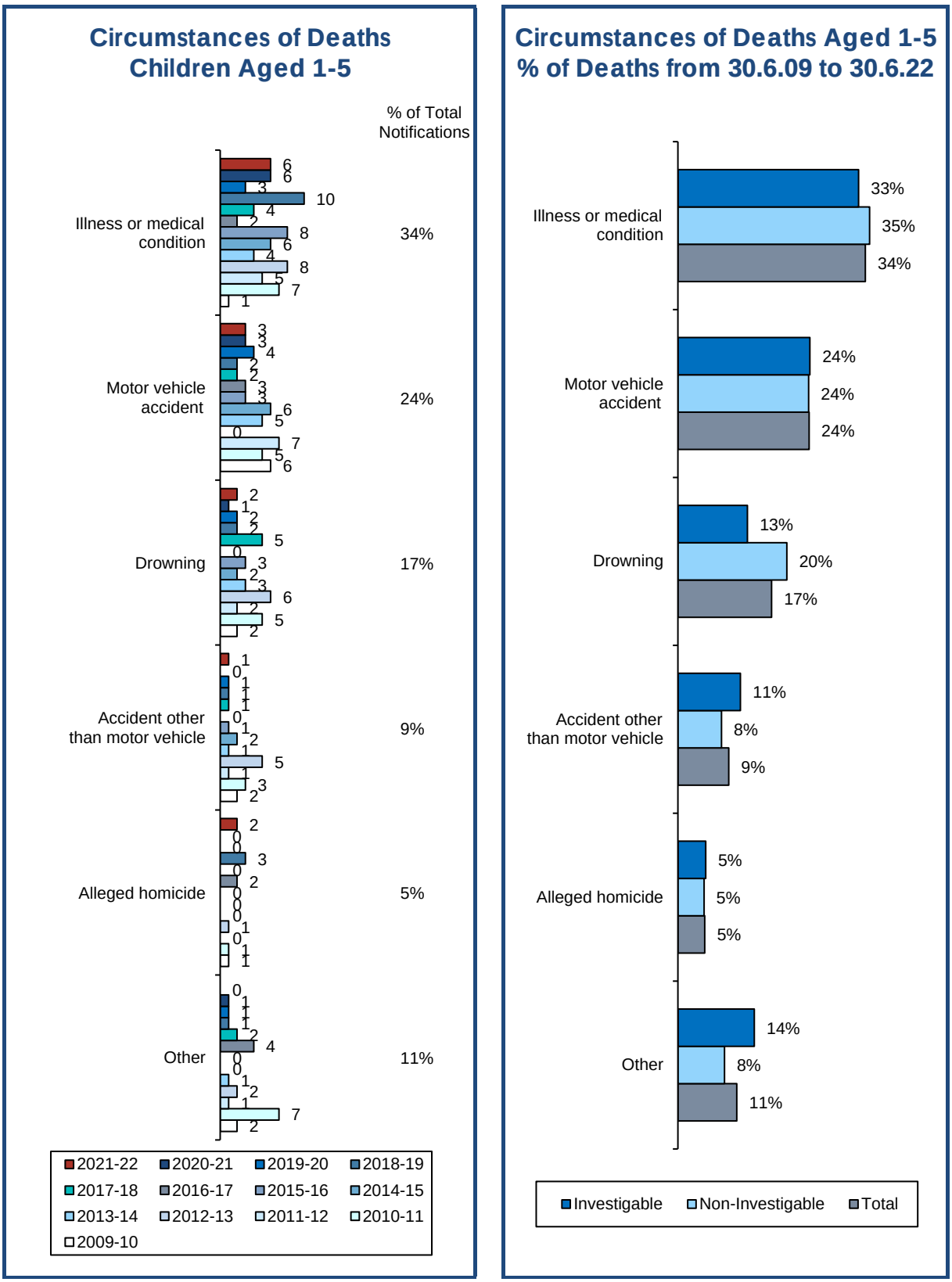


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 57% of investigable deaths and 57% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Aboriginal children – 53% of investigable deaths and 16% 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 – 44% 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 26% 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%).



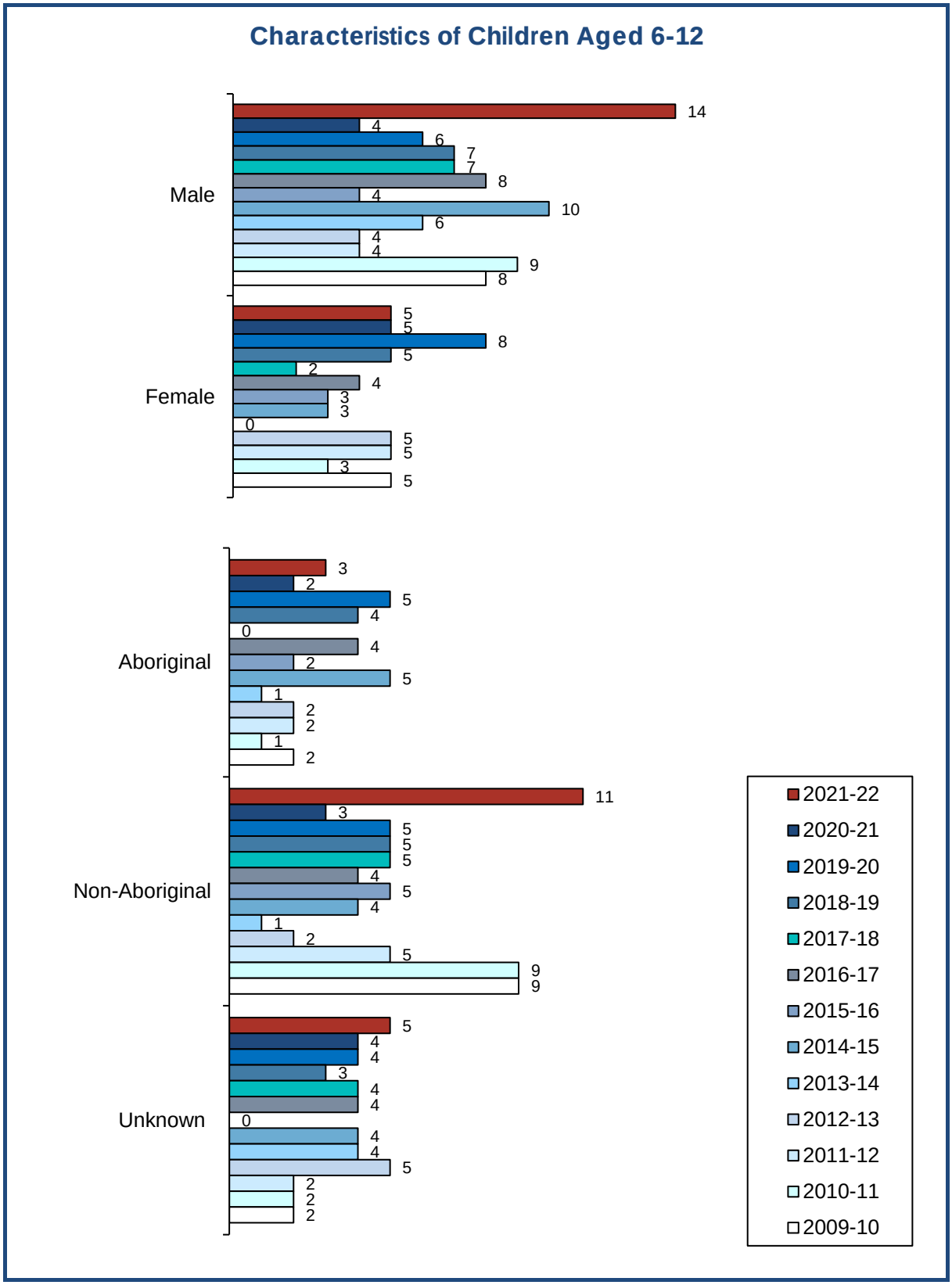
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

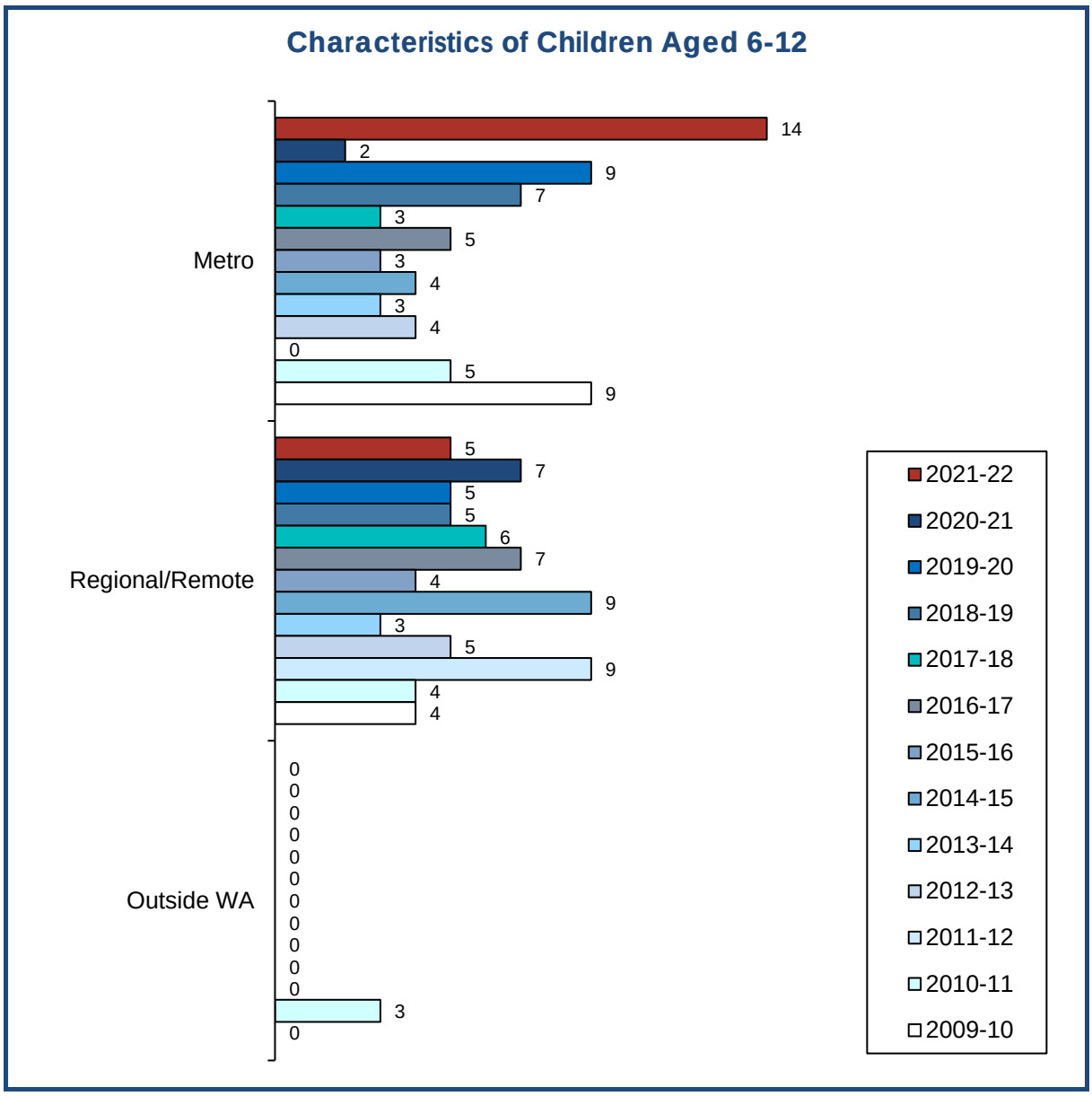
Seventy nine deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of children aged 6 to 12 years

Of the 1,073 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2022, there were 144 (13%) related to children aged from 6 to 12 years.

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



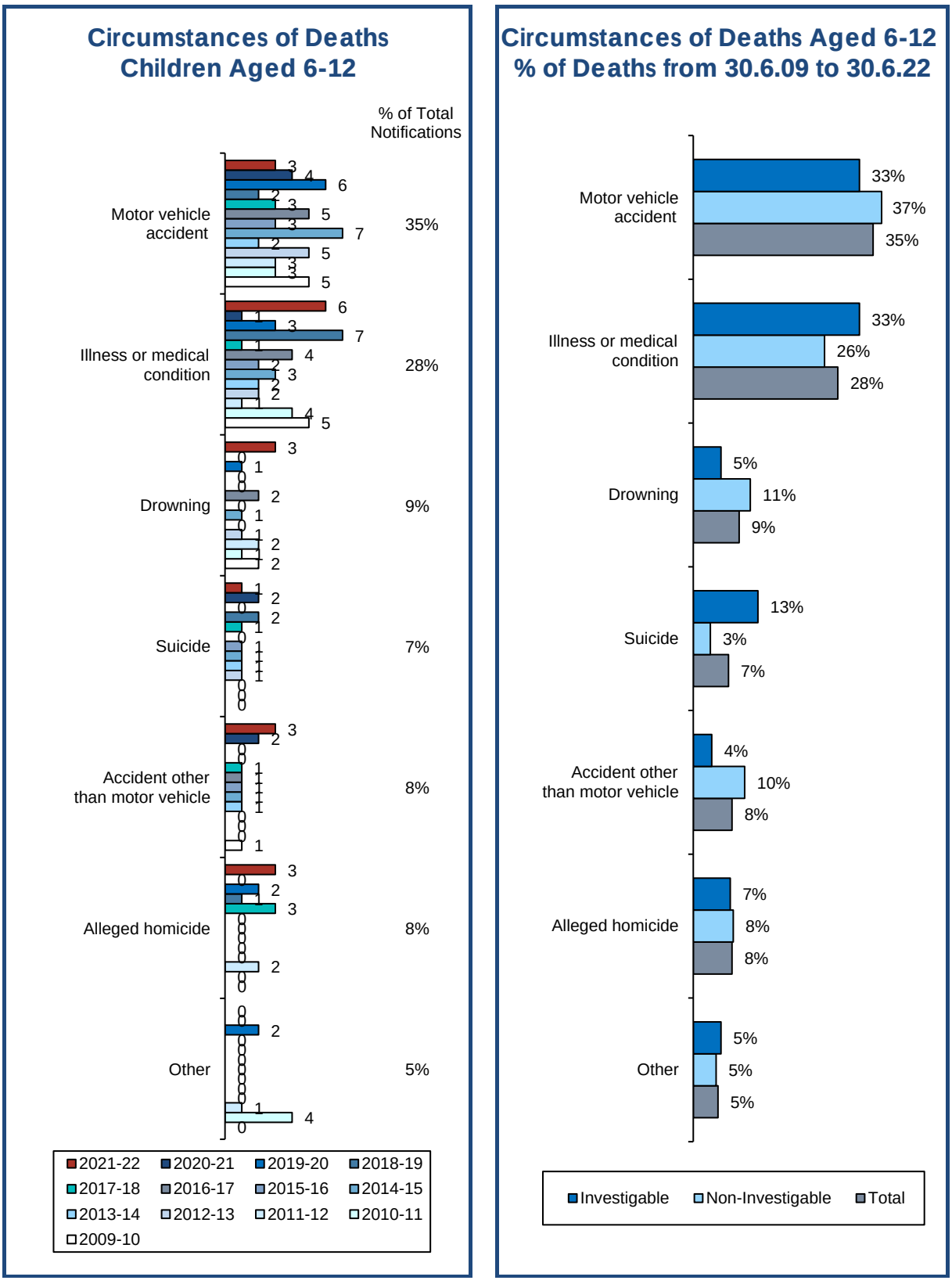


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 56% of investigable deaths and 67% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population;
- Aboriginal children – 50% of investigable deaths and 16% of non-investigable deaths of children aged 6 to 12 were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 56% of investigable deaths and 49% of non-investigable deaths of children aged 6 to 12, living in Western Australia, were children living in regional or remote locations compared to 26% in the child population.

As shown in the following chart, motor vehicle accidents are the most common circumstance of death for this age group (35%), followed by illness or medical condition (28%) and drowning (9%).



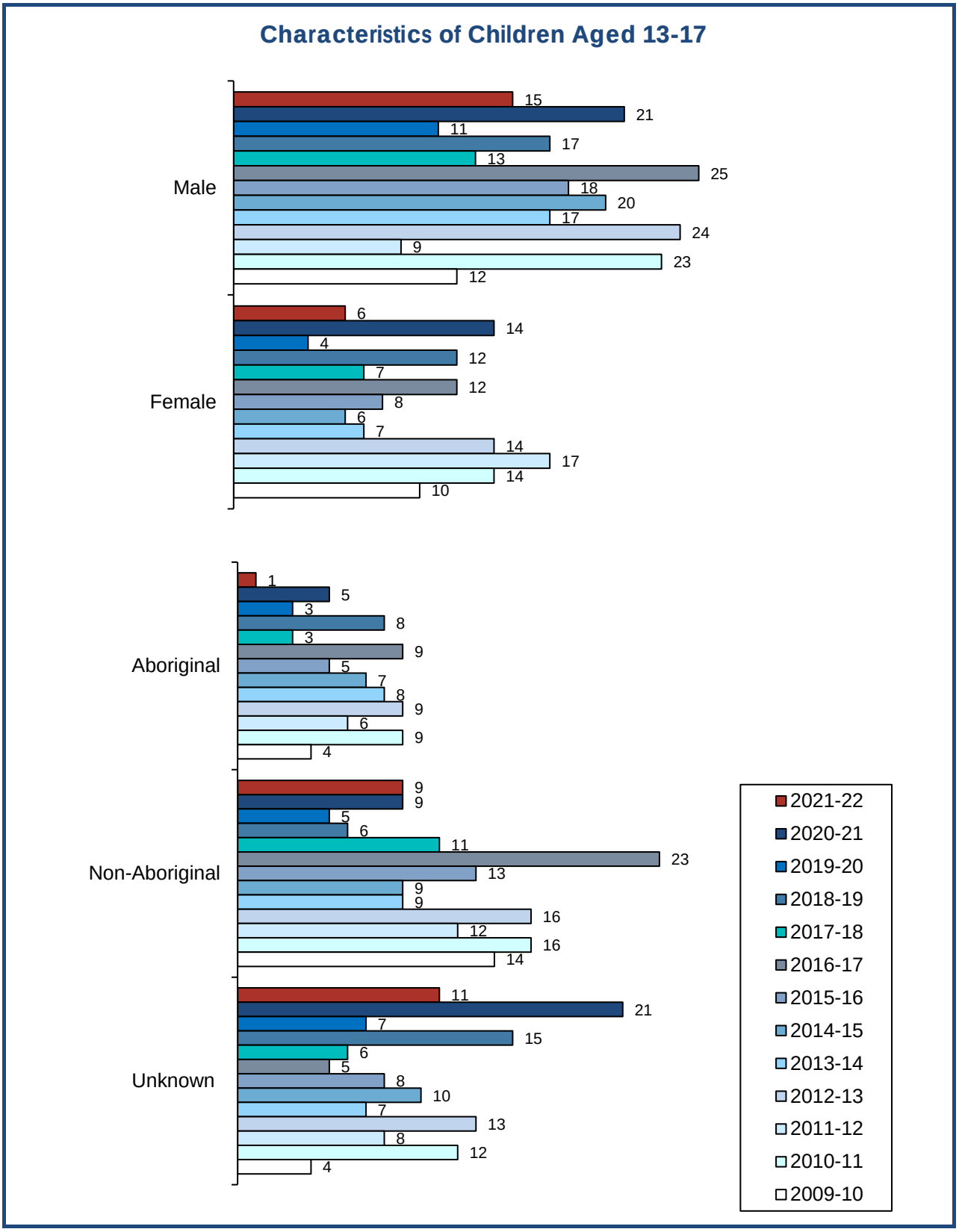
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

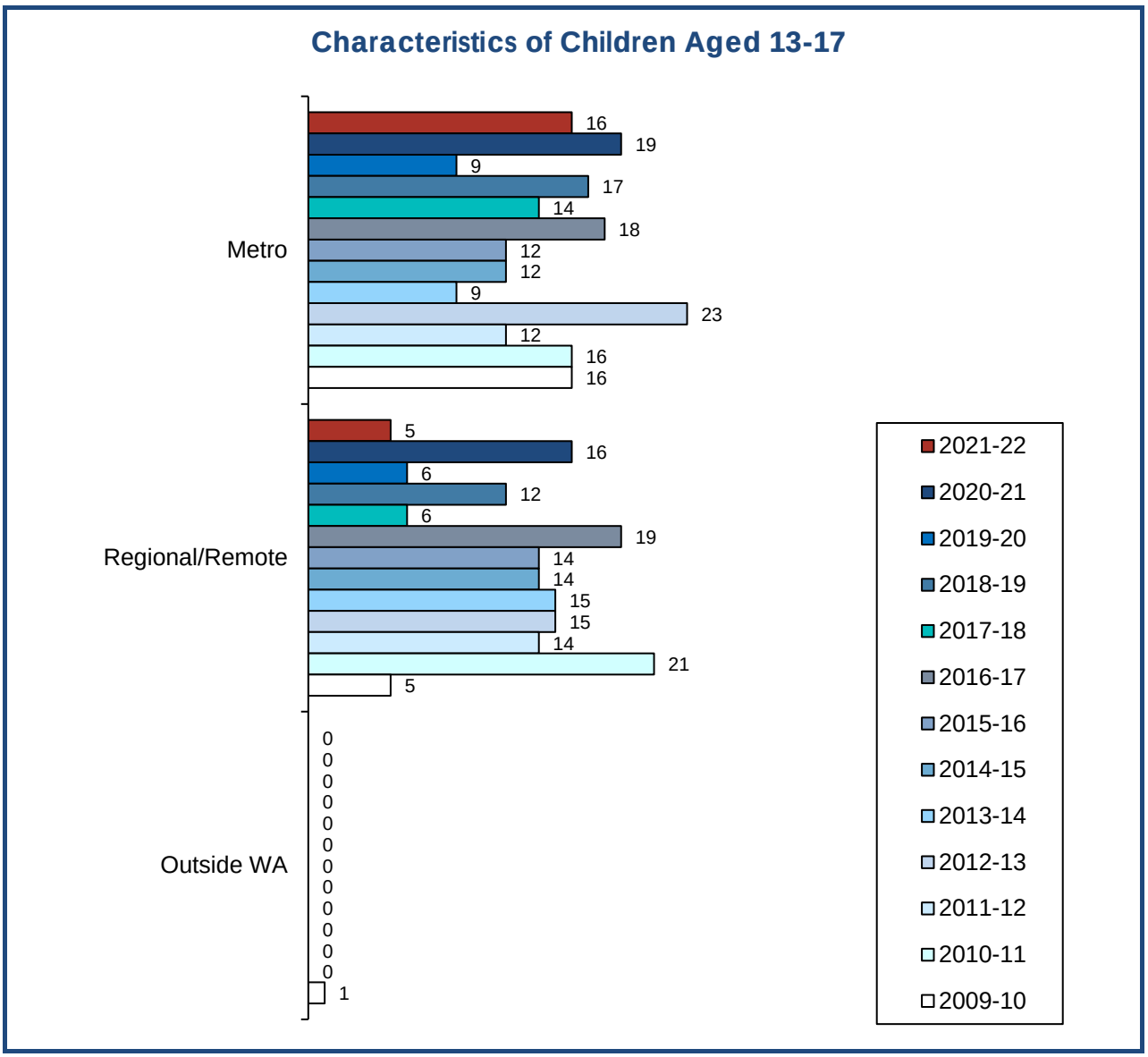
Fifty five deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of children aged 13 – 17 years

Of the 1,073 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2022, there were 356 (33%) related to children aged from 13 to 17 years.

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



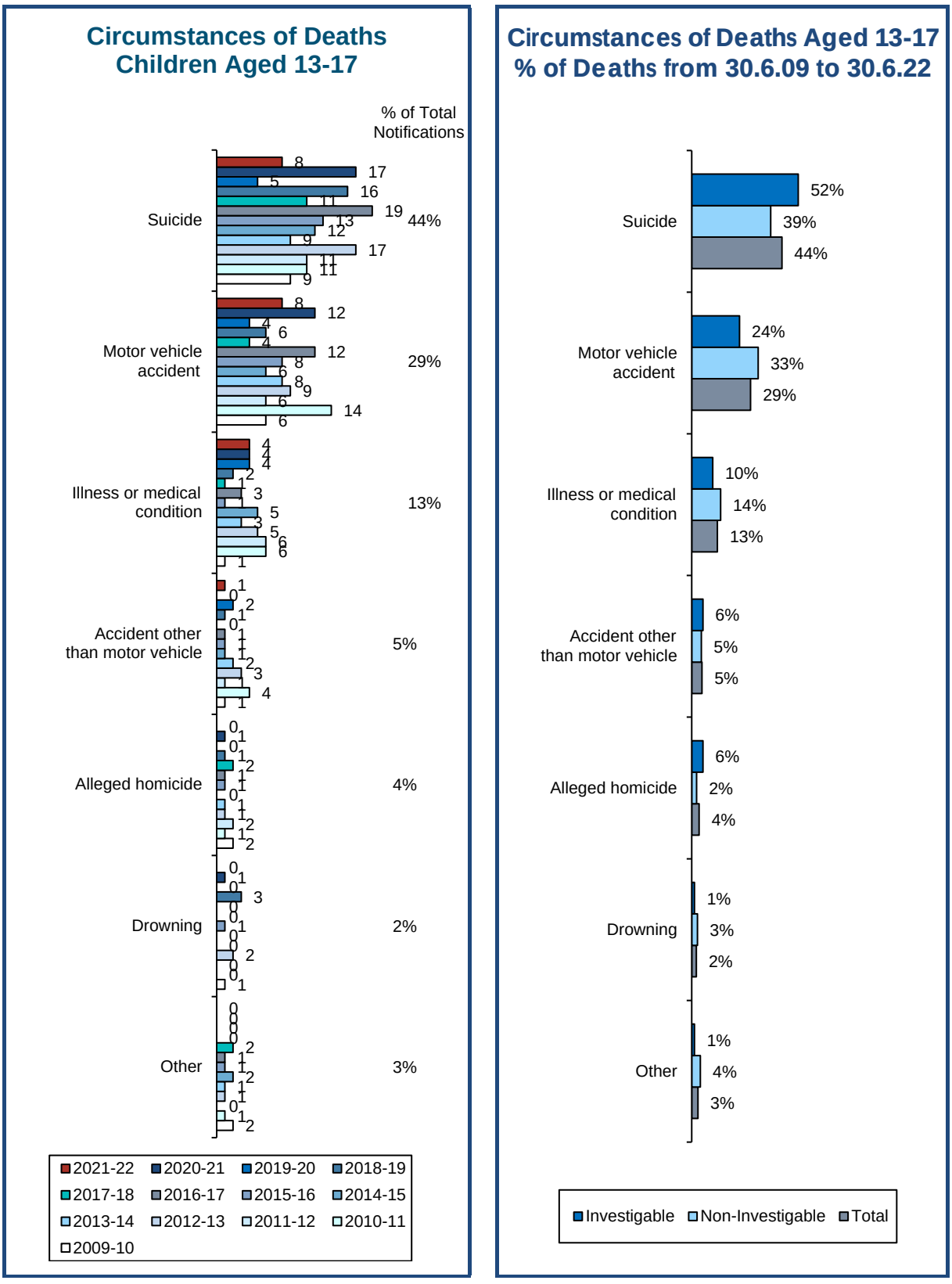


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 59% 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 – 52% of investigable deaths and 12% 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 – 54% of investigable deaths and 40% of non-investigable deaths of children aged 13 to 17, living in Western Australia, were living in regional or remote locations compared to 26% in the child population.

As shown in the following chart, suicide is the most common circumstance of death for this age group (44%), particularly for investigable deaths, followed by motor vehicle accidents (29%) and illness or medical condition (13%).



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.

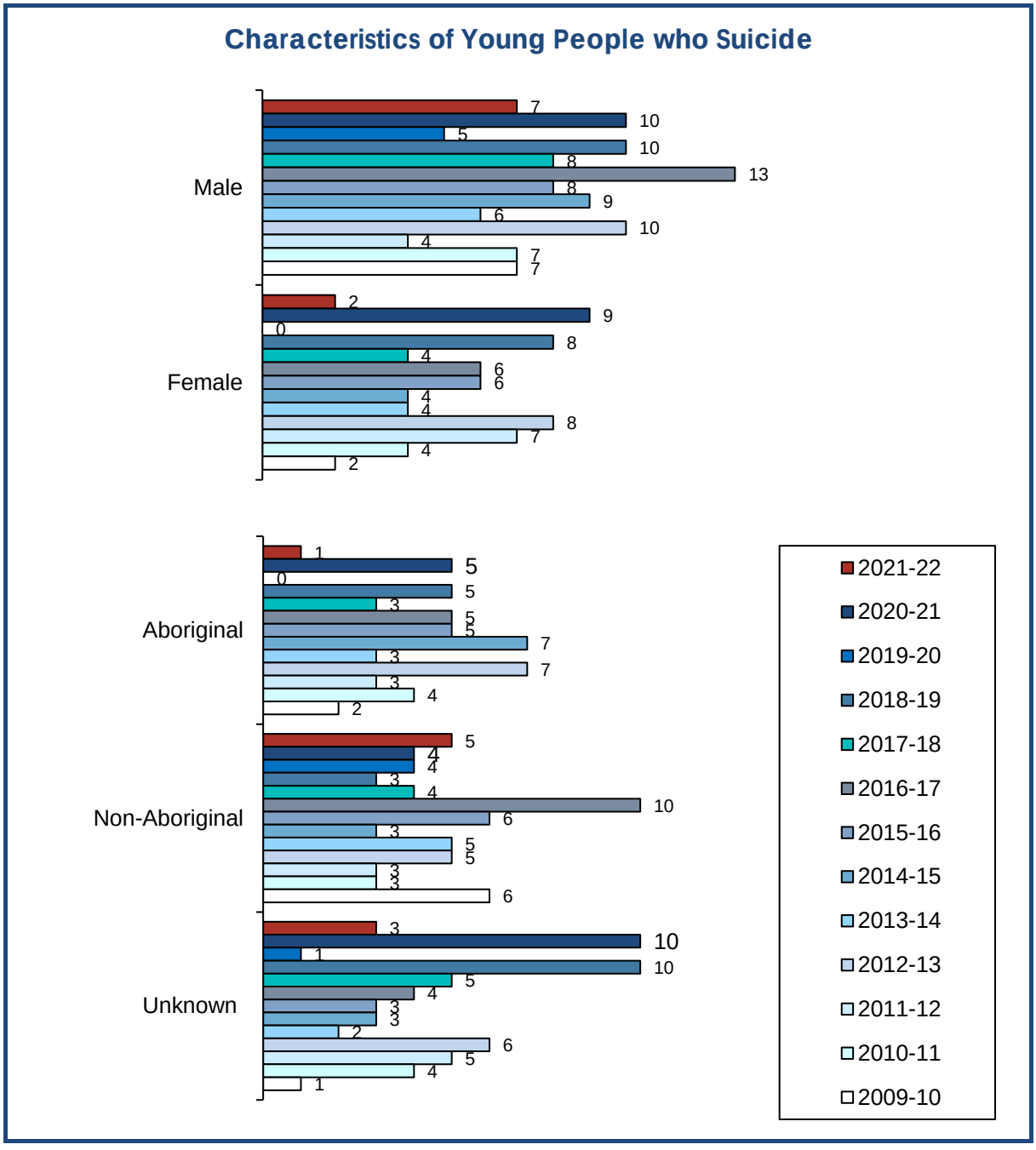
One hundred and forty five deaths of children aged 13 to 17 years were determined to be investigable deaths.

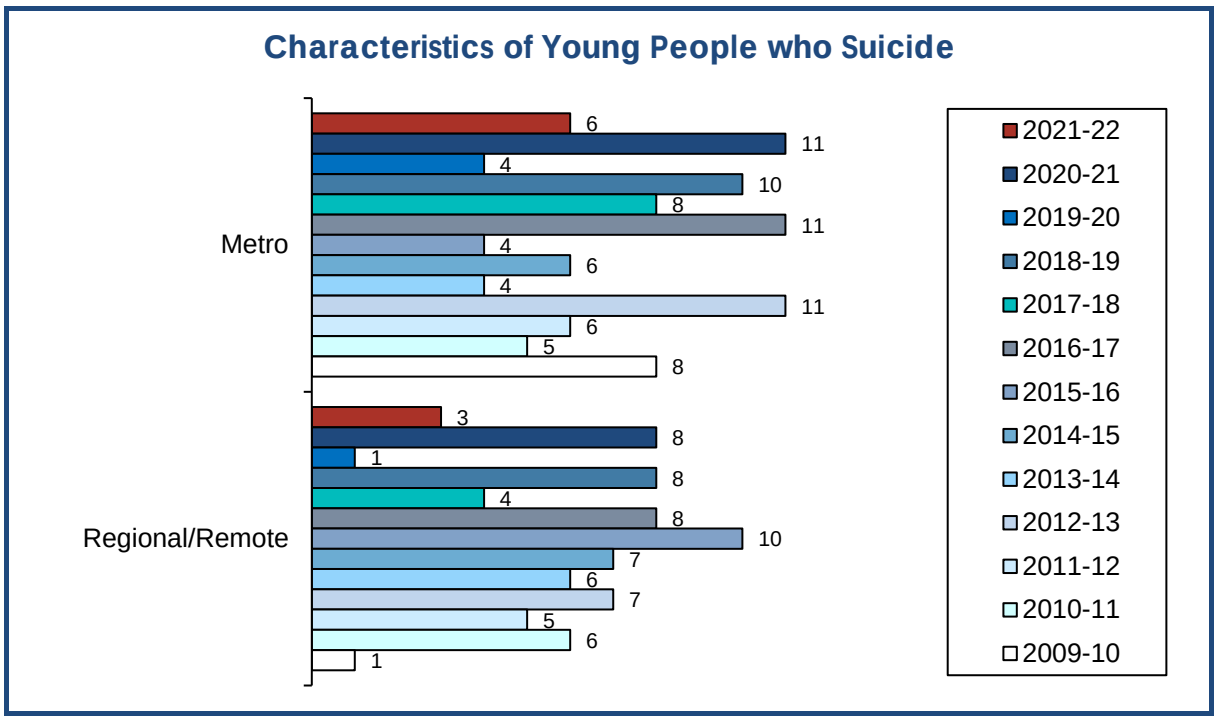
Suicide by young people

Of the 168 young people who apparently took their own lives from 30 June 2009 to 30 June 2022:

- Ten were under 13 years old;
- Nine were 13 years old;
- Eighteen were 14 years old;
- Thirty seven were 15 years old;
- Forty three were 16 years old; and
- Fifty one 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:

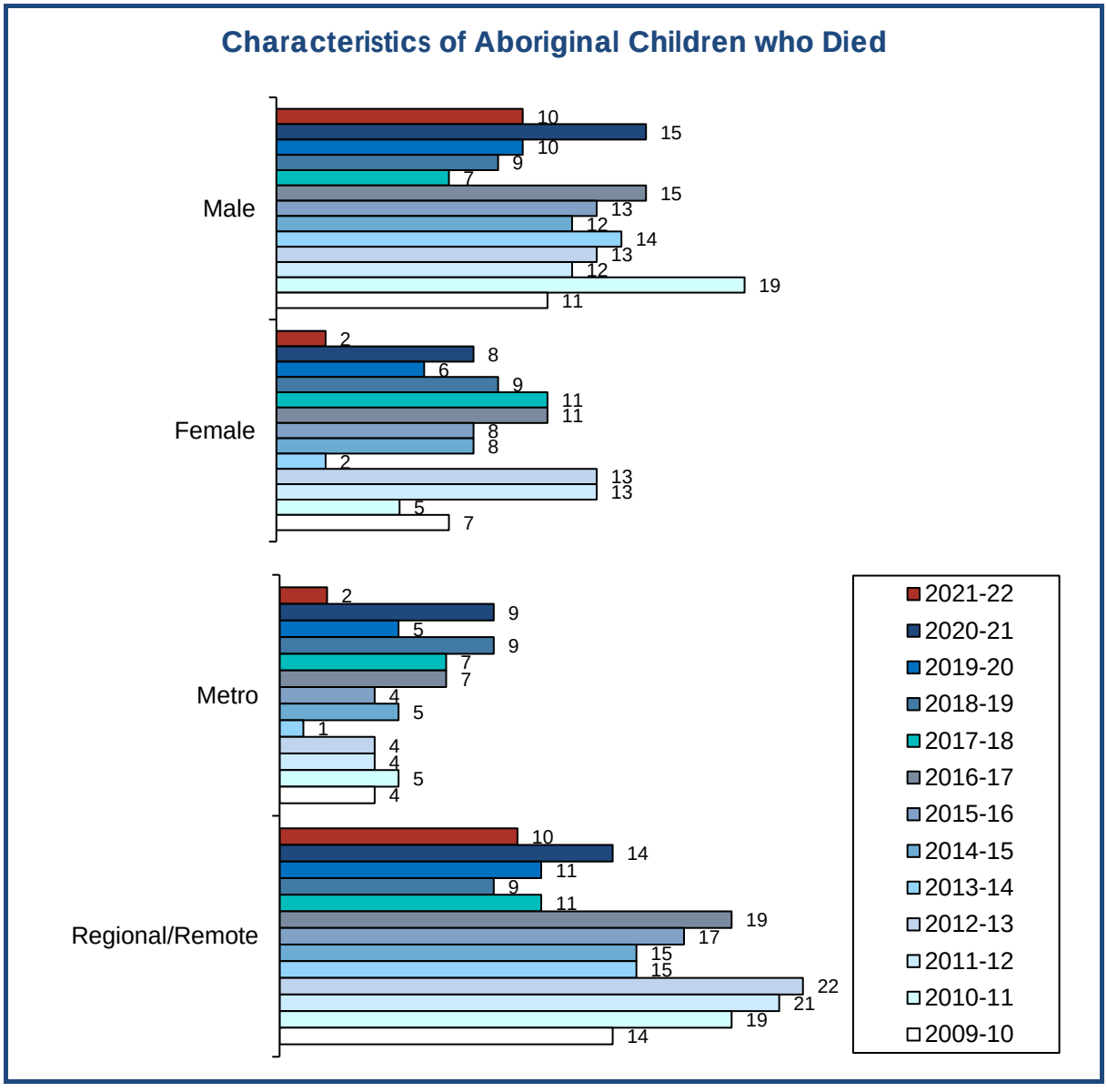
- Males – 54% of investigable deaths and 69% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 111 apparent suicides by young people where information on the Aboriginal status of the young person was available, 62% of the investigable deaths and 15% 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 55% 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 26% in the child population.

Deaths of Aboriginal children

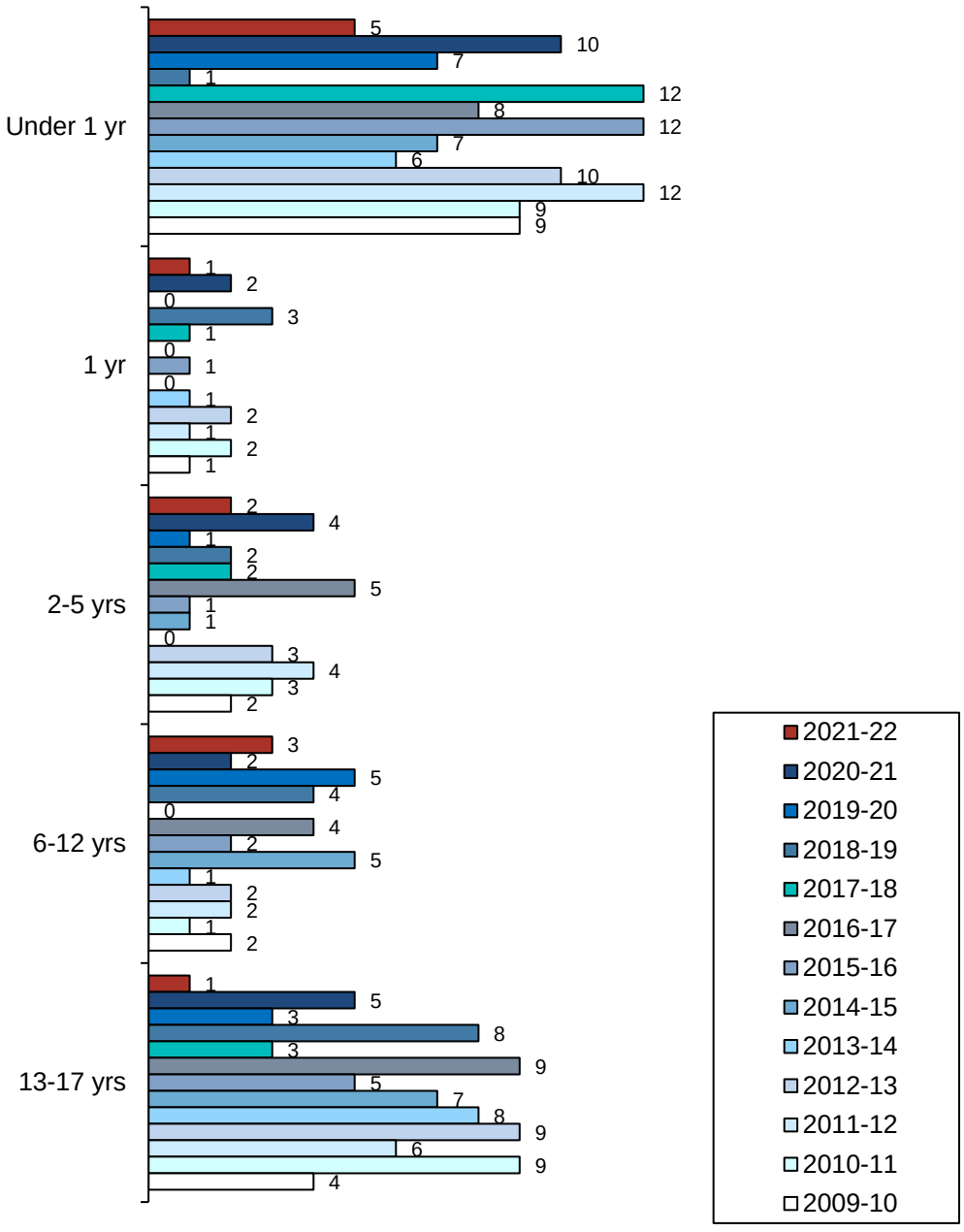
Of the 682 child death notifications received from 30 June 2009 to 30 June 2022, where the Aboriginal status of the child, or their parent/s, was recorded by agencies they had contact with in documentation provided to this Office, 263 (39%) of the children were identified as Aboriginal.

For the notifications received, the following chart demonstrates:

- Over the 13 year period from 30 June 2009 to 30 June 2022, the majority of Aboriginal children who died were male (61%). For 2021-22, 83% 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 13 year period, 75% of Aboriginal children who died lived in regional or remote communities.

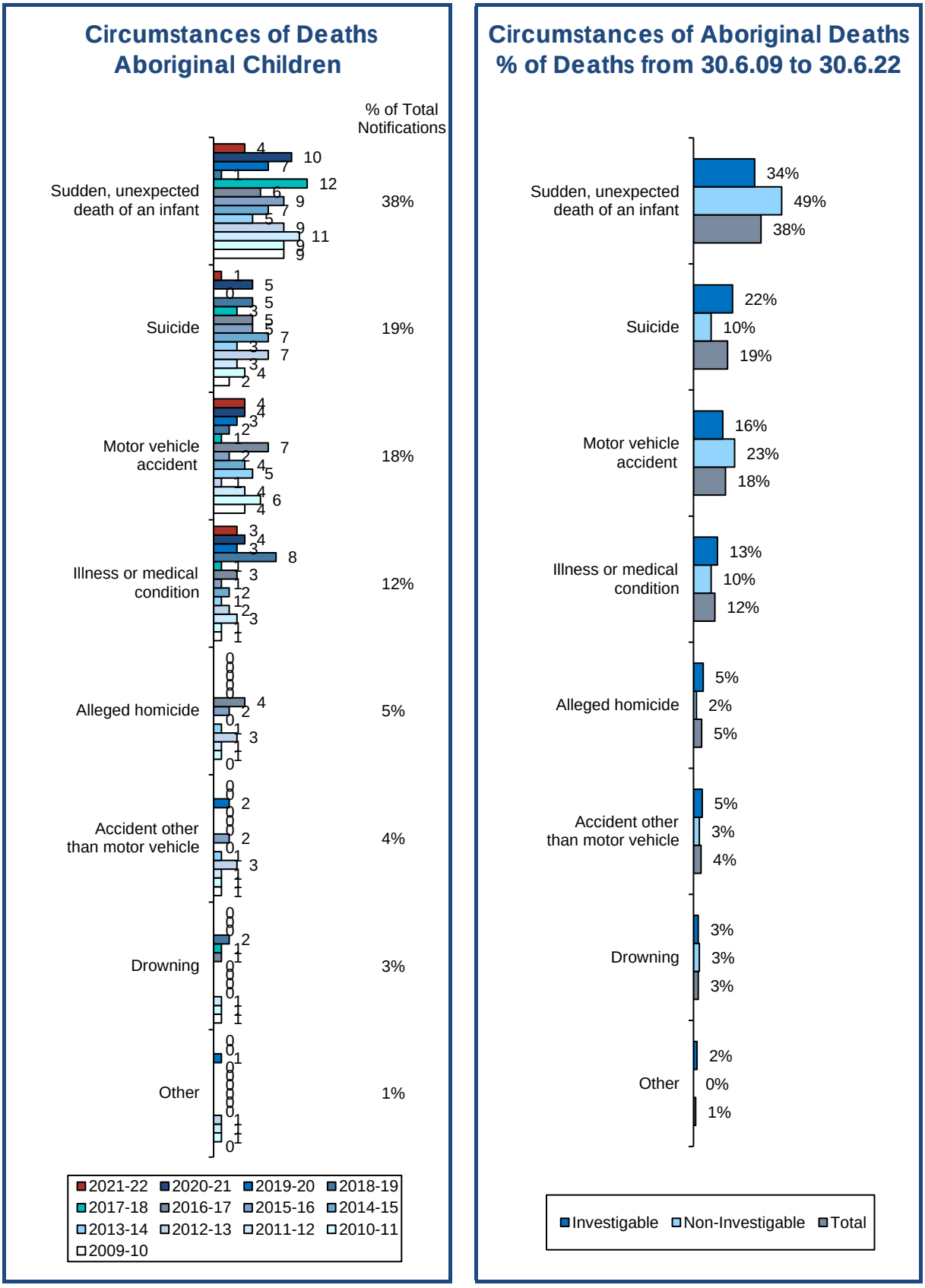


Characteristics of Aboriginal Children who Died



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 (19%), and motor vehicle accidents (18%) are the largest circumstance of death categories for the 263 Aboriginal child death notifications received in the 13 years from 30 June 2009 to 30 June 2022.



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 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 Department of Health 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, having been unwell in the weeks prior to death. At the time of death, Baby A's family were an open case to Communities Intensive Family Support (**IFS**), to address concerns for the harm and neglect of the children in the context of alleged parental drug and alcohol use and the children's reported exposure to family and domestic violence. This Office identified that limited IFS action had been undertaken in the months prior to Baby A's death, and further examined governance processes for ensuring the appropriate provision of IFS. The Ombudsman made the following recommendation:

> That Communities considers strengthening the governance framework for the implementation of IFS, including the delivery of contracted services, and provides a report to this Office by 31 December 2021.

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.

The *Royal Life Saving National Drowning Report 2021* noted that for 1 July 2020 to 30 June 2021, nationally '[drowning] deaths among children aged 0-4 years increased by 9% compared with the 10-year average and 108% compared with last year.'

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 Department of Health 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 Department of Health and 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 to by the relevant departments.

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

Deaths of primary school aged children from motor vehicle accidents

In 2021-22, the Ombudsman received three notifications of the deaths of children aged six to 12 years in the circumstances of motor vehicle accidents. Two of these three deaths occurred in regional or remote Western Australia. Considering all 13 years from 30 June 2009 to 30 June 2022, 67% of notifications of the deaths of children aged six to 12 in the circumstances of motor vehicle accidents 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 44% 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, Monitoring and 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 intra-agency and inter-agency communication to enable effective case management and collaborative responses to promote child safety and wellbeing.
- Not appropriate culturally responsive practice.
- Not adequately assessing the need for an interpreter.
- 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 Child Safety Investigations 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 family and domestic violence.
- Not adequately meeting policies and procedures relating to the assessment of parental drug and alcohol use.
- Not taking adequate action to promote safety and educational needs, and to reduce substance use and offending behaviour for young people on community based orders.
- Missed opportunity to identify 'at risk' youth and facilitate interagency communication and collaboration to promote Safety.
- Not providing clear guidance for the education Participation Teams on the minimum practice standards and culturally responsive practice.
- Not sufficient data collation or governance to evaluate the efficiency and effectiveness of education Participation Teams.
- Not taking sufficient action to engage students in approved education, training or employment options.
- Missed opportunity to develop a student plan to promote attendance and wellbeing.
- 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 2021-22 arising from child death reviews (certain recommendations may be de-identified to ensure confidentiality).

1. That Communities considers strengthening the governance framework for the implementation of IFS, including the delivery of contracted services, and provides a report to this Office by 31 December 2021.
2. DOE considers if action is required to strengthen the operation and effectiveness of Participation Teams including with respect to the collection of data, minimum practice standards, governance strategies and evaluation processes (including evaluating unsuccessful referrals), and provides the Ombudsman with a report, within four months of the finalisation of this review, that outlines the results of the DOE's consideration.
3. Communities provides the Ombudsman with a report by 30 June 2022 setting out:
   a. Communities' minimum practice standard for the provision and documentation of culturally responsive practice when conducting a Child Safety Investigation (**CSI**) with Aboriginal families;
   b. a governance process to ensure CSIs are not approved if they do not meet this standard; and
   c. how the Department will monitor and evaluate the implementation and effectiveness of this minimum practice standard.
4. In implementing Draft recommendation 3, Communities includes information on the minimum practice standard for assessing the need for, and facilitating the use of, accredited interpreters when conducting a CSI with Aboriginal families.
5. Due to issues in the recruitment and retention of suitable experienced staff to the Regional District, Communities will explore immediate options to support the district to meet demand and work more intensively with Intensive Family Support cases, including undertaking regular case reviews.
6. In 2022, Communities will review IFS practice guidance to ensure that IFS case practice requirements include mechanisms to review cases, including the circumstances of individual children within family groups, and involve external stakeholders in ways which are achievable for districts.
7. Communities will undertake a desktop audit of all IFS cases open to the Regional District on 1 April 2022, identify cases where activities to consult internal and external stakeholders have not been sufficient, and take action to ensure that these cases are subject to a review and/or Multidisciplinary Case Consultation (**MCC**).
8. Communities will provide a report to the Ombudsman within six months of the finalisation of this review, which:
   a. details actions taken to review IFS practice guidance;
   b. details actions taken to address barriers to provision of IFS by the Regional District in accordance with Communities' legislative and practice requirements in all the circumstances;
   c. identifies all cases open to IFS in the Regional District as of 1 April 2022;
   d. indicates the dates that MCC/case reviews occurred; and
   e. provides a copy of the most recent MCC/case review.

Steps taken to give effect to the recommendations arising from child death reviews in 2019-20

The Ombudsman made 14 recommendations about ways to prevent or reduce child deaths in 2019-20. 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 considers the findings of this review (including, when appropriate in Communities' view to provide a holistic approach and plan, the outcome of any other relevant reviews of the deaths of children in the care of the CEO by the Ombudsman or other oversight agencies) and provides the Ombudsman, within six months of the finalisation of this review, with Communities' plan to enhance compliance with Communities' legislative responsibilities to children in the CEO's care, as administered through Communities' practice requirements associated with:

- **assessment and management of family and/or significant other carers;**
- **care planning (including cultural care planning);**
- **reunification planning; and**
- **responding to concerns for the safety and wellbeing of children in the CEO's care.**

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 13 February 2020, in which Communities relevantly informed this Office that:

> Since the death of [Child A], Communities has commenced a range of initiatives to improve practice and enhance compliance with legislative responsibilities to children in the CEO's care…
>
> The Agency Capability Program has commenced as a response to a recent internal Agency Capability Review conducted by Communities' Strategy and Transformation division. This will include a range of improvements to practice, systems and process including establishment of an expert child protection unit and panel to advise the Director General on stewardship of the child protection system in Western Australia…
>
> In 2019, the Central Review Team (CRT) initiated a project to assess outstanding risk arising from oversight agency review processes and the recurrent issues they have identified. The first deliverable in this project was the *Review of child deaths: Findings for practice and policy* identifying practice issues and common barriers to child safety…
>
> Relevant to recommendation one, the Review of child deaths identified care planning compliance as a sub-theme under the heading 'supporting and monitoring quality practice'. The review also noted intersections with other practice findings and recommendations relating to care planning, including cultural care planning arising from the investigation *Planning for Children in Care: An Ombudsman Own Motion Investigation into the Administration of the Care Planning Provisions of the Children and Community Services Act2004* (2011).

Over the next 12 months Communities' plan to enhance compliance with legislative responsibilities to children in the CEO's care will focus on consolidating and strengthening monitoring and evaluation structures, including supporting the development of these where this is required.

The letter dated 13 February 2020 included, at Attachment 1, a summary of the 'specific projects and reforms' being undertaken at that time, which Communities identified as relevant to the implementation of Recommendation 1.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 25 March 2022, containing a report prepared by Communities.

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

This recommendation has been actioned

The Communities report to the Ombudsman Western Australia (OWA) 13 February 2020 set out a range of initiatives to improve practice and enhance compliance with legislative responsibilities to children in the care of the CEO.

Since 2020 further progress has been made across those initiatives as detailed below.

The Specialist Child Protection Unit

The Specialist Child Protection Unit (SCPU) was established in October 2020 to elevate the profile of child protection and provide leadership on child protection matters, both within Communities and across the sector. The establishment of the SCPU provides an opportunity to steward the sector to adopt best practice, embrace culturally appropriate services and embed sector-wide continuous improvement, improving outcomes for children, young people and their families.

Children and Community Services Amendment Act 2021

The Children and Community Services Amendment Bill 2021 was passed by the WA Parliament on 14 October 2021 and received Royal Assent on 19 October 2021 to become the *Children and* Community *Services Amendment Act 2021* (**the Amendment Act**).

Upon commencement, the Amendment Act will implement recommendations of the final report of the Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission), to expand mandatory reporter groups, and the 2017 Statutory Review of the *Children and Community Services Act 2004* (Statutory Review).

The new provisions will commence from 1 May 2022, with the exception of the mandatory reporting and Aboriginal representative organisations amendments. The WA Government has committed to implement an Aboriginal Representative Organisations Pilot in a Metropolitan district and a Regional district for a period of 12-months, commencing mid-2022. The changes will strengthen the *Children and Community Services Act 2004* (the Act) to better protect WA's children from harm as a result of abuse and neglect. They are also intended to drive improved outcomes for children who are in the care of Communities' CEO, with a particular focus on strengthening connection to family, culture and Country for Aboriginal children in care. Amendments intended to strengthen this connection include:

- principles to preserve and enhance connection with the culture and traditions of a child's family or community and the use of interpreters;
- changes to the Aboriginal and Torres Strait Islander (ATSI) child placement principle to prioritise proximity to community;
- strengthening principles of self-determination and community participation;

- increased consultation and participation of Aboriginal people in decision-making processes;
- cultural support planning requirements; and
- increased Aboriginal representation on the Care Plan Review Panel.

Cultural Care Planning

The Amendment Act introduces new requirements for cultural support planning for Aboriginal children, Torres Strait Islander children and children of a culturally or linguistically diverse background. Cultural Support Planning implementation is being led by the SCPU with input from Aboriginal Practice Leaders (APL). Communities has developed updated case practice guidance and related resources including a template and prompt list to support compliance with cultural support plan requirements.

An updated Casework Practice Manual (CPM) entry 3.4.3 Cultural Support Planning was published on 17 February 2022 to give guidance to the commencement of Cultural Support Planning practice. An amended version has been approved for publication on 1 May 2022 to reflect the mandatory status of Cultural Support Planning.

Communities' electronic case management data-base ASSIST has been updated to prevent a care plan and cultural support plan for an Aboriginal child from being finalised without electronic APL endorsement.

Written Proposals

From 1 May 2022, new provisions under section 143A of the Act (Content of Proposal) will require section 143 Written Proposals to the Court for children in the CEO's care to include:

- arrangements for promoting, where appropriate, the child's relationships with family or significant others;
- for time-limited applications, arrangements for working towards reunification with parents, or explanation of why reunification may be contrary to the child's best interests;
- for Aboriginal or CALD children, an outline of arrangements for placement in accordance with the Aboriginal child placement principle or CALD placement guidelines, and a cultural support plan; and
- for an Aboriginal child, that consultation requirements have been met.

To support compliance with the new requirements a new Written Proposal template and practice guidance '*Written Report to Court'* is in development and will be available for staff by 1 May 2022.

Additional updated policy and practice guidance

Communities' Service Delivery and Operational Improvement are reviewing and updating additional CPM entries to support compliance with legislative responsibilities. This includes:

- A new introductory chapter to highlight legislative responsibilities (published 23 December 2021); and
- a plan to update entries for Care Planning, Quarterly Care Reports, Care Plan Review Planning.

Rapid Response

The new provisions under section 22 of the Act (cooperation and assistance) – intended to strengthen the Rapid Response commitment – will require prescribed public authorities to prioritise requests for assistance to children in the care of the CEO of Communities, children under a protection order (special guardianship) (SGOs) and care leavers who qualify for assistance under section 96 of the Act, provided the

requests are consistent with, and do not compromise, the performance of the agencies' functions.

Agencies to be prescribed are:

- the Departments of Education, Justice (Corrective Services), Training and Workforce Development, and Local Government, Sport and Cultural Industries;
- Mental Health Commission; and
- WA Health (to be prescribed at a later date).

Communities continues to work with all government agencies who are signatories to the 2009 Rapid Response framework to better respond to the needs of children in care and care leavers.

To support implementation a new Casework Practice Manual entry has been developed to provide guidance to child protection workers. This entry and other related resources will be available for use by 1 May 2022. The related resources include a process map and template letters.

Urgent Placements

Recommendation 6 of the Statutory Review was that the Act expressly provide the CEO to make a time-limited emergency placement in accordance with regulations and that regulations should prescribe the timeframes within which the necessary safety checks, carer approvals and consultation requirements are to be completed.

To implement Recommendation 6, the Amendment Act provides a new regulation-making power in section 79(2)(a)(iv). This will enable regulations to be made to create a new type of interim placement arrangement under s.79.

Interim placements are necessary when no other placement options are immediately available for a child with approved carers and they most often occur when a child is placed with a family member or other person significant to the child who is not already approved as a carer.

Interim placement options with family are central to adherence to the ATSI Child Placement Principle. Since 2018, extensive consultations have occurred with Regional Executive Directors, metropolitan and regional District Directors, Assistant District Directors, Aboriginal Practice Leaders, Service Delivery, and the Child Carer and Connection Hub, to inform the ongoing discussions regarding the timeframes to be prescribed for interim placements.

Communities' Community Services Division is finalising the development of a policy and associated practice guidance and it has been recommended that the Regulations prescribe a timeframe of six months. Compliance will be supported by the introduction of practice guidance on how to facilitate the incremental assessment of carer competence and making the best use of opportunities presented by existing care planning and review activities, rather than seeing it as a separate task.

Training for existing staff

Communities SCPU is delivering webinar practice clinics to current staff to support implementation of the amendments across Communities. Across January and February 2022, SCPU led 7 practice clinics providing an overview of the amendments and planned training approach. Clinics were targeted towards district and regional leadership, specialist staff including Senior Practice Development Officers, APLs and Legal staff.

SCPU will be delivering the following online practice clinics available to all staff:

- Amendments to improve outcomes for Aboriginal children and families including cultural support planning, to occur 1 March, 17 March, 14 April, 3 May, 26 May, and 23 June 2022;

- Written Proposals, to occur 15 March, 31 March, 21 April, 31 May, 7 July, 21 July 2022;
- Special Guardianship Orders to occur 8 March, 7 April, 19 April, 17 May, 28 June 2022;
- Urgent Placements, Rapid Response and Leaving Care 10 March, 22 March, 5 April, 28 April, 9 June, 12 July 2022; and
- Overview of legislative amendments 11 March, 14 April, 12 May, 14 June 2022.

Additional targeted training on the legislative amendments and cultural support planning was provided to APLs from around the state at the APL workshop held 2 February 2022 with additional workshops scheduled for APLs on 5 May, 3 August and 3 November 2022; and combined APLs and SPDO workshops on 4 May and 4 November 2022. These workshops will provide an opportunity for feedback to be obtained on the implementation of cultural support planning in districts.

APLs will be provided with existing training resource packages to conduct district training sessions on cultural support planning. These will be scheduled to occur as determined by district APLs depending on district training and learning requirements.

…

Training for new child protection workers

Communities' mandatory *Child Protection Foundation Pathway* covers the following relevant content:

- Orientation Program 1
  - ATSI placement principle
  - Updating and implementation of the Legislative amendments
- Orientation Program 2
  - Child Safety Investigations (CSI's)
  - Updating and implementation of the Legislative amendments
- Orientation Program 3
  - Cultural support planning
  - Updating and implementation of the Legislative amendments
- Orientation Program 4
  - Care planning (including cultural care planning)
  - Reunification planning
  - Updating and implementation of the Legislative amendments-
  - highlighting section 22 and Rapid Response – Shared responsibility
  - across government agencies, with the ARO changes coming in over
  - time
  - Cultural support planning
  - ATSI placement principle
  - Stability and Connection Planning
  - Reunification planning
  - Leaving care planning

Communities' Child Protection Worker Learning Pathway - Orientation Program 4 – Legislative Amendments for Aboriginal Children in Care (Including Cultural Support Planning) was updated in July 2021 to reflect the impending amendments. This training is scheduled to occur on 15 March, 10 May, 19 July, 11 October, and 22 November 2022.

All remaining legislative amendments have been added to the mandatory Orientation Programs. These programs are in the final stages of endorsement and will be operational for 1 May 2022.

In 2022/2023, Communities' Learning & Development will be working with the SCPU and Service Design and Operational Improvement to review and update the Child Protection Foundation Pathway programs to incorporate practice changes using the 'ADDIE' model for instructional systems design, evaluation and review, coupled with current continuous improvement processes. These will be conducted in 2022/2023.

Aboriginal Cultural Capability Reform Program

On 28 September 2021, Communities Leadership Team (CLT) approved the Aboriginal Cultural Capability Reform Program (ACCRP) *Project Management Plan*. This program was forecasted in Communities report dated 13 February 2020 and is led by the Aboriginal Outcomes Division working in partnership with all divisions. The program aims to embed culturally responsive systems, policies and practices through the Department's governance, roles, functions and operations, create and support culturally safe environments for Aboriginal staff and people accessing Communities' services and work towards improving opportunities and outcomes for Aboriginal people in Western Australia (WA).

Stability and Connection Planning Policy and Practice Updates

Communities' CPM entry *3.4.15 Stability and Connection Planning* was published on 18 May 2020 to include the new *Stability and Connection Planning Policy* that replaces the former *Permanency Planning Policy*. The *Stability and Connection Planning Policy*:

- Maintains existing decision-making timeframes with flexibility to extend these timeframes with appropriate approval if this is in a child's best interests.
- Emphasises reunification as the primary goal within a parallel planning process that includes consideration of culturally appropriate, stable long-term out of home care options in circumstances where it is not possible for children to return safely to parents.
- Strengthens the relationship between stability and connection planning and care planning, including the critical importance of effective cultural support planning.
- Focuses on stability and connection for Aboriginal and Torres Strait Islander children and young people through implementation of all five elements of the ATSI child placement principle which intends to enhance and preserve connection to family and culture for Aboriginal children in care.
- The child, parent/s and extended family (maternal and paternal) are recognised as the most valuable resources for effective cultural support planning, and are integral to its success. Wherever possible, the child's family members should lead cultural support planning processes.
- Integrates other related aspects of policy and practice, including the Family Finding model, cultural support planning, adherence to the ATSI child placement principle and the Care Team Practice Approach.
- Aligns and supports other changes Communities is making to achieve Closing the Gap targets and improving outcomes for Aboriginal children and families.

To aid compliance with, and complement, practice and policy guidance contained in the CPM, Communities has published numerous related resources available via the CPM including:

- Stability and Connection Planning Form (template form)
- Stage 1- 4 Guidance Instructions
- Assist User Guides – Stability and Connection Planning
- Stability and Connection Planning Factsheet.

The SCPU delivered information sessions and/or training sessions for internal and external stakeholders in the revised *Stability and Connection Planning* practice guidance and resources between February and August 2020…

Family Care Assessment Workshop

The Family Care Assessment Workshop is a two-day training targeted to staff undertaking family/significant other carer assessments and those endorsing assessments (Team Leaders and Aboriginal Practice Leaders). Content includes: understanding competencies defined in the regulations and policy; family care and urgent placement policy; identification of concerns; cultural awareness, experiential training activities to facilitate engagement; addressing concerns through Carer Support Plans and Quality Assurance (QA) for those endorsing and approving assessments.

…Delivery of this workshop recommenced in 2021 with most districts receiving training between March and June 2021... The Family Care Assessment Workshop will continue to run four times per year at the Learning and Development Centre and an online platform option is in development. The QA supervision tool remains available on the CPM for approving officers.

Foster Care Reviews

In line with Royal Commission Recommendation 12.7, Communities updated CPM entry 3.1.8 *Foster Care Review Process* to include the requirement to speak with a child in care in the absence of their carer (published 15 December 2021*).*

…

Aboriginal Family Led Decision Making (AFLDM)

Communities is working with Aboriginal stakeholders to progress a pilot of AFLDM. AFLDM aims to address the over-representation of Aboriginal children in out of home care and child protection systems. It supports the right to self-determination of Aboriginal people and creates a forum where family members have input into decisions for children in cases where harm has been substantiated or the child is subject to a protection order or in pre-birth planning.

The pilot partners with Aboriginal people and Aboriginal Community Controlled Organisations (ACCO) to deliver the initiative. In doing so it will contribute towards the long-term benefits of the ACCO Strategy and strengthening the Aboriginal sector in WA.

The pilot commenced in October 2021 and aims to enable Aboriginal families to lead decision making about the safety and wellbeing of their children. It will also inform consideration of whether AFLDM should be enacted in legislation, which will be considered in the next statutory review of the Act. Two pilot sites have been chosen- Midwest Gascoyne (Geraldton Streetwork Aboriginal Corporation) and Mirrabooka (Wungening Aboriginal Corporation). Aboriginal Convenors were trained by an Aboriginal trainer, from Spirit Dreaming Education and Training Solutions and Australian Family Group Conferencing.

IPS Management Consultants, a certified majority Indigenous owned company, has been contracted to undertake the evaluation.

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

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

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 25 March 2022, containing a report prepared by Communities.

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

> **This recommendation has been actioned and is under consideration.**
>
> Through the Learning and Development Centre, Communities offers quarterly in-person one day general first aid training for General Foster Carers and Family and Significant Other Carers in Perth. This training can be attended by Community Sector Organisation Foster Carers and Regional Carers. Upcoming training sessions are currently scheduled to occur on 19 May and 17 June 2022.

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

Recommendation 3: DOE confirms to the Ombudsman at the completion of Semester 1, 2020 that, for all students identified as at 'severe attendance risk' at the completion of the 2019 school year who are enrolled at Regional District High School for the 2020 school year, they have either:

- **A 'documented plan' in accordance with DOE's *Student Attendance in Public Schools Policy and Procedures (2015)* and aligned with Recommendations 15 and 16 of the Ombudsman's major own motion investigation report *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (2014); or**
- **An interagency plan developed through, and case managed by, the Regional District Youth at Risk Network; or**
- **Have an improved school attendance rate and no longer meet the criteria for requiring a 'documented plan' as outlined in DOE's *Student Attendance in Public Schools Policy and Procedures (2015).***

Steps taken to give effect to the recommendation

DOE provided this Office with a letter received 30 July 2020, in which DOE relevantly informed this Office that:

> **Response: Achieved**
>
> The ability to be able to deliver on this was constrained through COVID-19. This work has been prioritised and achieved.

This Office requested that DOE inform the Office of any further information on the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 1 April 2022, containing a report prepared by DOE.

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

The Department of Education's revised *Student Attendance in Public Schools* policy and procedures, implemented on 19 July 2021, emphasise the importance of:

- developing a positive attendance culture and providing engaging environments to support student learning;
- promoting the importance of student attendance, and building shared responsibility for attendance with children, families and the broader community;
- engaging in community-initiated approaches to enhance student attendance;
- strengthening local initiatives and solutions using place-based approaches;
- a culturally responsive approach to student attendance through explicit links to the Aboriginal Cultural Standards Framework;
- early intervention and support to restore attendance; and
- the layers of support for student attendance, including the use of Education Regional Offices and relevant cross-agency or community groups such as District Leadership Groups.

The *Student Attendance in Public Schools* policy and procedures are supported by a refreshed Student Attendance Toolkit, implemented December 2021, which includes additional and updated resources. The toolkit includes professional learning modules that support schools to develop student attendance approaches tailored to the school context.

Every day matters: 10-point plan to improve attendance supports the implementation of the *Student Attendance in Public Schools* policy and procedures through:

- community-led action;
- support for schools, families and communities; and
- system action and accountability.

The implementation of the plan is a phased approach.

The 10-point plan sets expectations of how schools are to work and engage with broader communities and agencies to increase the attendance of students, in particular those with challenging and complex needs.

Under the plan, local action groups co-design attendance strategies that meet the unique needs and aspirations of their community. Schools are supported with:

- a co-design guide;
- development of a co-design resource hub with practical supporting resources to build understanding of the guide along with tools to support co-design processes is ongoing; and
- evaluation tools for the co-design process and outcomes have been developed, which will be tested in 2022 and refined.

Schools will be held accountable for student attendance and cultural responsiveness through the *Statement of Expectation and Public School Review* process. The Statement outlines the expectations for each school in relation to its planning and self-assessment. It requires school principals to develop a school plan containing attendance targets along with priorities and strategies to achieve them. School principals are required to sign the Statement of Expectation which is noted by the school council/board and then progressed for the Director General's signature.

At Regional District High School, students who were enrolled during 2020 and were at severe attendance risk and remain at severe attendance risk in 2022, continue to remain on the Documented Plan, with regular contact with the student and their families by the school to determine and address barriers to schooling, and encourage increased school attendance.

DOE further informed this Office, by letter dated 4 July 2022, that a 'review of attendance planning' at the Regional District High School in June 2022 had 'revealed that further work is required to ensure all at risk students are on attendance plans. Attendance remains a priority of the school going forward'.

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

Recommendation 4: DOE provides the Ombudsman with a report at the completion of Semester 1, 2020 that outlines:

- **The revised approaches aimed at improving attendance at Regional District High School in 2020 and indicates how they have engaged with and embedded the 'five cultural standards' outlined in DOE's *Aboriginal Cultural Standards Framework (2015)*;**
- **In the context of Regional District High School's engagement with the 'five cultural standards' outlined in DOE's *Aboriginal Cultural Standards Framework (2015),* where the school places itself on the 'continuum'; and**
- **How DOE reviews (including but not limited to the Public School Review process) the effectiveness of these revised approaches aimed at improving attendance, to ensure that Regional District High School is on the pathway to becoming 'culturally responsive' ('proficient') on the 'continuum' of the 'five cultural standards' outlined in DOE's *Aboriginal Cultural Standards Framework (2015).***

Steps taken to give effect to the recommendation

DOE provided this Office with a letter received 30 July 2020, in which DOE relevantly informed this Office that:

> **Response: Progressing**
>
> The staff understand the importance of creating an inclusive, welcoming environment for Aboriginal students, however the *Aboriginal Cultural Standards Framework* is yet to be embedded through the delivery of curriculum and specified in classroom planning and practices.
>
> An internal self-reflection of progress against the *Aboriginal Cultural Standards Framework (2015) continuum* was determined as being at the 'Developing' phase.

This Office requested that DOE inform the Office of any further information on the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 1 April 2022, containing a report prepared by DOE.

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

> The Department's updated *Code of Conduct and Standards,* published 26 November 2021, includes *Standard 2: Create cultural safety,* which addresses the expectation that Department staff create and maintain safe and responsive work and learning environments.

The scheduled Term 4, 2020, Public School Review for Regional District High School was deferred due to the Statewide deferral of Public School Reviews as a result of COVID-19 restrictions. The review is currently scheduled for Term 2, 2022, pending the prevalence/impact of COVID-19 in the Region at that time.

The Director of Education has continued to visit the Regional District High School principal and leadership team at least twice per Term to support the work of the leadership team in engaging with the Community.

The school has continued to reflect and rate itself against the *Aboriginal Cultural Standards Framework* continuum and would still, overall, be rated as "Developing."

Commencing Term 1 2022, the school has employed an Elder in Residence/Cultural Consultant, a local Aboriginal woman, to provide a link between the school and community and educate students and non-Aboriginal staff about important cultural protocols. Learning on Country involving local Aboriginal Elders and families occur in every phase of schooling.

During 2021 and early 2022, the Regional Education Office employed an Extended Services Coordinator to support Regional District High School in building on positive community relations and provide feedback to the school on its effectiveness of programs and aspirations of their children. The region provided a laptop computer and mobile phone to support this work. The Director of Education has maintained regular contact with the Extended Services Coordinator.

The Director of Education in the Region has planned a strategic approach to inducting and preparing new staff to living and working in the Region. The Region Induction Program includes a three-stage induction:

- Remote Teaching Service induction provided centrally;
- Targeted Region induction provided by the region; and
- School-based induction.

As part of this three-stage induction, Regional District High School has developed a Cultural Induction, delivered at the beginning of each year. The school has plans to improve induction of new staff further with:

- Aboriginal staff 'adopting' a new teacher to provide mentorship on cultural knowledge; and
- A school-specific induction video relating to the culture, history and geography of the Region.

The Extended Services Coordinator, with the assistance of an Aboriginal and Islander Education Officer (AIEO), carried out face-to-face chats, small group meetings across town camps and townsite between November to December 2021, to gather feedback from parents and carers on the delivery of education at Regional District High School. A community survey/feedback form was completed with each of the participants during these meetings. The survey results were overwhelmingly positive:

- 100% of parent responses indicated they feel that their child/children get a good education;
- 82% of parent responses indicated they feel welcome when they enter the school grounds;
- 95% of respondents said it was most important that their child/children graduate with good literacy and numeracy abilities and 100% said it was most important they finish school with a driver's licence, first aid certificate, job ready portfolio, Medicare card and bank card; and
- Respondents indicated that Regional District High School communicates well with parents, engages with parents and students and hosts successful school events, including open night, breakfast club and reading breakfast.

These findings were shared with the Regional District High School Community in a

newsletter in February 2022.

The Regional Education Office facilitated a School Leadership conference in 2021 with the theme Leading Culturally Responsive Schools within a Unified Public School System. Sessions received by attending school principals included:

- What do culturally responsive schools look like and feel like?
- Building and maintaining community partnerships.
- Region best practice.
- Working with our Communities.

The Department continues to provide professional learning, advice and guidance to public schools in Western Australia to:

- Embed whole-school culturally responsive practices and approaches in their context;
- Strengthen their whole-school planning using the Aboriginal Cultural Standards Framework; and
- Develop and use knowledge of Aboriginal histories, cultures, languages, experiences and family relationships to positively impact student wellbeing and achievement.

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

Recommendation 5: Communities provides the Ombudsman with a report by 31 July 2020 evaluating the effectiveness of the new Regional *'Children and Young People At Risk Meetings'* framework, including commentary relating to each of the six points detailed in the 'Purpose' section of the *Terms of Reference – Regional District Children and Young People At Risk Meetings (September 2019)*

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 31 July 2020, which relevantly informed this Office that:

> Communities' response to COVID-19, including the disruption to the schedule of the *Children and Young People at Risk Meetings* (the Meetings), has contributed to the delay in commencing the evaluation. However…Communities has made progress in development of the final Scope of the *Review of the Region Children and Young People at Risk Meetings* (the Review).

A copy of the Review scoping paper was provided to this Office.

Communities further provided this Office with a copy of the *Review of the Regional Children and Young People at Risk Meetings: Project Plan*, on 10 February 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 a letter to this Office dated 25 March 2022, containing a report prepared by Communities.

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

> **This recommendation has been actioned.**
>
> Communities committed to reviewing the *Regional Children and Young People at Risk Meetings*.
>
> There was a delay to project commencement due to the COVID-19 State of Emergency declared on 15 March 2020, as the Regional District Leadership Groups

(DLGs) decided to suspend all Regional Children and Young People at Risk Meetings for several months.

Communities provided the Ombudsman's office with the *Review of the Regional Children and Young People at Risk Meetings: Scoping Paper* in August 2020 and a detailed project plan in January 2021. These documents outlined the intention to split the Review into two parts in order to evaluate:

- the efficacy of the meeting process – Part One;
- the extent to which expectations are met – Part One; and
- whether outcomes are improved for children, young people and their families – Part Two.

The *Review of the Regional Children and Young People at Risk Meetings: Report Part One*, which assessed meeting processes and referrals, was completed, and provided to the Ombudsman's office in August 2021.

Part One made interim findings in the areas of:

- cultural security;
- family engagement;
- Region DLG engagement;
- management of suicide risk;
- meeting processes;
- processes around exited children and young people;
- processes around relocated children and young people;
- records management;
- referral processes; and
- shared case plans.

Part Two seeks to measure two outcomes:

- being referred to the Meetings reduces the risk experienced by at-risk children and young people; and
- interagency communication and collaboration prevents or reduces suicide in children and young people who experience multiple risk factors and have contact with multiple agencies.

It was originally anticipated Part Two would be completed by February 2022. However, due to workforce fluctuations, operational challenges and reduced stakeholder access over the December-January period, progress has been slower than expected. It is now anticipated that Part Two will be completed by July 2022.

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

Recommendation 6: That WACHS CAMHS considers, as part of the intake assessment process for a new client, that identification of the young person's circumstances and categorisation as being in Group 1-4, based on 'factors associated with suicide' outlined in the Ombudsman's *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (2014), to determine whether a timely referral to Regional District 'Children and Young People At Risk Meetings', is indicated.

Steps taken to give effect to the recommendation

WACHS provided this Office with a letter dated 11 February 2020, in which WACHS relevantly informed this Office that:

- Regional Mental Health and Drug Services (MHDS) has submitted a business case to the Mental Health Commission (MHC) to fund specific youth Mental Health Services with an aim to improve services and resources which are available for youth in remote towns and regions…
- Again highlighted in the case of [Youth B], is the need for a comprehensive electronic medical record system which will bring WACHS systems together to ensure a complete record is maintained for mental health patients across the entire region (and broader system), giving clinicians the ability to view and access medical records at both hospital sites and community clinics.
- Following the review of the Children at Risk (CAR) Project Meeting process in the Region; revised CAR meetings are being re-established at major and remote sites in the Region with community meetings serviced by the Region Aboriginal Medical Services (AMS) planned to commence in February 2020. The Region Population Health Unit (PHU), Clinical Nurse Specialist, has been requested to attend the CAR meetings as co-chair to ensure the format and new processes are consolidated.

WACHS further provided this Office with a letter dated 31 July 2020 in which WACHS relevantly informed this Office that:

- The Region Mental Health and Drug Service (MHDS) Child and Adolescent Mental Health Service (CAMHS) intake process is based primarily around clinical judgement, as is the decision to refer to the relevant 'children and young persons at risk' meeting.
- These processes typically consider all the factors outlined in the Ombudsman's Investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people (2014) that determine group categorisation 1-4. MHDS do not, however, use these categorisations in their decision making, and this categorisation is not mandated by WACHS. While the Chief Psychiatrist endorses a role for actuarial tools and the Department of Health has policies regarding risk assessment and management tools, it must be noted that actuarial risk assessment tools are of limited predictive value on their own. MHDS do use the Child Risk Assessment and Management Plan [CRAMP tool] to support clinical judgement.
- The rationale is that clinical judgement is better suited to the complexity of the decision-making process, based on the factors relevant to the young person and their family, including effective use of various services' resources, compared with prescribed decision-making processes. As noted, MHDS consistently consider referrals to the children and young persons at risk meetings in their intake process.

WACHS further informed this Office in the letter dated 31 July 2020 that:

> …WACHS is currently reviewing and updating the internal webPAS Child at Risk Alert procedure. This procedure describes the requirements of WACHS clinicians to activate Child at Risk Alert (CAR Alert) on webPAS. The CAR Alert is a critical means of sharing information with other clinicians who may have contact with the child. It supports the identification of risks and prevention of harm to children. WACHS has also commenced reporting the number of CAR Alerts weekly at an Executive Huddle enabling the WACHS Executive to have full oversight of the number of CAR Alerts within each region.

This Office requested further information of the steps taken to give effect to the recommendation. In response, WACHS provided a letter to this Office dated 25 March 2022 in which WACHS relevantly informed this Office that:

> Every clinician in WACHS is responsible for identifying, raising, reviewing and updating Child at Risk (CAR) Alerts for children who are considered to be at risk. As noted in my letter dated 31 July 2020, the WACHS webPAS Child at Risk Alert Procedure has been reviewed and formalises the requirement for WACHS clinicians

to activate a CAR Alert on the statewide patient administration system (webPAS) and outlines the actions required to protect the safety and wellbeing of children at risk. This includes the recommendation to communicate these concerns with the Department of Communities (DOC) to enable a multi-agency response to social and environmental factors.

WACHS Region is planning to conduct an audit in collaboration with DOC to confirm activating a CAR Alert in webPAS is resulting in appropriate communication and management of these children at risk. Due to current COVID-19 planning and response this audit will likely be progressed in late 2022.

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

Recommendation 7: WACHS, as a Service Delivery Partner to the Regional District Youth at Risk Network meetings, provides the Ombudsman with a report by 31 July 2020, summarising, from WACHS's perspective, whether the Regional District 'Children and Young People At Risk Meetings' model assists WACHS to ensure a multi-agency response to address 'social factors such as living conditions and environmental factors' for young people at risk of suicide.

Steps taken to give effect to the recommendation

WACHS provided a range of information in a letter to this Office dated 31 July 2020 in which WACHS relevantly informed this Office that:

- The revised Children at Risk (CAR) meetings commenced within the Region in November 2019 and continued until the peak of the COVID pandemic. The CAR meetings have only recently been re-implemented.
- The objectives of the CAR Terms of Reference (TOR) are being met. Department of Communities Child Protection and Family Support (DCPFS) ensure the TOR are followed carefully and are referred to during meetings. The TOR identify a clear pathway for referrals to CAR Meetings. A common email address for referrals has been developed and is being used. Meetings follow a formal process and agenda rather than the previous casual, conversational style. The new formal process provides health professionals with a forum to communicate concerns, and gives confidence that issues will be discussed, addressed and formally documented.
- The CAR is the consistent meeting at a number of sites within the Region and has markedly reduced duplication. It has enabled gaps in services to be identified, managed or reported. There has been consistent representation of Aboriginal staff members at the CAR Meetings, and they are key and valued participants.
- Parents of CAR are now informed of referrals and offered the support and partnership of service providers to assist the family.
- WACHS is co-chair of the CAR meetings with Department of Communities. The Young Person at Risk (YPAR) is co-chaired by WAPOL. A benefit of co-chairing is that it provides a shared responsibility to ensure there is representation and collaboration at the meetings.
- WACHS has seen benefits from the implementation of a consistent WACHS co-chair from January 2020, including ensuring health is present at the CAR meetings, which means a broader attendance from health staff pursuant to site specific cases. WACHS brings the child and family health expertise to the meetings and DCPFS have reported improvement in having a consistent co-chair from WACHS.
- Other benefits of the CAR meetings include improved coordinated service delivery, with referrals required to be submitted one week prior to the meeting. This enables

agencies to be informed and well versed on the case, resulting in meaningful discussion occurring in a timely manner with plans developed for the families. A lead agency is identified at each meeting for families, noting the lead agency often changes dependent on need of the case. Plans and actions are reviewed every four (4) weeks and agencies are updated on actions at the meeting. This has strengthened accountability.

- An improved knowledge of services offered throughout the Region has resulted in a great improvement to networking and communication between agencies and identification of the services available throughout the region.
- The Adverse Childhood Experiences (ACE) Score is mandatory to be completed for each child referred. This provides an opportunity for agencies to share knowledge surrounding the child, discussing 10 vulnerability factors including living conditions and environmental factors. Housing is discussed routinely for each family referred, and addressed pursuant to the information provided.
- A strengths-based approach is used, with a focus on positive factors and supports and what can be drawn on locally to improve outcomes for children. Agencies are encouraged to explore the family's concerns and consider the family's goals. There is observation of positive professional relationships being developed between services and a sense of collaboration to support children and their families.

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

Recommendation 8: DOE considers where, following the suicide of a student or community member postvention support follow-up is being implemented, actions to ensure students at 'attendance risk', are being afforded this support.

Steps taken to give effect to the recommendation

DOE provided a range of information in a letter to this Office dated 4 March 2020 in which DOE relevantly informed this Office that:

> The *School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self Injury* guide schools in responding to suicidal behaviour and Non-Suicidal Self Injury, including in the area of postvention. The Department understands postvention needs to be situation specific and matched to the presenting context, such as the ongoing needs of the school community. Identifying vulnerable groups and individuals, which may include students at 'attendance risk' is part of the postvention process.
>
> The Region District High School *Suicide Postvention Response Plan* incorporates an emergency response team whose members include the principal, associate principals (primary and secondary), school psychologist, chaplain and someone from the Shire youth service. The school's postvention strategies also include partnering with government agencies and non-government organisations to support students…
>
> The Region Aboriginal Community Incident Management Framework outlines the process which occurs after major incidents such as suicide. All relevant government agencies and non-government organisations take part in a teleconference to identify the people affected by the suicide, agree on the actions required to provide postvention support and outline who is responsible for taking the agreed actions.

DOE further informed this Office in a letter received 30 July 2020 that:

> **Response: Achieved**
>
> The school, with the support of the Department's central and regional services, is well positioned to provide a high standard of postvention support following the suicide of a student or community member.

This Office requested that DOE inform the Office of any further information on the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 1 April 2022, containing a report prepared by DOE.

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

> The 2020 update of the *School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-Injury* strengthened the section on school-based responses in postvention, including reference to considering the impact and needs of students not attending or disengaged from school.

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

Recommendation 9: DOE, as a Service Delivery Partner to the Regional District YARN meetings, provides the Ombudsman with a report by 31 July 2020, summarising, from DOE's perspective, whether the Regional District 'Children and Young People At Risk, Meetings' model assists Regional District High School to support and engage with students at 'attendance risk'.

Steps taken to give effect to the recommendation

DOE provided this Office with a letter received 30 July 2020, in which DOE relevantly informed this Office:

> Following extensive consultations considering the YARN meetings, YARN at Region has been discontinued. It has been replaced by the Region 'Children and Young People at Risk Meetings' tailored to respond to two cohorts:
>
> - Children at Risk (CAR) meetings (0-10 years)
> - Young People at Risk (YPAR) meetings (10-17 years)

The DOE letter received 30 July 2020 included a *Report outlining the rationale for change: Establishment of the Region Children and Young people at Risk Meetings*, which states that:

> It is too early to make judgements as to the effectiveness of CAR and YPAR as the forums are in the process of being implemented across a number of different and distinct places. For the Regional District High School, the staff are required to engage in the forums and make an earnest contribution, along with other partners, to address risk factors. This includes sharing relevant information, assisting in the development and delivery of strategies, acting as a case manager where best suited and considering the impact of planned interventions as part of future meetings. As with all CAR and YPAR across the Region, the forums at the Region will need to consider how to operationalise the intent of the Children and Young People Priority Working Group that school attendance is a key priority for the forums.

This Office requested that DOE inform the Office of any further information on the steps taken to give effect to the recommendation. In response, DOE provided a range of information in a letter to this Office dated 1 April 2022, containing a report prepared by DOE.

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

> YARN Meetings are attended by Region District High School representatives including the Principal and Associate Principal. Discussions at YARN meetings focus on health, learning Issues and crime.
>
> Students identified as "High Risk" in relation to school attendance are discussed at separate regular interagency meetings to develop plans, which include, where appropriate: the Western Australia Police Force, Child Protection and Family Support, Western Australian Child Health Service, Aboriginal Service, Juvenile Justice Team, Child and Adolescent Mental Health Service, Aboriginal Corporation and Region District High School.

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

Recommendation 10: That, by 1 July 2020, Communities provides the Ombudsman with:

- **A copy of the adjusted *Intensive Family Support (IFS) Monitoring Framework* and clarification on how this has been developed to 'better reflect the impact and effectiveness of Best Beginnings Plus (BB Plus)' and how ongoing monitoring will ensure IFS integration into BB Plus, to provide a child protection response, is effective; and**
- **A copy of the formal Review of BB Plus against *The Berry Street Childhood Institute: A review of Best Beginnings as part of a Child Protection strategy focused on engaging earlier with vulnerable families, July 2016,* with clarification on how 'greater integration with Child Protection work' has been strengthened to ensure compliance with the responsibilities under the *Children and Community Services Act 2004.***

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 7 July 2020, in which Communities relevantly informed this Office that:

> While Communities' response to COVID-19 has contributed to the delay in commencing the evaluation, there is a clear plan moving forward to ensure that this important work is undertaken…
>
> Since the findings and recommendations have been delivered, Communities has made progress in the development of the final draft, *Best Beginning Plus Evaluation Approach*, which is pending approval through the Community Service Leadership Team (CSLT)…
>
> Regarding Recommendations 10 and 11, Communities' focus over the next 12 months will include supporting and consolidating practice improvements, particularly in the areas of IFS, high-risk infants and building the cultural competence of the Communities workforce to better understand, communicate and effectively respond to Aboriginal and Torres Strait Islander families.
>
> The information gathered through these monitoring processes will be considered by Communities CSLT, to inform decisions about next steps including the scope of the Impact Evaluation planned for 2021.
>
> The Central Review Team (CRT) will continue to monitor the implementation of the above Recommendations and the finding as it relates to the 'assessment and safety planning for the wellbeing of an infant'. CRT will provide regular reports on progress to the CSLT. Communities will also provide you with regular updates on the *Best Beginnings Plus Evaluation Approach* in line with key milestones within this project.

Project	**Implementation**	**Monitoring and evaluation**
<u>Best Beginnings Plus Evaluation Approach (the Approach)</u> The Approach encompasses three components: • Monitoring Framework (the Framework); • Interim Evaluation; and	The interim evaluation will consider the intended outcomes and include: (1) reviewing and analysing existing data, reports and records, including but not limited to co-	Final Evaluation Approach endorsed by July 2020 Interim Evaluation of Best Beginnings Plus to commence by September 2020. Draft Interim Evaluation report

• Impact Evaluation. In brief, the Framework establishes the ongoing collection and analysis of data to determine whether expected results are being achieved. The Evaluations are systemic and objective processes to make judgements about the merit and worth of an initiative at a specific point in time during delivery. They aim to use the evidence-base built through the application of the Framework. The Evaluations will supplement this with further data collection such as interviews, surveys of broader stakeholders and follow up with clients. Together, this Framework and the Evaluations represent the intended evaluative approach surrounding Best Beginnings Plus.	design and integration within IFS Teams; (2) undertaking culturally appropriate internal and external stakeholder consultation; (3) identifying any gaps in data, sourcing reporting and analysis; (4) provision of contextual analysis of findings; and (5) a final interim evaluation report, including contextually appropriate observations and recommendations. The detailed scope of the impact evaluation will be finalised following the interim evaluation.	completed by November 2020. Monitoring Framework completed by December 2020. Impact Evaluation report completed December 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 a letter to this Office dated 25 March 2022, containing a report prepared by Communities.

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

Steps have been proposed to give effect to this recommendation.

Evaluation of Best Beginnings Plus Service

Communities has prepared a Scope of Works for procurement of a consultant to undertake an Evaluation of the Best Beginnings Plus Service (the evaluation). The Scope of Work has been endorsed and a quote is being sourced from Quantum Consulting Australia under a Common Use Agreement as an appropriate service to undertake the evaluation of the Best Beginnings Plus Service.

The evaluation will be complete, or substantially complete, by 30 June 2022. The objectives of the evaluation are to:

- Analyse and evaluate Best Beginnings Plus against the findings made in the Berry Street Review.
- Assess and evaluate the extent to which greater integration of child protection work has been strengthened to ensure compliance with Communities' responsibilities under the Act.
- Assess the extent to which Communities co-designed the Best Beginnings Plus model from an Aboriginal perspective to ensure the model's cultural safety.
- Develop lessons learned and opportunities for improvement for the Best Beginnings Plus service model, with a focus on upholding culturally informed practice and integration.
- Design a comprehensive implementation plan detailing how Communities can address any identified gaps in the Best Beginnings Plus service model and improve future practice.
- Assess the role and relationship of Best Beginnings Plus with externally contracted Early Intervention Family Support (EIFS) services Aboriginal In-Home Support Services, Intensive Family Support Services and Family Support Networks as part of the EIFS strategy.
- Present a monitoring framework that integrates Best Beginnings Plus into Intensive Family Support and ensures an effective child protection response.
- Identify the extent to which the evaluation can inform and propose elements for a wider Intensive Family Support Monitoring Framework that is yet to be developed.

Child Protection Monitoring Framework

In 2020, Communities planned to consolidate existing child protection monitoring frameworks into one overarching framework, the Child Protection Monitoring Framework (CPMF). The CPMF would provide an integrated approach to monitoring that is owned and managed by Communities as a whole, and to provide a system wide view of child protection activities undertaken at pre-determined intervals.

It was intended to consolidate existing outcomes, monitoring questions and indicators from across the agency, as a result of analysis of the seven child protection program specific monitoring frameworks (including the previous proposed Best Beginnings Plus Evaluation Framework - see letter dated 7 July 2020). Similar outcomes were identified, aligned and consolidated to produce six service-level outcomes. The consolidation identified some thematic areas that were not being monitored.

The draft framework has received in-principle support from relevant internal business units within Communities. A stakeholder analysis and engagement map has been prepared, and engagement with stakeholders is scheduled, pending Oversight Group endorsement.

A project plan with a phased approach has been developed. The Draft Project Management Plan is to be presented to Oversight Group in April 2022.

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

Recommendation 11: That, in providing the formal Review of BB Plus against the Berry St Report in accordance with Recommendation 10, Communities also provide clarification on how Communities conducted a 'comprehensive examination and development of the model from an Aboriginal perspective' involving 'co-design' with 'Aboriginal consultants' to ensure BB Plus is culturally safe for use with Aboriginal families.

Steps taken to give effect to the recommendation

This Office requested 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 25 March 2022, containing a report prepared by Communities.

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

> **Steps have been proposed to give effect to this recommendation.**
>
> See Recommendation 10 - Evaluation of Best Beginnings Plus. This work is also complemented by initiatives discussed at Recommendation 1 including the ACCRP.
>
> The ACCRP will drive an agency-wide Aboriginal cultural reform agenda to improve the cultural competency of staff and Communities' capability to enable sustainable, positive whole of life outcomes for Aboriginal people, children, families and communities.
>
> Long term and meaningful change, both internally for staff and externally for the Aboriginal people that we work with, will require Communities to continue to build and maintain a culturally competent workforce. Communities aims to facilitate new, different and culturally responsive ways of working across all aspect of Communities' work that impacts on Aboriginal people living in WA.
>
> The six priority reform areas for Communities to focus its cultural reform journey are:
>
> 1. Valuing Culture
> 2. Engagement and Partnerships.
> 3. Aboriginal Workforce Development
> 4. Workforce Cultural Capability
> 5. Culturally Responsive Systems and Services
> 6. Leadership and Accountability
>
> Developing Communities' Aboriginal cultural capability is informed by a model of cultural competence that describes cultural awareness, cultural safety and cultural security to drive organisational change and capacity building. The three main initiatives to drive and embed cultural competence are:
>
> - Development of a Communities Aboriginal Cultural Framework: The foundation elements of the framework will include a Statement of Intent, cultural values, guiding principles and language, and explores what cultural safety, cultural security and cultural capability looks like in a Communities' context.
> - Service Delivery Transformation: The ACCRP will maintain a focus on building and maintaining cultural competence of its workforce and service and operational improvements through working in partnership with Aboriginal people, organisations and communities.
> - Aboriginal Cultural Learning Program: Building on from the cultural learning delivered to staff in 2020 and 2021, three focus areas include:
>
> I. Cultural learning for all metropolitan staff

II. Targeted Leaders program for staff responsible for leading and managing people

III. Development of Communities cultural learning approach that ensures delivery of place-based cultural learning for staff located throughout regional Western Australia

Communities has continued to partner with Aboriginal Productions (Dr Richard Walley OAM) who provided initial cultural validation of the approach to delivering Communities inaugural Aboriginal Cultural Framework and Learning Program. Procurement of further Aboriginal expertise to help shape and inform the development of the Aboriginal Cultural Framework and Learning Program is currently in progress.

In October 2019, Indigenous Psychological Services (IPS) provided Communities with 49 recommendations to improve the cultural capability of child protection service delivery. These recommendations are being integrated and considered at the whole of organisation level. On 15 February 2022, Communities released publicly the IPS report and the ACCRP - key actions to address recommendations.

Communities is committed to the cultural reform journey as described by the significant amount of work that has been undertaken across a range of programs and initiatives.

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

Recommendation 12: That Communities, including but not necessarily limited to in the circumstances of developing the Communities' *Action Plan for At Risk Youth,* considers the findings of this review with a view to enhancing collaborative case management arrangements with Department of Justice to promote the safety and wellbeing of young people in the care of the CEO subject to detention at Banksia Hill Detention Centre and/or community based dispositions and provides a report to the Ombudsman within six months of the finalisation of this review with the results of this consideration.

Steps taken to give effect to the recommendation

Communities provided a range of information in a letter to this Office dated 23 November 2020, containing a report prepared by Communities.

In the letter, Communities relevantly informed this Office that:

Since the death of [Youth C], Communities has commenced a range of initiatives to improve practice including measures to increase communication and collaboration between the Department of Justice and Communities. A summary of relevant key projects, progressed and underway, as they relate to recommendation 12 is summarised in the report. The focus of these projects and initiatives has been to promote joint working between the agencies to ensure the best outcomes for children and young people in care, including those in detention at Banksia Hill Detention Centre.

Communities is also working to finalise the *At Risk Youth Strategy 2021 – 2016 (The Strategy)* (formerly referred to as the Action plan for At Risk Youth). Findings from the child death review for [Youth C], and other reviews for at-risk youth, have been used to inform the policy context and priority areas. Once the Strategy is finalised, Communities will provide your office with a further progress report including a copy of the Strategy, the focus of implementation work and development of the associated evaluation framework.

The report provided by Communities outlined implementation of the following projects:

- Co-located Senior Child Protection Worker at Banksia Hill Detention Centre;
- Review of the Region's Children and Young People At Risk Meeting;
- Entry Level Training Program for Youth Custodial Officers;
- Review of the *Children and Community Services Act 2004;*
- *At Risk Youth Strategy* 2021 – 2026; and
- Review of relevant practice guidance.

This Office requested further information of the steps taken to give effect to the recommendation. In response, further information was provided by Communities in a letter to this Office dated 25 March 2022, containing a report prepared by Communities.

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

> **This recommendation has been actioned.**
>
> *At Risk Youth Strategy 2022-2027*
>
> Communities is finalising the *At Risk Youth Strategy 2022-2027* (Strategy) to improve responses for young people aged 10 to 24 years with multiple and complex problems who are at risk of harm and have increased vulnerability of experiencing poor life outcomes.
>
> The draft Strategy supports a cross-agency, partnership approach for the earlier identification, assessment of need and appropriate response for at risk young people. Responding to the diverse needs of these young people and their families requires all levels of government, the community services sector, Aboriginal Community Controlled Organisations, peak bodies and non-government organisations to work together in a collaborative and integrated approach.
>
> The young people who are the focus of the draft Strategy have multiple and complex problems and are at increased risk of requiring a tertiary and/or statutory response, including entry into the child protection, police, justice and acute mental health systems.
>
> The development of the draft Strategy was informed by extensive stakeholder consultations, including representatives from other government agencies, peak bodies, ACCOs, the community services sector and young people with lived experience of relevant issues.
>
> The draft Strategy has been developed to incorporate broader State Government priorities including the National Agreement on Closing the Gap. Findings from this Ombudsman child death review, and other reviews for at-risk youth, have been used to inform the policy context and priority areas.
>
> The draft Strategy was approved by the Minister for Child Protection on 17 December 2021 and is in the final stages of publishing design…
>
> The draft Strategy defines four interrelated focus areas to achieve improved outcomes for at risk young people. The focus areas define priority outcomes and provide high-level guidance for the future development of activities and deliverables over the duration of the strategy.
>
> Focus Area One of the Strategy considers partnerships, collaboration and integrated responses with the defined priority outcome that: 'at risk young people with multiple and intersecting issues are identified and responded to through an integrated cross-agency approach'.
>
> Focus Area One builds upon Communities' initiatives reported to the Ombudsman in November 2020. These initiatives promote joint working between agencies to ensure the best outcomes for children and young people in care, including those in detention at Banksia Hill and include:

- Strengthened information sharing provisions in the Act.
- The establishment of the co-located Senior Child Protection Worker at Banksia Hill Detention Centre.
- Communities' Regional Executive Director and Director Professional Practice attendance at regular risk review meetings with Banksia Hill Detention Centre Superintendent.
- Communities review of the Region Children and Young People At Risk meetings (see Recommendation 5 above).
- The Amendment Act will strengthen requirements for across agency work through a legislated rapid response (see Recommendation 1) and leaving care planning.

The new amendments related to leaving care planning will require:

- a leaving care plan to be prepared once a child reaches 15.
- leaving care plans to include the social services proposed to be provided for the child post-care; and
- children leaving care be provided with the social services the CEO considers appropriate having regard to the child's needs.

Implementation supports related to rapid response are discussed at Recommendation 1. To support leaving care planning, Communities has prepared draft practice guidance and related resources. These will be available to staff in advance of the commencement of the new laws and will include:

- Amendments to CPM Entry 3.4.14 - Leaving care and transitioning to adult (draft) to include the new requirements.
- Leaving Care Checklists for Staff:
  - Phase 1 Preparation.
  - Phase 2 Transition.
  - Phase 3 Post Care.
- Leaving Care Plan template.

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

Recommendation 13: Communities provides the Ombudsman with a report within 12 months of the finalisation of this review outlining Communities' strategies to monitor the provision of supervision (quantity and quality) to child protection staff in accordance with Communities' practice requirements.

Steps taken to give effect to the recommendation

Communities provided a range of information in a letter to this Office dated 31 May 2021, in which Communities relevantly informed this Office that:

> Supervision and performance management for child protection workers is undertaken utilising two Communities systems, both processes complement each other. During case supervision, individual cases are discussed in the context of caseworkers' knowledge, skills and experience and their capacity, including time, availability, and the number and nature of cases. It is the supervisor's role to identify, communicate and manage performance issues, and to provide an opportunity for caseworkers to improve their work performance through learning and development opportunities. Case supervision must occur every four weeks, with the exception where Director approval has been provided for sessions to occur every six weeks. These sessions

are recorded as case supervision documents, case notes and email correspondence, which are identifiable on case files.

Communities Let's Talk Performance Management process is currently being implemented as a replacement for the previous Reaching Forward Performance Management system. Let's Talk provides for two sessions per year and is used alongside case supervisions to explore, identify and record child protection staff learning and development goals to strengthen workers theoretical knowledge. Records of supervisions inform monthly Critical Priorities Reports which provide data on the quantity of supervision completed by Districts.

Along with the launch of Let's Talk across Communities, further steps have been taken to strengthen the delivery of quality and quantity of supervision, including:

- The Casework Practice Manual (CPM) has been updated to reflect the introduction of the Let's Talk Performance Management process. Further updates will be made following a broader review of supervision practices anticipated to commence in 2022. The broader review will consider strengthened guidance for supervisors in initiating the conversations with child protection workers in relation to responding to alcohol and other drugs, mental health and family and domestic violence as harm types.
- A Working Party is being established to examine issues including supervision and the application and governance of the Monitored List (in accordance with the Ombudsman Recommendation delivered in the child death case of [Child D]).
- The implementation of the Team Leader Program that aims to support Team Leaders with a curated program to strengthen their capacity to support child protection workers with developing theoretical knowledge and practical skills.
- Signs of Safety 100 Days of Training. The bootcamps focus will be on delivering a range of learning sessions to child protection workers and leadership teams to further achieve and embed theoretical knowledge and practice skills of child protection workers and the leadership within Communities.
- Learning and Development are delivering a comprehensive Advanced Practice Supervision training to District Directors and Assistant District Directors with further discussion to deliver the training to Team Leaders later in 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 a letter to this Office dated 25 March 2022, containing a report prepared by Communities.

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

This recommendation has been actioned.

Supervision compliance is a critical priority area for Communities due to its link with child safety. Communities has mechanisms to monitor the provision of supervision to child protection staff, including monthly Critical Priorities Reports and Standards Monitoring Unit (SMU) reporting.

Critical priorities reporting includes statistics on staff supervision compliance from the Performance Management Tracking System and provides lists of non-compliance to enable remedy. In October 2021, the distribution list for Critical Priorities Reports was amended to include Communities Director General.

SMU reviews supervision according to standard 8.2 (d) of the *Better Care, Better Services Quality and Safety* Standards (the Standards) defined as 'Staff have access to support and advice, and are provided with regular supervision by appropriately qualified and experienced staff'.

SMU reporting provides an intelligence source and employs two pathways to progress practice improvements and compliance: within individual districts; and across Communities.

SMU provides a risk rating of a District's non-compliance in supervision in accordance with the Department of Communities Risk Assessment Table. Supervision has been rated as an 'Extreme' risk in the current Cycle 7 assessments reflecting its importance to child safety.

Given supervision has been rated as an extreme risk, non-compliant districts must provide the SMU with a report within 3 months that details a treatment mitigation plan in line with the risk framework and actions the district will take to address (compared to a 12 month period for medium to low risks).

When the SMU reports identify systemic non-compliance and deficiencies across Communities, these are reported to CLT and Communities Risk Management and Audit divisions.

To assess compliance with the Standards, the SMU interviews leadership, staff and service users including children and young people, their families and carers as well as examining documentation. The SMU examines ASSIST case plan supervision documents to evidence case practice supervision and will consider evidence of supervision in other documents including emails and other case documents. The SMU reviews provide some evidence that supervision is occurring that is not necessarily reflected in ASSIST or the Performance Management Tracking System. The SMU does not review documents stored on the Performance Management Tracking System or Let's Talk Performance records.

In line with this and other Ombudsman recommendations, future SMU reviews will assess whether team leaders have completed *Advanced Supervision Training* as a measure of assessing standard 8.2.

Learning and Development Supports

To complement the above compliance activities, Communities has undertaken some initiatives to develop our leaders and child protection staff and improve the quality of supervision.

Let's Talk

In July 2021, Communities Let's Talk performance management system replaced the Child Protection legacy performance management system Reaching Forward and established a standardised performance process across Communities. Let's Talk provides for a three-session cycle (Planning, Review conversation and End-of-cycle) per calendar year. Let's Talk is in addition to regular case planning supervision and is focused on enabling conversation and clarity between individual and line manager as to the individual's role responsibilities, navigating barriers and enablers to achieving outcomes or meeting responsibilities and requiring workers and their supervisors to explore what learning and development is needed to perform their role, with consideration to skills, knowledge and behaviours.

A series of presentations were delivered across all Communities' work units to support the implementation of Let's Talk as Communities' performance management system.

On 8 April 2021 updates were made to Communities' Casework Practice Manual (CPM) entry 4.1.7 *Supervision in case practice/service delivery* to include Let's Talk requirements and its link to the management of learning and development needs.

On 14 October 2021, the Let's Talk Performance and Development SharePoint was added as related resource to Communities CPM entry 4.1.7. The SharePoint provides guidance to workers on use of Let's Talk which includes sections for exploring and recording learning and development needs.

Communities' People Division, Learning and Development, in partnership with subject matter experts from external agencies, have led continual learning opportunities for leadership groups within Communities discussed below.

Advanced Practice Supervision training-

During 2021, Communities in collaboration with *Stara*, a learning and consultancy service that specialises in delivering training in professional practice supervision, delivered four training packages in *Advanced Practice Supervision*. The course identifies and explores domains of supervision, including both case management and professional development. The content includes:

- Essential skills for providing quality professional practice supervision;
- Challenges to providing effective supervision and developing responses to difficult situations in supervision;
- Emotional literacy, self-awareness, and critical reflection in supervision practice; and
- Effective feedback skills.

These training packages were developed for and targeted towards District Directors, Assistant District Directors and Team Leaders who provide supervision to child protection workers. During 2021 a total of 36 participants comprising District Directors, Team Leaders, Senior Practice Development Officers, Clinical Psychologists and Residential Care Managers attended a 3-day workshop held during June, July, September, and December. The program is being delivered to the two Regional Districts in May and June 2022; with consideration to be given to providing additional training for metropolitan and regional districts later in 2022.

Psychological Safety in Supervision training

Communities is collaborating with the Australian Association of Social Workers to design an e-learning course on psychological safety in practice supervision. This recognises that psychological safety is fundamental to an effective supervision process. Work commenced in 2022 and the course is anticipated to be released later in the year.

Intentional Leadership Program

In 2021, a 12-week *Intentional Leadership Program* (Leadership Program) from the Institute of Managers and Leaders Australia New Zealand (IML) was piloted by Learning and Development. The program is designed to support professionals moving into a leadership role and has a strong focus on both leader and team effectiveness. Ten Team Leaders from Communities across the state participated in at least six interactive online sessions with an experienced facilitator with additional out-of-session peer support and regular mentorship with the participant Team Leader's line manager (Assistant District Directors or District Directors). Feedback from participants and their line managers has been positive and consideration is being given to wider implementation of this program.

Team Leader Program

In late 2019, a Project Board was developed to oversee the development of the Team Leader Program. The Team Leader Program aims to support Team Leaders to strengthen their capacity to support child protection workers and to enhance Team Leaders' critical decision-making capability. The Project Board acts to provide advice, review, guide and make decisions to enable the successful delivery of the Child Protection Team Leaders Program. The Project Board continues to meet to determine and refine relevant content for this competency-based development program. A Team Leader Pathway was prepared following extensive internal consultation and is currently pending approval. The project to develop the full learning program will

continue until December 2024 and it is anticipated that all courses will be developed and operationalised by this time.

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

Recommendation 14: In implementing the 'voluntary actions' outlined in Communities' 2019 internal 'child death case review' following the deaths of [Child A] and [Child B], that the Regional District identifies what action is required to ensure:

- **Assessment and safety planning for vulnerable infants that is consistently compliant with legislative responsibilities under the *Children and Communities Services Act 2004*;**
- **The use of available legislative powers 'to escalate its response to concerns for the safety and wellbeing of children, in the context of parental non-engagement'; and**
- **That Child Safety Investigations are not closed with the documented rationale of 'unable to assess' when a family's location is known to Communities.**

Steps taken to give effect to the 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 25 March 2022, containing a report prepared by Communities.

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

This recommendation has been actioned

Duty of Care Action Plan

Following on from the deaths of infants [five children] in the District, the Ombudsman raised 'Duty of Care Referrals' with Communities on 10 June and 31 July 2020. A Duty of Care Action Plan was developed with the District, which included steps to be taken over a three-month period. All steps were completed, which included:

- Introduction of a second Child Safety Team in the District;
- High Risk Infant, Pre-Birth Planning and Pre-Birth Planning Facilitation training delivered to most staff in the District; and
- Introduction of a second Aboriginal Practice Leader and Best Beginnings Plus worker in the District.

The Duty of Care Action Plan increased capacity within the District to undertake assessment and safety planning for vulnerable infants and children, in accordance with Communities legislative responsibilities under the Act. The impact of the second Child Safety Team has been significant with smaller caseloads in the highest risk area ensuring that staff are better able to assess and respond to issues of child safety.

Since the introduction of a second Child Safety Team:

- Average case numbers in the District Child Safety Teams have reduced from 14 per team member in December 2018 to 9.5 per team member as at 21 February 2022; and
- Child safety team cases on the monitored list have reduced from 43 in December 2018 to seven as at 21 February 2022 with cases generally allocated within 7 days.

Direction to staff

On 2 June 2020, the Acting District Director sent an email communication to all staff, outlining practice requirements in relation to CSI's and sighting/interviewing children, the use of section 34 Warrant Access and the use of the outcome 'unable to assess'.

Child Safety Investigation Checklist

In 2020 the District developed and implemented the 'CSI Checklist' as a way of quality assuring CSIs within the district. The CSI Checklist was completed by the Child Protection Worker and used by Team Leaders providing approvals for CSI's, to ensure that steps have been taken in accordance with practice requirements and guidance. The CSI Checklist included:

- Prompts for Child Protection Workers to consider the use of a section 34 Warrant Access where parental permission is not granted to sight and/or interview a child; and
- A requirement for the outcome 'unable to assess' to not be used, where a family's location is known and they have been difficult to engage.

On 24 September 2020, use of the CSI Checklist ceased to be mandatory, however, the checklist remains available for use by staff as a local resource and continues to be used informally.

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 2021-22, timely review processes have resulted in 71% of all reviews being completed within six months.

Expanded child death review function

During 2021-22, 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. Since 1 July 2020, all child deaths that occur in Western Australia are now notified to the Ombudsman, with associated data collated for the establishment of the WA Child Death Register. The Child Death Review section of the Annual Report 2022-23 will provide reporting on all child deaths that occur in Western Australia.

Major Own Motion Investigations Arising from Child Death Reviews

In addition to taking action on individual child deaths, the Office identifies patterns and trends arising out of child death reviews to inform major own motion investigations that examine the practices of public authorities that provide services to children and their families.

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

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; and
- 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, Monitoring and 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, 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.

The Ombudsman's Advisory Panel

The Ombudsman's Advisory 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 Ombudsman's Advisory Panel met three times in 2021-22.

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 2021-22 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 2021-22, the Ombudsman created a critical new executive position, Assistant Ombudsman Aboriginal Engagement and Collaboration, which was advertised in April 2022.

Significant work was undertaken throughout 2021-22 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.