Our Performance in 2023-24

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
  - Financial Performance
- Complaint Resolution
- Child Death Review
- Family and Domestic Violence Fatality Review
- Own Motion Investigations, Inspection and Monitoring
- Reportable Conduct Scheme
- Collaboration and Access to Services

Summary of Performance

Key Performance Indicators

Key Effectiveness Indicators

The Ombudsman aims to improve decision making and administrative practices in public authorities. The Office does this by investigating and resolving complaints, 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.

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	2022-23	2023-24 Target	2023-24 Actual	Variance from Target
Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies (a)	100%	100%	**100%**	-
Number of improvements to practices or procedures as a result of Ombudsman action (b)	75	100	**40**	(60)
Where the Ombudsman made recommendations regarding reportable conduct, the percentage of recommendations accepted by relevant entities (c)	Not applicable	100%	**Not applicable**	Not applicable
Number of actions taken by relevant entities to prevent reportable conduct (d)	26	51	**97**	46

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 2023-24, there were 209 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman.

Key Efficiency Indicators

Key Efficiency Indicators	2022-23	2023-24 Target	2023-24 Actual	Variance from Target
Percentage of allegations finalised within three months	96%	95%	**95%**	-
Percentage of allegations finalised within 12 months	100%	100%	**100%**	-
Percentage of allegations on hand at 30 June less than three months old	93%	90%	**88%**	(2%)
Percentage of allegations on hand at 30 June less than 12 months old	100%	100%	**100%**	-
Average cost per finalised allegation (a)	$1,547	$1,890	**$1,314**	(576)
Average cost per finalised notification of death (b)	$8,415	$14,655	**$11,571**	(3,084)
Average cost per notification of reportable conduct (c)	$6,027	$6,000	**$3,687**	(2,313)
Cost of monitoring and inspection functions (d)	$735,183	$1,168,000	**$1,000,679**	(167,321)

For further details, see the Key Performance Indicator section.

Summary of Financial Performance

	2022-23 Actual ('000s)	2023-24 Target ('000s)	2023-24 Actual ('000s)	Variance from Target ('000s)
Total cost of services	$12,611	15,620	14,205	(1,415)
Income other than income from State Government	$2,685	2,745	2,711	(34)
Net cost of services	$9,926	12,875	11,494	(1,381)
Net increase/(decrease) in cash and cash equivalents	$1,229	20	2,008	1,988
Total equity	$1,524	808	3,062	2,254

The variation mainly relates to an underspend in expenditure. Further explanations are contained in Note 9 'Explanatory Statement' to the Financial Statements.

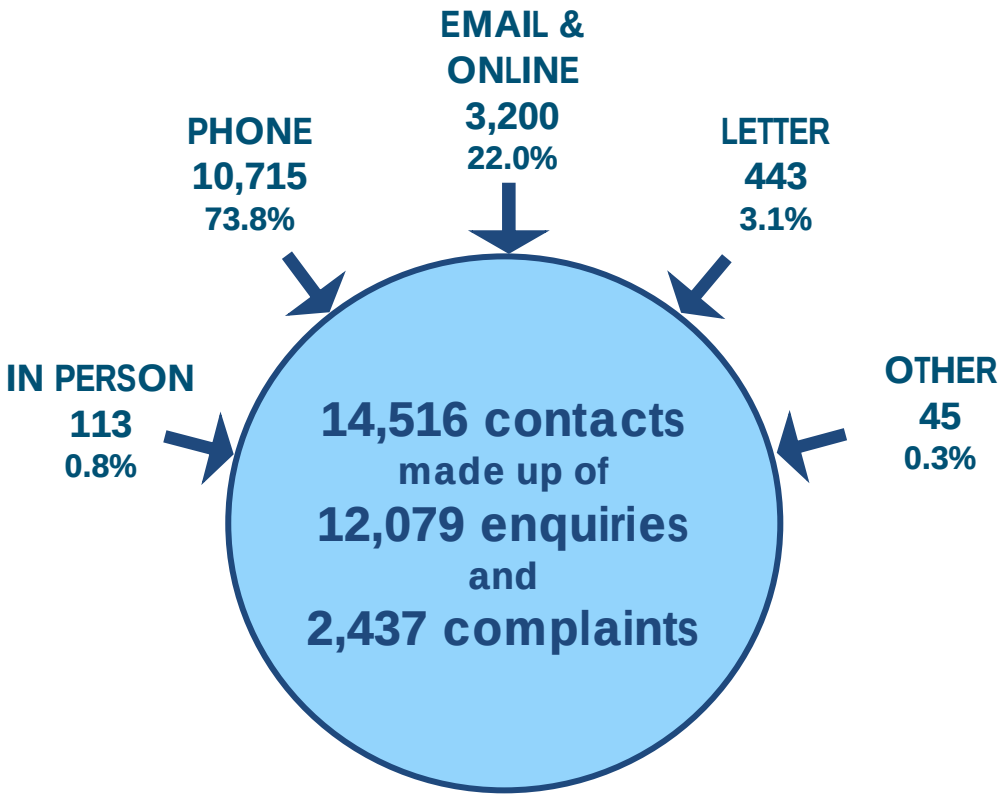
Complaint Resolution

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 2023-24, the Office received 14,516 contacts from members of the public consisting of:

- 12,079 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 2,437 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

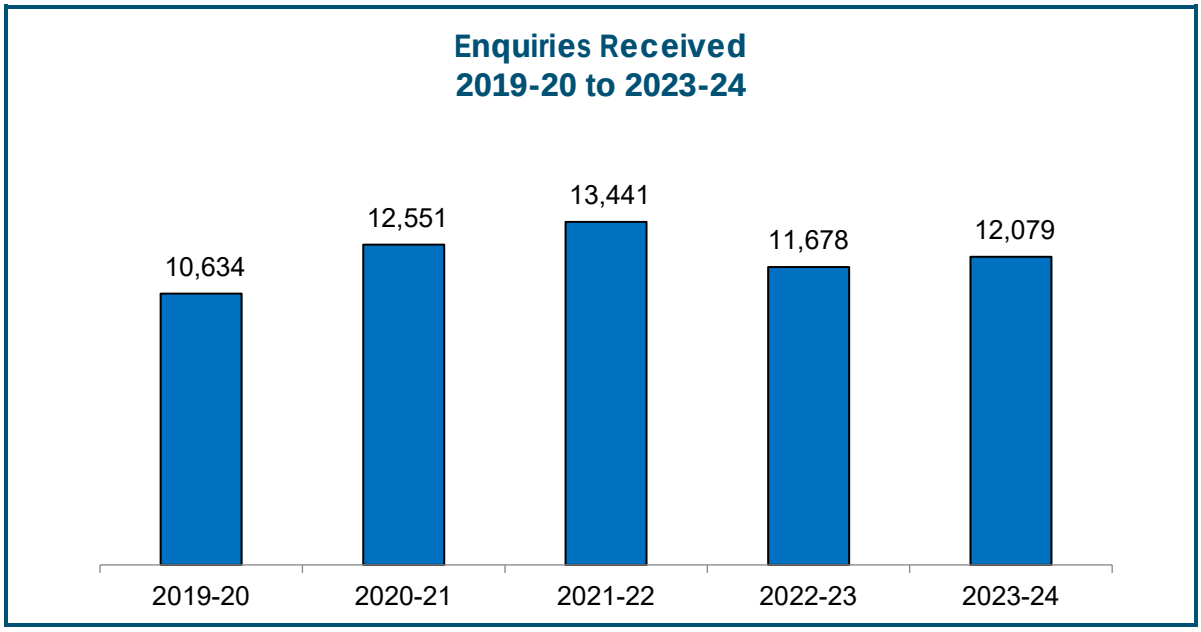


Enquiries Received

There were 12,079 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 approximately 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.

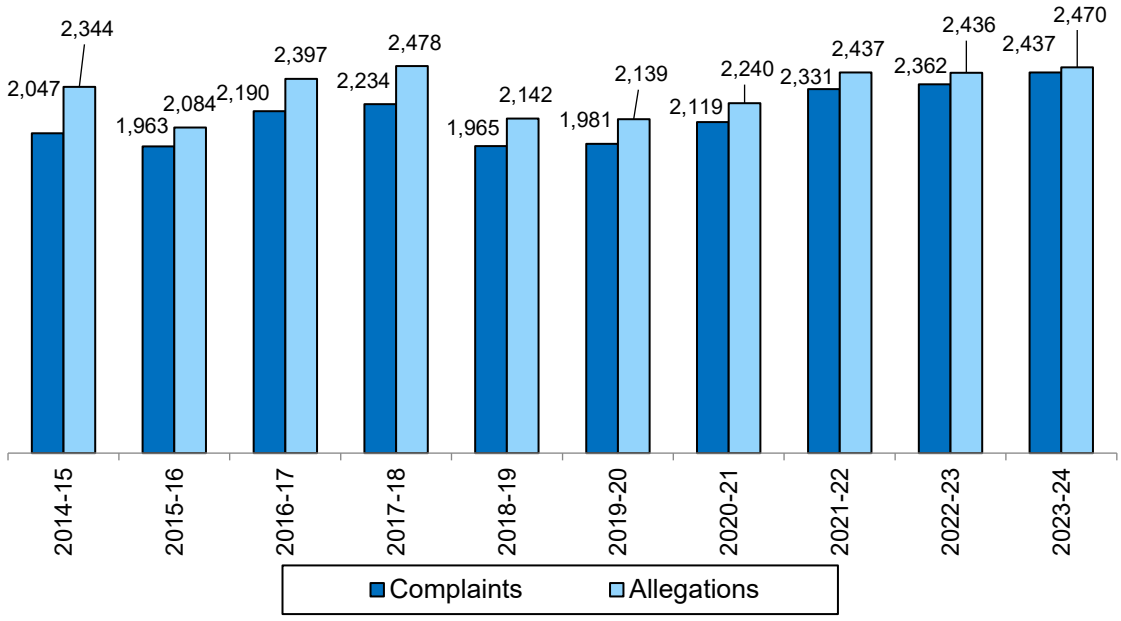


Enquirers are generally encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

Complaints Received

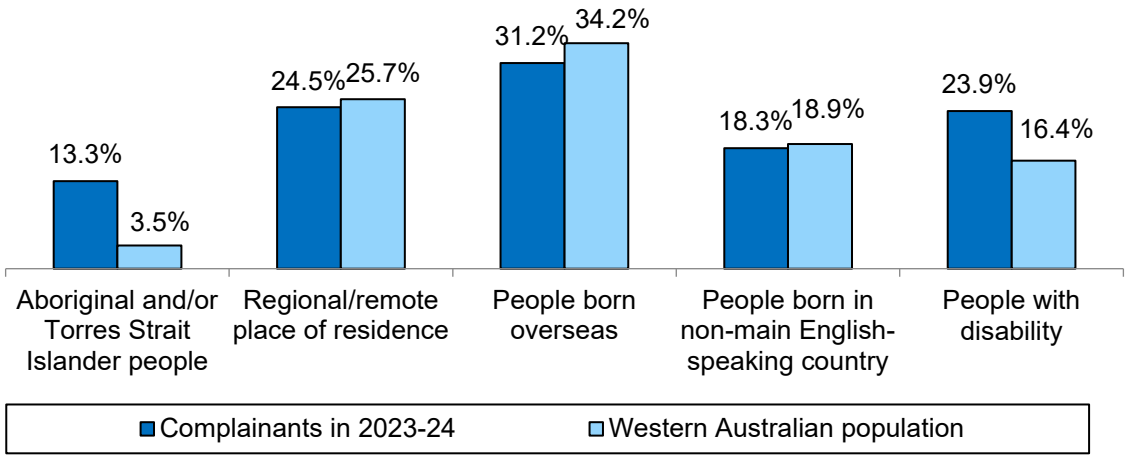
In 2023-24, the Office received 2,437 complaints, with 2,470 separate allegations, and finalised 2,417 complaints. There are more allegations than complaints because one complaint may cover more than one issue.

Total Number of Complaints and Allegations Received 2014-15 to 2023-24



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.

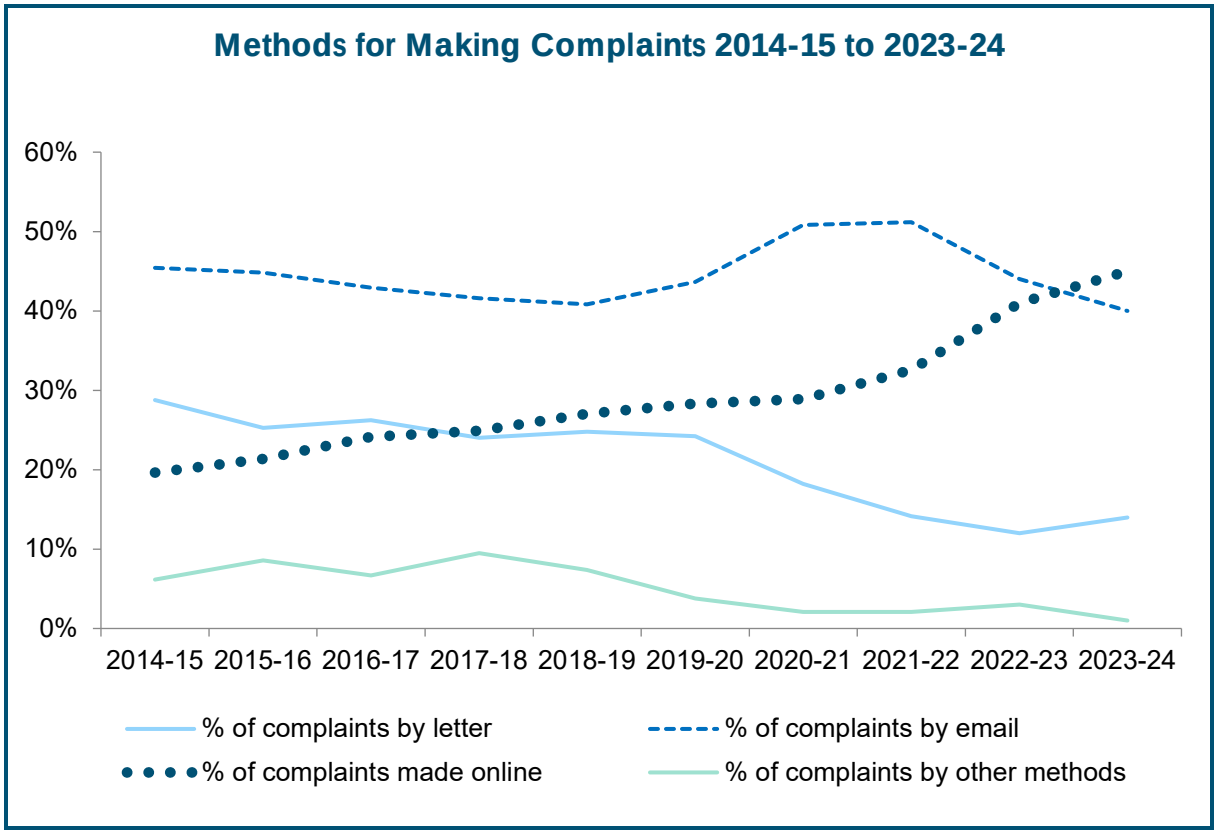
Characteristics of Complainants in 2023-24



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

In 2023-24, 45% of complaints were lodged through the Office's online complaint form, overtaking email (40%) for the first time as the preferred method to lodge complaints. There were also 14% of complaints lodged by letter and one 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. The 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 sustained improvements in the time taken to handle complaints.

In 2023-24:

- The percentage of allegations finalised within 3 months was 95%; and
- The percentage of allegations on hand at 30 June less than 3 months old was 88%.

95% of allegations were finalised within 3 months.

Complaints Finalised in 2023-24

There were 2,417 complaints finalised during the year and, of these, 1,593 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 1,040 were finalised at initial assessment, 513 were finalised after an Ombudsman investigation and 40 were withdrawn.

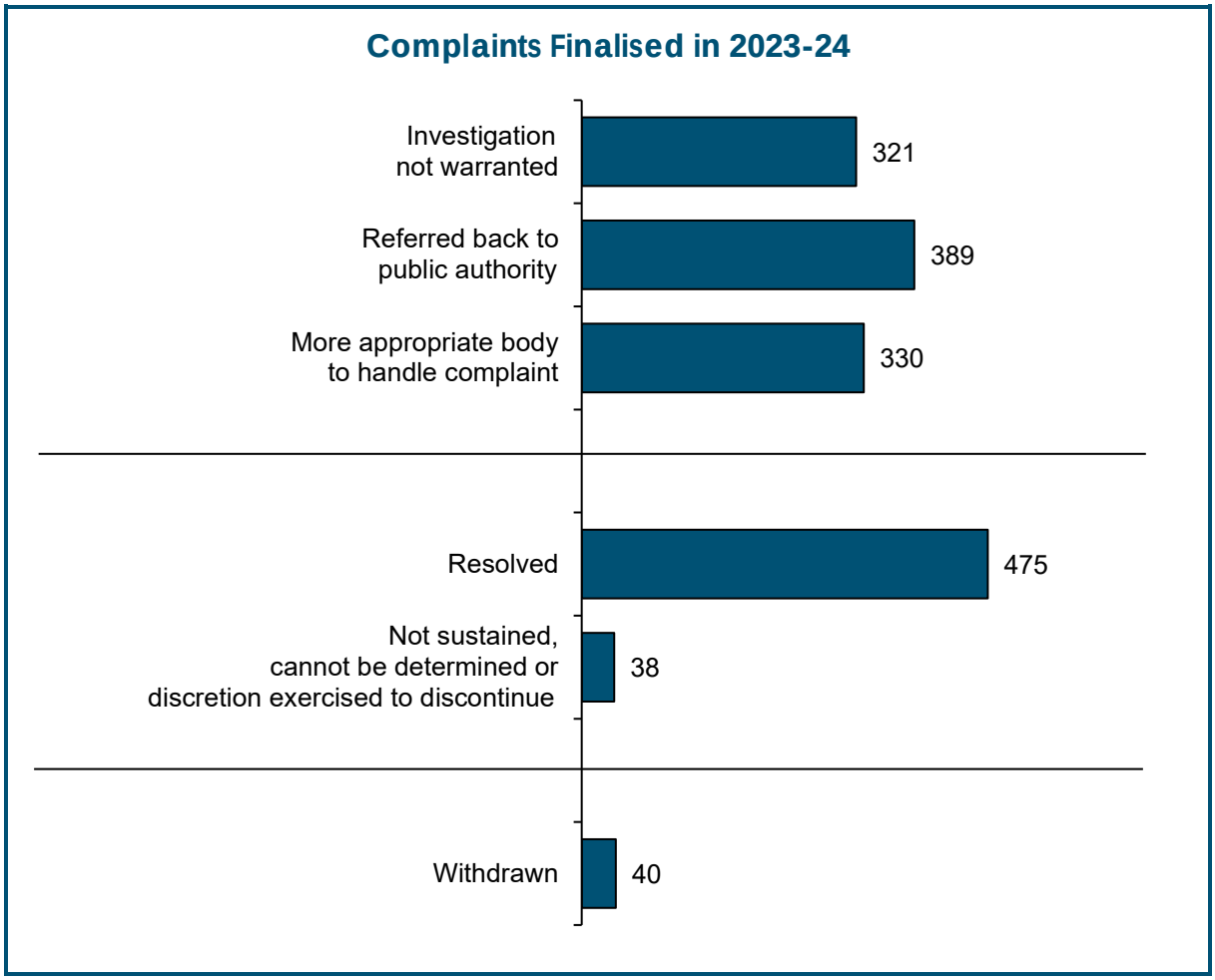
Complaints finalised at initial assessment

Over a third (37%) of the 1,040 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 330 (32%) 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 513 complaints finalised after investigation, 90% 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.

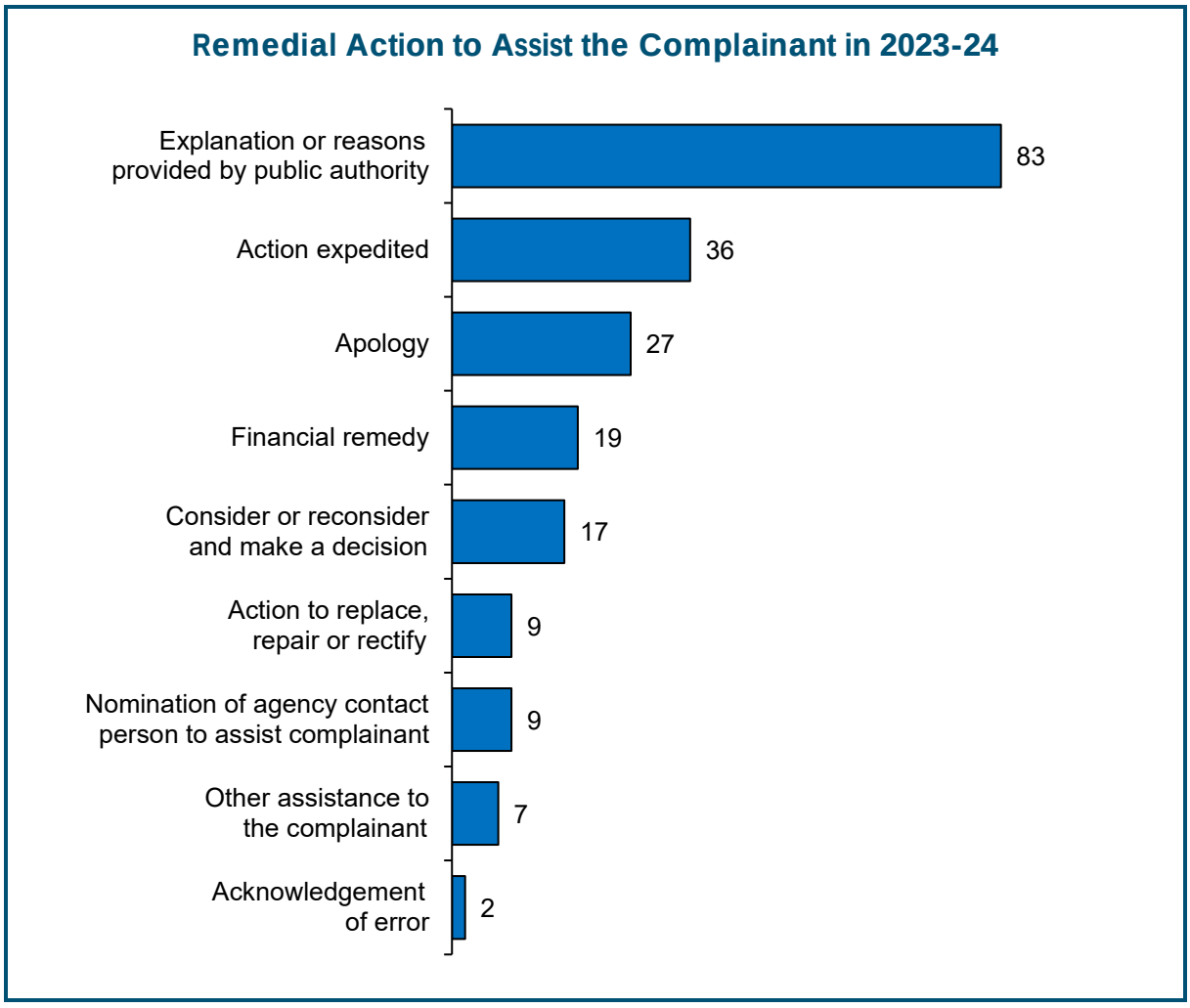


Note: Investigation not warranted includes complaints where the matter is not in the Ombudsman's jurisdiction.

Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2023-24, there were 209 remedies provided by public authorities to assist complainants. 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 92 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.



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. In 2023-24, public authorities made 32 improvements to improve their administration following the Ombudsman's investigations.

Case Study

Decision reversed and rebate granted following Ombudsman involvement

A person installed a security system and applied to a public authority for a rebate that the public authority was offering. The public authority declined the application on the basis that the installer was not appropriately licenced. The person had the installation inspected by another installer with the appropriate licence and reapplied for the rebate. The public authority again declined the application. The person complained to the Ombudsman.

The Ombudsman contacted the public authority to commence an investigation into the decision to decline the rebate application. The public authority reviewed the matter and decided that the original decision was correct under the rebate rules. However, the public authority considered that the decision to decline the application went against the spirit of the rebate scheme considering that the installer's incorrect licence was out of the person's control and the person had acted in good faith. Therefore, the public authority changed its decision, approved the rebate application and apologised for any frustration or anxiety the original decision may have caused.

Case Study

Public authority's email spam filter altered

A person complained to the Ombudsman about a significant delay in receiving any response from a public authority that was providing support to the person.

The Ombudsman contacted the public authority, which provided information about the support the person had received and acknowledged that there had been a delay in processing a payment for the person's support. The public authority progressed the payment but said it could not locate relevant emails from the person.

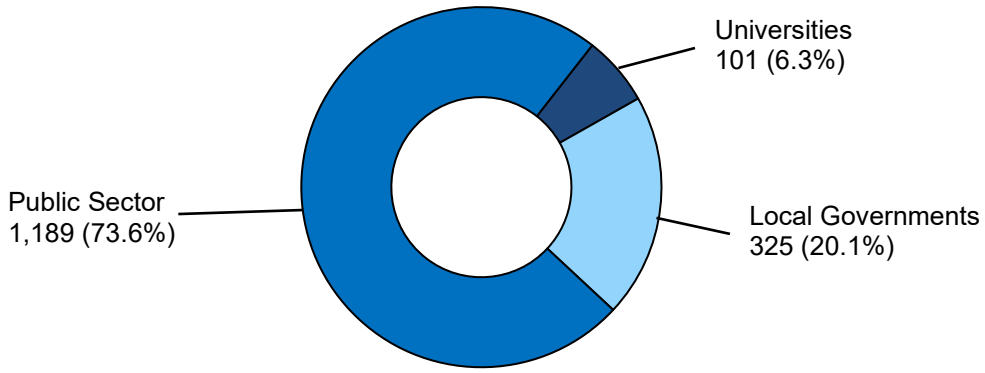
The public authority identified that the emails had been marked as spam and not received by the intended recipient. The Ombudsman asked the public authority to consider how to prevent the issue occurring again in the future. The public authority subsequently informed the Ombudsman that its email security system had been amended to provide a more proactive, risk-based approach to monitoring emails.

About the Complaints

Of the 2,437 complaints received, 1,615 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 822 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.

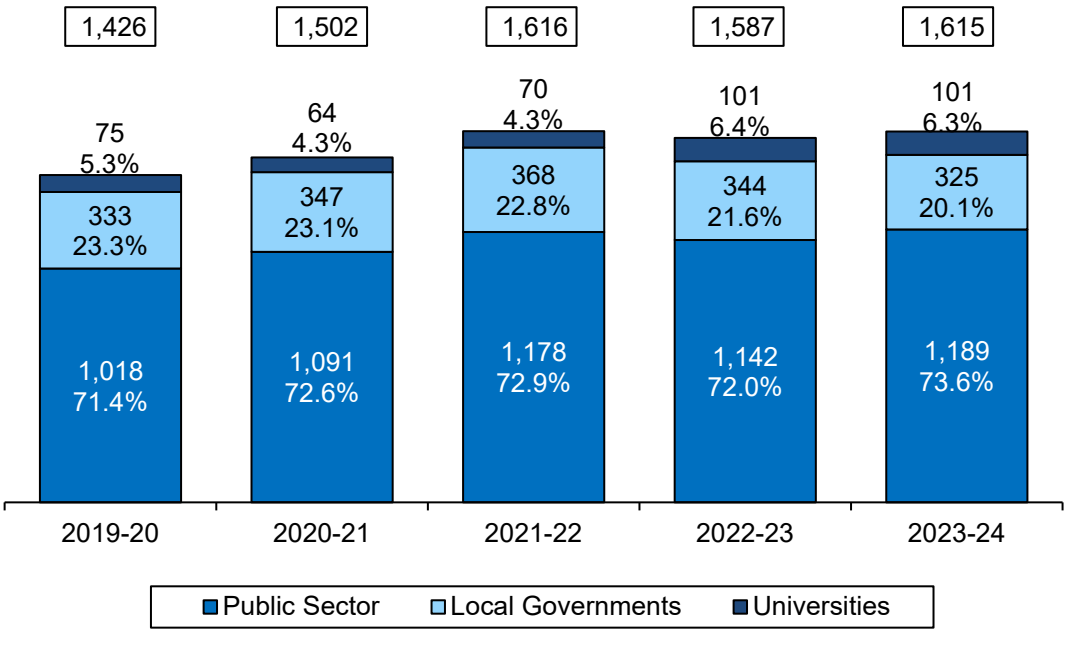
Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (1,189 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (325 complaints); and the university sector (101 complaints).

Complaints Received about Public Authorities within the Ombudsman's Jurisdiction in 2023-24



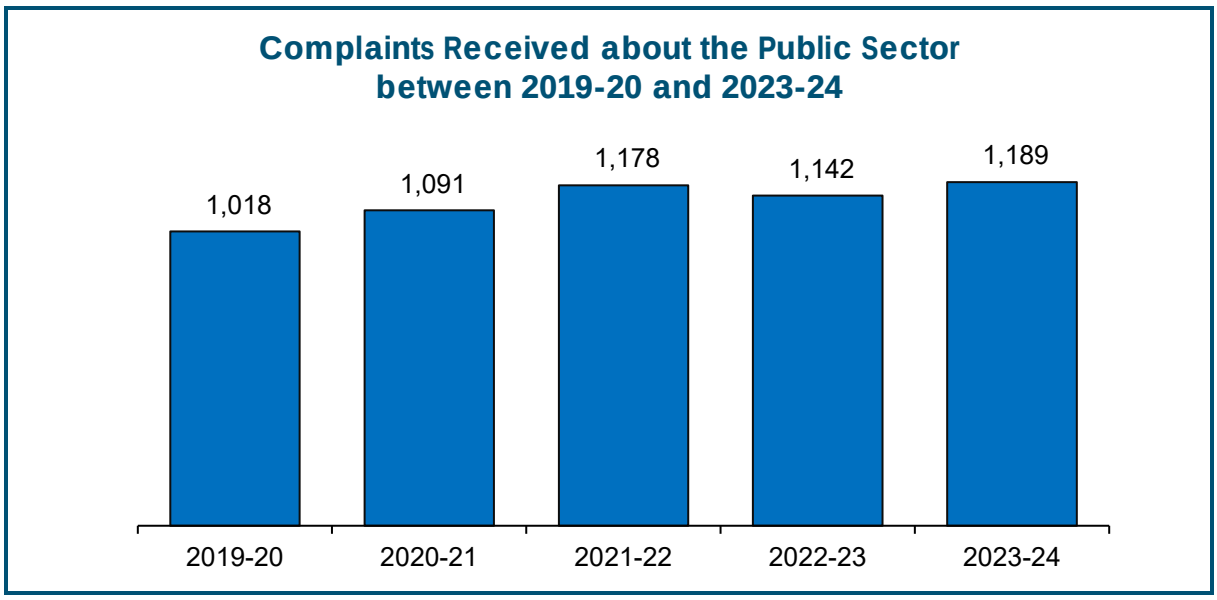
The proportion of complaints about each sector in the last five years is shown in the following chart.

Complaints Received about Public Authorities within the Ombudsman's Jurisdiction between 2019-20 and 2023-24

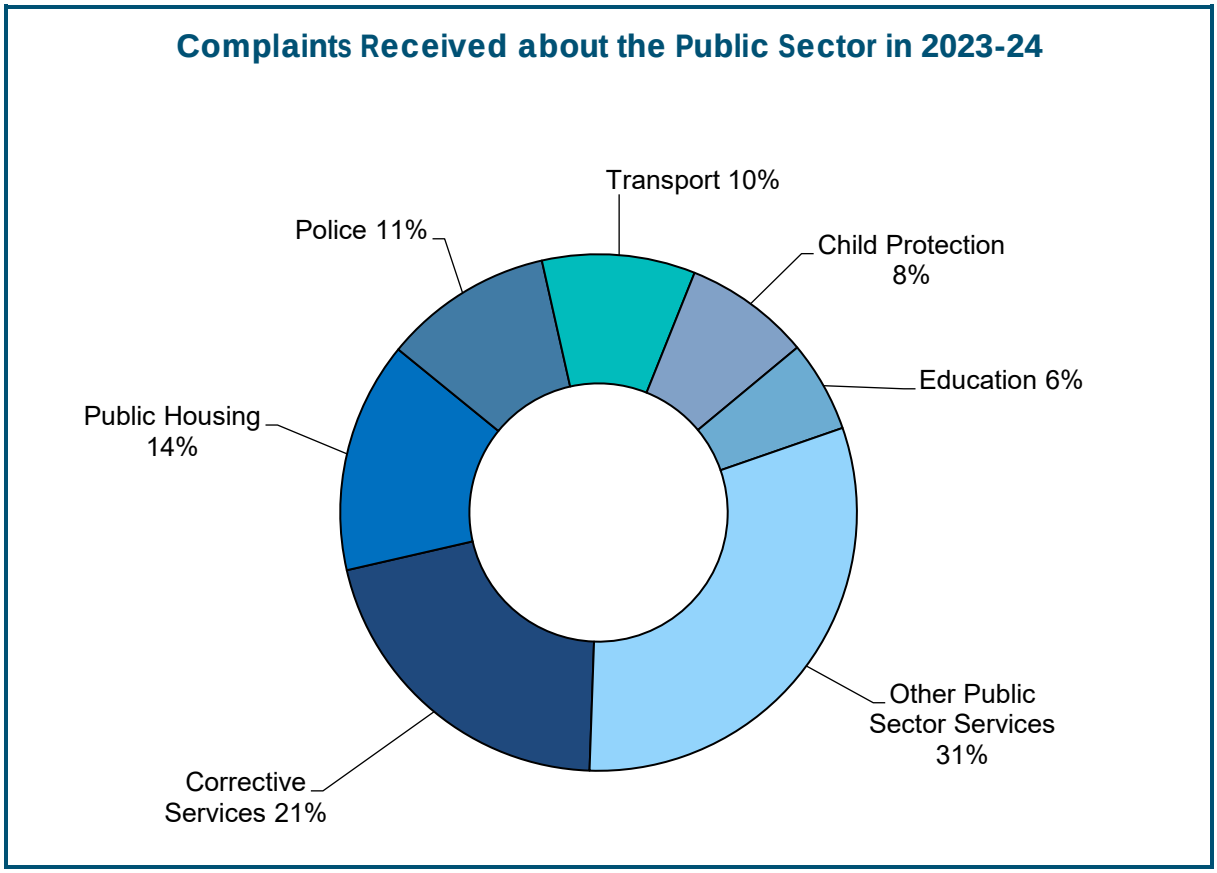


The Public Sector

In 2023-24, there were 1,189 complaints received about the public sector and 1,161 complaints were finalised. The number of complaints about the public sector as a whole since 2019-20 is shown in the chart below.



Public sector agencies deliver a very diverse range of services to the Western Australian community. In 2023-24, complaints were received about key services as shown in the following chart.



Note: Percentages may not add to 100% due to rounding.

Of the 1,189 complaints received about the public sector in 2023-24, 69% were about six key service areas covering:

- Corrective services, in particular prisons (248 or 21%)
- Public housing (172 or 14%)
- Police (126 or 11%)
- Transport, including roads, public transport and licensing (114 or 10%)
- Child protection (94 or 8%)
- Education, including public schools and TAFE colleges (68 or 6%). Information about universities is shown separately under the university sector.

The remaining 31% of complaints were about 72 other public authorities, of which 89% had 10 or fewer complaints in 2023-24. 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 2023-24, there were 189 actions taken by public sector bodies as a result of Ombudsman action following a complaint. These resulted in 167 remedies being provided to complainants and 22 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

Hospital reimburses lost property after Ombudsman involvement

A person complained to a hospital about a vulnerable family member losing property at the hospital. They said the family member was not in a position to keep track of their belongings when they were transferred to the ward. The hospital investigated the complaint and did not find any evidence of staff carelessness or mishandling of property and therefore declined to replace the property. The person complained to the Ombudsman.

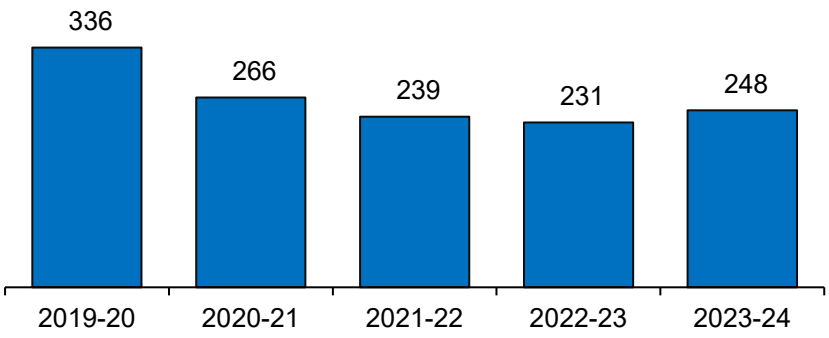
The Ombudsman contacted the health service responsible for the hospital to determine the status of the hospital's investigation into the matter. As a result of the Ombudsman's enquiry, the health service completed a further assessment and determined that the hospital's policy on personal property will be reviewed. The health service also decided to reimburse the person for the lost property.

The Ombudsman later followed up with the health service to confirm that the reimbursement had been processed and the hospital's policy had been updated to address the handling of valuable personal property.

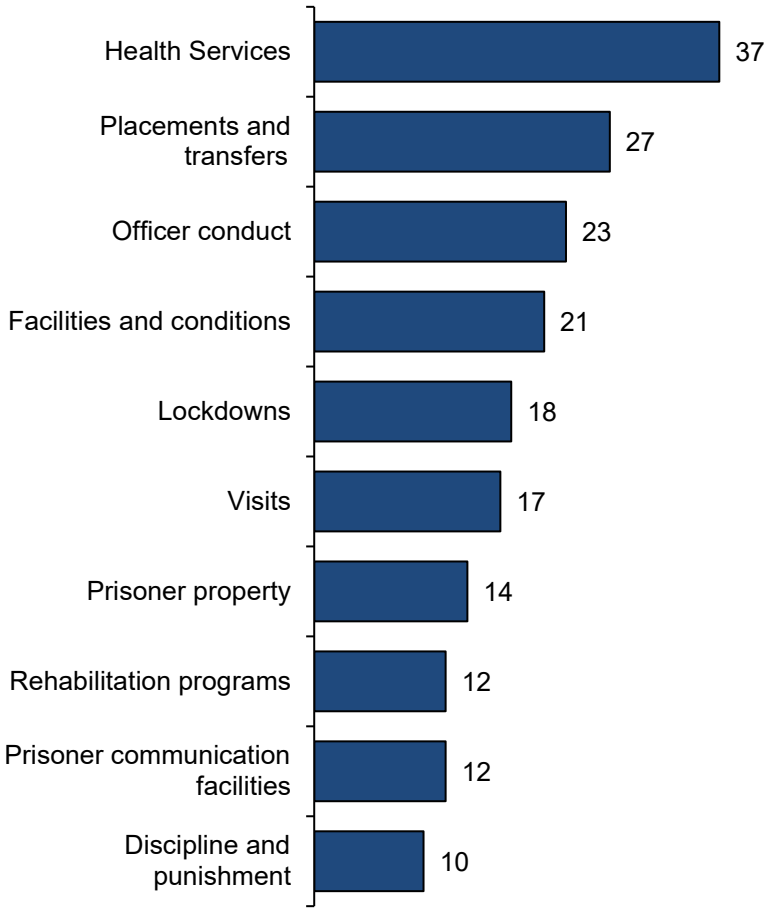
Public sector complaint issues and outcomes

Corrective Services

Complaints received



Most common allegations

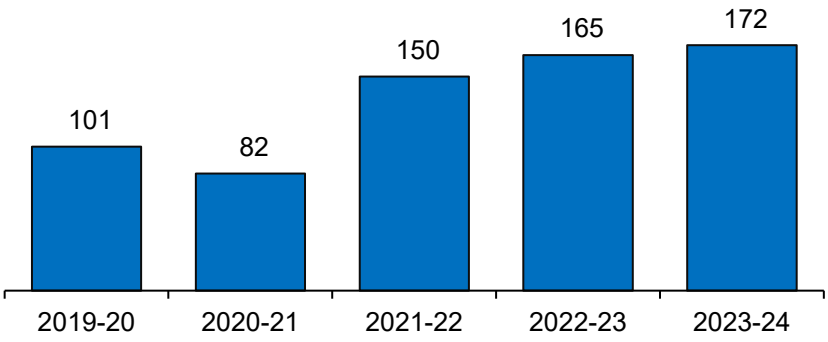


Outcomes achieved

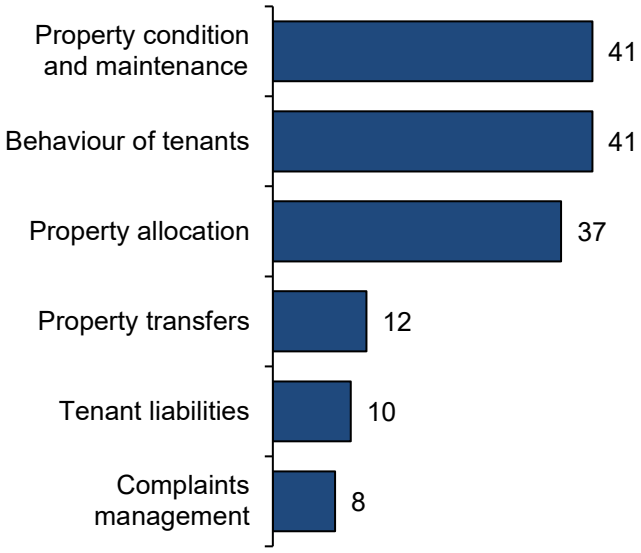
- Financial payment or ‘act of grace’ payment
- Action to replace, repair or rectify a matter
- Consider or reconsider a matter and make a decision
- Action expedited
- Explanation given or reasons provided
- Staff training and discipline.

Public Housing

Complaints received



Most common allegations

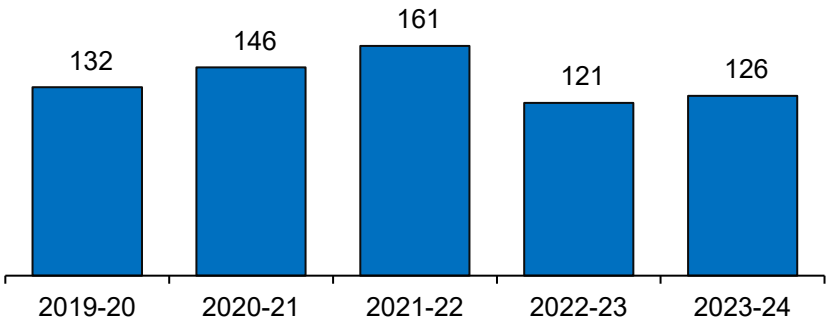


Outcomes achieved

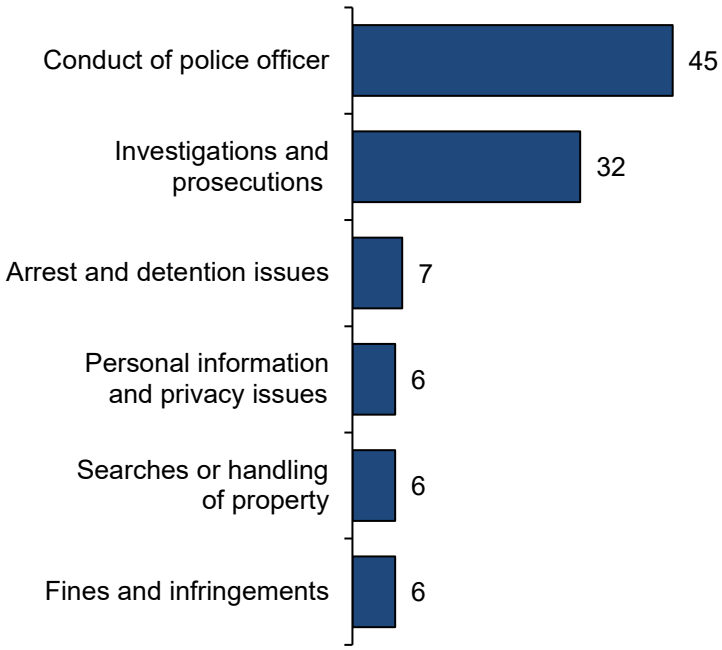
- Monetary charge reduced, withdrawn or refunded
- Action to replace, repair or rectify a matter
- Consider or reconsider a matter and make a decision
- Apology given
- Acknowledgement of error
- Action expedited
- Explanation given or reasons provided
- Senior officer nominated to handle the matter
- Change to business systems or practices
- Staff training.

Police

Complaints received



Most common allegations

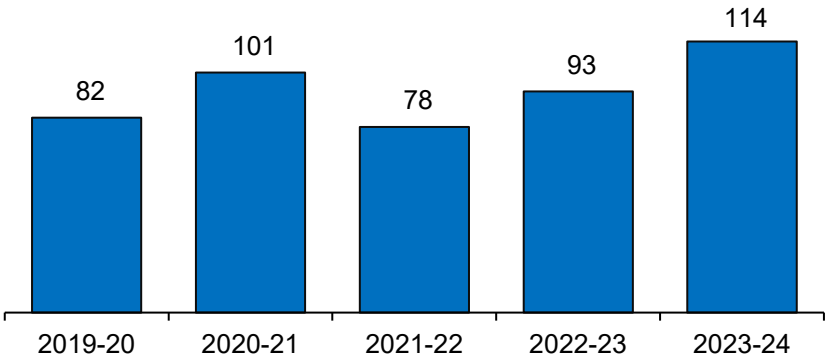


Outcomes achieved

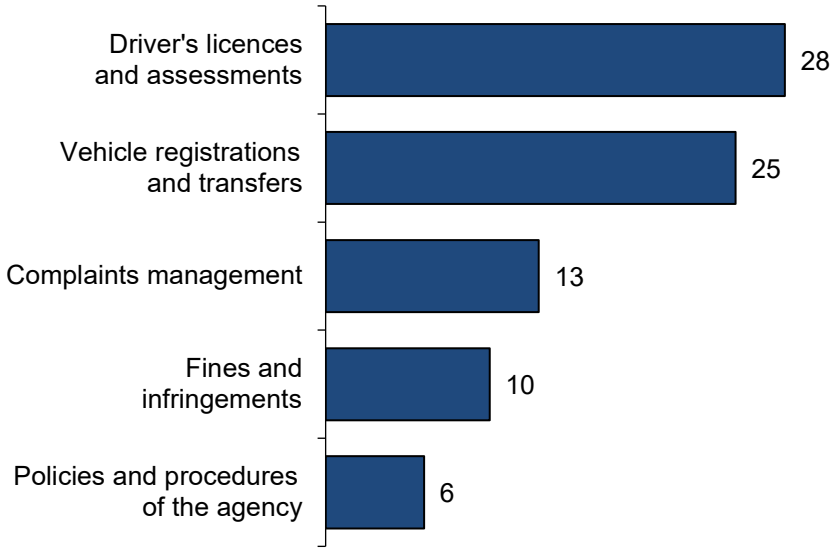
- Apology given
- Action expedited
- Explanation given or reasons provided.

Transport

Complaints received



Most common allegations

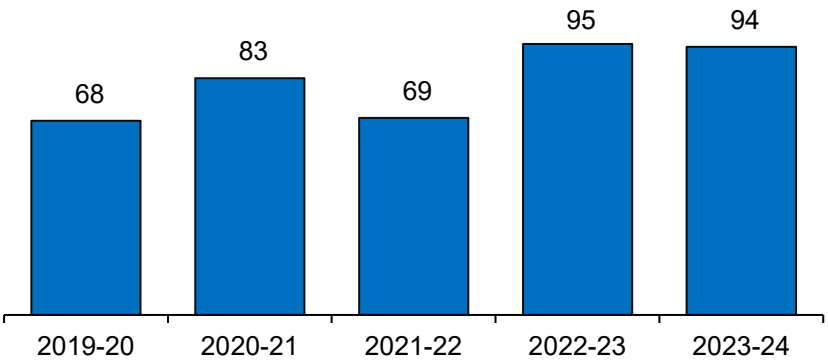


Outcomes achieved

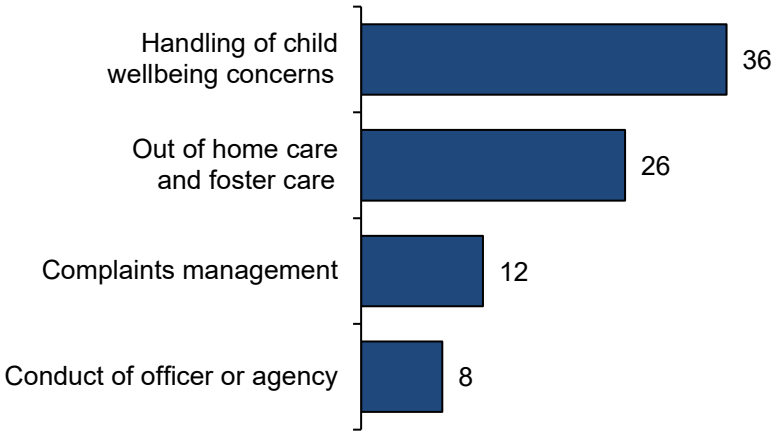
- Monetary charge reduced, withdrawn or refunded
- Apology given
- Acknowledgement of error
- Action expedited
- Explanation given or reasons provided
- Senior officer nominated to handle the matter
- Change to business systems or practices
- Update to publications and websites
- Staff training.

Child Protection

Complaints received



Most common allegations

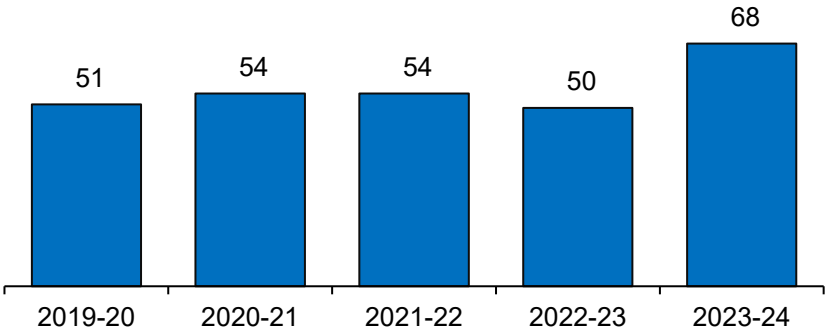


Outcomes achieved

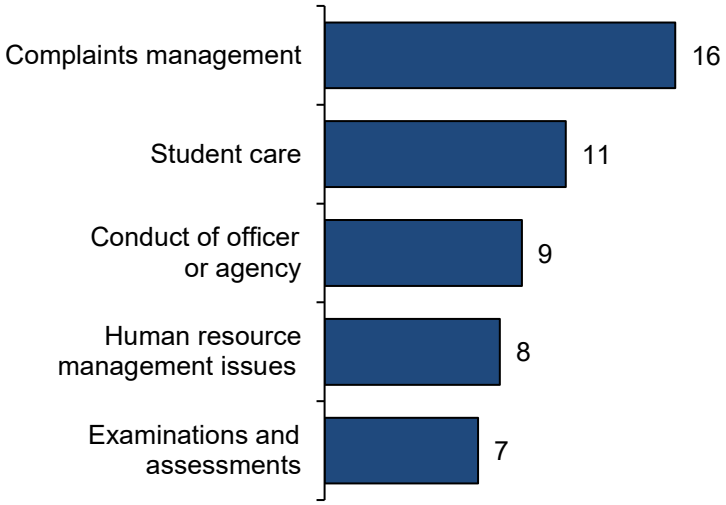
- Consider or reconsider a matter and make a decision
- Apology given
- Acknowledgement of error
- Action expedited
- Explanation given or reasons provided
- Senior officer nominated to handle the matter
- Change to policy or procedure
- Staff training.

Education

Complaints received



Most common allegations



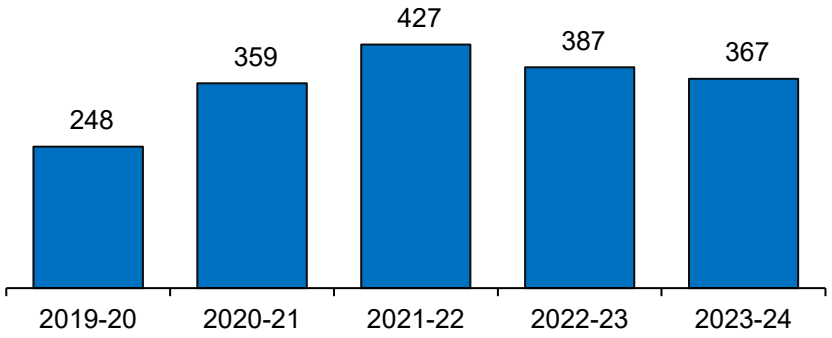
These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2018* relating to TAFE colleges and other public education agencies. Further details on these appeals are included later in this section.

Outcomes achieved

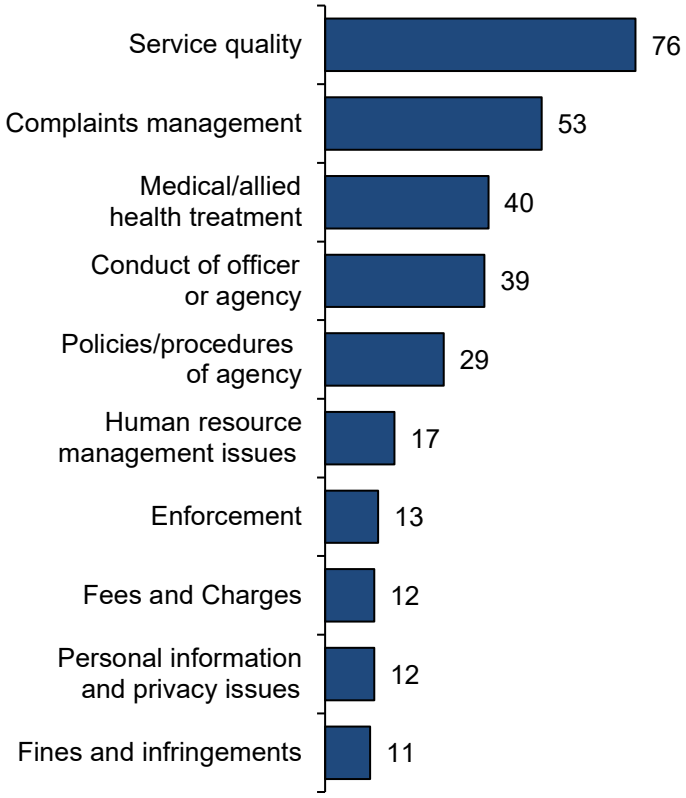
- Action to replace, repair or rectify a matter
- Consider or reconsider a matter and make a decision
- Apology given
- Action expedited
- Explanation given or reasons provided.

Other Public Sector Services

Complaints received



Most common allegations



Outcomes achieved

- Monetary charge reduced, withdrawn or refunded
- Action to replace, repair or rectify a matter
- 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, procedure, business systems or practices
- Conduct audit or review
- Staff training.

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

Case Study

Ombudsman involvement leads to overdue maintenance being completed

A public housing tenant complained to the public authority about maintenance work that had not been completed at their property. The public authority had visited the property to identify the work required and raised work orders with their maintenance contractor, but 12 months later the maintenance issues were still not resolved. The tenant complained to the Ombudsman.

The Ombudsman contacted the public authority about the maintenance delay and requested information about the status of the public authority's work orders. The public authority acknowledged that the maintenance issues had not been resolved in a timely manner and explained it had followed up with the maintenance contractor and visited the property to identify more extensive work to remedy the issues at the property. The Ombudsman requested that the public authority consider further remedies for the tenant in light of the maintenance problems that were not resolved.

The public authority wrote to the tenant to acknowledge that the problems were not resolved in a timely manner, explain the timeframe for completing the outstanding works, and offer a rent credit to acknowledge the inconvenience the tenant experienced.

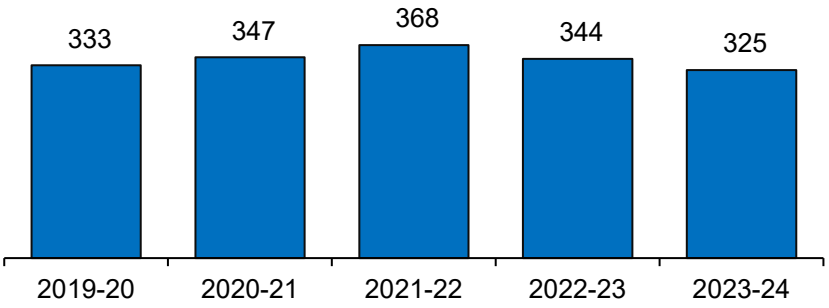
The Ombudsman later followed up with the public authority to confirm that the rent credit had been applied and the maintenance works completed.

The local government sector

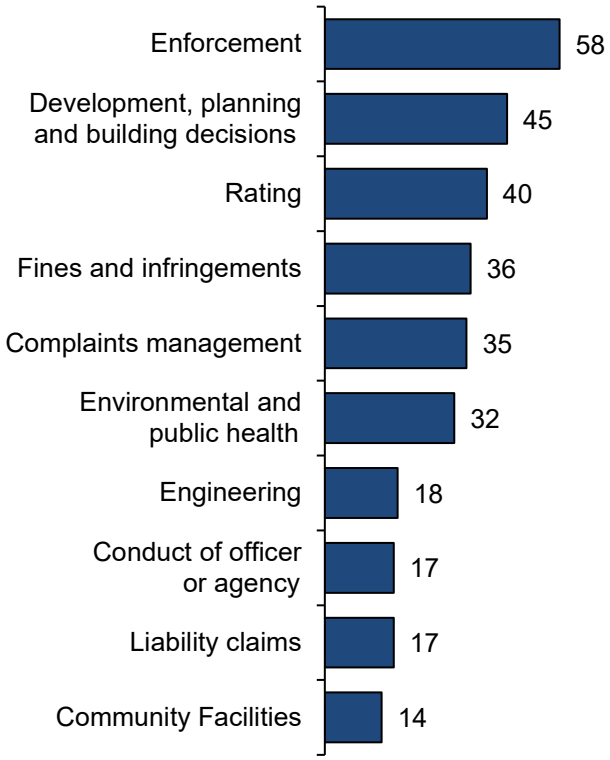
The following section provides further details about the issues and outcomes of complaints for the local government sector.

Local Government

Complaints received



Most common allegations



Outcomes achieved

- Financial payment or monetary charge withdrawn
- Action to replace, repair or rectify a matter
- Consider or reconsider a matter and make a decision
- Apology given
- Action expedited
- Explanation given or reasons provided
- Change to business systems or practices
- Update to publications or websites
- Conduct audit or review
- Improved record keeping
- Staff training.

Case Study

Local government apologises and improves process for development consultation

A resident contacted their local government about a neighbouring development. The resident complained that the local government had not responded to their concerns about the development, which they raised as part of the local government's community consultation. The resident also complained that the development was encroaching on their property and the local government was not taking adequate enforcement action. The local government did not provide a response that was satisfactory to the resident, so the resident complained to the Ombudsman.

The Ombudsman contacted the local government, which said it was still investigating the resident's concerns. The Ombudsman referred the complaint to the local government for it to respond directly to the resident and inform the Ombudsman what actions it takes in response to the complaint.

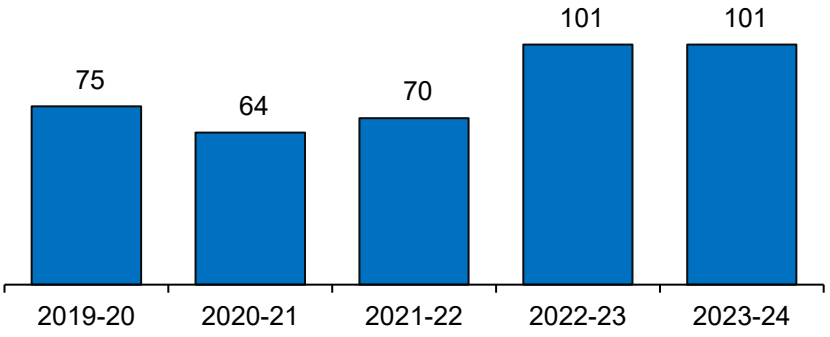
The local government wrote to the resident to explain that the concerns the resident raised during community consultation on the development were considered and some adjustments were made by the developer. The local government acknowledged that it did not provide the resident with notice of the outcome of the consultation and apologised for the oversight. The local government also amended its systems to ensure that people who make submissions are notified of the outcome as part of the development assessment process. The local government continued to work with the builder in relation to the encroachment on the resident's property.

The university sector

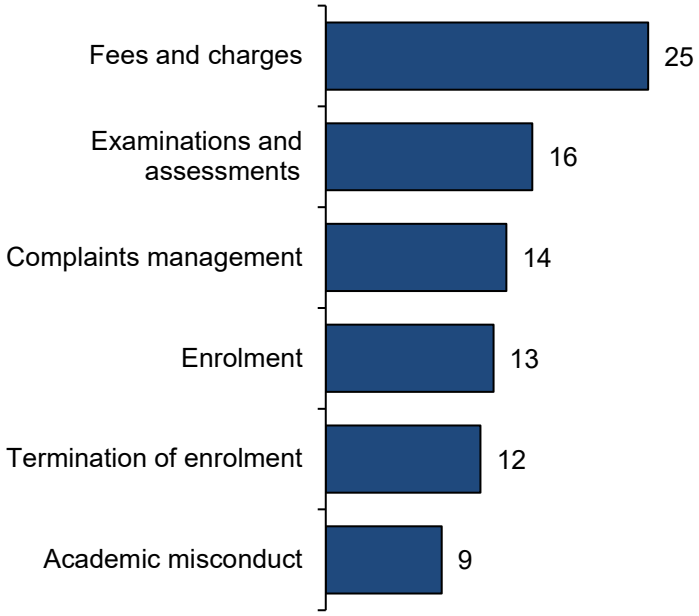
The following section provides further details about the issues and outcomes of complaints for the university sector.

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, withdrawn or refunded
- Action to replace, repair or rectify a matter
- Consider or reconsider a matter and make a decision
- Action expedited
- Change to policy or procedure
- Conduct audit or review
- Improved record keeping
- Staff training.

Case Study

Fees waived after university incorrectly awarded advanced standing

A student completed units of a degree at one university and then transferred to another university. The second university awarded the student advanced standing, which is recognition for prior learning, and the student completed their degree. The student subsequently applied for registration with the professional practice governing body, however their registration was rejected on the basis that the units completed at the first university did not provide full coverage of the subjects. The student contacted the second university about the advanced standing being incorrect resulting in a degree that did not meet the requirements for registration.

The university worked with the student to enrol them in two units to cover the relevant subjects. The student requested a fee waiver for the units, which the university granted. The university also clarified the registration requirements with the professional practice governing body and implemented new administrative processes to ensure future awards of advanced standing meet the requirements for registration.

The student commenced the final unit required to meet registration requirements and again applied for the fees to be waived. The university declined the request. The student complained to the university, which upheld its decision. The student then complained to the Ombudsman.

The Ombudsman commenced an investigation and requested a report from the university along with evidence to support its position. The Ombudsman considered whether the university's decision to decline a fee waiver for the final unit was reasonable, considering that the university acknowledged it had awarded advanced standing incorrectly and granted a fee waiver the other affected units. The university subsequently decided to waive the fees for the unit as a goodwill gesture to settle the matter.

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 that 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:

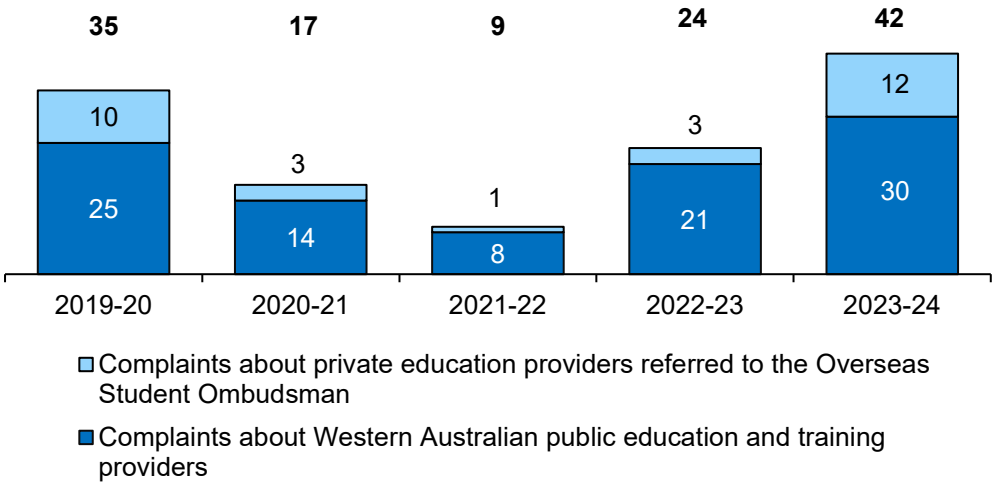
- Provides a free complaint resolution service;
- Is independent and impartial and does not represent either the overseas students or education and training providers; and
- Can make recommendations arising out of investigations.

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 2019-20 and 2023-24



During 2023-24, the Office received 42 complaints from overseas students, including 30 complaints about public education and training providers. All of the 30 complaints about public education providers within the Ombudsman's jurisdiction were about universities. The Office also received 12 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 30 complaints by overseas students about public education and training providers involved 30 separate allegations, relating to:

- Fees and charges (13);
- Termination of enrolment (8);
- Enrolment issues (4)
- Handling of academic misconduct allegations (2);
- Examinations and assessments (2); and
- Other issues (1).

During the year, the Office finalised 30 complaints by overseas students about public education and training providers.

Case Study

University provides refund to overseas student following Ombudsman involvement

An international student was enrolled in units of study with a university but did not complete all assessments and received a grade of zero for the units. The student requested a refund of their tuition fees as their medical circumstances made it difficult for them to complete the units.

The university considered the request but rejected it on the basis that the medical circumstances were pre-existing and known to the student before the census date, which is the cut-off date to be able to withdraw from units and obtain a refund. The university said that it had already made adjustments to accommodate the student's medical circumstances and help them complete the units. The university said that there was no evidence that the student's ability to complete the units had changed after the census date.

The student appealed the university's decision and provided more information about difficulties accessing support services and a further medical certificate with more information about the student's circumstances. The university confirmed its original decision. The student then complained to the Ombudsman.

The Ombudsman commenced an investigation and requested a report and evidence from the university. The university further reviewed the case, and considering all the evidence and the student's circumstances, changed its position and agreed that the student had been impacted by their medical circumstances after the census date. Accordingly, the university provided a refund to the student.

Charitable Trusts

On 21 November 2022, the Ombudsman commenced an important new function as the Western Australian Charitable Trusts Commission (**WACTC**) following the commencement of the *Charitable Trusts Act 2022* (**CT Act**).

Complaints may be made directly to the Ombudsman as the WACTC or matters may be referred to the Ombudsman by the Attorney General for investigation.

Charitable trusts play a significant role in the Western Australian Aboriginal community as they are utilised to hold mining royalties and native title settlement funds.

Role of the Ombudsman as the Western Australian Charitable Trusts Commission

The role of the Ombudsman, as WACTC, is set out in Section 30 of the CT Act, and is to:

(a) conduct investigations, including audits of the accounts of charitable trusts under investigation;
(b) make an investigator's report on each investigation; and
(c) make recommendations to the trustees of charitable trusts in respect of matters arising out of investigations.

The Ombudsman is afforded specific powers under the CT Act as well as being able to rely on existing powers under the *Parliamentary Commissioner Act 1971* which includes the powers, rights and privileges of a Royal Commission.

The CT Act also provides the Ombudsman with specific investigative powers, including the power to issue a notice requiring a person to provide a document or information relating to a charitable trust or concerning any person involved in the administration of a charitable trust.

The Ombudsman must prepare a report on an investigation and that report must be provided to the Attorney General. The report may be accompanied by a notice for a trustee to take reasonably necessary action(s) in a specified timeframe. Failure to comply with a notice and take those actions is grounds for the removal of the trustee.

Complaints and enquiries received

From 1 July 2023 to 30 June 2024, the Office received:

- Three enquiries about Charitable Trusts; and
- Two complaints about Charitable Trusts.

Of the two complaints received, one was resolved by the Office during 2023-24. Two charitable trusts investigations remained ongoing.

If a complaint is outside the Ombudsman's jurisdiction, where possible, the Office provides the complainant with contact details for other State and Commonwealth regulators who may be able to assist with their complaint.

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*.

There were no public interest disclosures received during the year.

Indian Ocean Territories

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

Terrorism

The Ombudsman can receive complaints from a person detained under the *Terrorism (Preventative Detention) Act 2006* about administrative matters connected with their 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 2023-24, three reviews were undertaken, representing 0.1 per cent of the total number of complaints finalised by the Office. In all cases, the original decision was upheld.

Stakeholder Liaison

The Office liaised with a range of agencies in relation to complaint resolution in 2023-24, including:

- Department of Communities;
- Department of Education; and
- Various prisons.

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:

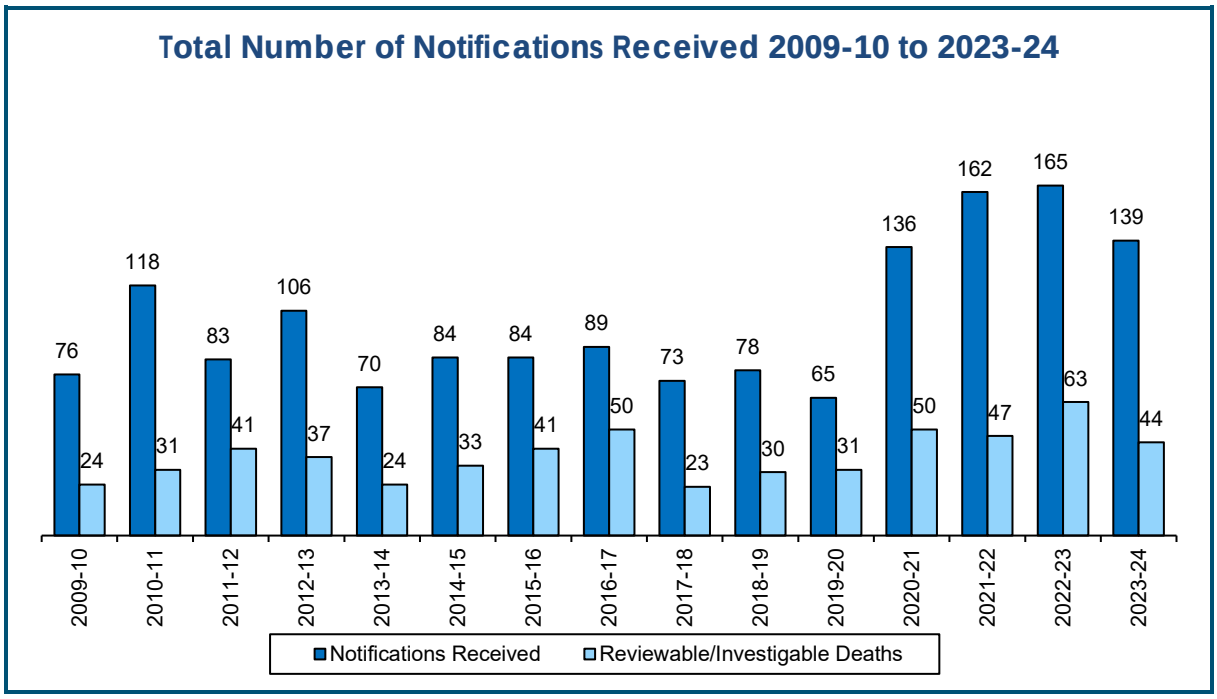
- The number of child death notifications and reviews;
- The comparison of investigable deaths over time;
- Demographic information identified from child death notifications;
- Circumstances in which child deaths have occurred;
- Social and environmental factors associated with investigable child deaths;
- 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

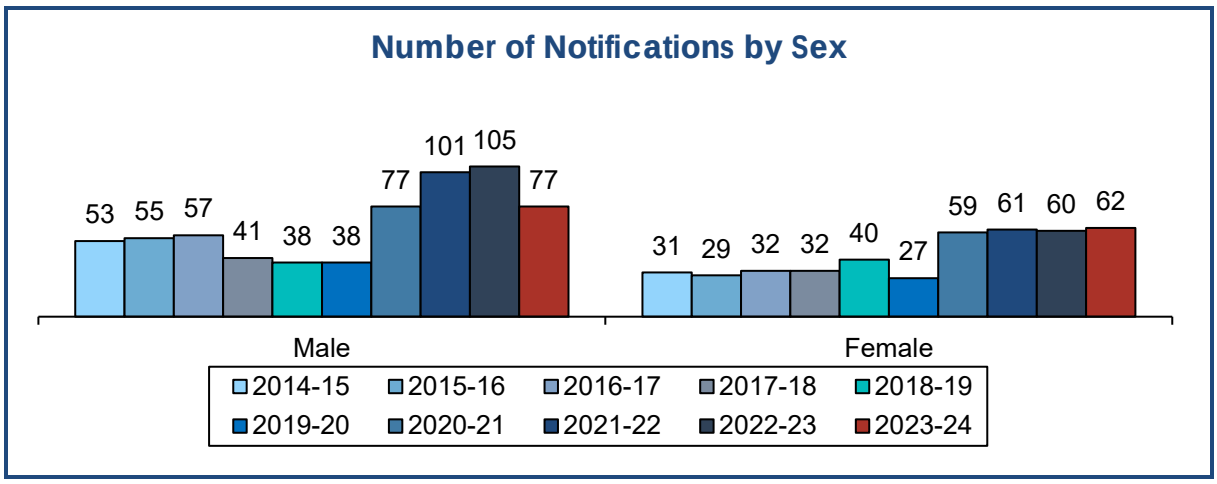
Information is obtained on a range of characteristics of the children who have died including sex, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

The following charts show:

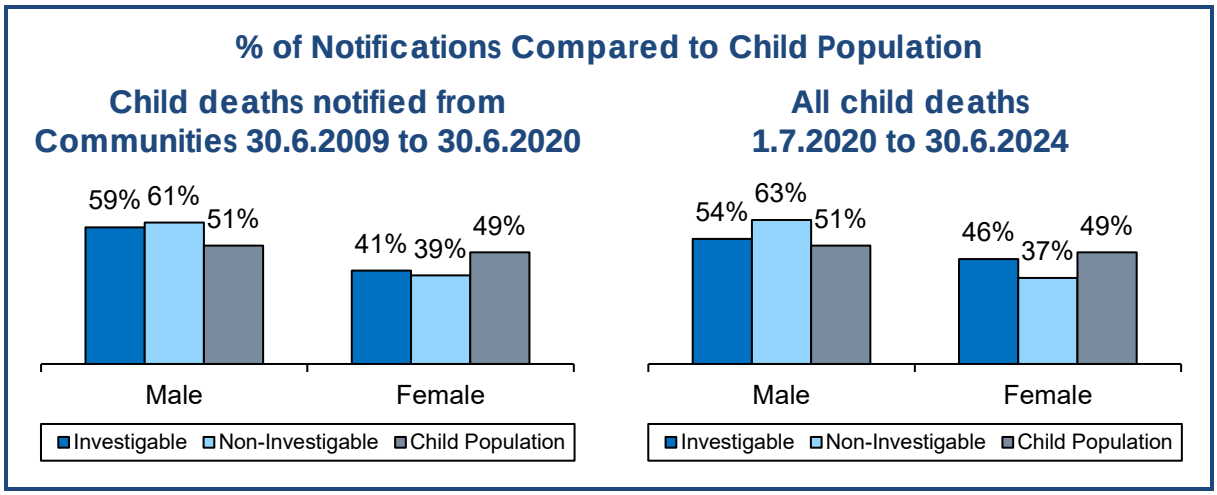
- The number of children in each group for each year for the last 10 years.
- The percentage of children in each group for both investigable deaths and non-investigable deaths, compared to the child population in Western Australia,
    - for the period from 30 June 2009 to 30 June 2020, when the Ombudsman 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.



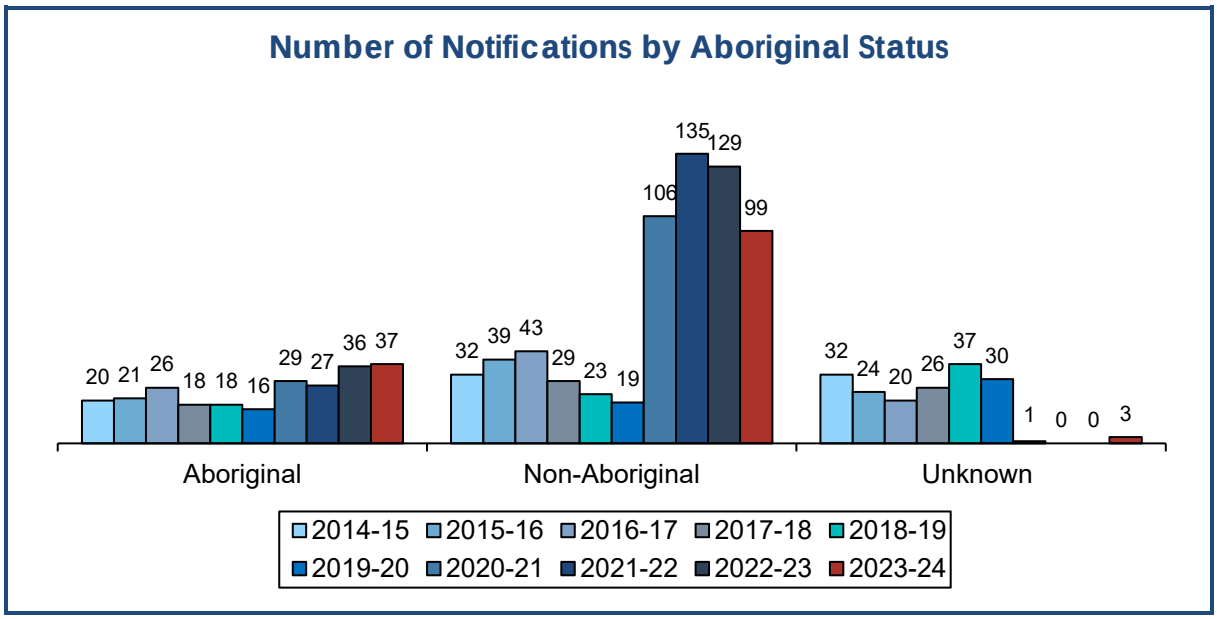
Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



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.

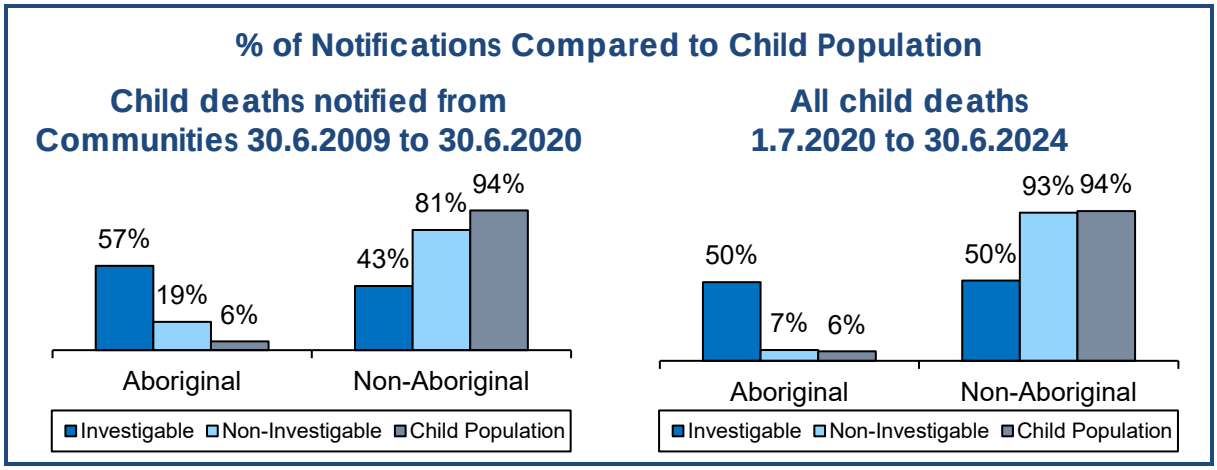
Aboriginal status

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.

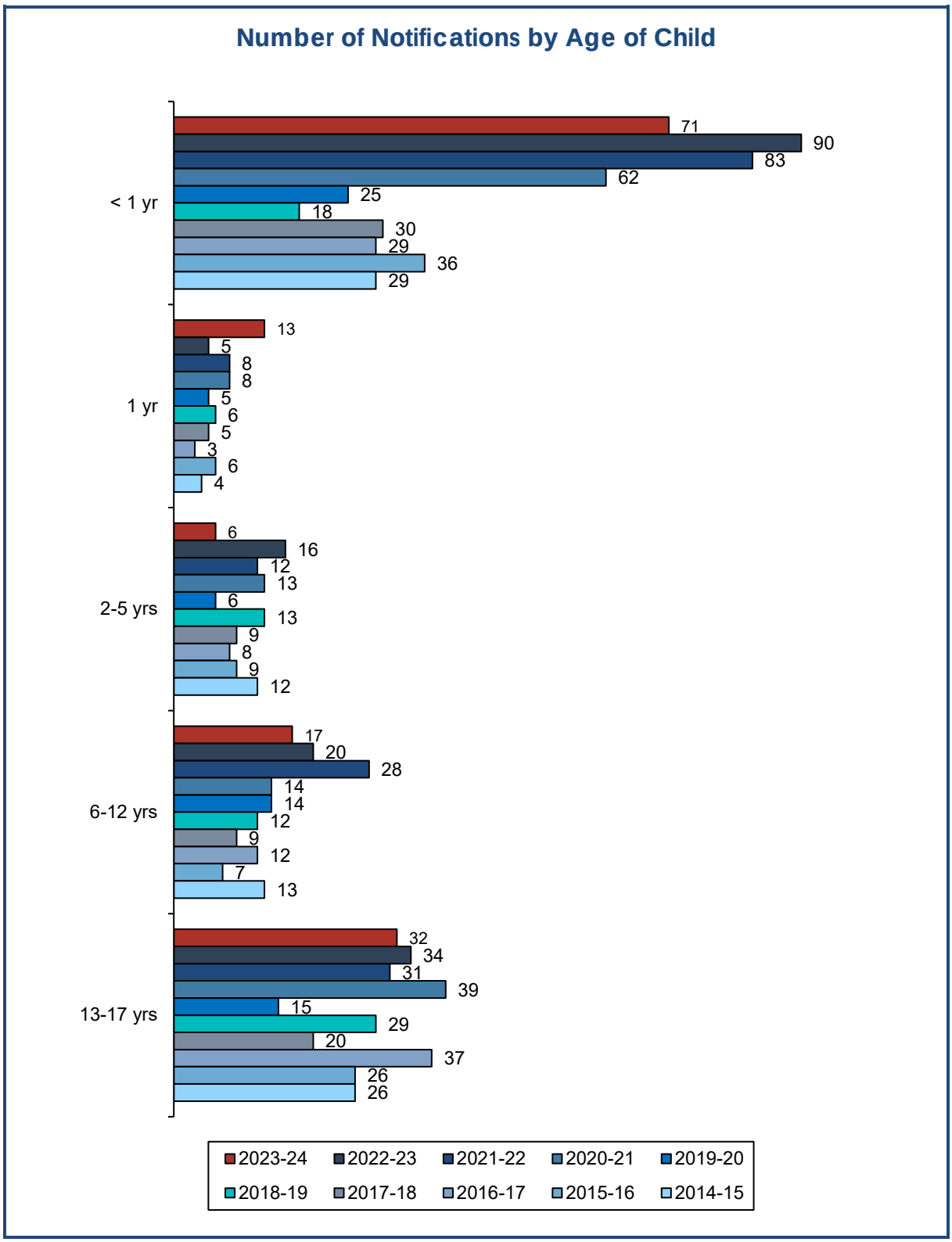


Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported because further information may become available on the Aboriginal status of the child during the course of a review.

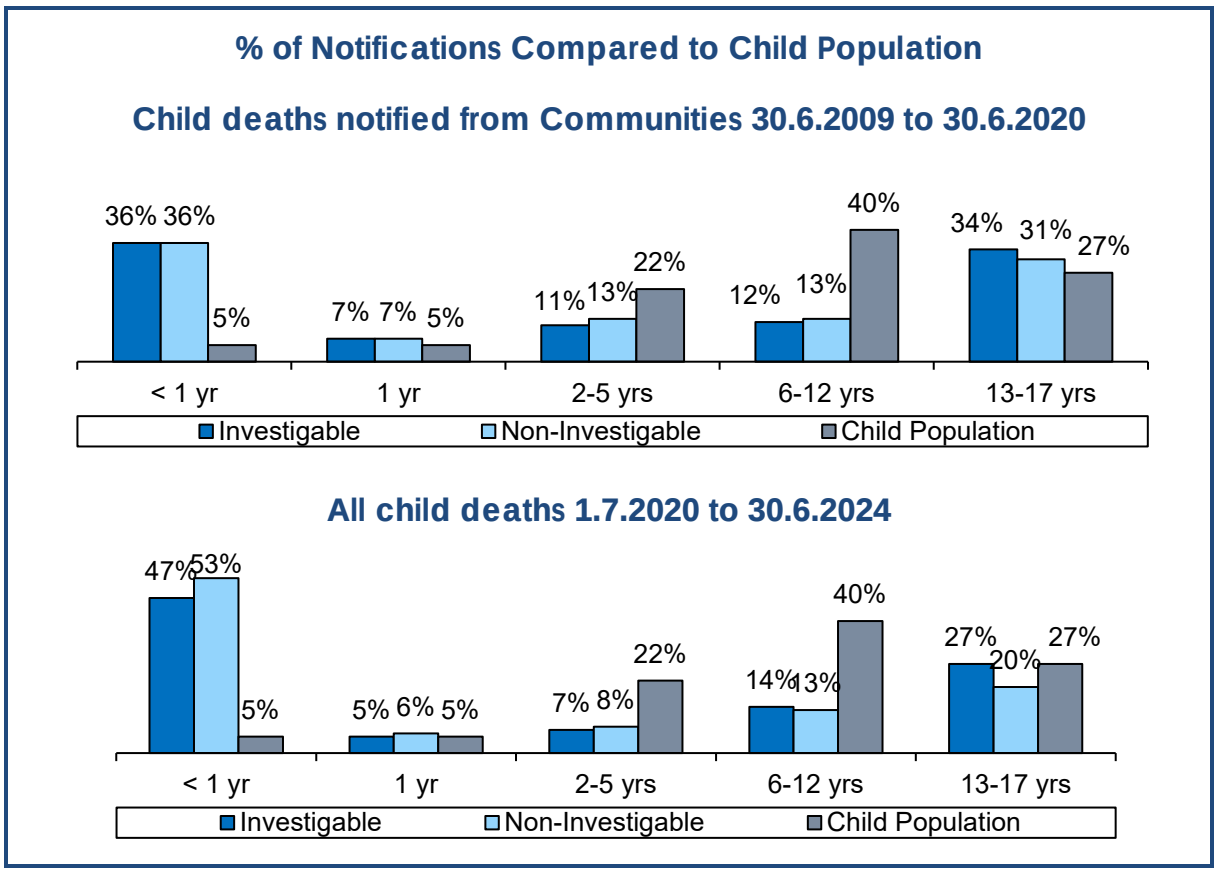
Further analysis of the data shows that Aboriginal children are more likely than non-Aboriginal children to be under the age of one and living in regional and remote locations.

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.

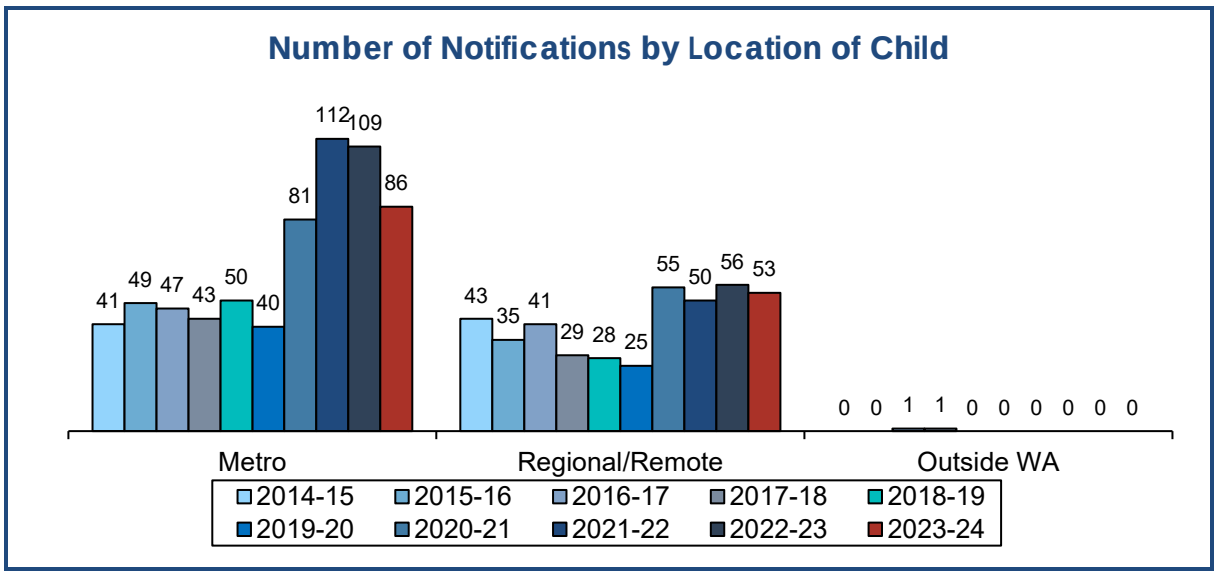


Note: Percentages may not add to 100 per cent due to rounding.

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

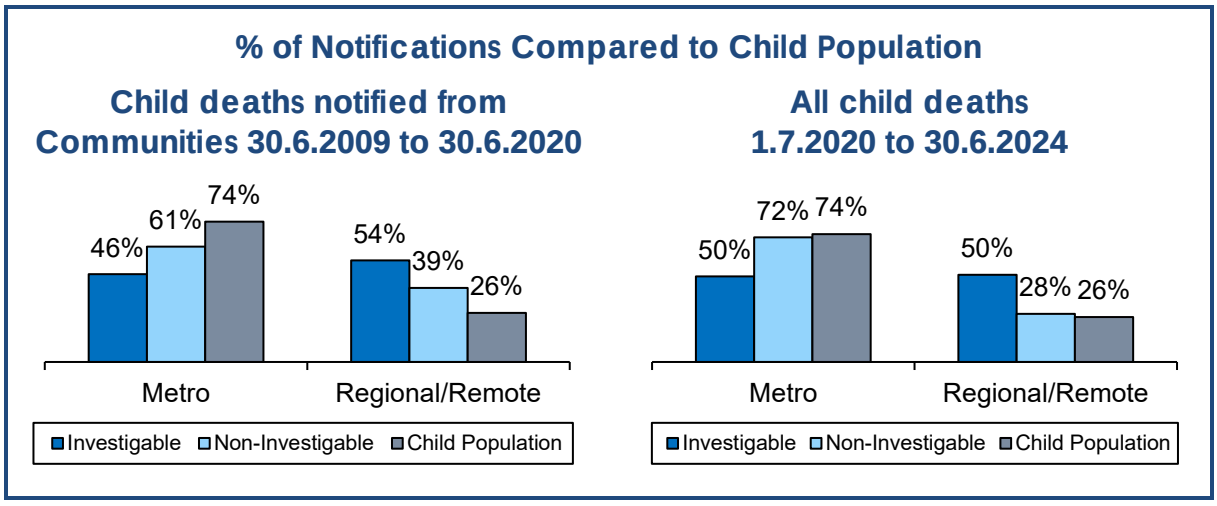
Location of residence

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.



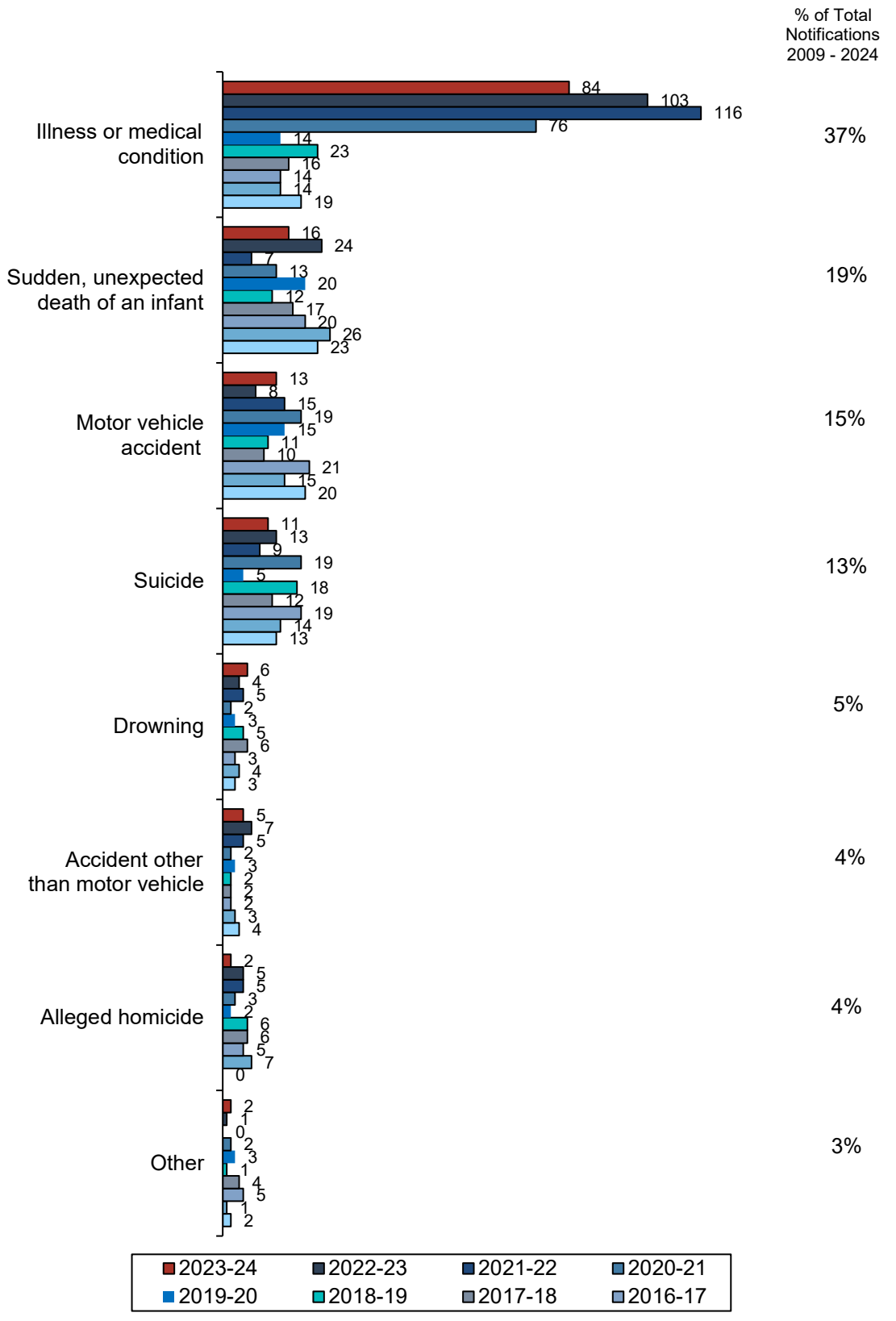
Further analysis of the data shows that 72% of Aboriginal children who died were living in regional or remote locations when they died. Most non-Aboriginal children who died lived in the metropolitan area but the proportion of non-Aboriginal children who died in regional areas (30%) is higher than would 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%).

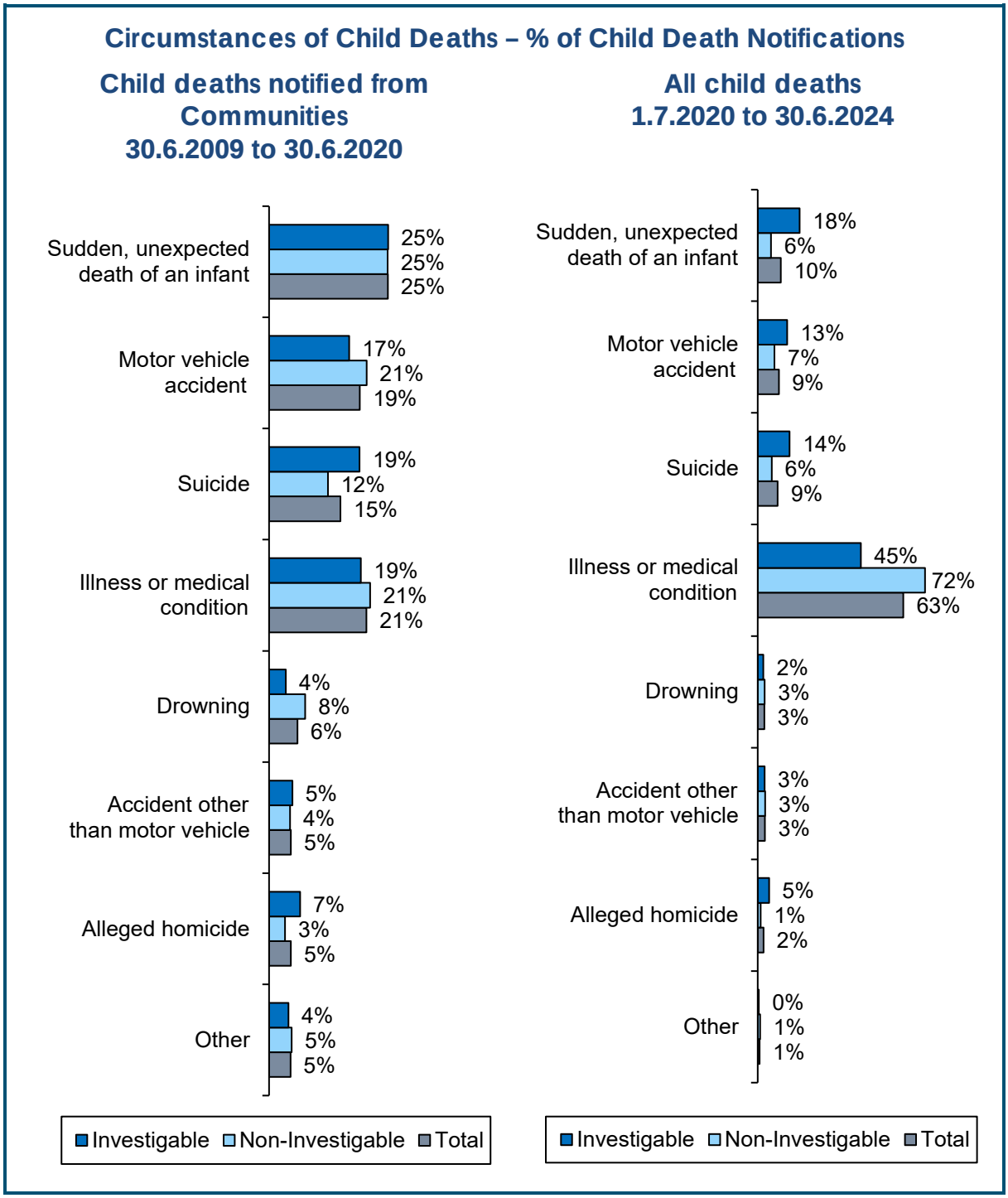
For the period 30 June 2009 to 30 June 2020, when the Ombudsman received notifications from Communities about child deaths reported to the Coroner, the main circumstances of death were:

- 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

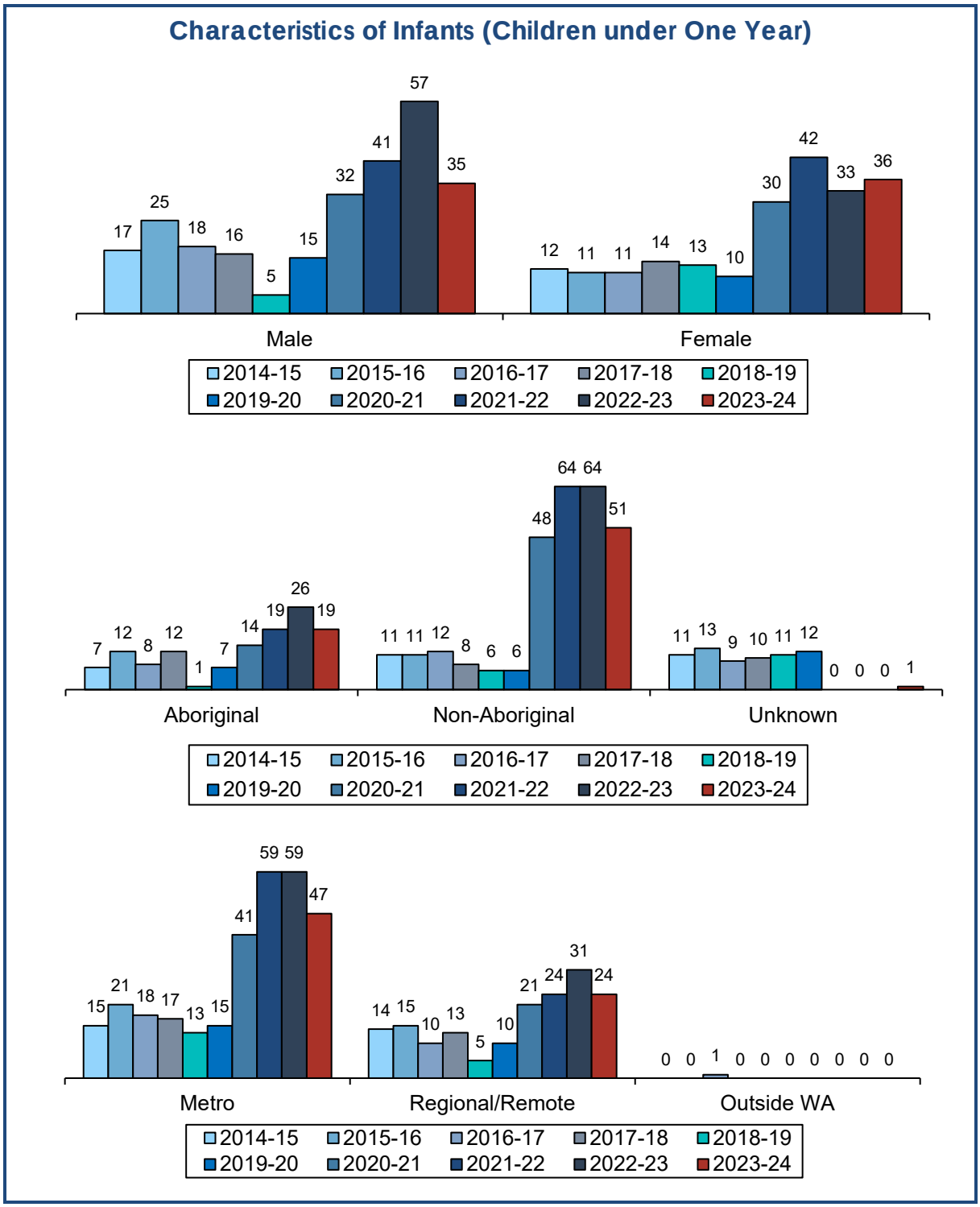
In child deaths notified to the Ombudsman in 2023-24, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

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.

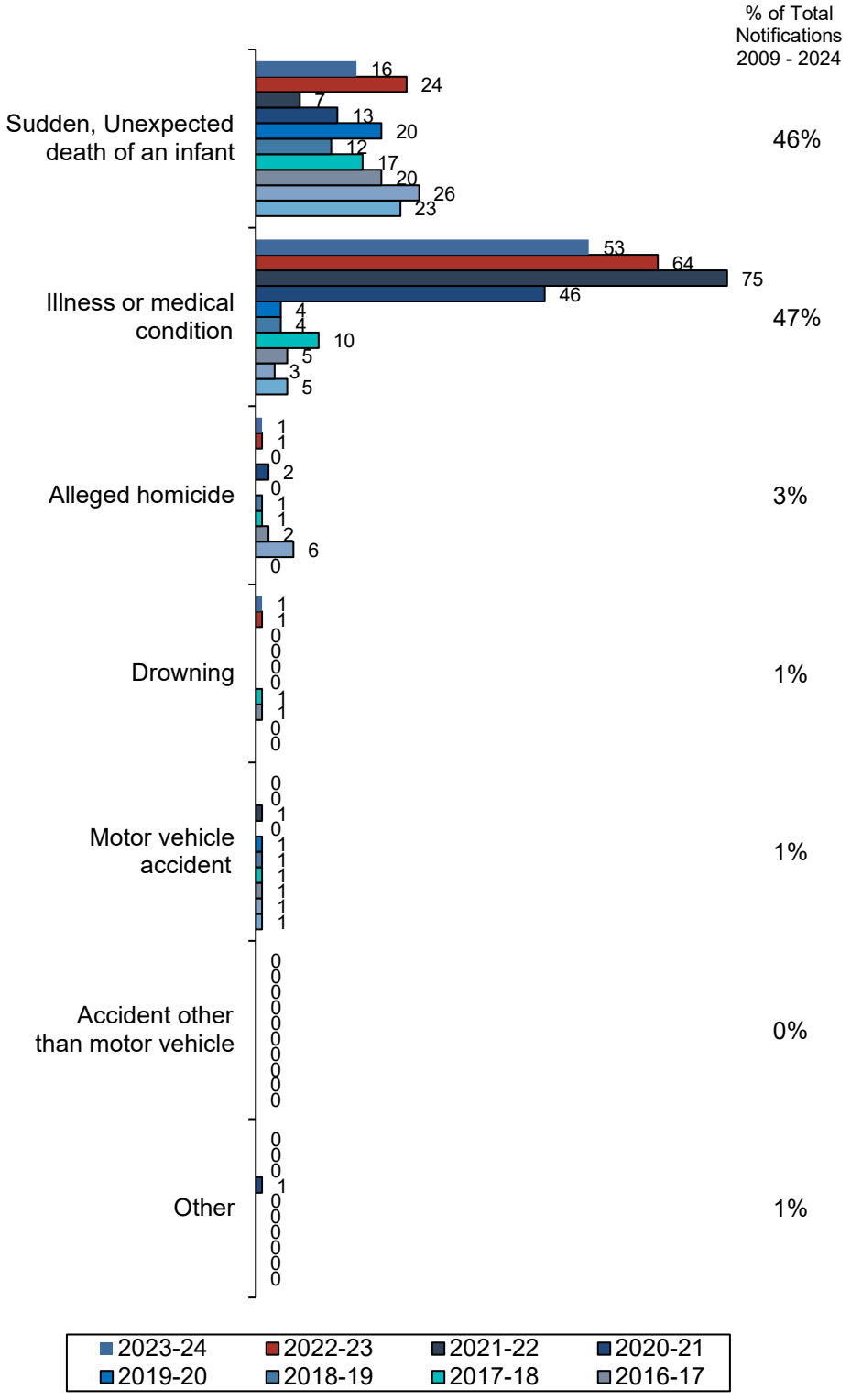
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

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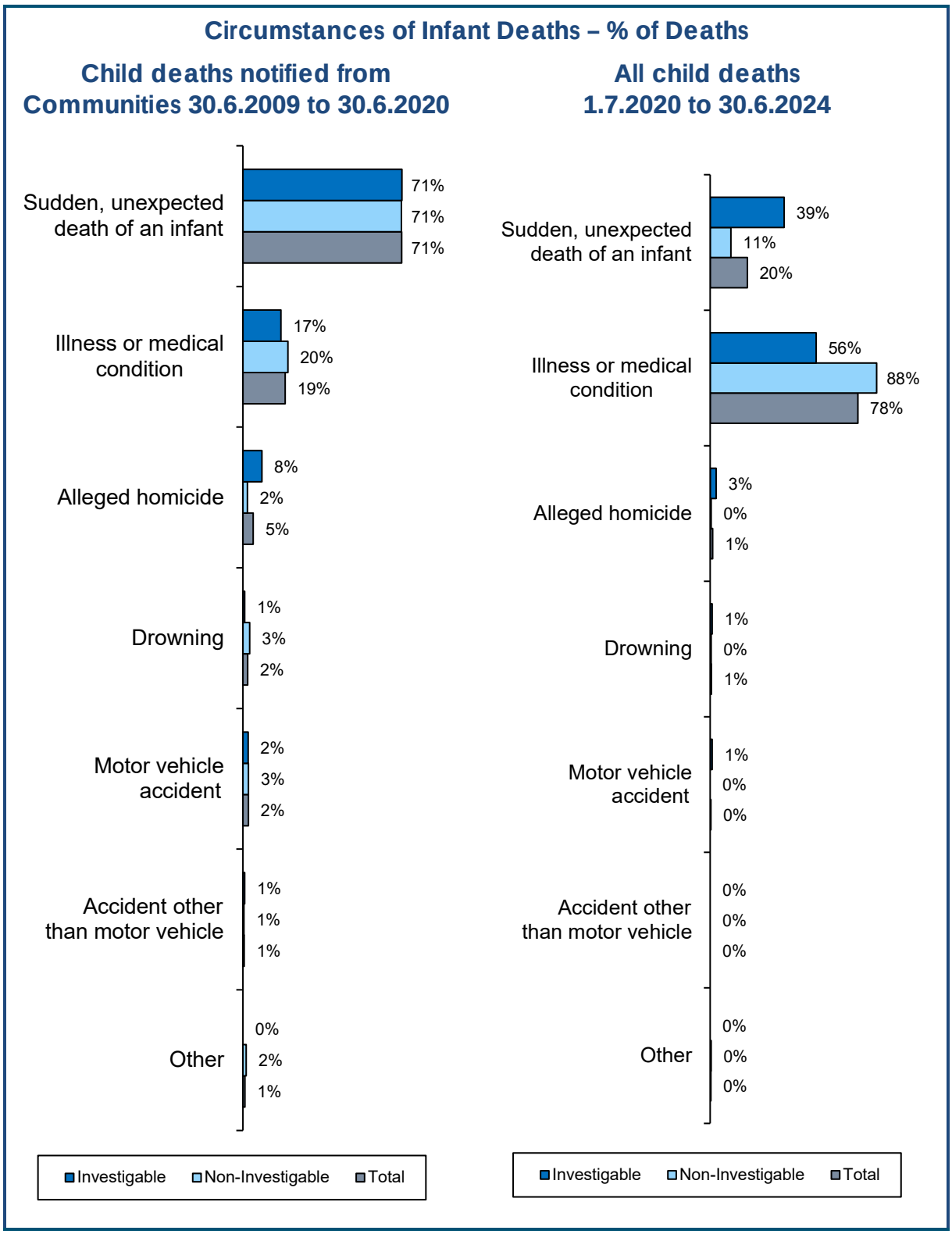
Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.



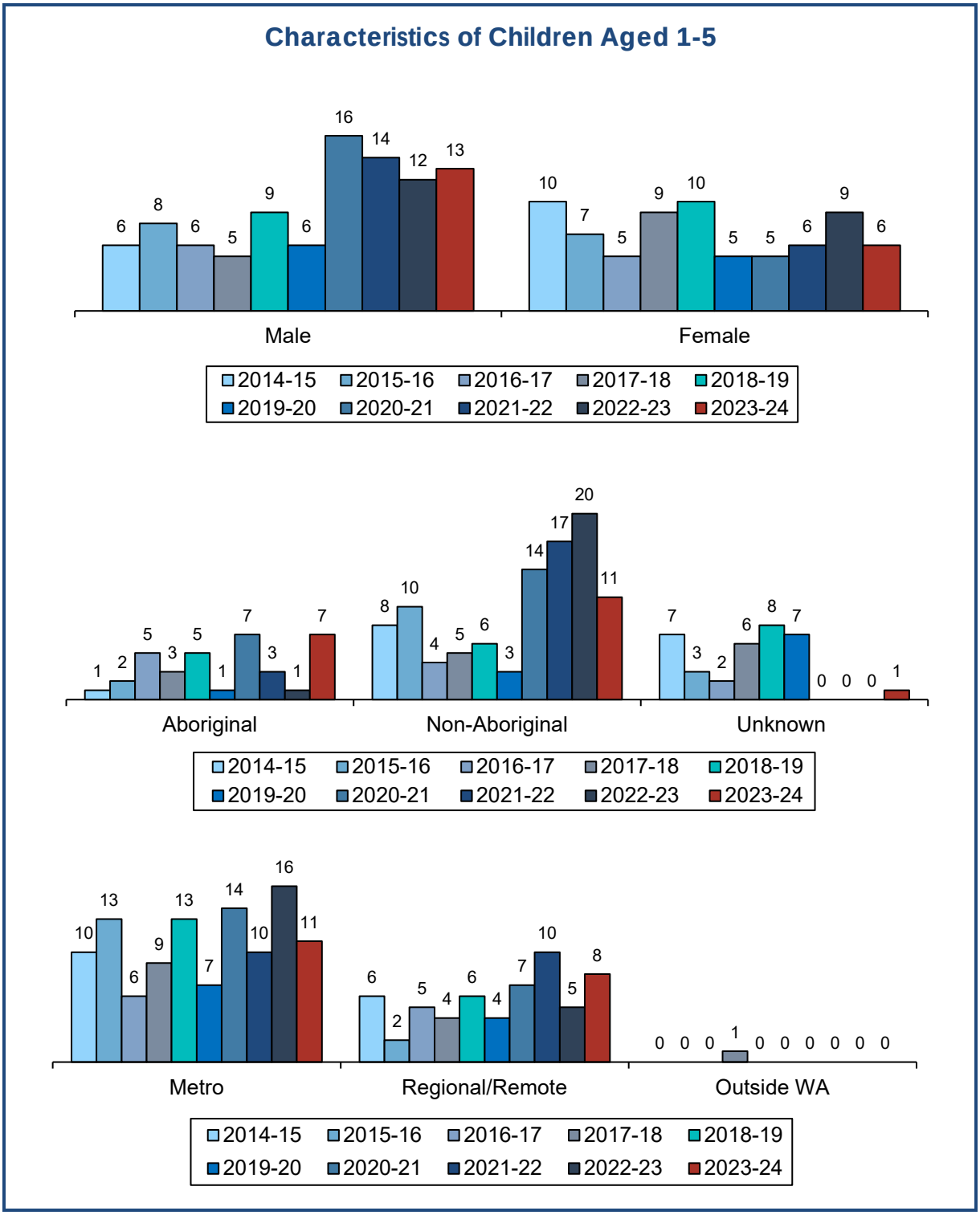
Note: Percentages may not add to 100 per cent due to rounding.

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.



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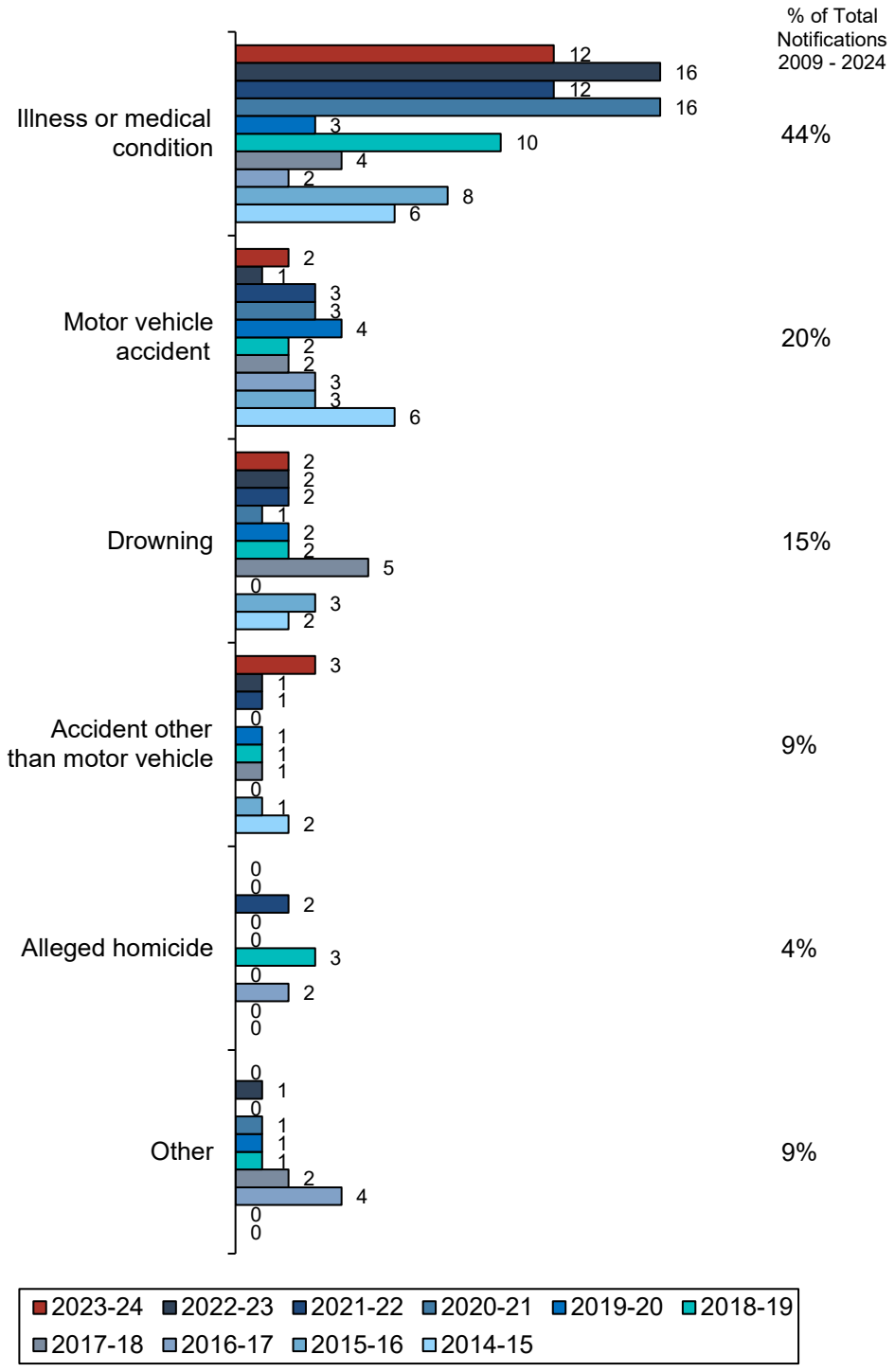
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

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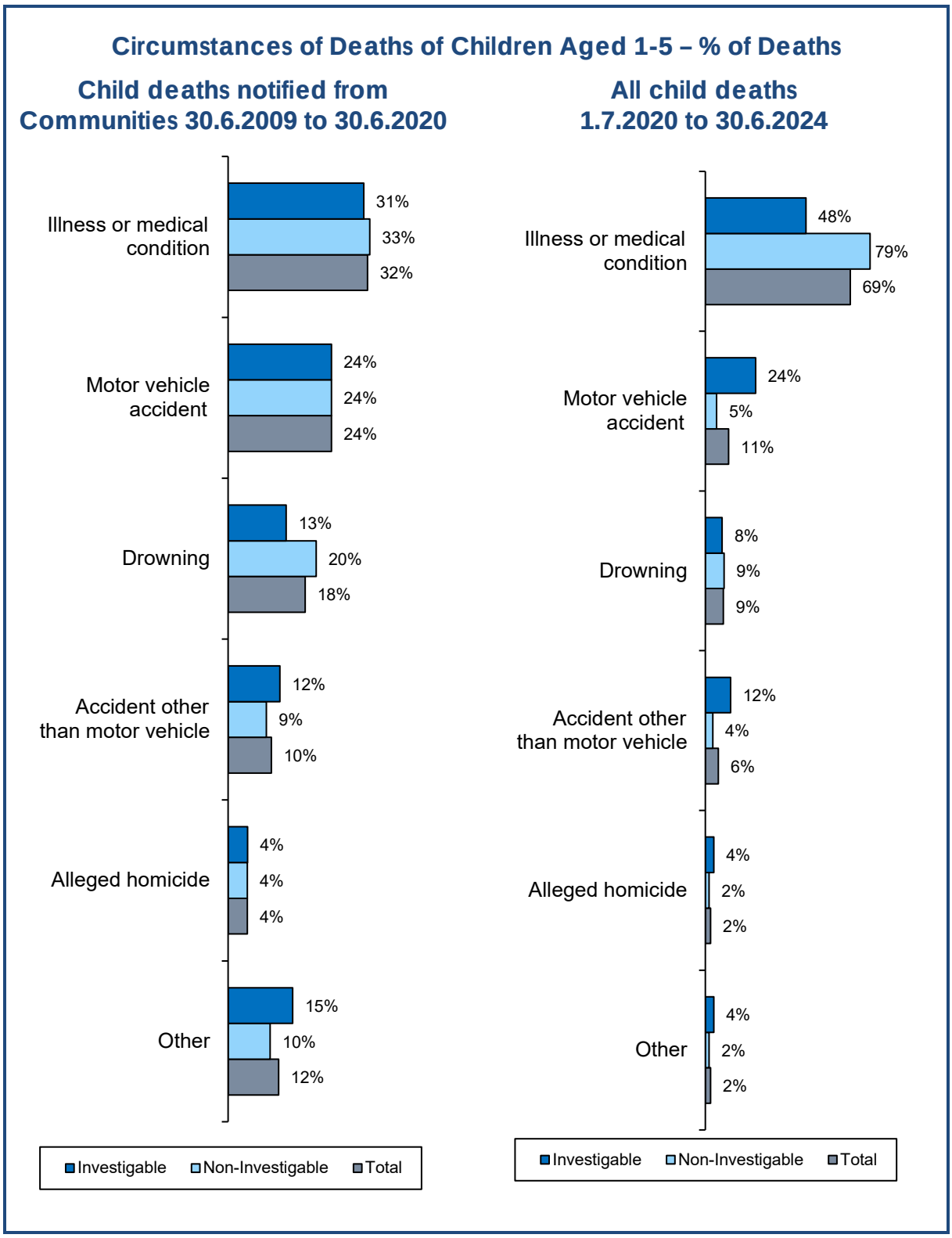
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

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.



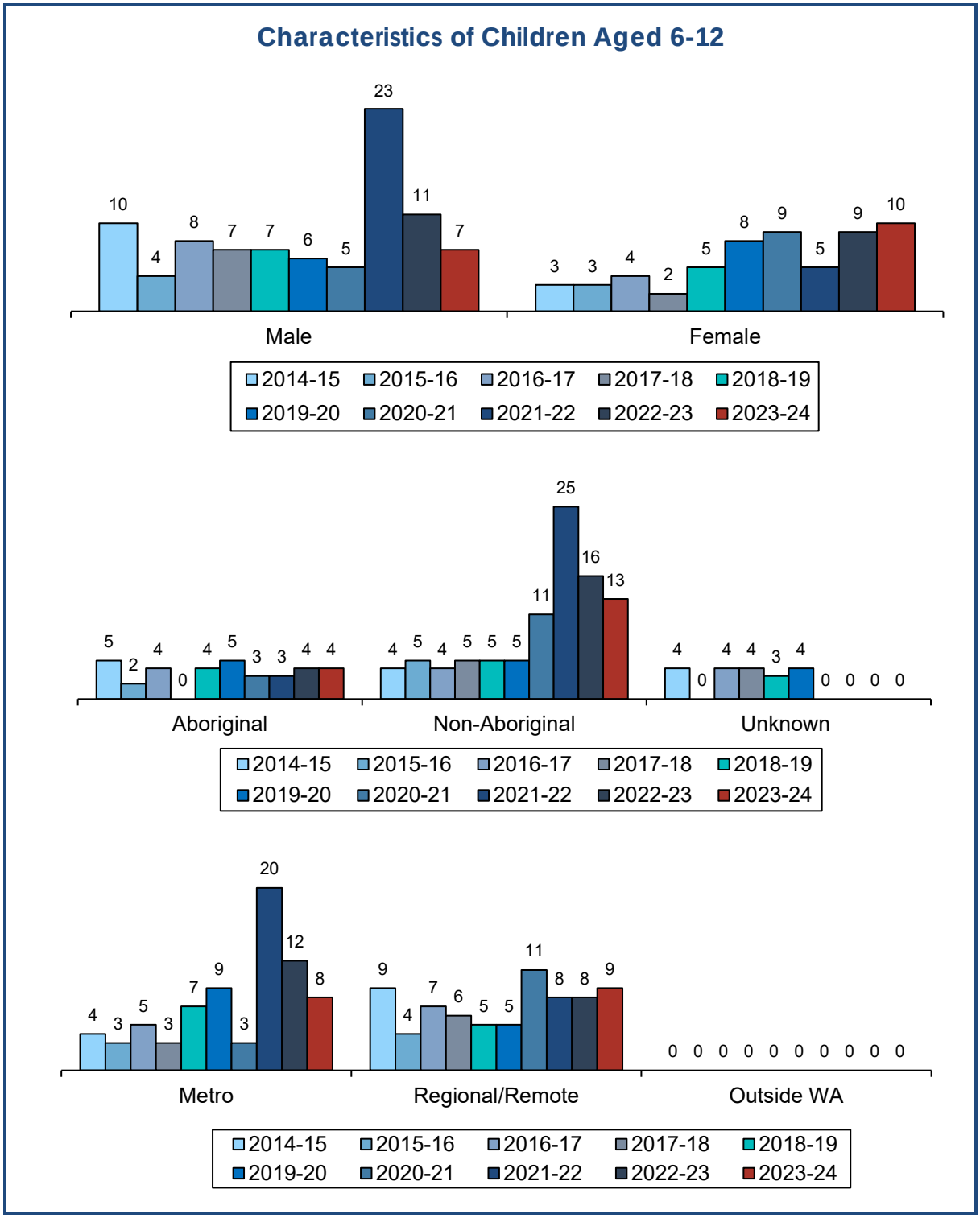
Note: Percentages may not add to 100 per cent due to rounding.

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.



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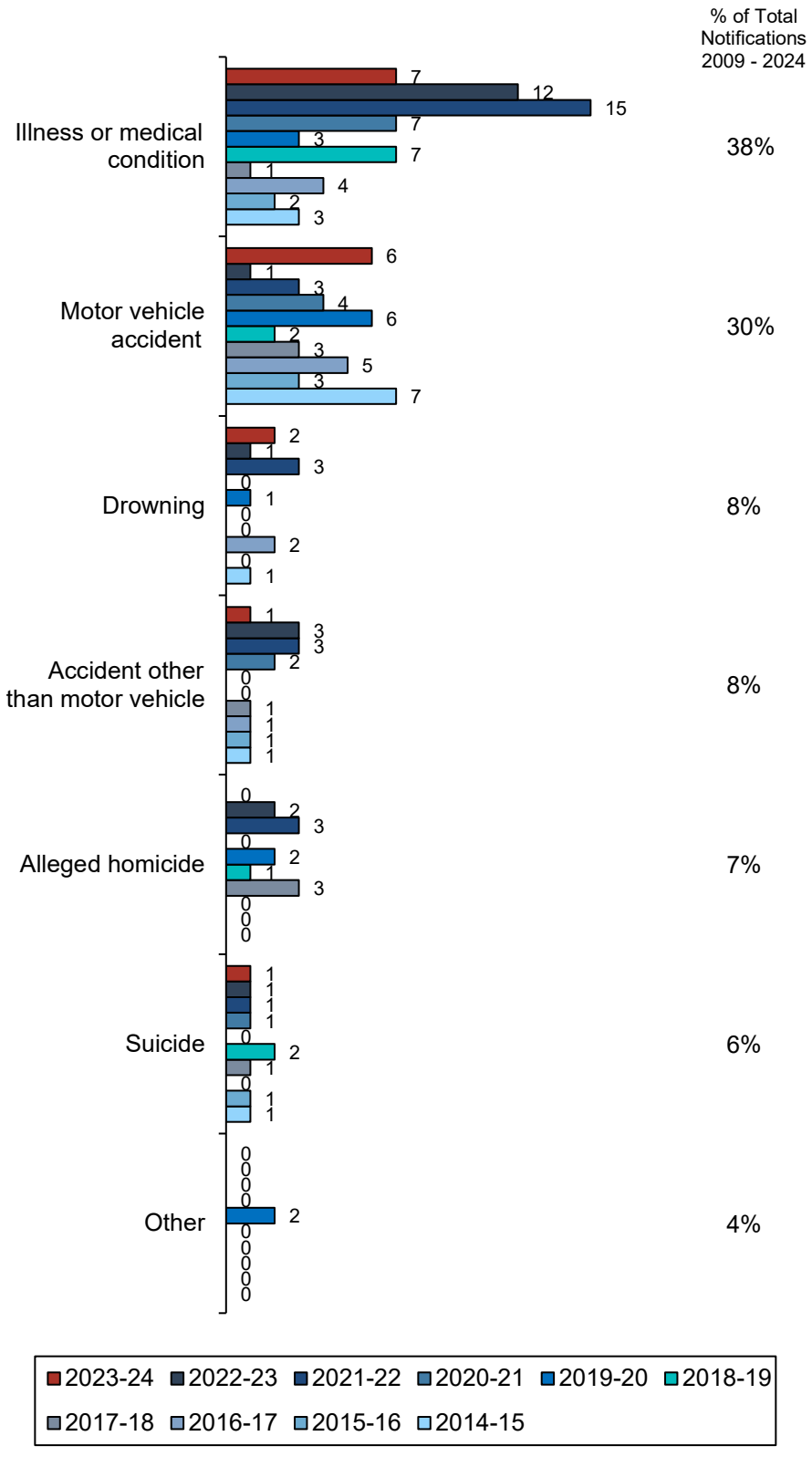
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

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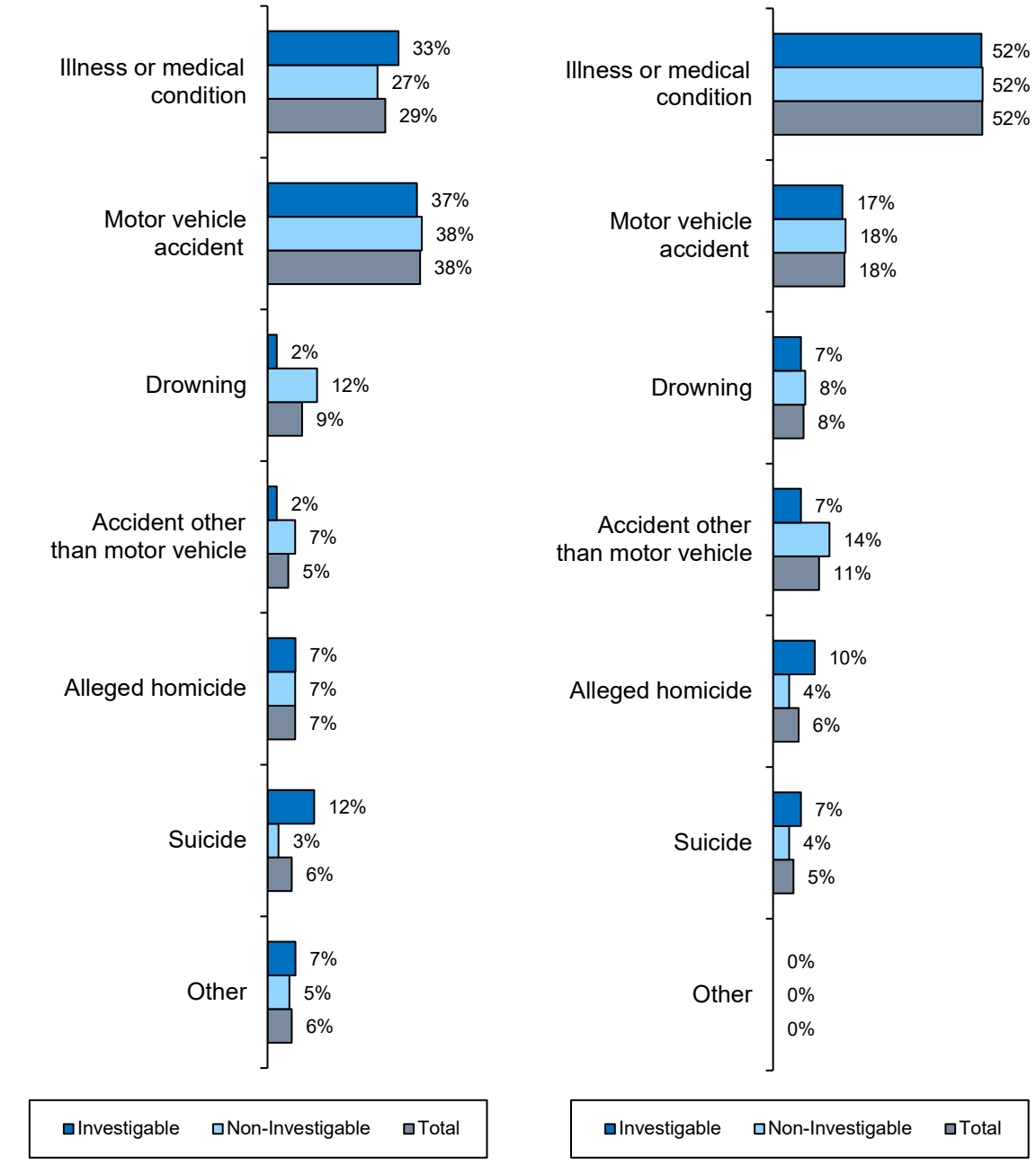
Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.

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



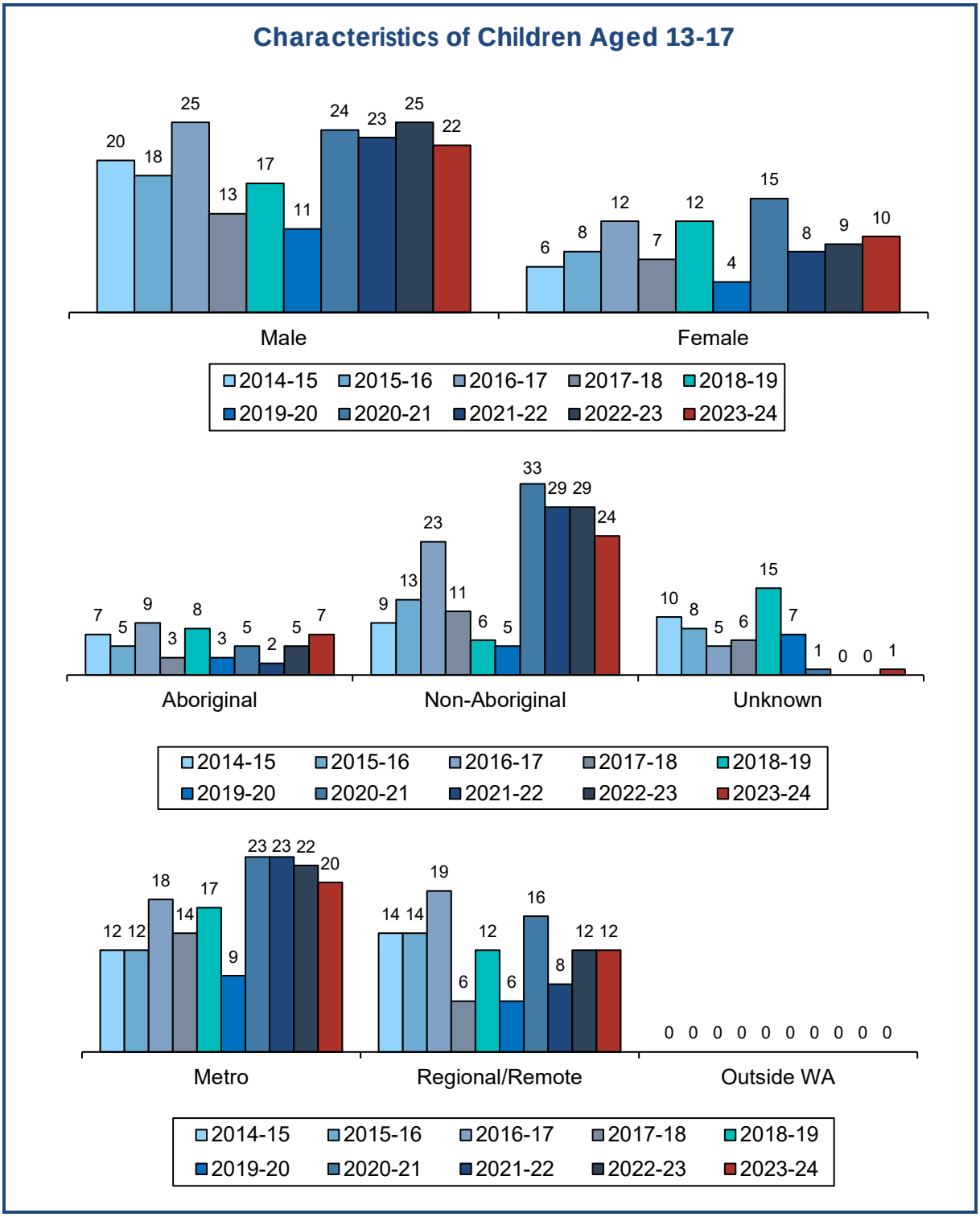
Note: Percentages may not add to 100 per cent due to rounding.

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.



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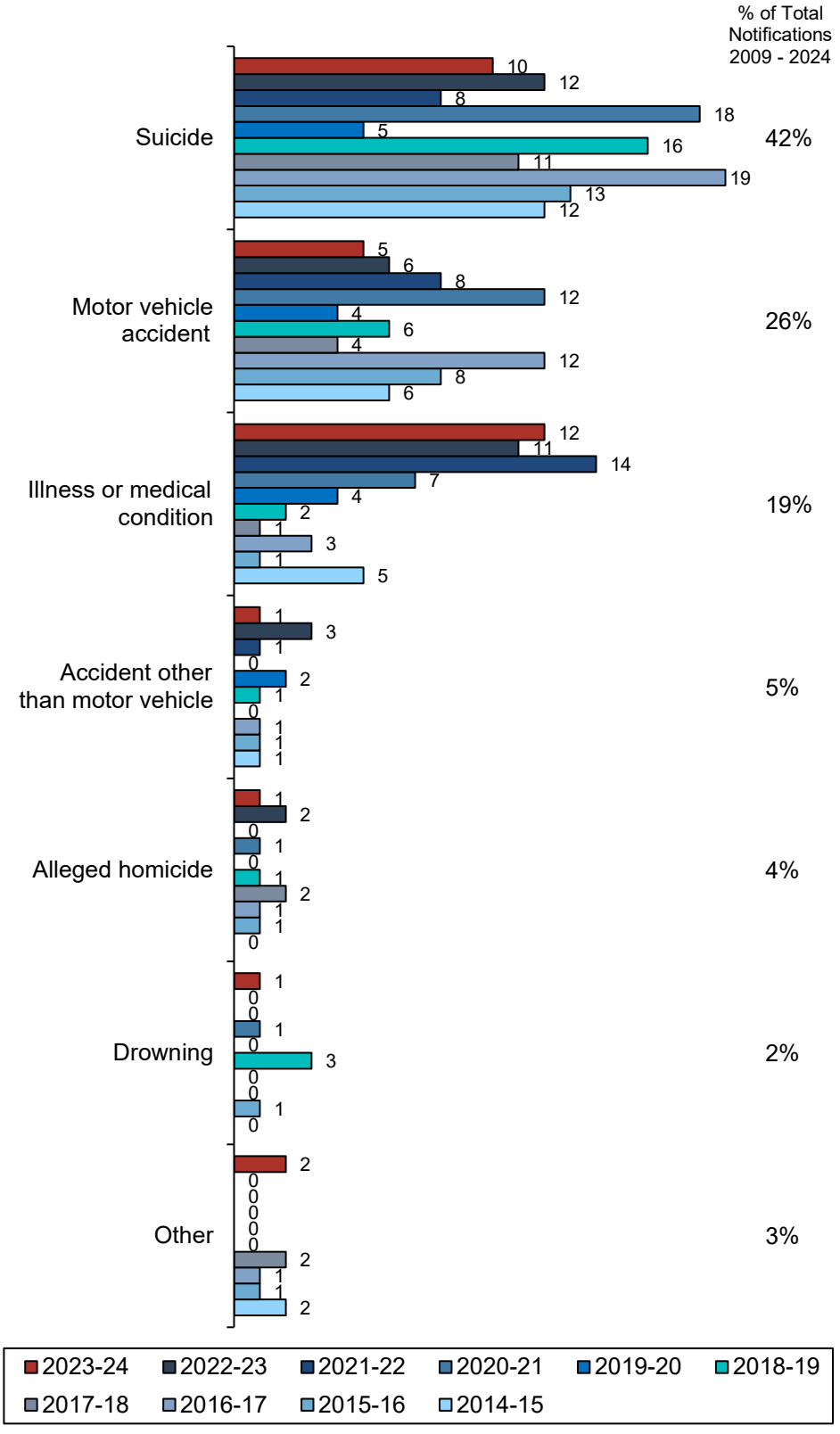
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

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

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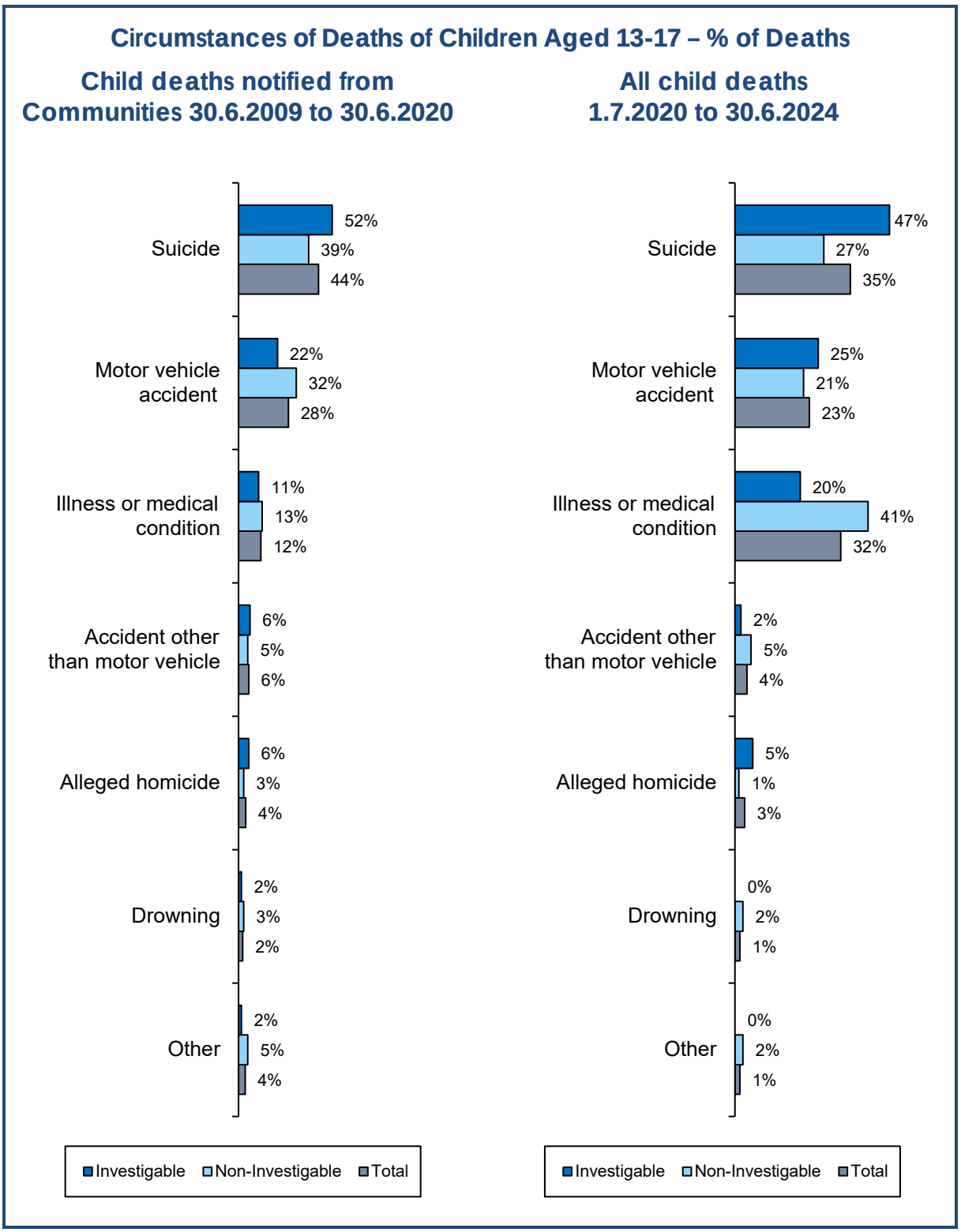
Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.



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

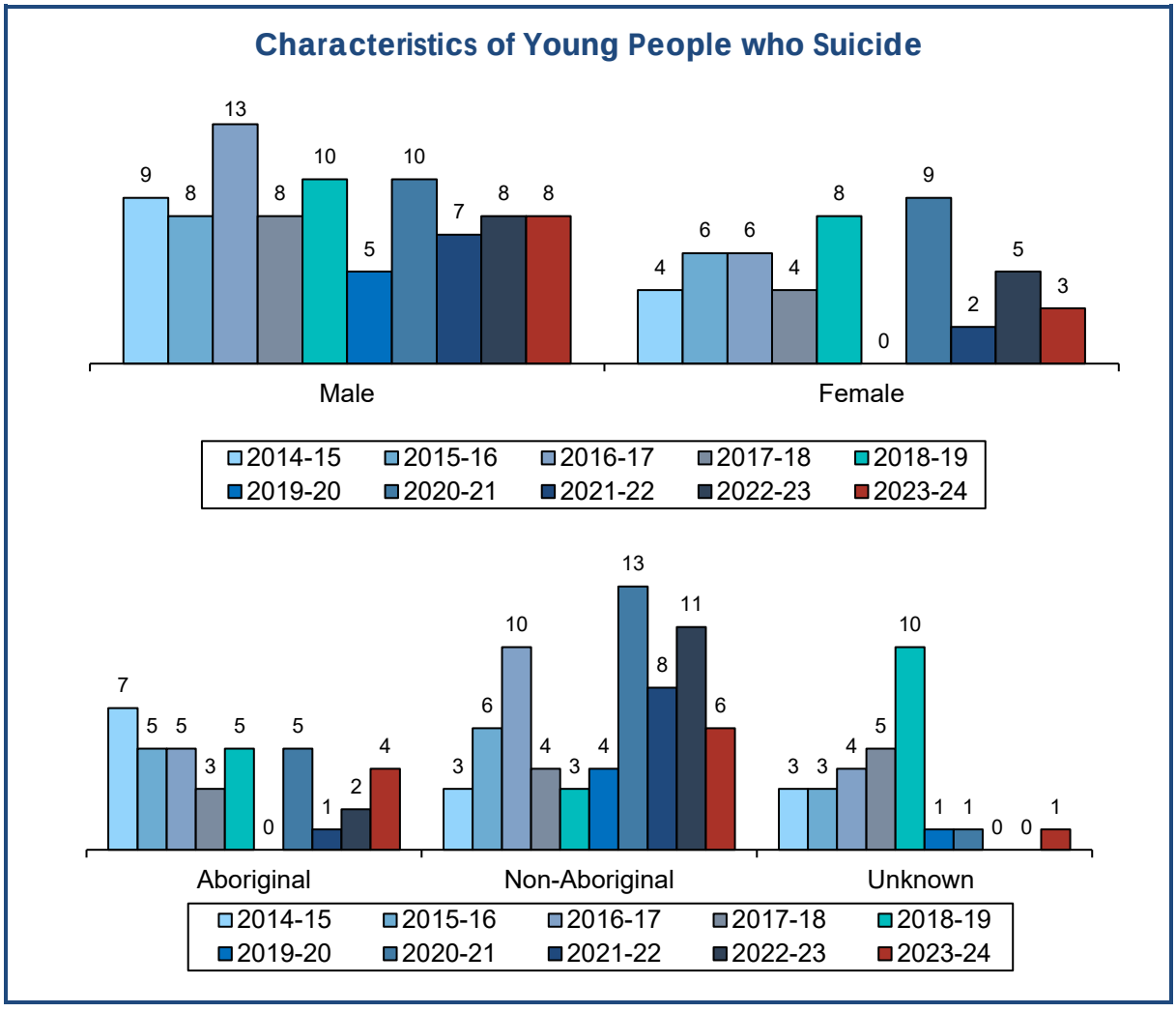
One hundred and eighty deaths of children aged 13 to 17 years were determined to be investigable deaths.

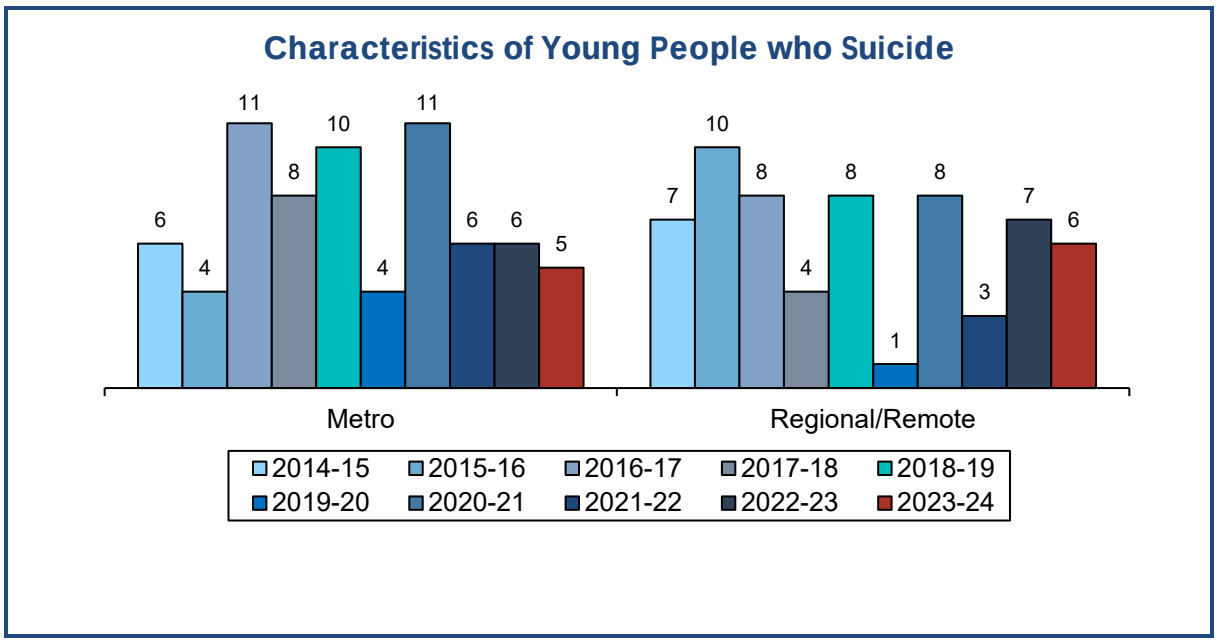
Suicide by young people

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

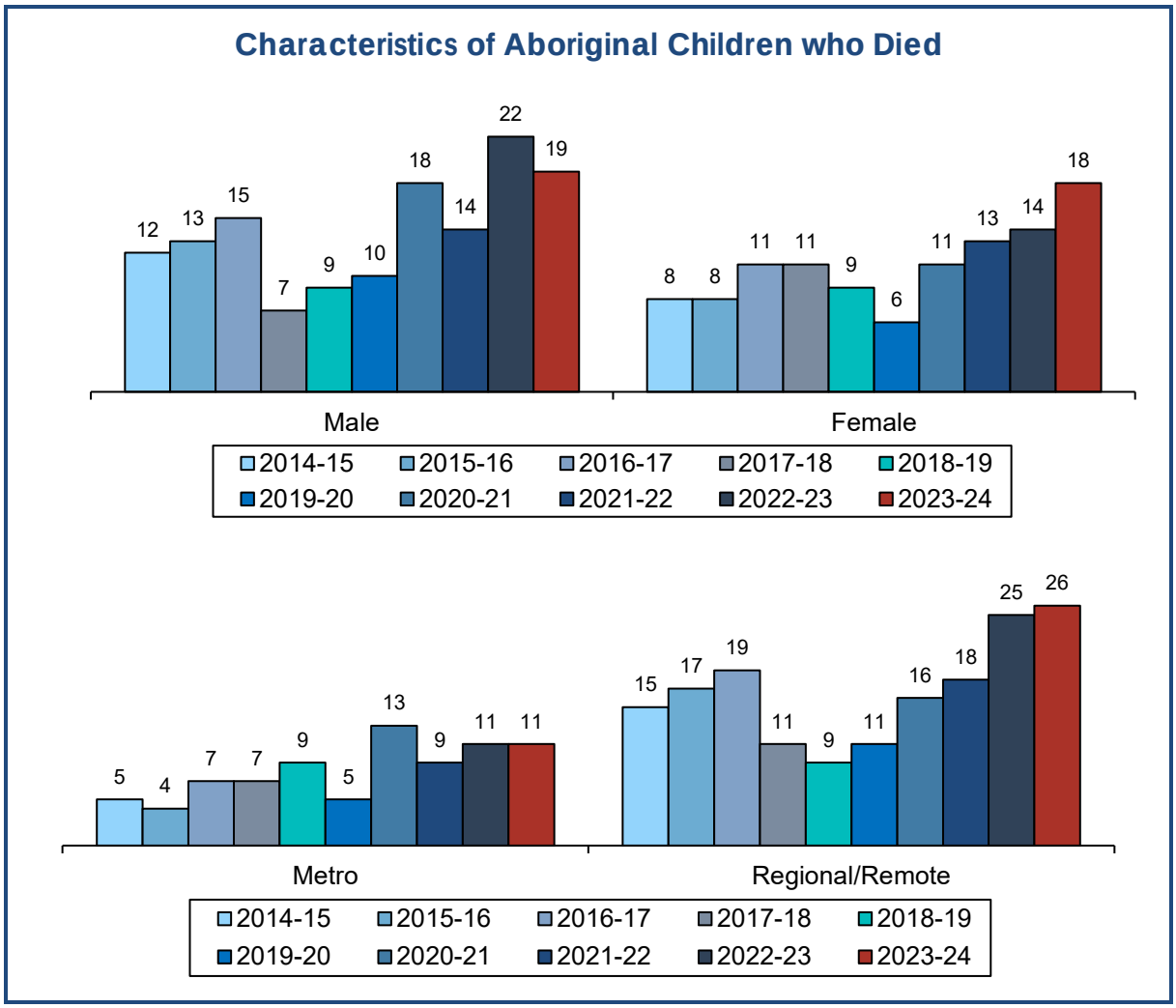
- Males – 54% of investigable deaths and 71% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 146 apparent suicides by young people where information on the Aboriginal status of the young person was available, 56% of the investigable deaths 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]

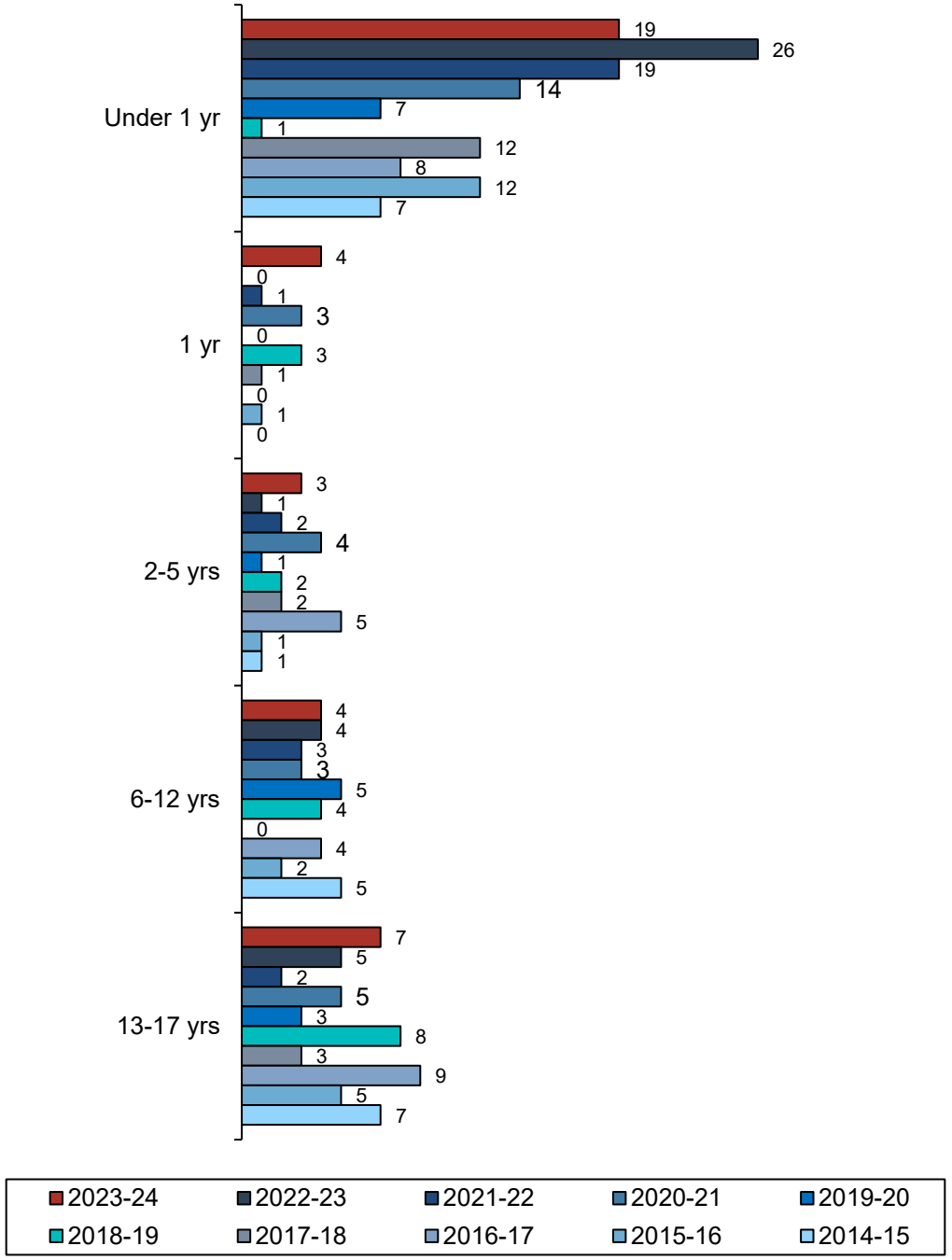
For the notifications received:

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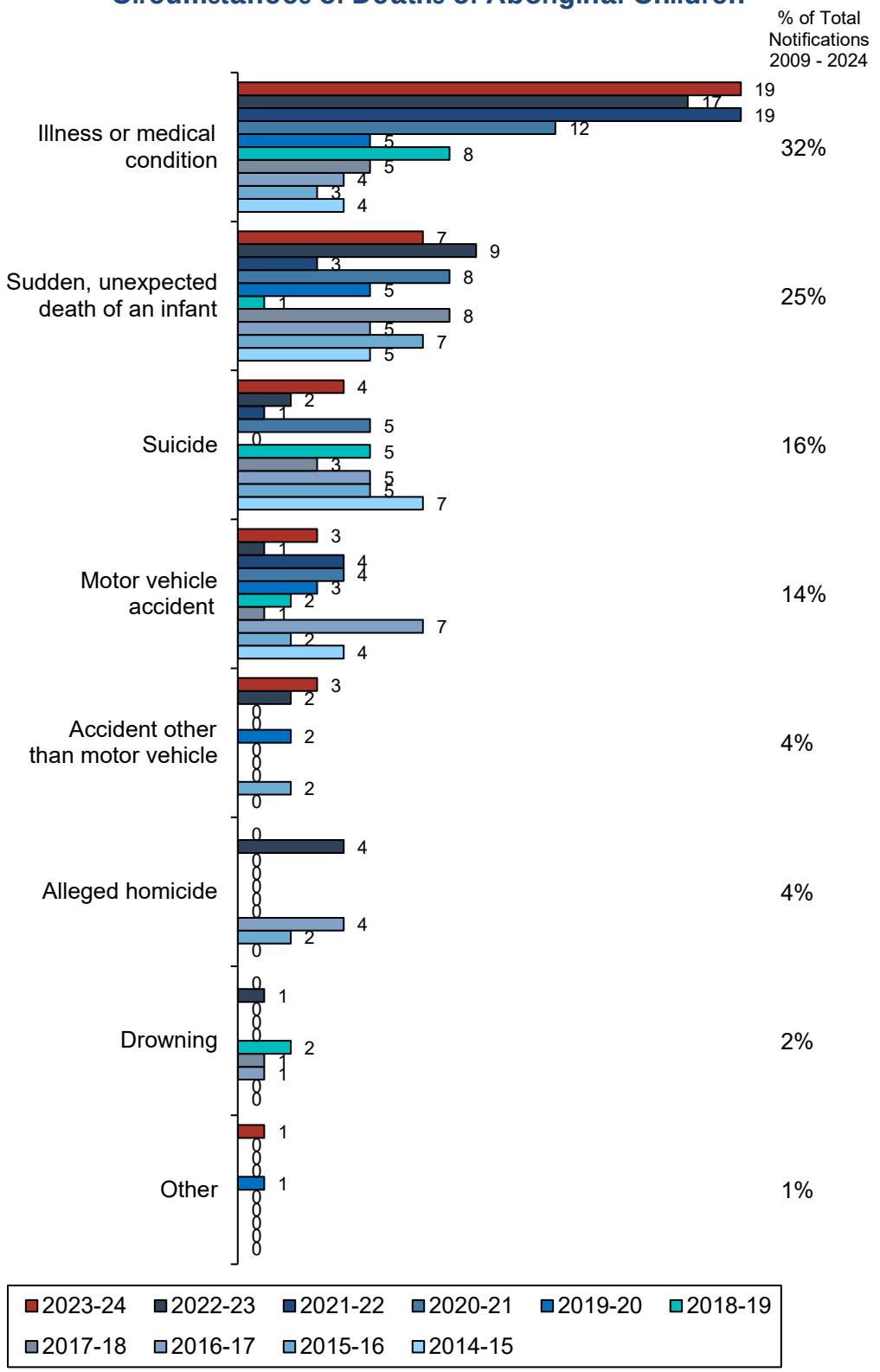
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

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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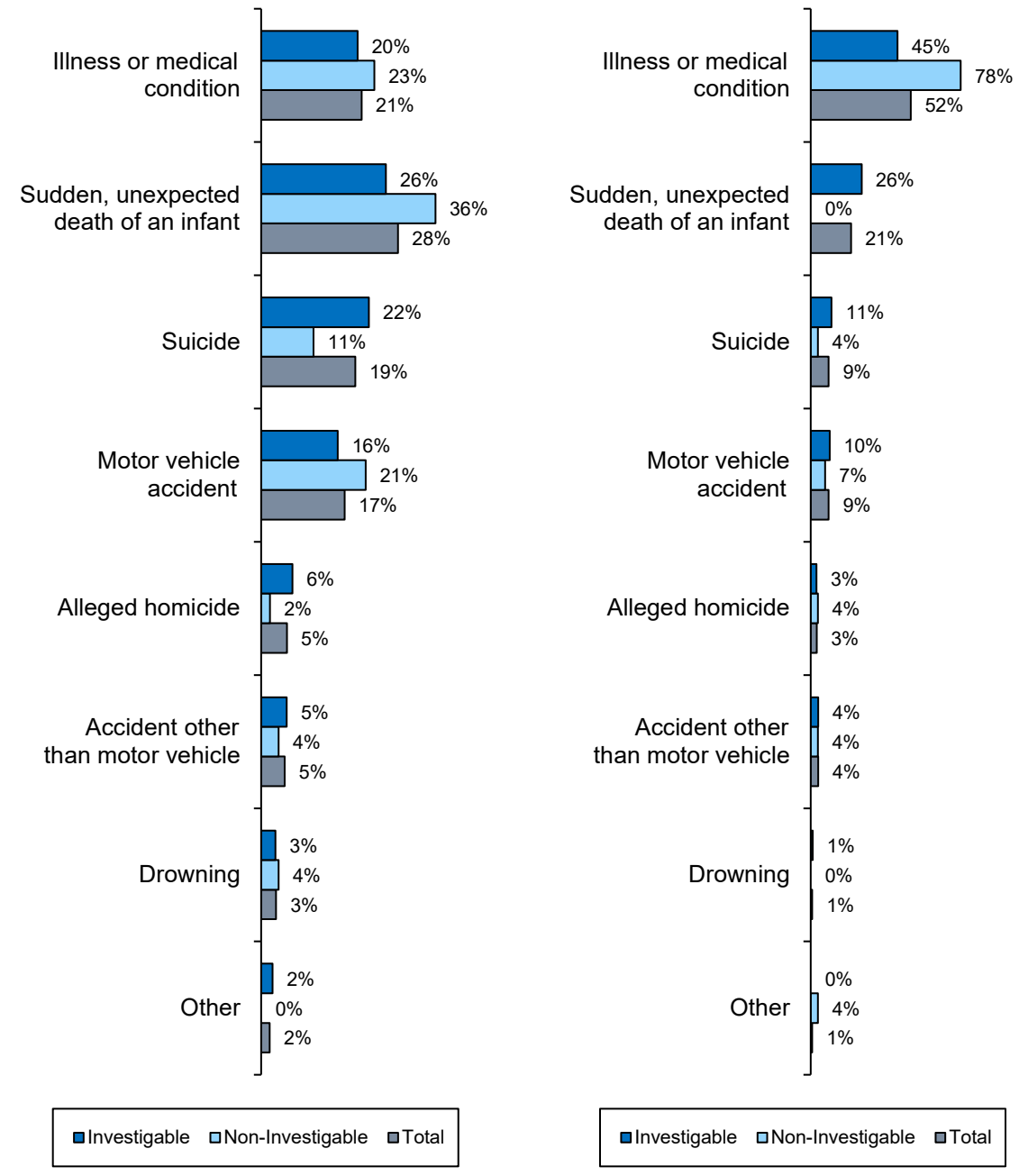
Circumstances of Aboriginal Child Deaths – % of Deaths



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.

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:

- 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;
- 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.

Learnings from the review of family and domestic violence related fatalities provides opportunity to influence policy development and service provision, to prevent or reduce the risk of future family and domestic violence related deaths. At the request of the State Government, the Ombudsman Western Australia commenced the responsibility for reviewing family and domestic violence fatalities on 1 July 2012.

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.

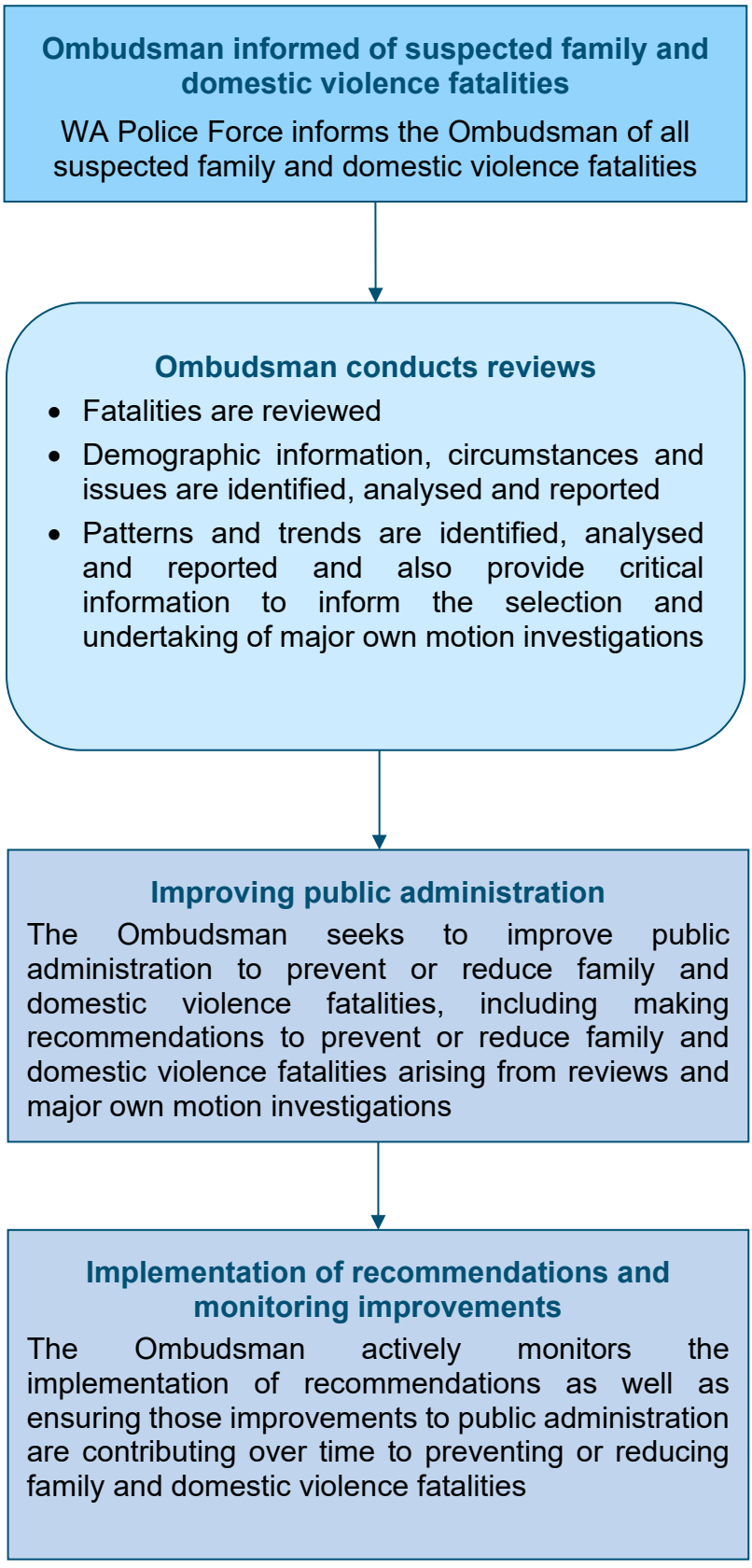
WA Police Force informs the Office of all family and domestic violence fatalities and provides information about the circumstances of the death together with any relevant information of prior WA Police Force contact with the person who died and the suspected perpetrator. A family and domestic violence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

If the relationship meets this definition, a review is undertaken. A review may also be undertaken where a fatality occurs in the circumstances of family and domestic violence.

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.

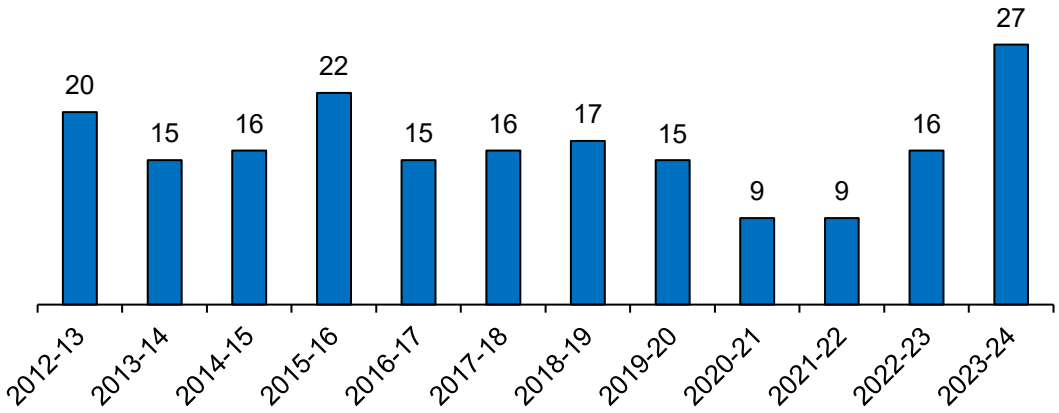
The Family and Domestic Violence Fatality Review Process



Analysis of Family and Domestic Violence Fatality Reviews

Number of family and domestic violence fatality reviews

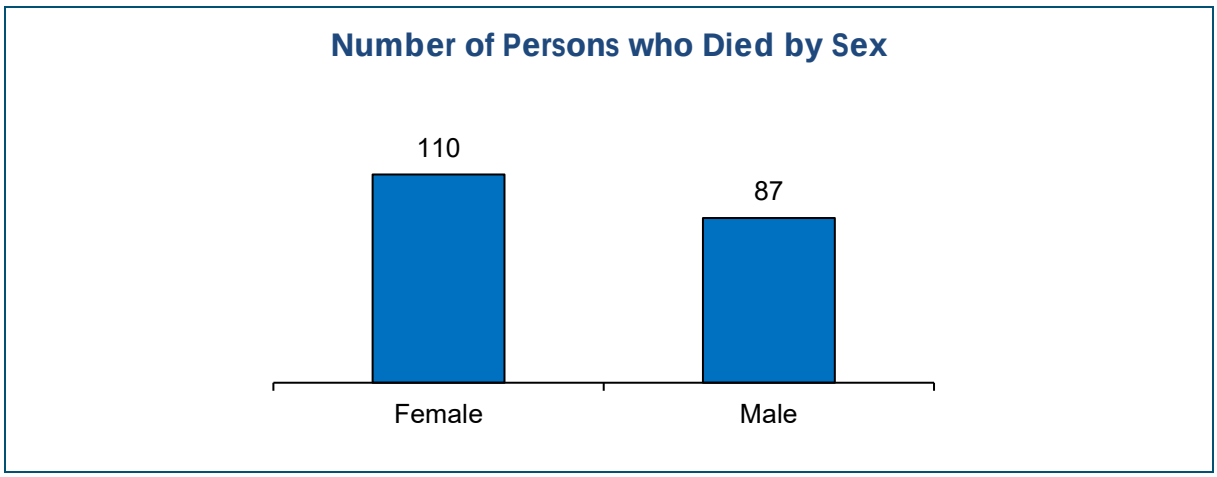
The chart below identifies the number of reviewable family and domestic violence fatalities notified to the Ombudsman. This chart reflects data of notification, not date of death.

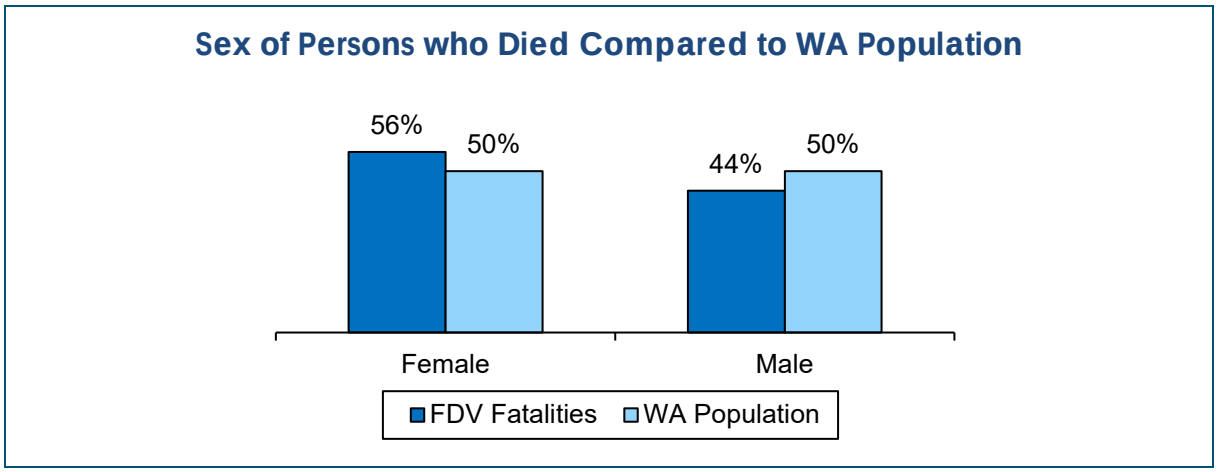


Demographic information identified from family and domestic violence fatality reviews

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.

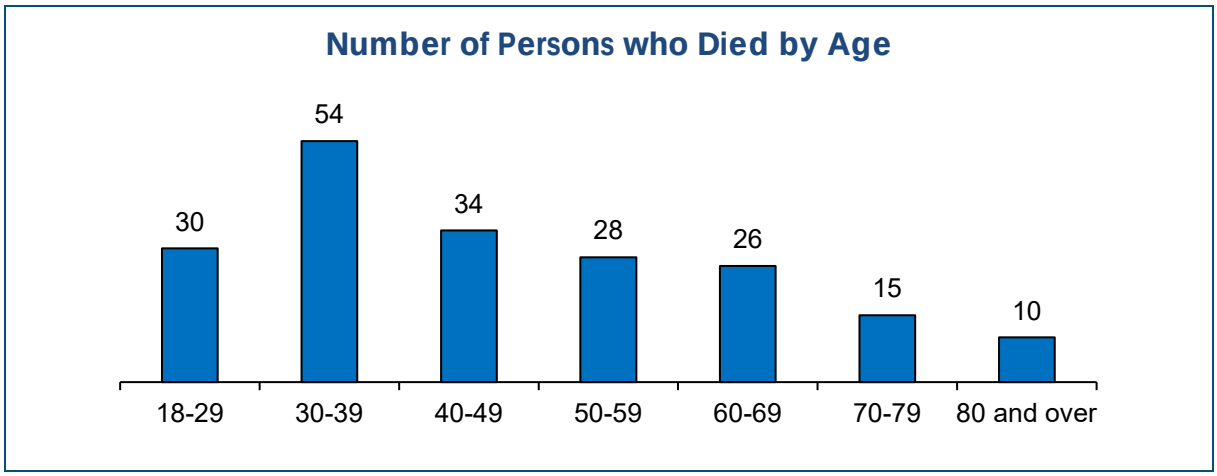
The following charts show characteristics of the persons who died for the 197 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2024. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

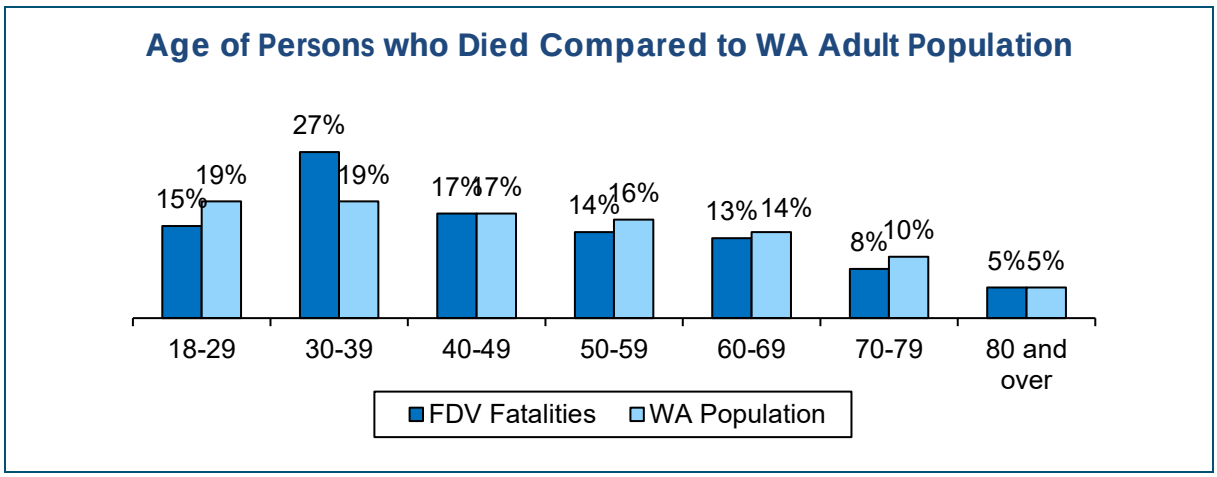




Information is collated on the sex of the deceased, and the suspected perpetrator, as identified in agency documentation provided to this Office. Compared to the Western Australian population, females who died in the 12 years from 1 July 2012 to 30 June 2024 were over-represented, with 56% of persons who died being female compared to 50% in the population.

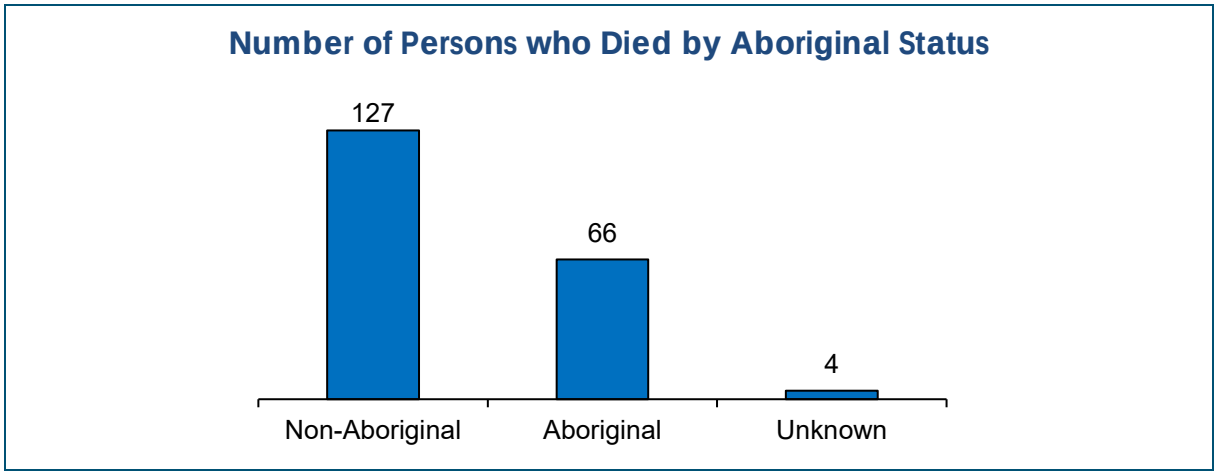
In relation to the 110 females who died, 98 involved a male suspected perpetrator, eight involved a female suspected perpetrator, one involved multiple suspected perpetrators of both sexes and three were apparent suicides. Of the 87 men who died, 30 involved a female suspected perpetrator, 33 involved a male suspected perpetrator, four involved multiple suspected perpetrators of both sexes and 20 were apparent suicides.

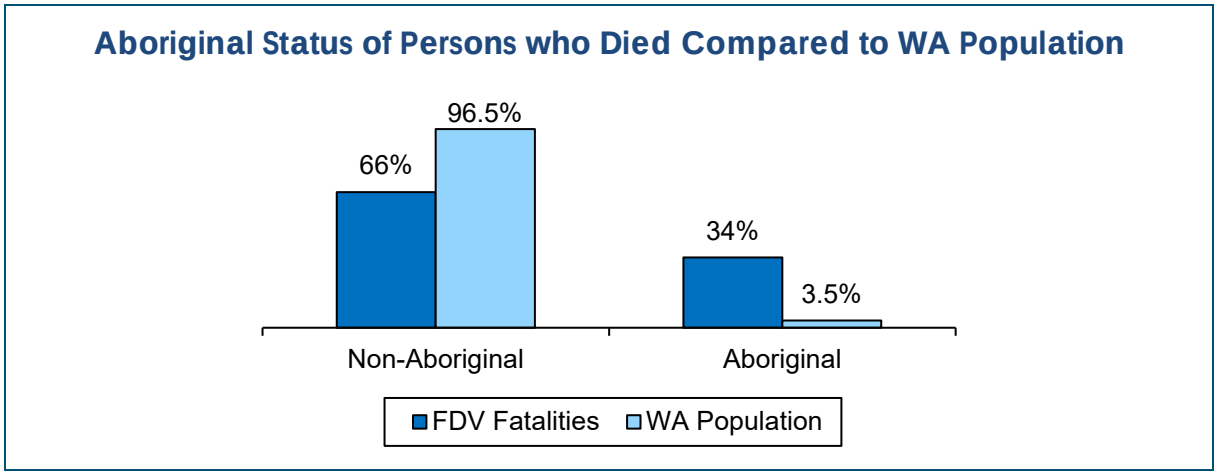




Note: Percentages may not add to 100% due to rounding.

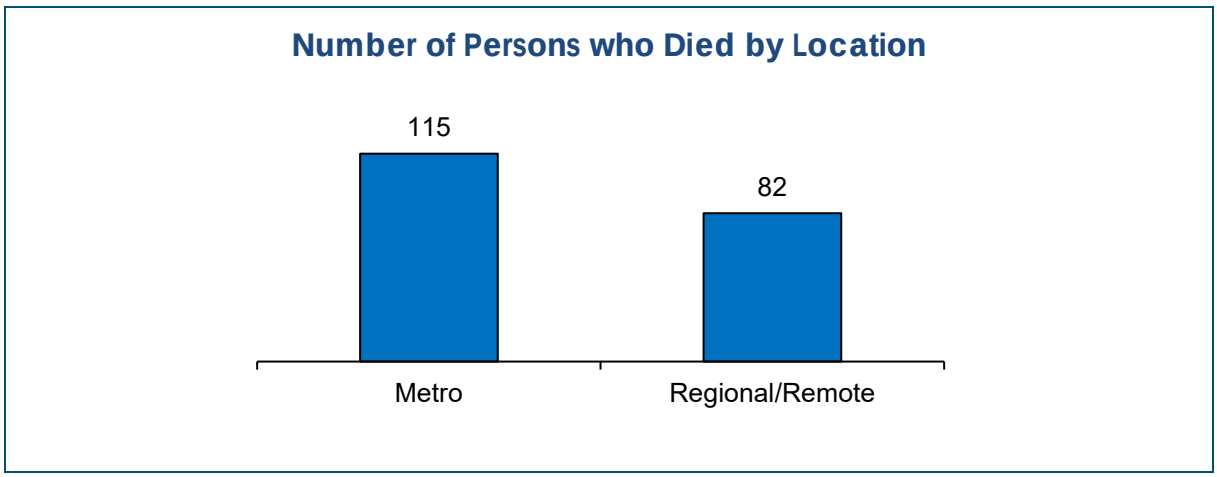
Compared to the Western Australian adult population, the age group 30-39 is over-represented, with 27% of persons who died being in the 30-39 age group compared to 19% of the adult population.

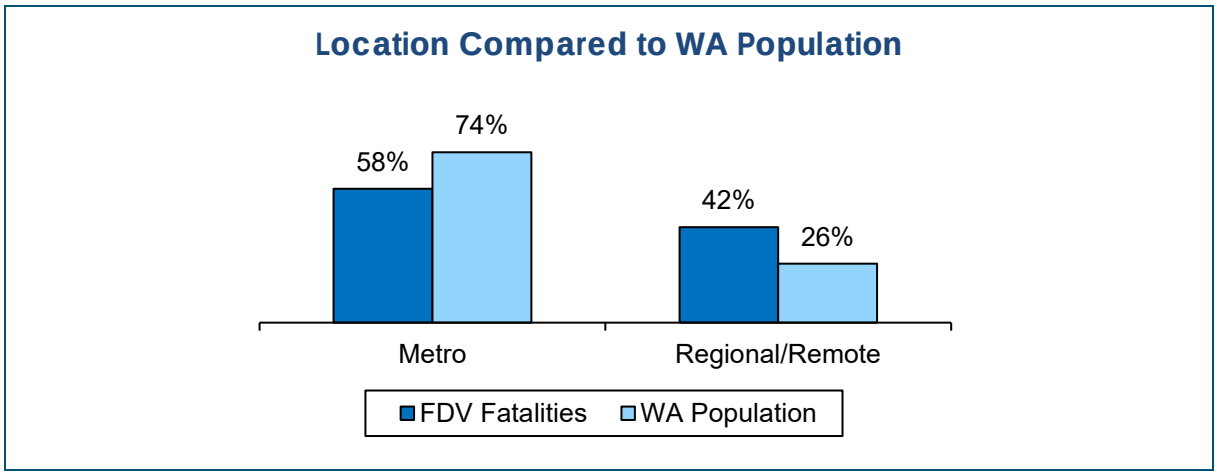




Note: In the above chart, percentages are based on those where Aboriginal status is known.

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 34% of people who died in the 12 years from 1 July 2012 to 30 June 2024 being Aboriginal compared to 3.5% in the population. Of the 66 Aboriginal people who died, 40 were female and 26 were male.





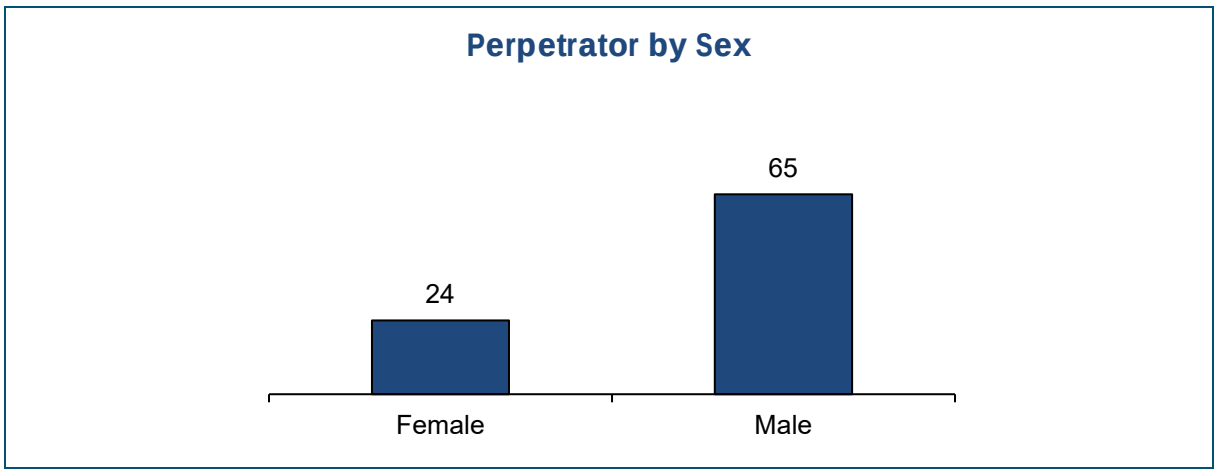
Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 42% of the people who died in the 12 years from 1 July 2012 to 30 June 2024 living in regional or remote locations, compared to 26% of the population living in those locations.

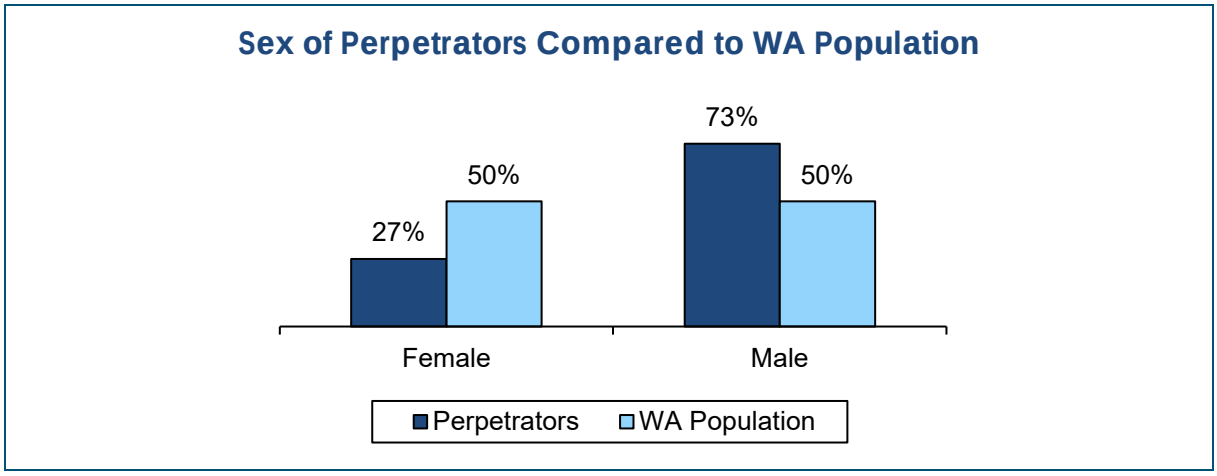
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2024 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2024.

Of the 197 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2024, coronial and criminal proceedings were finalised in relation to 89 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 89 perpetrators where both the coronial process and the criminal proceedings have been finalised.



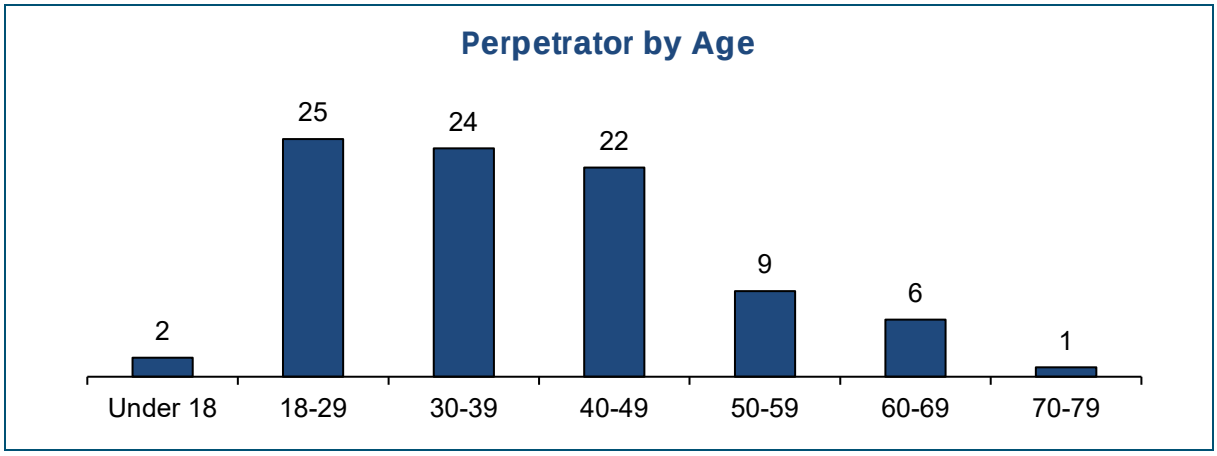


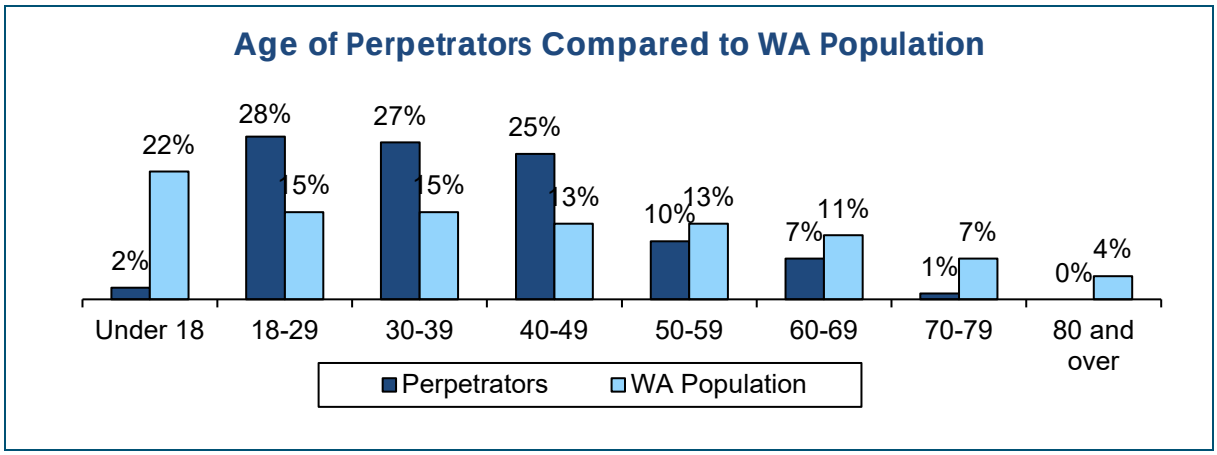
Compared to the Western Australian population, male perpetrators of fatalities in the 12 years from 1 July 2012 to 30 June 2024 were over-represented, with 73% of perpetrators being male compared to 50% in the population.

Twenty-one males were convicted of manslaughter, 43 males were convicted of murder and one male was convicted of unlawful assault occasioning death. Eleven females were convicted of manslaughter, 12 females were convicted of murder, and one female was convicted of unlawful assault occasioning death.

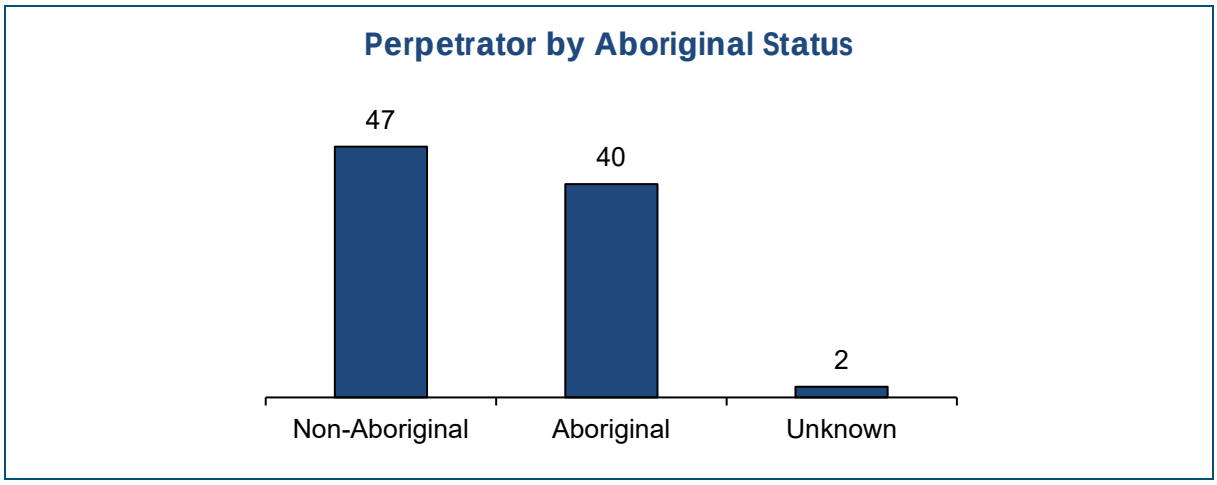
Of the 23 fatalities by the 24 female perpetrators, in 22 fatalities the person who died was male, and in one fatality the person who died was female. Of the 66 fatalities by

the 65 male perpetrators, in 49 fatalities the person who died was female, and in 17 fatalities the person who died was male.

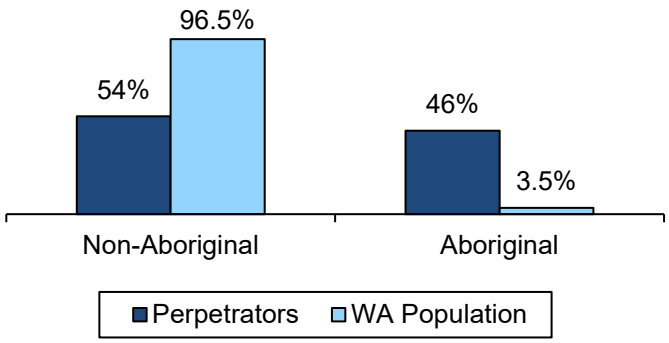




Compared to the Western Australian population, perpetrators of fatalities in the 12 years from 1 July 2012 to 30 June 2024 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 28% of perpetrators being in the 18-29 age group compared to 15% in the population, 27% of perpetrators being 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.



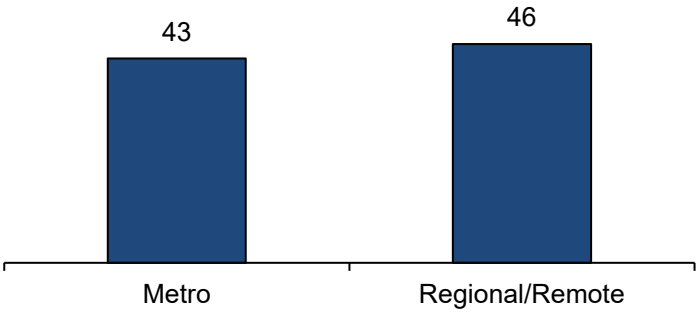
Aboriginal Status of Perpetrators Compared to WA Population



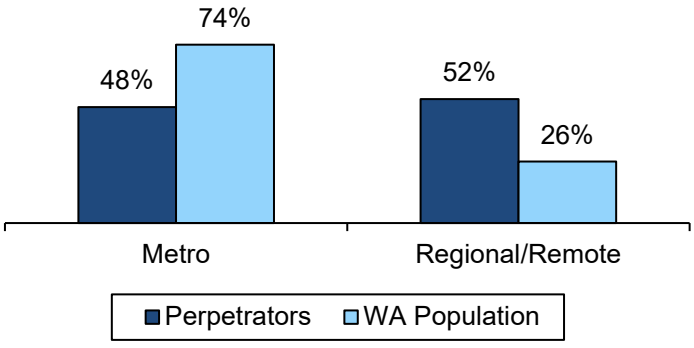
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the 12 years from 1 July 2012 to 30 June 2024 were over-represented with 46% of perpetrators (where Aboriginal status was recorded in information provided to this Office) being Aboriginal compared to 3.5% in the population.

In 38 of the 40 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location



Perpetrators by Location Compared to WA Population

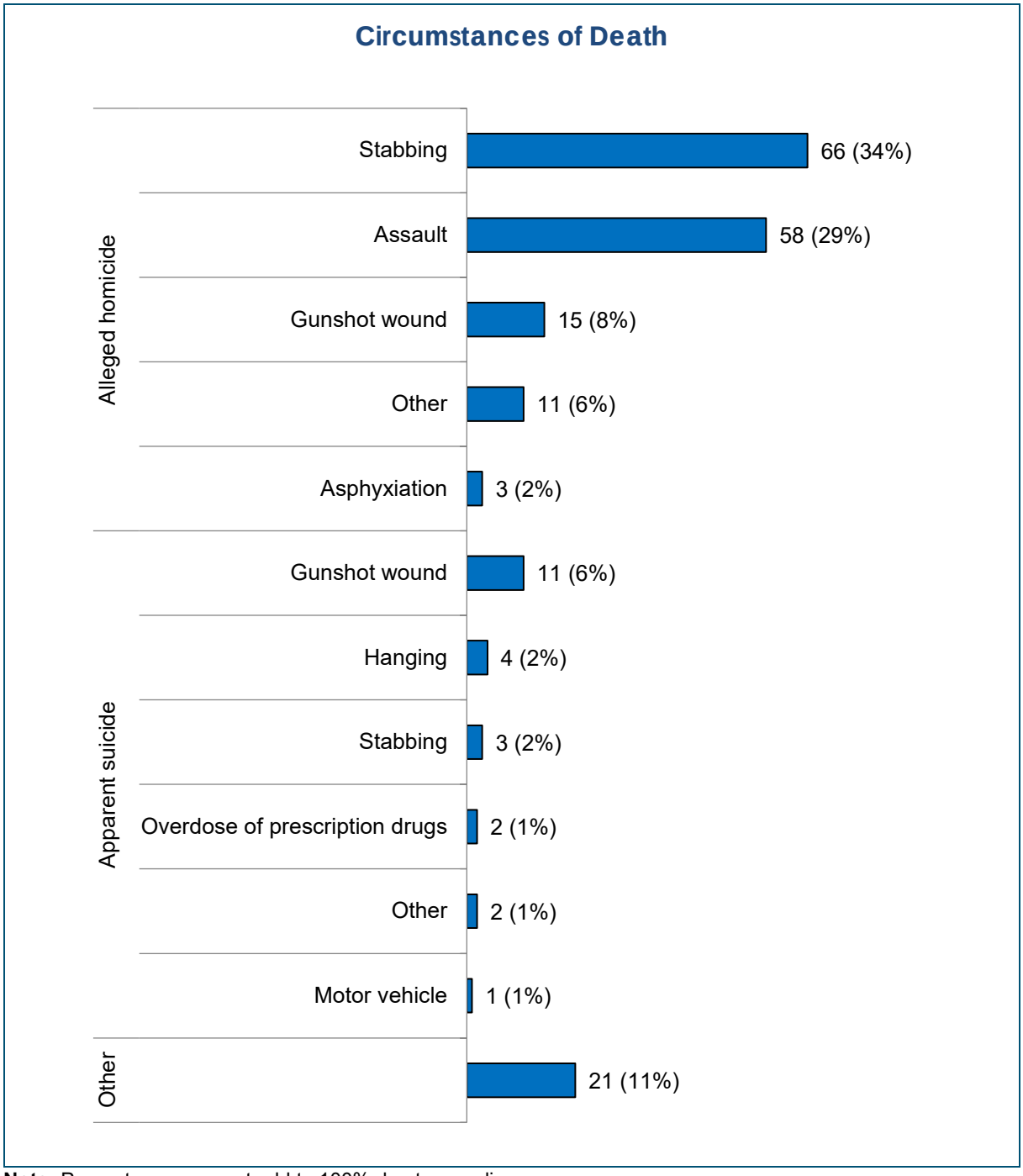


Compared to the Western Australian population, of the 89 fatalities from 1 July 2012 to 30 June 2024 for which coronial and criminal proceedings were finalised, regional or remote locations were over-represented, with 52% of the fatal incidents occurring in regional or remote locations compared to 26% 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.

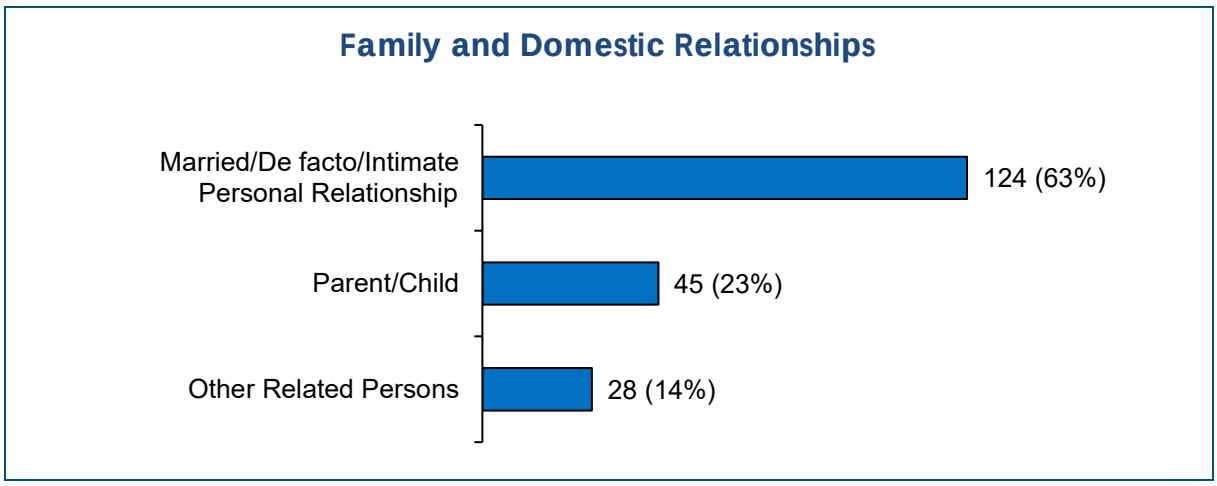
The following chart shows the circumstance of death as categorised by the Ombudsman for the 197 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2024.



Note: Percentages may not add to 100% due to rounding.

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.



Note: Percentages may not add to 100% due to rounding.

Of the 197 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2024:

- 124 fatalities (63%) involved a married, de facto or intimate personal relationship, of which there were 100 alleged homicides, 17 apparent suicides and seven in other circumstances. The 124 fatalities included 24 deaths that occurred in 12 cases of alleged homicide/suicide and, in all 12 cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. Of the other five apparent suicides, four involved males and one involved a female. Of the remaining 88 alleged homicides, 63 (72%) of the people who died were female and 25 (28%) were male;
- 45 fatalities (23%) involved a relationship between a parent and adult child, of which there were 27 alleged homicides, six apparent suicides and 12 in other circumstances. Of the 27 alleged homicides, 12 (44%) of the people who died were female and 15 (66%) 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 28 people who died (14%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, 10 (36%) were female and 18 (64%) were male.

Issues Identified in Family and Domestic Violence Fatality Reviews

Having undertaken reviews of family and domestic violence fatalities since 1 July 2012, this Office has identified learnings for system improvements in how key stakeholder agencies work to promote the safety and wellbeing of women and children. The following issues reflect some of the common and current identified patterns and trends in these reviews:

- Beyond the limited legislated responsibilities relating specifically to family and domestic violence (ie the *Restraining Orders Act 1997* and *Criminal Code*) agencies develop policy and procedures in accordance with their commitment to National and State family and domestic violence strategies. While the intent is to promote perpetrator accountability and behaviour change, and victim safety, there is opportunity for improvement in agency implementation and facilitation of these policies. This Office has identified that competing demands across agencies can impact on policy compliance.
- Many key stakeholder agencies and community services are involved in the lives of the perpetrator and victim in the months leading up to the fatality. Reviews by this Office have identified a need for increased, timely information sharing and collaborative safety planning.
- Working with families in a culturally safe and responsive manner is critical. Common findings across reviews undertaken by this Office are 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.
- The nexus between family and domestic violence, drug and alcohol use, and/or mental health issues is prevalent in the fatalities reviewed by this Office. Findings indicate a need for improved understanding by agencies in working with these coexisting challenges, and increased pathways for effective treatment programs.

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 family and domestic violence fatalities. The following two recommendations were made by the Ombudsman in 2023-24 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. The WA Police Force provides a copy of the Family Violence Division's Regional District Health Check to this Office along with setting out any further actions that are required to ensure District compliance with family and domestic violence (**FDV**) practice requirements.

2. That the WA Police Force provides the Ombudsman with a copy of the Internal Investigation report, once completed, in relation to its response to protect Ms A's safety from 9 October 2021 to 24 October 2021.

The Ombudsman's *Annual Report 2024-25* will report on the steps taken to give effect to the six recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2022-23. The Ombudsman's *Annual Report 2025-2*6 will report on the steps taken to give effect to the two recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2023-24.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2021-22

The Ombudsman made one recommendation about ways to prevent or reduce family and domestic violence fatalities 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 recommendation;
- The steps that are proposed to be taken to give effect to the recommendation; or
- If no such steps have been, or are proposed to be taken, the reasons therefore.

Recommendation 1: The WA Police Force provides a report to the Ombudsman by 1 October 2022 on the progress of discussions with the 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.

Steps taken to give effect to the recommendation

Through the Ombudsman's FDV fatality reviews, we have identified that when perpetrators of violence are being supervised on community-based orders, the Department of Justice is not always aware of contact the perpetrator may have with WA Police Force. This Office is of the view that improved information sharing would provide the Department of Justice with the timely opportunity to address perpetrator accountability through supervision of persons on community orders.

The WA Police Force provided this Office with a letter dated 21 September 2022, in which WA Police Force relevantly informed this Office that:

> The WA Police Force Family Violence Division has opened discussion with the Department of Justice (Adult Community Corrections) to create a working group whereby the type of information to be shared will be determined, any legal preclusions identified, and identified and technical solutions proposed to enable efficient and timely exchange.
>
> …
>
> On the 14 July 2022, an executive meeting was conducted and an agreement was reached to progress a working group to explore opportunities for improved information sharing for family violence interactions…
>
> Three subgroups are now being formed which include Business, Legal and Technical Advisory Groups to provide recommendations enabling the working group to reach agreement and resolve any identified issues that may hinder the realisation of an effective information sharing process.

This Office requested that WA Police Force inform the Office of any further information on the steps taken to give effect to the recommendation. In response, WA Police Force provided a letter to this Office dated 12 March 2024, in which the WA Police Force relevantly informed this Office that:

> The WA Police Force has established an information sharing working group with the DOJ to identify and resolve issues impacting information sharing access.
>
> An outcome from the group has led to the establishment of an expansion of DOJ's access to WA Police Force Systems with 70 additional Adult Community Correction (ACC) employees provided access to the WA Police Force Incident Management System (IMS) to proactively access pertinent data on Family Violence Incident Reports (FVIR).
>
> The WA Police Force provides DOJ with a daily report pertaining to family violence incidents that may be cross referenced by DOJ to identify any individuals subject to a DOJ order.

This Office is monitoring the effectiveness of this action, and the capacity of DOJ to use this IMS access to identify WA Police Force contact when supervising family and domestic violence perpetrators in the community, in current family and domestic violence fatality reviews.

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 2023-24, timely review processes have resulted in 62% of all reviews being completed within six months and 69% 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.

The Office 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 arising from own motion investigations are provided in the Own Motion Investigations, Inspections and Monitoring section.

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 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 report Filicides in a domestic violence and family context 2010-2018 (First Edition 2024);
- 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.

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 2023-24, included:

- The Coroner;
- Relevant public authorities including:
  - WA Police Force
  - Health Service Providers
  - The Department of Justice
  - The Department of Communities;
- The Centre for Women's Safety and Wellbeing and relevant non-government organisations; and
- Research institutions including universities.

Own Motion Investigations, Inspections and Monitoring

This section outlines the work of the Office in relation to:

- 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;
- Reviews of the steps taken by government agencies to give effect to our own motion investigation recommendations to improve public administration; and
- Inspection and monitoring functions.

Own Motion Investigations

One of the ways 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 the opportunity to comment on draft conclusions and any recommendations.

Own Motion Investigations in 2023-24

In 2023-24, significant work was undertaken on:

- A report on giving effect to the recommendations arising from the *Investigation into family and domestic violence and suicide*, which was tabled in Parliament in November 2023.
- A project examining the systems of organisations covered by the Reportable Conduct Scheme.
- An investigation into the management of tenant liabilities in public housing.

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 are actively monitored by the Office to ensure its implementation and effectiveness in relation to the observations made in the investigation.

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

About the report

During 2023-24, the departments of Health, Education, Communities and the Mental Health Commission met on a regular basis to discuss and agree on approaches to address joint recommendations arising from *Preventing suicide by children and young people 2020.*

As the need for improved collaboration between public authorities is a key theme of the report, this joint initiative is commendable, as is the identification of future opportunities for further work on giving effect to the recommendations.

Of note is the work undertaken by the departments of Health and Communities to give effect to Recommendation 5 of the report, which related to the collection of gender data in a non-binary form.

A report on giving effect to the recommendations arising from the *Investigation into family and domestic violence and suicide*

About the report

On Thursday 20 October 2022, the Western Australian Ombudsman tabled in Parliament the report of his major own motion investigation titled *Investigation into family and domestic violence and suicide* (**the Report**).

The Report included a comprehensive set of state-wide data relating to 68 women and child victims of family and domestic violence who died by suicide in 2017 and their prior interactions with State Government departments and authorities.

The Ombudsman gave a commitment to Parliament that, following the tabling of each major own motion investigation, 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 12 months after the tabling of the major own motion investigation.

Accordingly, in November 2023, the Ombudsman tabled in Parliament *A report on giving effect to the recommendations arising from the Investigation into family and domestic violence and suicide*.

Objectives

The Report made nine recommendations to five State Government departments about ways to prevent or reduce family and domestic violence related deaths by suicide.

The objectives of the Report were to consider, in accordance with sections 25(4) and (5) of the Act:

- 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;
- If no such steps have been, or are proposed to be taken, the reasons therefore; and
- If relevant, whether it appeared to the Ombudsman that no steps that seem to him to be appropriate have been taken within a reasonable time of his making of the Report and recommendations.

Methodology

On 28 June 2023, the Ombudsman wrote to the Mental Health Commissioner, the Director General of the Department of Communities, the Director General of the Department of Health, the Director General of the Department of Justice and the Commissioner of the WA Police Force 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 in order to clarify or validate information provided in their reports to the Ombudsman;
- Developed a preliminary view and provided it to relevant State Government departments 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

Overall, the Office found that steps have been taken, or are proposed to be taken, to give effect to each of the recommendations.

The steps taken to give effect to Recommendations 5 and 8 were considered in *A report on giving effect to the recommendations arising from the Investigation into family and domestic violence and suicide* and were further assessed in 2023-24 as outlined below.

Steps taken to give effect to Recommendations 5 and 8 of the *Investigation into family and domestic violence and suicide*

Recommendation 5: The Department of Communities, in order to better inform practice and policy, conducts a review and examines current data on:

- **the presence of family and domestic violence in duty interactions concerning older children and adolescents;**
- **intake rates related to duty interactions concerning older children and adolescents, particularly where family and domestic violence is identified;**
- **policy, practice, and culture in relation to how the Department of Communities responds to older children and adolescents; and**

provides the resulting review report to this Office within 12 months of the tabling in the Western Australian Parliament of the report of this Investigation.

Steps taken to give effect to the recommendation

The Ombudsman's report on giving effect to the recommendations arising from the *Investigation into family and domestic violence and suicide* further stated that:

> The Office requested that the Department of Communities inform the Office of the steps taken to give effect to the recommendation. In response, the Department of Communities provided the following information:
>
> > A report responding to recommendation five, is due to your office in October 2023.
> >
> > The review has commenced and is examining actions taken by Communities since 2017 to improve outcomes for children and young people impacted by family and domestic violence, including legislative and policy reforms or updates to practice guidance, staff training and service delivery models.
> >
> > The review includes analysis of relevant data including emerging themes and practice trends relating to family and domestic violence responses for older children and adolescents.
>
> **Having carefully considered the information provided by the Department of Communities, I am of the view that steps are proposed to be taken to give effect to Recommendation 5. Further, the Office will carefully consider the report from the Department of Communities as set out in the recommendation upon receipt and**

publish an update on the steps taken to give effect to Recommendation 5 in the Ombudsman's 2023-24 Annual Report.

The Department of Communities provided the review report as outlined by Recommendation 5 as required.

A summary of the review report is outlined below.

Communities' response to recommendation five, adopted two main strategies:

1. Analysis of Communities (Child Protection) administrative data concerning notification and intake for family and domestic violence, broken down by child age; and
2. A review of Communities (Child Protection) policy and casework practice guidance relating to the age of the child and / or the presence of family and domestic violence, a thematic review of oversight agency findings and qualitative review of a defined cohort of child protection decision making.

Part 1 Interactions of children, older children and adolescents

To achieve this, data from the period 1 July 2017 and 31 December 2022 was extracted from Communities' Client Management System (Assist) and analysed, with specific attention to duty interactions and associated decision making about next steps.

Key findings included:

- A significant increase in the proportion of interactions recorded in Assist that include children, which can be attributed to changes in recording practices.
- A gradual increase in the proportion of interactions that include children, that also include either an older child or adolescent.
- An increase in the proportion of interactions involving children where family and domestic violence is recorded. This increase is noted to be greater for children less than 10 years of age, than it has been for older children and adolescents.

In relation to Communities statutory child protection responses, the following key themes were identified, specifically relating to older children and adolescents:

- Family and domestic violence is more likely to be recorded in duty interactions regarding children under the age of 10 years.
- While the presence of family and domestic violence in duty interactions influences decision making for children 14 years and under, Intake rates for adolescents are comparatively lower.
- Identification of family and domestic violence in duty interactions for adolescents is not increasing at the same rates as Interaction recordings concerning all children, inclusive of older children.

- Children in the adolescent age cohort are less likely to be subject to further action being taken by Communities to promote or safeguard the wellbeing of the child pursuant to S.31 of *Children and Community Services Act 2004*.

The findings have informed the identification of opportunities to improve policies and practices regarding Communities' legislative role and responsibilities in circumstances where a child or young person is referred to Child Protection due to concerns about family and domestic violence. These findings will be considered as part of the implementation of the One Communities Family and Domestic Violence Informed Practice Approach, a five-year enhancement project that was endorsed by Communities Leadership Team in March 2023.

Review of the data related to decision making in duty Interactions for adolescents, notes there is an observable difference in decisions for No Further Action, Intake and Intake to Child Safety Investigation in this age cohort, compared to outcomes for 'all children' and 'older children'. With adolescents less likely to be intake for child safety investigation, although the general trend over the reporting periods considered is that adolescents are more likely to be intaked now, compared to 2017 data (9.2 per cent in 2017 compared to 11 per cent in 2022).

Some of the range of practice considerations for Communities work with older children and adolescents, includes:

- That Communities responsibilities set out in the *Children and Community Services Act 2004* are not stratified by age. Communities has the same responsibilities to safeguard the wellbeing of all children (0-17 years);
- Identifying abuse and neglect can include recognition of trauma response behaviours including substance abuse, self-harm or attempted suicide, disengagement from education and antisocial (including criminal) behaviour;
- The agency and autonomy of young people can create unique strengths and challenges to case work. Young people are capable of influencing family dynamics, degree of service engagement and adherence with safety plans (as an example); and
- The age of consent and the mature minor ('gillick') principle. The age of consent in Western Australia is 16 years.

Part 2. Policy, Practice and Culture

Recommendation 5 of the Own Motion Investigation requested that Communities review and examine current data on:

- Policy, practice and culture in relation to how the Department of Communities responds to older children and adolescents.

To inform this aspect of the report, the following steps have been undertaken:

- Review of Communities policies relating to family and domestic violence, and at-risk youth (inclusive of the former Department for Child Protection and Family Support);

- Review of Child Protection Casework Practice Manual, and any practice changes that occurred within the data period;
- Thematic review of oversight agency findings in relation to older children and adolescents within the data period; and
- Qualitative analysis of a small number of case files (n = 7).

Part 3. Considering the findings of this data

Several significant reform projects have been undertaken by Communities since the conclusion of the investigative period considered by the Ombudsman. Communities' policies and practice guidance related to family and domestic violence are currently subject to review, as per the redevelopment of the Child Protection Casework Practice Manual platform, enhancements of the Family and Domestic Violence Response Teams and development of a single agency policy setting aligned with the One Communities Family and Domestic Violence Informed Practice Approach.

In August 2024, the Department of Communities provided additional information relevant to recommendation 5 in relation to family and domestic violence policy and practice, specifically that:

- On 29 July 2024, the Child Protection Casework Practice Manual transitioned to a new software platform (The Guide), increasing functionality that enables more streamlined access to existing content and practice guidance. The second phase of The Guide will launch in early 2025 and will include updated guidance to support Child Protection officers in identifying and responding to family and domestic violence, including working with adolescents. The mapping of content development is underway and will be informed by the findings of the data report and the principles and critical components of the Safe and Together Model.
- The findings have also been considered through development of the One Communities Family and Domestic Violence Informed Practice Approach, noting the final draft for Communities whole of agency policy makes specific statements with respect to children and young people as victim-survivors of family and domestic violence.

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

Recommendation 8: The Mental Health Commission, in collaboration with relevant State Government departments and authorities and stakeholders, develop and disseminate a common understanding of what constitutes a trauma-informed approach for Western Australian State Government departments and authorities. Including, but not limited to:

- **A definition and key principles of a trauma-informed approach;**
- **Domains of implementation (including, but not limited to, an organisation's strategic leadership, policy, training for staff, and evaluation);**
- **Consideration of vicarious trauma in the service delivery context;**
- **This approach being intersectional, and elevates the voices and experiences of Aboriginal and/or Torres Strait Islander people; and**
- **A timeline for undertaking this work.**

Steps taken to give effect to the recommendation

The report on giving effect to the recommendations arising from the *Investigation into family and domestic violence and suicide* also stated:

> While it is noted that the Mental Health Commission has commenced work to give effect to Recommendation 8, this work commenced more than eight months after the tabling of the report of the Investigation in Parliament.
>
> Given the exceptionally serious, and extraordinarily egregious nature, of men's violence to women, including the very welcome public attention being in relation to this violence, the fact that an eight-month period elapsed prior to commencing this work is of concern.
>
> For this reason, the Office informed the Mental Health Commission that the Office will review this matter again on 31 December 2023, and it is expected that this work will be significantly advanced, and have a clear timeline for completion, in accordance with, and giving effect to, Recommendation 8. The Mental Health Commission has, pleasingly, now prioritised work to address this recommendation and has committed to providing the Office an update on their progress, including a clear timeline for completion, by 31 December 2023.

The Mental Health Commission provided an update on the steps taken to give effect to Recommendation 8. This included the Terms of Reference for the working group to develop a Trauma-Informed Approach and a timeline for completion of the Trauma-Informed Approach. A summary of the Terms of Reference and timeline for completion supplied by the Mental Health Commission is outlined below:

Introduction

The State Government Working Group for the Development of a Trauma-Informed Approach (**Working Group**) is being established for the purpose of supporting the development of a trauma-informed approach for State Government departments and authorities, as required by Recommendation 8 made by the Western Australian Ombudsman in his major own motion investigation into family and

domestic violence (**FDV**) and suicide report (**the Report**): Investigation into family and domestic violence and suicide report.

Background

On 20 October 2022, the Western Australian Ombudsman tabled in Parliament the Report of his major own motion investigation into FDV and suicide. The Report provided extensive data relating to 68 women and children who were identified as victims of FDV and had died by suicide, and their prior contact with State Government departments and authorities.

As of result of the investigation, the Report identified a range of opportunities across all stages of service engagement to improve the identification of, and responses to FDV in Western Australia. This included an identified need for State Government departments and authorities to use trauma-informed approaches to better meet the needs of individuals who have experienced multiple circumstances of vulnerability, including but not limited to, when responding to FDV and suicidality.

Arising from the findings of the report, the Ombudsman assigned nine recommendations to five State Government departments.

Related to Recommendation 8, Recommendation 9 from the Report was allocated to the WA Police Force, Department of Justice, Department of Health, and Department of Communities. The recommendation directs the named departments to take into account the outcomes of Recommendation 8 by considering: 'how a trauma-informed approach may be incorporated into their operations; and work to improve their organisation's understanding of trauma.'

The close relationship between the two recommendations necessitates that a collaborative cross-agency approach is taken to the work required to meet Recommendation 8. The Mental Health Commission will lead the development of an overarching trauma-informed approach for State Government departments and authorities, in collaboration with other Mental Health Commission directorates, a range of government agencies, Aboriginal people and people with lived experience, families and carers.

Purpose/objectives

Chaired by the Mental Health Commission, the purpose of the Working Group is to provide cross-agency advice and guidance on the development of a trauma-informed approach for State Government, in line with the components outlined in Recommendation 8.

The Working Group's primary objectives are to:

- Ensure across agency contribution into the development of a trauma-informed approach for Western Australian State Government departments and authorities;
- Provide strategic oversight, advice, and input on the components of a trauma-informed approach, as outlined in Recommendation 8.
- Contribute to and provide feedback on the development of a guide to a trauma-informed approach, for dissemination to State Government departments and authorities;

- Identify relevant stakeholders and networks to engage for targeted consultation on the draft guide; and
- Be informed by community, lived experience and outcomes of recent reviews, latest evidence and best practice.

Membership

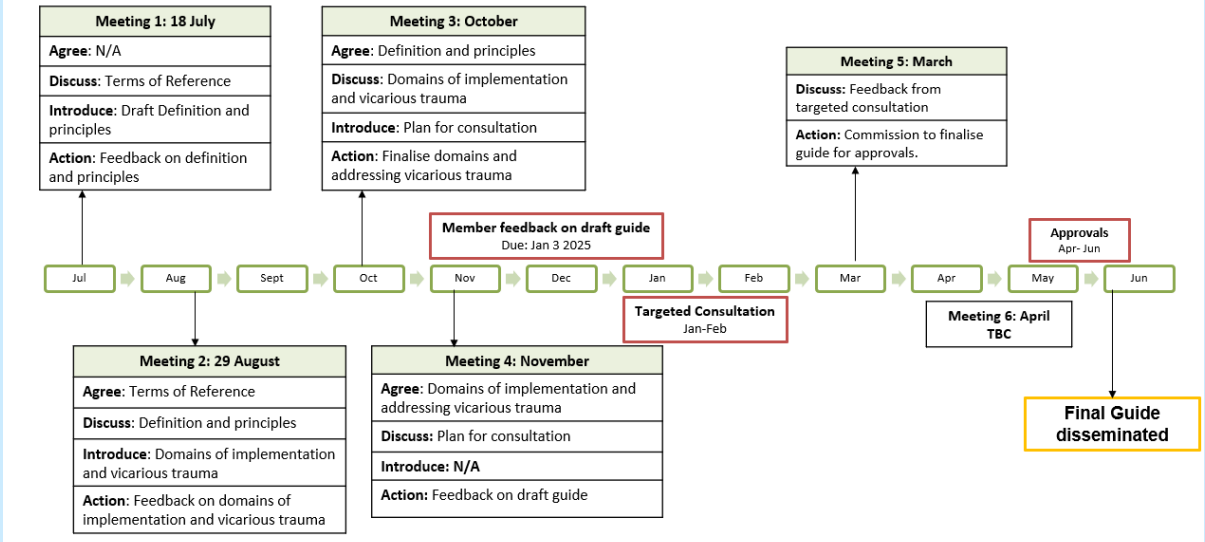
The Working Group consists of representatives from:

- Mental Health Commission
- Department of Education
- Department of Communities
- Department of Health
- Department of Justice
- WA Police Force
- Aboriginal Health Council of Western Australia
- Lived experience representatives

Agencies are responsible for nominating representatives from their agencies with the relevant skills and expertise to deliver on the purpose, objectives, and priorities of the Working Group.

Other agency representatives or observers may be invited to attend meetings and participate as required and agreed by the Chair.

Timeline



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

The Office will continue to monitor the steps taken to give effect to Recommendation 8 and will publish an update in the Office's 2024-25 Annual Report.

Inspection and Monitoring Functions

Inspection of 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 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 the WA Police Force in order to ascertain the extent of the WA Police Force's compliance with Parts 2 and 3 of the Act.

Part 4 also provides that the Commissioner of Police must keep a register (**the register**) of certain information related to the exercise of powers conferred under the Act. The information in the register must be provided 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 first annual report, *Report of the monitoring activities of the Parliamentary Commissioner for Administrative Investigations under Part 4 of the Criminal Law (Unlawful Consorting and Prohibited Insignia) Act 2021* for the period ending 23 December 2023, was tabled in Parliament on 13 March 2024.

Monitoring of Protected Entertainment Precincts

The *Liquor Control Act 1988* (**the Liquor Control Act**) was amended through the *Liquor Control Amendment (Protected Entertainment Precincts) Act 2022* (**the Amendment Act**) to provide for the establishment of Protected Entertainment Precincts and for the exclusion of people from a precinct who behave in an unlawful, anti-social, violent, disorderly, offensive, indecent or threatening way, or are convicted of specified serious offences, which occurred in the precinct. The Amendment Act received Royal Assent on 1 December 2022 with Part 5AA of the Act (containing the protected entertainment precincts provisions) commencing on 24 December 2022.

Under the Liquor Control Act, the Ombudsman must keep under scrutiny the operation of, and the exercise of powers under, the provisions of Part 5AA of the Liquor Control Act, any regulations made for the purposes of Part 5AA and any regulations made to prescribe an area of the State to be a Protected Entertainment Precinct.

As soon as practicable after the third anniversary of the day on which Part 5AA of the Liquor Control Act comes into operation, the Ombudsman must prepare a report on the Ombudsman's monitoring work and activities and give a copy of the report to the Minister and to the Commissioner of Police.

The report must, if the Ombudsman has identified any group in the community that is particularly affected by the operation of, or the exercise of powers under the provisions of this new law, include a review of the impact of the operation of, and the exercise of powers under, those provisions on that group. The report may also include recommendations about amendments that might appropriately be made to the Liquor Control Act.

The Ombudsman may at any other time considered appropriate, prepare a report on the Ombudsman's work and activities and give a copy of the report to the Minister and the Commissioner of Police.

The Minister must cause a report to be tabled in Parliament as soon as practicable after the Minister received the report.

Reportable Conduct Scheme

Background

The *Royal Commission into Institutional Responses to Child Sexual Abuse* (**the Royal Commission**) highlighted the numerous times and ways in which children reported abuse and were not believed, or no action was taken. The Royal Commission recommended that States and Territories establish Reportable Conduct Schemes to prevent harm to children by holding organisations accountable for the conduct of their staff.

Western Australia's Reportable Conduct Scheme (**Scheme**) commenced on 1 January 2023, following amendments to the *Parliamentary Commissioner Act 1971* (**Act**). The Scheme expanded significantly on 1 January 2024 to include additional agencies, as well as additional types of reportable conduct.

What is the Reportable Conduct Scheme?

The Scheme compels heads of organisations that exercise care, supervision or authority over children to notify allegations of, or convictions for, child abuse by their employees to the Ombudsman and then investigate these allegations. The Ombudsman will monitor, oversee and review these investigations.

Expansion of the Scheme

The jurisdiction of the Scheme expanded on 1 January 2024 to include additional organisations as well as new types of reportable conduct.

From 1 January 2024, the Scheme included the following additional organisations:

- Accommodation and residential services;
- Religious institutions; and
- Disability services.

At full operation the Scheme now requires over 4,000 organisations across Western Australia to report to the Ombudsman.

The additional types of conduct added from 1 January 2024 are as follows:

- Significant neglect of a child; and
- Any behaviour that causes significant emotional or psychological harm to a child.

The role of the Ombudsman under the Reportable Conduct Scheme

The role of the Ombudsman under the Scheme is comprised of the following functions, set out in section 19M(1) of the Act:

(a) to oversee and monitor the reportable conduct scheme;

(b) to educate and provide advice to relevant entities in order to assist them to identify and prevent reportable conduct and to notify and investigate reportable allegations and reportable convictions;

(c) to support relevant entities to make continuous improvement in the identification and prevention of reportable conduct and the reporting, notification and investigation of reportable allegations and reportable convictions;

(d) to monitor the investigation of reportable allegations and reportable convictions by relevant entities;

(e) if the Commissioner considers it to be in the public interest to do so – to investigate reportable allegations and reportable convictions;

(f) if the Commissioner considers it to be in the public interest to do so – to investigate whether reportable allegations or reportable convictions have been appropriately handled or investigated or responded to by the head of a relevant entity;

(g) to make recommendations to relevant entities in relation to the findings of the investigations referred to in paragraph (e) or (f);

(h) to monitor the compliance of relevant entities with the reportable conduct scheme and whether appropriate and timely action is taken by a relevant entity;

(i) to monitor a relevant entity's systems for preventing, notifying and dealing with reportable conduct;

(j) to report to Parliament on the reportable conduct scheme;

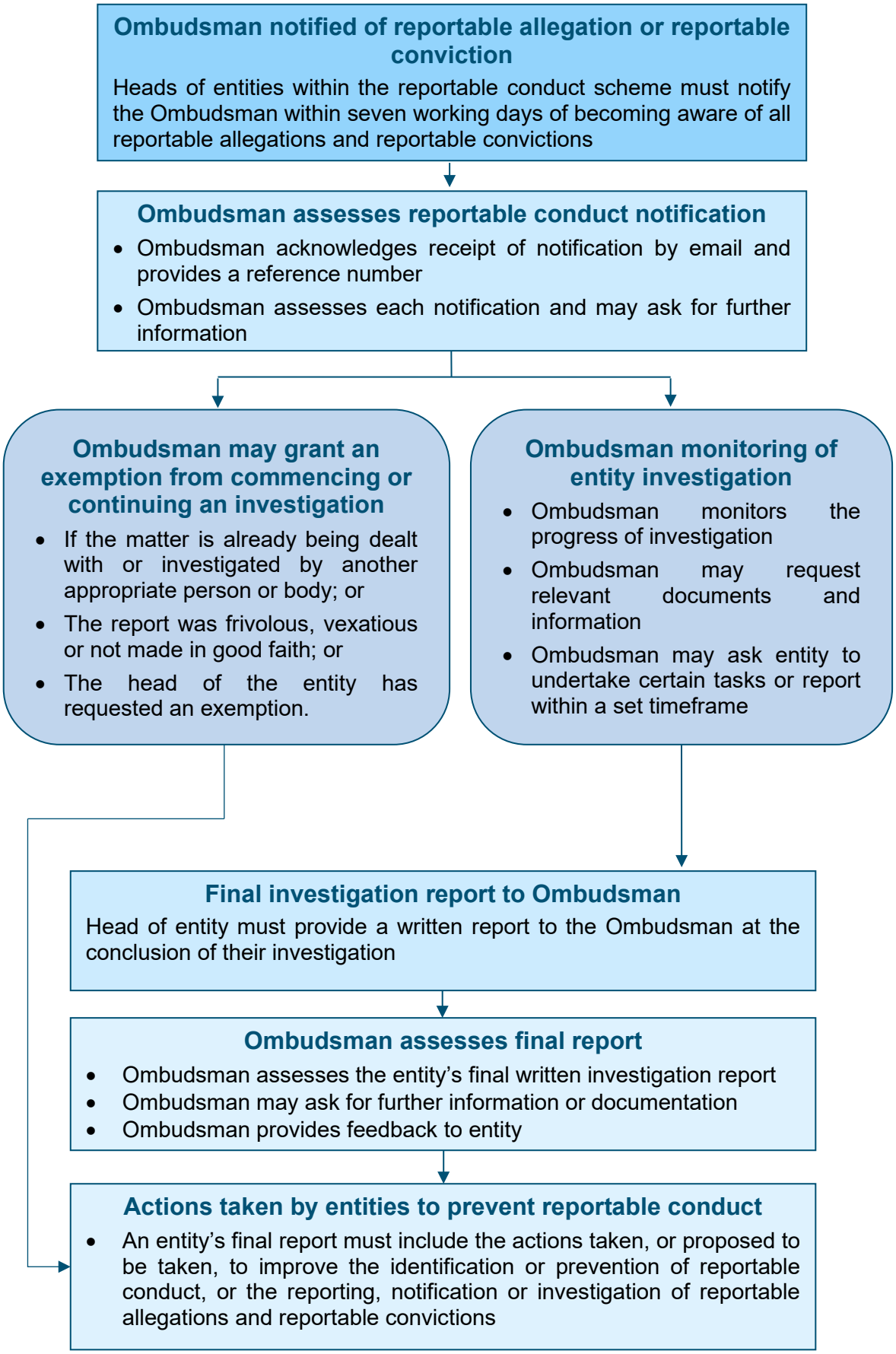
(k) to perform any other function conferred on the Commissioner under this Division.

In undertaking his role under the Scheme, the Ombudsman is required to regard the best interests of children as the paramount consideration, under section 19K of the Act:

19K. Paramount consideration

The Commissioner [Ombudsman] and any other person performing functions under this Division must regard the best interest of children as the paramount consideration.

The Reportable Conduct Process



Reportable allegations and convictions

Organisations within the scope of the Scheme are required to notify the Ombudsman within seven working days of becoming aware of:

- a **reportable allegation** (namely, matters that include 'any information that leads a person to form the belief on reasonable grounds that an employee of a relevant entity has engaged in reportable conduct or conduct that may involve reportable conduct'); and
- a **reportable conviction** (that are matters involving 'a conviction, whether before, on or after commencement day, for an offence under a law of this State, another State, a Territory or the Commonwealth that is an offence referred to in section 19G(1)(a) [a sexual offence] or (d) [an offence prescribed by the regulations for the purposes of this paragraph].'

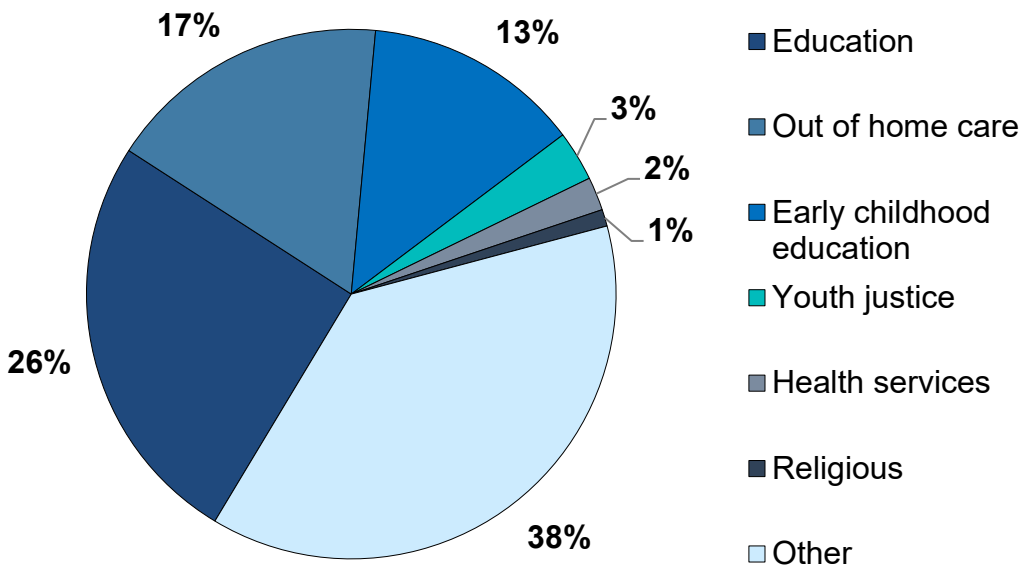
Notifications of reportable allegations

During 2023-24, the Office received 696 notifications of reportable allegations under the Scheme. The Office has not received any notifications of reportable convictions since 1 January 2023.

Notifications by sector

In 2023-24, the education, out of home care, and early childhood education sectors reported most frequently to the Office (26 per cent, 17 per cent and 13 per cent, respectively), as shown in the chart below:

Percentage of notifications of reportable allegations, by sector



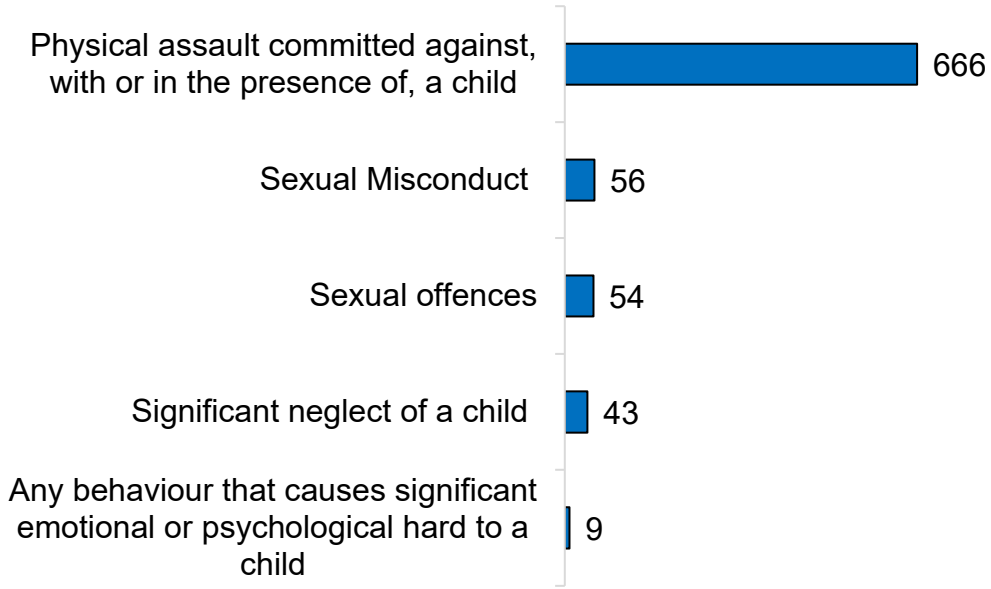
Reportable conduct notifications by reportable allegation type

Under the Act, there are six types of allegations of reportable conduct that must be reported to the Ombudsman:

- Sexual offences (against, with or in the presence of, a child);
- Sexual misconduct (against, with or in the presence of, a child);
- Physical assault (against, with or in the presence of, a child);
- Significant neglect of a child;
- Any behaviour that causes significant emotional or psychological harm to a child; and
- An offence prescribed by the regulations (none at present).

The majority of notifications received in 2023-24 involved allegations of physical assault (80 per cent), as shown in the chart below:

Number of reportable conduct notifications by type of reportable conduct



Enquiries

The Office has a dedicated reportable conduct enquiries line and email address as an important part of its function to provide information and education about the Scheme. During 2023-24, the Office received 290 enquiries.

Findings and outcomes of entity investigations of reportable conduct

Section 19Z of the Act requires organisations to provide the Office with a written report of the outcomes of all reportable conduct investigations, including the actions taken.

The Office assesses each investigation report against the requirements of the Act and may seek further information regarding an entity's response to a reportable allegation. A relevant entity may also be provided with advice or education to assist it in improving its systems for preventing, identifying and responding to reportable conduct.

Of the investigations undertaken by organisations, and monitored by the Office, in 2023-24, 98% were found to be compliant with the requirements of the Act. In 2023-24, the Office received 144 investigation reports.

Exempt investigations

The Ombudsman may exempt the head of a relevant entity from commencing or continuing an investigation in certain circumstances, including when:

- the matter is already being dealt with or investigated by another appropriate person or body; or
- the head of the relevant entity has made a request for the exemption in a notice under section 19Y of the Act.

During 2023-24, the Office received 89 requests from a relevant entity requesting an exemption from continuing an investigation:

- 5 requests were later withdrawn by the relevant entity;
- 70 exemptions were granted; and
- 14 requests for an exemption were under consideration on 30 June 2024.

Exempt organisations

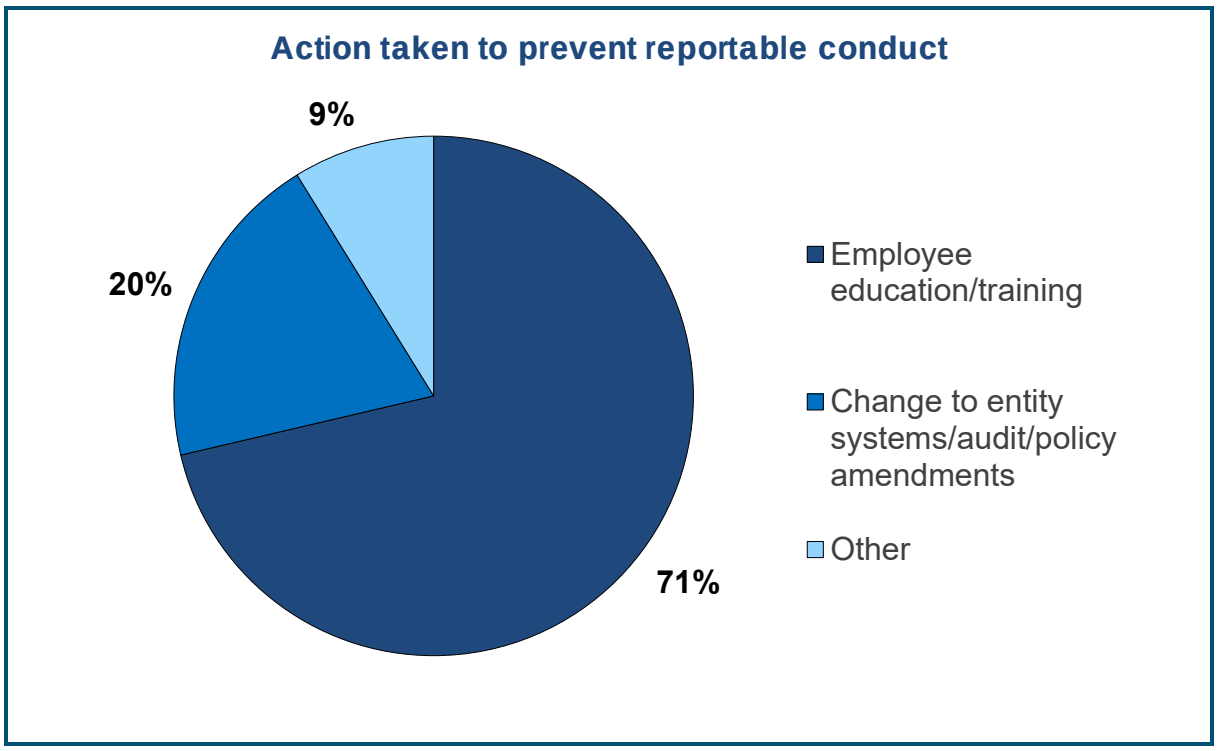
The Ombudsman may also exempt an organisation from the Scheme, by written notice given pursuant to section 19O of the Act.

During 2023-24, no organisations were exempted from the Scheme.

Action taken to prevent reportable conduct

During 2023-24, a total of 477 actions were taken by organisations to prevent reportable conduct at the conclusion of a reportable conduct investigation.

The chart below provides a summary of the types of actions taken to improve reportable conduct systems within organisations:



The Office collects a range of additional information about the improvement actions undertaken by organisations at all stages of the reportable conduct process, including actions taken prior to Ombudsman involvement and actions taken during the identification and notification of a reportable conduct matter regarding the safety of children.

The types of organisations covered by the Reportable Conduct Scheme

The Scheme only applies to organisations that exercise care, supervision or authority over children. The types of organisations covered by the Scheme include:

- Western Australian government departments and authorities, and local governments;
- Child protection and out-of-home-care services:
  - Providers of approved foster carers and kinships carers;
  - Providers of residential care and family group homes;
- Early childhood education and care services:
  - Providers of approved education and care services and child care services;
  - Providers of an approved family day care service;
- Education services:
  - Government and non-government schools;
  - TAFE colleges;
  - Registered training organisations;
  - Universities;
- Health services:
  - Public health service providers;
  - Licensed private hospital service providers;
  - Mental health service providers that have inpatient beds for children;
  - Drug and alcohol treatment service providers that have inpatient beds for children;
  - Ambulance services;
- Justice and detention services:
  - A provider of a juvenile detention centre; and
  - A provider of community justice services funded by the Department of Justice.
- Accommodation and residential services:
  - Providers of a homelessness service that provides overnight beds specifically for children as part of its primary activities and is funded by the Department of Communities;
  - Providers of boarding facilities for students who are children;
  - Organisations that provide overnight camps for children as part of its primary activity;
  - A provider of any other accommodation or respite services for children;
- Religious bodies; and
- Disability service providers.

Education and guidance

The Office undertakes its function of providing education and guidance through:

- Our dedicated enquiries line and reportable conduct email address;
- Providing information to organisations during reportable conduct investigations;
- Delivering in-person and online presentations to organisations; and
- Publishing a range of online guidance and support materials on our website.

During 2023-24, the Office worked closely and cooperatively with stakeholders in key sectors and organisations included in the Scheme to provide education and guidance to assist in building their capacity to meet their reporting obligations and comply with the Scheme. This included:

- Attending meetings with organisations and delivering workshops on the Scheme;
- Developing tailored guidance and support materials and education programs for each sector, in collaboration with peak bodies for the sector; and
- Providing information to organisations to assist them in their handling of individual investigations.

During 2023-24, the Office held a range of information sessions and workshops for organisations covered by the Scheme and other stakeholders. The Office provided 17 workshops with early education providers, five religious organisations, and 12 other in-scheme organisations; as well as regional outreach in Geraldton. An inter-agency forum was held in June 2024 to coordinate communication and engagement between agencies.

In addition, the Office regularly liaised with a range of bodies in relation to the Scheme, including:

- The Department of Communities
- The Department of Education
- The Department of Health
- The Department of Justice
- WA Police Force.

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 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 with integrity and accountability bodies to promote best practice, efficiency and leadership. Working with these bodies 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 other 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.

Our involvement:

The Ombudsman is a member of ANZOA. The Office periodically provides general updates on its activities and has nominated representatives who participate in interest groups in the areas of Indigenous engagement, systemic issues and policy influence, people and development, data and analytics, and public relations and communications.

Providing Access to the Community

Communicating with complainants

The Office provides a range of information and services to assist specific groups, and the public more generally, to understand the role of the Ombudsman and the complaint process. Many people find the Office's enquiry service and drop-in sessions held during regional visits assist them to make their complaint. Other initiatives in 2023-24 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 sessions 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 online. The importance of providing an accessible online service is demonstrated by the online complaint form overtaking email as the preferred method to lodge complaints for the first time. This year 45% of all complaints received were lodged through the online complaint form compared to 40% by email and the remaining 15% by post and other methods;
- 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. People with hearing and speech impairments can contact the Office using the National Relay Service;
- The Office's Regional Awareness and Accessibility Program targets awareness and accessibility for regional and Aboriginal Western Australians;
- The Office attends events to raise community awareness of, and access to, its services, such as information stands at:
    - The City of Armadale NAIDOC Festival in July 2023;
    - The Financial Counsellors' Association of WA Conference marketplace in October 2023;
    - Seniors Recreation Council of WA 'Have a Go Day' in November 2023;
    - The Wagin Woolorama Agricultural Show in March 2024; and
    - The Financial Counselling Australia Conference in May 2024.
- 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.

Staff from Ombudsman Western Australia (also representing the Energy and Water Ombudsman Western Australia) with staff from the Telecommunications Industry Ombudsman and Consumer Protection at the Wagin Woolorama Agricultural Show, March 2024.

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;
- Organisations that work with children on the Reportable Conduct Scheme;
- 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;
- People from diverse backgrounds, including information in a wide range of community languages;
- Access to the Ombudsman's reports such as *A report on giving effect to the recommendations arising from the Investigation into family and domestic violence and suicide*;
- The latest news about 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 2023-24:

- The total number of visits to the website was 198,430; nearly double the year before;
- The top five most visited pages (besides the homepage and the Contact Us page) on the site were *How to make a complaint*, *What you can complain about*, *Making your complaint*, *Reportable Conduct*, and *Complaints by Overseas Students*; and
- The *Effective Handling of Complaints Made to Your Organisation Guidelines* and *Procedural Fairness Guidelines* were the two most viewed documents.

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2023-24. Regional visits were conducted to:

- Carnarvon in the Gascoyne Region in September 2023;
- Esperance in the Esperance-Goldfields Region in December 2023; and
- Geraldton and Mullewa in the Mid-West Region in May 2024.

The visits include activities such as:

- Drop-in sessions, which provided an opportunity for members of the local community to raise their concerns face-to-face with the staff of the Office;
- Information sessions for the Aboriginal community, Elders and service providers, which 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 information about our role;
- Liaison with public authorities, including a workshop on *Effective Complaint Handling* in Geraldton in May 2024; and
- Liaison with organisations that work with children to provide information about the Reportable Conduct Scheme, including an *Introduction to the Reportable Conduct Scheme* information session in Geraldton in May 2024.

The Program is an important way for the Office to raise awareness of its services and provide access to its services for regional and Aboriginal Western Australians. In 2023-24, 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 Telecommunications Industry Ombudsman, the Australian Financial Complaints Authority, the Department of Energy, Mines, Industry Regulation and Safety – Consumer Protection, and the Aboriginal Legal Service. This collaborative approach provides additional benefits to people in the regions as it helps provide a 'one-stop-shop' model for complaints.

The Office also held an information stall at the Wagin Woolorama Agricultural Show in March 2024, in collaboration with the Energy and Water Ombudsman and Telecommunications Industry Ombudsman.

The Program enables the Office to:

- Deliver key services directly to regional communities, particularly through drop-in sessions 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.

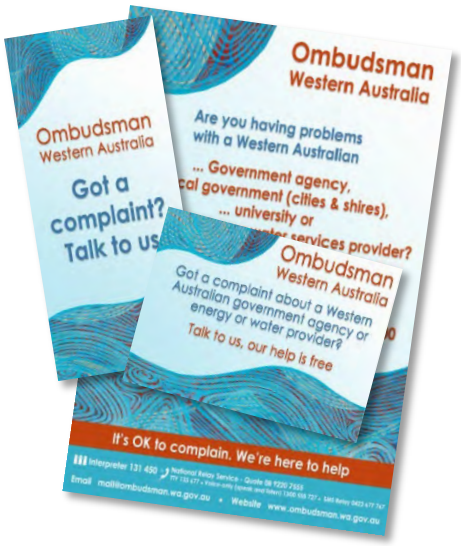
Staff from the Equal Opportunity Commission, Ombudsman Western Australia, Telecommunications Industry Ombudsman, Health and Disability Services Complaints Office, and the Australian Financial Complaints Authority at the drop-in session in Carnarvon, September 2023.

Staff from the Equal Opportunity Commission, Commonwealth Ombudsman, Aboriginal Legal Service, Ombudsman Western Australia, Telecommunications Industry Ombudsman, and Health and Disability Services Complaints Office in Esperance, December 2023.

Aboriginal engagement

In 2018, the Office established the Aboriginal Engagement and Collaboration Branch led by an Assistant Ombudsman, the first time an executive-level position was created for the Office's work with Aboriginal people.

The Office also engaged an Aboriginal artist in 2018 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 Aboriginal Engagement and Collaboration Branch members:

- Attended events and meetings with government and non-government service providers;
- Engaged with Aboriginal organisations to provide an opportunity to raise issues affecting the Aboriginal community and to raise awareness of the Office's role; and
- Participated in Aboriginal community information sessions in the regions as part of its Regional Awareness and Accessibility Program.

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

Prison Program

The Office continued the Prison Program during 2023-24. Three 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, Presentations and Training

The Ombudsman and staff delivered speeches, presentations and training throughout the year:

- Address by the Ombudsman and (then) IOI President on the occasion of the Australia and New Zealand Ombudsman Association annual *Meeting of the Minds* Conference in July 2023;
- *The Role of the Ombudsman* by the Manager Community Engagement and Business Intelligence to the Aboriginal Legal Service in July 2023;
- *Role of the Child Death Reviews and Family and Domestic Violence Fatality Reviews by the Ombudsman* by the Senior Assistant Ombudsman Reviews to the Youth Justice Services Team Leaders Conference in August 2023;
- An information session and roundtable meeting with staff from state government agencies and local governments as part of the regional visit to Carnarvon in September 2023;
- The Senior Assistant Ombudsman Energy and Water participated in the *Ask an Ombudsman* panel at the Financial Counsellors Association of WA Conference in October 2023;
- An information session and roundtable meeting with staff from state government agencies and local governments as part of the regional visit to Esperance in December 2023;
- *The Ombudsman and Energy and Water Ombudsman* by the Manager Community Engagement and Business Intelligence to financial counsellors hosted by the Financial Counselling Association of WA in March 2024;
- *Effective Complaint Handling* workshop by the Senior Assistant Ombudsman Energy and Water for staff from state government agencies and local governments as part of the regional visit to Geraldton in May 2024;
- *Introduction to the Reportable Conduct Scheme* presentation by the Oversight and Investigations Officer to government and non-government organisations that work with children as part of the regional visit to Geraldton in May 2024; and
- The Senior Assistant Ombudsman Energy and Water and the Principal Consultant Aboriginal Engagement and Collaboration participated in the *First Nations Yarning Circle* at the Financial Counselling Australia National Conference in May 2024.

Speeches by the Ombudsman are available on the Speeches by the Ombudsman page of the website.

Staff from the Reportable Conduct Team also held 32 information sessions, in person and online, about the Reportable Conduct Scheme to various government and non-government organisations. More information is provided in the Reportable Conduct Scheme section of this report.

Liaison with Public Authorities

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

See further details in the following sections:

- Complaint Resolution section
- Child Death Review section
- Family and Domestic Violence Fatality Review section
- Reportable Conduct Scheme section
- Own Motion Investigations, Inspections and Monitoring section.

Publications

The Office has a comprehensive range of publications about the role of the Ombudsman, which are available on the Ombudsman's website.

A range of new publications were developed during 2023-24, particularly for the Reportable Conduct Scheme.