Our Performance in 2021-22

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

Summary of Performance

Key Performance Indicators

Key Effectiveness Indicators

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

Key Effectiveness Indicators are the percentage of these recommendations and suggestions accepted by public authorities and the number of improvements that occur as a result of Ombudsman action.

Key Effectiveness Indicators	2020-21 Actual	2021-22 Target	2021-22 Actual	Variance from Target
Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies	100%	100%	**100%**	Nil
Number of improvements to practices or procedures as a result of Ombudsman action	109	100	**57**	-43

Another important role of the Ombudsman is to enable remedies to be provided to people who make complaints to the Office where service delivery by a public authority may have been inadequate. The remedies may include reconsideration of decisions, more timely decisions or action, financial remedies, better explanations and apologies. In 2021-22, there were 199 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman.

Comparison of Actual Results and Budget Targets

Public authorities have accepted every recommendation made by the Ombudsman, matching the actual results of the past four years and meeting the 2021-22 target.

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

The 2021-22 actual number of improvements to practices and procedures of public authorities as a result of Ombudsman action (57) differs from the 2021-22 target (100) and the 2020-21 actual (109) as there are fluctuations in improvements from year to year, related to the number, nature and outcomes of investigations finalised by the Office in any given year.

Key Efficiency Indicators

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

Key Efficiency Indicators	2020-21 Actual	2021-22 Target	2021-22 Actual	Variance from Target
Percentage of allegations finalised within three months	96%	95%	**97%**	+2%
Percentage of allegations finalised within 12 months	100%	100%	**100%**	Nil
Percentage of allegations on hand at 30 June less than three months old	87%	90%	**96%**	+6%
Percentage of allegations on hand at 30 June less than 12 months old	100%	100%	**100%**	Nil
Average cost per finalised allegation	$1,885	$1,890	**$1,749**	-$141
Average cost per finalised notification of death	$17,565	$17,500	**$17,097**	-$403
Cost of monitoring and inspection functions	$407,486	$415,000	**$516,576**	+$101,576

Comparison of Actual Results and Budget Targets

The 2021-22 actual results for the Key Efficiency Indicators met, or were comparable to, the 2021-22 target. Overall, 2021-22 actual results represent sustained efficiency of complaint resolution over the last five years.

The average cost per finalised allegation in 2021-22 ($1,749) is comparable with the 2021-22 target ($1,890) and the 2020-21 actual ($1,885). Since 2007-08, the efficiency of complaint resolution has improved significantly with the average cost per finalised allegation reduced by a total of 41% from $2,941 in 2007-08 to $1,749 in 2021-22.

The average cost per finalised notification of death ($17,097) is comparable with the 2021-22 target ($17,500) and the 2020-21 actual ($17,565).

The cost of monitoring and inspection functions ($516,578) is greater than the 2021-22 target ($415,000) and the 2020-21 actual ($407,486) in line with approved additional funding for a new function under the *Criminal Law (Unlawful Consorting and Prohibited Insignia) Act 2021* (**the Act**), which commenced on 24 December 2021.

Under the Act, the Ombudsman must keep under scrutiny the exercise of powers by the WA Police Force to ascertain the extent of their compliance with the Act.

For further details, see the Key Performance Indicator section.

Summary of Financial Performance

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

Financial Performance	2020-21 Actual ('000s)	2021-22 Target ('000s)	2021-22 Actual ('000s)	Variance from Target ('000s)
Total cost of services (sourced from Statement of Comprehensive Income)	$11,713	$11,270	**$11,422**	+$152
Income other than income from State Government (sourced from Statement of Comprehensive Income)	$2,498	$2,696	**$2,582**	-$114
Net cost of services (sourced from Statement of Comprehensive Income)	$9,216	$8,574	**$8,840**	+$266
Total equity (sourced from Statement of Financial Position)	$570	$889	**$368**	-$521
Net increase/decrease in cash held (sourced from Statement of Cash Flows)	-$567	$20	**-$58**	-$78

Comparison of Actual Results and Budget Targets

The 2021-22 actual results for both the total and net cost of services are comparable to the 2021-22 targets and the 2020-21 actual.

For further details see Note 9 'Explanatory Statement' in the Financial Statements section.

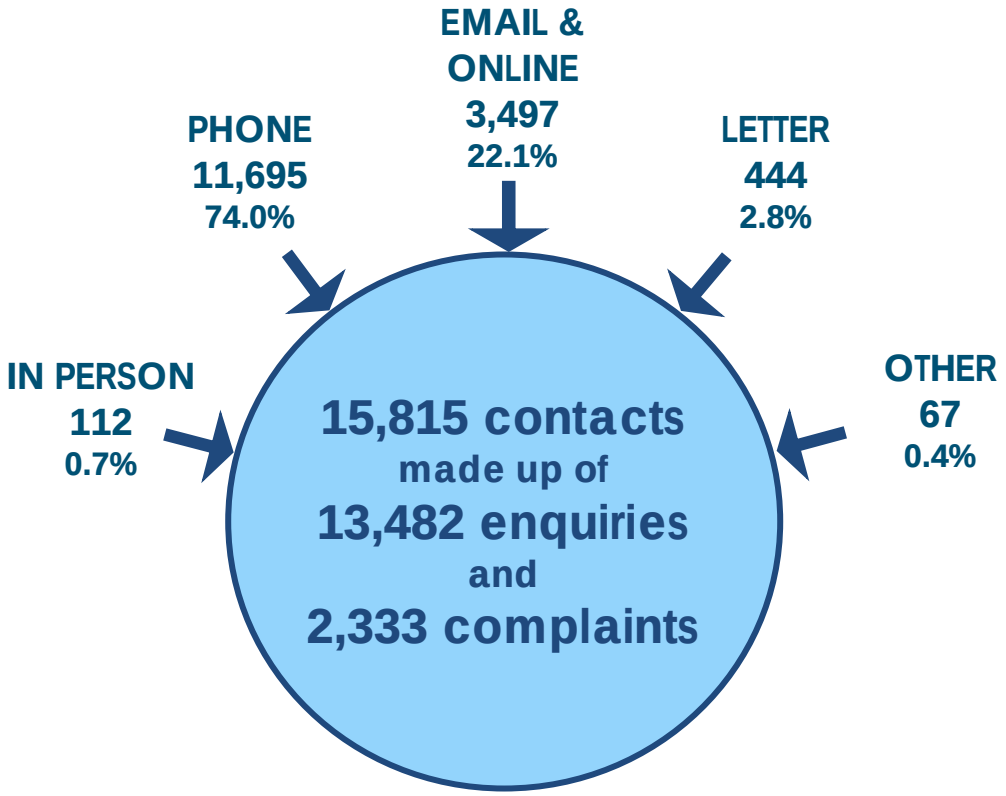
Complaint Resolution

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

Contacts

In 2021-22, the Office received 15,815 contacts from members of the public consisting of:

- 13,482 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 2,333 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

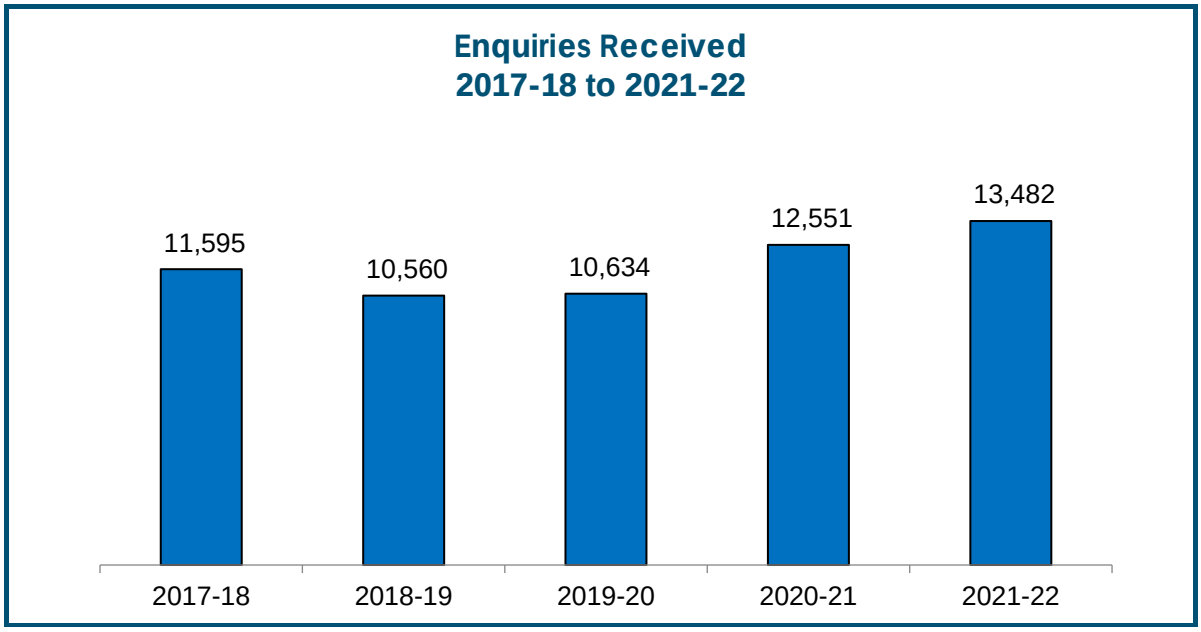


Enquiries Received

There were 13,482 enquiries received during the year.

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

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

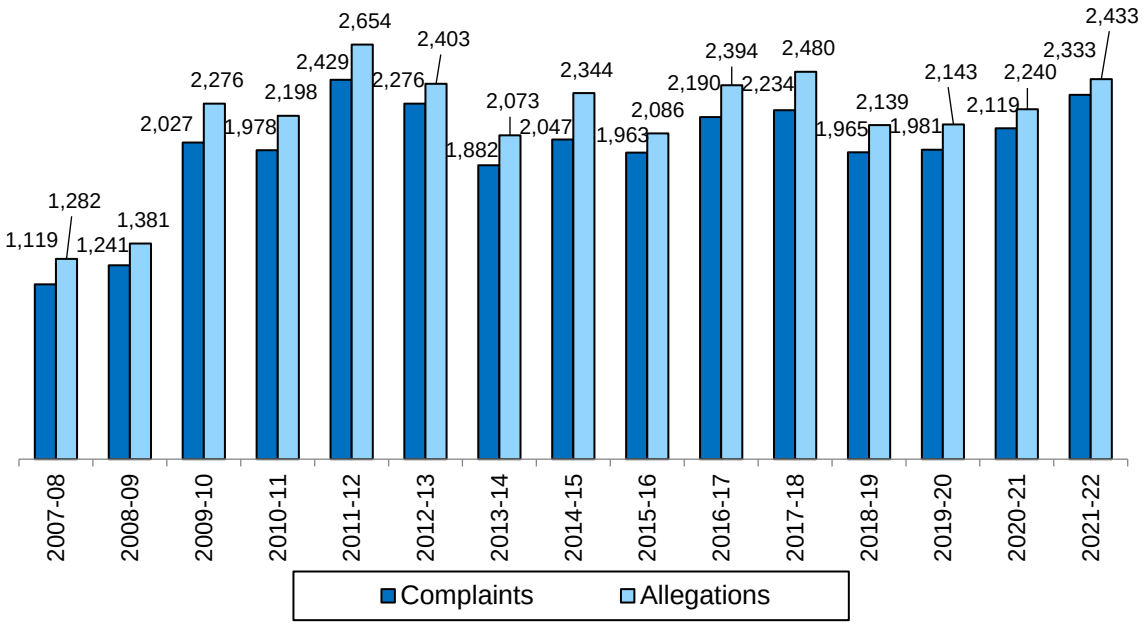


Enquirers are encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

Complaints Received

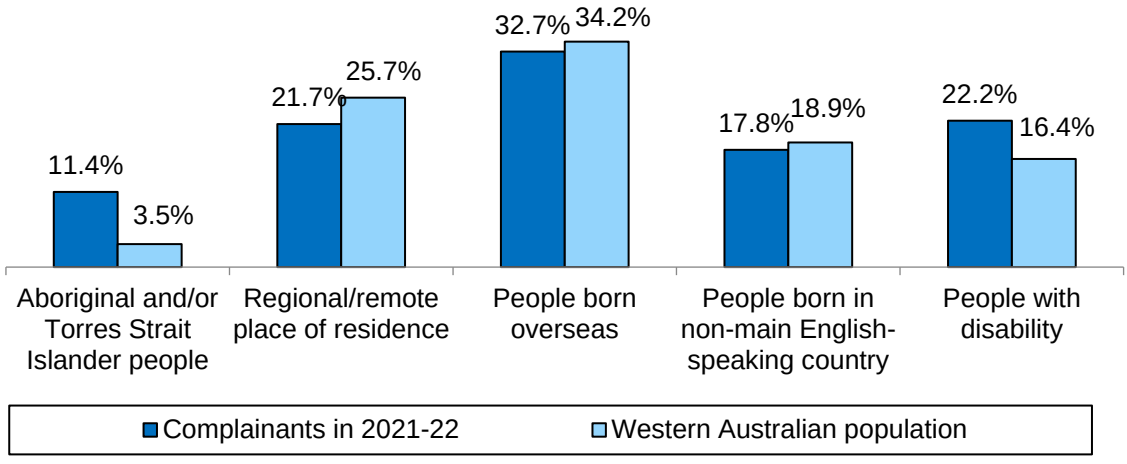
In 2021-22, the Office received 2,333 complaints, with 2,433 separate allegations, and finalised 2,333 complaints. There are more allegations than complaints because one complaint may cover more than one issue.

Total Number of Complaints and Allegations Received 2007-08 to 2021-22



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

Characteristics of Complainants in 2021-22

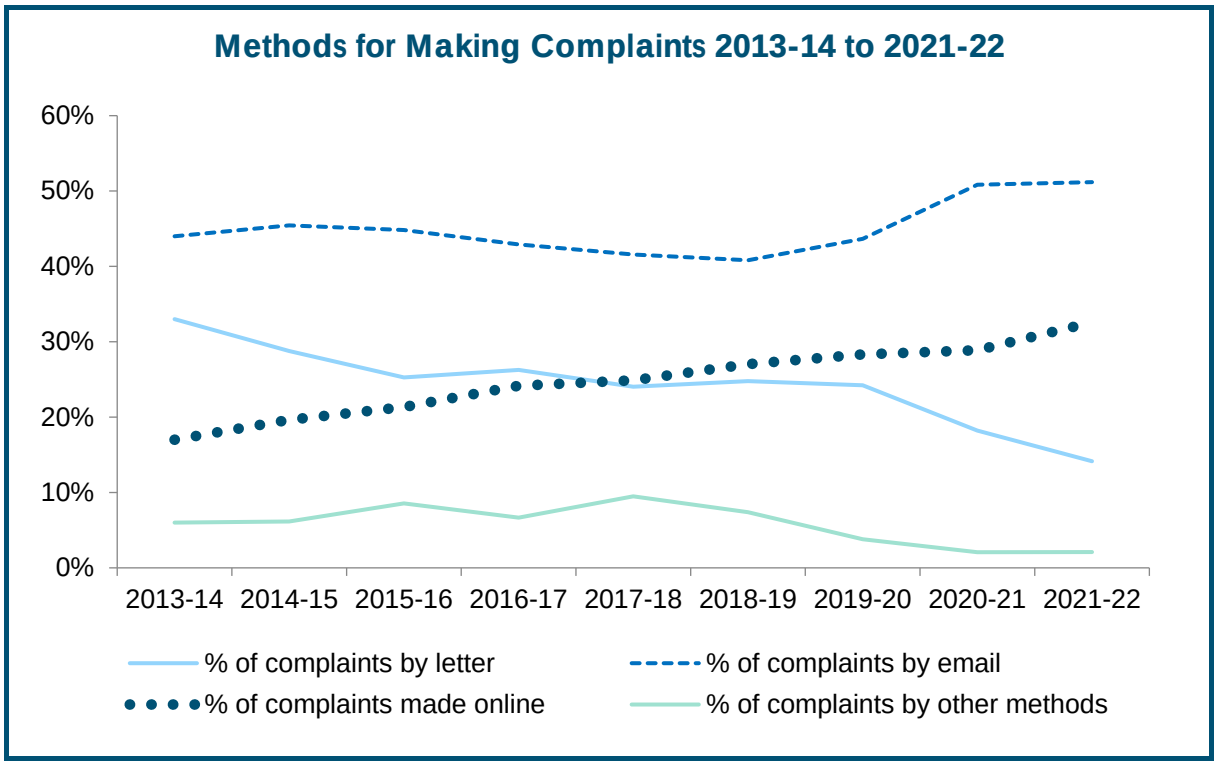


NOTE: Non-main English-speaking countries as defined by the Australian Bureau of Statistics are countries other than Australia, the United Kingdom, the Republic of Ireland, New Zealand, Canada, South Africa and the United States of America. Being from a non-main English-speaking country does not imply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

How Complaints Were Made

Over the last 14 years, the use of email and online facilities to lodge complaints has increased from 29% in 2008-09 to 84% in 2021-22. Over the same time, the proportion of people who lodge complaints by letter has declined from 64% to 14%.

In 2021-22, 51% of complaints were lodged by email, 33% through the Office's online complaint form, 14% by letter and two per cent by other methods including during regional visits and in person.



Resolving Complaints

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

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

Time Taken to Resolve Complaints

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

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

Building on the program, the Office developed and commenced a new organisational structure and processes in 2011-12 to promote and support early resolution of complaints. There have been further enhancements to complaint handling processes in 2021-22, in particular in relation to the early resolution of complaints.

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

In 2021-22:

- The percentage of allegations finalised within 3 months was 97%; and
- The percentage of allegations on hand at 30 June less than 3 months old was 96%.

97% of allegations were finalised within 3 months.

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

- The average age of complaints has decreased from 173 days to 37 days; and
- Complaints older than 6 months have decreased from 40 to two.

Complaints Finalised in 2021-22

There were 2,333 complaints finalised during the year and, of these, 1,618 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 1,113 were finalised at initial assessment, 459 were finalised after an Ombudsman investigation and 46 were withdrawn.

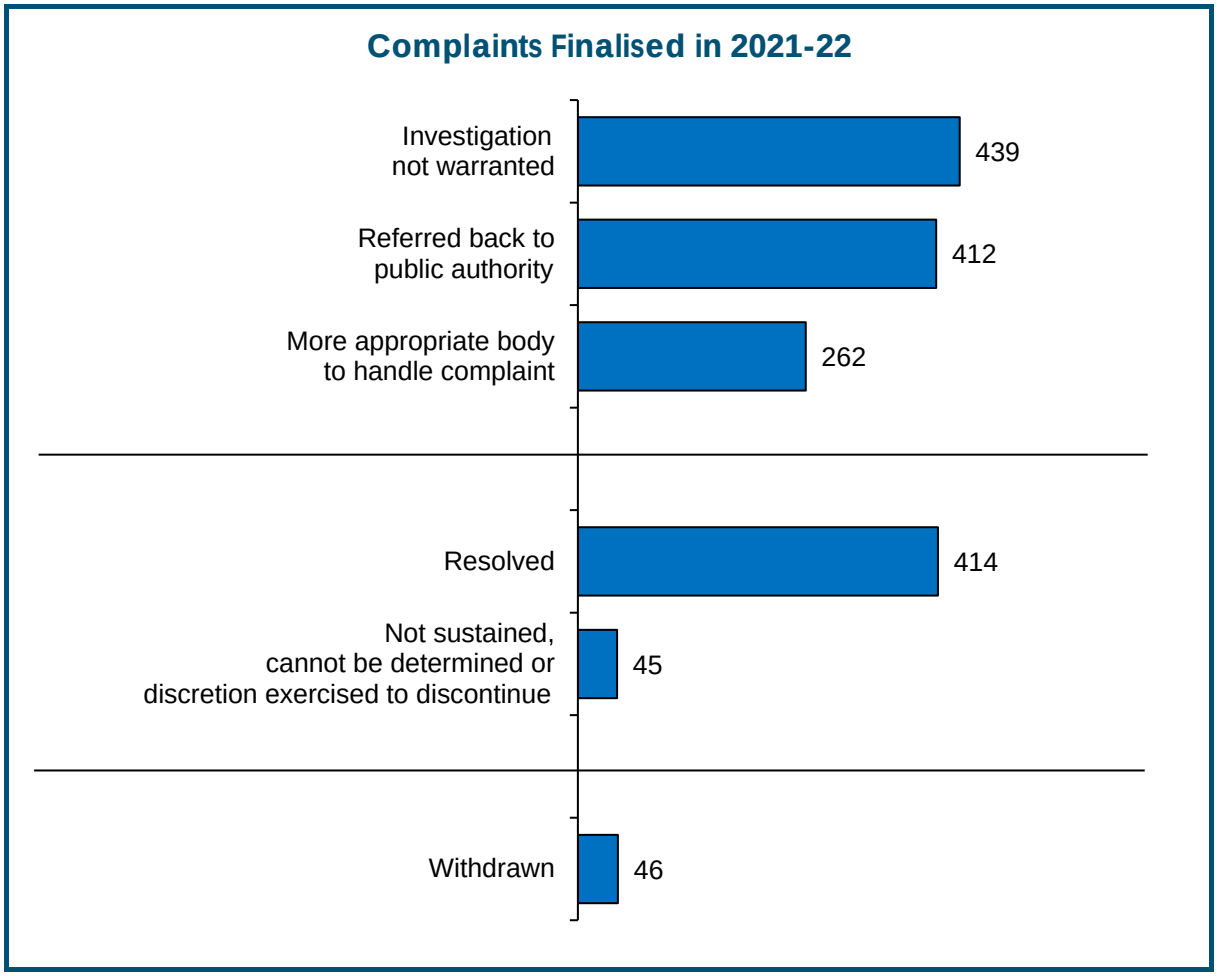
Complaints finalised at initial assessment

Over a third (37%) of the 1,113 complaints finalised at initial assessment were referred back to the public authority to provide it with an opportunity to resolve the matter before investigation by the Ombudsman. This is a common and timely approach and often results in resolution of the matter. The person making the complaint is asked to contact the Office again if their complaint remains unresolved. In a further 262 (24%) of the complaints finalised at initial assessment, it was determined that there was a more appropriate body to handle the complaint. In these cases, complainants are provided with contact details of the relevant body to assist them.

Complaints finalised after investigation

Of the 459 complaints finalised after investigation, 87% were resolved through the Office's early resolution approach. This involves Ombudsman staff contacting the public authority to progress a timely resolution of complaints that appear to be able to be resolved quickly and easily. Public authorities have shown a strong willingness to resolve complaints using this approach and frequently offer practical and timely remedies to resolve matters in dispute, together with information about administrative improvements to be put in place to avoid similar complaints in the future.

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

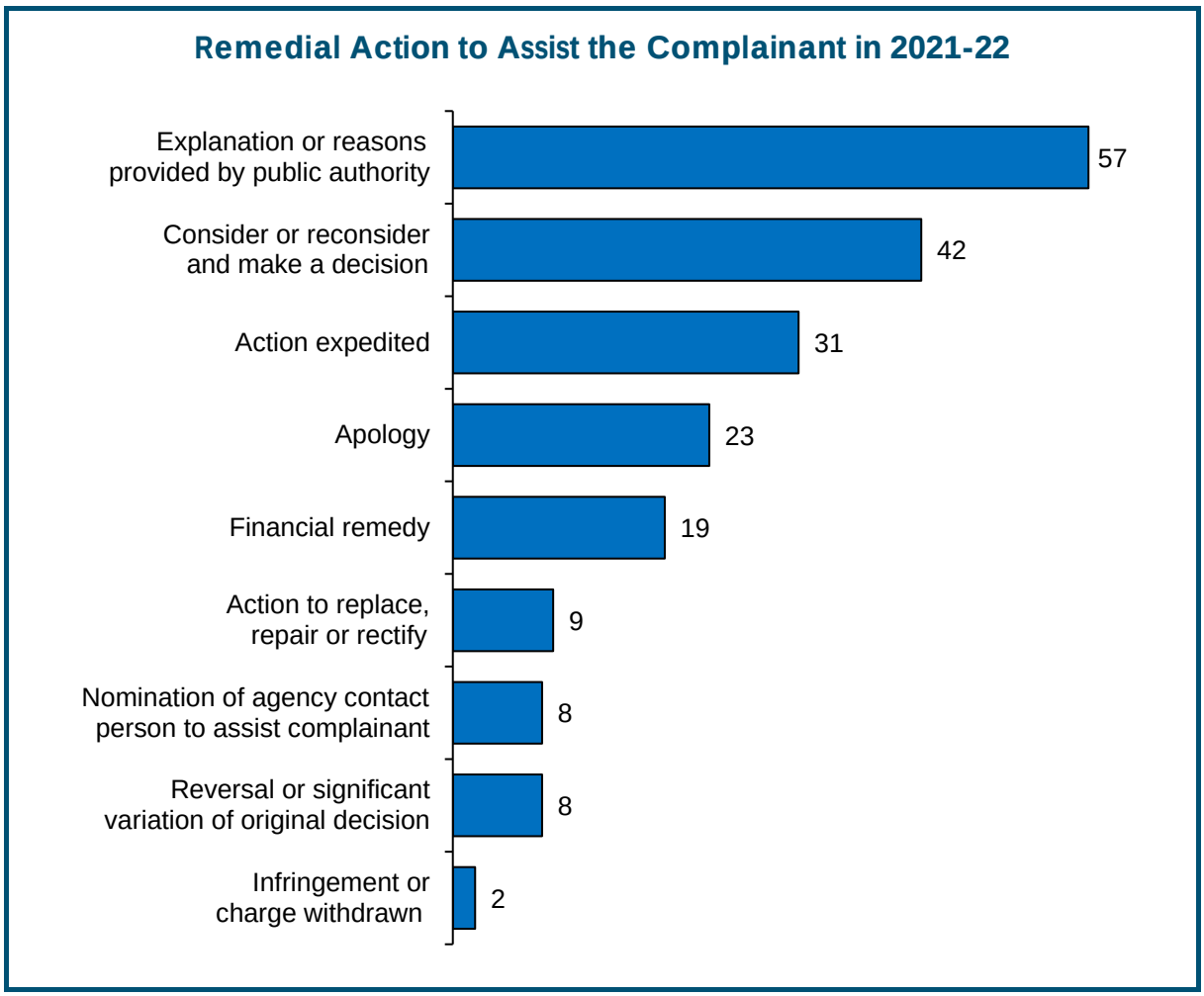


Note: Investigation not warranted includes complaints where the matter is not in the Ombudsman's jurisdiction.

Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2021-22, there were 199 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman. In some cases, there is more than one action to resolve a complaint. For example, the public authority may apologise and reverse their original decision. In a further 68 instances, the Office referred the complaint to the public authority following its agreement to expedite examination of the issues and to deal directly with the person to resolve their complaint. In these cases, the Office follows up with the public authority to confirm the outcome and any further action the public authority has taken to assist the individual or to improve their administrative practices.

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



Case Study

Tenant liability for damaged appliance waived

A public housing tenant lodged a request for repair of an appliance with the public authority. The public authority's contractor inspected the appliance, estimated its age at approximately eight years and deemed it beyond repair. The public authority subsequently replaced the appliance and billed the tenant for the replacement on the basis the appliance had allegedly been misused. The tenant appealed the decision, saying they had not caused the damage and had asked for the appliance to be fixed, not replaced, so should not be liable for the cost. The public authority's review upheld the original decision and the tenant complained to the Ombudsman.

Following investigation by the Ombudsman, the public authority reviewed the disputed tenant liability charge. The public authority found that its decision to charge the total cost of replacement was incorrect according to its policies, given the age of the appliance. As a result, the public authority decided to waive the tenant liability charge.

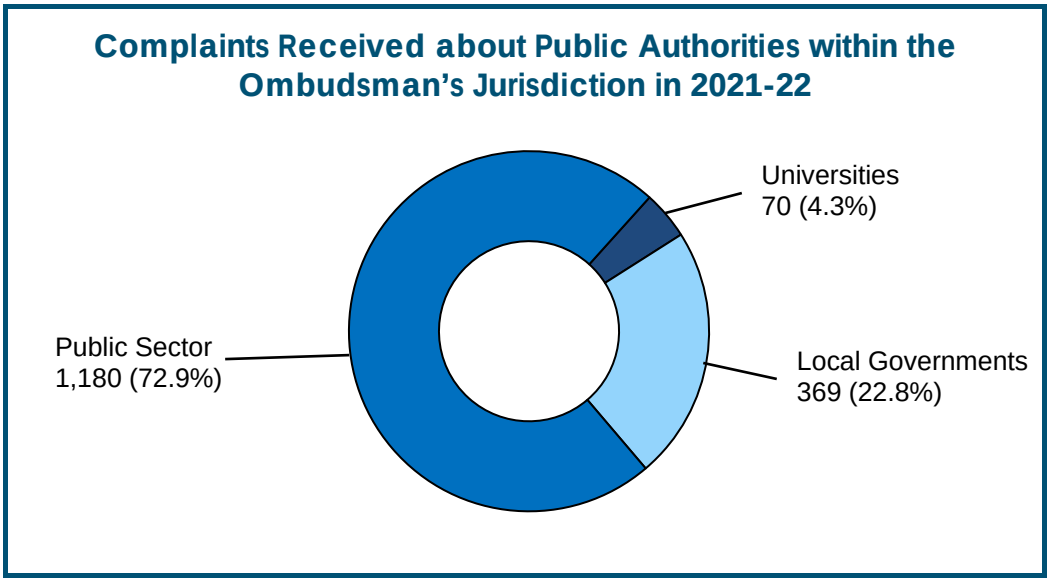
Outcomes to improve public administration

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

About the Complaints

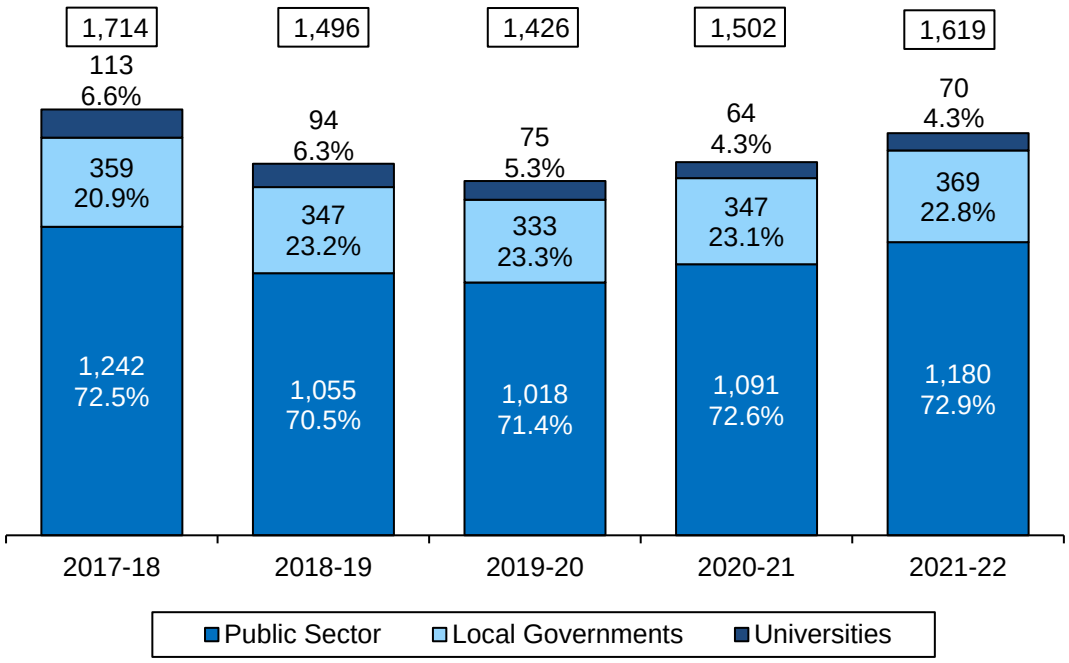
Of the 2,333 complaints received, 1,619 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 714 complaints were about bodies outside the Ombudsman's jurisdiction. In these cases, Ombudsman staff provided assistance to enable the people making the complaint to take the complaint to a more appropriate body.

Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (1,180 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (369 complaints); and the university sector (70 complaints).



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

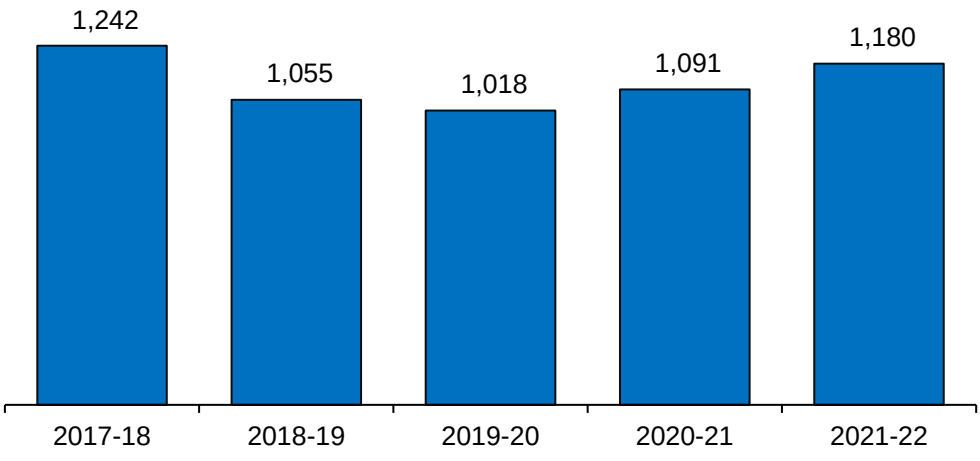
Complaints Received about Public Authorities within the Ombudsman's Jurisdiction between 2017-18 and 2021-22



The Public Sector

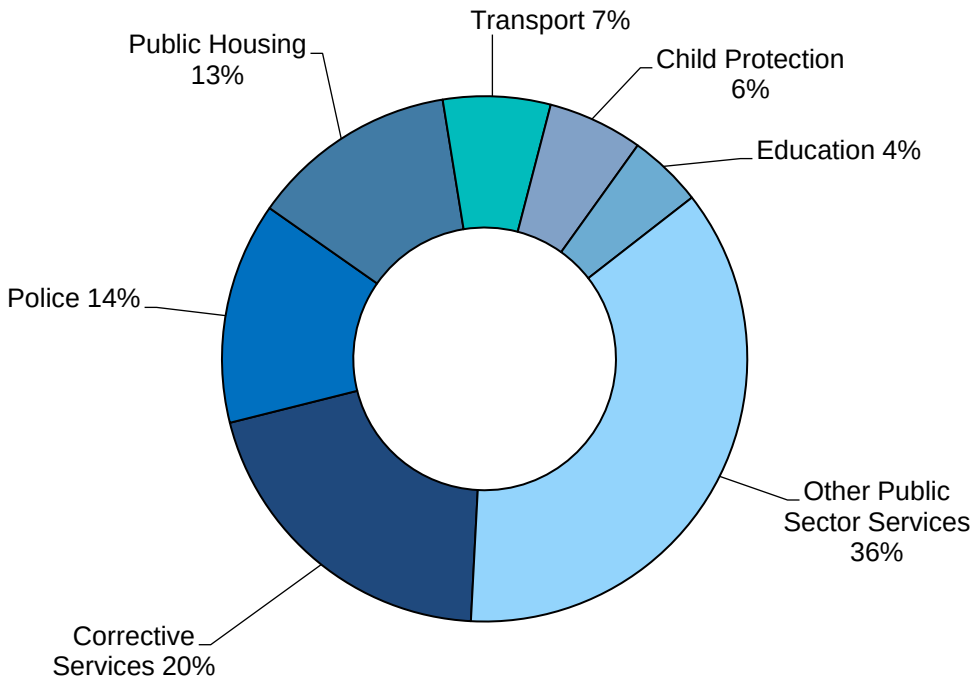
In 2021-22, there were 1,180 complaints received about the public sector and 1,190 complaints were finalised. The number of complaints about the public sector as a whole since 2017-18 is shown in the chart below.

Complaints Received about the Public Sector between 2017-18 and 2021-22



Public sector agencies deliver a very diverse range of services to the Western Australian community. In 2021-22, complaints were received about key services as shown in the following chart.

Complaints Received about the Public Sector in 2021-22



Of the 1,180 complaints received about the public sector in 2021-22, 64% were about six key service areas covering:

- Corrective services, in particular prisons (239 or 20%);
- Police (161 or 14%);
- Public housing (150 or 13%);
- Transport (78 or 7%);
- Child protection (69 or 6%);
- Education, including public schools and TAFE colleges (54 or 4%). Information about universities is shown separately under the university sector.

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

Outcomes of complaints about the public sector

In 2021-22, there were 160 actions taken by public sector bodies as a result of Ombudsman action following a complaint. These resulted in 133 remedies being provided to complainants and 27 improvements to public sector practices.

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

Case Study

Financial assistance granted after review

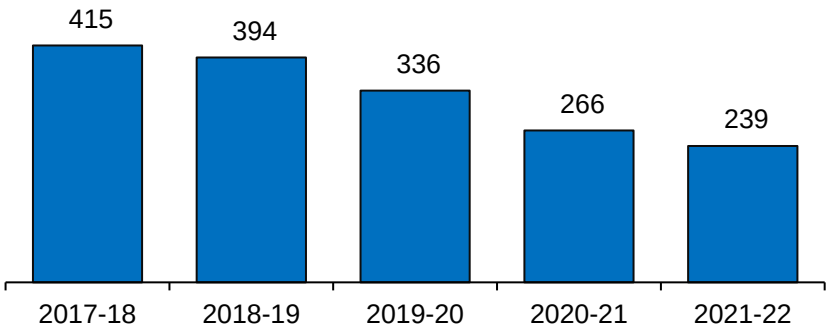
A person applied to a public authority for financial assistance for their business. The application was unsuccessful and the person requested a review of the decision. The public authority declined the request for review, saying the person did not provide evidence proving their eligibility for the financial assistance. The person complained to the Ombudsman on the basis that they met the eligibility criteria but were not given the opportunity to provide evidence before the review was refused.

Following the Ombudsman's investigation, the public authority agreed to conduct a full review of its original decision after giving the person an opportunity to provide further information about their eligibility. It also amended its policies to clarify the information that is required from people requesting a review. The public authority subsequently approved the person's application.

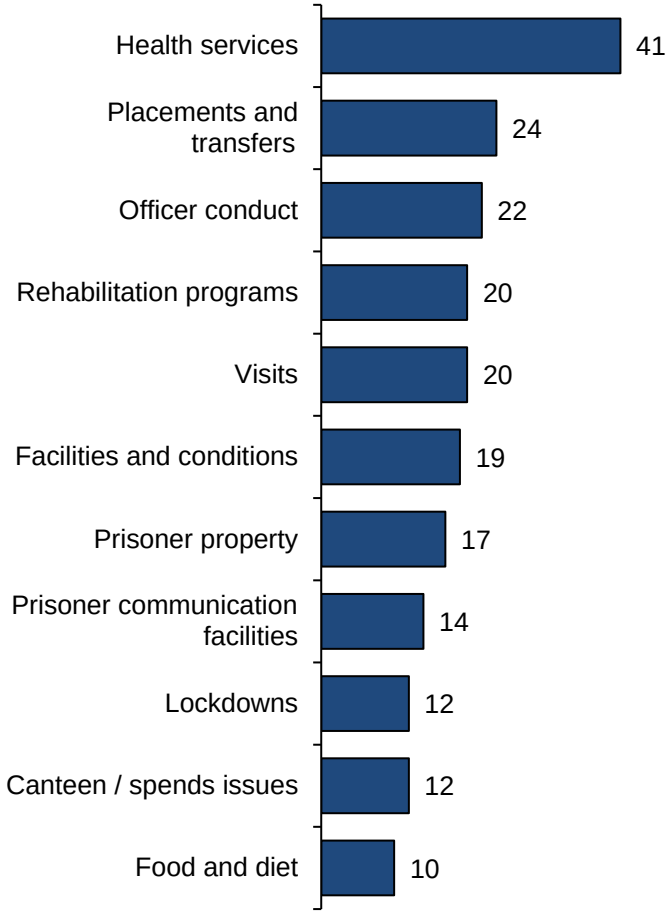
Public sector complaint issues and outcomes

Corrective Services

Complaints received



Most common allegations

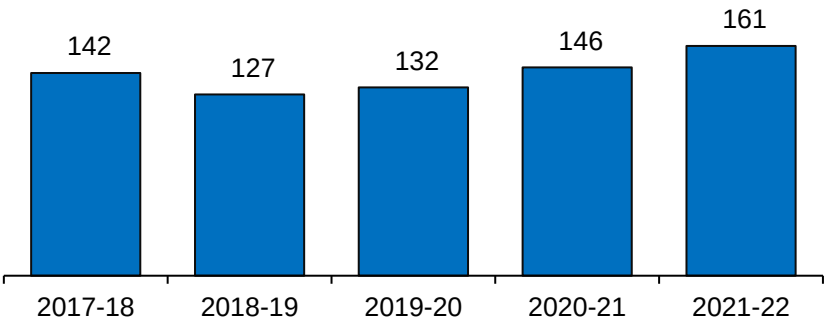


Outcomes achieved

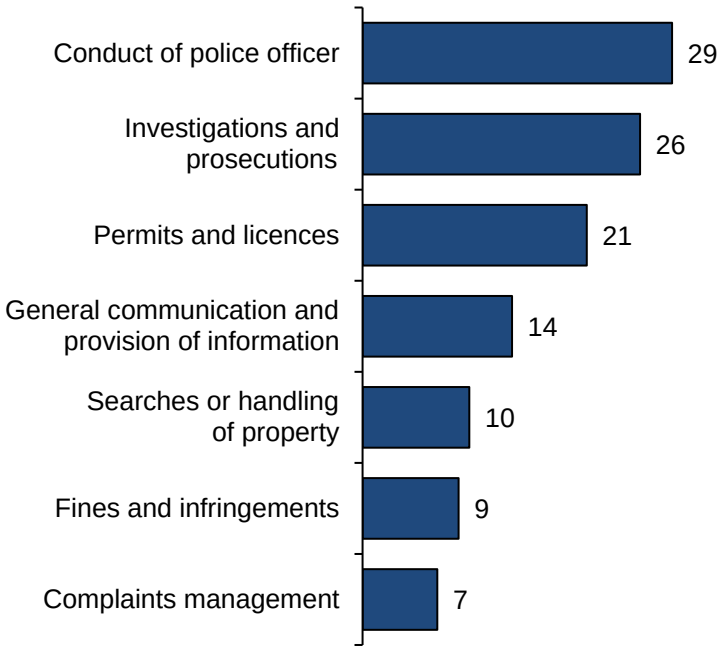
- Financial payment or monetary charge refunded;
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to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

Police

Complaints received



Most common allegations

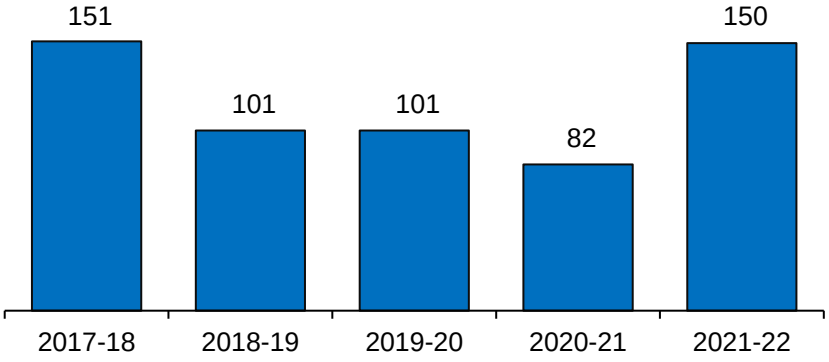


Outcomes achieved

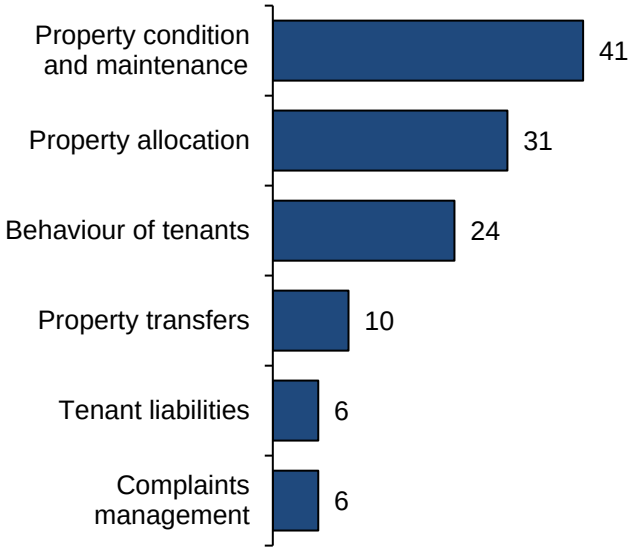
- Reversal or significant variation of original decision; and
- Action expedited.

Public Housing

Complaints received



Most common allegations

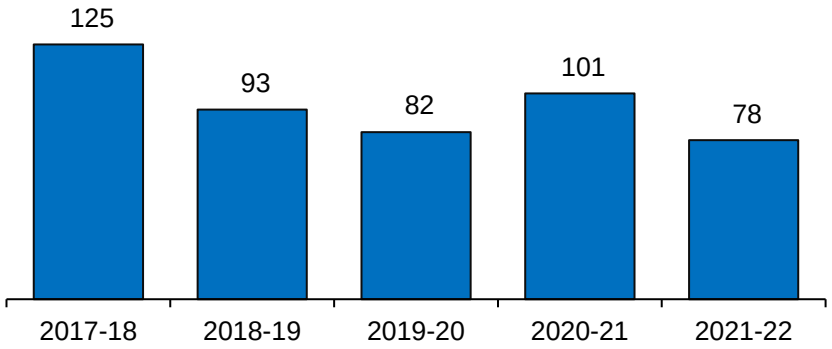


Outcomes achieved

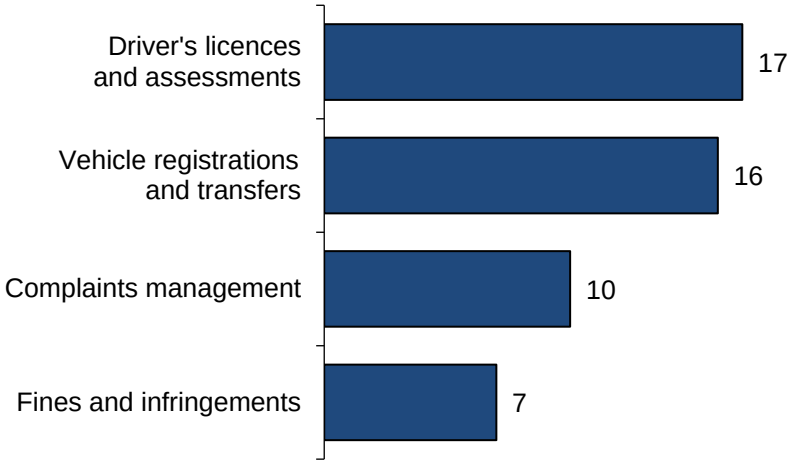
- Monetary charge reduced, refunded or rebate given;
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided; and
- Senior officer nominated to handle the matter.

Transport

Complaints received



Most common allegations

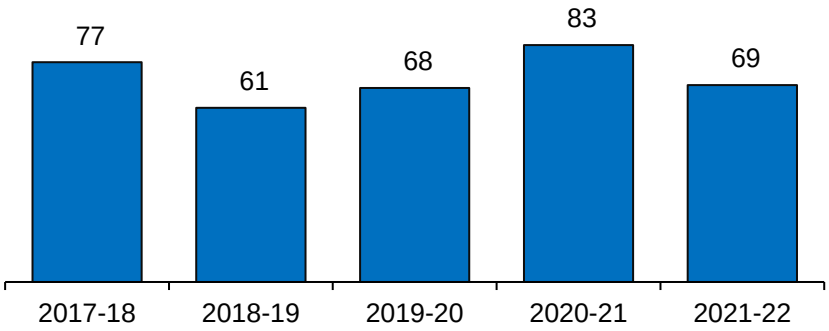


Outcomes achieved

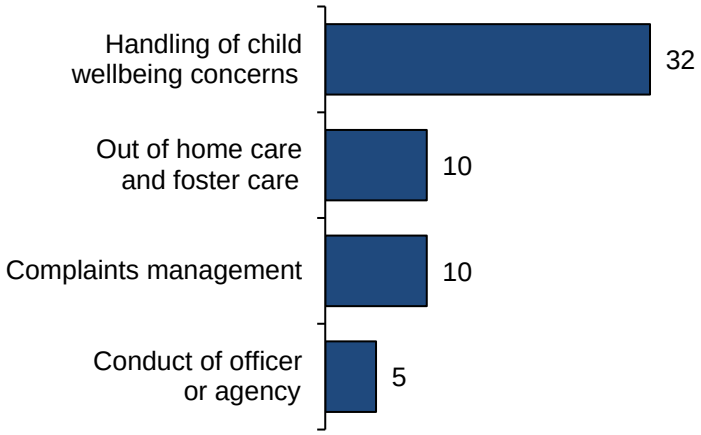
- Financial payment or monetary charge refunded;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to policy, procedures, business systems or practices; and
- Staff training.

Child Protection

Complaints received



Most common allegations

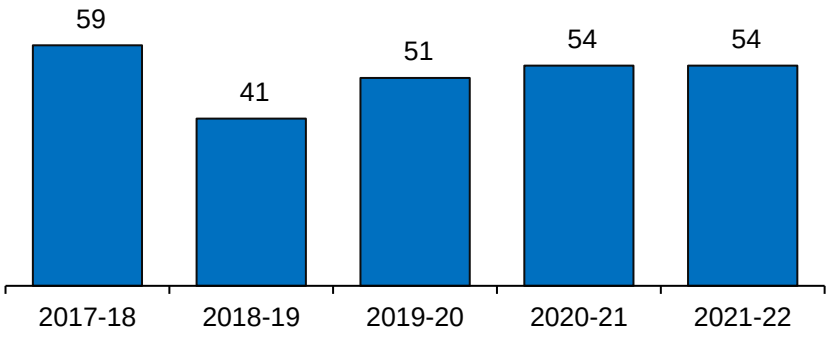


Outcomes achieved

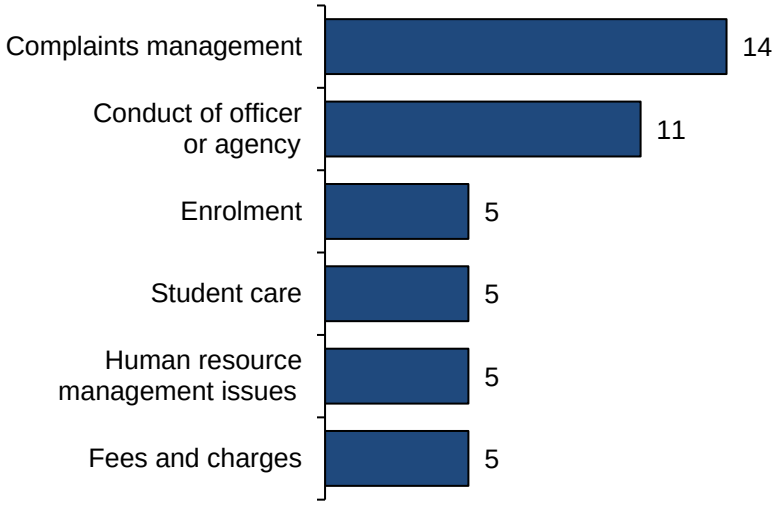
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy, procedure, business systems or practices; and
- Conduct audit or review.

Education

Complaints received



Most common allegations



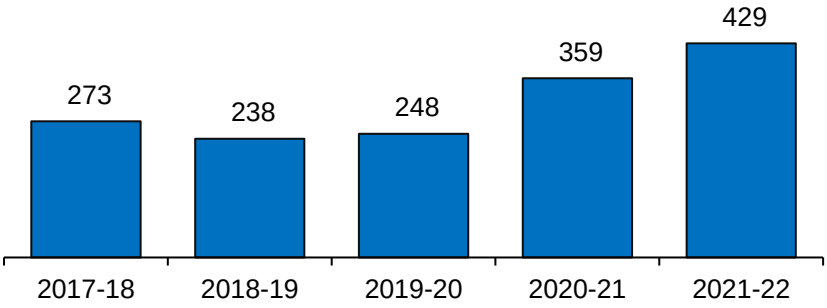
These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2018* relating to TAFE colleges and other public education agencies. Further details on these appeals are included later in this section.

Outcomes achieved

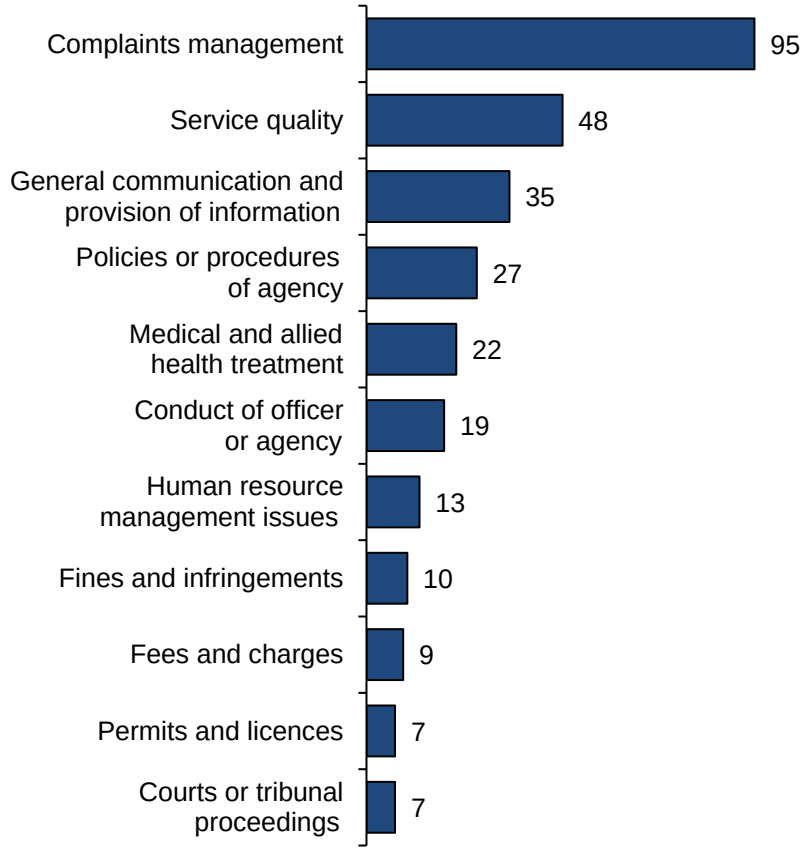
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to policy, procedure, business systems or practices;
- Conduct audit or review; and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

Other Public Sector Services

Complaints received



Most common allegations



Outcomes achieved

- Financial payment or 'act of grace' payment;
- Monetary charge reduced, refunded or rebate given;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to policy or procedure;
- Update to publications or website; and
- Conduct audit or review.

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

Case Study

Information updated and charges reduced

Information published on the Frequently Asked Questions (**FAQ**) page of a public authority's website was less detailed than information it published in an FAQ document. A person received an invoice from the public authority which was higher than they had expected based on the information on the FAQ page of the website. When the person complained to the public authority, the public authority provided an explanation, apologised for the confusion and provided information about payment options, however it did not amend the invoice. The person then complained to the Ombudsman.

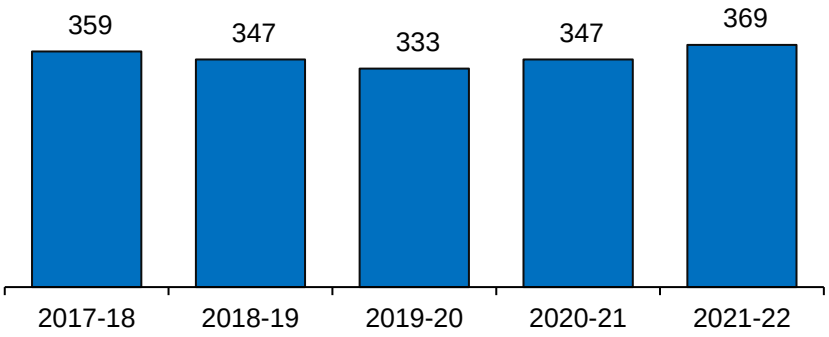
Following an investigation by the Ombudsman, the public authority updated the information on its website and offered the person an internal review of the original decision. The public authority subsequently reviewed the decision and reduced the amount of the invoice.

The local government sector

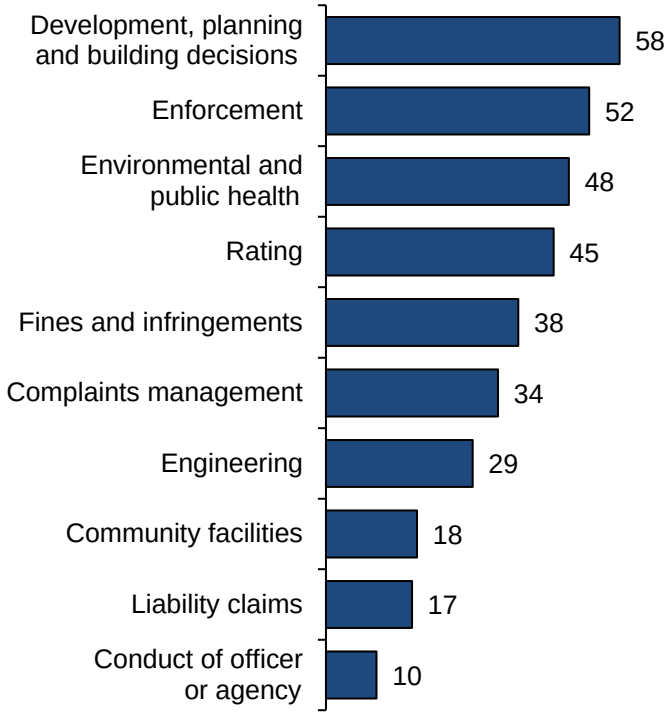
The following section provides further details about the issues and outcomes of complaints for the local government sector.

Local Government

Complaints received



Most common allegations



Outcomes achieved

- Financial payment or monetary charge refunded or withdrawn;
- Infringement or charge withdrawn;
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to business systems or practices;
- Conduct audit or review;
- Improve record keeping; and
- Staff training.

Case Study

Apology and improved customer service after significant delay

A resident made a request to a local government for information, however despite following up twice, did not receive a response over a six month period. The person complained to the Ombudsman about the lack of response.

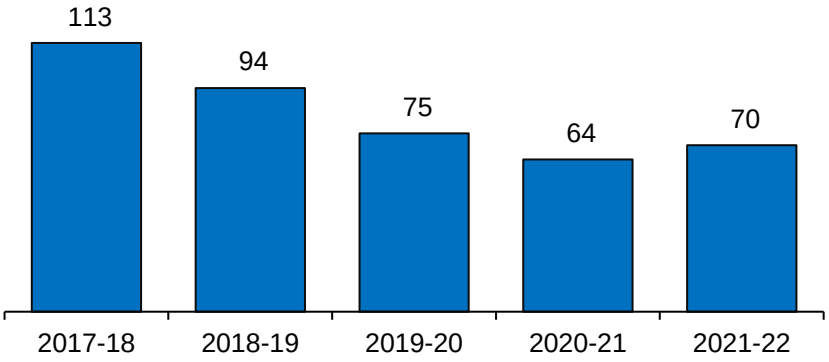
Following an investigation by the Ombudsman, the local government reviewed its processes to identify why the oversight occurred. The local government responded to the resident's request by phone and in writing and apologised for the substantial delay in providing a response. To avoid future occurrences, the local government employed an additional customer service officer and installed new customer service software. The software will be configured to ensure customer service requests are escalated if not addressed in a timely manner.

The university sector

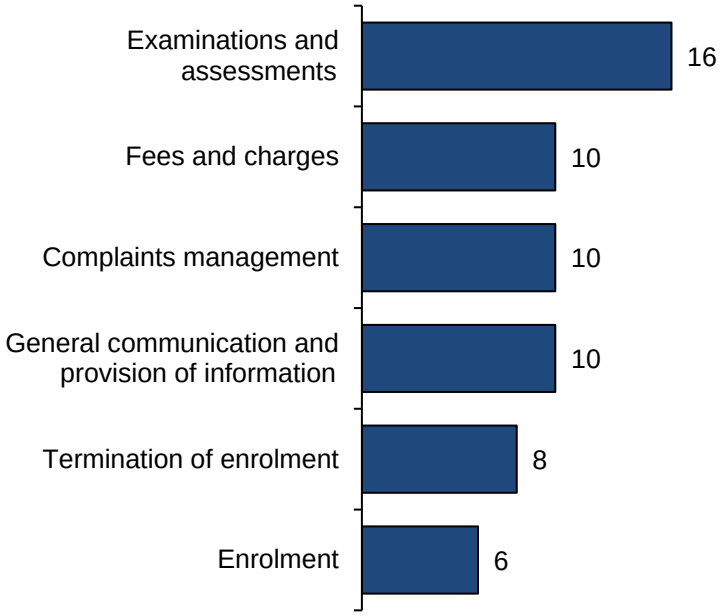
The following section provides further details about the issues and outcomes of complaints for the university sector.

Universities

Complaints received



Most common allegations



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

Outcomes Achieved

- Monetary charge reduced or refunded;
- Consider or reconsider a matter and make a decision;
- Apology;
- Change to business systems or practices; and
- Staff training.

Other Complaint Related Functions

Reviewing appeals by overseas students

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

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

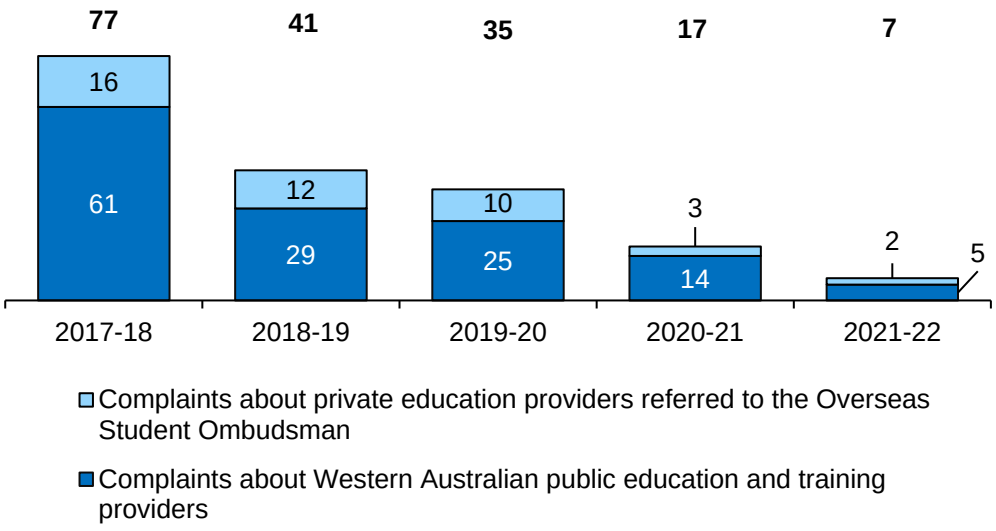
- Provides a free complaint resolution service;
- Is independent and impartial and does not represent either the overseas students or education and training providers; and
- Can make recommendations arising out of investigations.

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

Complaints lodged with the Office under the National Code

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

Complaints Received from Overseas Students under the National Code between 2017-18 and 2021-22



During 2021-22, the Office received seven complaints from overseas students, including five complaints about public education and training providers. Of the five complaints about public education providers within the Ombudsman's jurisdiction, three complaints were about universities and two were about other public education providers. The Office also received two complaints that, after initial assessment, were found to be about a private education provider. The Office referred these complainants to the Overseas Students Ombudsman.

The five complaints by overseas students about public education and training providers involved five separate allegations, relating to:

- Fees and charges (3);
- Termination of enrolment (1); and
- Transfers between education providers (1).

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

Case Study

University refunds fees after student withdraws from study

An international student enrolled to study at a university as part of a package with another education provider and paid a significant deposit. The student then withdrew from the course three months before the course commenced, as they wanted to return to their home country. When the student applied for a refund of the deposit of their course fees, the university rejected the application as the terms of the package contract stated no refund was available. The student appealed, but the university upheld its original decision and the student complained to the Ombudsman.

The Ombudsman's investigation considered the contract and supporting information provided to the student at the time of enrolment, which included terms covering refunds for both package and non-package tuition fees.

As a result of the Ombudsman's investigation, the university reconsidered the matter, acknowledged that the student may not have fully understood the terms of the contract for package offers and would consider whether the information should be amended to provide further clarity for package students. Considering the student's circumstances and early withdrawal, the university agreed to refund the tuition fees minus an administration fee. The university subsequently reviewed and amended its contract terms to improve clarity about the refund available for package offers.

Public Interest Disclosures

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

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

During the year, three disclosures were received.

Indian Ocean Territories

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

Terrorism

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

Requests for Review

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

In 2021-22, seven reviews were undertaken, representing one third of one per cent of the total number of complaints finalised by the Office. In all cases where a review was undertaken, the original decision was upheld.

Child Death Review

Overview

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

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

Background

In November 2001, prompted by the coronial inquest into the death of a 15 year old Aboriginal girl at the Swan Valley Nyoongar Community in 1999, the (then) State Government announced a special inquiry into the response by government agencies to complaints of family violence and child abuse in Aboriginal communities.

The resultant 2002 report, *Putting the Picture Together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities*, recommended that a Child Death Review Team be formed to review the deaths of children in Western Australia (Recommendation 146). Responding to the report the (then) Government established the Child Death Review Committee (**CDRC**), with its first meeting held in January 2003. The function of the CDRC was to review the operation of relevant policies, procedures and organisational systems of the (then) Department for Community Development in circumstances where a child had contact with the Department.

In August 2006, the (then) Government announced a functional review of the (then) Department for Community Development. Ms Prudence Ford was appointed the independent reviewer and presented the report, *Review of the Department for Community Development: Review Report* (**the Ford Report**) to the (then) Premier in January 2007. In considering the need for an independent, inter-agency child death review model, the Ford Report recommended that:

- The CDRC together with its current resources be relocated to the Ombudsman (Recommendation 31); and
- A small, specialist investigative unit be established in the Office to facilitate the independent investigation of complaints and enable the further examination, at the discretion of the Ombudsman, of child death review cases where the child was known to a number of agencies (Recommendation 32).

Subsequently, the *Parliamentary Commissioner Act 1971* was amended to enable the Ombudsman to undertake child death reviews, and on 30 June 2009, the child death review function in the Office commenced operation.

The Role of the Ombudsman in relation to Child Death Reviews

The child death review function enables the Ombudsman to review investigable deaths. Investigable deaths are defined in the Ombudsman's legislation, the *Parliamentary Commissioner Act 1971* (see Section 19A(3)), and occur when a child dies in any of the following circumstances:

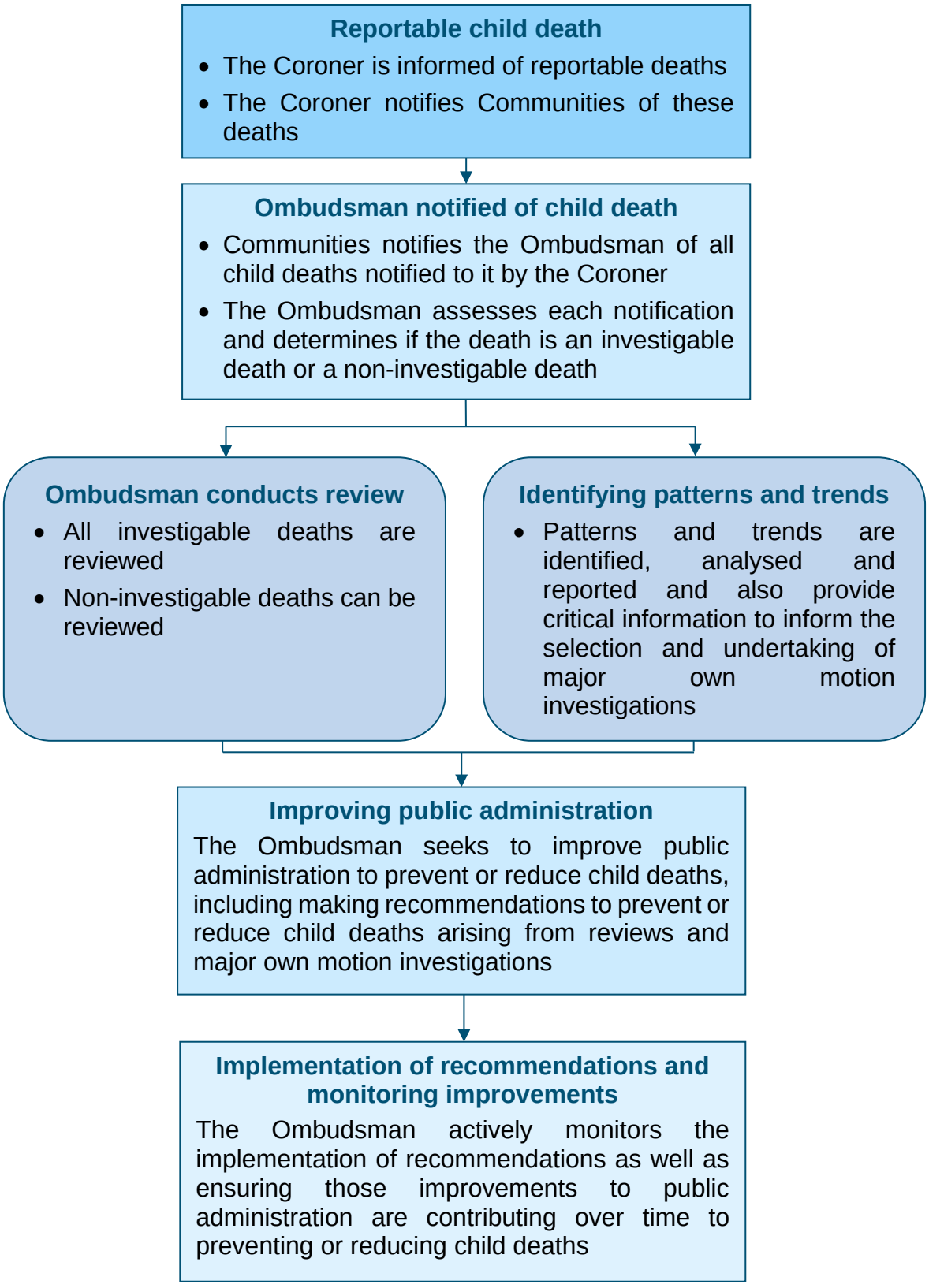
- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children and Community Services Act 2004*, the CEO had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child; and
    - Any of the actions listed in section 32(1) of the *Children and Community Services Act 2004* was done in respect of the child or a child relative of the child.
- The child or a child relative of the child is in the CEO's care or protection proceedings are pending in respect of the child or a child relative of the child.

In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

In addition to reviewing investigable deaths, the Ombudsman can review other notified deaths. The Ombudsman also undertakes major own motion investigations arising from child death reviews.

In reviewing child deaths the Ombudsman has wide powers of investigation, including powers to obtain information relevant to the death of a child and powers to recommend improvements to public administration about ways to prevent or reduce child deaths across all agencies within the Ombudsman's jurisdiction. The Ombudsman also has powers to monitor the steps that have been taken, are proposed to be taken or have not been taken to give effect to the recommendations.

The Child Death Review Process



Analysis of Child Death Reviews

By reviewing child deaths, the Ombudsman is able to identify, record and report on a range of information and analysis, including:

- The number of child death notifications and reviews;
- The comparison of investigable deaths over time;
- Demographic information identified from child death reviews;
- Circumstances in which child deaths have occurred;
- Social and environmental factors associated with investigable child deaths;
- Analysis of children in particular age groups; and
- Patterns, trends and case studies relating to child death reviews.

Notifications and reviews

Communities receives information from the Coroner on reportable deaths of children and notifies the Ombudsman of these deaths. The notification provides the Ombudsman with a copy of the information provided to Communities by the Coroner about the circumstances of the child's death together with a summary outlining the past involvement of Communities with the child and the child's family.

The Ombudsman assesses all child death notifications received to determine if the death is, or is not, an investigable death. If the death is an investigable death, it must be reviewed. If the death is a non-investigable death, it can be reviewed. The extent of a review depends on a number of factors, including the circumstances surrounding the child's death and the level of involvement of Communities or other public authorities in the child's life. Confidentiality of the child, family members and other persons involved with the case is strictly observed.

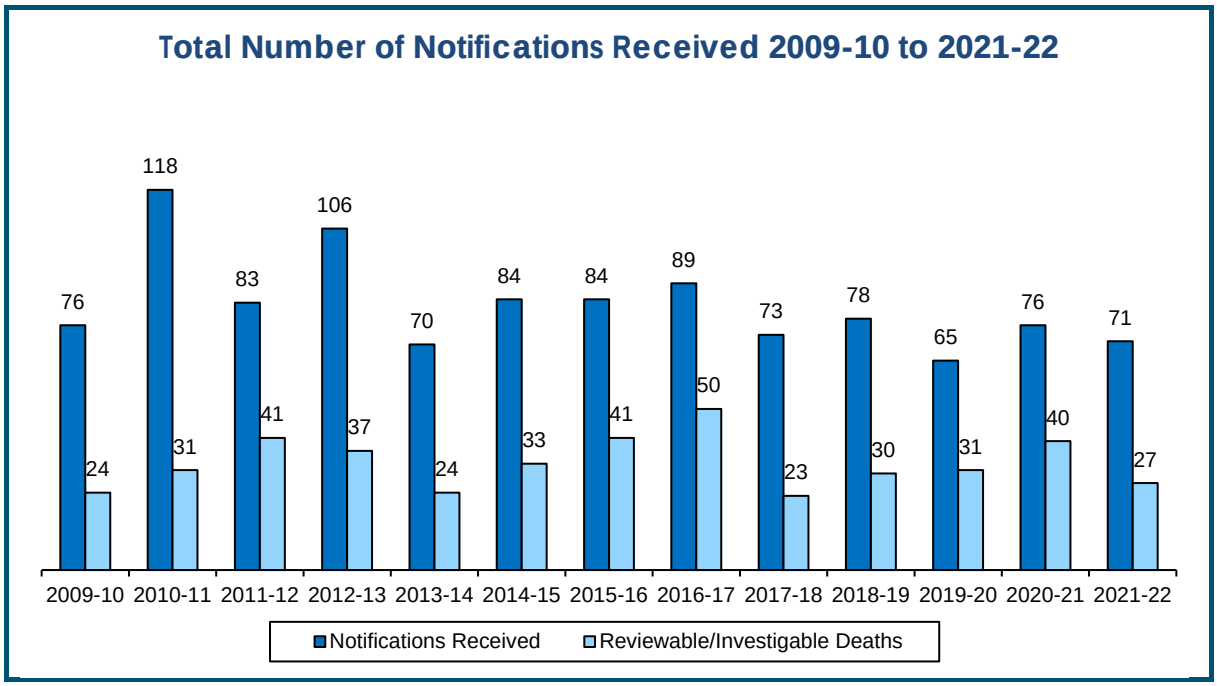
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

Child death review cases prior to 30 June 2009

At the commencement of the child death review jurisdiction on 30 June 2009, 73 cases were transferred to the Ombudsman from the CDRC. These cases related to child deaths prior to 30 June 2009 that were reviewable by the CDRC and covered a range of years from 2005 to 2009. Almost all (67 or 92%) of the transferred cases were finalised in 2009-10 and six cases were carried over. Three of these transferred cases were finalised during 2010-11 and the remaining three were finalised in 2011-12.

Number of child death notifications and reviews

During 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

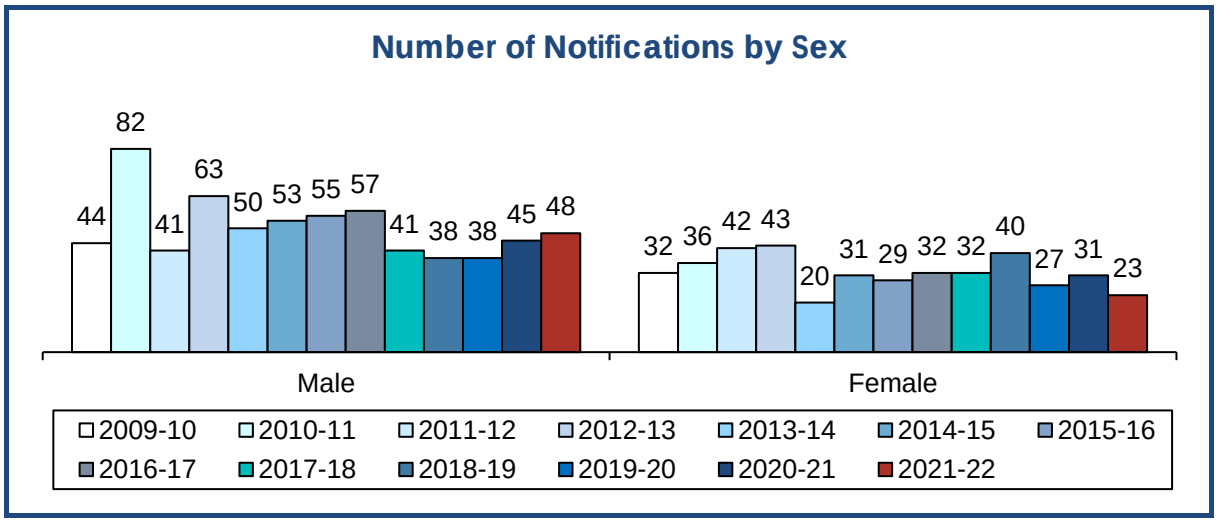
Information is obtained on a range of characteristics of the children who have died including sex, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

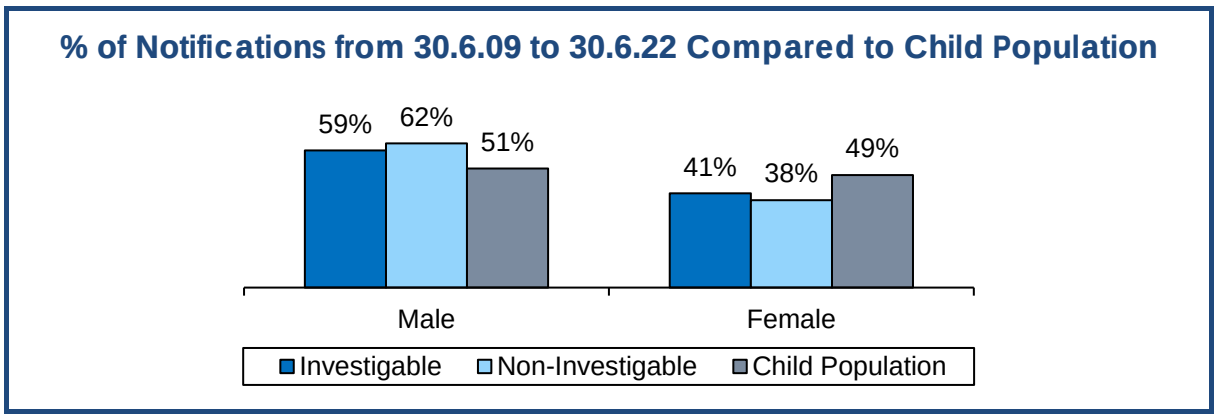
The following charts show:

- 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.

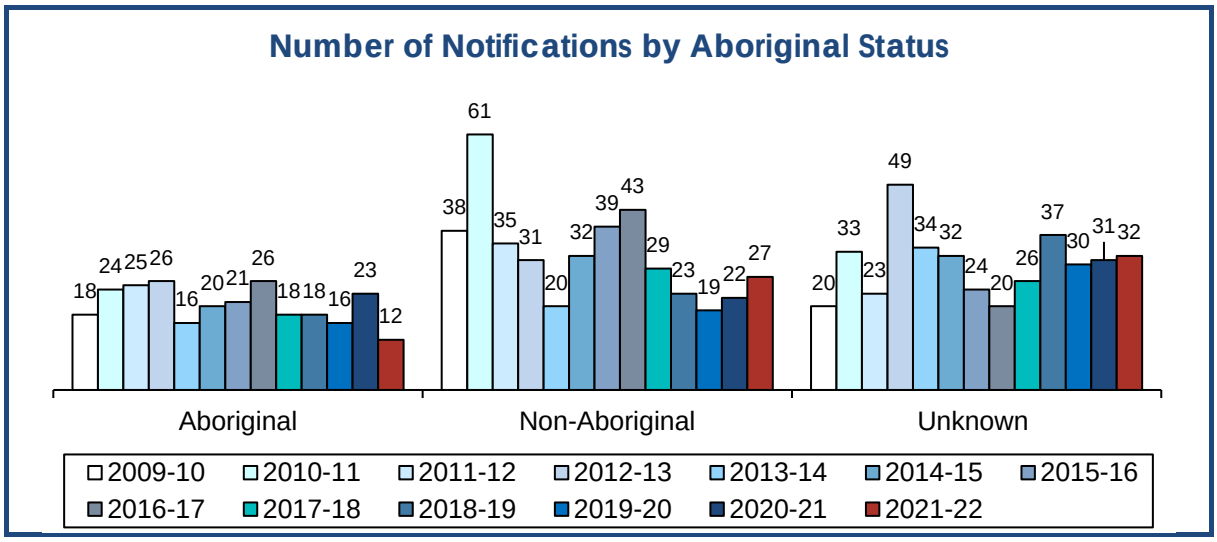


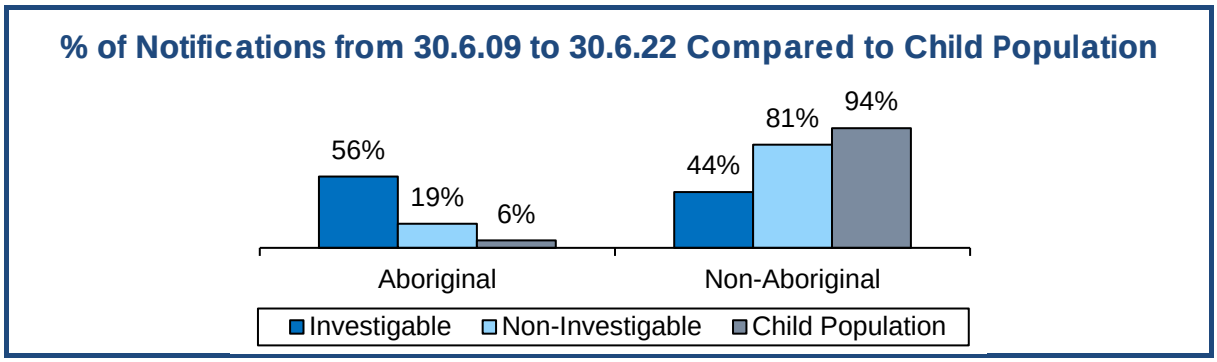


Further analysis of the data shows that, considering all 13 years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

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.



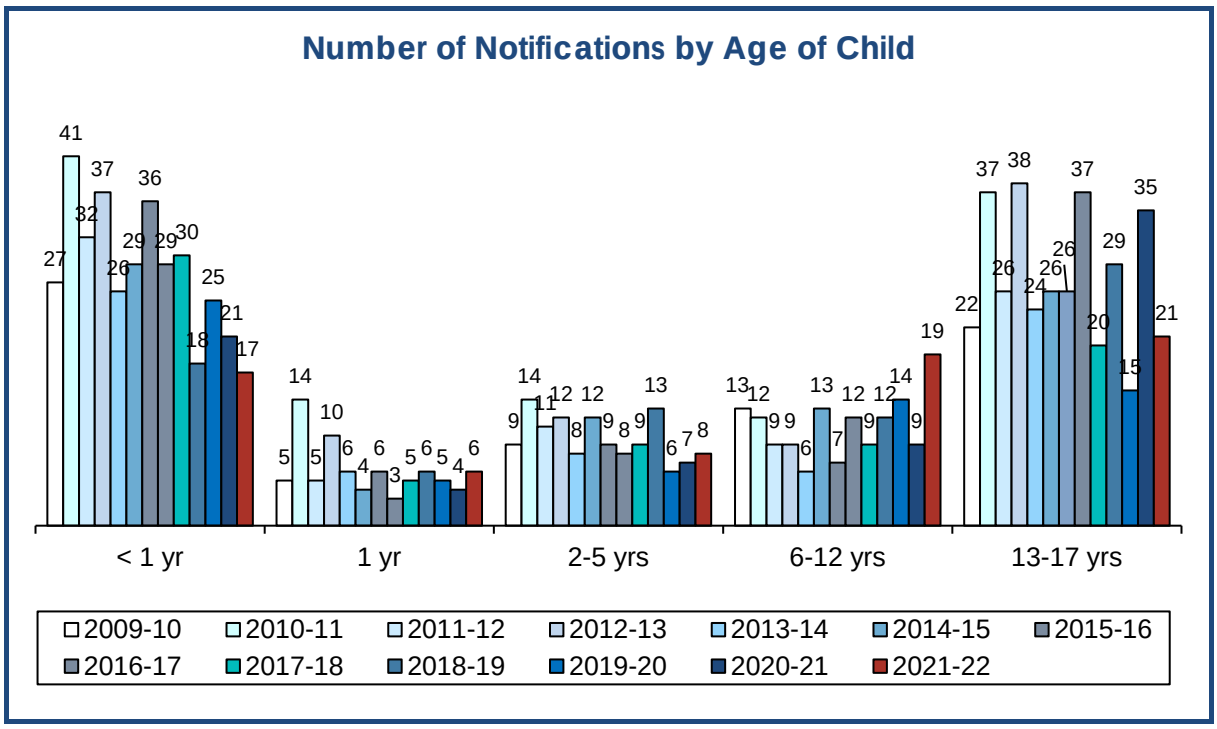


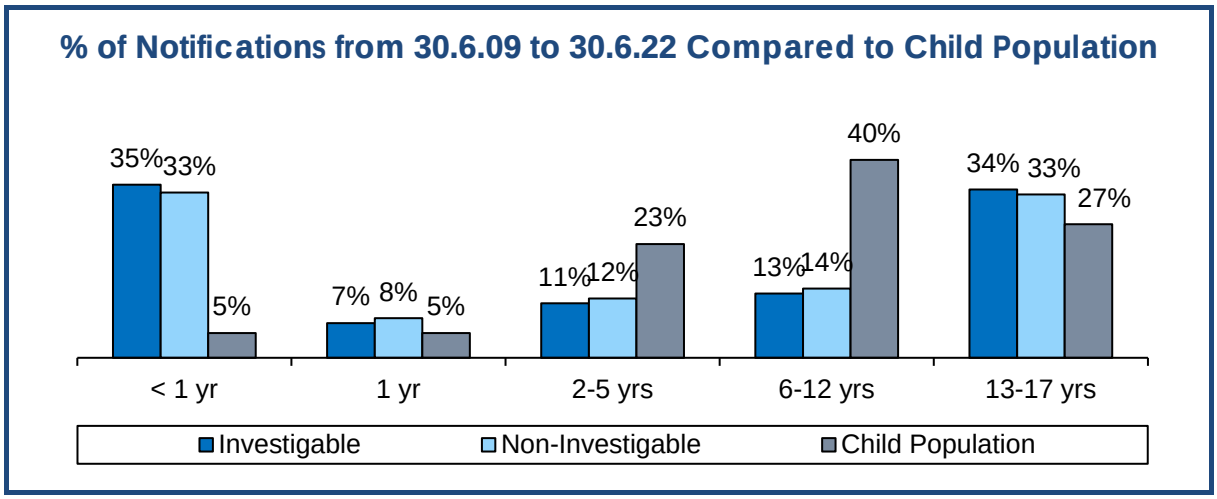
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

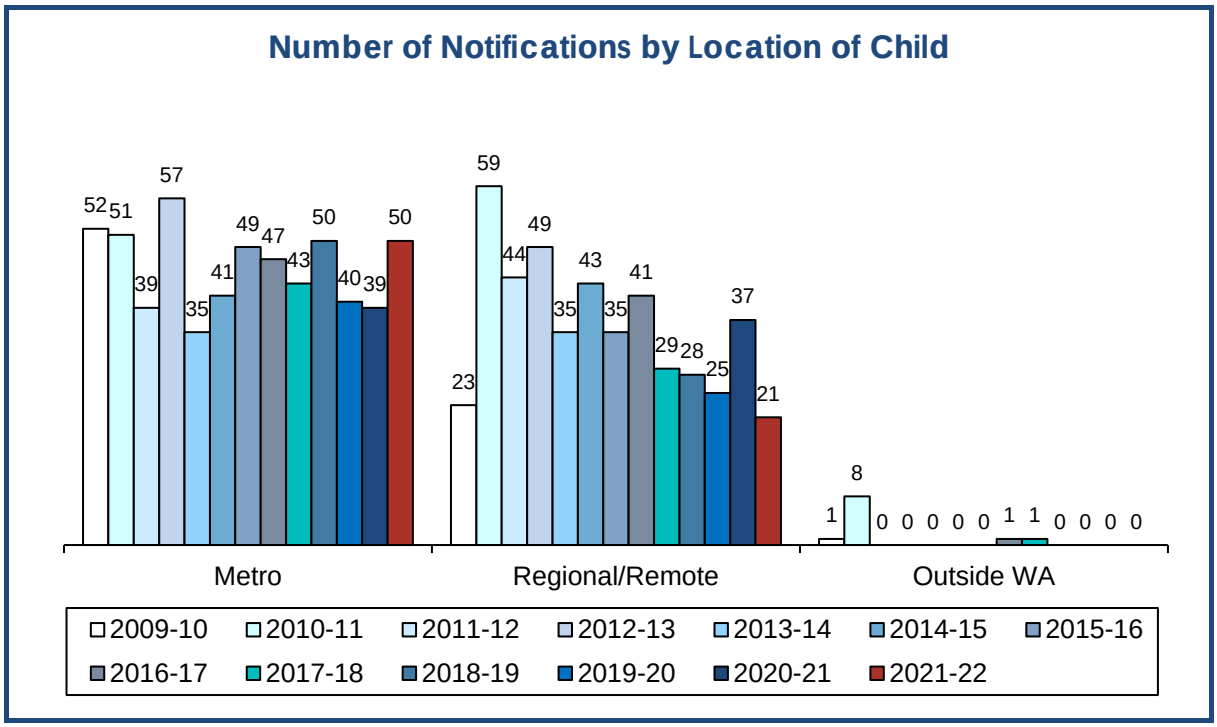




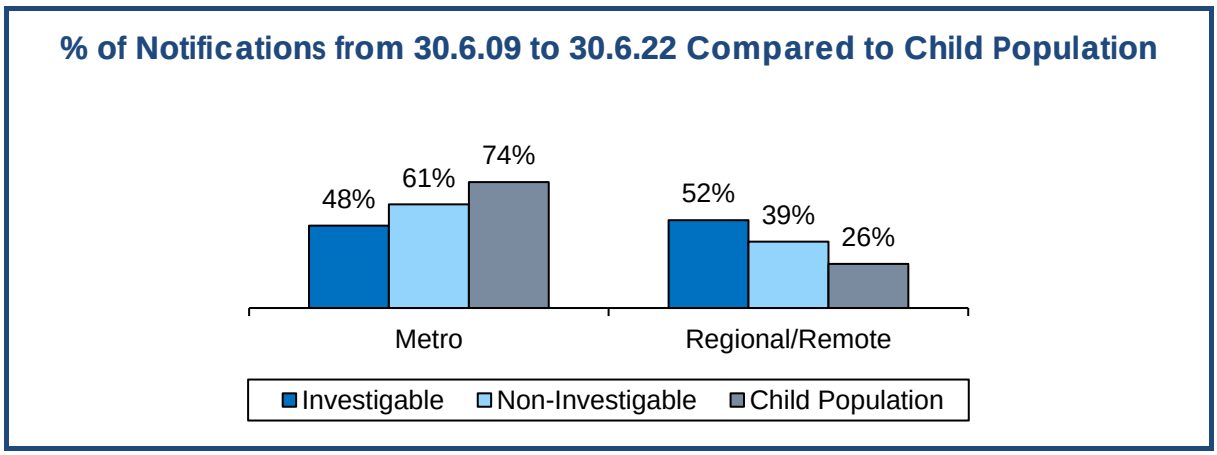
A more detailed analysis by age group is provided later in this section.

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

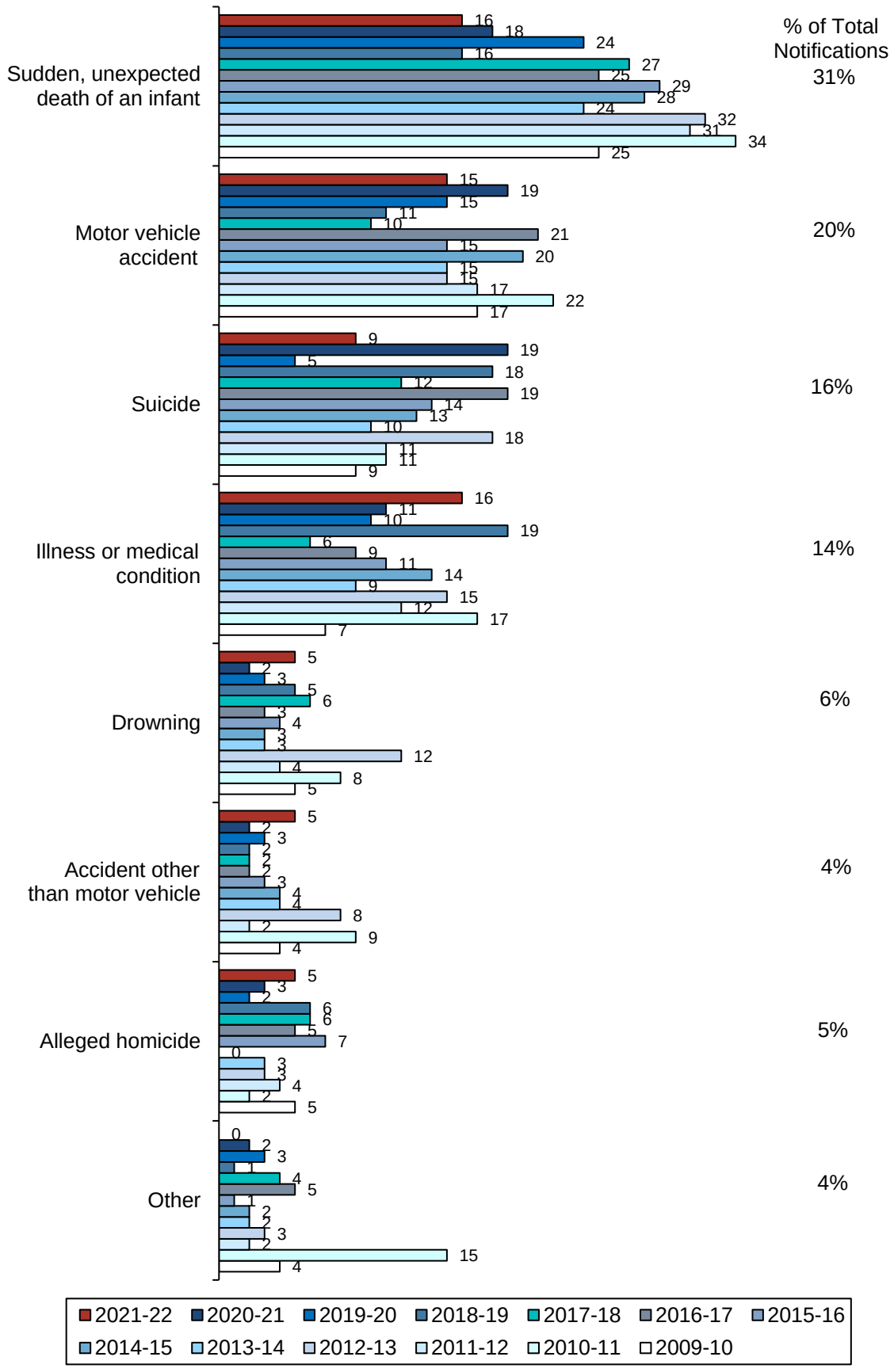
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally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



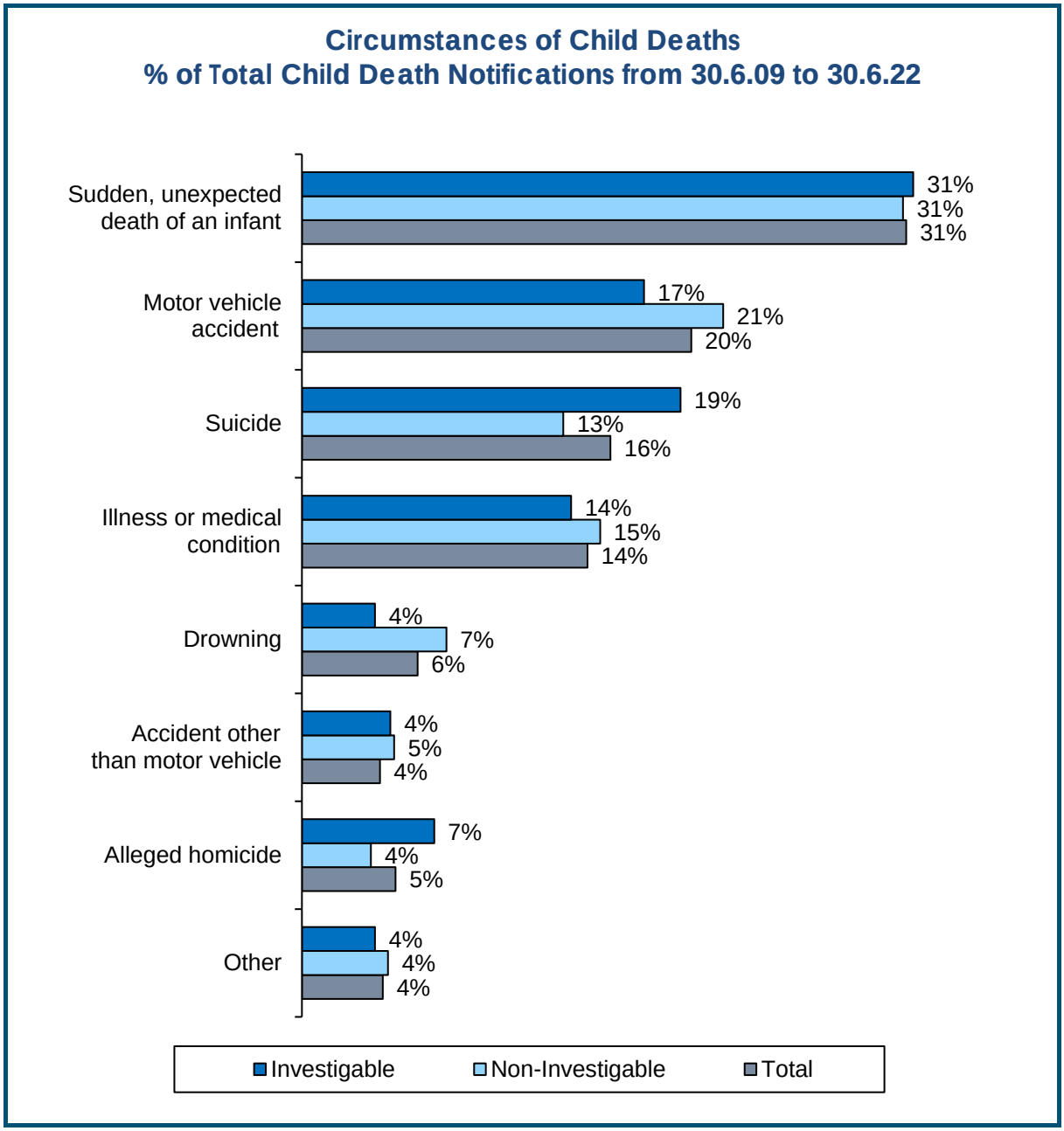
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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

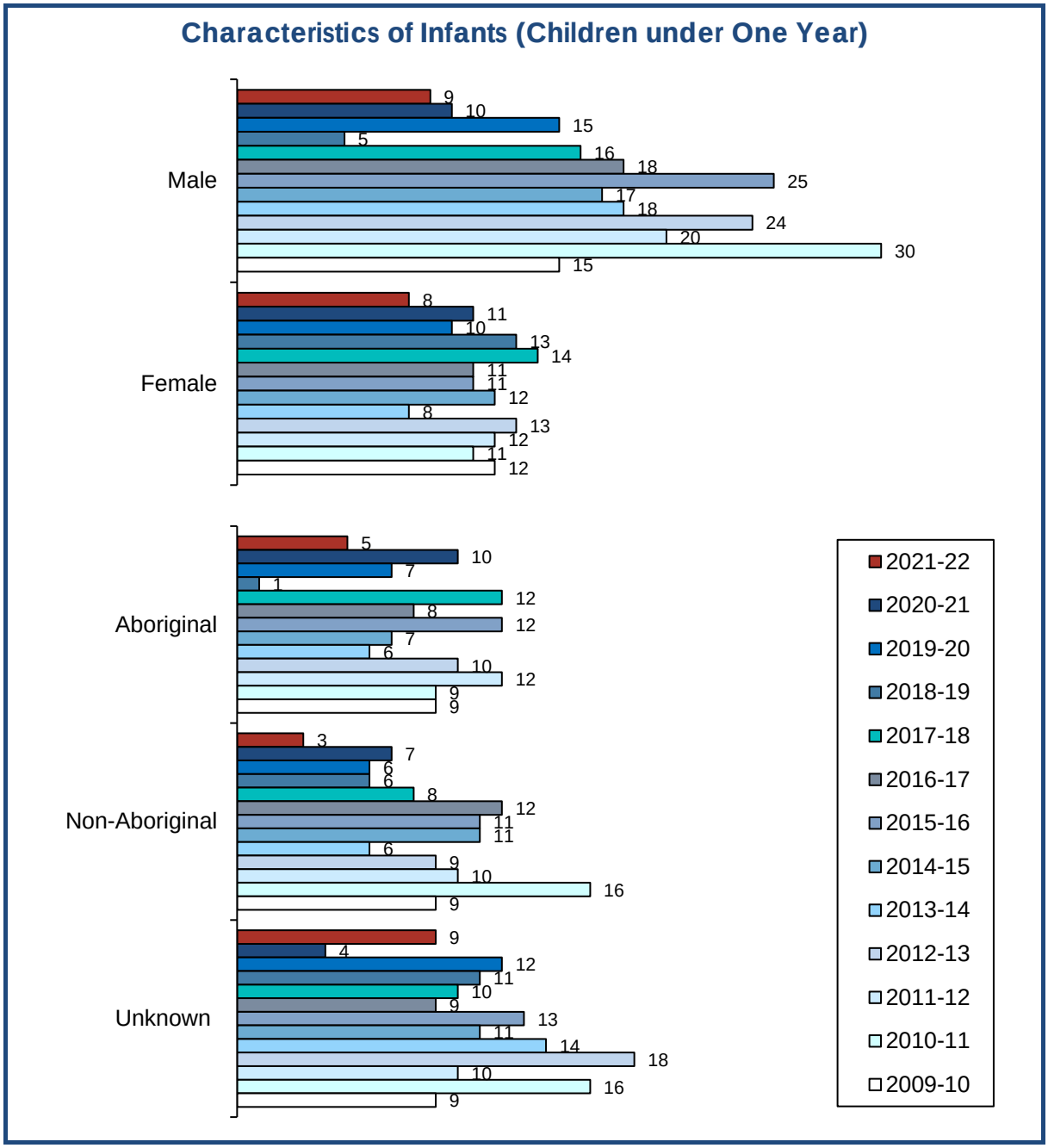
In child deaths notified to the Ombudsman in 2021-22, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

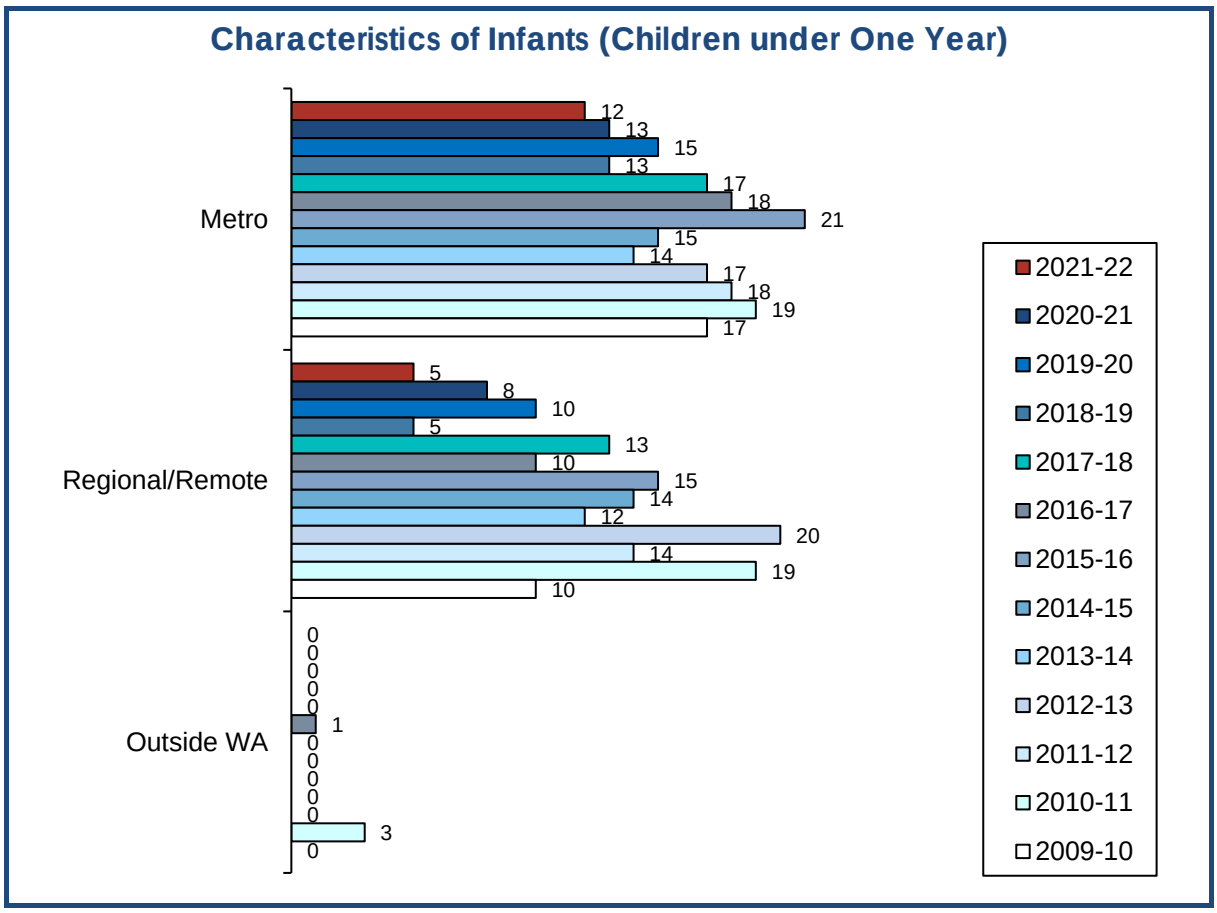
Analysis of children in particular age groups

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.



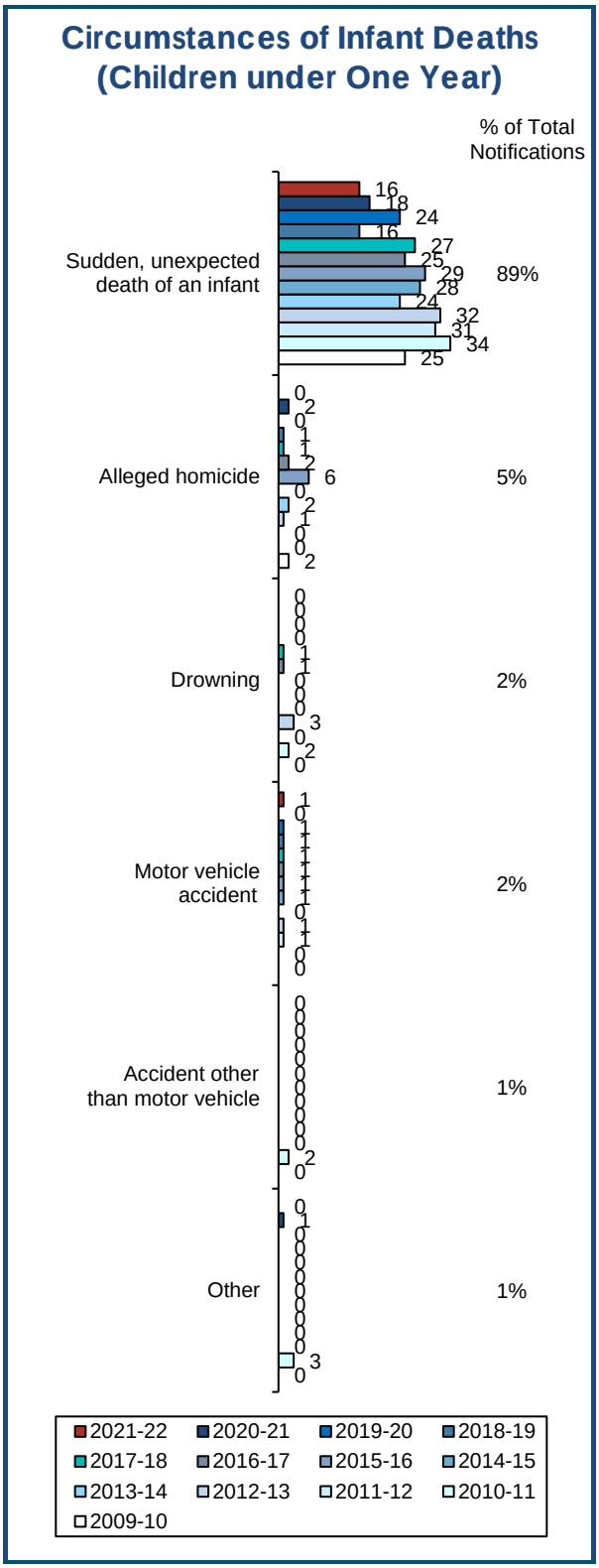


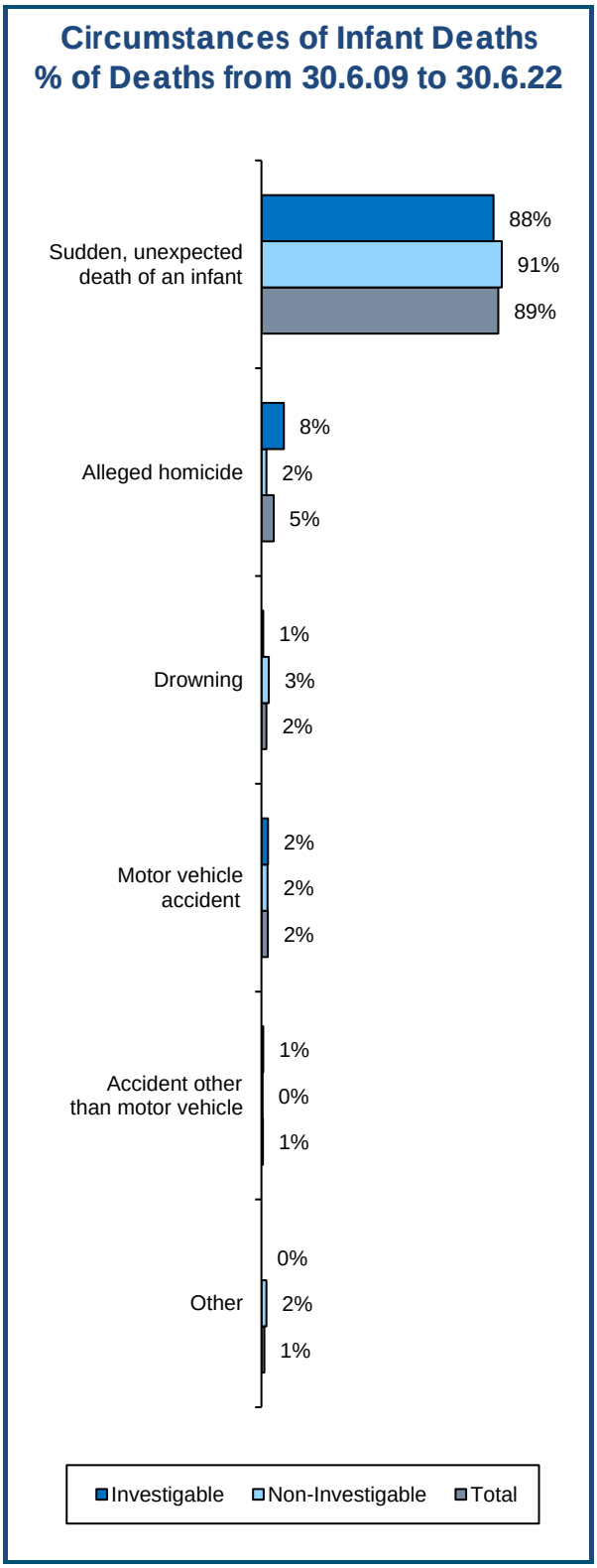
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.

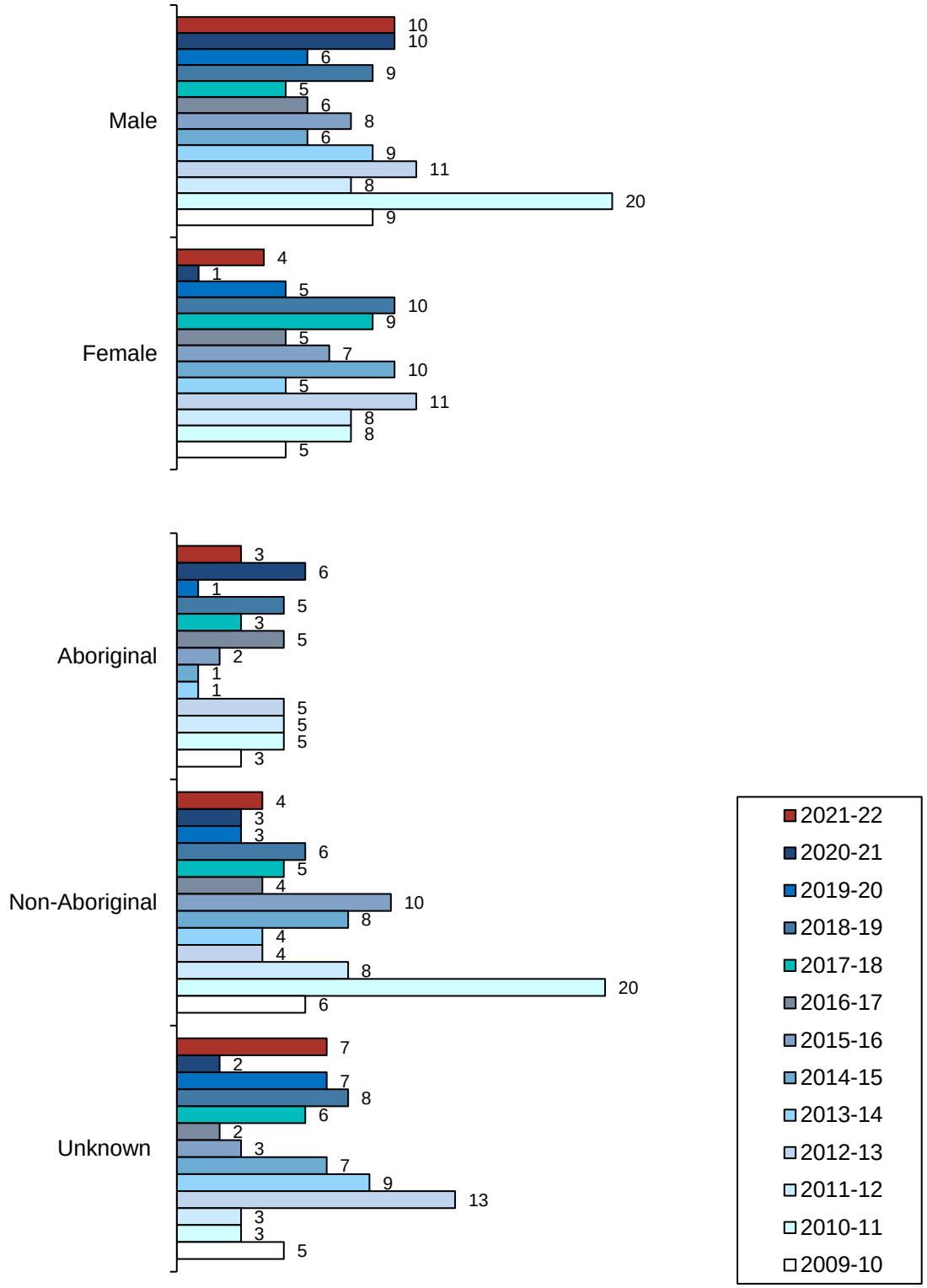
One hundred and fifty three deaths of infants were determined to be investigable deaths.

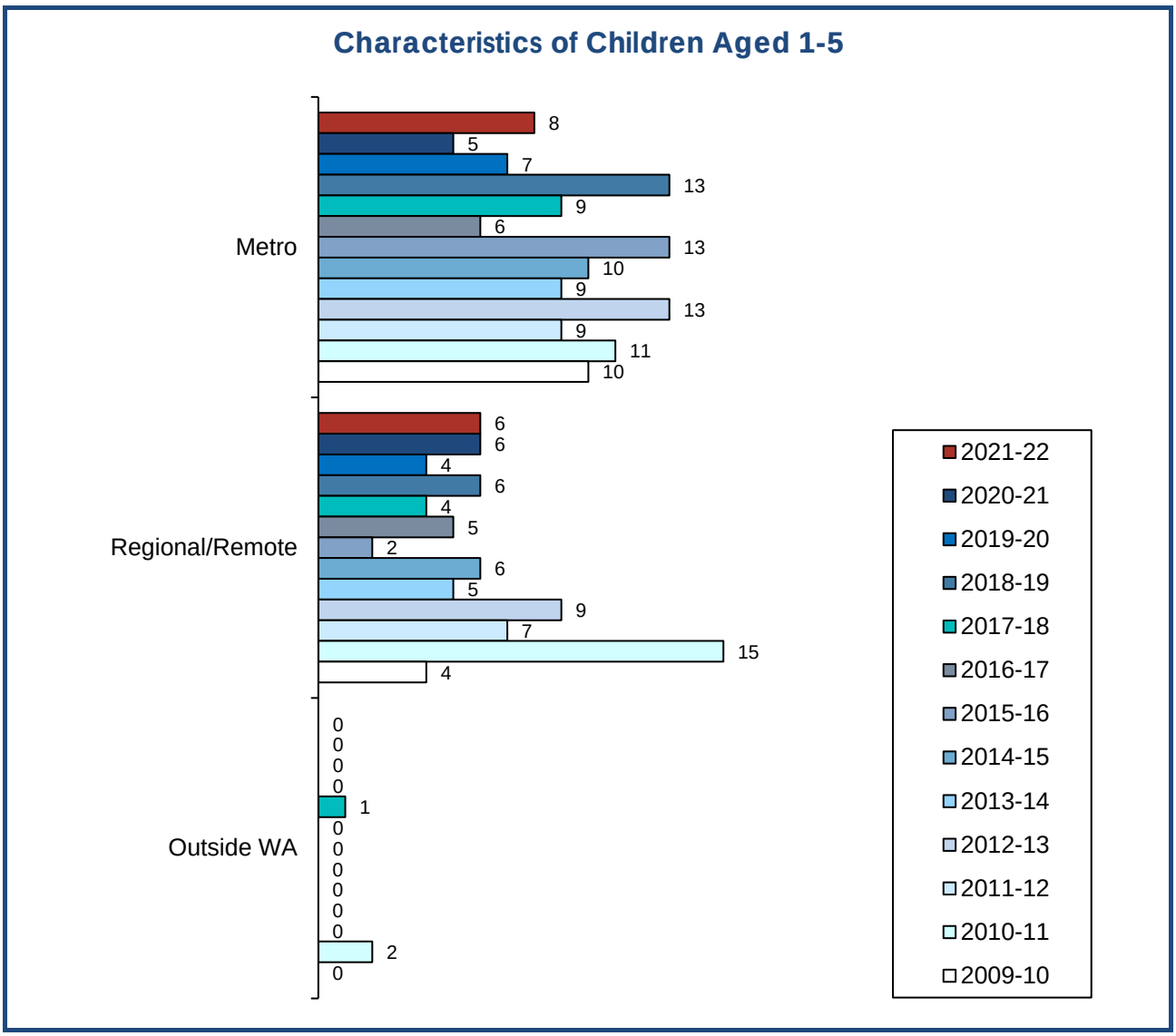
Deaths of children aged 1 to 5 years

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



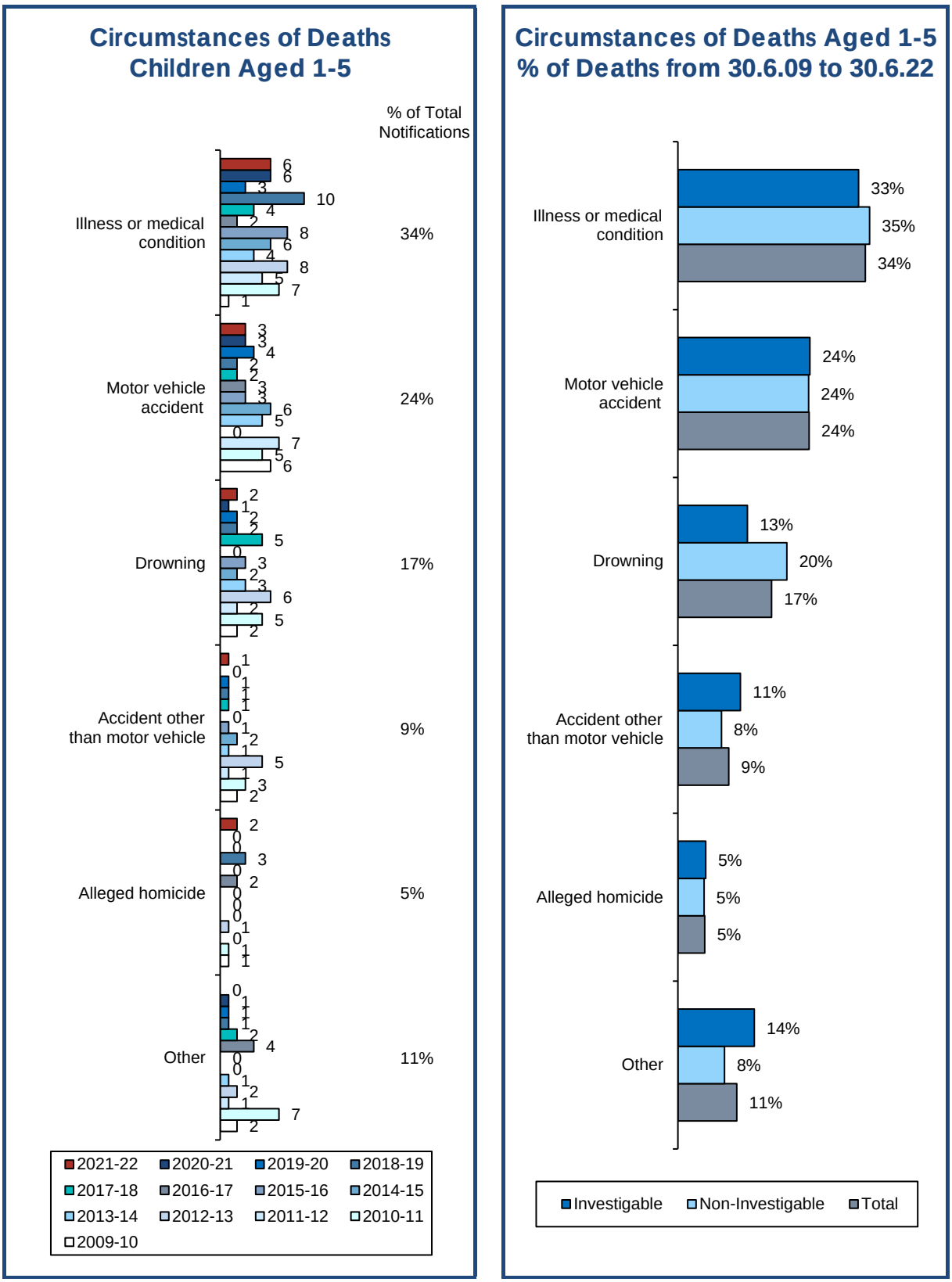


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).



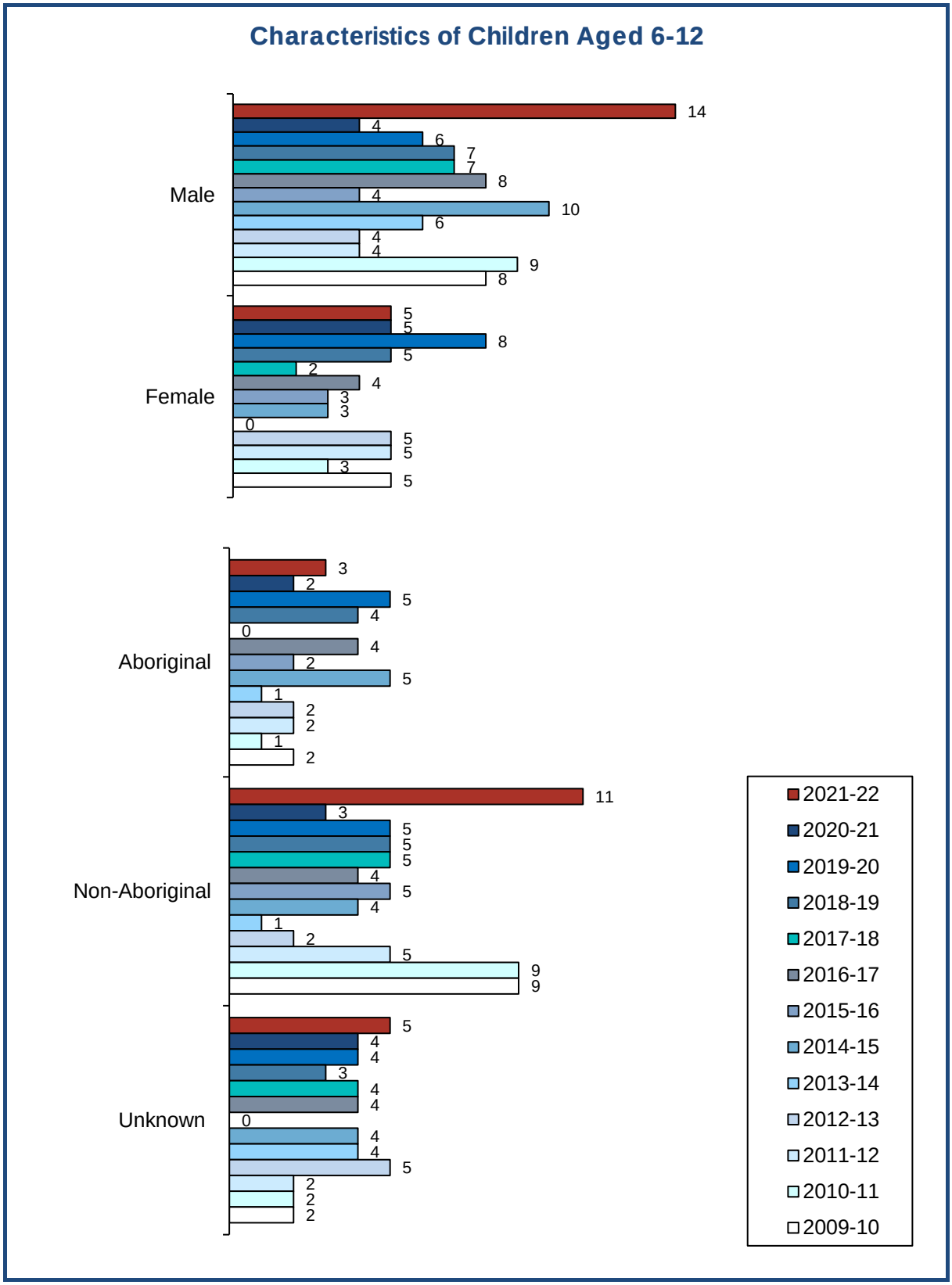
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

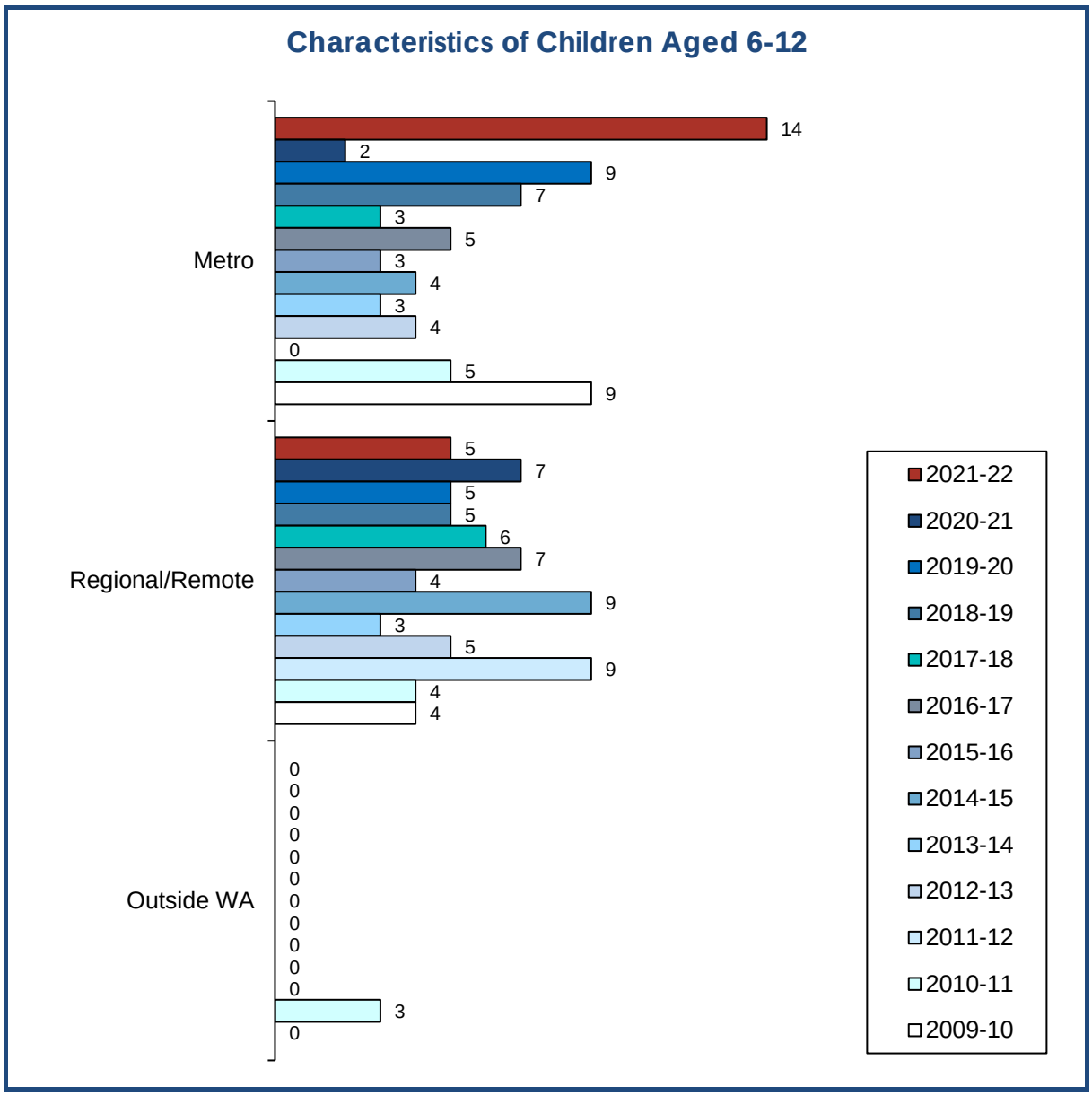
Seventy nine deaths of children aged 1 to 5 years were determined to be investigable deaths.

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.



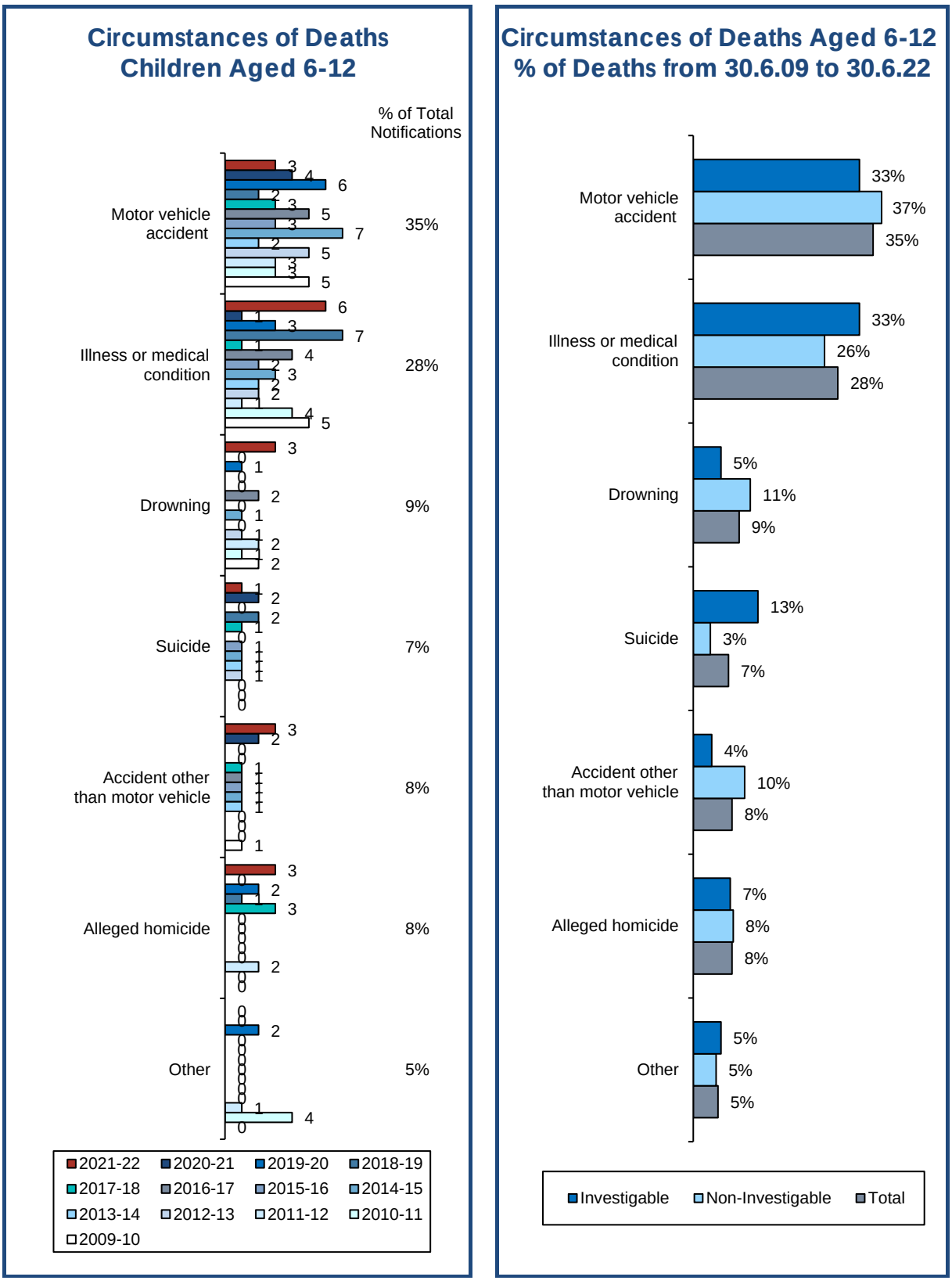


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).



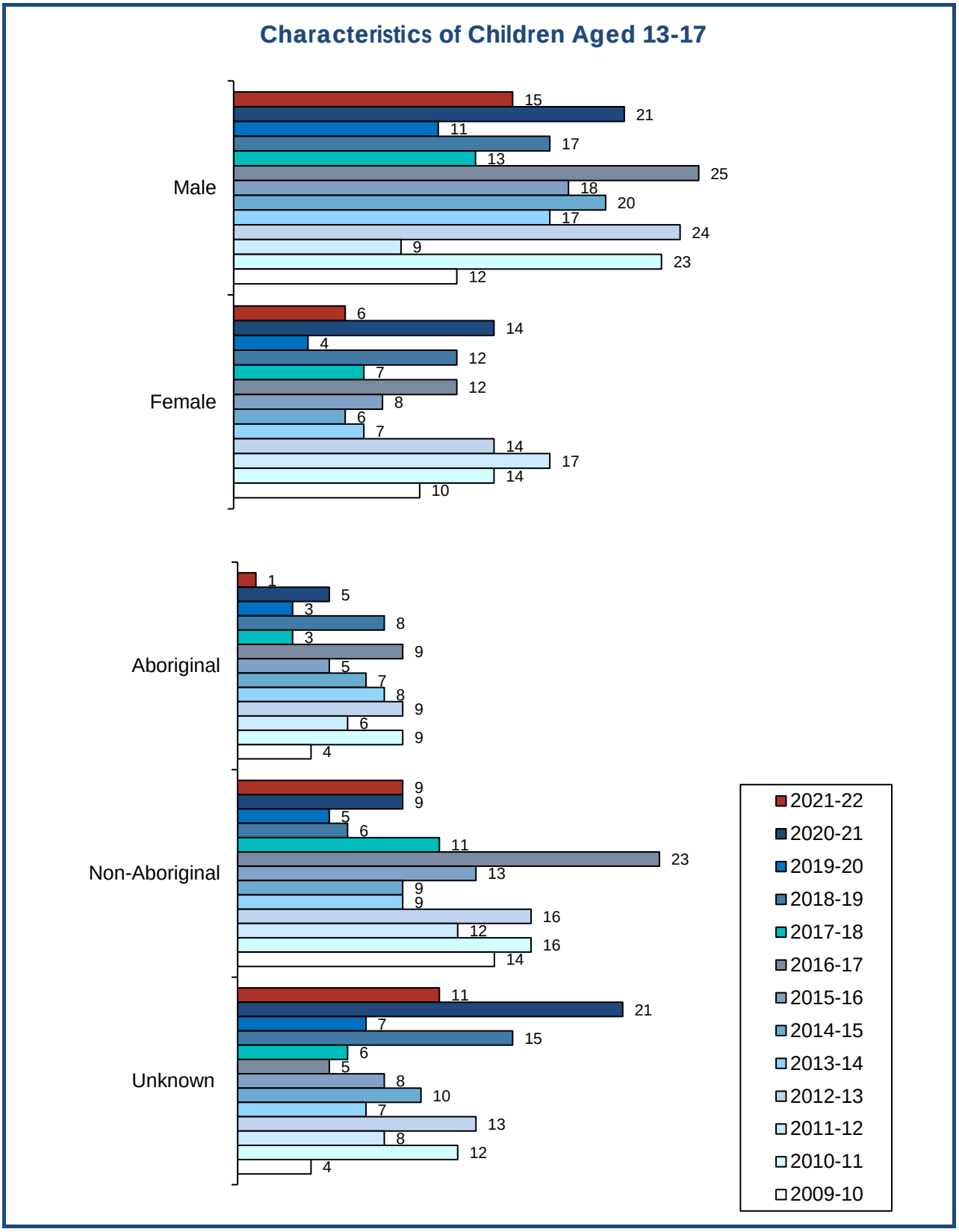
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

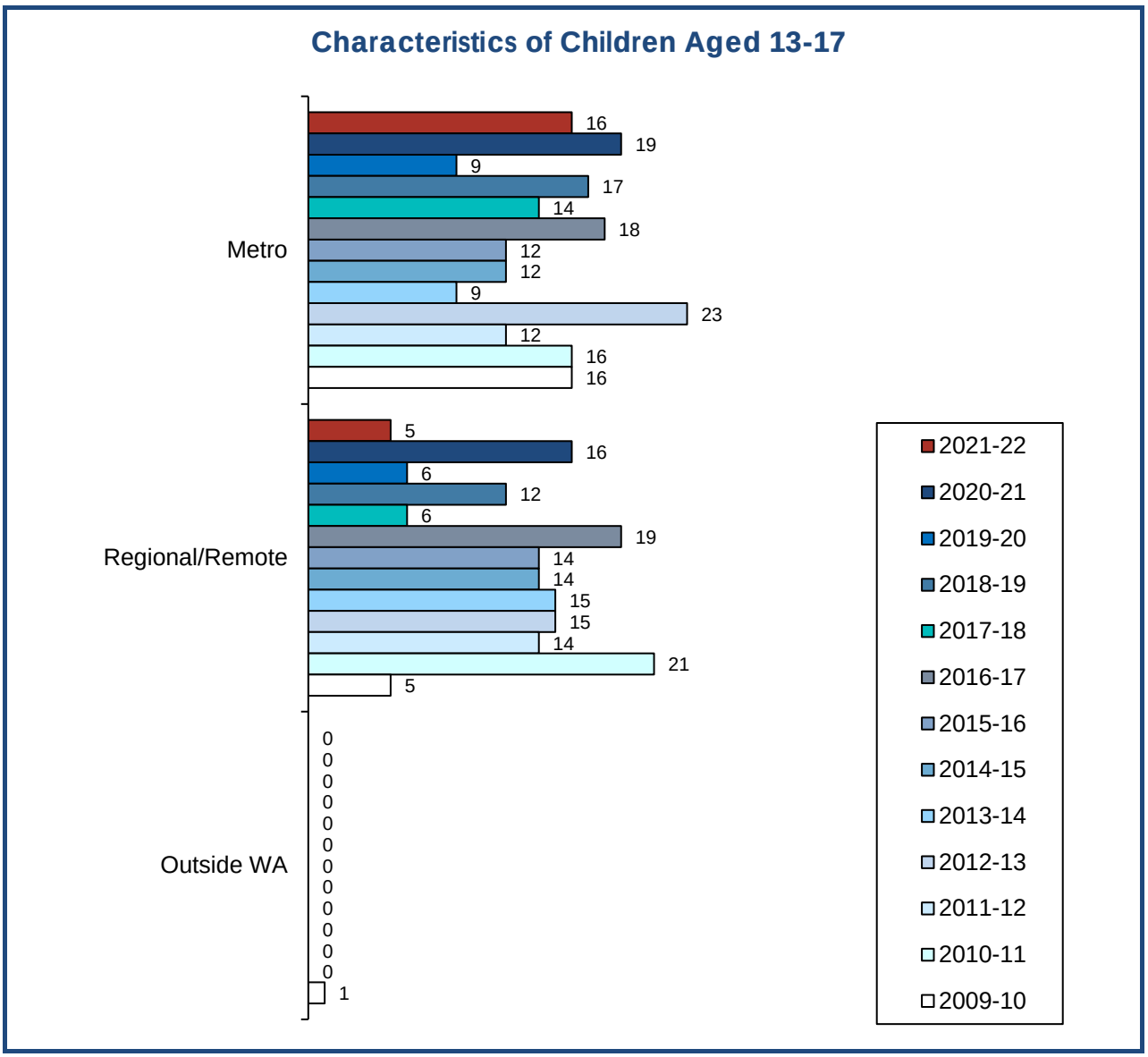
Fifty five deaths of children aged 6 to 12 years were determined to be investigable deaths.

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.



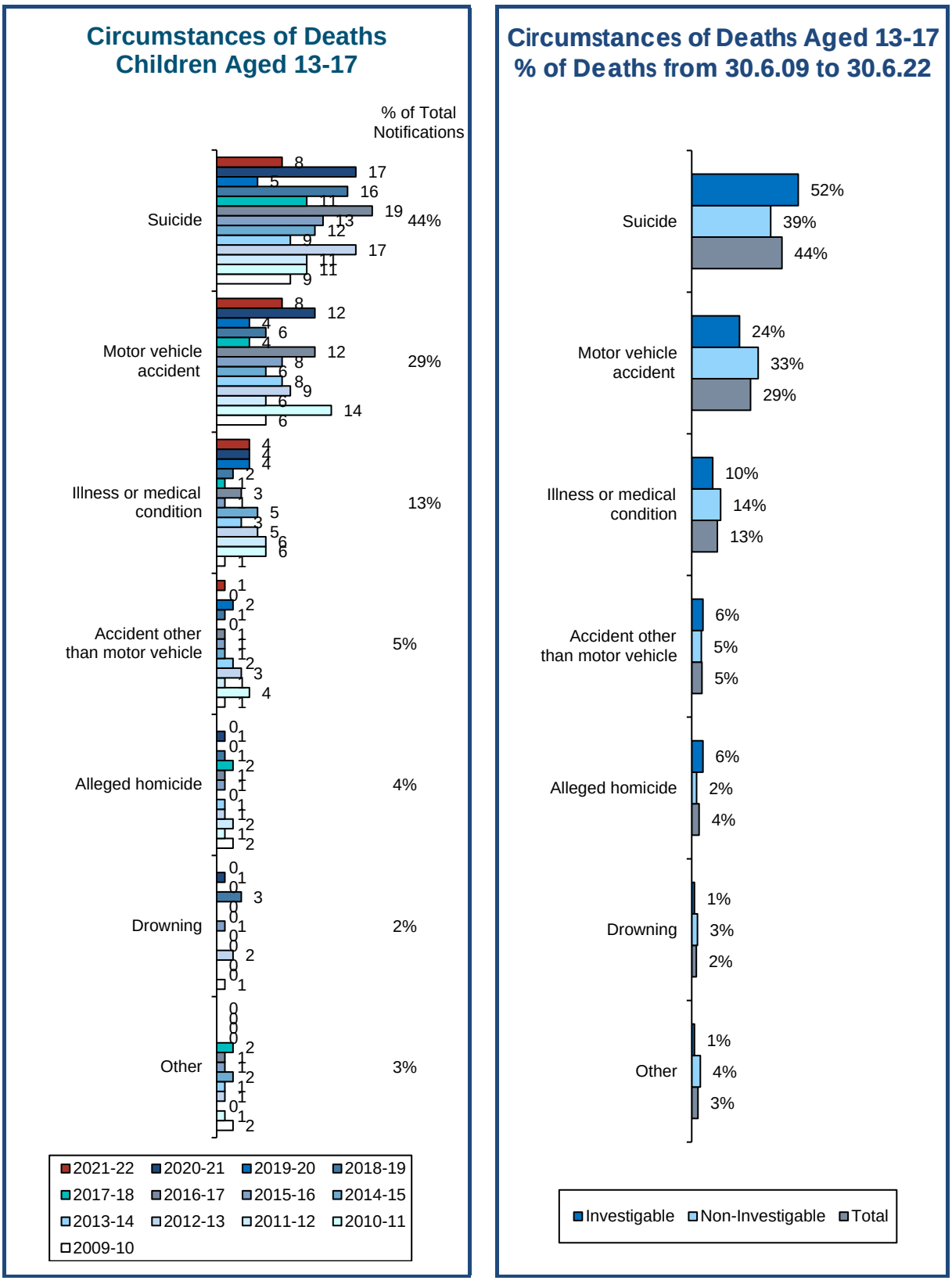


Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.

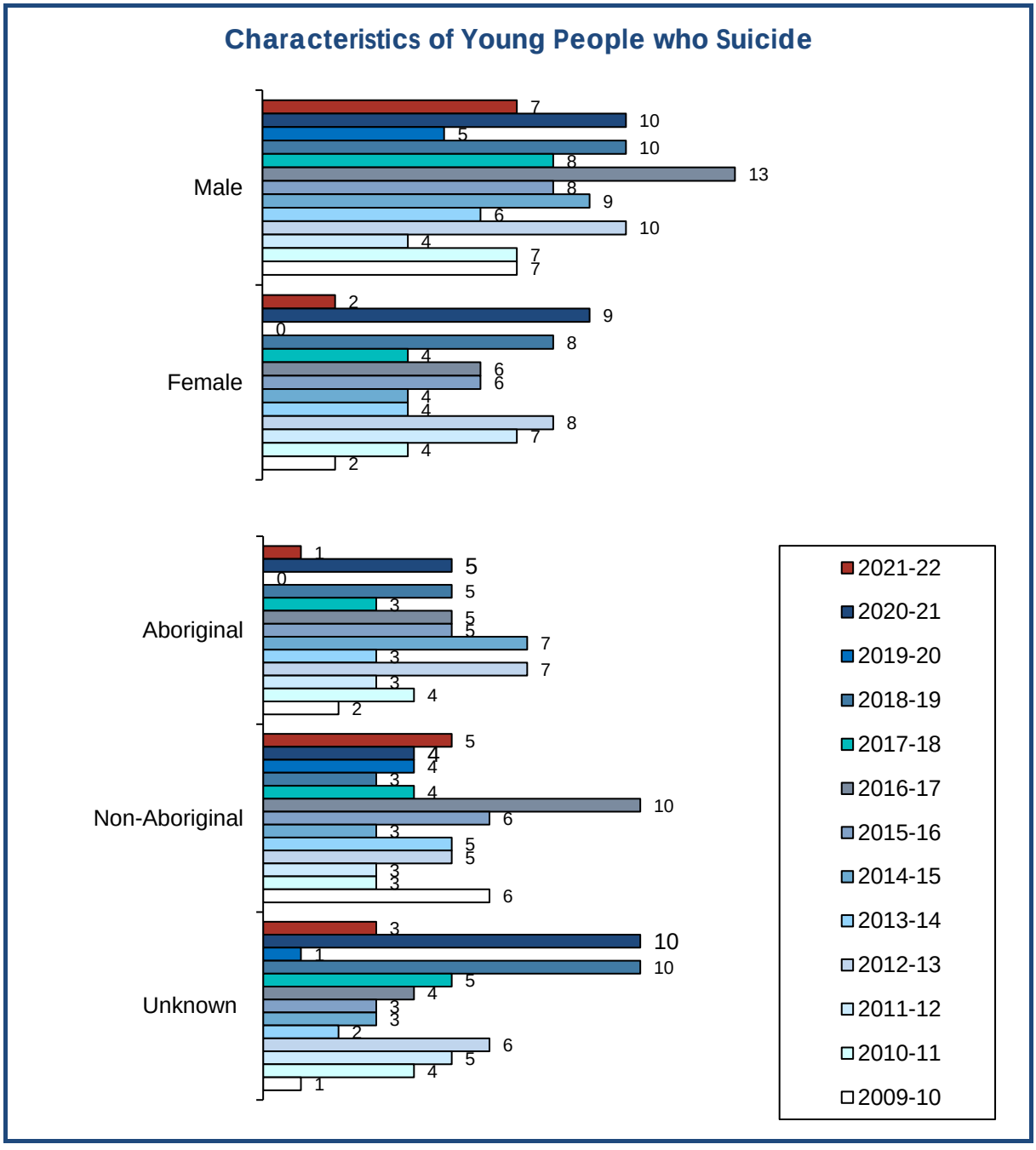
One hundred and forty five deaths of children aged 13 to 17 years were determined to be investigable deaths.

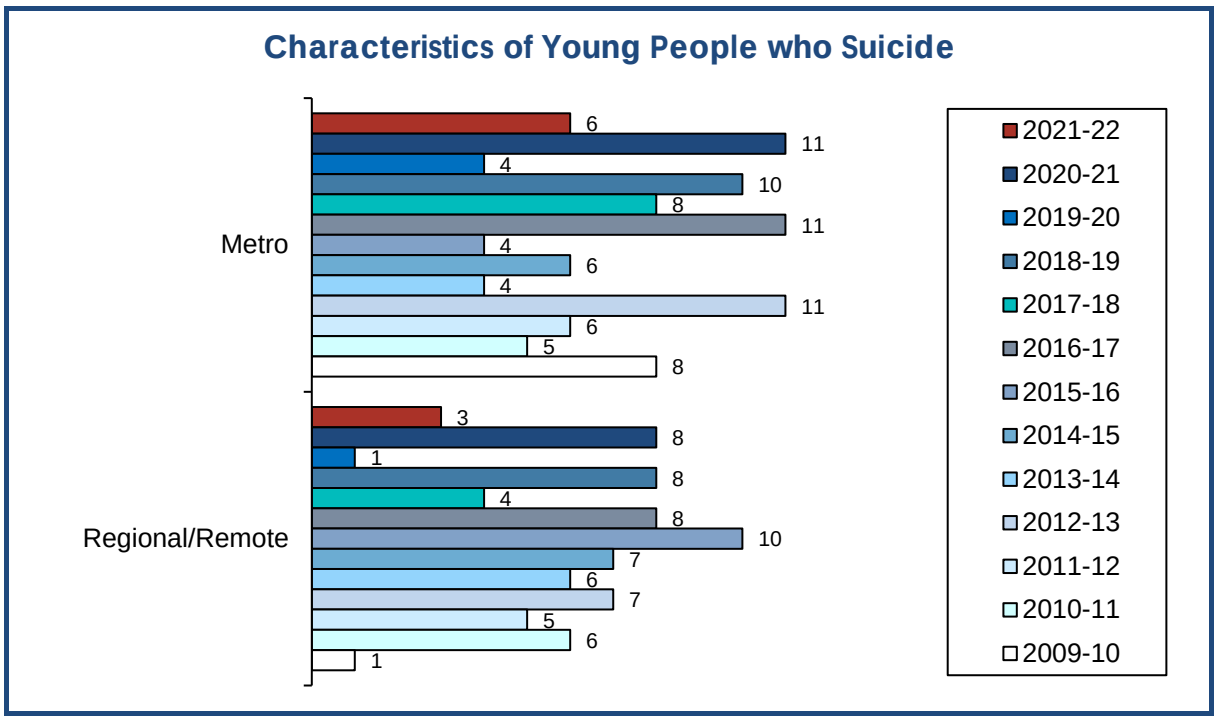
Suicide by young people

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:

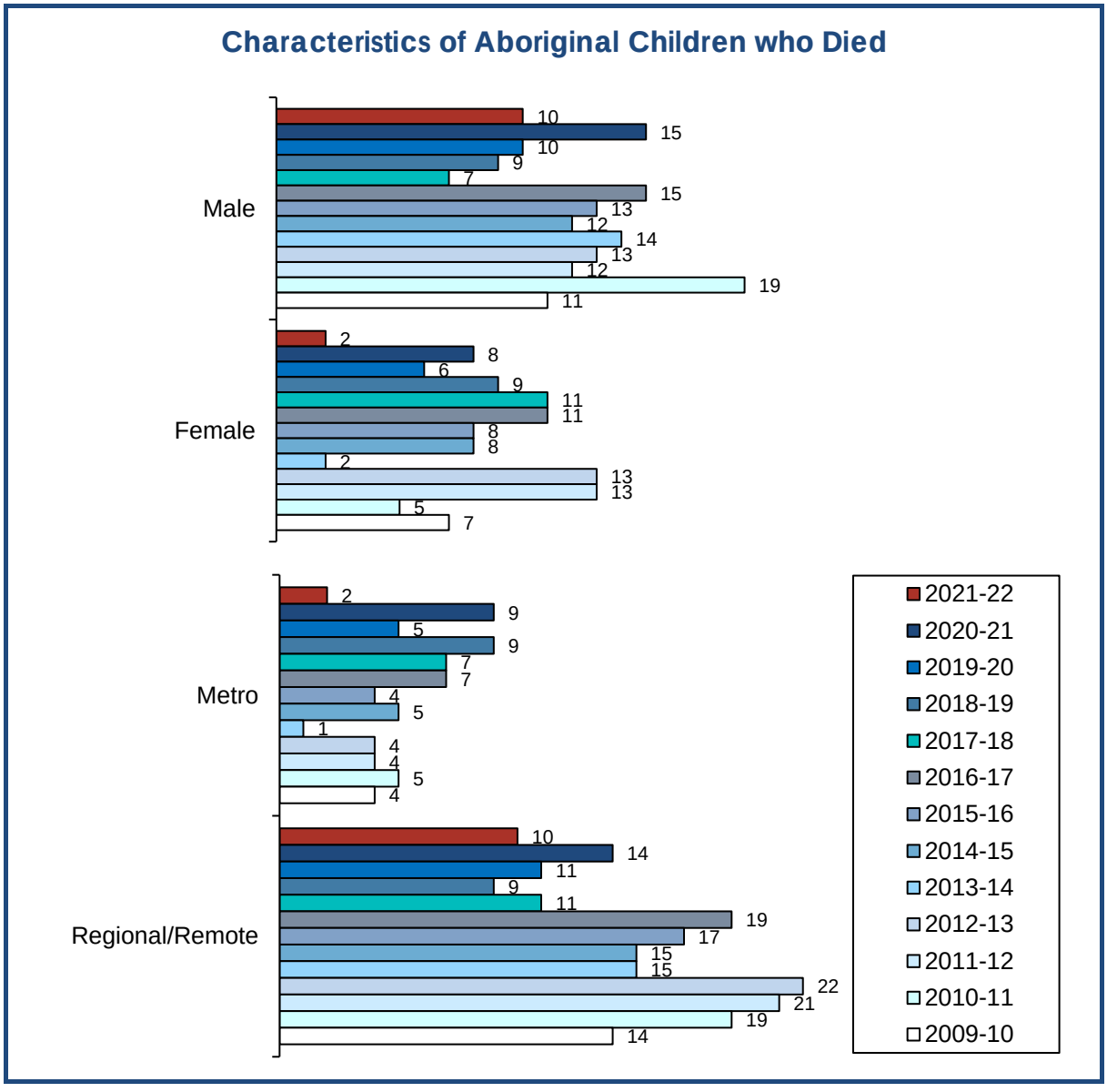
- Males – 54% of investigable deaths and 69% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 111 apparent suicides by young people where information on the Aboriginal status of the young person was available, 62% of the investigable deaths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

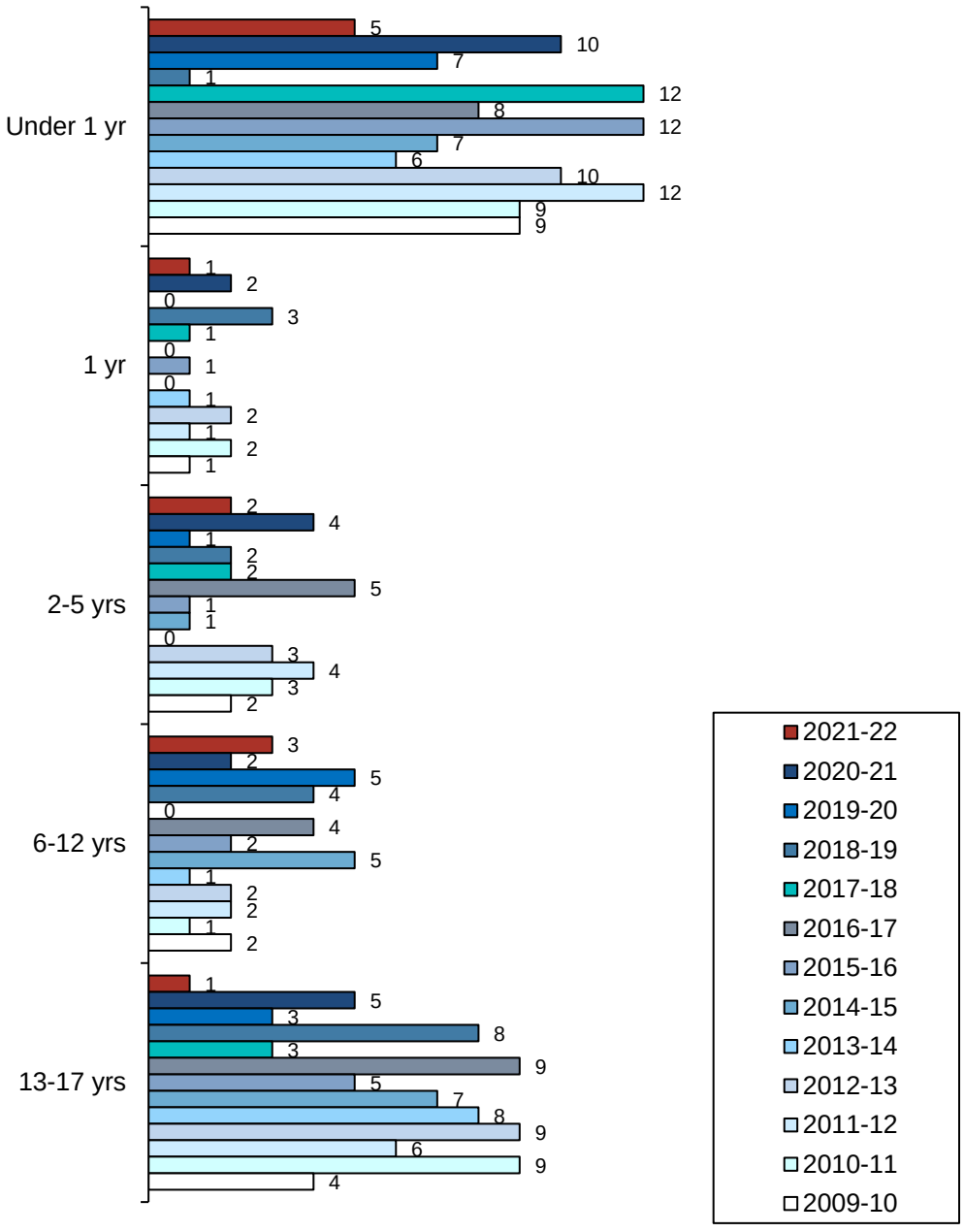
Of the 682 child death notifications received from 30 June 2009 to 30 June 2022, where the Aboriginal status of the child, or their parent/s, was recorded by agencies they had contact with in documentation provided to this Office, 263 (39%) of the children were identified as Aboriginal.

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.

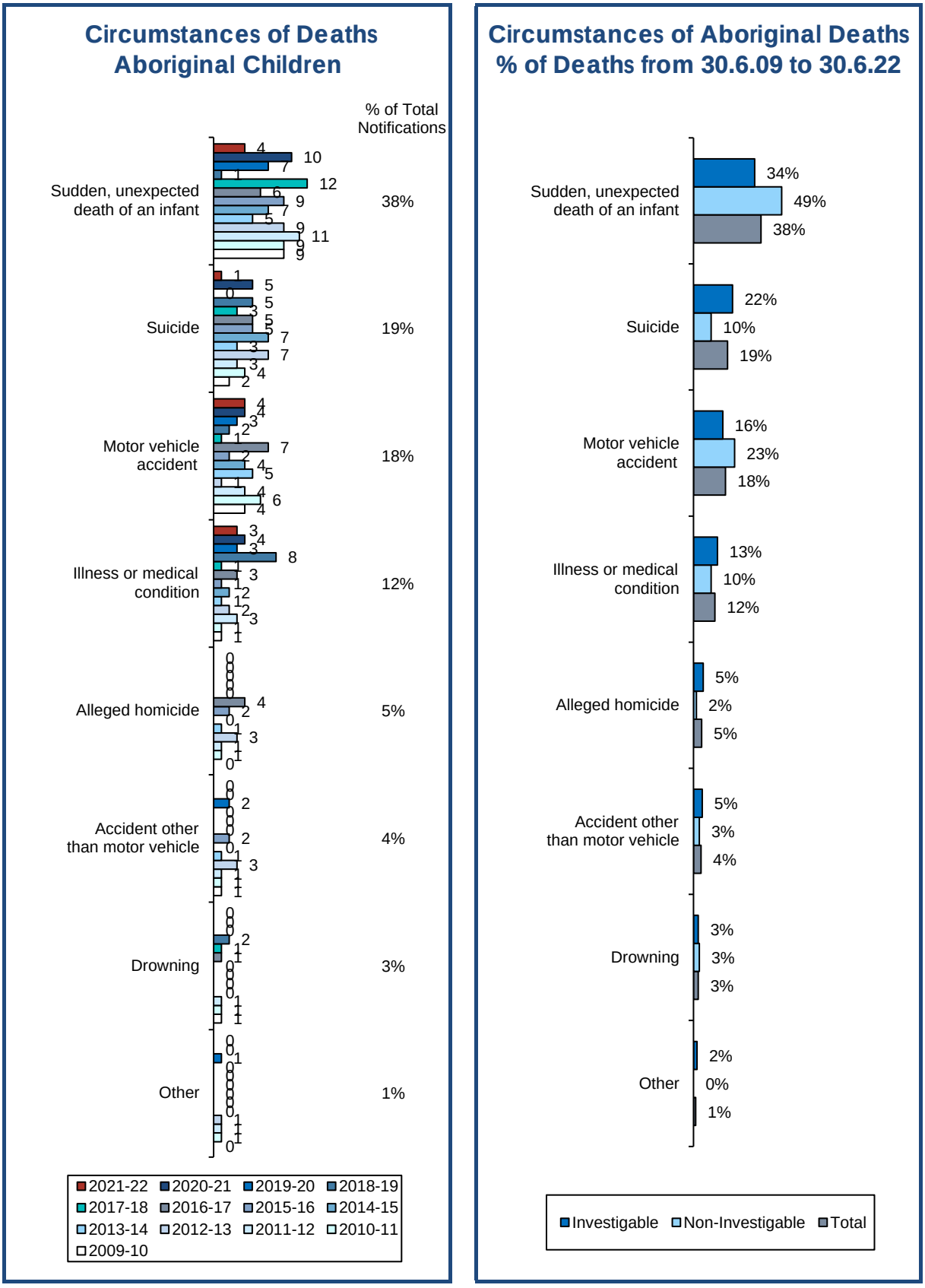


Characteristics of Aboriginal Children who Died



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.

Family and Domestic Violence Fatality Review

Overview

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

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

Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Information regarding the use of terms

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

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

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

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

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

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

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

(d) One of whom is a child who —

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

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

or

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

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

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

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

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

(b) Is related to the person's —

(i) Spouse or former spouse; or

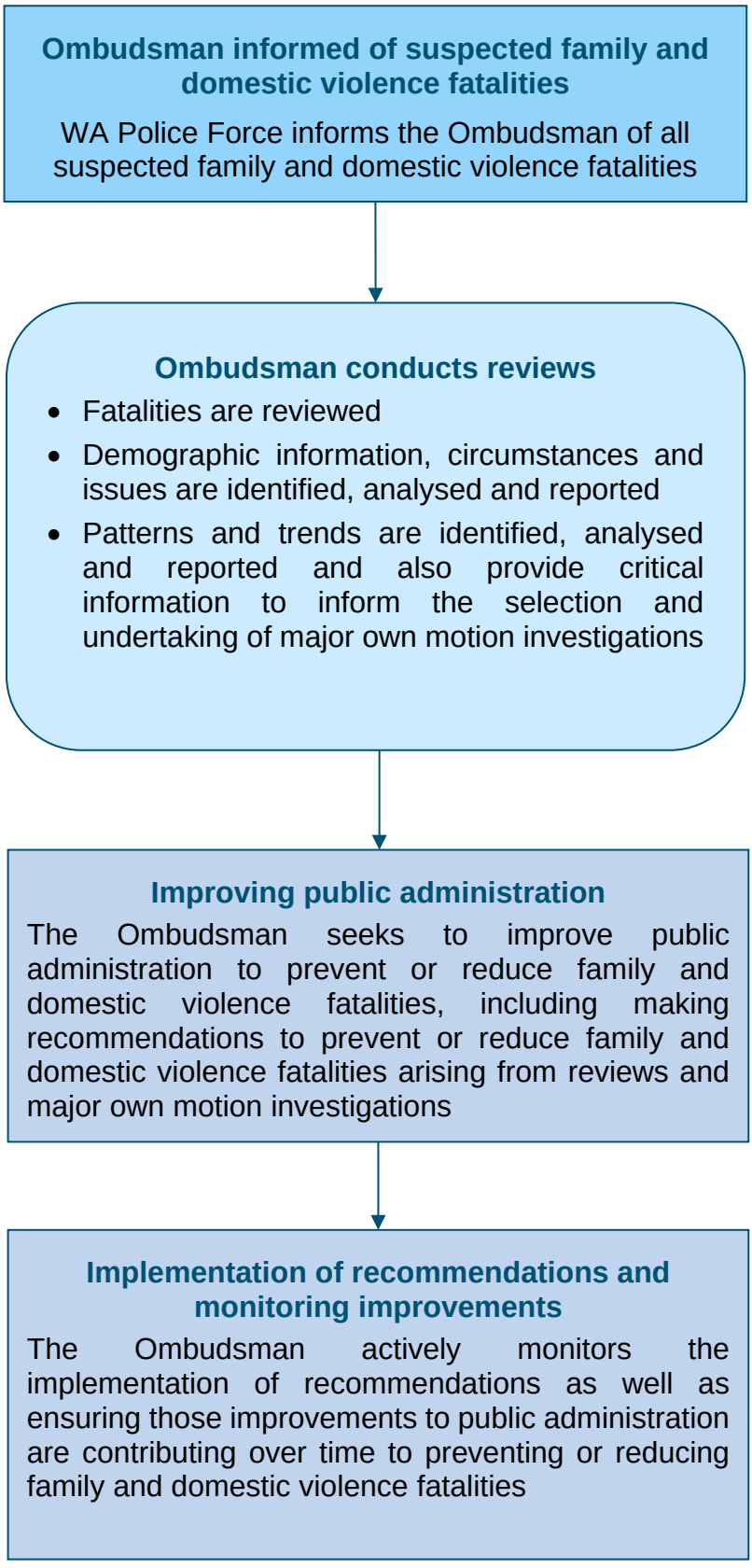
(ii) De facto partner or former de facto partner.

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

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

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

The Family and Domestic Violence Fatality Review Process



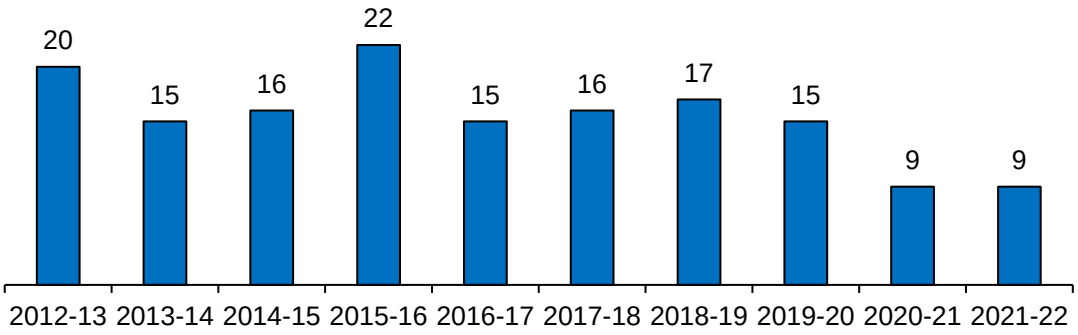
Analysis of Family and Domestic Violence Fatality Reviews

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

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

Number of family and domestic violence fatality reviews

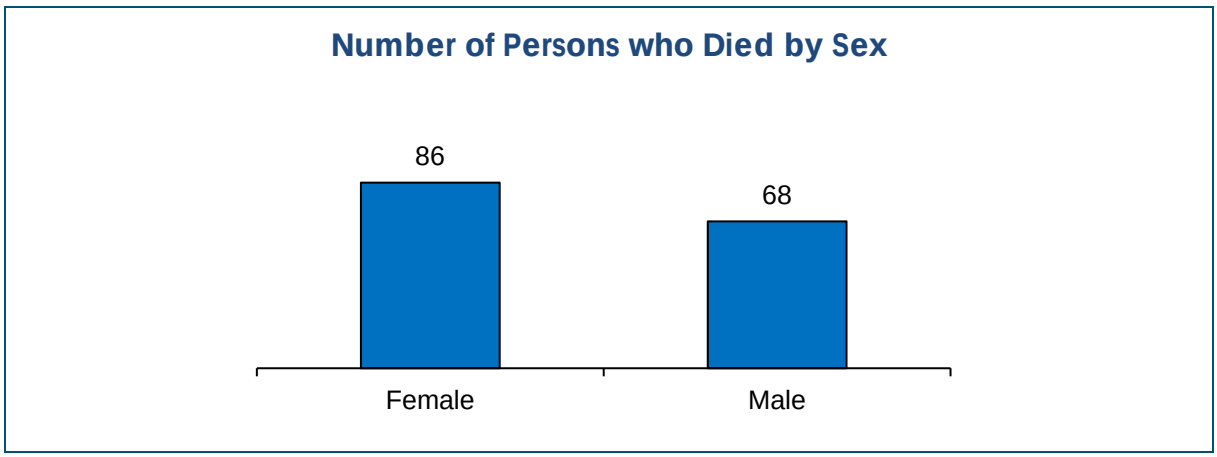
In 2021-22, the number of reviewable family and domestic violence fatalities received was nine, compared to nine in 2020-21, 15 in 2019-20, 17 in 2018-19, 16 in 2017-18, 15 in 2016-17, 22 in 2015-16, 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

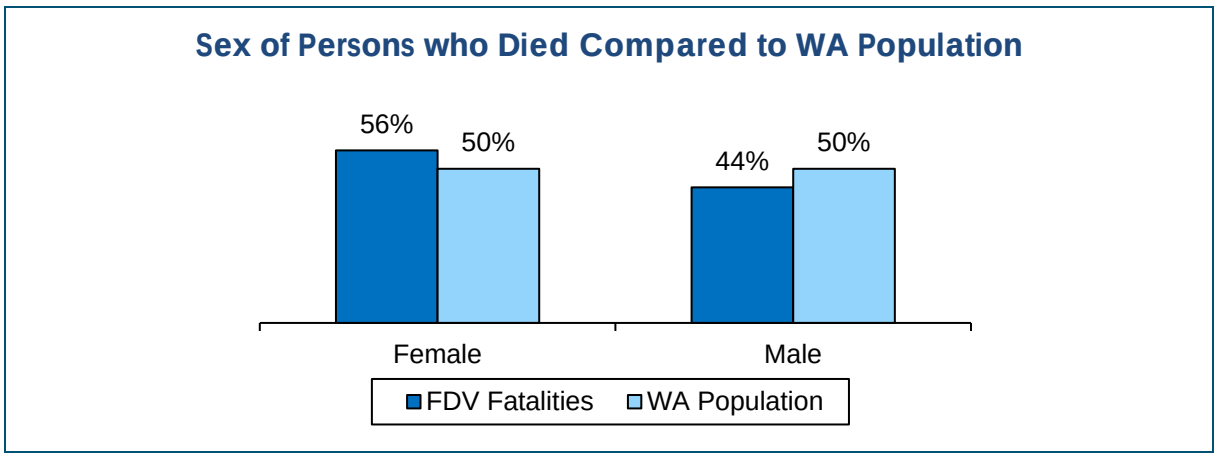


Demographic information identified from family and domestic violence fatality reviews

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

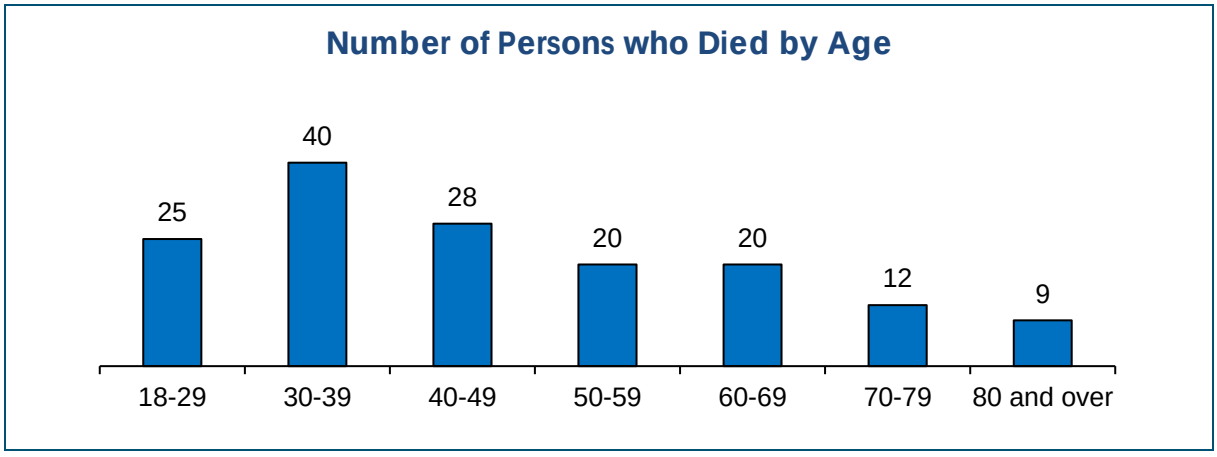
The following charts show characteristics of the persons who died for the 154 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2022. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

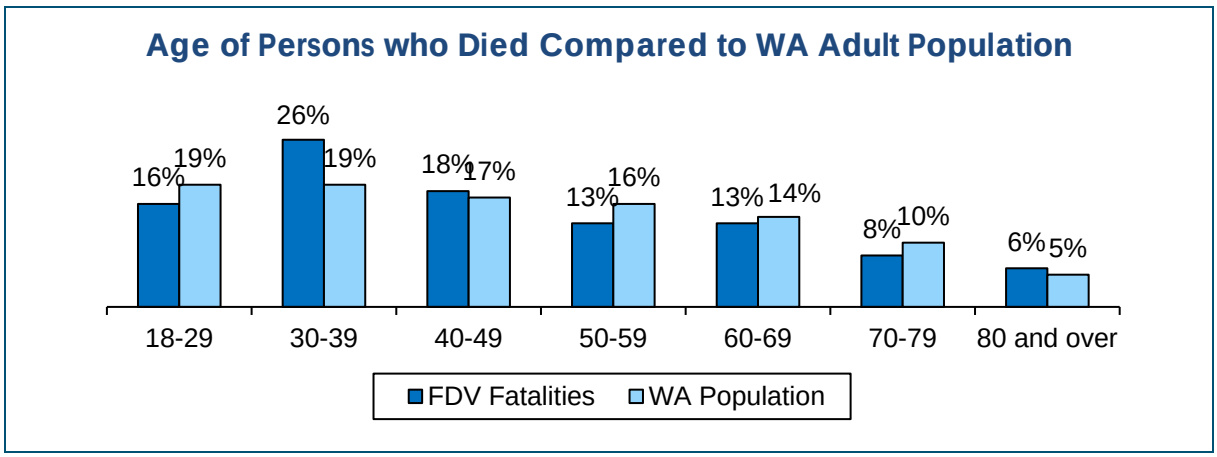




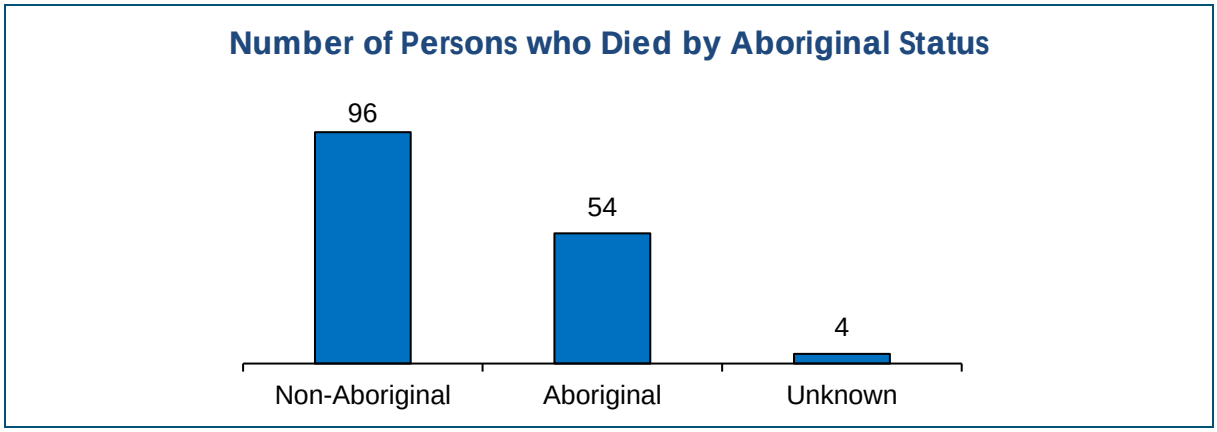
Information is collated on the sex of the deceased, and the suspected perpetrator, as identified in agency documentation provided to this Office. Compared to the Western Australian population, females who died in the 10 years from 1 July 2012 to 30 June 2022 were over-represented, with 56% of persons who died being female compared to 50% in the population.

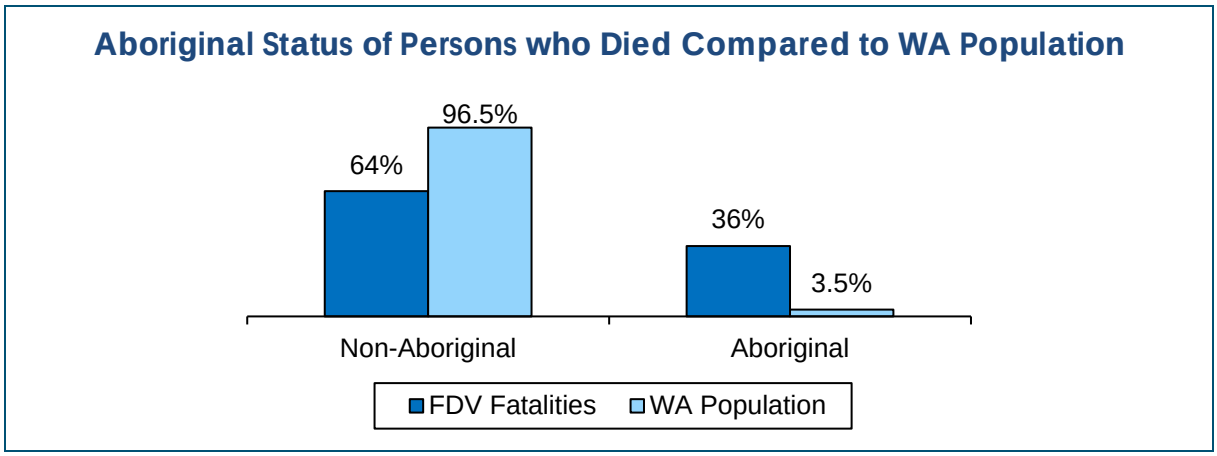
In relation to the 86 females who died, 80 involved a male suspected perpetrator. Of the 68 men who died, 12 were apparent suicides, 25 involved a female suspected perpetrator, 28 involved a male suspected perpetrator and three involved multiple suspected perpetrators of both sexes.





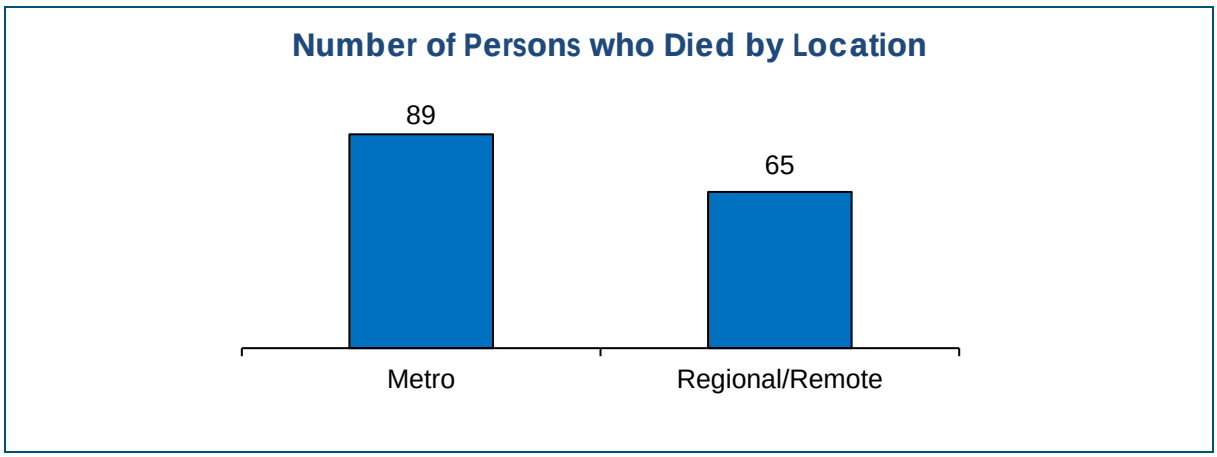
Compared to the Western Australian adult population, the age groups 30-39, 40-49 and 80 and over are over-represented, with 26% of persons who died being in the 30-39 age group compared to 19% of the adult population, 18% of persons who died being in the 40-49 age group compared to 17% of the adult population and six per cent of persons who died being in the 80 and over age group compared to five per cent of the adult population.

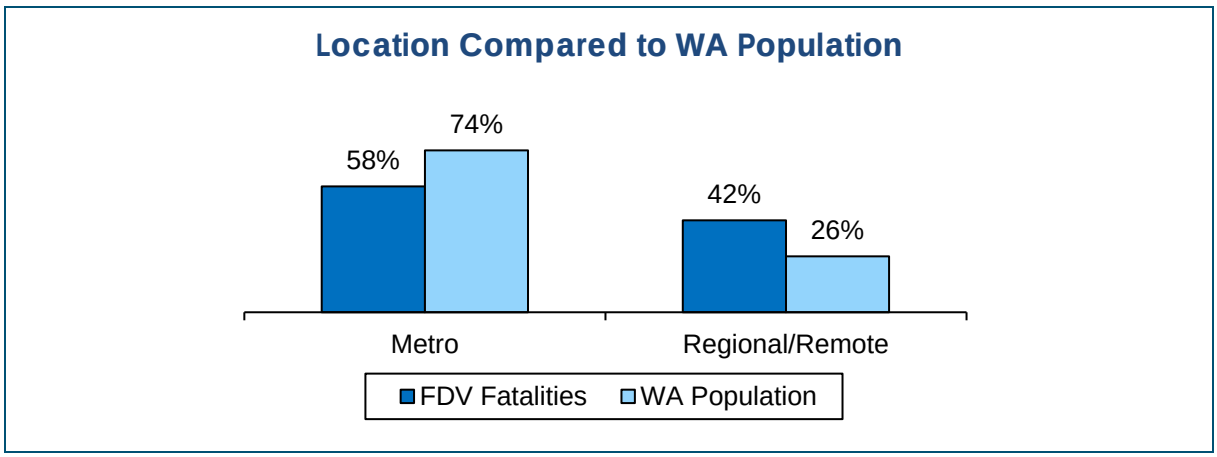




Note: In the above chart, percentages are based on those where Aboriginal status is known.

Information on Aboriginal status is collated where the deceased, and suspected perpetrator, identify as Aboriginal to agencies they have contact with, and this is recorded in the documentation provided to this Office. Compared to the Western Australian population, Aboriginal people who died were over-represented, with 36% of people who died in the 10 years from 1 July 2012 to 30 June 2022 being Aboriginal compared to 3.5% in the population. Of the 54 Aboriginal people who died, 33 were female and 21 were male.





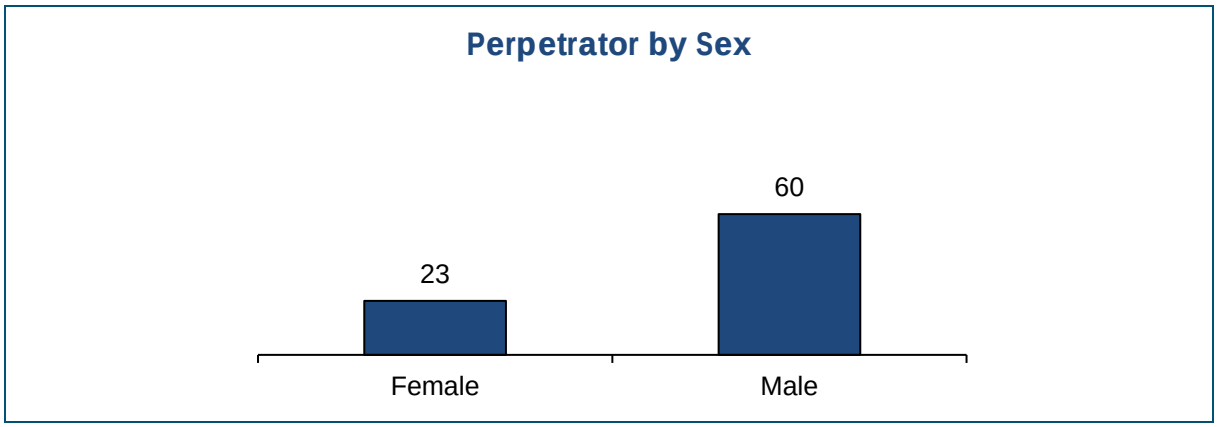
Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 42% of the people who died in the 10 years from 1 July 2012 to 30 June 2022 living in regional or remote locations, compared to 26% of the population living in those locations.

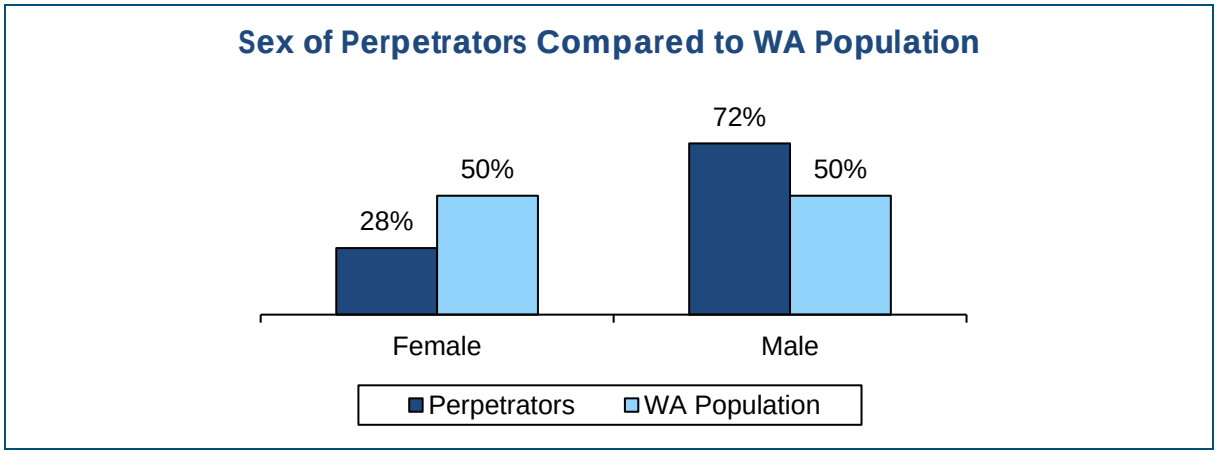
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2022 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2022.

Of the 154 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2022, coronial and criminal proceedings were finalised in relation to 83 perpetrators.

Information is obtained on a range of characteristics of the perpetrator including sex, age group and Aboriginal status. The following charts show characteristics for the 83 perpetrators where both the coronial process and the criminal proceedings have been finalised.

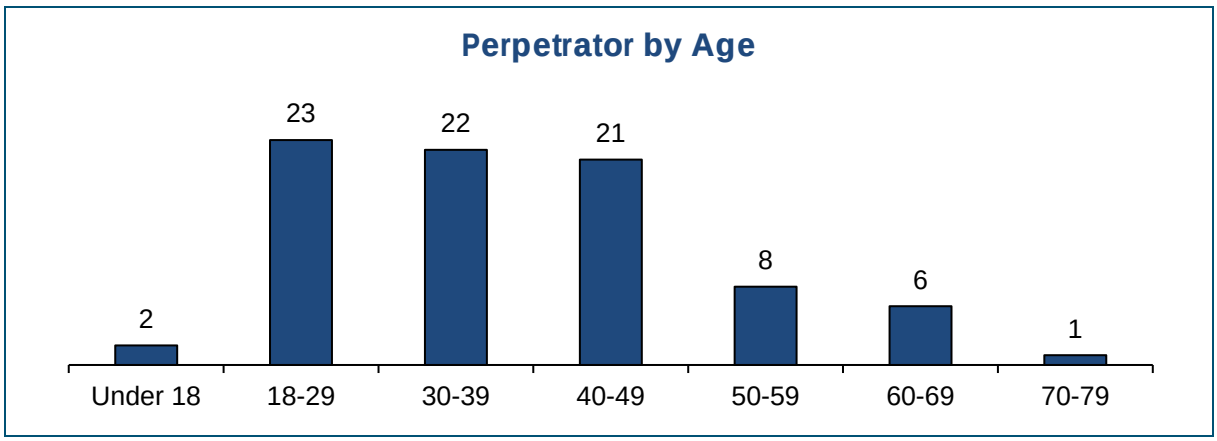


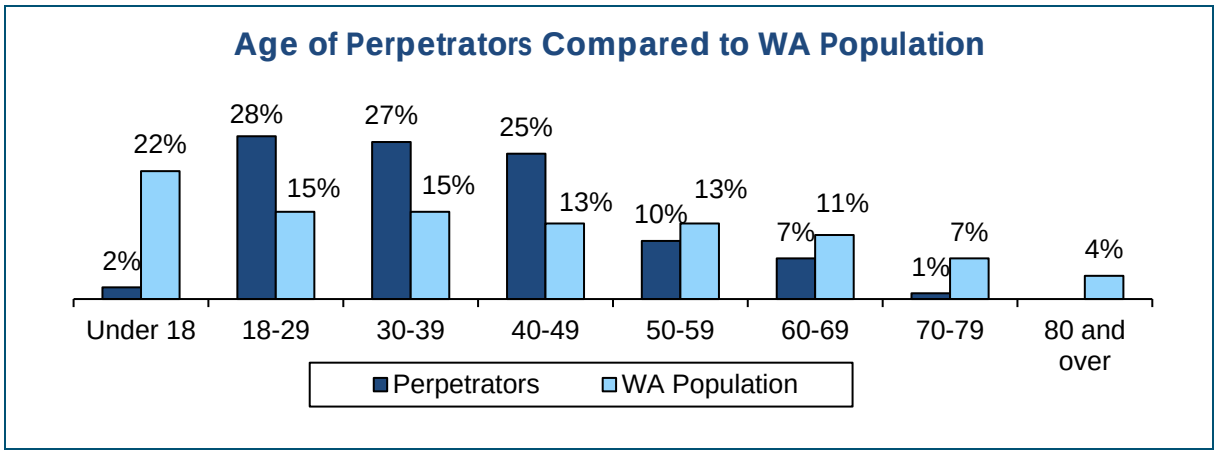


Compared to the Western Australian population, male perpetrators of fatalities in the 10 years from 1 July 2012 to 30 June 2022 were over-represented, with 72% of perpetrators being male compared to 50% in the population.

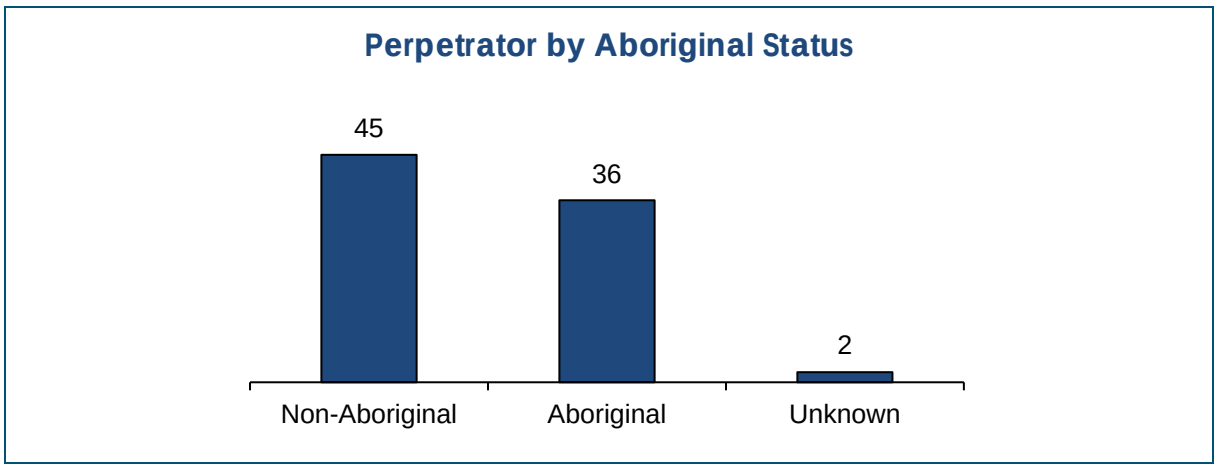
Eighteen males were convicted of manslaughter and 42 males were convicted of murder. Eleven females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death and 11 females were convicted of murder.

Of the 22 fatalities by the 23 female perpetrators, in 21 fatalities the person who died was male, and in one fatality the person who died was female. Of the 61 fatalities by the 60 male perpetrators, in 46 fatalities the person who died was female, and in 15 fatalities the person who died was male.

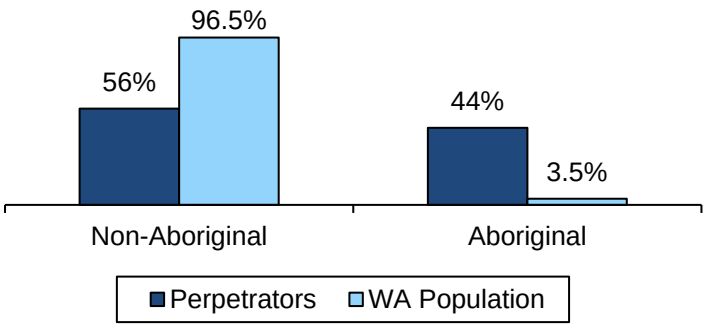




Compared to the Western Australian population, perpetrators of fatalities in the 10 years from 1 July 2012 to 30 June 2022 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 28% of perpetrators being in the 18-29 age group compared to 15% in the population, 27% of perpetrators being in the 30-39 age group compared to 15% in the population, and 25% of perpetrators being in the 40-49 age group compared to 13% in the population.



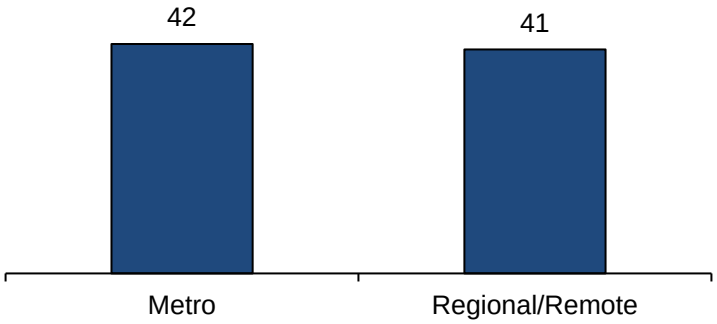
Aboriginal Status of Perpetrators Compared to WA Population



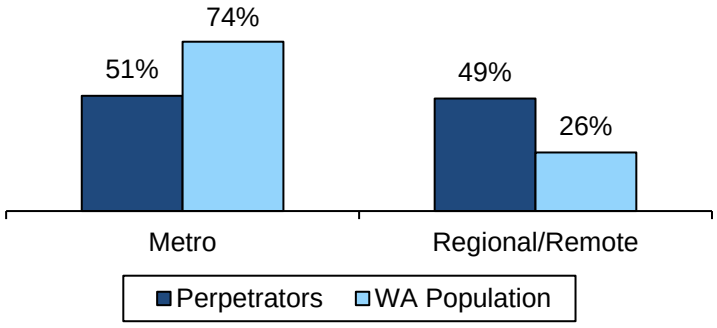
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the 10 years from 1 July 2012 to 30 June 2022 were over-represented with 44% of perpetrators (where Aboriginal status was recorded in information provided to this Office) being Aboriginal compared to 3.5% in the population.

In 34 of the 36 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location



Perpetrators by Location Compared to WA Population



Compared to the Western Australian population, the people who died in the 10 years from 1 July 2012 to 30 June 2022, who were living in regional or remote locations, were over-represented, with 49% of the people who died living in regional or remote locations compared to 26% of the population living in those locations.

Circumstances in which family and domestic violence fatalities have occurred

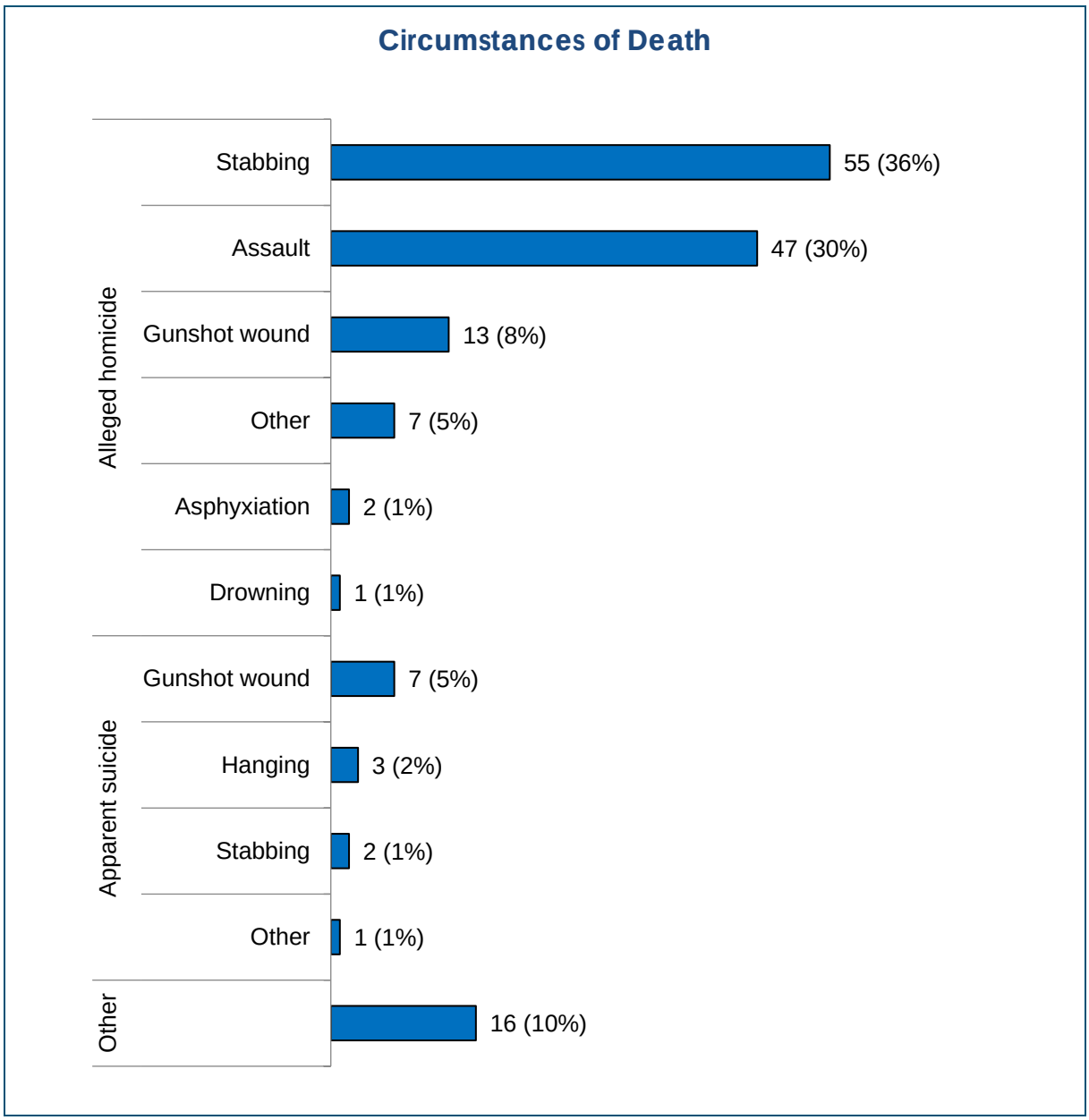
Information provided to the Office by WA Police Force about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

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

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

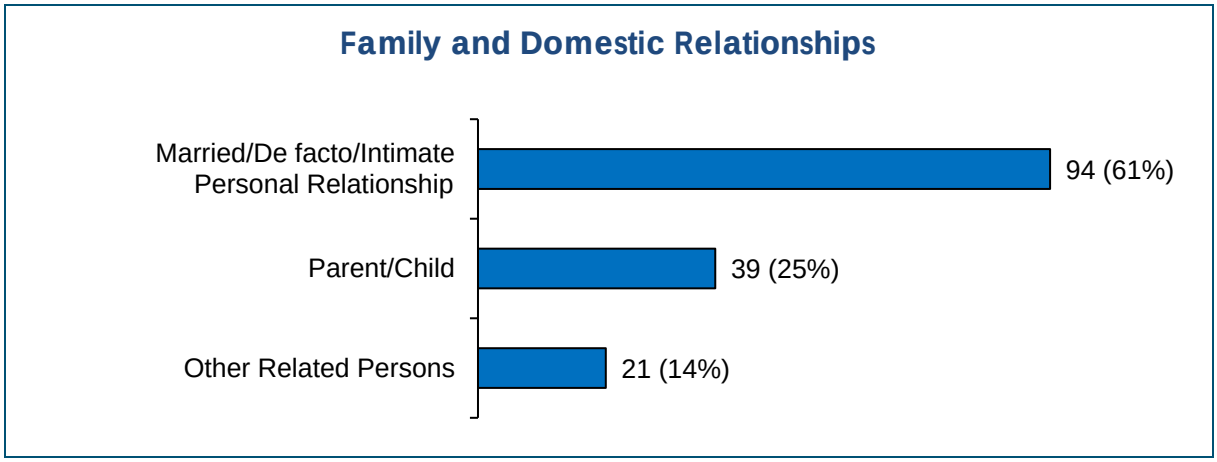
The principal circumstances of death in 2021-22 were alleged homicide by physical assault and stabbing.

The following chart shows the circumstance of death as categorised by the Ombudsman for the 154 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2022.



Family and domestic relationships

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



Of the 154 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2022:

- 94 fatalities (61%) involved a married, de facto or intimate personal relationship, of which there were 79 alleged homicides, nine apparent suicides and six in other circumstances. The 94 fatalities included 16 deaths that occurred in eight cases of alleged homicide/suicide and, in all eight cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. The ninth apparent suicide involved a male. Of the remaining 71 alleged homicides, 51 (72%) of the people who died were female and 20 (28%) were male;
- 39 fatalities (25%) involved a relationship between a parent and adult child, of which there were 27 alleged homicides, four apparent suicides and eight in other circumstances. Of the 27 alleged homicides, 10 (37%) of the people who died were female and 17 (63%) were male. Of these 27 fatalities, in 20 cases (74%) the person who died was the parent or step-parent and in seven cases (26%) the person who died was the adult child or step-child; and
- There were 21 people who died (14%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, eight (38%) were female and 13 (62%) were male.

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

State policy and planning to reduce family and domestic violence fatalities

The State Strategy states 'Communities is the lead agency coordinating strategy and policy direction in prevention of family and domestic violence in Western Australia'. Communities has now established, within its organisation, the Office for Prevention of Family and Domestic Violence to 'elevate the profile of family and domestic violence and provide the stewardship needed within Communities and across government to deliver improved outcomes in the areas of primary prevention, Aboriginal family safety, victim survivor safety and perpetrator accountability' (Department of Communities).

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

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

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

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that steps have been taken to give effect to the Ombudsman's recommendation. Subsequent to this recommendation, the First Action Plan, which runs until June 2022, was released with the State Strategy. This Office will continue to monitor implementation of the First Action Plan, and subsequent Action Plans, in family and domestic violence fatality reviews.

Type of relationships

The Ombudsman finalised 147 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2022.

For 90 (61%) of the finalised reviews of family and domestic violence fatalities, the fatality occurred between persons who, either at the time of death or at some earlier time, had been involved in a married, de facto or other intimate personal relationship. For the remaining 57 (39%) of the finalised family and domestic violence fatality reviews, the fatality occurred between persons where the relationship was between a parent and their adult child or persons otherwise related (such as siblings and extended family relationships).

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

For the 147 finalised reviews, the circumstances of the fatality were as follows:

- For the 90 intimate partner fatalities, 75 were alleged homicides, nine were apparent suicides, and six were other circumstances; and
- For the 57 non-intimate partner fatalities, 44 were alleged homicides, three were apparent suicides, and 10 were other circumstances.

Intimate partner relationships

Of the 75 intimate partner relationship fatalities involving alleged homicide:

- There were 55 fatalities where the person who died was female and the suspected perpetrator was male, 16 where the person who died was male and the suspected perpetrator was female, one where the person who died was male and the suspected perpetrator was male, and three where the person who died was male and there were multiple suspected perpetrators of both sexes;
- There were 30 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In 20 of these fatalities the person who died was female and in 10 the person who died was male;
- There were 35 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 13 at the residence of the person who died or the residence of the suspected perpetrator, eight at the residence of family or friends, and 19 at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 38 fatalities where the person who died lived in regional and remote areas, and in 28 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 57 non-intimate partner fatalities, there were 38 fatalities involving a parent and adult child and 19 fatalities where the parties were otherwise related.

Of the 44 non-intimate partner fatalities involving alleged homicide:

- There were 13 fatalities where the person who died was female and the suspected perpetrator was male, three where the person who died was female and the suspected perpetrator was female, 22 where the person who died was male and the suspected perpetrator was male, and six where the person who died was male and the suspected perpetrator was female;
- There were 13 non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 18 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 17 at the residence of the person who died or the residence of the suspected perpetrator, and nine at the residence of family or friends or in a public place; and
- There were 19 fatalities where the person who died lived in regional and remote areas.

Prior reports of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reports of alleged family and domestic violence between the parties. In 46 (61%) of the 75 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2022, alleged family and domestic violence between the parties had been reported to WA Police Force and/or to other public authorities. In 16 (36%) of the 44 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2022, alleged family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities.

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

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

Of the 62 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, from the records available:

- Four (6%) fatalities involved a deceased person with disability;
- None of the fatalities involved a deceased person in a same-sex relationship with the suspected perpetrator;
- 36 (58%) fatalities involved a deceased Aboriginal person; and
- 34 (55%) of the people who died lived in regional/remote Western Australia.

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

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

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

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

Identification of family and domestic violence incidents

Of the 62 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, WA Police Force was the agency to receive the majority of these reports. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, noted that DCPFS may become aware of family and domestic violence through a referral to DCPFS and subsequent assessment through the duty interaction process. Identification of family and domestic violence is integral to the agency being in a position to implement its family and domestic violence policy and processes to address perpetrator accountability and promote victim safety and support. However, the Ombudsman's reviews and own motion investigations continue to identify missed opportunities to identify, and respond to, family and domestic violence in interactions.

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

Provision of agency support to obtain a violence restraining order

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

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

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

Support to victims in reported incidences of family and domestic violence

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

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

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that WA Police Force had taken steps and/or proposed steps to be taken to give effect to these recommendations. Subsequent to these recommendations, Action Item 13(d) of the First Action Plan indicates the WA Police Force intends to undertake 'comprehensive family violence training that is reported in the WA Police Force Annual Report'. In 2020, WA Police Force introduced body worn cameras for use by police and it is now mandatory for body worn cameras to be activated when attending a family and domestic violence incident. This Office is now able to access video from body worn camera to examine police responses to family and domestic violence, including the provision of information of family violence restraining orders. The Office will continue to monitor, and report on,

the provision, by WA Police Force, of information and advice regarding family violence restraining orders.

Support to obtain a violence restraining order on behalf of children

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

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

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

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

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

Support during the process of obtaining a family violence restraining order

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identified the importance of opportunities for victims to seek help and for perpetrators to be held to account throughout the process for obtaining a, then, violence restraining order, and

that these opportunities are acted upon, not just by WA Police Force but by all State Government departments and authorities. In the report the Ombudsman recommended that:

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

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

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

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

Support when a family violence restraining order has not been granted

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

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

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

Provision of support to victims experiencing family and domestic violence

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

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

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

Risk assessment is conducted for a number of reasons including:

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

(pages 36-37)

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

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

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

Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 46 (61%) of the 75 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2022, prior family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities. The Ombudsman's reviews identify where perpetrators have a history of reported violence, with one or more partners, and examines steps taken to hold perpetrators to account for their actions and support them to cease their violent behaviours, in accordance with the intent of the former State Strategy.

The Ombudsman's reviews have examined processes for the rehabilitation of perpetrator behaviours, where perpetrators of family and domestic violence are imprisoned or supervised on community based orders. In 2021-22, the Ombudsman's reviews have continued to examine opportunities to improve information sharing across agencies, to address perpetrator behaviours, and has made one associated recommendation.

Case Study

Ensuring interagency communication and collaboration to promote perpetrator accountability

In reviewing a family and domestic violence fatality involving a perpetrator on a community order, the Ombudsman has identified the need to improve processes to ensure relevant interagency communication and collaboration. The Ombudsman made the following recommendation:

> The WA Police Force provides a report to the Ombudsman by 1 October 2022 on the progress of discussions with DOJ regarding information exchange when WA Police Force have contact with an individual subject to a community order, and the creation of a protocol to facilitate information sharing.

Fatalities with no prior reported family and domestic violence

Based on the information available to the Office, in 29 (39%) of the 75 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2022, the fatal incident was the only family and domestic violence between the parties that had been reported to WA Police Force and/or other public authorities. It is important to note, however, research indicating under-reporting of family and domestic violence. The Australian Bureau of Statistics' *Personal Safety Survey 2016* (www.abs.gov.au) collected information about help seeking behaviours, noting that:

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

and

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

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

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

Family violence involving Aboriginal people

Of the 147 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2022, Aboriginal Western Australians were over-represented, with 49 (33%) persons who died being Aboriginal. In all but four cases, the suspected perpetrator

was also Aboriginal. There were 38 of these 49 fatalities where the person who died lived in a regional or remote area of Western Australia, of which 28 were intimate partner fatalities.

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

Contextual factors for family violence involving Aboriginal people

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

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

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

> Indigenous women continuously balance off the desire to stop the violence by reporting to the police with the potential consequences for themselves and other family members that may result from approaching the police; often concluding that the negatives outweigh the positives. Synthesizing the literature on the topic reveals a number of consistent themes, including: a reluctance to report because of fear of the police, the perpetrator and perpetrator's kin; fear of "payback" by the offender's family if he is jailed; concerns the offender might become "a death in custody"; a cultural reluctance

> to become involved with non-Indigenous justice systems, particularly a system viewed as an instrument of dispossession by many people in the Indigenous community; a degree of normalisation of violence in some families and a degree of fatalism about change; the impact of "lateral violence" … which makes victims subject to intimidation and community denunciation for reporting offenders, in Indigenous communities; negative experiences of contact with the police when previously attempting to report violence (such as being arrested on outstanding warrants); fears that their children will be removed if they are seen as being part of an abusive house-hold; lack of transport on rural and remote communities; and a general lack of culturally secure services.
>
> (Blagg, H, Bluett-Boyd, N and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 13).

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

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

The Ombudsman's reviews and report have identified that Aboriginal victims want the violence to end, but not necessarily always through the use of family violence restraining orders. The Ombudsman's reviews have also examined agency action to facilitate co-design of locally based solutions to promote Aboriginal family and community safety. In 2020-21, the Ombudsman has made four recommendations that seek to support community led solutions. The implementation of these recommendations is being monitored, and will be reported on in the Annual Report 2022-23.

A separate strategy to prevent and reduce Aboriginal family violence

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

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

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

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

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

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

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

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to these recommendations. Subsequent to these recommendations, Action Item 5 of the First Action Plan intends to '[c]o-design the Aboriginal Family Safety Strategy with Aboriginal people and communities'. In March 2022 Communities released the draft *Aboriginal Family Safety Strategy* for community consultation. This Office will continue to monitor the finalisation and implementation of the *Aboriginal Family Safety Strategy*.

Limited use of violence restraining orders

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities,* November 2015, identified that while Aboriginal people are significantly over-represented as victims of family and domestic violence, they are less likely than non-Aboriginal people to seek a violence restraining order. The report examined the research literature and views of

stakeholders on the possible reasons for this lower use of violence restraining orders by Aboriginal people, identifying that the process for obtaining a violence restraining order is not necessarily always culturally appropriate for Aboriginal victims and that Aboriginal people in regional and remote locations face additional logistical and structural barriers in the process of obtaining a violence restraining order.

In the report, the Ombudsman recommended that:

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

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

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

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

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

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

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

The Ombudsman's reviews of the family and domestic violence fatalities of Aboriginal people and prior reported family violence between the parties, identify a high co-occurrence of alcohol consumption and family violence. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, examined the research literature on the relationship between alcohol use and family and domestic violence and found that the research literature regularly identifies alcohol as 'a significant risk factor' associated

with intimate partner and family violence in Aboriginal communities (Mitchell, L, *Domestic violence in Australia – an overview of the issues*, Parliament of Australia, 2011, Canberra, accessed 16 October 2014, pp. 6-7). As with family and domestic violence in non-Aboriginal communities, the research literature suggests that 'while alcohol consumption [is] a common contributing factor … it should be viewed as an important situational factor that exacerbates the seriousness of conflict, rather than a cause of violence' (Buzawa, E, Buzawa, C and Stark, E, *Responding to Domestic Violence*, Sage Publications, 4th Edition, 2012, Los Angeles, p. 99; Morgan, A. and McAtamney, A. 'Key issues in alcohol-related violence,' *Australian Institute of Criminology*, Canberra, 2009, viewed 27 March 2015, p. 3).

In the report, the Ombudsman recommended that:

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

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

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

Of the 49 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2022 involving Aboriginal people, 38 (78%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Nineteen (39%) of the Aboriginal people who died lived in the Kimberley region, which is home to 1.3% of all people and 16% of Aboriginal people in the Western Australian population.

As outlined above, *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to Recommendations 4 and 6 of the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015. These recommendations related to DCPFS developing 'a strategy that is specifically tailored to preventing and reducing Aboriginal family violence' that would encompass all regions of Western Australia and would ensure actively inviting and encouraging 'the involvement of Aboriginal people in a full and active way at each stage and level of the process' and being 'comprehensively informed by Aboriginal culture'. Subsequent to these recommendations, Item 5 of the First Action Plan intends to '[c]o-design the Aboriginal Family Safety Strategy with Aboriginal people and communities'. The Ombudsman's reviews have also examined agency action to facilitate co-design of locally based solutions to promote Aboriginal family and community safety. In 2020-21, the Ombudsman made four recommendations that seek to support community led solutions. The implementation of these recommendations is being monitored, and will be reported on in the Annual Report 2022-23.

Factors co-occurring with family and domestic violence

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

Co-occurrence with alcohol and other drug use

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

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

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

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

On the information available, relating to the 119 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2022, the Office's reviews identify where alcohol use and/or drug use are factors associated with the fatality, and where there may be a history of alcohol use and/or drug use.

	ALCOHOL USE		DRUG USE	
	Associated with fatal event	Prior history	Associated with fatal event	Prior history
Person who died only	4	5	5	8
Suspected perpetrator only	11	11	19	19
Both person who died and suspected perpetrator	39	47	13	23
Total	**54**	**63**	**37**	**50**

The Ombudsman's reviews and *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, have identified that in Western Australia, the former State Strategy did not mention or address alcohol use co-occurring with family and domestic violence.

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

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

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

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

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

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

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

recommendation. The Office will monitor the implementation and effectiveness of the *Western Australian Alcohol and Drug Interagency Strategy 2018-2022*, and the State Strategy to reduce family and domestic violence, in responding to family and domestic violence and co-occurrence with alcohol and drugs.

Co-occurrence of mental health issues

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

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

and

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

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

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

Issues Identified in Family and Domestic Violence Fatality Reviews

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

It is important to note that:

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

- Not providing culturally responsive practice when working with Aboriginal families.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities to provide perpetrator rehabilitation support.
- Not adequately investigating offences in the context of family and domestic violence.
- Missed opportunities to address family and domestic violence victim safety.
- Missed opportunity to facilitate safe accommodation.
- Missed opportunity to assess risk of harm and develop strategies to reduce or prevent family and domestic violence in the context of mental health issues and/or drug and alcohol use.
- Not undertaking sufficient family, intra-agency and inter-agency communication to enable effective case management and collaborative responses.
- Not adequately meeting policy and procedures of the Family and Domestic Violence Response Team.
- Not taking action consistent with legislative responsibilities of the *Children and Community Services Act 2004*, and associated policy, to determine whether children were in need of protection or whether action was required to safeguard child wellbeing.
- Inaccurate recordkeeping.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following recommendation was made by the Ombudsman in 2021-22 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. The WA Police Force provides a report to the Ombudsman by 1 October 2022 on the progress of discussions with DOJ regarding information exchange when WA Police Force have contact with an individual subject to a community order, and the creation of a protocol to facilitate information sharing.

The Ombudsman's *Annual Report 2022-23* will report on the steps taken to give effect to the eight recommendation made about ways to prevent or reduce family and domestic violence fatalities in 2020-21. The Ombudsman's *Annual Report 2023-24* will report on the steps taken to give effect to the recommendation made about ways to prevent or reduce family and domestic violence fatalities in 2021-22.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2019-20

The Ombudsman made two recommendations about ways to prevent or reduce family and domestic violence fatalities 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: Within three months of the finalisation of this review, Communities provides a report to the Ombudsman outlining Communities' plan for monitoring and evaluating the Family and Domestic Violence Response Team function and operation to ensure this service is providing an efficient, effective and collaborative response to families impacted by family and domestic violence, is improving victim safety, and is addressing perpetrator accountability.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 7 October 2019, in which Communities relevantly informed this Office that:

> The following points highlight the planning progress to date:
>
> - Following receipt of the recommendation, Communities convened a Family and Domestic Violence Response Team (FDVRT) Review Planning Group (the planning group) which consists of executive and senior officers from Communities and the Western Australia Police Force.

- Four planning group meetings have been convened. The purpose of the meetings was to decide on the appropriate level of review and redesign needed for the FDVRT model. It has been agreed that a phased service design approach will be taken.
- An FDVRT Review and Redesign Project Plan has been drafted, which includes the intended approach for completing phase one of the service design approach (review). The Plan will be provided to the Communities Policy Committee for approval on 8 October 2019. Once approved, the final plan will be forwarded to your office.
- It is proposed that Phase One of the approach will discover and define the challenges and issues with the FDVRT model, and will identify the core elements necessary for an effective and efficient operational model.
- Phase One will occur over six months, with the start date dependant on available funding to resource an external consultant to assist with review of the FDVRT model. This process will identify local issues and concerns, as well as national and international comparisons for the next phase. This project will be funded internally.
- Phase Two will consist of broad-level thinking and engagement with key stakeholders to co-design an innovative, efficient and effective FDVRT model.
- A redesigned FDVRT model will have funding implications for final co-design and for implementation at Phase Three.

Going forward, the planning group will support the FDVRT Review and Redesign Project with governance and reporting.

This Office requested further information of the steps taken to give effect to this recommendation. In response, Communities provided a range of information in an email to this Office dated 20 December 2021. Communities relevantly informed this Office that:

The project team have finalised the design of the enhanced Family Domestic Violence Response Team (FDVRT) service delivery model. The project team includes representatives from Communities, Justice and Police who have worked consultatively to implement the agreed deliverables, including:

- The inclusion of Justice Officers in the co-located FDVRT.
- Development of a Central Support and Coordination Team to provide governance of the model and ensure ongoing continuous improvement across the structure, policy, process and training. This is a tripartite arrangement, staffed by representatives of Communities, Police and Justice.

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

Recommendation 2: DOJ provides the Ombudsman with a report by 31 July 2020, that outlines, for the period 1 July 2019 to 30 June 2020:

- **The number of offenders who were sentenced for offences that occurred in the context of family and domestic violence;**
- **How many of these offenders were assessed as eligible and recommended for family and domestic violence rehabilitation intervention (individual or group); and**
- **How many of these offenders who were recommended for family and domestic violence rehabilitation intervention have since completed the intervention (individual or group).**

Steps taken to give effect to the recommendation

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

- The Department identified 731 offenders who were sentenced for offences that occurred in the context of FDV.
- Of the 731 offenders, the Department assessed 167 (23%) offenders' treatment needs and of these, 118 offenders (71%) were assessed as eligible and recommended for FDV rehabilitation intervention (individual or group).
- It is noted that 160 (28%) of the 564 offenders not assessed for treatment needs are engaged in the Department's assessment process and may be recommended for an FDV intervention in the future and 348 (62%) are ineligible to access a treatment program due to their sentence length being less than six months.
- Of the 118 offenders recommended for FDV rehabilitation intervention, 6 (5%) have completed the intervention, 29 (24%) are enrolled in an intervention and 52 (44%) will be enrolled in an intervention following the pending release of the Offender Programs schedule.

This Office requested DOJ provide any additional information relevant to the implementation of this recommendation. In response, DOJ provided a letter to this Office dated 30 March 2022, which relevantly informed this Office that:

> Further to this, the Department continues to identify and assess the risks of FDV offenders including those at high-risk of re-offending.
>
> The Department is in the process of developing a program of works to prioritise and update the suite of criminogenic treatment programs across adult prisons and for offenders managed in the community.
>
> The Department is currently progressing an Offender Programs Review Implementation Project. This focuses on rehabilitation through contemporary, evidence-based, innovative and effective criminogenic/non-criminogenic programs that target the specific needs of our offender cohort to break the cycle of offending.
>
> This project will implement a significant program of works that will augment the Department's current offender program suite and address identified gaps in service delivery. FDV rehabilitation programs are identified as a priority area for this project.

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

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

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of family and domestic violence fatalities. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2021-22, timely review processes have resulted in 41% of all reviews being completed within six months and 67% of reviews completed within 12 months.

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

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

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

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

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

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

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

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

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

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

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

Communities identified several issues which potentially relate to barriers to effective implementation, a range of Communities' 'proposed actions' to overcome these potential barriers were not considered to be appropriate.

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

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

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

Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

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

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through the Ombudsman's Advisory Panel, and other mechanisms, working with public authorities and communities where individuals may be at risk of family and domestic violence to consider safety issues and potential areas for improvement, and to highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information, where appropriate, with other accountability and oversight agencies including Ombudsmen and family and domestic violence fatality review bodies in other States to facilitate consistent approaches and shared learning;
- Engaging with other family and domestic violence fatality review bodies in Australia through membership of the Australian Domestic and Family Violence Death Review Network (**the Network**). The Network worked in partnership with the Australia's National Research Organisation for Women's Safety (**ANROWS**) to publish the *Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2010-2018, Second Edition 2022*. This collaboration is also working to develop analysis of the common risk factors in family and domestic violence homicides in Australia based on the breadth of information that is available to the Network. Additionally, the collaboration will develop a national dataset of the characteristics of the deaths of children by parents to inform prevention initiatives at a national level;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

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

The Ombudsman's Advisory Panel

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

The 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 those who are at risk of family and domestic violence or who have experienced family and domestic violence. Important stakeholders, with which the Office liaised as part of the family and domestic violence fatality review function in 2021-22, included:

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

Aboriginal and regional communities

In 2016, the Ombudsman established a Principal Aboriginal Consultant position to:

- Provide high level advice, assistance and support to the Corporate Executive and to staff conducting reviews and investigations of the deaths of certain Aboriginal children and family and domestic violence fatalities in Western Australia, complaint resolution involving Aboriginal people and own motion investigations; 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.

Own Motion Investigations, Monitoring and Improvement

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

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

Improvements from Complaints and Reviews

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

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

Own Motion Investigations

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

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

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

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

Selecting topics for own motion investigations

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

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

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

Own Motion Investigations in 2021-22

In 2021-22, significant work was undertaken on:

- *An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley*, which was tabled in Parliament in July 2021;
- A report on giving effect to the recommendations arising from *Preventing suicide by children and young people 2020*, which was tabled in Parliament in September 2021;
- An investigation into family and domestic violence and suicide, to be tabled in Parliament in 2022; and
- An investigation into services provided to children and young people with disordered eating, to be tabled in Parliament in 2022-23.

An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley

On 2 March 2021, the Honourable John Quigley MLA, Attorney General, wrote to the Ombudsman requesting an investigation into the Office of the Public Advocate's (**OPA**) role in notifying the family of Mrs Joyce Savage of the death of Mrs Savage. The Attorney General also requested that the investigation include the circumstances of OPA's notification to the families of Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mr Ayling and Mr Hartley.

On the same day, in accordance with section 16(1) of the *Parliamentary Commissioner Act 1971*, the Ombudsman initiated an investigation into OPA's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley (**the Investigation**).

Mrs Savage's daughter, Ms Kaye Davis, Mr Ayling's son, (also named) Mr Robert Ayling and Mr Hartley's brother, Mr Phillip Hartley, were contacted as part of the Investigation and each made themselves available during the Investigation to talk about their experiences and views. These experiences and views informed this report of the Investigation (**the Report**). The Ombudsman expressed his hope that the Report would, in turn, provide information to Ms Davis, Mr Ayling and Mr Hartley that is of assistance to them and he expressed his sincerest condolences to the families on the passing of Mrs Savage, Mr Ayling and Mr Hartley.

A person for whom OPA has been appointed as their guardian is a 'represented person'. This was the case for Mrs Savage, Mr Ayling and Mr Hartley. Each was a represented person. But Mrs Savage, Mr Ayling and Mr Hartley were more than represented people. Each led a long life, was a family member and a contributor to their communities. Any delay in notifying a family of the death of a family member will, of course, be upsetting for a family. Further, the delay does not give the dignity to the person's passing that they should, and must, be afforded.

As a result of the Investigation, the Ombudsman formed a number of opinions regarding OPA's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

Arising from these opinions, the Ombudsman made seven recommendations to OPA.

The Ombudsman is very pleased that OPA agreed to all seven recommendations. The Ombudsman will actively monitor the steps taken by OPA to give effect to the recommendations.

In the Ombudsman's view, these seven recommendations, when implemented, will be responsive to the families of Mrs Savage, Mr Ayling and Mr Hartley, but also ensure that in the future OPA does, without delay, notify family upon the death of a loved one.

The Report is available at:
https://www.ombudsman.wa.gov.au/Improving_Admin/AI_Reports.htm#OPA-Report-2021.

Monitoring the implementation of recommendations

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

A report on giving effect to the recommendations arising from *Preventing suicide by children and young people 2020*

About the report

Arising from the Ombudsman's responsibility to review child deaths, the Office undertook a major own motion investigation, *Preventing suicide by children and young people 2020* (**the Investigation**), tabled in Parliament on 24 September 2020.

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

The 2014 Investigation examined the deaths of 36 young people aged 14 to 17 years. Arising from these findings, the Ombudsman made 22 recommendations to four agencies, namely, the Mental Health Commission, Department of Health, Department of Education and the (then) Department for Child Protection and Family Support, all of which were accepted by these agencies.

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

- Deaths by suicide; and
- Hospital admissions and emergency department attendances for self-harming and suicidal behaviour.

Arising from the findings in the Investigation, the Ombudsman made seven recommendations about ways to prevent or reduce deaths of children and young people by suicide. The Mental Health Commission, Department of Health, Department of Communities and Department of Education each agreed to these recommendations.

The report is available at:
https://www.ombudsman.wa.gov.au/suicidebychildrenandyoungpeoplereport2020.

In 2016-17, the Ombudsman gave a commitment to Parliament that, following the tabling of each major own motion investigation, that the Office would undertake a comprehensive review of the steps taken by government agencies to give effect to the

Ombudsman's recommendations and then table the results of this review in Parliament twelve months after the tabling of the major own motion investigation.

Accordingly, the Ombudsman tabled in Parliament *A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020 (***the Report***)* in September 2021.

The report is available at: https://www.ombudsman.wa.gov.au/Improving_Admin/AI_Reports.htm#Youth-Suicide-Implementation-2021.

Objectives

The objectives of the Report 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.

This Report 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.

Methodology

On 21 May 2021, the Ombudsman wrote to the Mental Health Commissioner, the Director General of the Department of Communities, the Director General of the Department of Health, and the Director General of the Department of Education requesting a report on the steps that have been taken, or were proposed to be taken, to give effect to the recommendations of the Report.

Additionally, the Office:

- Obtained further information from the relevant State Government departments and authorities, in order to clarify or validate information provided in their reports to the Ombudsman;
- Collected additional information relevant to suicide by young people in Western Australia to inform the consideration of whether the steps taken by relevant State Government departments and authorities seem appropriate;
- Reviewed relevant current national and international literature regarding suicide by children and young people and the associated risk factors;
- Developed a preliminary view and provided it to relevant State Government departments and authorities for their consideration and response; and
- Developed a final report on whether steps have been taken to give effect to the recommendations.

Summary of Findings

The Office is very pleased that in relation to all the recommendations, the Mental Health Commission, the Department of Communities, the Department of Health, and the Department of Education we have found that steps have been taken, and are

proposed to be taken, to give effect to the recommendations. In no instance have we found that no steps have been taken to give effect to the recommendations.

In undertaking the review of the steps taken by the agencies to give effect to the recommendations, it is very evident that there is a particularly positive and very pleasing emphasis on strong cooperation and collaboration between the agencies. This is vitally important as the tragedy of suicide by children and young people cannot be prevented by a single program, service or agency working in isolation.

The work of the Office in ensuring that the recommendations of the Investigation are given effect does not end with the tabling of this report. The Office will continue to monitor and report on the steps taken to give effect to the recommendations arising from the Investigation. As such, provided below is a progress update on the steps taken to give effect to Recommendation 6 of the Investigation by the Department of Communities.

Progress update

On 22 October 2021, the Director General of the Department of Communities provided the Office with a progress update on Recommendation 6 of *Preventing suicide by children and young people 2020*, which stated that:

> Communities has recently established the Reviews and Recommendations Oversight Group (the Oversight Group), to align and streamline activity across the agency. The Oversight Group is scoped to endorse themed work packages and oversight the implementation of internal and external recommendations delivered to Communities.
>
> Oversight Group members, who represent relevant divisions across Communities and hold decision-making authority, are responsible for developing an environment of continuous service improvement through the identification of:
> - opportunities to inform and drive reforms through regular review of risk themes and practice trends; and
> - interdependencies and opportunities to work across business areas to deliver holistic, effective results.
>
> The Oversight Group is overseeing the implementation of [Recommendation] … 6 from the Ombudsman's Own Motion Investigation, *Preventing suicide by children and young people 2020* …
>
> In September 2021, the Oversight Group endorsed the project scope which will address Recommendation 6. The Cumulative Harm Project will improve policy frameworks, practice guidance, service delivery to support sustainable, holistic responses for children and young people who:
> - experience cumulative harm through multiple repeat presentations, which considered in isolation, do not reach the intake threshold.
> - experience acute distress as a result of cumulative harm and are at risk of suicide and/or suicide behaviours (including suicide attempt, suicidal ideation, self-harm and reckless risk-taking).
>
> The Cumulative Harm Project proposes to achieve these objectives by:
> - Reviewing and assessing policies, practice guidance, processes and tools that are used to address identifying, responding and intervening in:
>   - children, young people and families with history with Communities who are the subject of multiple interactions and are at risk of, or currently experiencing, cumulative harm; and

  - children and young people with history with Communities who are at risk of harm as a result of suicide behaviours, including those of a parent, carer or guardian.
- Develop improvement opportunities for service delivery, including communications, training, and development for frontline staff.

The Cumulative Harm Project will include data collection and research to assess and develop findings, which will be tested with key stakeholders. From this, recommendations relating to practice guidance, staff engagement opportunities and a corresponding implementation plan will be developed. It is anticipated that this Project will be finalised by June 2022.

Communities has updated the *Casework Practice Manual* (CPM) which provides guidance for Child Protection Workers, as authorised officers of the CEO, in carrying out the functions and powers of *Children and Community Services Act 2004* (the Act). On 30 August 2021, the CPM entry '*Alcohol and other drug use - at risk young people'* was introduced. This entry includes guidance on responding to young people, both in the CEO's care and otherwise, who are assessed as at immediate high risk due to their alcohol or other drug use, inclusive of medical and/or mental health crisis.

As you might be aware the *Children and Community Services Amendment Bill 2021* passed in WA Parliament on 14 October 2021. Amendments were made regarding young people once they leave the care of the CEO's care. These changes included:

- a leaving care plan must be prepared once a child reaches 15 years of age;
- leaving care plans should include the social services proposed to be provided for the child post-care;
- children leaving care must be provided with social services the CEO considers appropriate having regard to the child's needs, regardless of whether those needs are identified in the child's last care plan; and
- children leaving care are to receive written information on their entitlements post-care.

Public authorities named in regulations must prioritise CEO requests for assistance to a child in care, a child under an SGO or a care leaver who qualifies for assistance until they reach 25, provided it would be consistent with and not unduly prejudice the performance of the public authority's functions to do so.

As you might be aware Communities, in partnership with Anglicare WA, have piloted Home Stretch WA. The State Government in its 2021-22 State Budget committed $37.2 million to expand the Home Stretch pilot into a permanent state-wide program to enhances access to supports and services for young people aged 18 to 21 years who are leaving, or have left, out-of-home care.

Inspection and Monitoring Functions

Telecommunications interception records

The *Telecommunications (Interception and Access) Western Australia Act 1996*, the *Telecommunications (Interception and Access) Western Australia Regulations 1996* and the *Telecommunications (Interception and Access) Act 1979* (Commonwealth) permit designated 'eligible authorities' to carry out telecommunications interceptions. The Western Australia Police Force (**WA Police Force**) and the Corruption and Crime Commission are eligible authorities in Western Australia. The Ombudsman is

appointed as the Principal Inspector to inspect and report on the extent of compliance with the legislation.

Monitoring of the *Criminal Law (Unlawful Consorting and Prohibited Insignia) Act 2021*

On 24 December 2021, the *Criminal Law (Unlawful Consorting and Prohibited Insignia) Act 2021* (**the Act**) was promulgated. This is an Act to:

- Make consorting unlawful between certain offenders;
- Provide for the identification of organisations for the purposes of the Act;
- Prohibit the display in public places of insignia of identified organisations;
- Provide for the issue of dispersal notices to members of identified organisations and make any consorting contrary to those notices unlawful;
- Provide for police powers relating to unlawful consorting and insignia of identified organisations; and
- Make consequential and other amendments to the *Community Protection (Offender Reporting) Act 2004* and *The Criminal Code*.

Parts 2 and 3 of the Act provide for unlawful consorting notices, insignia removal notices, display of prohibited insignia, dispersal notices and the use of police powers and criminal charges relating to these parts.

Part 4 of the Act provides that the Ombudsman must keep the exercise of powers conferred under the Act under scrutiny. Further, the Ombudsman must inspect the records of WA Police Force in order to ascertain the extent of WA Police Force's compliance with Parts 2 and 3 of the Act.

The Commissioner of Police must keep a register (**the register**) of the issue and service of all notices under the Act, the revocation or variation of any notice issued and served under the Act, any prosecution for an offence under the Act, the use of any police powers whilst operationalising the Act and any certificate of service given under the Act. The Commissioner of Police must provide the register to the Ombudsman.

Further, under Part 4 of the Act, the Ombudsman must report annually on the monitoring activities undertaken as soon as practicable after each anniversary of the day on which Part 4 came into operation. The Ombudsman must provide a copy of the annual report to the responsible Minister and the Commissioner of Police.

The annual report may include any observations that the Ombudsman considers appropriate to make about the operation of the Act and must include any recommendations made by the Ombudsman and details of any actions taken by the Commissioner of Police in respect of any recommendations. The annual report must include any information contained in the register. The annual report must also include a review of the impact of the operation of the Act on a particular group in the community if such an impact came to the attention of the Ombudsman.

The Minister must cause the annual report to be tabled in Parliament within 12 sitting days after the Minister receives a copy of the report.

Continuous Administrative Improvement

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

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

Guidance for Public Authorities

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

Publications

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

Workshops for public authorities

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

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

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

Working collaboratively

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

Collaboration and Access to Services

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

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

Working Collaboratively

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

Information sharing with Ombudsmen from other jurisdictions

Background:

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

The Office's involvement:

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

Australia and New Zealand Ombudsman Association

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

Background:

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

The Office's involvement:

The Office is a member of ANZOA. The Office periodically provides general updates on its activities and also has nominated representatives who participate in interest groups in the areas of Indigenous engagement, complaints management, systemic issues and policy influence, and public relations and communications. In October 2021, the office's public relations and communications interest group representative presented on the youth engagement initiatives of ANZOA members as part of a webinar open to all staff of the ANZOA membership.

Providing Access to the Community

Communicating with complainants

The Office provides a range of information and services to assist specific groups, and the public more generally, to understand the role of the Ombudsman and the complaint process. Many people find the Office's enquiry service and drop-in clinics held during regional visits assist them to make their complaint. Other initiatives in 2021-22 include:

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

Access to the Ombudsman's services

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

- Access to the Office through a Freecall number, which is free from landline phones;
- Access to the Office through email and online services. The importance of email and online access is demonstrated by their use this year in 84% of all complaints received (51% by email and 33% through the website complaint form);
- Information on how to make a complaint to the Ombudsman is available in 17 languages in addition to English and features on the homepage of the Ombudsman's website. People may also contact the Office with the assistance of an interpreter by using the Translating and Interpreting Service;
- The Office's accommodation, building and facilities provide access for people with disability, including lifts that accommodate wheelchairs and feature braille on the access buttons and people with hearing and speech impairments can contact the Office using the National Relay Service;
- The Office's Regional Awareness and Accessibility Program and Youth Awareness and Accessibility Program target awareness and accessibility for regional and Aboriginal Western Australians as well as children and young people;
- The Office attends events to raise community awareness of, and access to, its services, such as:
    - The Dowerin Machinery Field Days Agricultural Show in August 2021;
    - The Multicultural Communities Council WA mini-expo as part of the Mental Health Week event in October 2021;
    - The Financial Counsellors' Association of WA Conference marketplace in November 2021; and
- The Office's visits to adult prisons and the juvenile detention centre provide an opportunity for adult prisoners and juvenile detainees to meet with representatives of the Office and lodge complaints in person.

Ombudsman website

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

- Members of the public on the complaint handling services provided by the Office as well as links to other complaint bodies for issues outside the Ombudsman's jurisdiction;
- Public authorities on decision making, complaint handling and conducting investigations;
- Children and young people as well as information for non-government organisations and government agencies that assist children and young people, including downloadable print material tailored for children and young people. The youth pages can be accessed at www.ombudsman.wa.gov.au/youth;
- Access to the Ombudsman's reports such as *A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020* and *An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley*;
- The latest news on events and collaborative initiatives such as the Regional Awareness and Accessibility Program; and
- Links to other key functions undertaken by the Office such as the Energy and Water Ombudsman website and other related bodies including other Ombudsmen and other Western Australian accountability agencies.

The website continues to be a valuable resource for the community and public sector as shown by the increased use of the website this year. In 2021-22:

- The total number of visits to the website was 103,579;
- The top two most visited pages (besides the homepage and the Contact Us page) on the site were *Making a complaint* and *What you can complain about*; and
- The Office's *Effective Handling of Complaints Made to Your Organisation Guidelines* and *Procedural Fairness Guidelines* were the two most viewed documents.

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

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2021-22. A regional visit was conducted to Kununurra, Wyndham, Halls Creek, and a remote Aboriginal community in the East Kimberley Region in August-September 2021 and Broome, Derby and Fitzroy Crossing in the West Kimberley Region in October 2021. The visits include activities such as:

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

The Program is an important way for the Office to raise awareness of, access to, and use of, its services for regional and Aboriginal Western Australians. The visits were coordinated with the Western Australian Energy and Water Ombudsman, the Health and Disability Services Complaints Office, the Equal Opportunity Commission, the Commonwealth Ombudsman, the Corruption and Crime Commission and the Department of Mines, Industry Regulation and Safety (Consumer Protection).

The Office also held an information stall at the Dowerin Machinery Field Days Agricultural Show in August 2021, in collaboration with the Health and Disability Services Complaints Office.

The Program enables the Office to:

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

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

The Office held an information stall at the Dowerin Machinery Field Days Agricultural Show in August 2021.

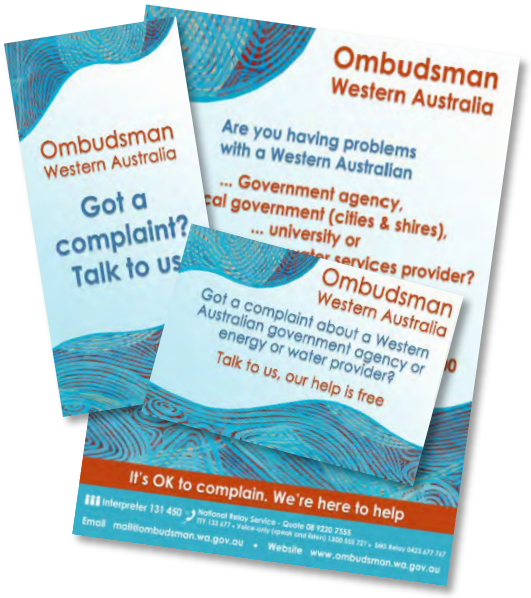
Aboriginal engagement

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

In 2018, the Office established two additional Aboriginal positions and in 2021-22, created a critical new executive position, Assistant Ombudsman Aboriginal Engagement and Collaboration, which will be recruited in 2022.

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

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



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

- Aboriginal community information sessions as part of its Regional Awareness and Accessibility Program;
- An opportunity arose for a visit to a remote community during the visit to the East Kimberley Region; and
- Seeking consultation with Aboriginal people with particular expertise for major investigations, reports and other functions of the Office. See further details in the Own Motion Investigations, Monitoring and Improvement section.

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

Youth Awareness and Accessibility Program

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

The website also has:

- A suite of promotional materials targeted at, and tailored for, children and young people; and
- A poster for children and young people translated into 15 community languages.

In 2021-22, these materials along with a colouring-in version of the poster was distributed to the community and community organisations during the Office's Regional Awareness and Accessibility Program visits to the East Kimberley and West Kimberley Regions and the Dowerin Machinery Field Days Agricultural Show.

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

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

Prison Program

The Office continued the Prison Program during 2021-22. Four visits were made to prisons and the juvenile detention centre to raise awareness of the role of the Ombudsman and enhance accessibility to the Office for adult prisoners and juvenile detainees in Western Australia.

Speeches and Presentations

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

- *The Western Australian Ombudsman*, presented by the Principal Project Officer in collaboration with the Health and Disability Services Complaints Office to clients of the Lorikeet Centre in July and November 2021 and May 2022;
- *Update from Ombudsman and Energy and Water Ombudsman WA*, presented by the Senior Investigating Officer to the Financial Counsellors' Association Conference Regional and Remote Day in November 2021;
- *Aboriginal and Torres Strait Islander Identification and Reporting*, presented by the Principal Investigator and Analyst, Reviews Team, to the Ombudsman's Advisory Panel in December 2021;
- *The Role and Functions of the Ombudsman*, presented by the Deputy Ombudsman to the Department of Education Regional Directors forum in February 2022;
- *Processes and Opportunities into the Future*, presented by the Senior Assistant Ombudsman Reviews to staff of the Department of Communities in March 2022;
- *Department of Education Information Sharing*, presented by the Senior Assistant Ombudsman Reviews to staff of the Department of Education in May 2022;
- *Ombudsman and Energy and Water Ombudsman WA*, presented by the Assistant Ombudsman Energy and Water to the WA Council of Social Services' Community Relief and Resilience Forum in May 2022;
- *Review Role of Ombudsman Western Australia*, presented by the Senior Assistant Ombudsman Reviews to staff of the Department of Education in May 2022; and
- *The Role and Functions of the Ombudsman*, presented by the Deputy Ombudsman to the Local Government Elected Members Association in June 2022.

Video recorded and written speeches by the Ombudsman are available on the Speeches by the Ombudsman page of the website.

The Ombudsman's speeches and presentations as President of the International Ombudsman Institute are detailed in the International Ombudsman Institute section of this report and the President's Speeches and Engagements page of the website.

Liaison with Public Authorities

Liaison relating to complaint resolution

The Office liaised with a range of bodies in relation to complaint resolution in 2021-22, including:

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

Liaison relating to reviews and own motion investigations

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

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

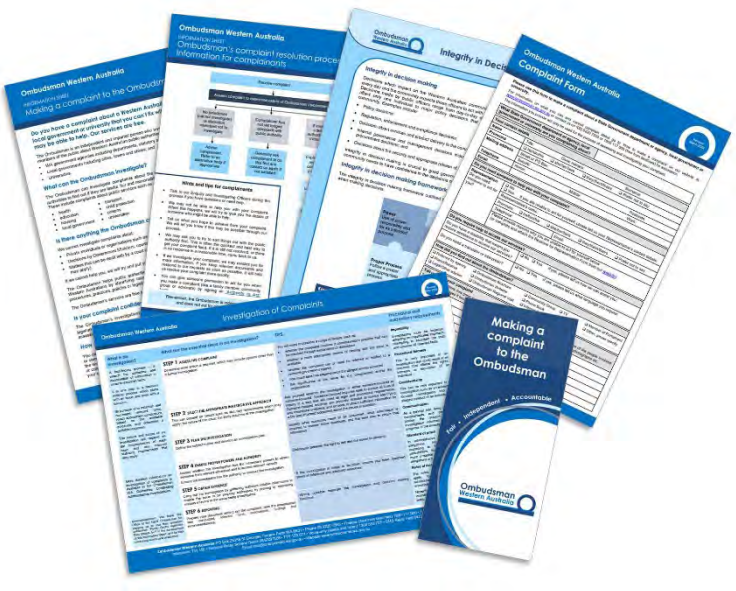
Liaison relating to inspection and monitoring functions

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

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

Publications

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



International Ombudsman Institute

The International Ombudsman Institute (**IOI**), established in 1978, is the only global organisation for the cooperation of more than 205 independent Ombudsman institutions from more than 100 countries worldwide. The IOI is organised into six regional chapters: Africa; Asia; Australasia & Pacific; Europe; the Caribbean & Latin America and North America.

In May 2021, the Ombudsman commenced his four-year term as President of the IOI at the Closing Ceremony of the 12th quadrennial World Conference of the IOI held (virtually) in Dublin.

In the 43-year history of the IOI, the Ombudsman is the only Australian that has been elected President. It was also the first time a President was elected by a vote open to all members of the IOI. Historically, the President was elected by a majority vote of the World Board of the IOI.

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

2021-22 initiatives

Secretary General of the IOI undertakes an official visit to the President of the IOI

On 13 March and 14 March 2022, the Secretary General of the IOI and Ombudsman of the Republic of Austria, Mr Werner Amon, undertook an official visit to the President of the IOI Mr Chris Field, in Perth. The Secretary General was accompanied by the Executive Director of the IOI Secretariat, Mr Meinhard Friedl.

This was the first in-person meeting of the President and Secretary General. In addition to a lengthy exchange of official business matters at the offices of the Western Australian Ombudsman, and an opportunity to showcase our wonderful city, a formal lunch was held in the Secretary General's honour by the President at Parliament House and attended by the Honorary Consul of Austria, Mr Wilfried Wimmler.



Top left: The President of the IOI, the President's Chief of Staff, former Executive Director of the IOI, and former Secretary General of the IOI; Centre: Former Secretary General of the IOI and the President of the IOI; Right: Former Secretary General of the IOI and the President of the IOI.

World Board Meeting in New York

In May 2022, the World Board of the IOI met in New York. New York was chosen as it provided the opportunity, following the adoption by the United Nations of Resolution 72/186 on *The role of Ombudsman and mediator institutions in the promotion and protection of human rights, good governance and the rule of law*, to meet with Ambassadors to discuss further strengthening the relationship of cooperation and collaboration between the IOI and the United Nations.

President meets the Australian Ambassador and Permanent Representative to the United Nations in New York

The President met with the Australian Ambassador and Permanent Representative to the United Nations in New York, the Hon. Mitch Fifield. The Ambassador and the President were able to undertake an extremely useful dialogue regarding strengthening the relationship of cooperation and collaboration between the IOI and the United Nations. The President is exceptionally grateful to Ambassador Fifield and the Australian Government for their ongoing support of his role as President of the IOI and for the institution of the Ombudsman in its work in promoting good governance, the rule of law and human rights.

Left to right: Australia's Ambassador and Permanent Representative to the United Nations in New York and the President of the IOI.

President meets Ambassador and Deputy Permanent Representative of Canada to the United Nations in New York

The President was delighted to meet with Ambassador Richard Arbeiter, Deputy Permanent Representative of Canada to the United Nations in New York and Paul Dube, Ombudsman for Ontario and IOI Regional President, North America to discuss the relationship of the IOI and the United Nations.

Left to Right: Ontario Ombudsman, Canada's Ambassador and Deputy Permanent Representative to the United Nations in New York and the President of the IOI.

President attends official dinner at the New Zealand Official Residence of the Ambassador to the United Nations in New York

The President was delighted to attend an official dinner at the residence of the New Zealand Ambassador and Permanent Representative to the United Nations in New York, Ms Carolyn Schwalger, together with the Second Vice President of the IOI and Chief Ombudsman of New Zealand, Mr Peter Boshier and a number of distinguished guests, including the Secretary General of the IOI, Mr Werner Amon.

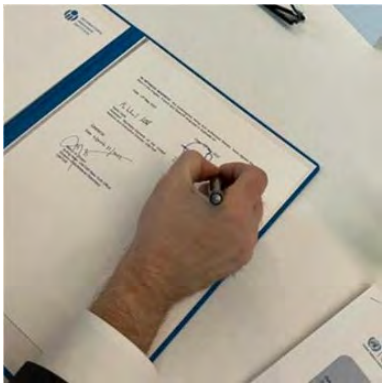
Left to right: Former Secretary General of the IOI, New Zealand's Ambassador and Permanent Representative to the United Nations in New York, and Chief Ombudsman New Zealand, and the President of the IOI.

President and Austrian Consul General in New York invite IOI World Board members to a Reception at the Austrian Consulate General

The President hosted, with the Austrian Consul General in New York, Ms. Helene Steinhäusl, and the Secretary General of the IOI and Ombudsman of the Republic of Austria, Mr Werner Amon, a Welcome Reception in New York at the Consulate for the IOI World Board.

Left to right: The President of the IOI, former Secretary general of the IOI and Austrian Consul General.

United Nations Assistant Secretary-General and United Nations Institute for Training and Research Executive Director and President of the IOI sign an MoU



The President of the IOI signs the MOU.

On 12 May 2022, at the meeting of the IOI Board of Directors in New York, United Nations Assistant Secretary-General and UNITAR Executive Director Mr. Nikhil Seth, who joined the virtual ceremony from Geneva, and the President signed a Memorandum of Understanding (**MoU**) between the IOI and the United Nations Institute for Training and Research (**UNITAR**). The work of UNITAR makes a vital contribution to better outcomes for citizens globally, particularly those in developing nations. There is significant alignment in the work of the IOI and UNITAR. Furthermore, the IOI is forging even closer ties with the United Nations by signing this MoU, following on from the United Nations Resolution on *The role of Ombudsman and mediator institutions in the promotion and protection of human rights, good governance and the rule of law*. This MoU is a strong foundation upon which the IOI can, and will, continue to learn from each other to provide the most informed and effective work for the communities we have the privilege to serve.

United Nations Ombudsman attends IOI World Board meeting in New York

The President, Secretary General and World Board of the IOI were delighted to host United Nations Ombudsman Shireen Dodson. Ms Dodson briefed the IOI World Board on her important work, including ensuring that all of her offices and staff globally are responsive to the most important human rights and equality for all.

Left to right: Former Secretary General of the IOI, the United Nations Ombudsman, the President of the IOI, the President's Chief of Staff and First Vice President of the IOI.

Farewell Reception hosted by Australia's Ambassador and Permanent Representative to the United Nations in New York

On 12 May 2021, His Excellency, the Honourable Mitch Fifield, Australian Ambassador and Permanent Representative to the United Nations in New York, hosted a Farewell Reception for the IOI World Board on the occasion of the President's visit to New York.

Left to right: Former Secretary General of the IOI, the President of the IOI, and Australia's Ambassador and Permanent Representative to the United Nations in New York.

Left to right: Former Secretary General of the IOI, Public Protector South Africa, Chairperson of the Commission on Administrative Justice (Office of the Ombudsman) Kenya, the President of the IOI, Public Protector Zambia and Provedoria de Justiça de la República de Angola (Ombudsman of the Republic of Angola).

Official visit to Graz and Styria on the occasion of the 45th anniversary of the Austrian Ombudsman Board

President meets Governor of Styria

Left to right: The President of the IOI, Federal Chancellor of Austria, the Ombudsman's Chief of Staff, the Personal Assistant to the former Secretary General of the IOI, the former Secretary General of the IOI and the former Executive Director of the IOI.

On 4 June 2022, it was the President's honour and privilege to meet His Excellency Mr Hermann Schützenhöfer, Governor of Styria. It was a genuine pleasure for the President to discuss with His Excellency the vital work of the IOI in protecting and promoting human rights, good governance and the rule of law. The President also discussed the very valued friendship of Austria and Australia, including our recently entered Strategic Cooperation Arrangement. His Excellency has made an extraordinary contribution to public life over five decades. It was particularly generous of him to receive the President as one his last acts in office.

President provided guided tour as part of official visit to Graz

As part of the President's official visit to Graz, on 4 June 2022 the President was provided a guided tour of the Landeszeughaus in Graz, the world's largest historic armoury. The President was very grateful to the Director and guide for sharing with us this superb museum.

Left to right: The President's Chief of Staff, the President of the IOI and Director.

The President also undertook a private tour of the Grazer Landhaus, an exceptional Renaissance Palace dating back to 1527, and home to the Parliament of Styria.

On 5 June 2022, the President was provided a private tour of the Feuerwehr Verband (Fire Brigade Association and Museum St. Florian). The President was very grateful to the wonderful Directors of the Museum for being such generous hosts.

Left to right: The President of the IOI and former Secretary General of the IOI.

Left to right: The President of the IOI and former Secretary General of the IOI.

President meets Chancellor of the Republic of Austria

It was a singular honour for the President to meet the Chancellor of Austria, His Excellency Karl Nehammer on 9 June 2022. The President had the opportunity to discuss with His Excellency the role of the Ombudsman institution internationally in promoting and protecting democracy, good governance, the rule of law and human rights. His Excellency was exceptionally gracious to provide time to meet with the President given his extraordinarily busy schedule. The President was deeply grateful for their exchange.

Left to right: Federal President of the National Council of the Republic of Austria, the President of the IOI and former Secretary General of the IOI.

President attends meeting with Federal President of the National Council of the Republic of Austria

It was a great honour for the President to meet with the Federal President of the National Council of the Republic of Austria, Wolfgang Sobotka on 9 June 2022. His Excellency and the President discussed the work of the Ombudsman institution internationally with regard to its role in upholding democratic principles, good governance, the rule of law and human rights.

President provides addresses at the Parliament at the Hofburg

The President was deeply honoured to be the international guest speaker on the occasion of the 45th Anniversary of the Austrian Ombudsman Board held at the Parliament at the Hofburg on 8 June 2022. His Excellency, Doctor Alexander Van der Bellen, Federal President of the Republic of Austria; Magister Wolfgang Sobotka, President of the National Council; Magister Christine Schwarz-Fuchs, President of the Federal Council and the three members of the Austrian Ombudsman Board also addressed the ceremony.

President of the IOI.

The following is an extract of the address:

> Guten morgen. It is a great honour to join you in the Parliament at the Hofburg to commemorate the forty-fifth anniversary of the Austrian Ombudsman Board and for your Presidents to allow me to address you in this wonderful Parliament. Today is, in my view, a celebration of the democratic state, of this great Republic of Austria and of a treasured and trusted institution … There can be no question that the Austrian Ombudsman Board embodies the very essence of the Paris Principles, Venice Principles and the United Nations Resolution … The Austrian Ombudsman Board is both an Ombudsman with all the gravitas that its history bestows upon it, but absolutely a modern Ombudsman institution committed to human rights, good governance and the rule of law … As mentioned by the President of the Federal Council, no proper recognition of the many accomplishments of the Austrian Ombudsman Board could be complete without acknowledging the contribution that it makes to the international

Ombudsman community and the citizens they serve. Since 2009, the Secretariat of the International Ombudsman Institute, or IOI, has been based in the Austrian Ombudsman Board. The IOI represents over two hundred Ombudsman institutions from more than 100 countries worldwide across six global regions - Africa, Asia, the Australasian and Pacific, Europe, the Caribbean and Latin America and North America … It is of note that I consider the Austrian Ombudsman Board, the Secretary General and the IOI Secretariat first and foremost as friends. They are, of course, also enormously valued colleagues and I take the opportunity today to thank them for their exceptional work in service of the international Ombudsman community – it is inconceivable to me that anyone could do more, or better, than the IOI Secretariat. I thank all three members of the Austrian Ombudsman Board for their unfailing support. This is also a propitious time for one other remark. I take great pleasure, both publicly and privately, and all around the world, to acknowledge the support that makes the IOI Secretariat possible. But I have never had this opportunity in the one place that it is most meaningful to do so – this Parliament. On this auspicious occasion, I wish to acknowledge, and formally thank, the Parliament of the Republic of Austria and successive Austrian governments for their generous support of the IOI Secretariat. Austria is, of course, a domicile of a number of supranational bodies. It is the contribution of a true international citizen that you provide this support. I, for one, am certain that the IOI would not exist in any meaningful way without your commitment. Before concluding it would, I think, be remiss of me not to mention one other matter. In 2021, I was the first Australian to have the privilege of being elected President of the IOI. As such, I want to recognise the Republic of Austria is a longstanding and very valued friend of my country. Apart from nearly sharing the same name, we enjoy annual bilateral trade of two billion dollars and, as like-minded countries, we cooperate on a range of issues of mutual interest, particularly in multilateral institutions. In September 2021, Australia and Austria signed a Strategic Cooperation Arrangement to deepen our collaboration. On the occasion of my visit to this magnificent city, and the wonderful province Styria, I thank you personally for the warmth and hospitality you have shown me and my Chief of Staff Rebecca Poole. To conclude, it is a testament to the wisdom of the Parliament of the Republic of Austria forty-five years ago, that we are here today to celebrate this anniversary. The institution of the Ombudsman upholds the great principles of democracy, human rights, good governance and the rule of law. I thank the Austrian Ombudsman Board for being a champion of these principles for four and a half decades. The Austrian Ombudsman Board is an institution woven into the very fabric of the democratic state with a constitutional mandate to protect human rights. Your work in service of this Parliament, the citizens of this great country and, of course, in supporting the global institution of the Ombudsman, is an achievement of which you ought to be extraordinarily proud and, for which, I am profoundly grateful.

The President was also honoured to provide an address at the Parliament of the Republic of Austria on the occasion of the 10th anniversary of the Austrian Ombudsman Board's Optional Protocol to the Convention against Torture (**OPCAT**) mandate on 7 June 2022.

President of the IOI.

President appears before the People's Advocacy Committee of the Parliament of the Republic of Austria

The President was given the great privilege to appear before the People's Advocacy Committee of the Parliament of the Republic of Austria on 8 June 2022. After providing an introductory statement, the President was delighted to answer a series of deeply thoughtful questions from the Honourable Members of the Committee.

Left to Right: The former Secretary General of the IOI, the President of the IOI.

Peter Tyndall awarded Golden Order of Merit of the Republic of Austria

Former IOI President and Ombudsman and Information Commissioner for Ireland, Peter Tyndall, travelled to Vienna to attend the celebrations of the 45th Anniversary of the Austrian Ombudsman Board. On 8 June 2022, he also became the first ever recipient of the Golden Order of Merit, recognising his exceptional service to the IOI and the institution of the Ombudsman.

Top left: The President of the IOI; Top right: the President of the IOI, former President of the IOI and Ombudsman and Information Commissioner of Ireland and former Secretary General of the IOI; Bottom left: Golden Order of Merit; Bottom right: former President of the IOI and Ombudsman and Information Commissioner of Ireland.

President provided private tour of the Parliament of the Republic of Austria

The President was given a private tour by His Excellency Alexis Wintoniak, Vice Director of the Parliament of the Republic of Austria on 9 June 2022. This magnificent Parliament is under renovation and restoration. While the program of works is being undertaken, the Parliament is presently located at the Imperial Palace (Hofburg). The President was accompanied on the tour by Mr Werner Amon, Secretary General of the IOI, and prior to his appointment as Ombudsman, a very longstanding and senior member of the Parliament.

Left to right: The Ombudsman's Chief of Staff and the President of the IOI.

President meets Secretary-General of the OECD

Left to right: Secretary-General of the OECD and the President of the IOI.

It was the President's privilege to meet with the Secretary-General of the Organisation for Economic Co-operation and Development (**OECD**), Mr Mathias Cormann. The Secretary-General was incredibly gracious to meet with the President in Paris coinciding with the President's official visit to Graz and Austria.

Economic co-operation and development are absolute cornerstones of human dignity. Without them, the institutions of democracy cannot be funded, nor essential civic infrastructure, nor vital social justice programs.

The President discussed with the Secretary-General the work of the IOI, and its more than 200 members from over 100 countries, in supporting good governance and the rule of law through work on anti-corruption measures, integrity, transparency and good governance. Adherence to the rule of law reduces sovereign risk and encourages the private capital investment that is essential to strong economies and caring, successful societies.

President meets Australian Ambassador to France, Her Excellency Ms Gillian Bird

As part of the President's official visit to meet the Secretary General of the OECD, the President met with the Australian Ambassador to France, Her Excellency Gillian Bird. Given that the President was in Paris for a very short time, it was particularly gracious of Her Excellency to accommodate their meeting. Her Excellency has extensive senior Ambassadorial experience, and it was very kind of her to offer so much thoughtful and helpful insight into the work that the IOI is currently undertaking with supra-national and other bodies. The President was greatly honoured by the very kind offer to host the President on the occasion of his next visit.

Left to right: The President of the IOI and the Australian Ambassador to France.

President meets Australian Ambassador and Permanent Representative to the OECD

The President was delighted to meet Ambassador Brendan Pearson, Permanent Representative of Australia to the OECD. The Ambassador and President had a very productive discussion regarding the work of the IOI and the OECD. The Ambassador very kindly offered to engage in further exchange about these matters. The President was very grateful to the Ambassador for the perspectives he was able to bring to discussions which will assist the IOI's ongoing approach to these matters.

Left to right: The President of the IOI and Ambassador and Permanent Representative of Australia to the OECD.

President's addresses

In 2021-22, the President:

- Delivered a statement, by video, in support of the Fifth International Conference, *Human rights protection in Eurasia: exchange of best practices of Ombudspersons*, held in Moscow on 12 October 2021;
- Delivered a Welcome Address, by video, to the working seminar on the Manchester Memorandum hosted by the Parliamentary and Health Service Ombudsman of the United Kingdom from 9-10 November 2021;
- Delivered a Keynote Address, by video, at the Plenary Session of the Forum for Institutions Supporting Democracy inaugural Virtual Conference on Constitutional Democracy, *The need for collaboration on the promotion of good governance and ethical leadership in responding to the impact of Covid 19 and corruption on constitutional democracy*, held in South Africa on 11 November 2021;
- Joined, by videoconference, a Ukrainian Network of Integrity and Compliance panel discussion "Compliance as a necessary component of investment protection in Ukraine", on 17 November 2021, as part of the Ukraine Business Integrity Month;
- Addressed the Caribbean Ombudsman Association webinar *How to be effective as a small Ombuds institution*, on 25 November 2021;

Top: The President of the IOI; Bottom: Deputy Business Ombudsman of Ukraine.

- Provided an opening greeting, by video, to delegates at the international conference on *Advancing the Rights of the Elderly in an Age of Longevity*, on the occasion of the 50th anniversary of the State Comptroller and Ombudsman of Israel, on 1 December 2021;
- Provided an opening address, by video, to the XII Virtual Assembly and Seminar of the Latin American Institute of the Ombudsman, *Human Rights and Transition: The Ombudsmen and their contribution to the future*, held on 2 December 2021;
- Attended a webinar jointly organised by the African Ombudsman Research Centre and the IOI on 25 January 2022. The webinar focussed on the benefits of membership of both the African Ombudsman and Mediators Association and the IOI for Ombudsman institutions in Africa;
- Provided a Welcome Address, by video, to the General Assembly of the European Region of the IOI on 26 May 2022;

Ombudsman and President of the IOI.

Ombudsman and President of the IOI.

- Provided an Address at the Parliament of the Republic of Austria on the occasion of the 10th Anniversary of the Austrian Ombudsman Board's OPCAT mandate in Vienna, Austria, on 7 June 2022; and
- Provided an Address at the Parliament of the Republic of Austria on the occasion of the 45th Anniversary of the Austrian Ombudsman Board in Vienna, Austria, on 8 June 2022.

Video recorded and written speeches by the Ombudsman as President of the IOI are available on the President's Speeches and Engagements page of the Ombudsman's website.