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:

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

The Role of the Ombudsman in Relation to Child Death Reviews

The Ombudsman is notified of all child deaths in Western Australia. The Office undertakes reviews of certain child deaths to identify learnings, and analyses data on child deaths to identify patterns and trends, which enables the Ombudsman to make recommendations for system improvements that may prevent or reduce the risk of future child deaths.

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 addition to determining if a child death is an investigable death, since 1 July 2020, the Ombudsman also identifies whether the child death will be reviewed by the Coroner (reportable deaths) or an existing medical review mechanism (including *Perinatal and Infant Mortality Review Committee* and a health service provider's *Mortality Review Committee*). The Ombudsman will review all investigable deaths as well as those child deaths that are not reviewed by one of these existing death review mechanisms.

The Ombudsman can also review other notified child deaths. Under Section 16 of the *Parliamentary Commissioner Act 1971*, the Ombudsman may determine to undertake a child death review under his own motion, where a child death may not be defined as an investigable death in accordance with Section 19A(3).

In undertaking a child death review, 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. The Ombudsman may also undertake major own motion investigations arising from child death reviews (discussed later in this section).

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

The Ombudsman is notified of all child deaths that occur in WA

Births, Deaths and Marriages notifies the Ombudsman of all registered child deaths

The Department of Health notifies the Ombudsman of all child deaths known to Health Service Providers

Communities notifies the Ombudsman of all child deaths notified to it by the Coroner (those deaths that are reportable to the Coroner)

The Ombudsman reconciles the data from the three notification sources to identify the individual child deaths. Each child death notification is assessed to determine:

- whether the death is an investigable death or a non-investigable death; and
- whether a review will be conducted by an existing medical death review mechanism (including the *Perinatal and Infant Mortality Review Committee* and health service provider's *Mortality Review Committee*).

Ombudsman conducts review

- All investigable deaths are reviewed
- All deaths that are not reported to the Coroner, and not reviewed by an existing medical death review mechanism are reviewed
- Other deaths can be reviewed

Identifying patterns and trends

- Data on all child deaths is obtained, and reconciled
- Patterns and trends are identified, analysed and reported and also provide critical information to inform the selection and undertaking of major own motion investigations

Improving public administration

The Ombudsman seeks to improve public administration to prevent or reduce child deaths, including making recommendations to prevent or reduce child deaths arising from reviews and major own motion investigations

Implementation of recommendations and monitoring improvements

The Ombudsman actively monitors the implementation of recommendations as well as ensuring those improvements to public administration are contributing over time to preventing or reducing child deaths

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:

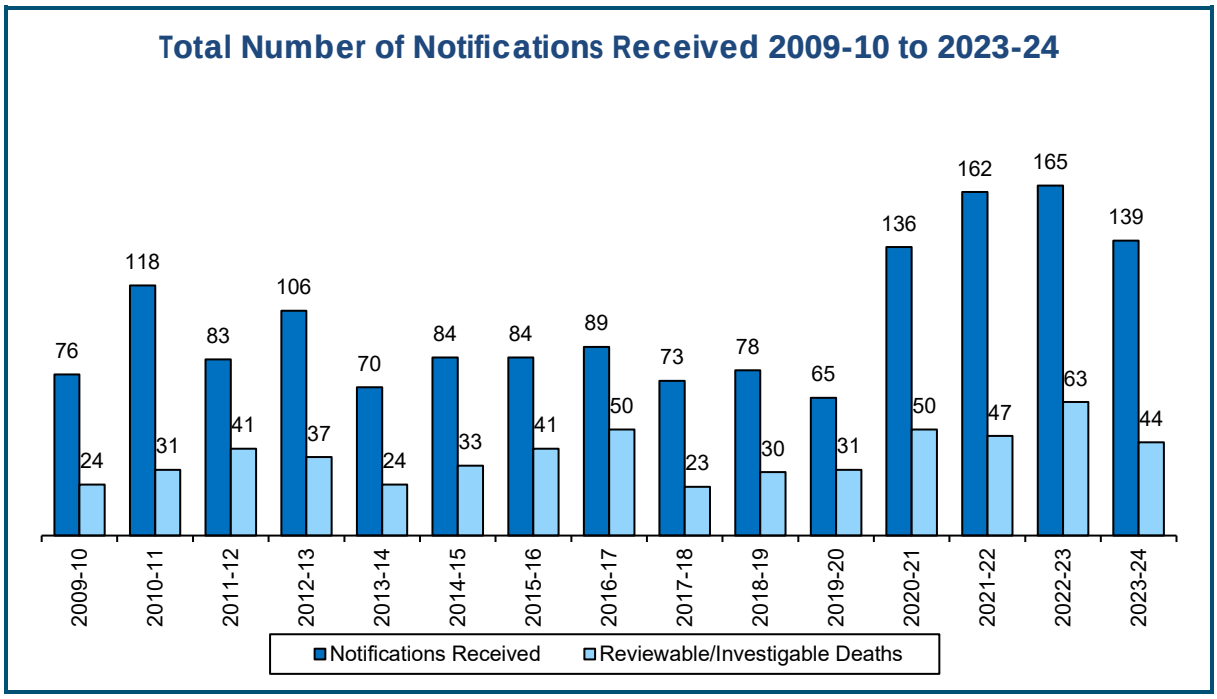
- The number of child death notifications and reviews;
- The comparison of investigable deaths over time;
- Demographic information identified from child death notifications;
- Circumstances in which child deaths have occurred;
- Social and environmental factors associated with investigable child deaths;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

Number of child death notifications and reviews

Expanded data on child deaths

From 1 July 2020, the Ombudsman has received notifications of all child deaths in Western Australia. The data for the year 2020-21 onwards relates to all child deaths, while data from earlier years relates to child deaths reported to the Coroner and notified from Communities.

During 2023-24, there were 44 child deaths that were investigable and subject to review from a total of 139 child death notifications received.



Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Due to a lag in death registration and notification of relevant death data, number of death notifications will increase for the last reported year. In the 2022-23 Annual Report, complete data on 143 deaths (57 Investigable Deaths) had been provided to the Ombudsman. As additional data was provided in 2023-24, this has been revised to 165 deaths (63 Investigable deaths) notified to the Ombudsman in 2022-23.

Demographic information identified from child death reviews

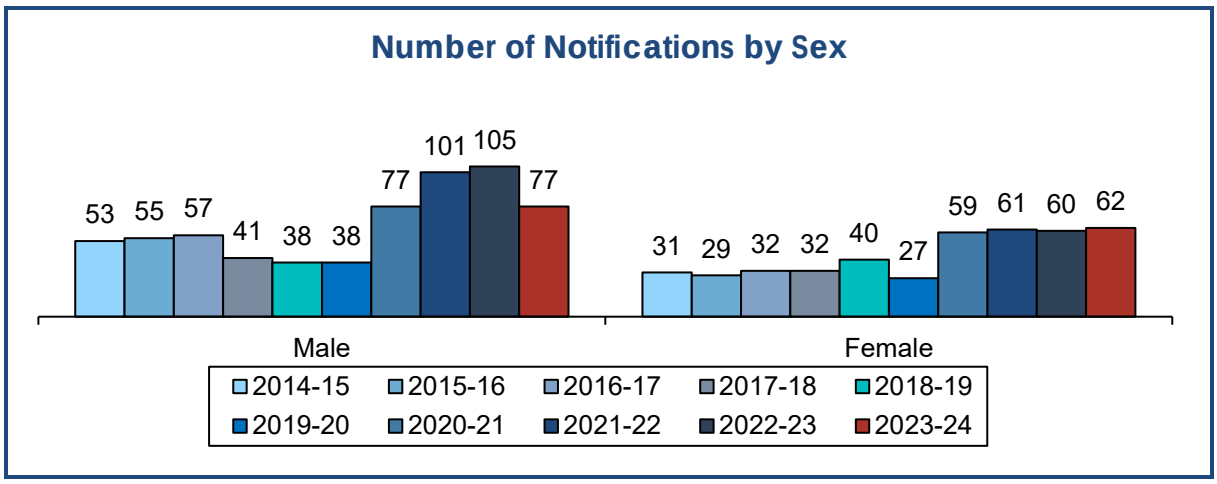
Information is obtained on a range of characteristics of the children who have died including sex, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

The following charts show:

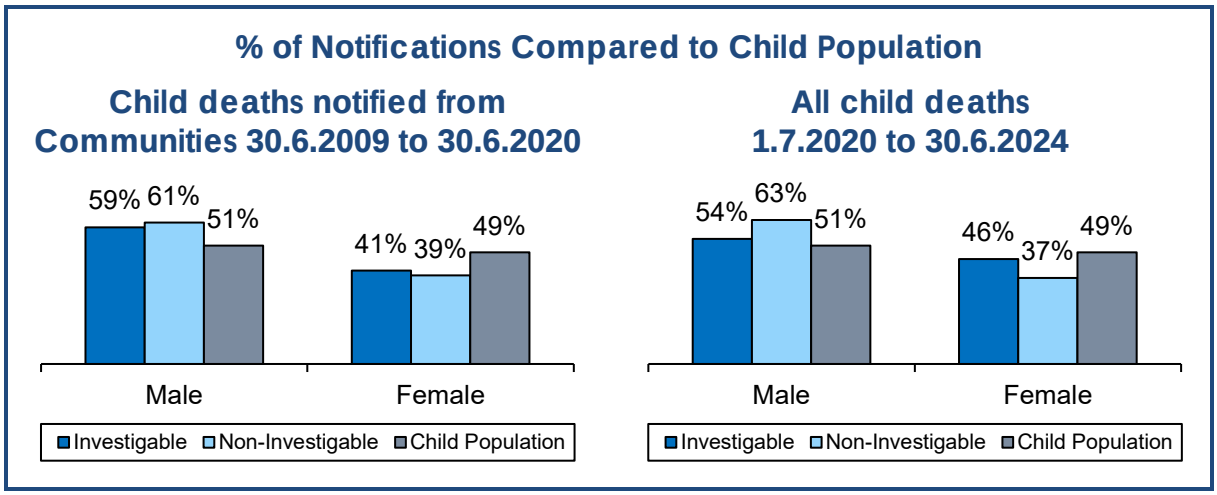
- The number of children in each group for each year for the last 10 years.
- The percentage of children in each group for both investigable deaths and non-investigable deaths, compared to the child population in Western Australia,
    - for the period from 30 June 2009 to 30 June 2020, when the Ombudsman received notifications from Communities of deaths reported to the Coroner; and
    - for the period from 1 July 2020 to 30 June 2024 relating to all child deaths.

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, male children are over-represented compared to the population for both investigable and non-investigable deaths.



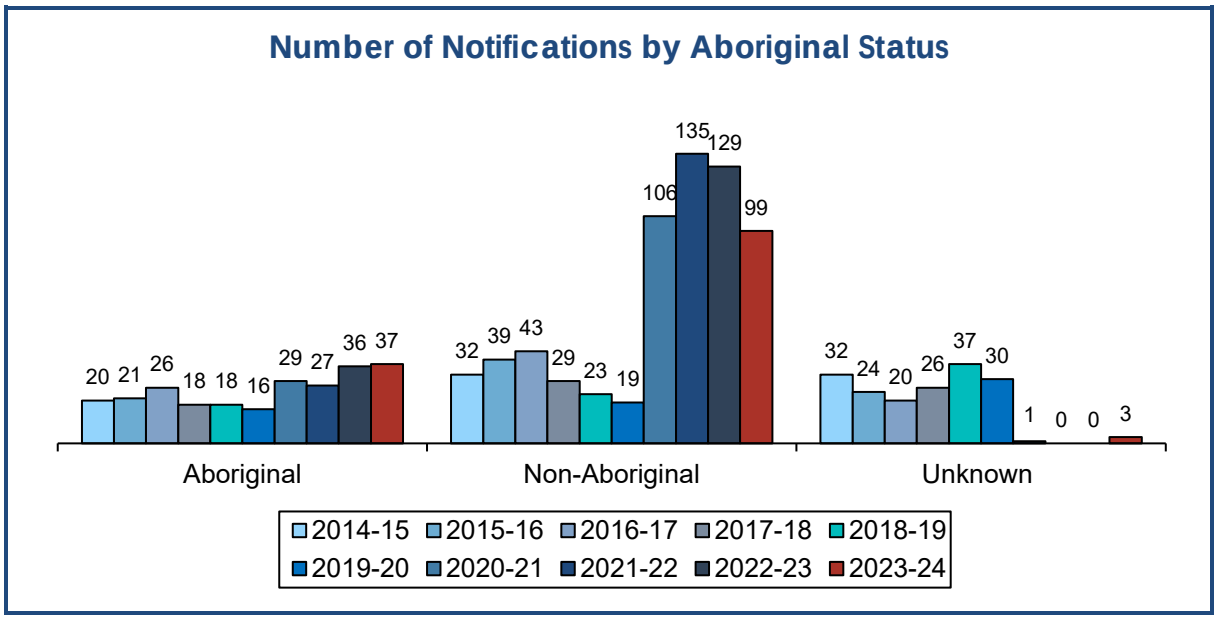
Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



Further analysis of the data shows that, considering all 15 years of the Ombudsman's child death review function, male children are over-represented for all age groups, but particularly for children aged over six years.

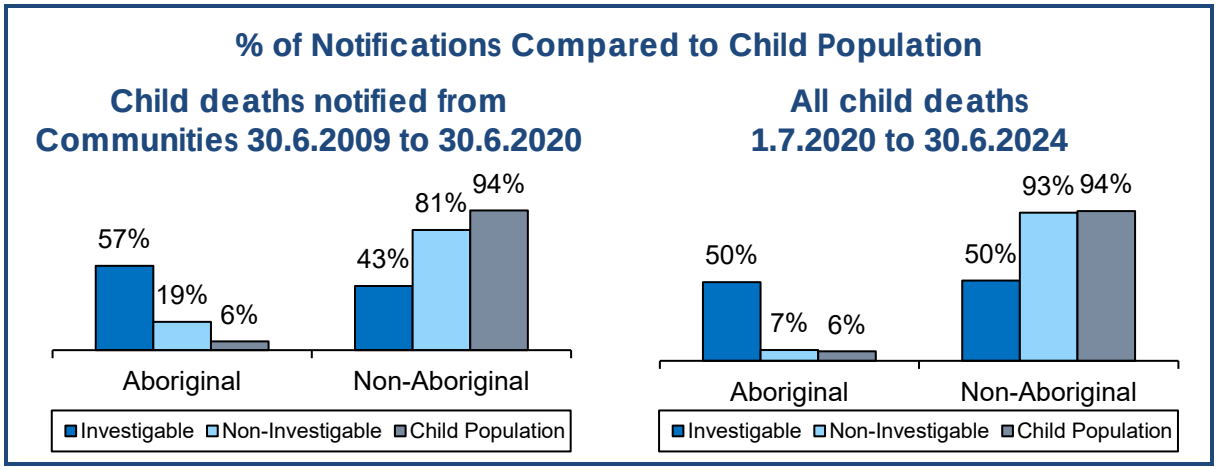
Aboriginal status

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 1: The 'Aboriginal' category in the charts includes children who are Torres Strait Islander and children who are both Aboriginal and Torres Strait Islander. Use of the term 'Aboriginal' reflects the dominant heritage of First Nations people in Western Australia.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

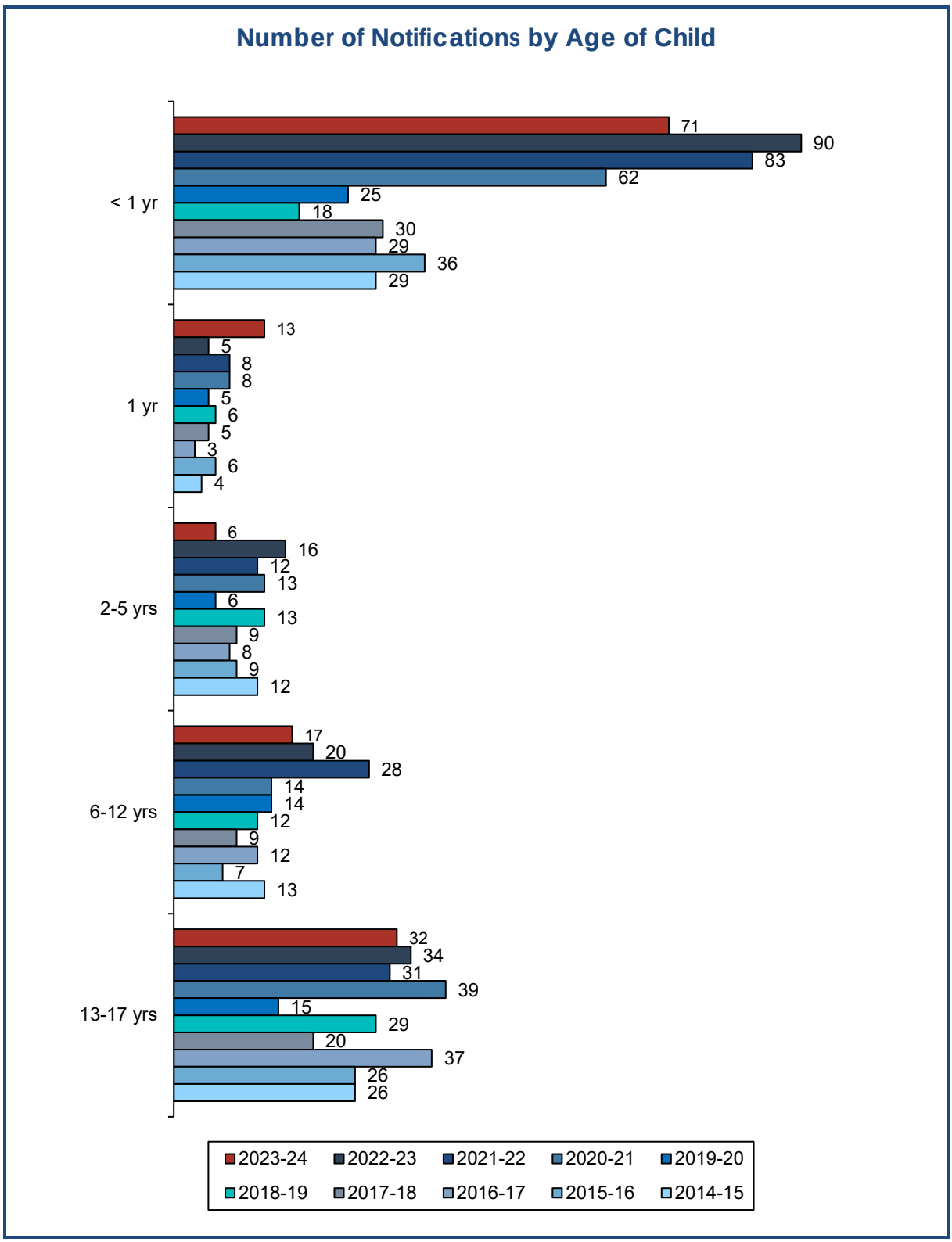


Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported because further information may become available on the Aboriginal status of the child during the course of a review.

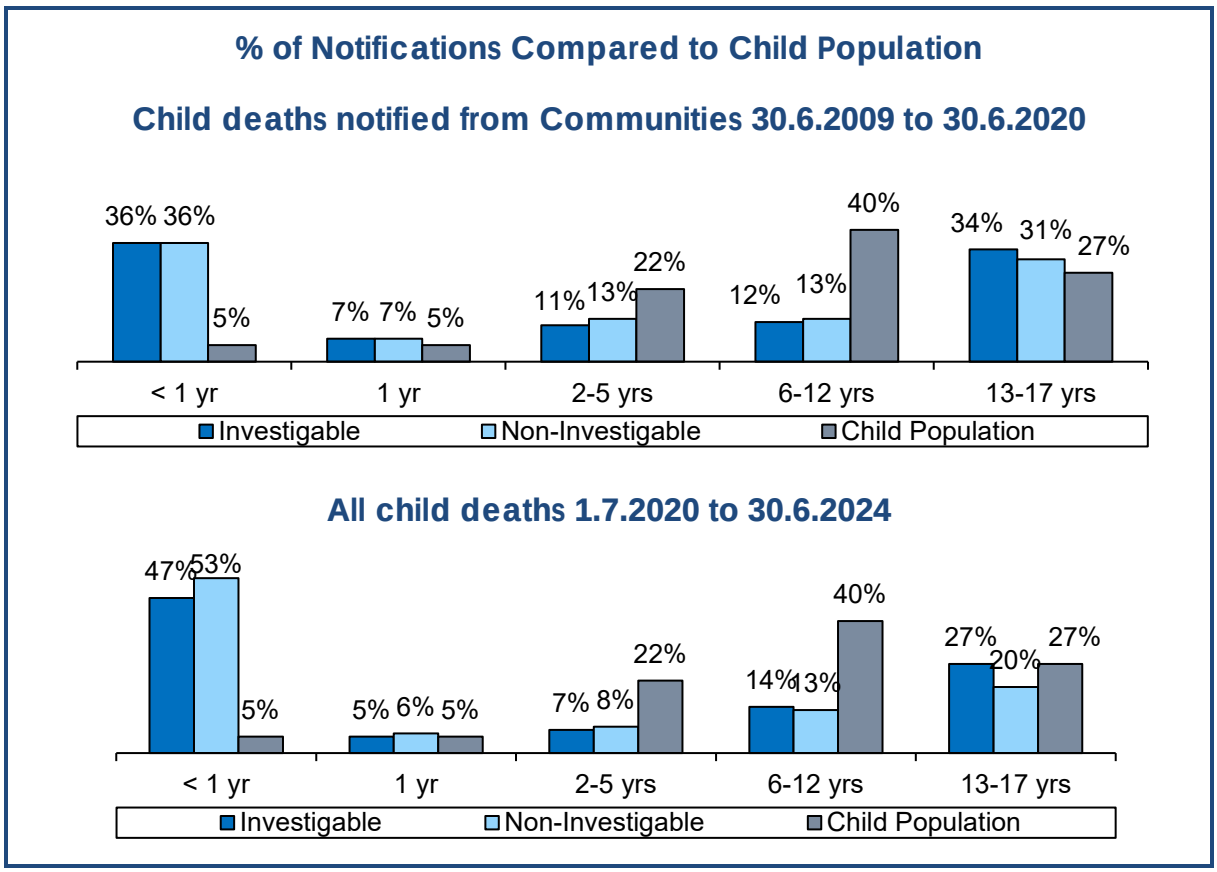
Further analysis of the data shows that Aboriginal children are more likely than non-Aboriginal children to be under the age of one and living in regional and remote locations.

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.



Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

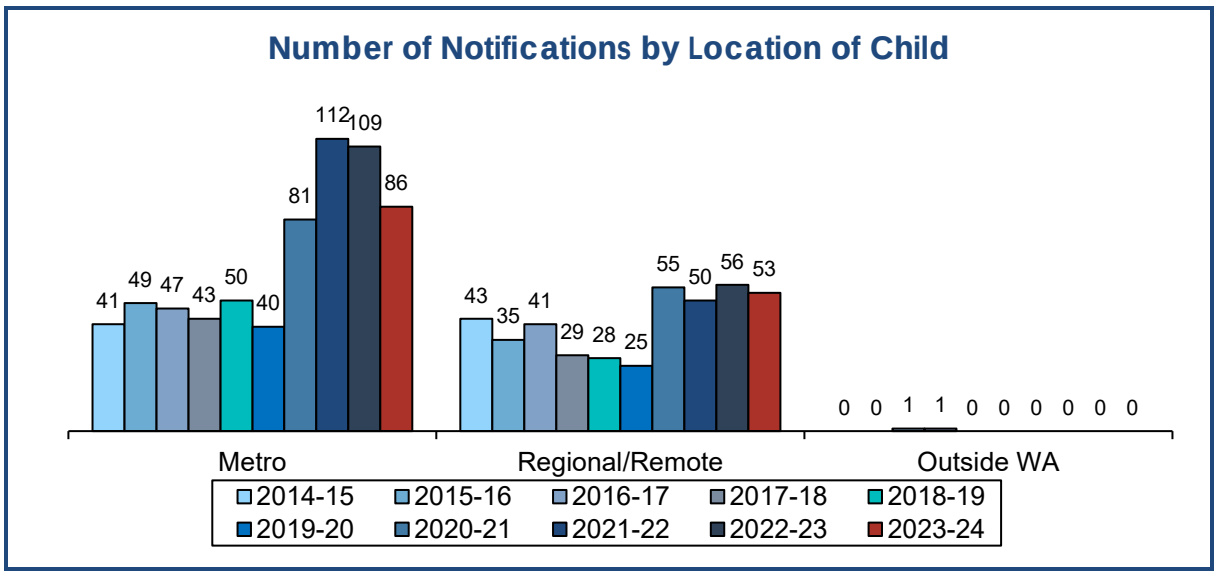


Note: Percentages may not add to 100 per cent due to rounding.

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

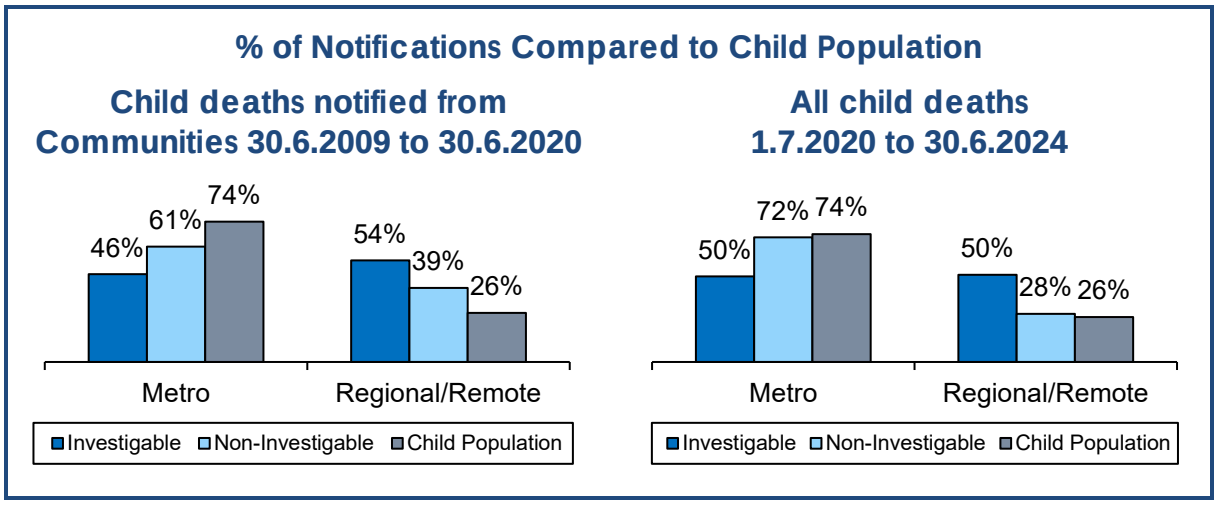
Location of residence

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 1: 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 because further information may become available on the place of residence of the child during the course of a review.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



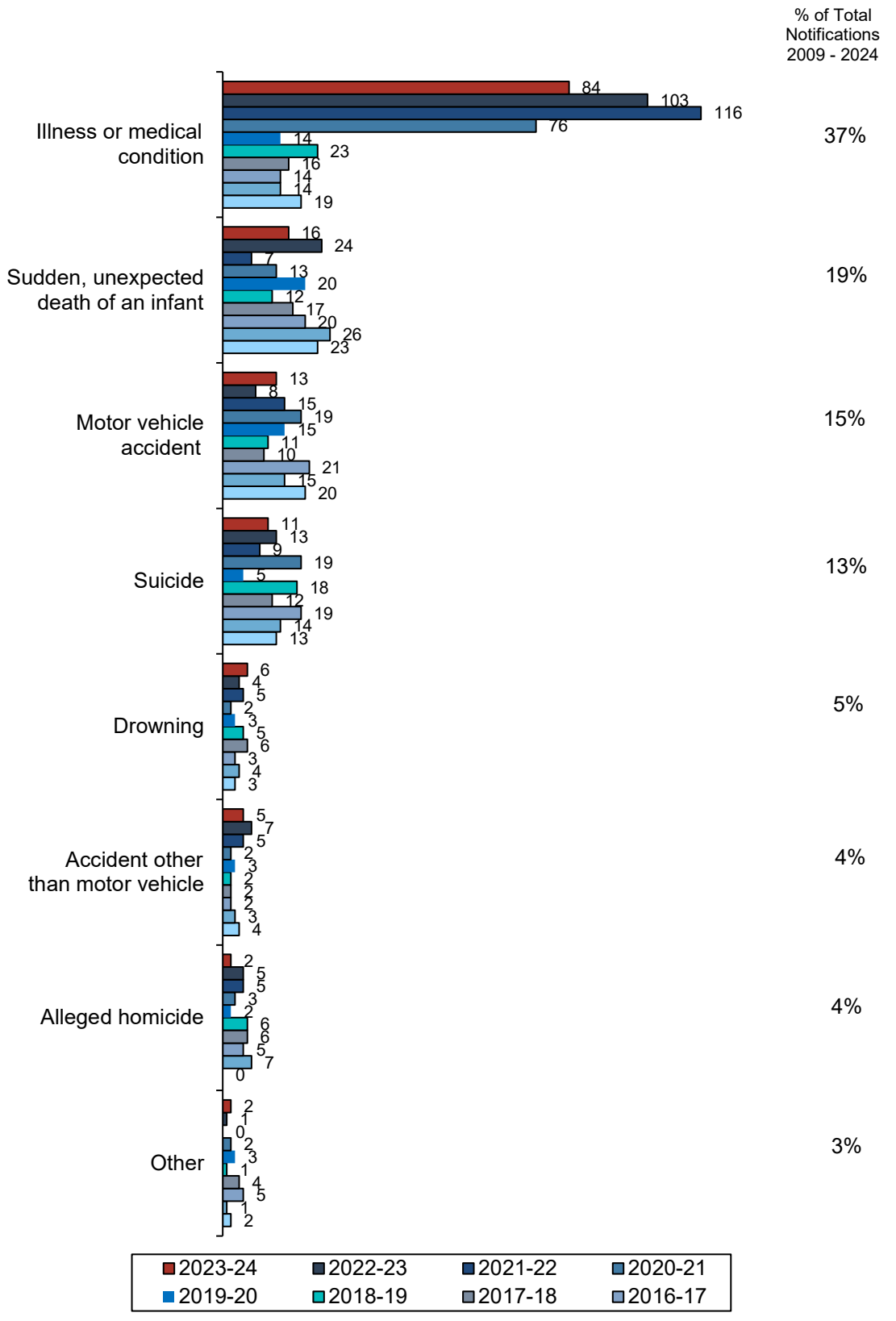
Further analysis of the data shows that 72% of Aboriginal children who died were living in regional or remote locations when they died. Most non-Aboriginal children who died lived in the metropolitan area but the proportion of non-Aboriginal children who died in regional areas (30%) is higher than would 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 following chart shows the circumstances of notified child deaths for the last 10 years.

Circumstances of Child Deaths



Note 1: Numbers may vary slightly from those previously reported because further information may become available on the circumstances in which the child died during the course of a review.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.

The main circumstances of death for the 1,528 child death notifications received in the 15 years from 30 June 2009 to 30 June 2024 are illness or medical condition (37%), sudden, unexpected deaths of infants (19%) and motor vehicle accidents (15%).

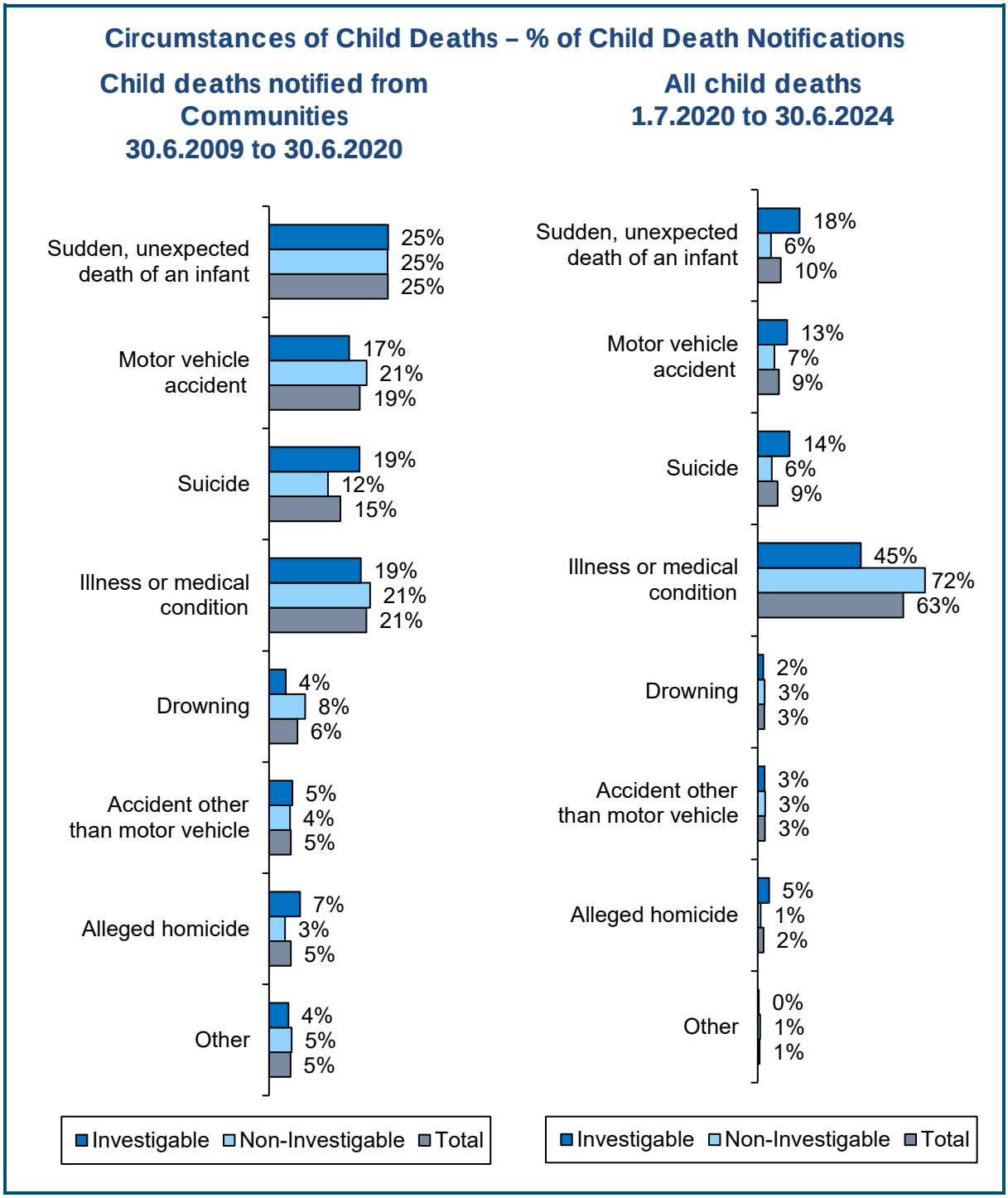
For the period 30 June 2009 to 30 June 2020, when the Ombudsman received notifications from Communities about child deaths reported to the Coroner, the main circumstances of death were:

- Sudden, unexpected deaths of infants, representing 25% of the total child death notifications over this period (17% of the child death notifications received in 2009-10, 23% in 2010-11, 33% in 2011-12, 25% in 2012-13, 30% in 2013-14, 27% in 2014-15, 31% in 2015-16, 22% in 2016-17, 23% in 2017-18, 15% in 2018-19, and 31% in 2019-20); and
- Motor vehicle accidents, representing 19% of the total child death notifications over this period (22% of the child death notifications received in 2009-10, 19% in 2010-11, 20% in 2011-12, 14% in 2012-13, 21% in 2013-14, 24% in 2014-15, 18% in 2015-16, 24% in 2016-17, 14% in 2017-18, 14% in 2018-19, and 23% in 2019-20.

For the period 1 July 2020 to 30 June 2024, when the Ombudsman received notifications of all child deaths in Western Australia, the main circumstances of death were:

- Illness or medical condition, representing 63% of the total child death notifications over this period (56% of child death notifications received in 2020-21, 72% in 2021-22, 62% in 2022-23 and 60% in 2023-24); and
- Sudden, unexpected deaths of infants, representing 10% of the total child death notifications over this period (10% of child death notifications received in 2020-21, 4% in 2021-22, 15% in 2022-23 and 12% in 2023-24).

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



Note: Percentages may not add to 100 per cent due to rounding.

Considering all 15 years of the Ombudsman's child death review function, there are three areas where the circumstance of death shows a higher proportion for investigable deaths than for deaths that are not investigable. These are:

- Suicide;
- Alleged homicide; and
- Sudden, unexpected death of an infant.

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 2024.

Social or Environmental Factor	% of Finalised Reviews of investigable deaths from 30.6.2009 to 30.6.2024
Family and domestic violence	73%
Parenting	62%
Drug or substance use	48%
Alcohol use	43%
Parental mental health issues	30%
Homelessness	21%

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 67% of the cases;
  - Drug or substance use was a co-existing factor in 57% of the cases;
  - Alcohol use was a co-existing factor in 52% of the cases;
  - Parental mental health issues were a co-existing factor in 35% of the cases; and

- Homelessness was a co-existing factor in 25% of the cases.

- Where alcohol use was present:
  - Parenting was a co-existing factor in 77% of the cases;
  - Family and domestic violence was a co-existing factor in 87% of the cases;
  - Drug or substance use was a co-existing factor in 69% of the cases;
  - Parental mental health issues were a co-existing factor in 32% of the cases; and
  - Homelessness was a co-existing factor in 32% of the cases.

Reasons for contact with Communities

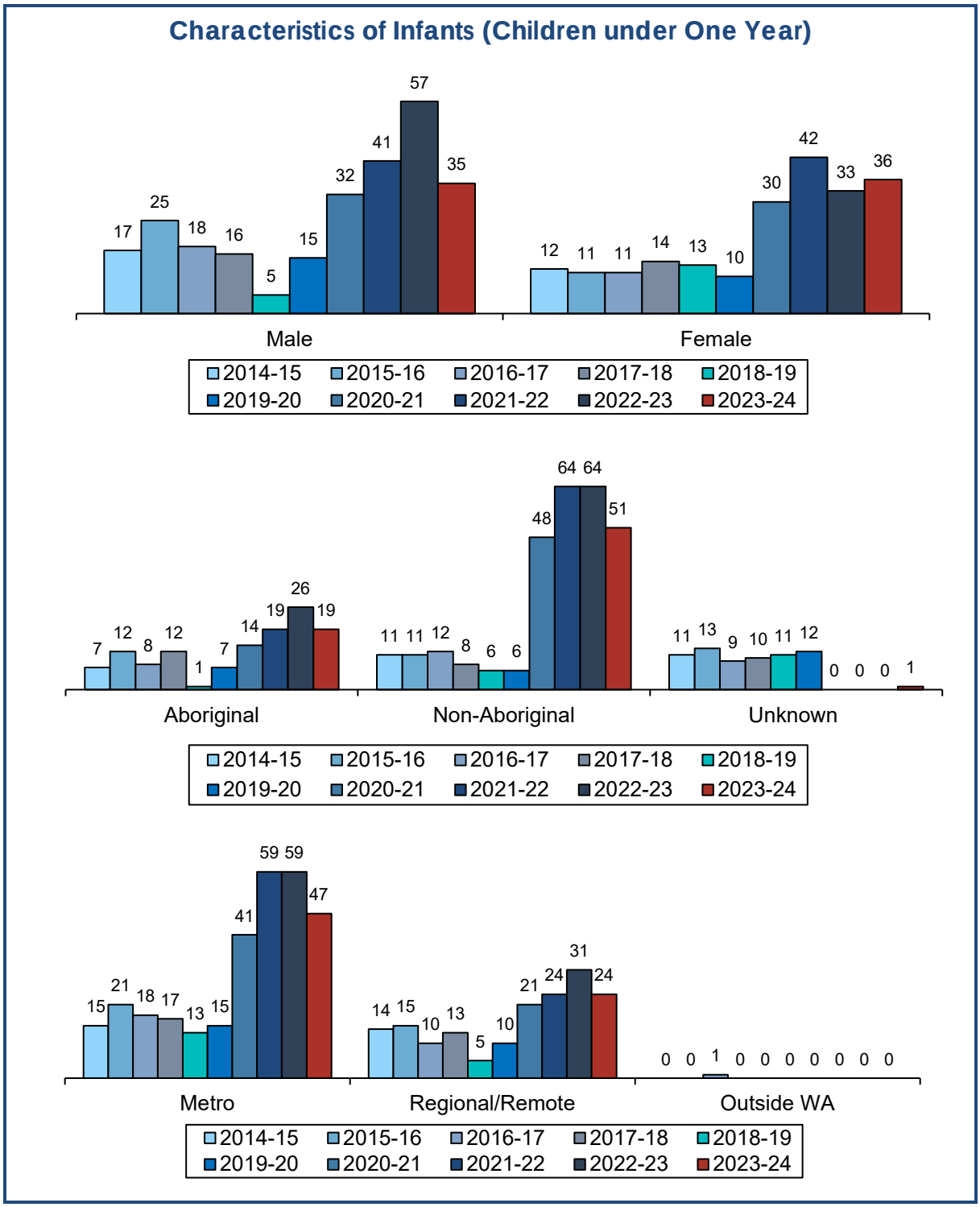
In child deaths notified to the Ombudsman in 2023-24, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

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 1,528 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2024, there were 636 (42%) related to deaths of infants. The characteristics of infants who died in the last 10 years are shown in the following charts.



Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

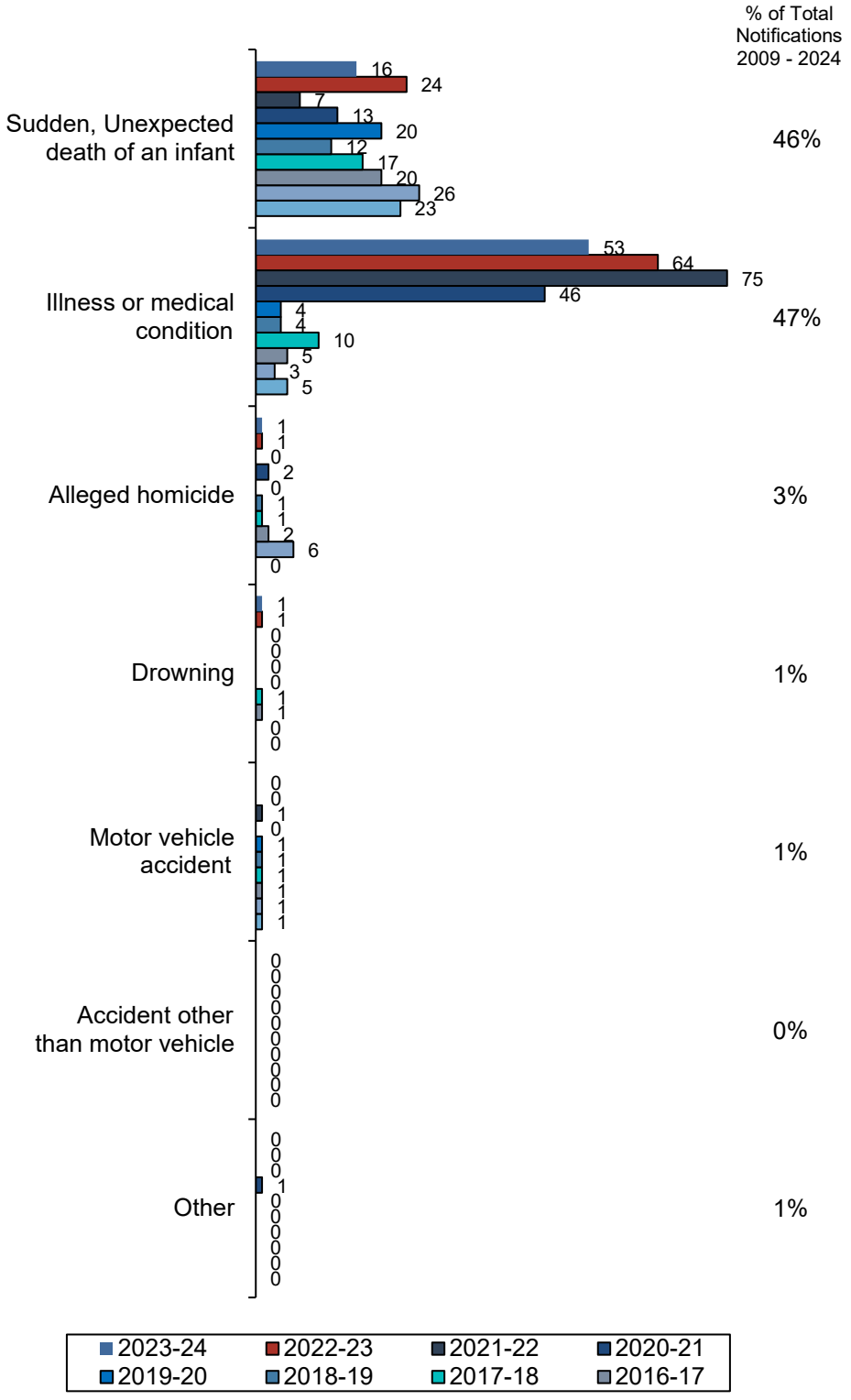
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

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

- Males – 58% of investigable infant deaths and 58% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 65% of investigable deaths and 15% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 53% of investigable infant deaths and 30% 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 636 infant deaths, 293 (46%) were categorised as sudden, unexpected deaths of an infant and 81% of these (238) appear to have occurred while the infant had been placed for sleep. There were also 47% of infant deaths (300) in circumstances of illness or medical condition, however the majority of these (238) were notified to the Ombudsman under the expanded jurisdiction from 1 July 2020. There were a small number of other deaths as shown in the following charts.

Circumstances of Infant Deaths (Children under One Year)



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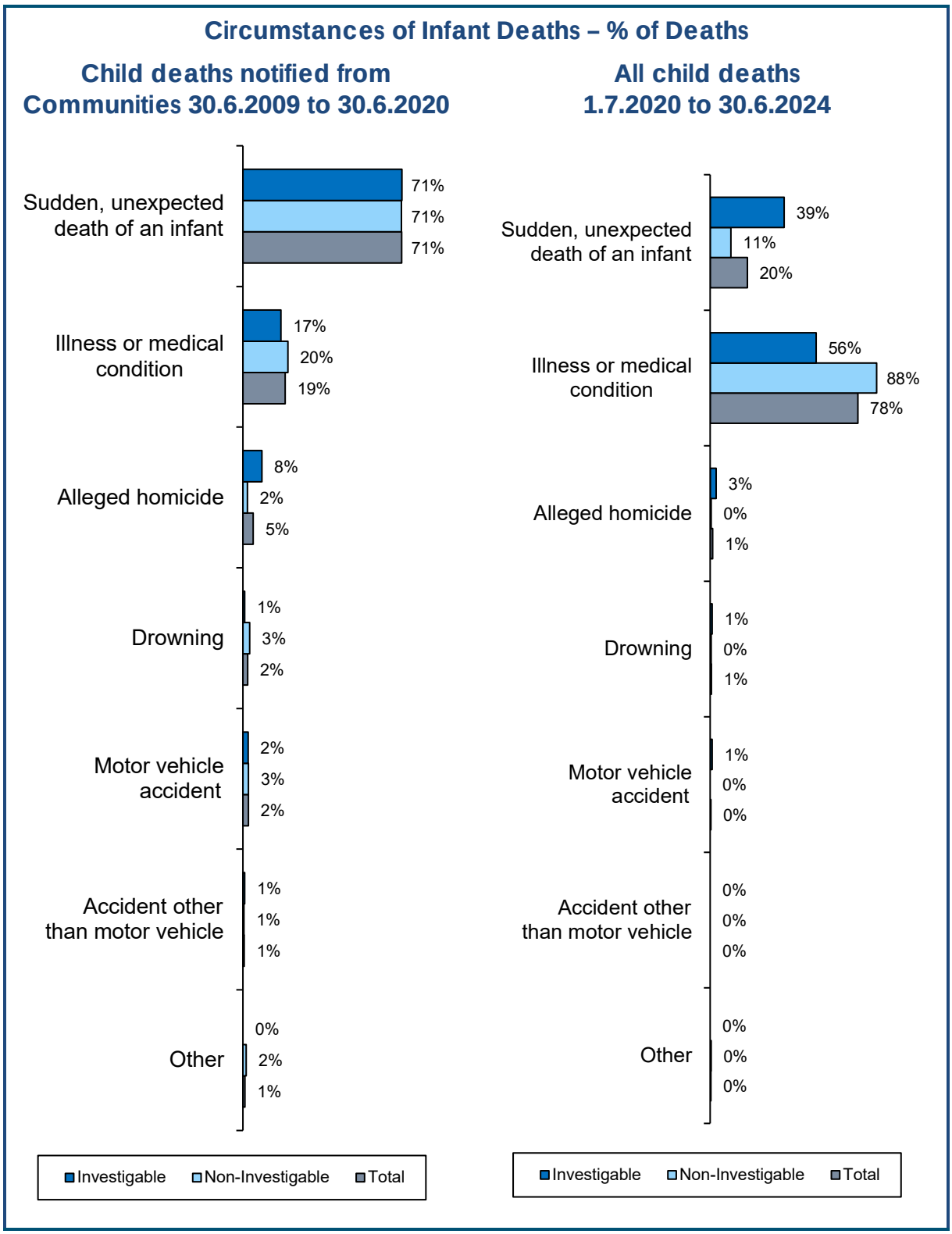
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.



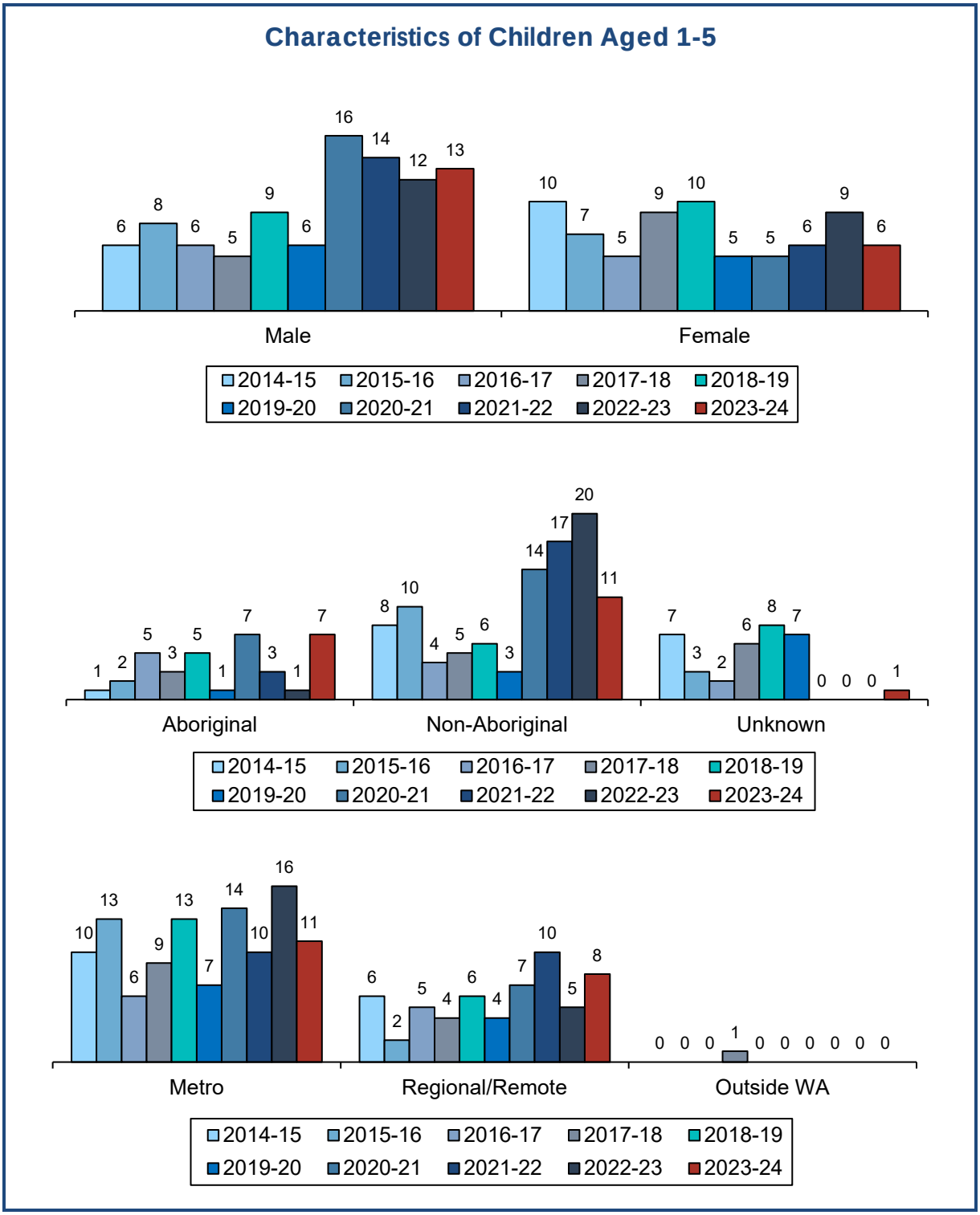
Note: Percentages may not add to 100 per cent due to rounding.

Two hundred and twenty-five deaths of infants were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 1,528 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2024, there were 261 (17%) related to children aged from 1 to 5 years.

The characteristics of children who died in the last 10 years aged 1 to 5 are shown in the following charts.



Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

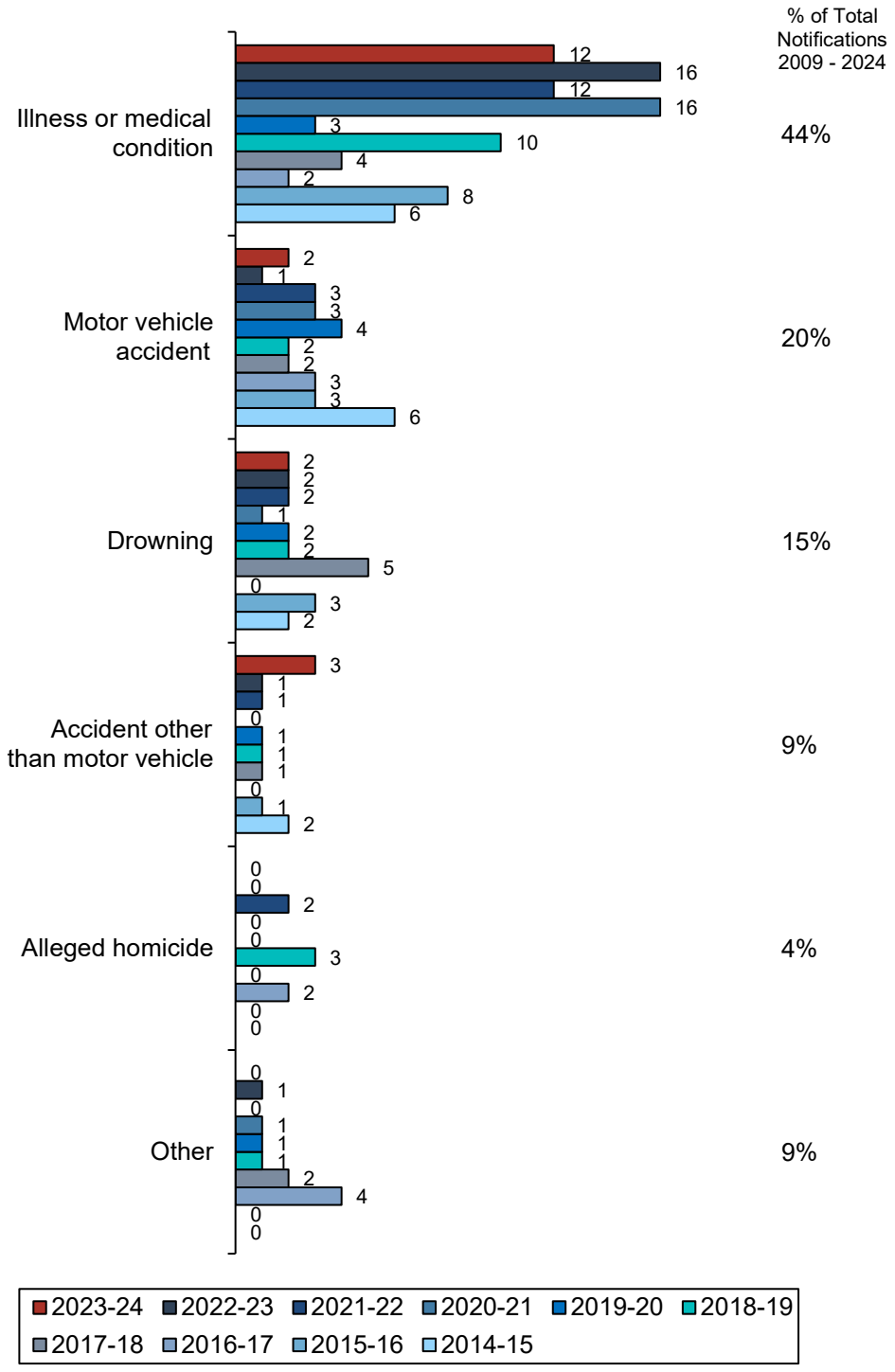
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

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 60% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Aboriginal children – 51% of investigable deaths and 12% of non-investigable deaths of children aged 1 to 5 were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 47% of investigable deaths and 33% 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 (44%), followed by motor vehicle accidents (20%) and drowning (15%).

Circumstances of Deaths of Children Aged 1-5



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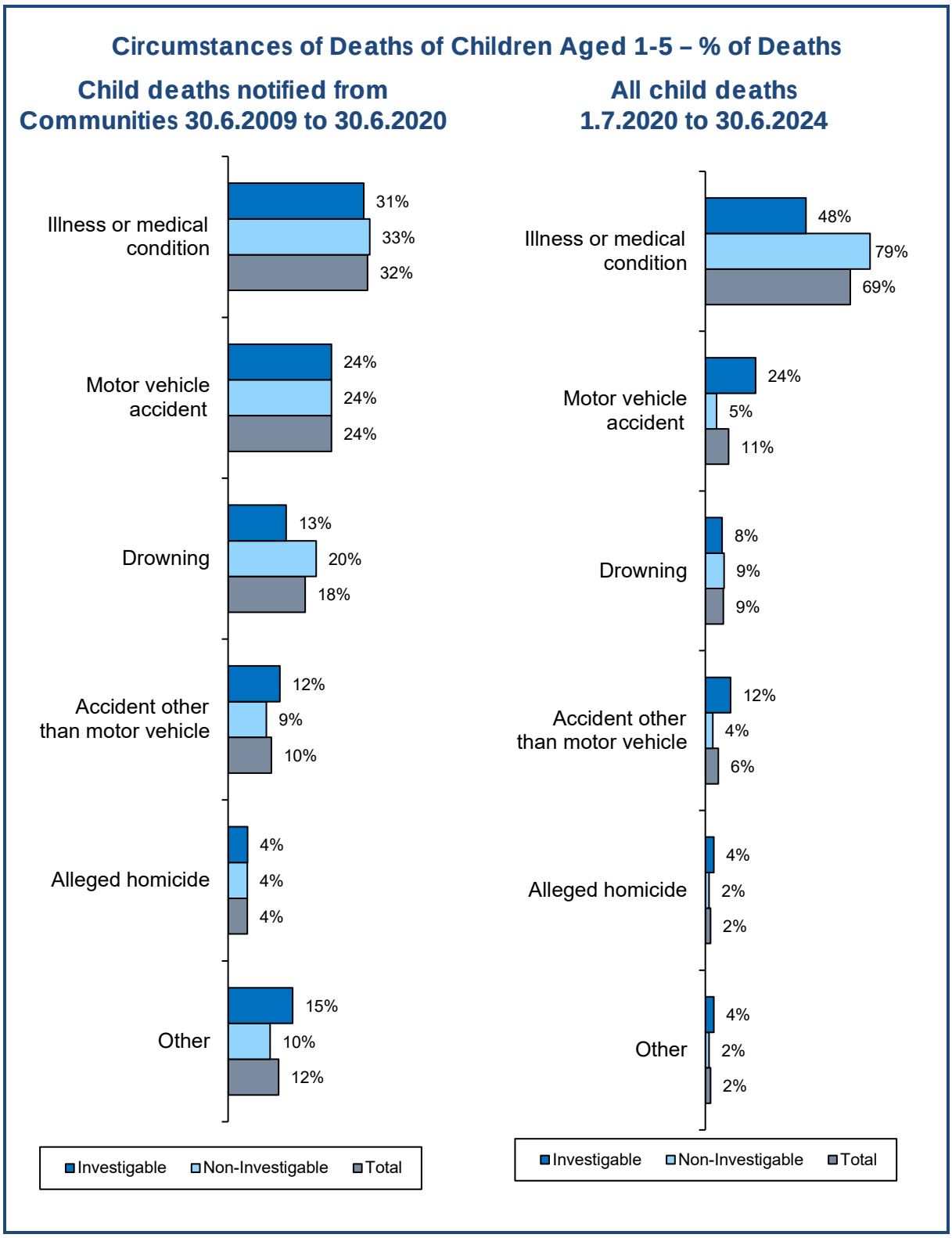
Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.



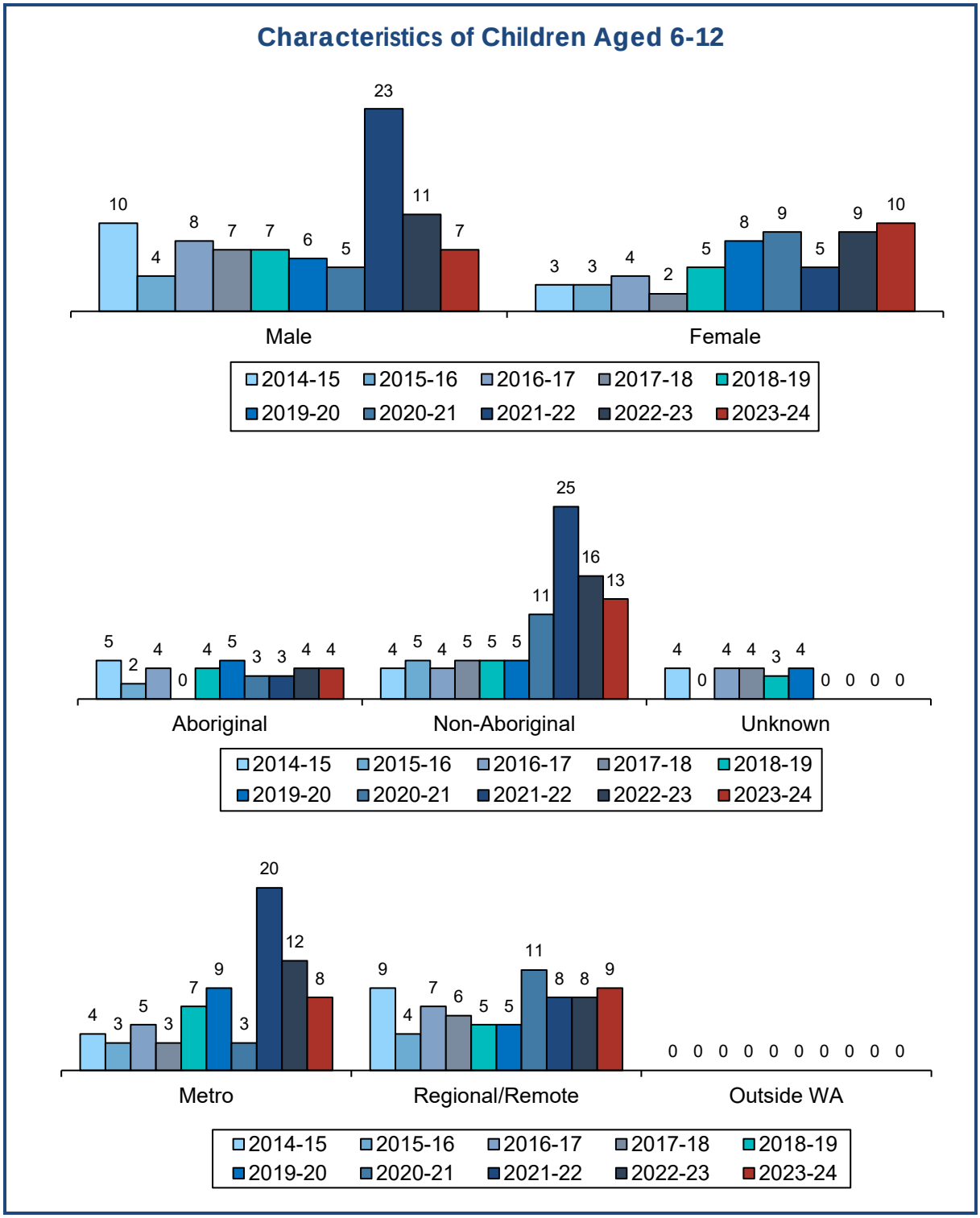
Note: Percentages may not add to 100 per cent due to rounding.

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

Deaths of children aged 6 to 12 years

Of the 1,528 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2023, there were 195 (13%) related to children aged from 6 to 12 years.

The characteristics of children who died in the last 10 years aged 6 to 12 are shown in the following charts.



Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

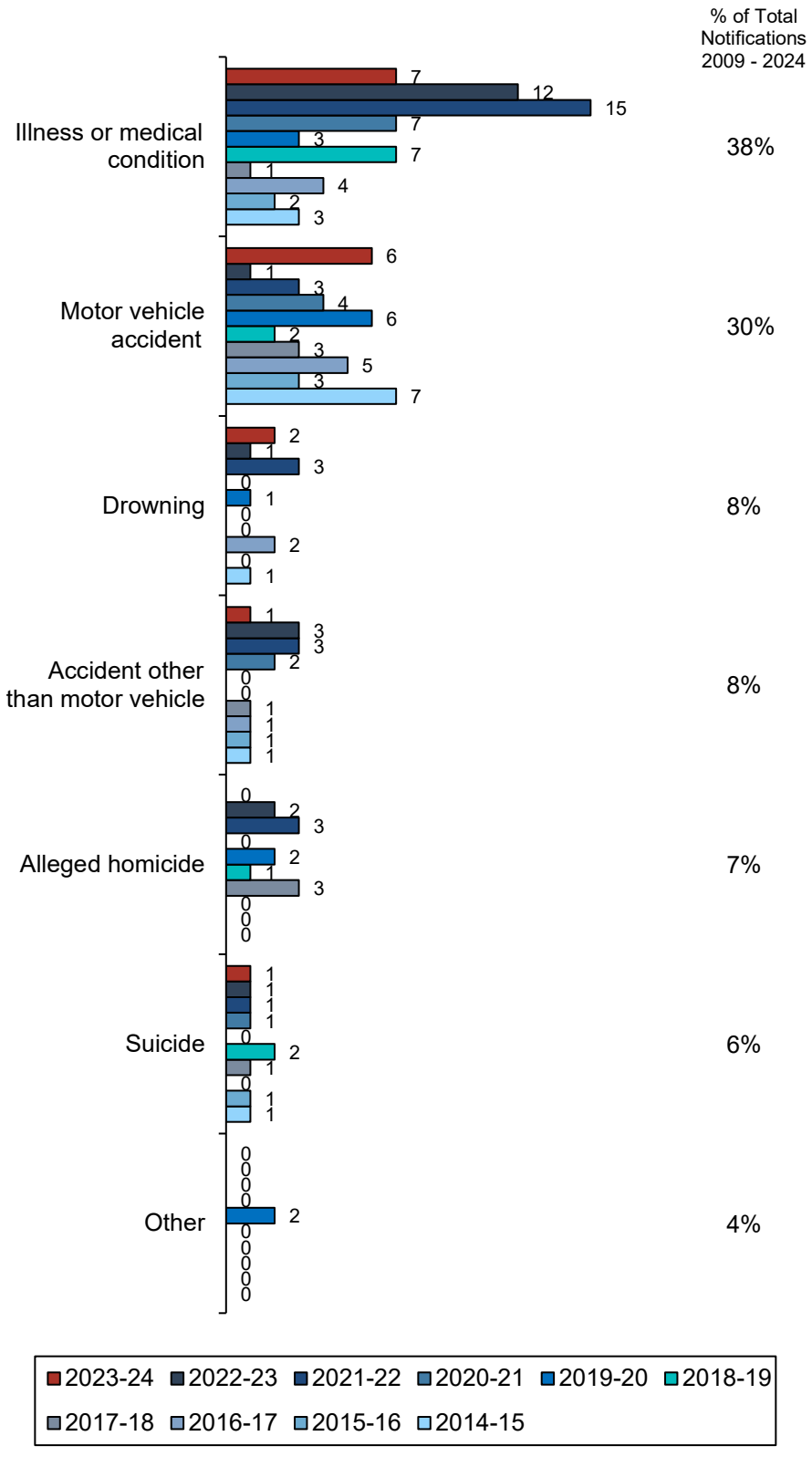
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

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 65% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population;
- Aboriginal children – 49% of investigable deaths and 10% 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 – 58% of investigable deaths and 46% 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, illness or medical conditions are the most common circumstance of death for this age group (38%), followed by motor vehicle accidents (30%).

Circumstances of Deaths of Children Aged 6-12



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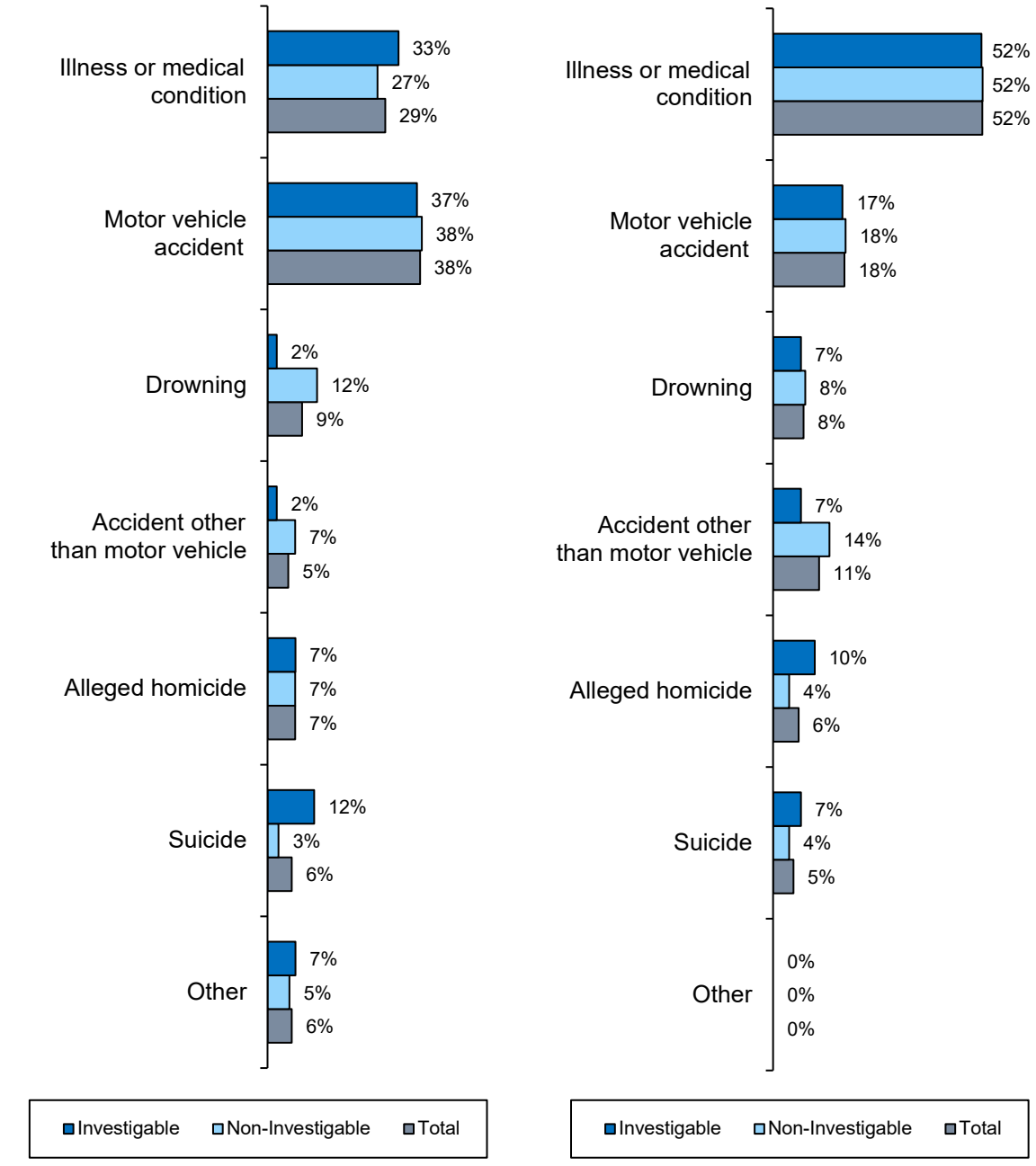
Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.

Circumstances of Deaths of Children Aged 6-12 – % of Deaths



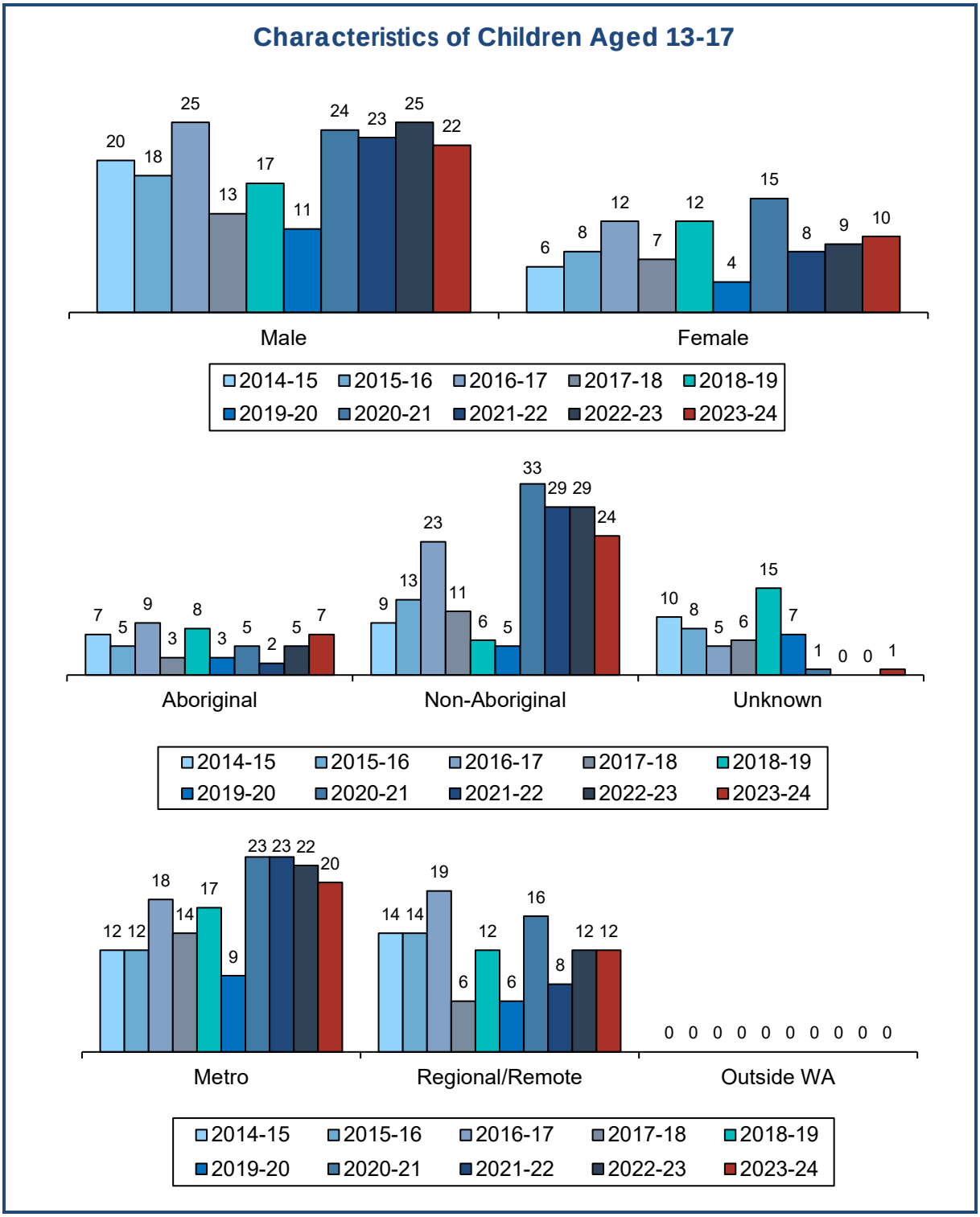
Note: Percentages may not add to 100 per cent due to rounding.

Seventy two deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of children aged 13 – 17 years

Of the 1,528 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2024, there were 436 (29%) related to children aged from 13 to 17 years.

The characteristics of children who died in the last 10 years aged 13 to 17 are shown in the following charts.



Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

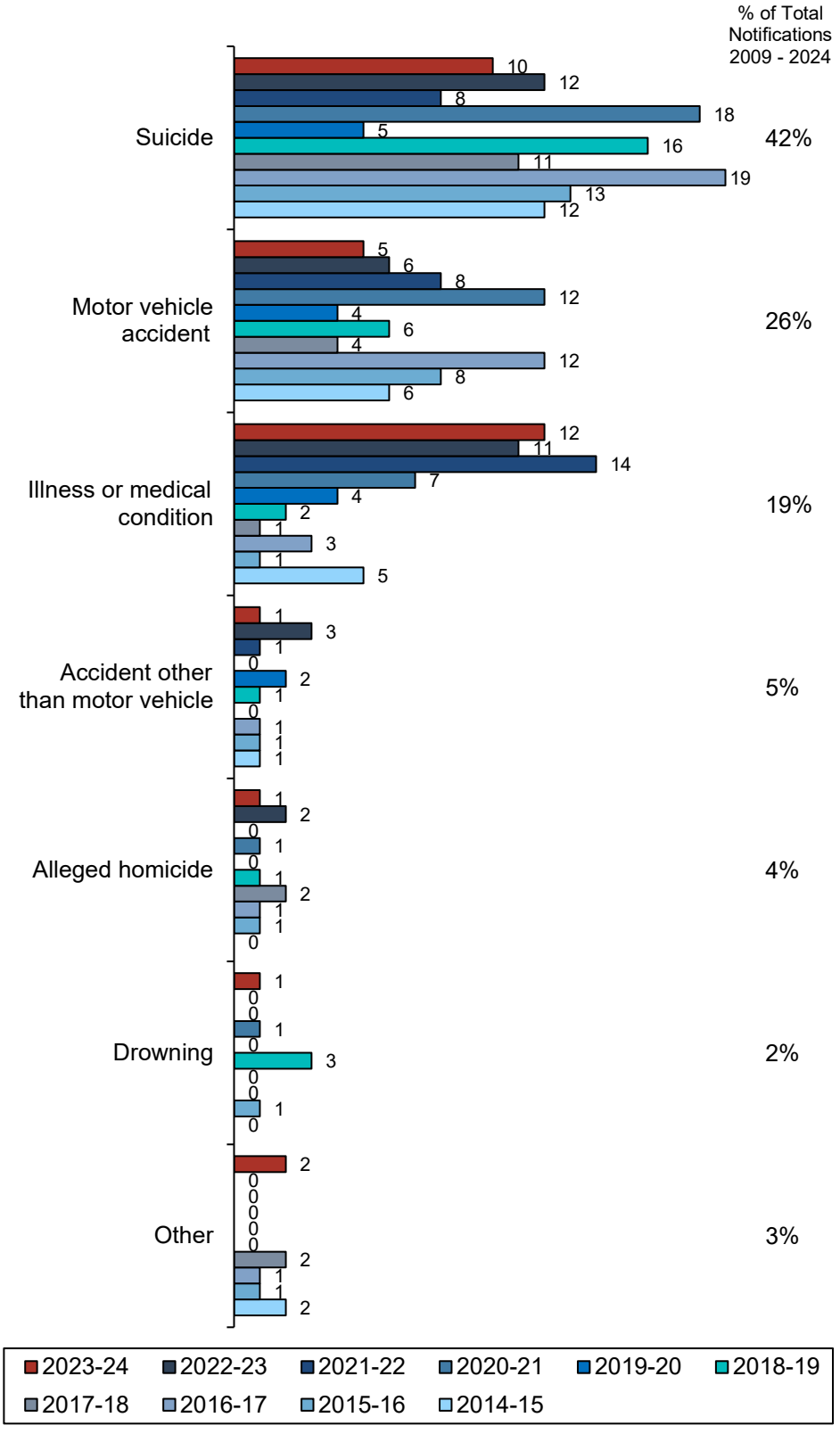
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

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

- Males – 60% of investigable deaths and 68% of non-investigable deaths of children aged 13 to 17 were male compared to 51% in the child population;
- Aboriginal children – 45% of investigable deaths and 9% 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 – 52% of investigable deaths and 37% 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 (43%), particularly for investigable deaths, followed by motor vehicle accidents (27%) and illness or medical condition (17%).

Circumstances of Deaths of Children Aged 13-17



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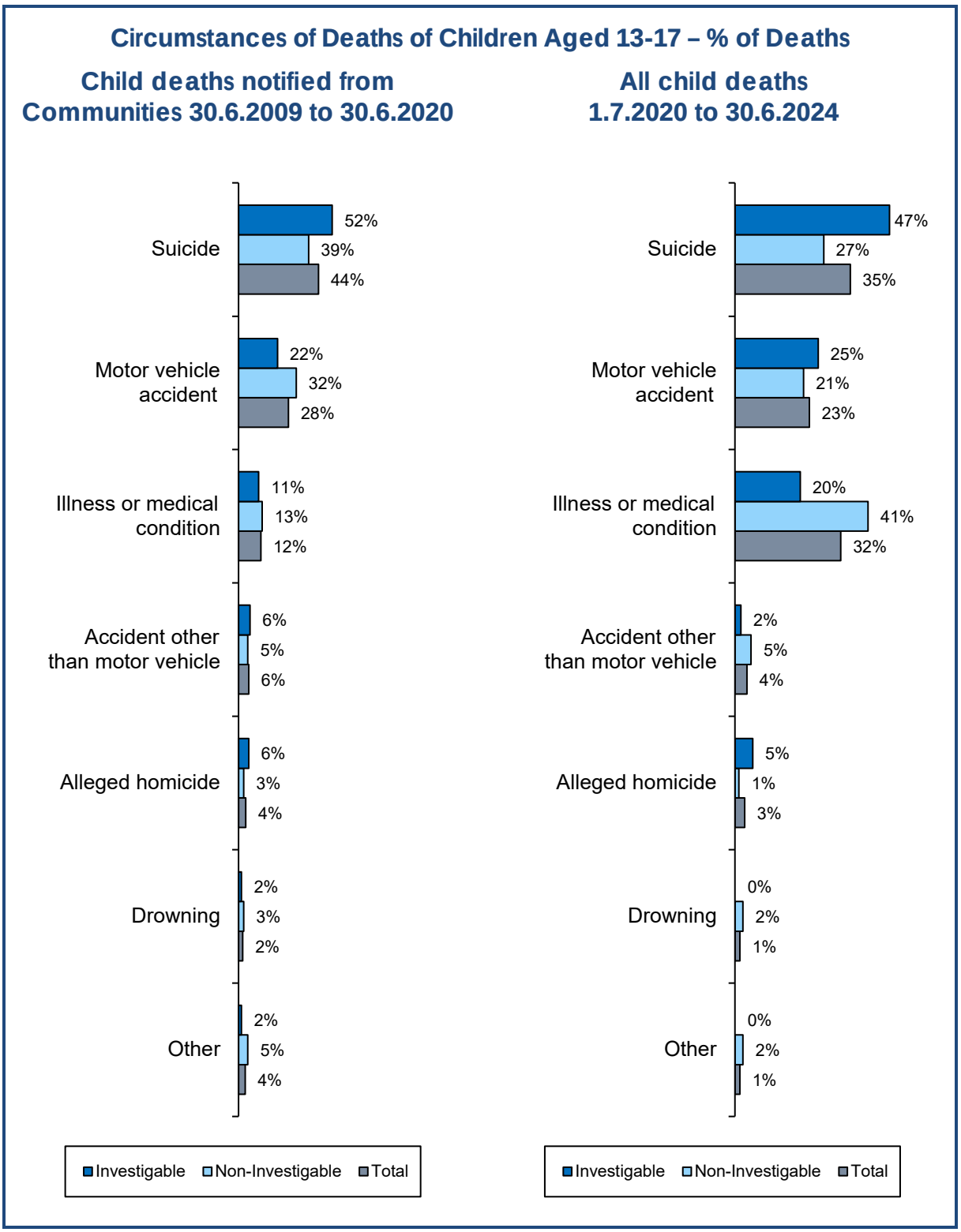
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.



Note: Percentages may not add to 100 per cent due to rounding.

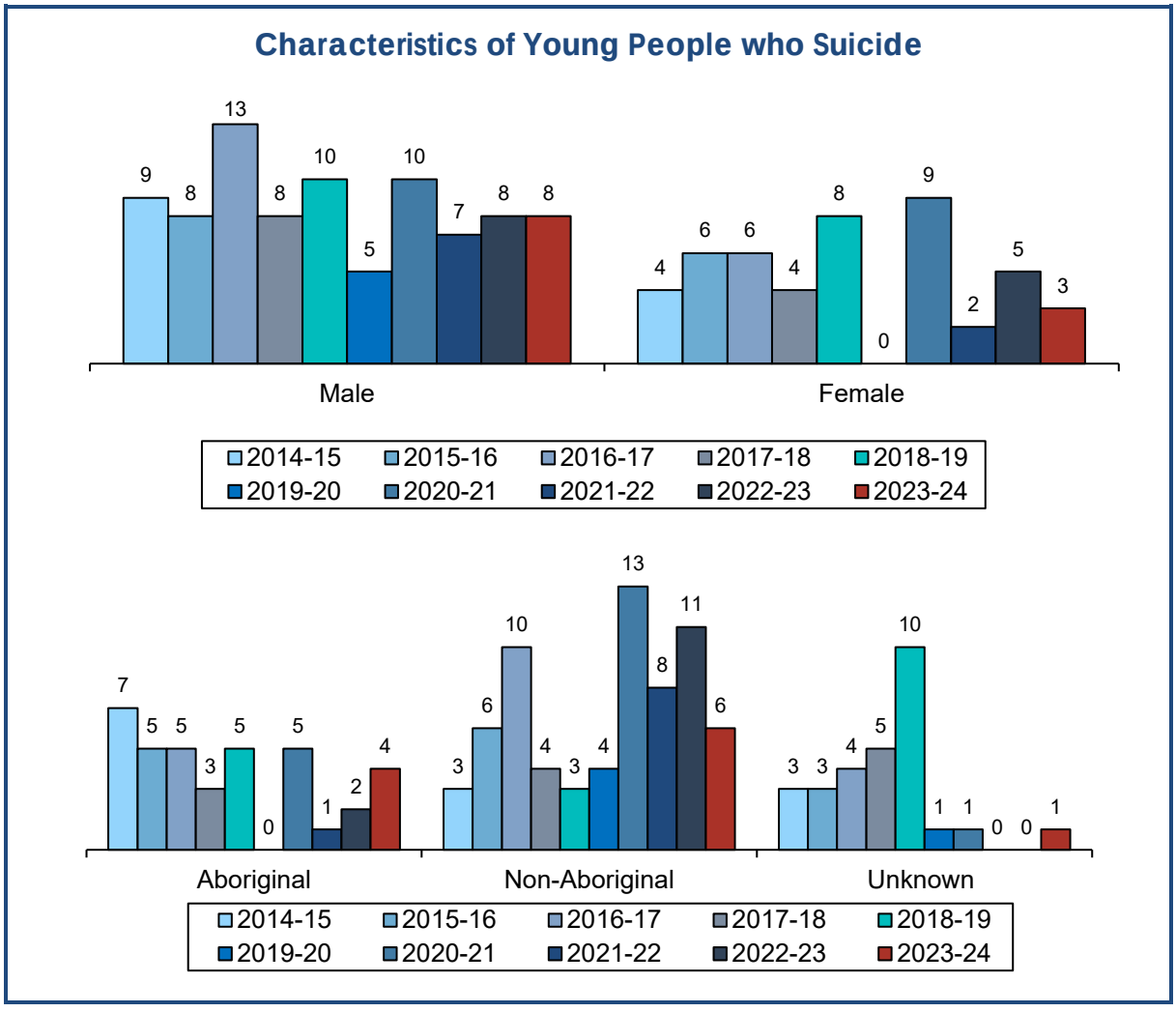
One hundred and eighty deaths of children aged 13 to 17 years were determined to be investigable deaths.

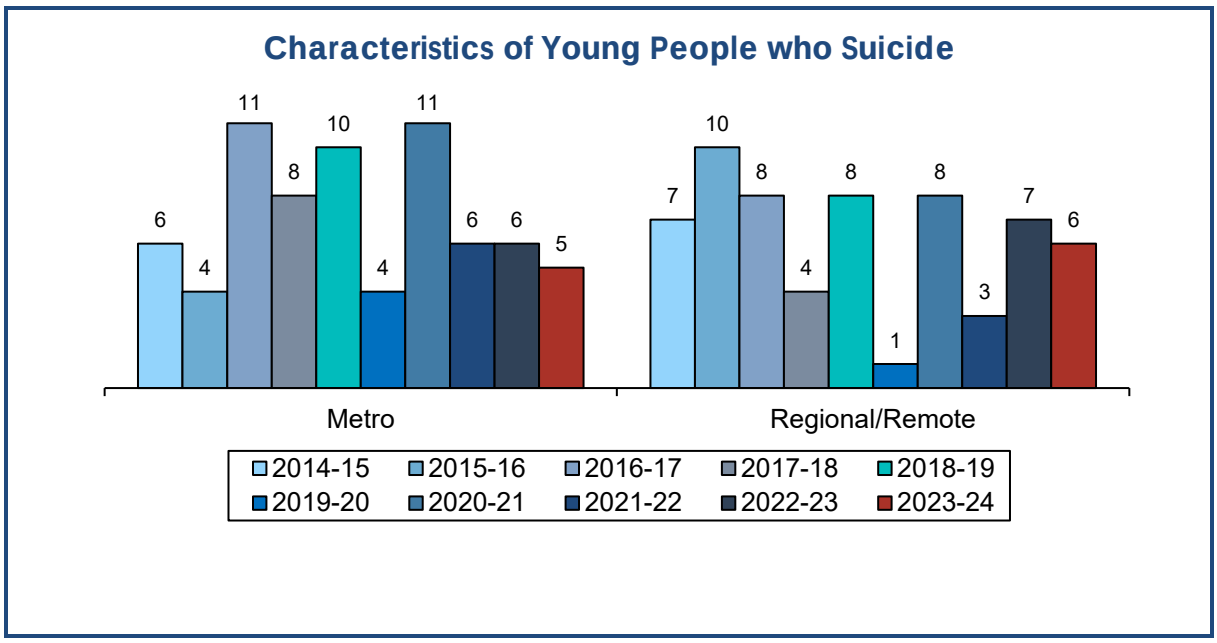
Suicide by young people

Of the 192 young people who apparently took their own lives from 30 June 2009 to 30 June 2024:

- Eleven were under 13 years old;
- Twelve were 13 years old;
- Twenty were 14 years old;
- Thirty nine were 15 years old;
- Fifty were 16 years old; and
- Sixty were 17 years old.

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





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Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

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

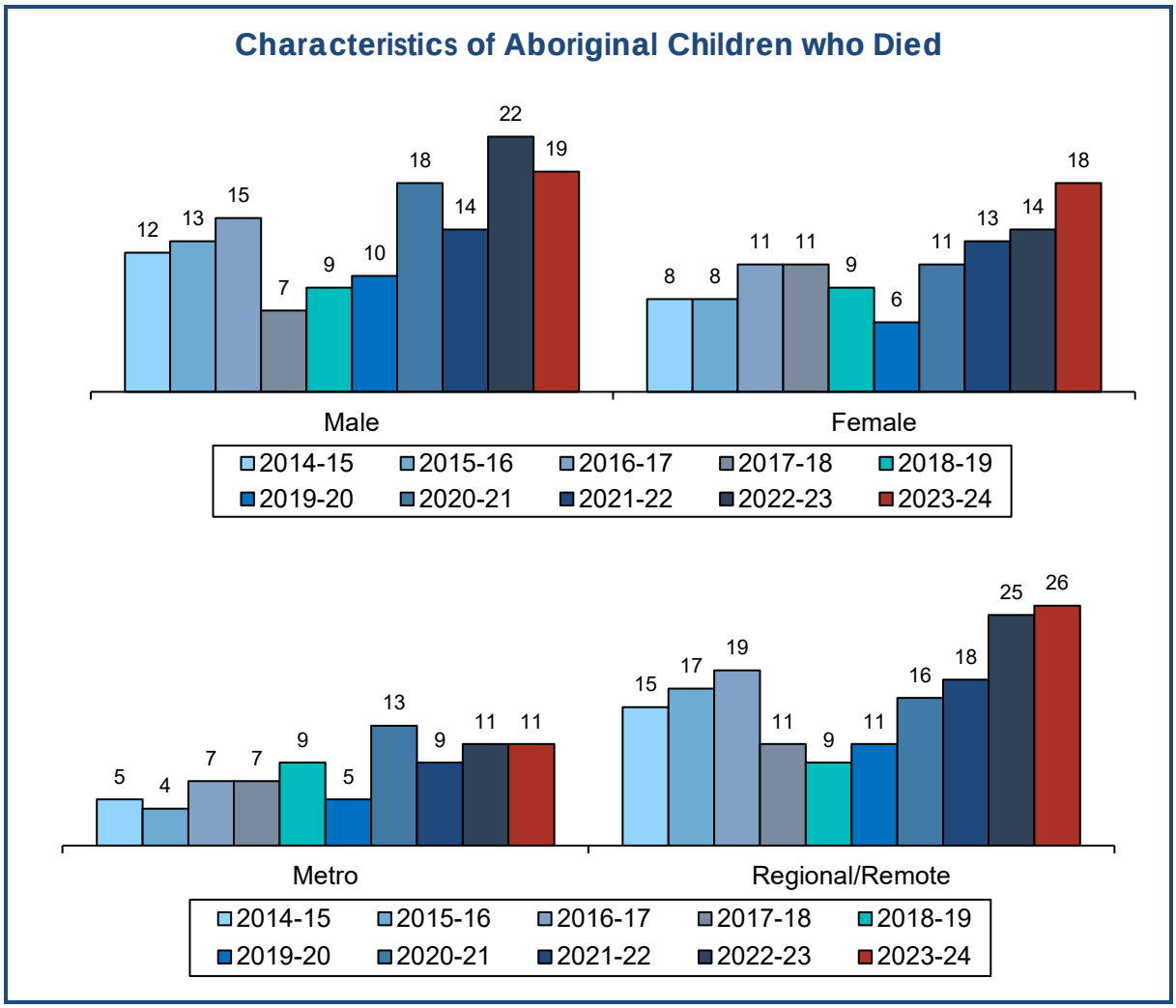
- Males – 54% of investigable deaths and 71% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 146 apparent suicides by young people where information on the Aboriginal status of the young person was available, 56% of the investigable deaths and 12% 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 56% of investigable suicides by young people and 34% 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 1,196 child death notifications received from 30 June 2009 to 30 June 2024, 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, 357 (30%) of the children were identified as Aboriginal.[1]

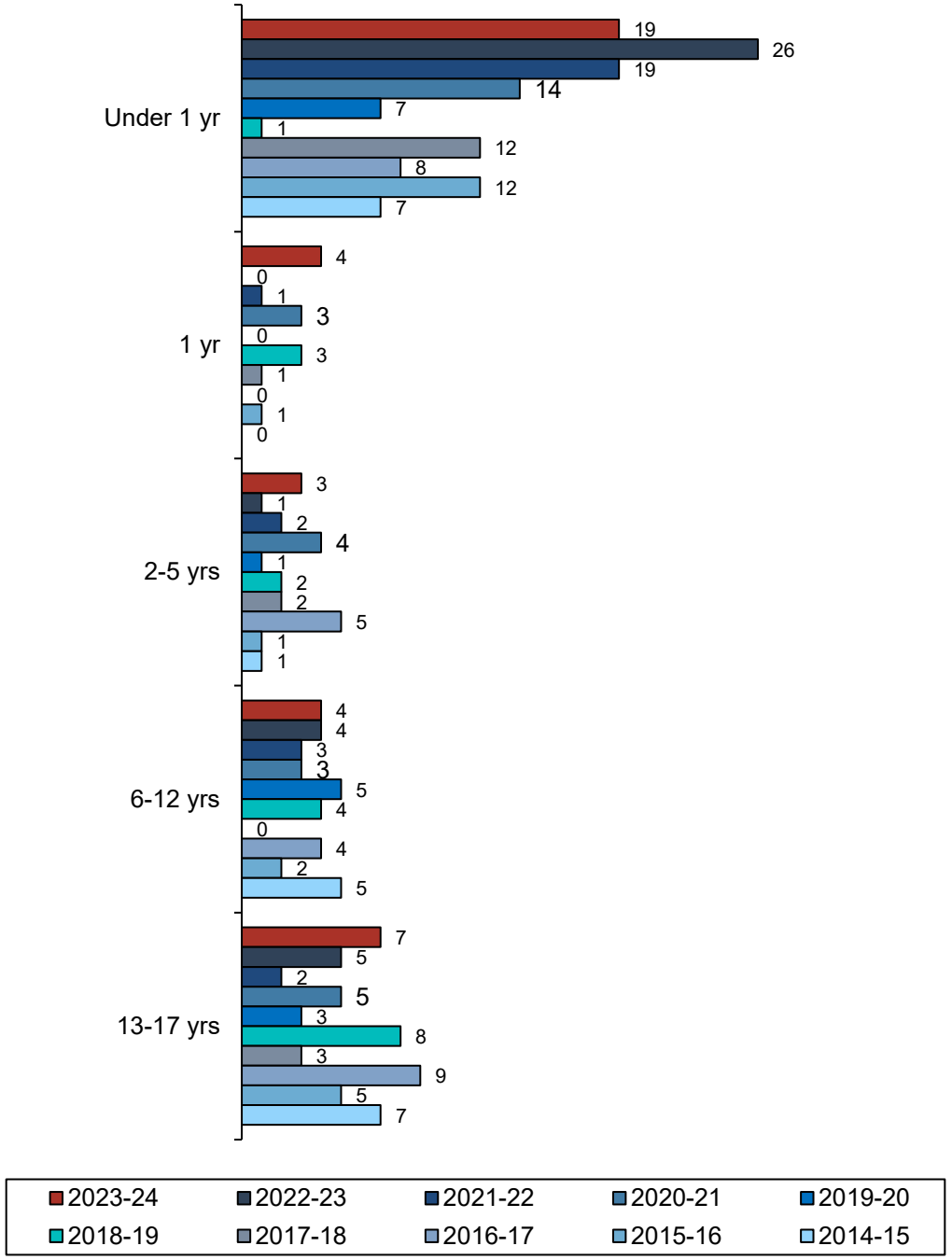
For the notifications received:

- Over the 15 year period from 30 June 2009 to 30 June 2024, the majority of Aboriginal children who died were male (58%). For 2023-24, 51% 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 15 year period, 72% of Aboriginal children who died lived in regional or remote communities.



[1] 'Aboriginal' includes children who are Torres Strait Islander and children who are both Aboriginal and Torres Strait Islander. Use of the term 'Aboriginal' reflects the fact that the principal heritage of the first Western Australians are Aboriginal Western Australians and is in no way intended to exclude Torres Strait Islander people.

Characteristics of Aboriginal Children who Died



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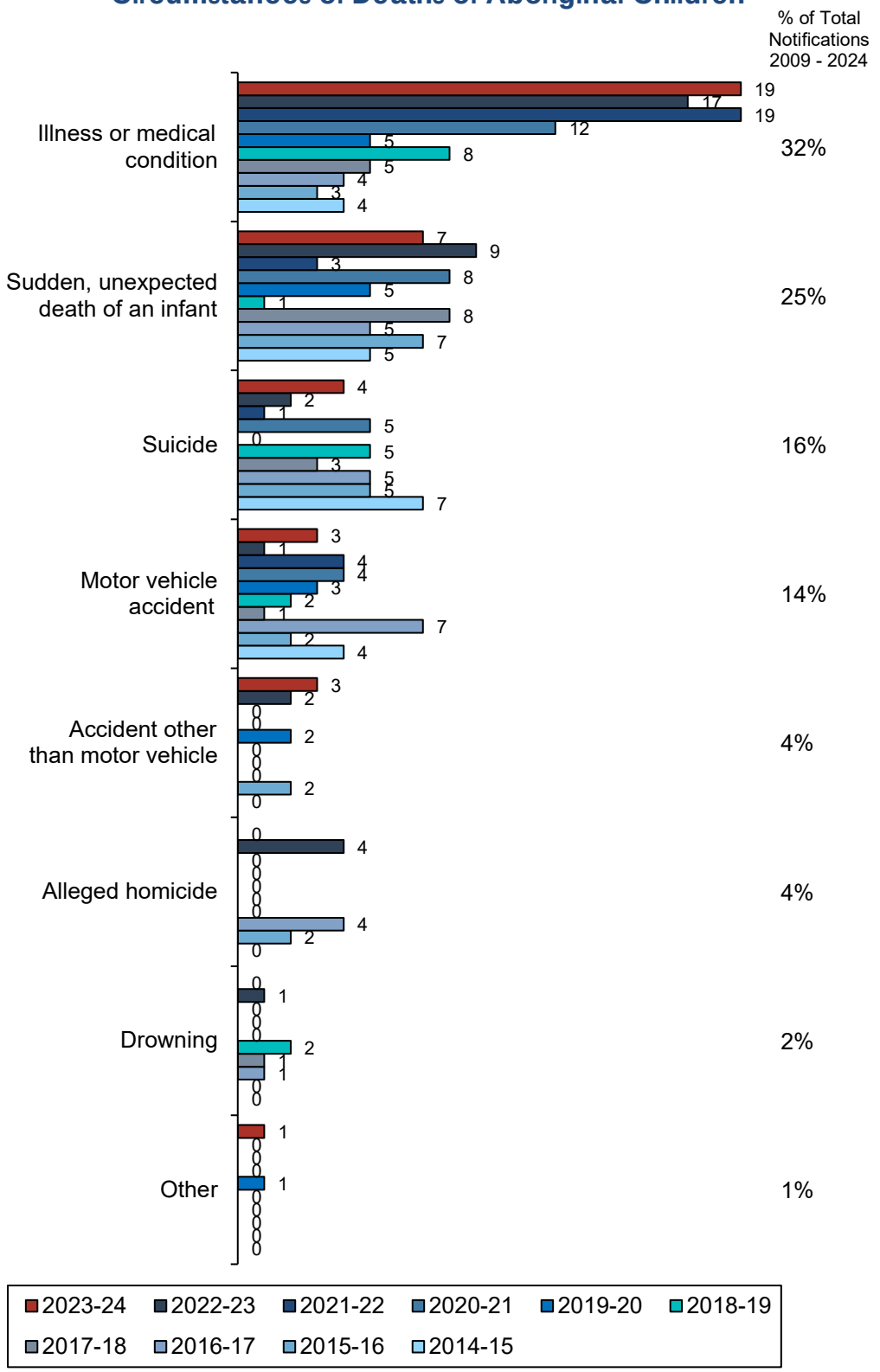
As shown in the following chart, illness or medical condition (32%), sudden, unexpected deaths of infants (25%), suicide (16%), and motor vehicle accidents (16%) are the largest circumstance of death categories for the 357 Aboriginal child death notifications received in the 15 years from 30 June 2009 to 30 June 2024. However, 67 (59%) of reported deaths in circumstances of illness or medical condition are in the four years since 1 July 2020 when the jurisdiction expanded to all child deaths.

Circumstances of Deaths of Aboriginal Children



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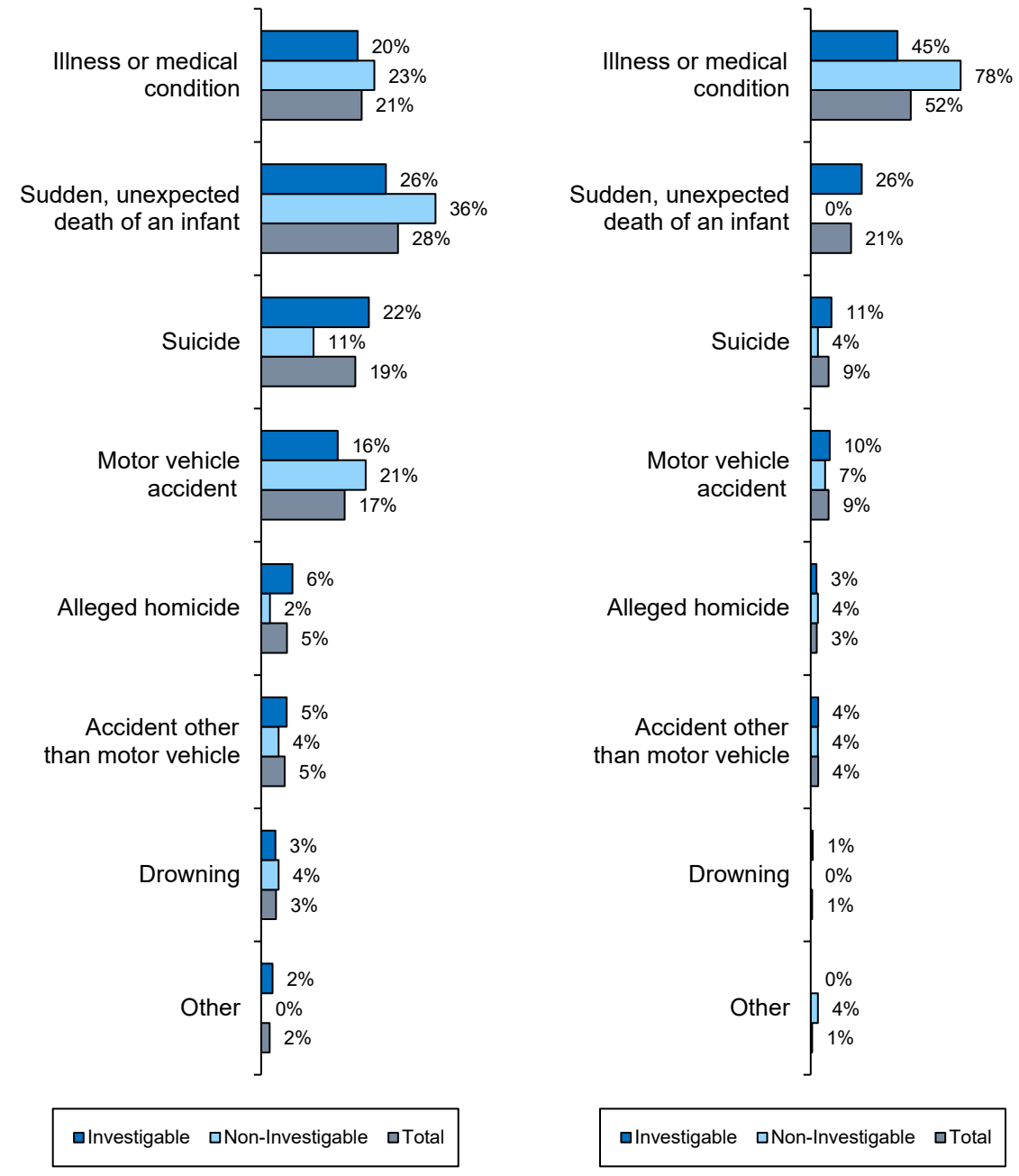
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.

Circumstances of Aboriginal Child Deaths – % of Deaths



Note: Percentages may not add to 100 per cent due to rounding.

Issues Identified in Child Death Reviews

Having undertaken reviews of child deaths since 30 June 2009, this Office has identified learnings for system improvements in how key stakeholder agencies work to promote the safety and wellbeing of children. The following issues reflect some of the common and current identified patterns and trends in these reviews:

- Key stakeholder agencies (including education, child protection, health and justice) operationalise their legislative responsibilities through policy and procedures for working with children and families, to promote child wellbeing and safety. Child Death Reviews often identify issues of compliance in implementing these policy and practice requirements. Where this may indicate systemic compliance issues, this Office will examine how agencies facilitate compliance (training, supervision of staff, delegations for critical decision making, workload management etc), how agencies monitor policy implementation (real time tracking, data analysis and reporting, oversight frameworks etc) and how agencies measure outcomes and effectiveness.
- Pro-active and timely interagency communication and collaboration is important where a child has contact with multiple government agencies and community service providers. Where Child Death Reviews identify issues with information sharing and joint assessment and safety planning, this Office will examine associated barriers to identify where improvements can be affected.
- Working with families in a culturally safe and responsive manner is critical to promoting child safety and wellbeing. Common across Child Death Reviews is the need for increased use of interpreters, improved mapping of cultural background and connections, an integrated trauma informed approach, and accessing expert consultation for assessment and safety planning that incorporates culturally aligned strategies.
- For investigable deaths, the home environment may include exposure to child protection risk factors including family and domestic violence, parental drug/alcohol use and associated neglect. Infants and children living with disability are particularly vulnerable in these living circumstances. Our reviews examine how agencies work with these family circumstances to identify pathways for supporting change to improve a child's life trajectory.

Often, agencies are working to address the issues identified in our reviews, and this Office will monitor the progression of this work and outcomes. The Ombudsman will also make recommendations to facilitate improvement in these areas and will track agency implementation of these recommendations and their impact in preventing or reducing the risk of future child deaths in similar circumstances.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce child deaths. The following six recommendations were made by the Ombudsman in 2023-24 arising from child death reviews (certain recommendations may be de-identified to ensure confidentiality).

1. That Communities provides the Ombudsman with a copy of the Child Safety Investigation Review report, once completed, in relation to the assessment of alleged child sexual abuse of Miss A.
2. In addition to providing a practice clinic on the appropriate application of the Gillick Principle, Communities reviews the Casework Practice Manualand determines whether amendments to the relevant entries and/or any further action is required to ensure that all child protection staff responsible for decision making regarding alleged child sexual abuse of children under 16 years of age have the appropriate induction; ongoing guidance and training; and supervision in relation to the *Children and Community Services Act 2004*, the *Criminal Code Act Compilation Act 1913*; consent, and the appropriate application of the Gillick Principle, and reports back to the Ombudsman within 12 weeks of the finalisation of this review.
3. Communities consider the findings of this review and provides the Ombudsman within four months of the finalisation of this review, with a report outlining how Communities evaluates the implementation and effectiveness of the High-risk Infant Casework Practice Manual entry and related resources in promoting child safety. In particular, the report should address whether governance processes are effective in ensuring child protection practices associated with assessment and safety planning for high-risk infants are promoting child safety and that practice is consistent with the principles, powers and duties outlined in the *Children and Community Services Act 2004*.
4. WA Police considers the findings of this review and provides a report to the Ombudsman within three months of the finalisation of this review that outlines the:
    - WA Police's current initiatives associated with improving responses to child protection and care (including copies of any new policies and/or procedures); and
    - results of the WA Police's considerations of options associated with the administration of arrest warrants in the circumstances where the arrested person is a parent with caregiving responsibilities for infants/children and/or may be breastfeeding.
5. Communities undertakes an internal review to ascertain how the issues identified in this child death review occurred and provides a report to the Ombudsman within six months of the finalisation of this child death review, outlining the internal review findings and whether any further action is required to facilitate the Communities' provision of parental responsibility for children in CEO Care including:
    - to promote compliance with legislative and practice requirements that 'must' be undertaken; and
    - provide a collaborative, trauma-informed response to children at-risk of suicide.

6. The Communities considers the findings of this review and determines whether any immediate actions are required to promote disability informed child protection responses, including but not limited to consideration of:
    - options within the Communities current client management (including the alert function) to facilitate storage and retrieval of information of a child's disability;
    - the adequateness of current practice guidance for disability informed assessment and safety planning, including location of this information in the Casework Practice Manual chapter that relates to children in the CEO's care, Interaction Tool completion guidance, and alignment of Child Safety Investigation priority guidance with Question 16 of the Interaction Tool; and
    - whether clarification is required on how to access specialist disability consultation, including how to gain the views of children with disabilities, and when such consultation is required.

The Ombudsman's *Annual Report 2024-25* will report on the steps taken to give effect to the four recommendations made about ways to prevent or reduce child deaths in 2022-23. The Ombudsman's *Annual Report 2025-26* will report on the steps taken to give effect to the six recommendations made about ways to prevent or reduce child deaths in 2023-24.

Steps taken to give effect to the recommendations arising from child death reviews in 2021-22

The Ombudsman made eight recommendations about ways to prevent or reduce child deaths in 2021-22. 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 therefore.

Recommendation 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.

Steps taken to give effect to the recommendation

Under ntified, to diverthe *Earlier Intervention and Family Support Strategy*, Intensive Family Support (**IFS**) is Communities' key initiative to work with families where child protection risk has been idet children from entering the Chief Executive Officer's care. IFS assists families to develop safety for their children.

Through the Ombudsman's child death reviews, we identified that there was not a governance mechanism to monitor operational compliance with practice requirements (such as safety planning, the development of Multidisciplinary Case Consultation and

timely referral to contracted IFS Service Providers) and effectiveness in service delivery. This Office identified the need for Communities to strengthen the governance framework, to promote IFS implementation and optimise outcomes for children and families.

Communities provided this Office with a letter dated 29 December 2021, in which Communities relevantly informed this Office that:

> The recently established Reviews and Recommendations Oversight Group (the Oversight Group) has oversight of the implementation of all recommendations delivered to Communities. The Oversight Group has allocated the recommendation to the Service and Operational Improvement division which has commenced work on implementation as follows:
>
> **Support to Intensive Family Support Service providers**
> Between 9 March and 30 July 2021, the Earlier Intervention and Family Support Strategy (EIFS) Team undertook statewide support visits to Intensive Family Support (IFS) providers and Communities' districts, which included visits within the Regional District on 28 and 29 June 2021. During these visits, resources and support was provided to promote collaborative relationships and processes between providers and Districts.
>
> **Meeting with IFSS Providers**
> On 22 November 2021, Communities facilitated a two-hour workshop with all IFSS providers via Microsoft Teams, to:
>
> - discuss the recommendation and its implication for IFSS providers;
> - explore a governance structure and processes which could be applied to future contracts; and
> - discuss the development of a Related Resource for Child Protection Workers and staff, which details each individual provider's meeting and correspondence requirements as outlined in IFSS provider contracts and agreed place based processes between Districts and providers.
>
> Outcomes of the meeting included:
> - discussion on the need to promote consistencies in service provision across IFSS providers, Communities' provision of IFS and in collaborative processes between service providers and Communities;
> - discussion on the need to improve mechanisms for information sharing between IFSS providers,
> - agreement to further explore a future governance framework via a planned IFSS Providers Forum (see below); and
> - agreement to develop a Related Resource for Child Protection Workers and staff as stated above.
>
> **IFSS Providers Forum**
> An IFSS Providers Forum (the Forum) was … to be held on 21 February 2022 and will include an agenda item for further discussion on options for a future governance framework.
>
> **Casework Practice Manual Updates**
> New practice guidance for Child Protection Workers regarding considerations when working with Earlier Intervention and Family Support (EIFS) contracted services is in the final stages of development. The new guidance includes considerations when making referrals and working with high-risk cases. It is anticipated the guidance will be uploaded to the Casework Practice Manual (CPM) in 2022.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to this recommendation. In response, Communities provided information in a letter to this Office dated 25 March 2024, containing a report prepared by Communities.

In its report, Communities relevantly informed this Office that:

New Casework Practice Manual Entry

- A new entry, EIFS and Related Resources has been added to the CPM to provide more focused guidance for staff in relation to how they can work collaboratively with external IFS services. The new guidance outlines the following:
  - How each IFS service works to support families according to their individual need.
  - Referral pathways for each IFS service.
  - Understanding the different roles and responsibilities for IFS service providers and how this interacts with Communities' case management responsibilities.
  - How to work collaboratively with IFS service providers to meet child safety goals, while promoting a culturally and trauma informed response.
  - A Regional Service Model (RSM) which was developed in place of the existing IFSS model delivered in East Kimberley, Pilbara and Southwest regions.

Regional Service Model

- In 2022, Communities engaged an external Aboriginal consultant to develop the RSM, which was appropriate for local needs and allowed for future expansion to other regions across the State.
- The RSM provides a trauma-informed culturally responsive service where outcomes are delivered through collaboration and collective effort.
- A new Related Resource, *Referral Pathways – EIFS Regional Service Model*, has been developed and is included in the new CPM entry.

IFSS Communication and Governance

- A new Related Resource, *IFSS Communication and Governance Summary*, provides guidance to Communities' District staff in working with IFS services in their region as well as outside their districts.
- The resource was developed by IFS service providers to outline their internal processes when working with Communities Districts, referral processes, and sets out service expectations.
- The Related Resource is included in the new CPM entry.

Next Steps

In 2024, Communities will undertake a review of EIFS functions with a focus on internal and external services working in collaboration to deliver safe and effective services to families.

While Communities' report indicates steps have been taken to support IFS implementation, two years after this recommendation was made by the Ombudsman, it is unclear that there is sufficient governance to monitor IFS operational compliance. This Office will continue to examine the implementation and effectiveness of IFS in future child death reviews. It is also noted that the Office of the Auditor General released the report *Implementation of the Earlier Intervention and Family Support Strategy* on 27 June 2024, which examines IFS and makes associated recommendations.

Following careful consideration of the information provided, Communities has considered strengthening the governance framework of IFS and provided this Office with a report, however, it is not clear that adequate steps have been taken to give effect to the intent of this recommendation.

Recommendation 2: Department of Education (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.

Steps taken to give effect to the recommendation

Where 15- to 17-year-olds may have disengaged from education, Participation Teams provide support to the young person to move from schooling to further education, training or employment. Through the Ombudsman's reviews, the need to improve the operation and effectiveness of these teams was identified.

DOE provided this Office with a letter received 22 July 2022, in which DOE relevantly informed this Office that:

> DOE has initiated an internal assessment of the Operation of Participation Coordination…
>
> A working group has been formed to deliver a proposal, for consideration by Corporate Executive, to improve DOE's approach to participation….
>
> The internal assessment has identified the 5 following system-wide improvement opportunities to strengthen Department participation strategies and processes:
>
> **Improvement Opportunity 1 (IO1):** Assess data collection and management processes to provide recommendations that enable improvements to the tracking, monitoring, supporting, and reporting on students disengaging from school and/or transitioning in and out of alternatives to full-time school.
>
> **Improvement Opportunity 2 (IO2):** Develop System-supported engagement approaches for at-risk year 9 and 10 students, with the aim of retaining them in schooling in years 11 and 12.
>
> **Improvement Opportunity 3 (IO3):** Review planning, provision and delivery of Education and Training Participation Plans (ETPPs) to enhance quality, relevance and equity of access.
>
> **Improvement Opportunity 4 (IO4):** Build the cultural responsiveness of participation and engagement services for Aboriginal students, with a focus on connection and contribution to culture and community.
>
> **Improvement Opportunity 5 (IO5):** Review the functions and responsibilities of Engagement and Transition managers and Participation Coordinators, to ensure the focus of their efforts aligns with system strategy and directions, and that their expertise has the greatest impact.

This Office requested that DOE inform the Office of any further information on the steps taken to give effect to this recommendation. In response DOE provided information in a letter to this Office dated 11 March 2024 containing a report prepared by DOE.

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

> DOE has given the recommended consideration to whether action is required to strengthen the operation and effectiveness of the participation function and that a process had commenced to progress the further work.
>
> The outcome of consideration through the body of work [outlined above] was corporate executive providing in-principle support for improvements in the following areas identified in the recommendation.
>
> **Data Collection**

DOE has developed a new online Notice of Arrangements (NOA) for more accurate and timely NOA data collection.

DOE has mapped and scoped data management practices that can better support Participation teams and assist with more effective monitoring and reporting. The preferred solution identified as part of this work is progressing.

Minimum Practice Standards
DOE is developing a code of practice for Participation teams and consistent approaches for key priority areas of Participation service delivery including:

- inter/intra-regional transfer of students requiring Participation support.
- supporting students who are pregnant or parenting.
- students refusing to engage.

Engagement and Transition Managers from the 8 regions meet and have workshops to improve system wide communication and support.

Governance strategies
DOE is progressing work and oversight of improvement activities with two new positions for the current financial year – Executive Consultant, Participation Operational Priorities and Principal Consultant, Operational Initiatives.

Activity and progress is reported to the People and Services Committee, a subcommittee of the Corporate Executive.

Quarterly assurance process on progress of work is undertaken by DOE.

Evaluation Processes
In further developing data collection and reporting, the scoping of the new Participation Management Database includes the need to be able to draw information and data to support ongoing evaluation of the efficiency and effectiveness of the Participation function.

By improving the efficiency and effectiveness of the Participation function, the Request for Assistance (RFA) process is currently being considered. Supported by a working group, this is considering the current process for requesting assistance for a student and working towards an approved education, training or employment outcome for them. This work includes consideration of when a referral (RFA) is not successful (not approved) and to improve the process to ensure continuity of support and no gaps in service to students.

It is noted that, having informed the Ombudsman of five improvement opportunities in July 2022, DOE continues to take associated actions.

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

Recommendation 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 Communtiies will monitor and evaluate the implementation and effectiveness of this minimum practice standard.

Steps taken to give effect to the recommendation

While Communities is undertaking work to effect improvement in culturally safe and responsive practice with Aboriginal children, families and communities (including the development of the Aboriginal Cultural Framework to outline Communities' Aboriginal

cultural reform for the next five years), the timeframe for this organisational change is long term. Through child death reviews, this Office identified there was a need for some immediate action, to ensure child protection workers were meeting the minimum practice standard in working with Aboriginal families.

Communities provided this Office with a letter dated 4 July 2022, which included a copy of a project plan titled *Strengthening Culturally Responsive Practice in Child Safety Investigations*.

Communities further informed this Office, by email dated 19 September 2022 that:

> Communities shares the Ombudsman's view that there are opportunities to strengthen Communities' culturally responsive practice, and in particular in relation to Child Safety Investigations (CSIs) for Aboriginal children. On 4 July 2022 Communities provided your office with the Project Plan *Strengthening Culturally Responsive Practice in Child Safety Investigations* (the Project Plan). Following on from this, your office provided feedback in relation to the Project Plan which outlined a view that the Project Plan may not address the Ombudsman's findings and associated recommendation…
>
> As a result of consultations, the Specialist Child Protection Unit is progressing elements of the Project Plan, including the jurisdictional scan, and reviewing the Aboriginal Practice Leader consultations form. It is anticipated that the work of Aboriginal Outcomes division in the Aboriginal Cultural Capability Reform Program (ACCRP) and the Aboriginal Competency Framework may inform future activities of the working group. The Specialist Child Protection group is also liaising with Learning and Development who are engaging with team leaders in selected districts to inform a review of the CSI Reviewer training…

Following provision of this information, this Office informed Communities that the Project Plan did not appear to give effect to the recommendation.

This Office subsequently requested that Communities inform the Office of any further information on the steps taken to give effect to this recommendation. In response, Communities provided information in a letter to this Office dated 25 March 2024, containing a report prepared by Communities.

While Communities' report indicates steps have been taken towards improving culturally safe and responsive practice, it is the view of this Office that sufficient action has not been taken to give effect to this recommendation. The Office met with Communities to discuss this matter, and Communities subsequently provided this Office with a letter dated 26 July 2024, which provided further information on actions relevant to this recommendation:

> Communities' initial response to this recommendation was the Strengthening Culturally Responsive Practice in CSIs Project. This project was finalised in 2023 and improved the quality of Aboriginal Practice Leader (APL) consultations and revised the CSI Reviewer Training module. In addition, a revised Capability Matrix for Leading Culturally Responsive Practice in CSIs was developed and implemented.
>
> <u>Communities' Case Practice Manual (CPM)</u>
>
> Over the past two years there has been considerable investment of time and funding to transition the CPM to a new platform. Communities' workforce identified the functionality of the CPM as a significant issue impacting upon their practice. Through a commissioning process, LivePro has been adopted and existing CPM information has been uploaded over the preceding months. The new platform, known as the Guide, will be launched on Monday 29 July 2024, a significant milestone in this project.
>
> Over the next six months, work will be undertaken on the qualitative content for the new Guide. Whilst some amendments have been made to the CPM entry on CSIs, to clarify expected actions for culturally responsive practice, it is recognised that further work is needed to strengthen practice guidance on culturally responsive practice in CSIs…

Signs of Safety Child Protection Practice Framework

Western Australia implemented the Signs of Safety Practice Child Protection Framework in 2008. Despite this length of time, there is a continual need to focus on Signs of Safety implementation and building practice breadth and depth, in particular in the context of staff turnover. Elia is an international organisation that describes itself as "the home of Signs of Safety". Over the past two years, Elia have been engaged by Communities to deliver safety planning training to every district, noting safety planning is a core component of CSIs. Elia's most recent visit in June 2024 included a strategic planning session with District Directors. As a result, District Directors have decided to focus on the first twelve months of a worker's journey into child protection, to build confident practitioners. Every District is finalising a Signs of Safety plan, to enable visibility and accountability of efforts. When Elia return in September, they will be visiting the Pilbara and Kimberley regions, where turnover and lower numbers of qualified staff impact the quality of child protection practice. Elia will focus on building expertise in child protection practice in the context of CSIs, with a focus on culturally responsive practice.

Communities is on a journey of building culturally responsive practice, with more work underway. Communities is committed to this work and respectfully requests your consideration to a further 12 months to enable our agency to take further steps to give effect to this recommendation.

I would also like to take this opportunity to note Communities' broader programs of work to increase culturally safe and responsive practice across Communities eleven portfolios. These include:

- Aboriginal Community Controlled Organisation (ACCO) Strategy 2022-2032
- Aboriginal Engagement Framework (AEF)
- Aboriginal Cultural Capability Reform Program (ACCRP)
- Aboriginal Workforce Support Program
- Aboriginal Cultural Framework
- Reconciliation Action Plan

It is noted that Communities has indicated that further steps will be taken in the next 12 months to give effect to this recommendation.

Following careful consideration of the information provided, it is determined that adequate steps have not at this time been taken to give effect to this recommendation. Communities have proposed to give effect to this recommendation in 2024-25.

Recommendation 4: In implementing 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.

Steps taken to give effect to the recommendation

Where English is not a person's first language, there may be a need for an interpreter to be engaged when discussing child protection assessment and safety planning. This Office has identified through child death reviews that there is a need for Communities to take action to ensure interpreter use when appropriate.

Communities provided this Office with a letter dated 4 July 2022 and an email dated 19 September 2022, as detailed in Recommendation 3.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to this recommendation. In response, Communities

provided information in a letter to this Office dated 25 March 2024, containing a report prepared by Communities.

In its report, Communities relevantly informed this Office that:

> On 1 May 2022, Recommendation 46 of the 2017 Statutory Review of the Children and Community Services Act 2004 (the Act) came into effect. This sets out the principles in section 9 of the Act to include reference to the use of interpreters when working with children, parents and families where they may have difficulty understanding or communicating in English. Implementation of this recommendation included strengthening policy and practice guidance and improvements to Communities' client database, Assist.
>
> In 2023, Communities strengthened the APL Consult process. To reflect these changes, updates were made to the consultation form providing additional information to inform and frame the consultation with an APL, including:
> - Language/tribal group,
> - Whether an interpreter is required, and
> - Any relevant family/kinships connections to support identification of important relationships that may not have otherwise been captured.
>
> These changes were actioned following consultation with Aboriginal Practice Leaders across the state.

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

Recommendation 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 IFS cases, including undertaking regular case reviews.

Steps taken to give effect to the recommendation

Following on from Recommendation 1, this Office identified that a Regional District's IFS was experiencing particular issues meeting operational requirements for providing IFS to families. Recommendations 5-8 intended to require the Department to take action to ensure IFS operation in that Regional District was supported to function adequately.

This Office requested that Communities inform the Office of the steps taken to give effect to this recommendation. In response, Communities provided information in a letter to this Office dated 25 March 2024, containing a report prepared by Communities.

In its report, Communities relevantly informed this Office that:

> In 2022, the Regional District took steps to overcome challenges in the recruitment and retention of staff. Communities also allocated new funding for the provision of an additional IFS Team within the Regional District, to be based in a second town within the Regional District.

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

Recommendation 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.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 8 August 2022 in which Communities relevantly informed this Office that:

> The Specialist Child Protection Unit has undertaken broad internal stakeholder consultation to gather information on Communities' service delivery experience in relation to Multidisciplinary Case Consultations (MCCs).

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to this recommendation. In response, Communities provided information in a letter to this Office dated 25 March 2024, containing a report prepared by Communities.

In its report, Communities relevantly informed this Office that:

> Following receipt of this recommendation, Communities' Specialist Child Protection Unit undertook broad internal stakeholder consultations to gather information on Communities' service delivery experience in relation to Multidisciplinary Case Consultations (MCCs)…
>
> Internal stakeholder feedback has been collated and has informed:
> - amendments to the *Intensive Family Support CPM* entry, and
> - a planned broader review of EIFS, inclusive of Intensive Family Support, which will include a focus on MCCs.
>
> In January 2024, Communities provided the Ombudsman's with details of a Project Charter that is being finalised outlining the parameters for review of EIFS functions. The review of EIFS functions will focus on the synergy and gaps of internal and external services working in collaboration to deliver safe and effective services to families. The project will provide a comprehensive review of critical functions and case practice guidance of internal IFS teams.
>
> In scope of the project will be critical functions within the Child Protection IFS teams including service provisions, case practice guidance and functions, previous evaluations and MCCs. This will include current policies, procedures, and practices as well as structural composition of the IFS teams. Recommendations from the Ombudsman in the context of internal IFS team practices, processes, and roles and responsibilities will also be considered. This work is underway and anticipated completion is August 2024.
>
> <u>Current Status</u>
> The CPM entry Intensive Family Support has been updated to provide more focused guidance for staff. The new guidance includes the following:
>
> - Guidance for MCC meetings has been moved under the heading 'tools and culturally secure practice' to reinforce the message that MCCs are part of a suite of tools in the IFS tool kit for Child Protection Workers.
> - Support for the use of professional judgement and supervision over prescriptive practice.
> - A focus on the importance of reviewing safety plans and using MCCs and other IFS tools as and when is appropriate for the circumstances of the case. This focus better aligns practice guidance to feedback received from consultations about when the use of MCCs in practice has been a helpful tool.
>
> On 5 March 2024, these changes were communicated to the Child Protection Workforce via broadcast email.

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

Recommendation 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).

Steps taken to give effect to the recommendation

At the time of this child death review, it was a Communities' practice requirement that when a family was transferred to IFS, a Multidisciplinary Case Consultation (MCC) would be convened and recorded. The MCC was a consultation held between specialist staff that focused on the best interests of the child and developed an IFS plan to engage the family in improving the child's safety and wellbeing. This Office identified that the Regional District needed to take action to ensure all IFS cases had a current MCC recorded and reviewed as required.

Communities provided this Office with a letter dated 8 August 2022 in which Communities relevantly informed this Office that:

> On 1 April 2022, the IFS cases open to the Regional District totalled 32 Family Groups and included 79 individual children. Of those 32 family groups:
>
> - 25 had MCC's completed,
> - 2 had no recent MCC, however did have a Signs of Safety Mapping meeting, and
> - 5 had no MCC or recent review.
>
> Four of the cases that had not been subject to a MCC or review were closed to IFS after 1 April 2022.

This Office notes that the practice requirement to undertake a MCC at the commencement of IFS has now been removed from Communities' Casework Practice Manual as a 'must' action, but still remains as part of the process. This Office will continue to monitor that IFS provision has a clear plan, which has been developed in the child's best interests.

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

Recommendation 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 recommendation

Communities provided this Office with a letter dated 8 August 2022 in which Communities relevantly informed this Office of steps taken to address the recommendation actions.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to this recommendation. In response Communities provided information in a letter dated 25 March 2024.

In regard to *a. actions taken to review IFS practice guidance,* see Recommendation 6.

In regard to *b. 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,* see Recommendation 5 and 6.

In regard to *c.* identifies all cases open to IFS in the Regional District as of 1 April 2022, see Recommendation 7.

In regard to *d. indicates the dates that MCC/case reviews occurred; and e. provides a copy of the most recent MCC/case review*, dated copies of the most recent MCC/case reviews for cases open to IFS in the Regional District as of 1 April 2022 were provided by Communities to the Office, in August 2022.

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 2023-24, timely review processes have resulted in 69% of all reviews being completed within six months.

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.

The Office also actively monitors the steps taken to give effect to recommendations arising from own motion investigations.

Details of the Office's own motion investigations and monitoring of the steps taken to give effect to recommendations are provided in the Own Motion Investigations, Inspections and Monitoring 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 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.

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 2023-24 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
  - Various health service providers
  - Department of Education
  - Department of Justice
  - The Mental Health Commission
  - WA Police Force
  - 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.