Child Death Review

This section sets out the work of the Ombudsman's office in relation to its child death review function. Information on this work has been divided as follows:

- Background;
- The role of the Ombudsman's office in child death reviews;
- Notifications and reviews;
- Patterns and trends identified from child death reviews;
- Improvements to public administration to prevent or reduce child deaths;
- Major own motion investigations arising from child death reviews; and
- Stakeholder liaison.

Background

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

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

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

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

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

The Role of the Ombudsman's Office in Child Death Reviews

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

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

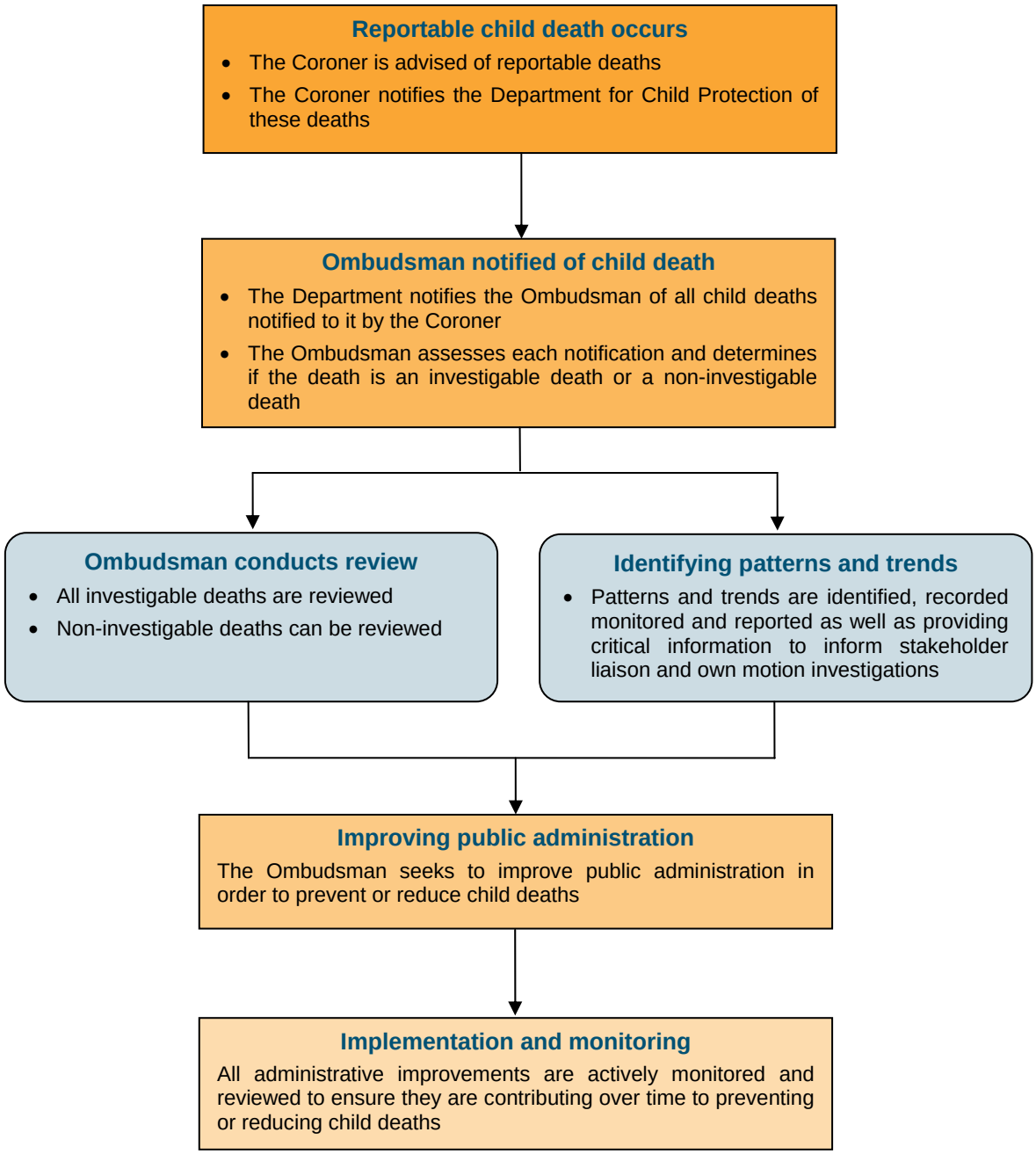
In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

By reviewing child deaths and identifying patterns and trends the Ombudsman seeks to improve public administration to prevent or reduce child deaths.

In addition to reviewing investigable deaths the Ombudsman can investigate the actions of other public authorities.

In reviewing child deaths the Ombudsman has wide powers of investigation, including powers to obtain information relevant to the death of a child.

The Child Death Review Process



Notifications and Reviews

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

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

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

Child Death Review Cases Prior to 30 June 2009

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

Number of Child Death Reviews in 2010-11

During 2010-11 there were 31 child deaths that were investigable and subject to review from a total of 118 child death notifications received.

Comparison of Investigable Deaths over Time

The Ombudsman commenced the child death review function on 30 June 2009. Prior to that, child death reviews were undertaken by the CDRC with the first full year of operation of the CDRC in 2003-04.

The following table provides the number of deaths that were determined to be investigable by the Ombudsman or reviewable by the CDRC compared to all child deaths in Western Australia for the eight years from 2003-04 to 2010-11. It is important to note that an investigable death is one which meets the legislative criteria and does not necessarily mean that the death was preventable, or that there has been any failure of the responsibilities of the Department.

Comparisons are also provided with the number of child deaths reported to the Coroner and deaths where the child or a relative of the child was known to the Department. It should be noted that children or their relatives may be known to the Department for a range of reasons.

Year	A Total WA child deaths (excluding stillbirths) (See Note 1)	B Child deaths reported to the Coroner (See Note 2)	C Child deaths where the child or a relative of the child was known to the Department (See Note 3)	D Reviewable/ investigable child deaths (See Note 4)
2003-04	177	92	42	19
2004-05	212	105	52	19
2005-06	210	96	55	14
2006-07	165	84	37	17
2007-08	187	102	58	30
2008-09	167	84	48	25
2009-10	201	93	52	23
2010-11	199	118	60	31

Abbreviations

Department: Department for Child Protection for the years 2006-07 to 2009-10 and Department for Community Development **(DCD)** for the preceding years.

Notes

1. The data in Column A has been provided by the Registry of Births, Deaths and Marriages. Child deaths within each year are based on the date of death rather than the date of registration of the death. The CDRC included numbers based on dates of registration of child deaths in their Annual Reports in the years 2005-06 through to 2007-08 and accordingly the figures in Column A will differ from the figures included in the CDRC Annual Reports for these years because of the difference between dates of child deaths and dates of registration of child deaths.
2. The data in Column B has been provided by the Office of the State Coroner. Reportable child deaths received by the Coroner are deaths reported to the Coroner of children under the age of 18 years pursuant to the provisions of the *Coroners Act 1996*. The data in this section is based on the number of deaths of children that were reported to the Coroner during the year.
3. The data in Column C has been provided by the Department and is based on the date the notification was received by the Department. For 2003-04 to 2007-08 this information is the same as that included in the CDRC Annual Reports for the relevant year. In the 2005-06 to 2007-08 Annual Reports, the CDRC counted 'Child death notifications where any form of contact had previously occurred with the Department: recent, historical, significant or otherwise'. In the 2003-04 and 2004-05 Annual Reports, the CDRC counted 'Coroner notifications where the families had some form of contact with DCD'.
4. The data in Column D relates to child deaths considered reviewable by the CDRC up to 30 June 2009 or child deaths determined to be investigable by the Ombudsman from 30 June 2009. It is important to note that reviewable deaths and investigable deaths are not the same, however, they are similar in effect. The definition of reviewable death is contained in the Annual Reports of the CDRC. The term investigable death has the meaning given to it under section 19A(3) of the *Parliamentary Commissioner Act 1971*.

Timely Handling of Notifications and Reviews

In 2010-11 the Ombudsman finalised 105 child death notifications. The Ombudsman's office places a strong emphasis on the timely review of child deaths. This ensures reviews are most relevant and contribute, in the most timely way possible, to the prevention or reduction of future deaths. Of the 105 notifications finalised in 2010-11, 57 per cent were closed within three months and 87 per cent were closed within six months.

Patterns and Trends Identified for Child Death Reviews

By examining all child death notifications, the Ombudsman is able to capture data relating to demographics, risk factors, social and environmental characteristics and identify patterns and trends in relation to child deaths. When child death notifications are finalised, all relevant issues are identified and recorded. Over time these issues indicate relevant patterns and trends in relation to child deaths. These patterns and trends are identified, recorded, monitored, reported and discussed. They also provide critical information for own motion investigations such as the Ombudsman's current own motion investigations examining planning for children in the care of the Department and deaths of infants, particularly sleep related infant deaths.

Important Information on Interpretation of Data

Information in this section is presented across the first two years of the operation of the Ombudsman's child death review function to give a better understanding of developing patterns and trends over time. However as the information in the following charts is based on two years of data only, significant care should be undertaken in interpreting the underlying trends arising from this data or trends from year to year.

Characteristics of Children who have Died

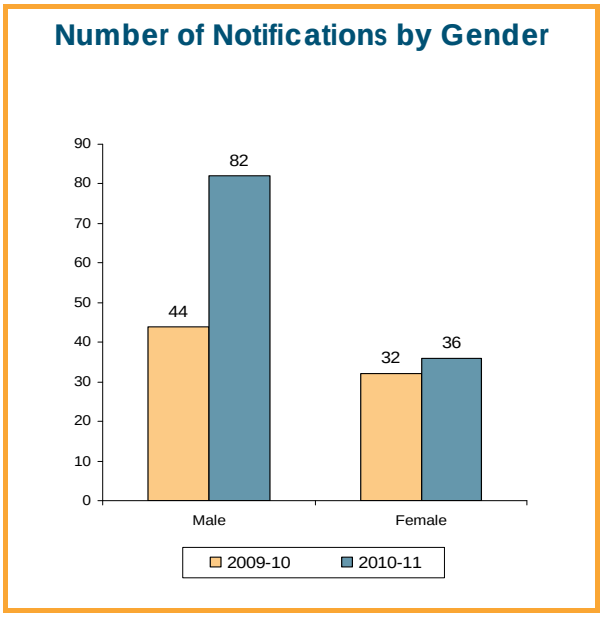
Information is obtained on a range of characteristics of the children who have died including gender, Indigenous status, various age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able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

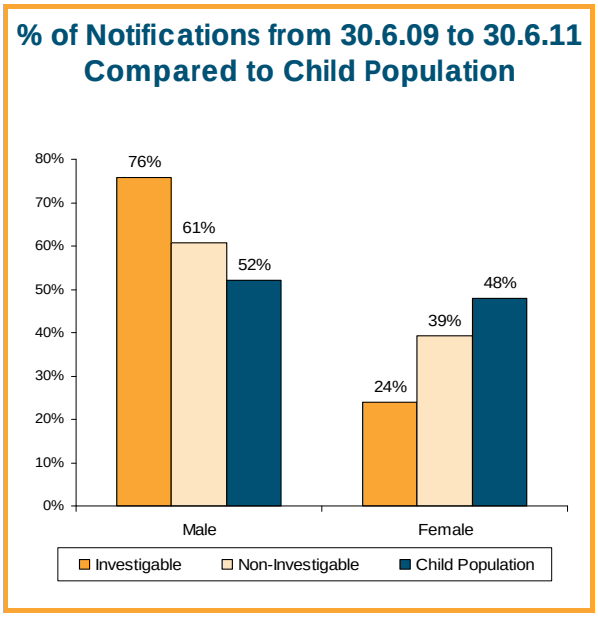
The following charts show:

- The number of children in each group for 2009-10 and 2010-11; and
- For the period from 30 June 2009 to 30 June 2011, the percentage of children in each group for both investigable deaths and non-investigable deaths, compared to the child population in Western Australia.

Males and Females

As shown in the following charts, male children are over-represented compared to the population in all deaths but particularly in investigable deaths.

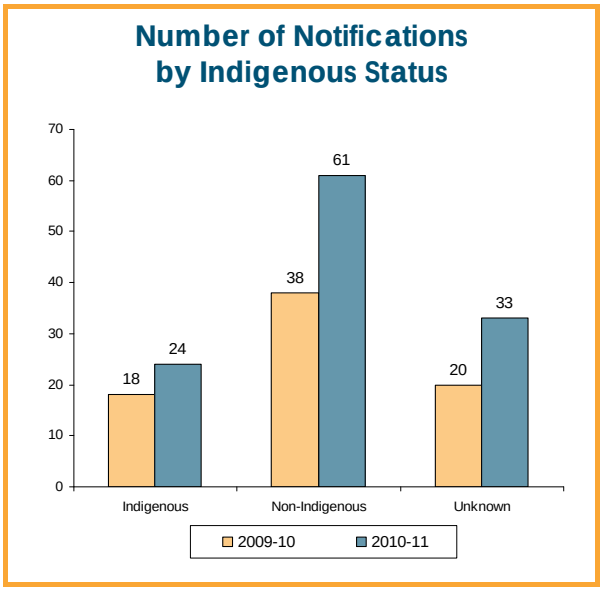


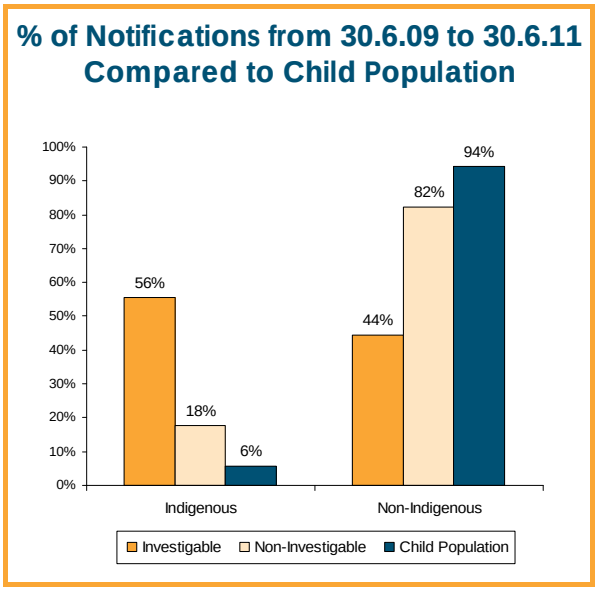


Further analysis of the data shows that male children who die are more likely than females to be Indigenous and living in regional areas.

Indigenous Status

As shown in the following charts, Indigenous children are over-represented compared to the population in all deaths and more so for investigable deaths.



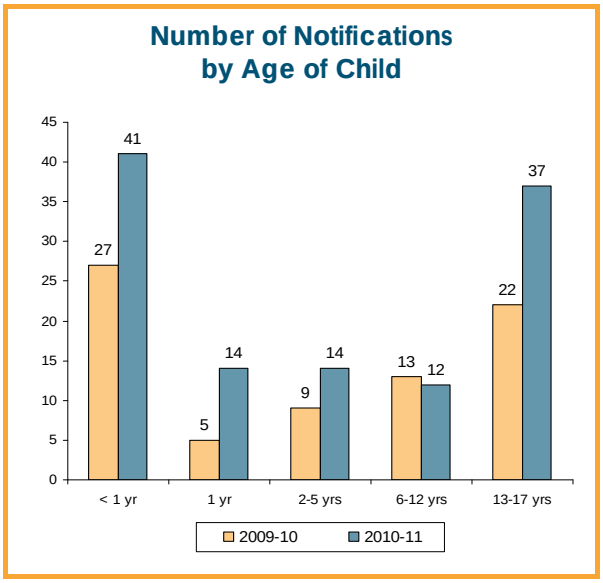


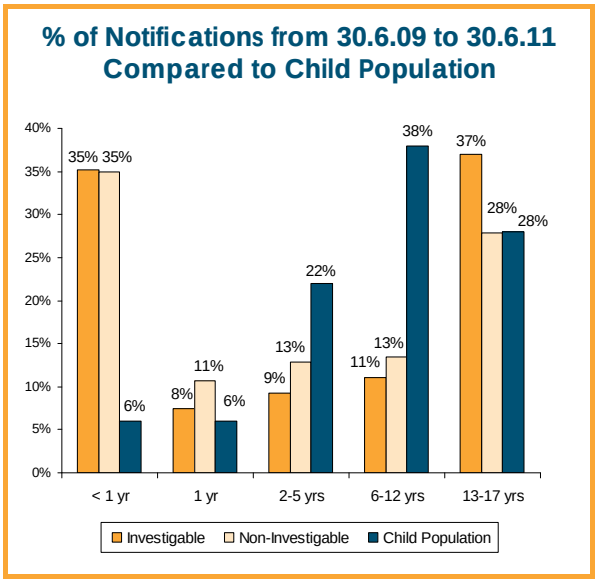
Note: Percentages for each group are based on the percentage of children whose Indigenous status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Indigenous status of the child.

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

Age Groups

As shown in the following charts, children under two years and children aged between 13 and 17 are over-represented compared to the child population as a whole.

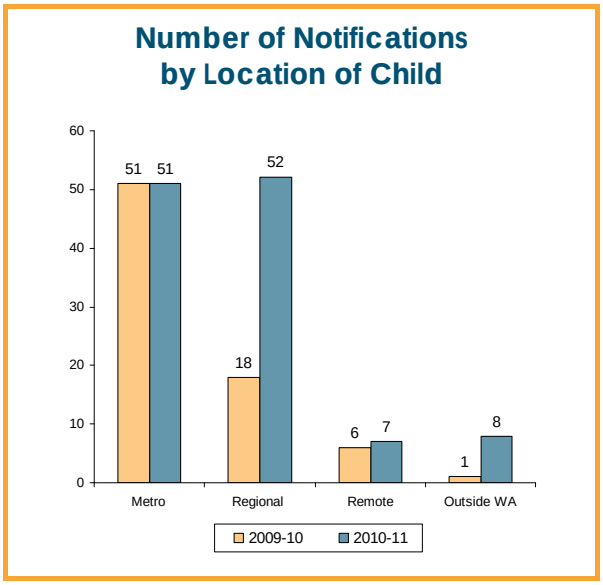


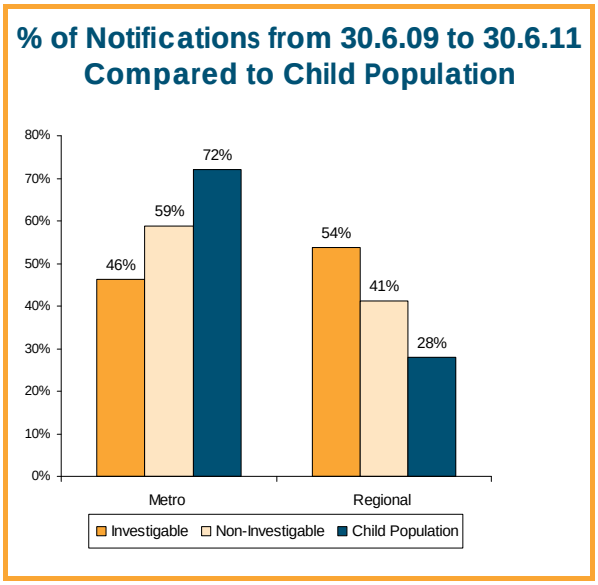


Further analysis of the data shows that a higher proportion of Indigenous children and children living in remote locations are under the age of one compared to other groups. A more detailed analysis by age group is provided later in this section.

Location of Residence

As shown in the following charts, children in regional locations are over-represented compared to the child population as a whole, and more so for investigable deaths.





Note: Outside WA includes children whose residence is not in Western Australia, but the child died in Western Australia. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on place of residence of the child.

Further analysis of the data shows that most Indigenous children who died were living in regional or remote locations when they died. However non-Indigenous children who died are also more likely to live in regional locations than the child population as a whole.

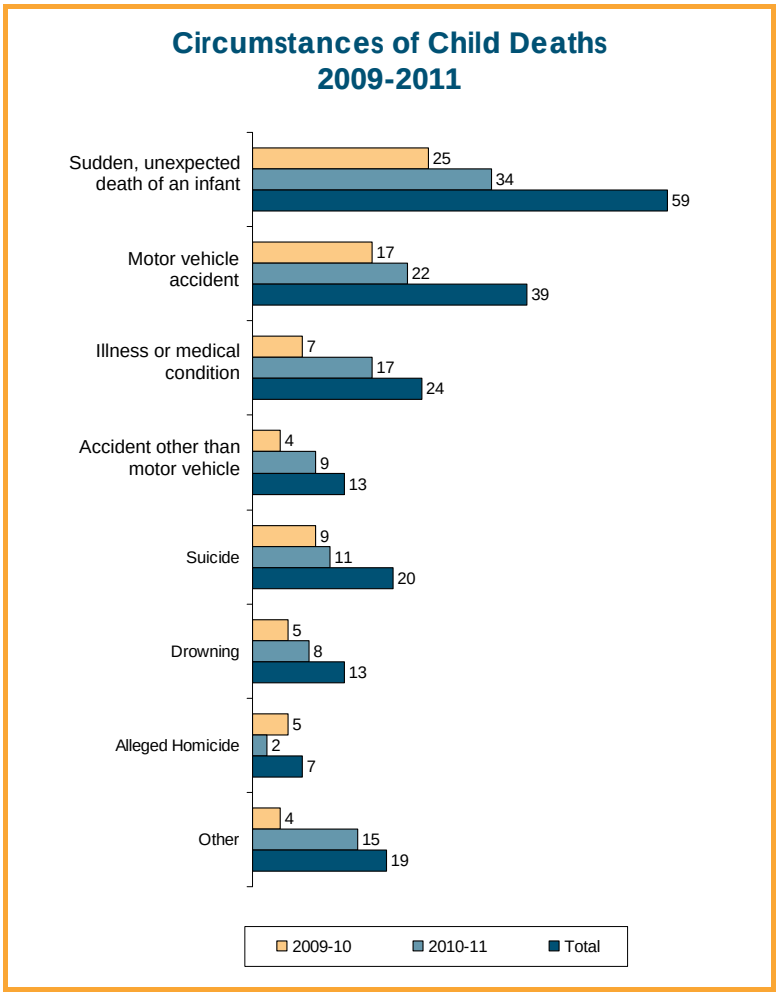
Circumstances of Child Deaths

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

The circumstances of death are categorised by the Ombudsman as:

- Sudden, unexpected death of an infant – that is, infant deaths in which the likely cause of death cannot be explained immediately;
- Motor vehicle accident – the child may be a pedestrian, driver or passenger;
- Illness or medical condition;
- Accident other than a motor vehicle accident – this includes accidents such as house fires, electrocution, falls and crushing injuries;
- Suicide;
- Drowning;
- Alleged Homicide; and
- Other.

The following chart shows the circumstances of notified child deaths over the last two years.



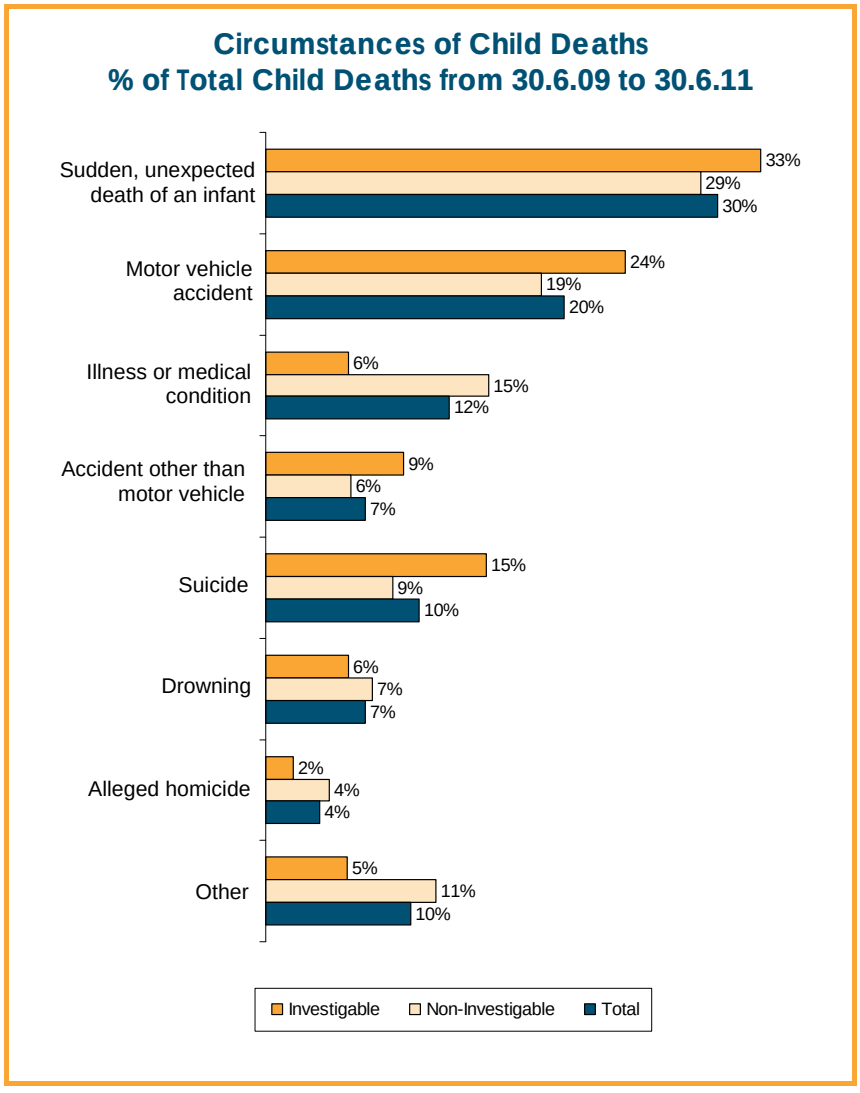
Note 1: In 2010-11 the "Other" category includes eight children who died in the SIEV (Suspect Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

Note 2: The numbers for each circumstance of death may vary from numbers previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

The two main circumstances of death are:

- Sudden, unexpected deaths of infants, representing 33% of the total child death notifications received in 2009-10 and 29% in 2010-11; and
- Motor vehicle accidents, representing 24% of the total child death notifications received in 2009-10 and 19% in 2010-11.

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



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

- Sudden, unexpected death of an infant;
- Motor vehicle accidents;
- Accidents other than motor vehicle; and
- Suicide.

Longer Term Trends in the Circumstances of Death

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

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

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

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

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

Ombudsman from 30 June 2009 – See Note 2

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

Year	Accident other than motor vehicle	Motor Vehicle Accident	Illness or medical condition	Asphyxiation /Suffocation	Alleged Homicide	Drowning	SUDI *	Suicide	Other
2009-10	4	17	7		5	5	25	9	4
2010-11	9	22	17		2	8	34	11	15

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

Note 1: The source of the CDRC's data is the CDRC's Annual Reports for the relevant year. For 2007-08, only partial data is included in the Annual Report. The remainder of the data for 2007-08 and all data for 2008-09 has been obtained from the CDRC's records transferred to the Ombudsman. Types of circumstances are as used in the CDRC's Annual Reports.

Note 2: The data for the Ombudsman is based on the notifications received by the Ombudsman during the year. The types of circumstances are as used in the Ombudsman's Annual Reports.

Social and Environmental Factors Associated with Investigable Deaths

A number of social and environmental factors affecting the child or their family may impact on the wellbeing of a child, such as:

- Family and domestic violence;
- Alcohol use;
- Parental supervision;
- Drug or substance use; and
- Homelessness.

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 the Department or another public authority.

Social or Environmental Factor	% of Finalised Investigable Deaths
Family and domestic violence	65%
Alcohol use	35%
Parental supervision	26%
Drug use	17%
Homelessness	17%

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:
  - Alcohol use was a co-existing factor in a third of the cases; and
  - Parental supervision was a co-existing factor in a third of the cases.
- Where alcohol use was present:
  - Drug or substance use was a co-existing factor in over a third of the cases; and
  - Parental supervision was a co-existing factor in half of the cases.

Reasons for Contact with the Department

In 2010-11 the majority of children were known to the Department because of contact relating to them or their family for financial problems or concerns for a child's wellbeing. Other reasons included family and domestic violence, parental support and access, foster or adoption enquiries.

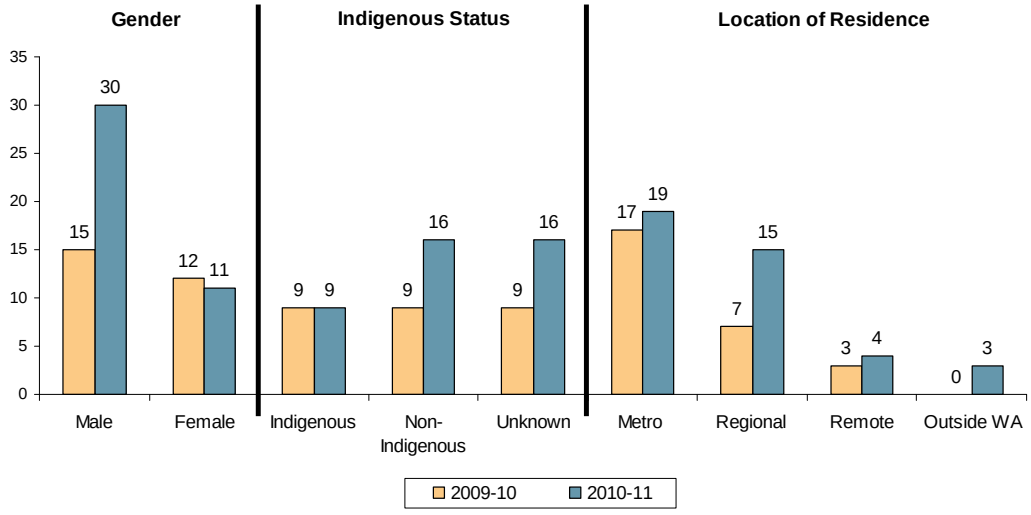
Patterns and Trends of Children in Particular Age Groups

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 the four groupings of infants (children under one year), 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 194 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2011, 68 (35%) were deaths of children aged less than one year **(infants)**. The characteristics of infants who died are shown in the following chart.

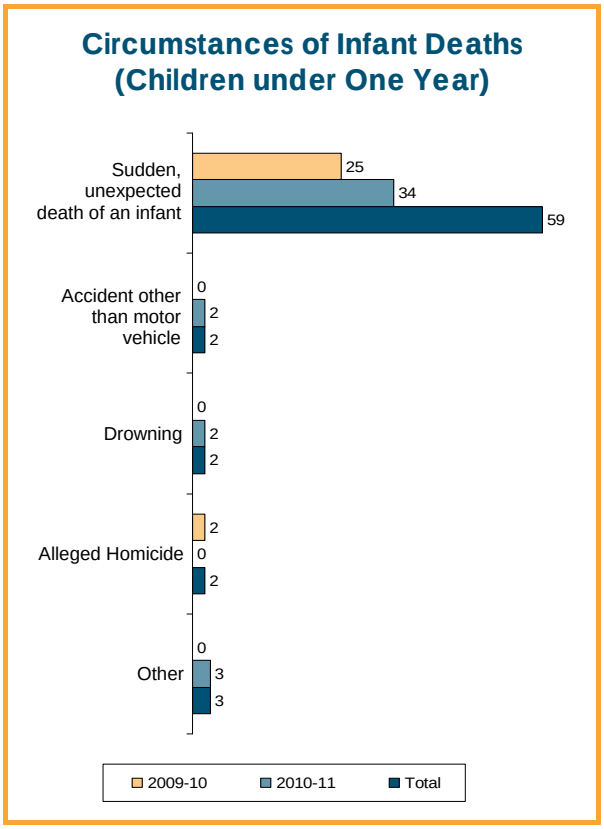
Characteristics of Infants (Children under One Year)

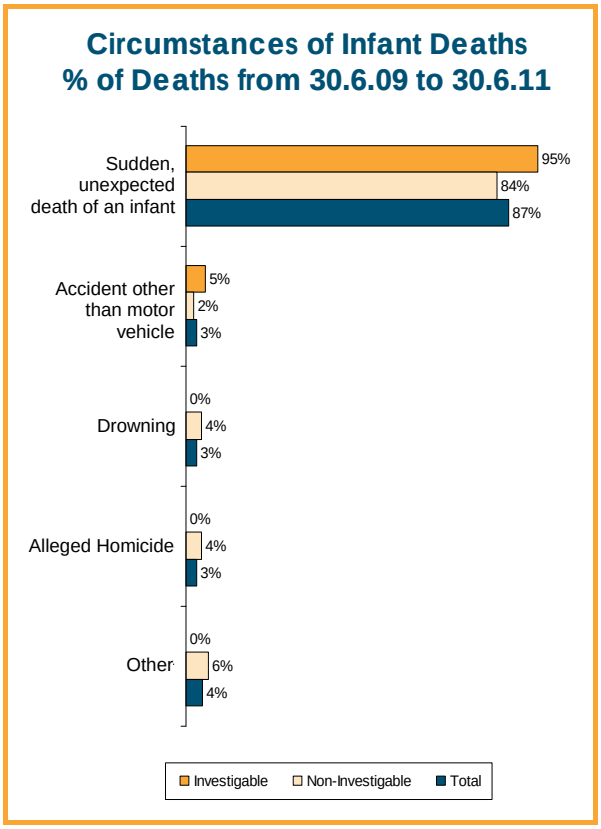


Further analysis of the data showed that, for these infant deaths, there was an over-representation compared to the child population for:

- Males – 89% of investigable infant deaths and 57% of non-investigable infant deaths were male compared to 52% in the child population;
- Indigenous children – 69% of investigable deaths and 26% of non-investigable deaths were Indigenous children compared to 6% in the child population; and
- Living in regional or remote locations – 58% of investigable infant deaths and 39% of non-investigable deaths of infants, living in Western Australia, were children living in regional or remote locations compared to 28% in the child population.

An examination of the patterns and trends of the circumstances of infant deaths showed that of the 68 infant deaths, 59 (87%) were categorised as sudden, unexpected deaths of an infant and the majority of these (39) appear to have occurred while the infant had been placed for sleep. There were a small number of other deaths as shown in the following chart.



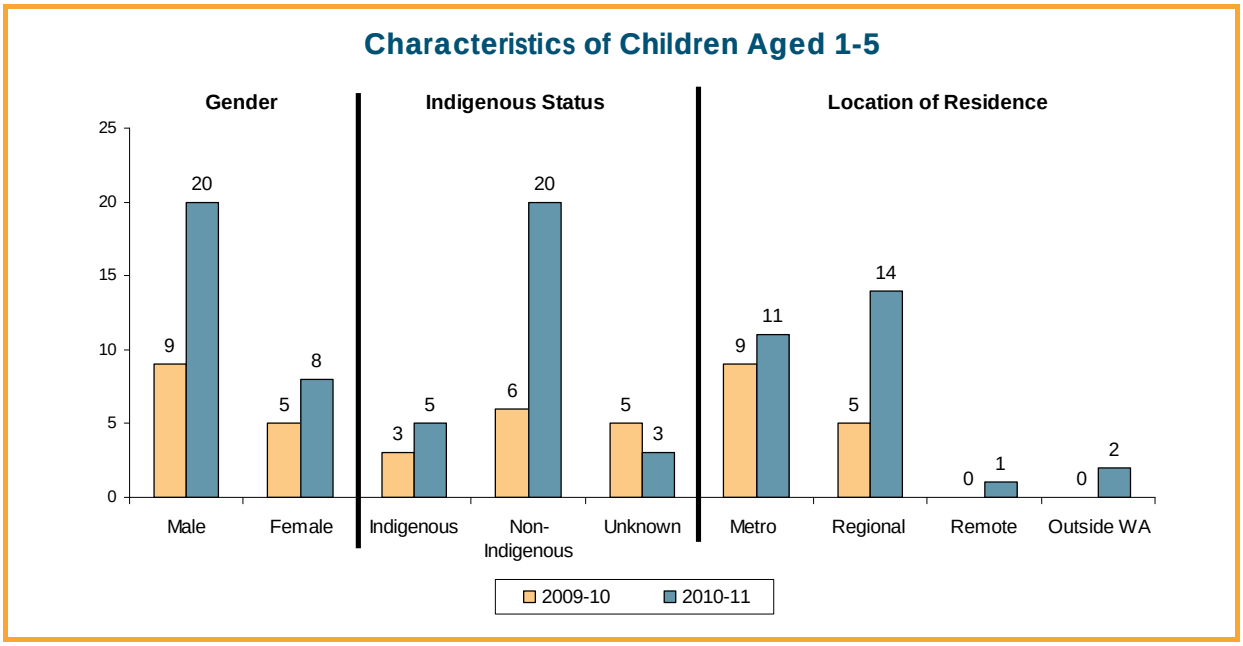


Nineteen infant death notifications received from 30 June 2009 to 30 June 2011 were determined to be investigable deaths.

Deaths of Children Aged 1 – 5 Years

Of the 194 child death notifications received from 30 June 2009 to 30 June 2011, there were 42 (22%) deaths of children aged one to five years.

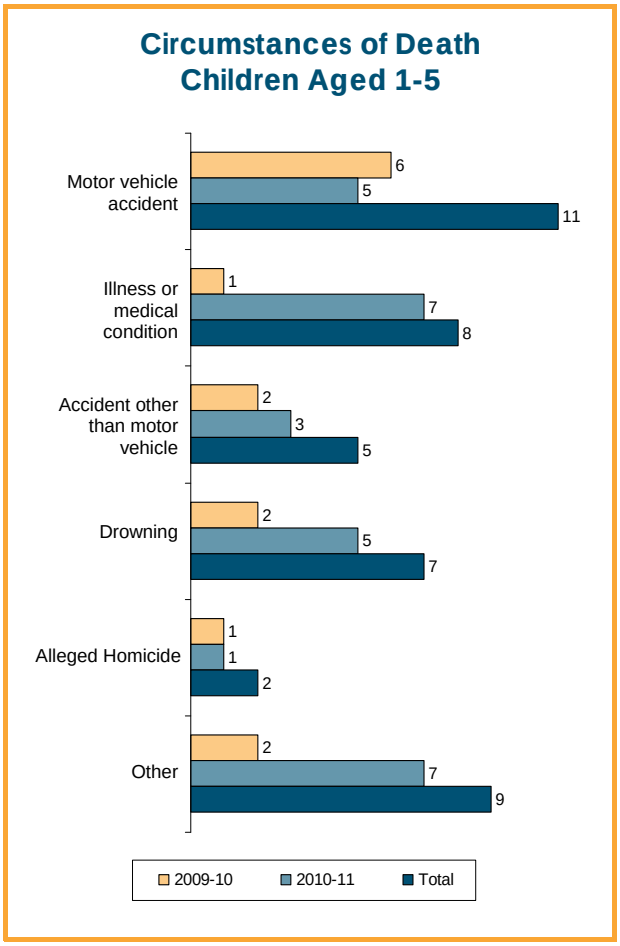
The characteristics of children aged 1-5 are shown in the following chart.

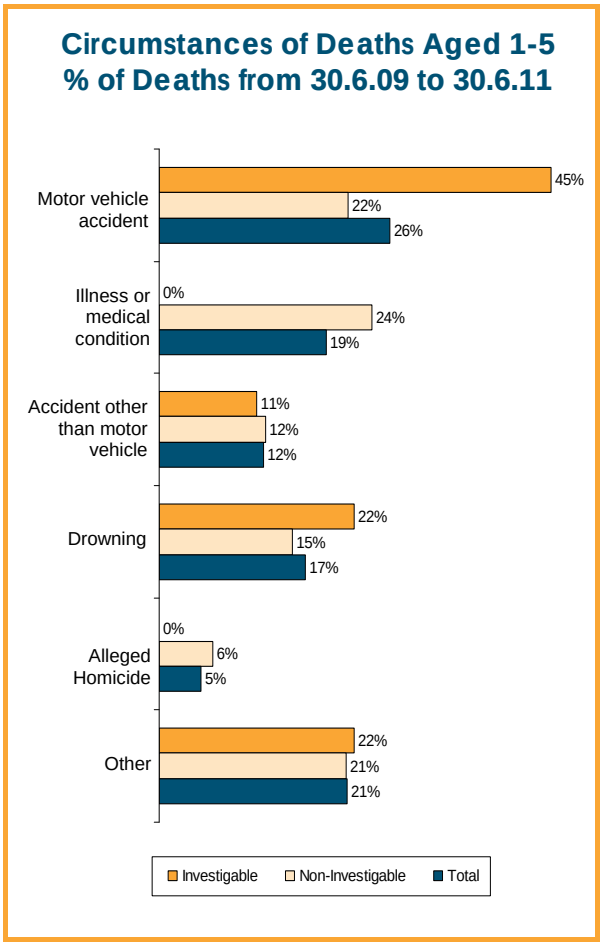


Further analysis of the data showed that, for these deaths, there was an over-representation compared to the child population for:

- Males – 78% of investigable deaths and 67% of non-investigable deaths of children aged 1 to 5 were male compared to 52% in the child population;
- Indigenous children – 63% of investigable deaths and 12% of non-investigable deaths of children aged 1 to 5 were Indigenous children compared to 6% in the child population; and
- Living in regional or remote locations – 56% of investigable deaths and 48% of non-investigable deaths of children aged 1 to 5, living in Western Australia, were children living in regional or remote locations compared to 28% in the child population.

As shown in the chart below, motor vehicle accidents is the largest circumstance of death category for this age group.

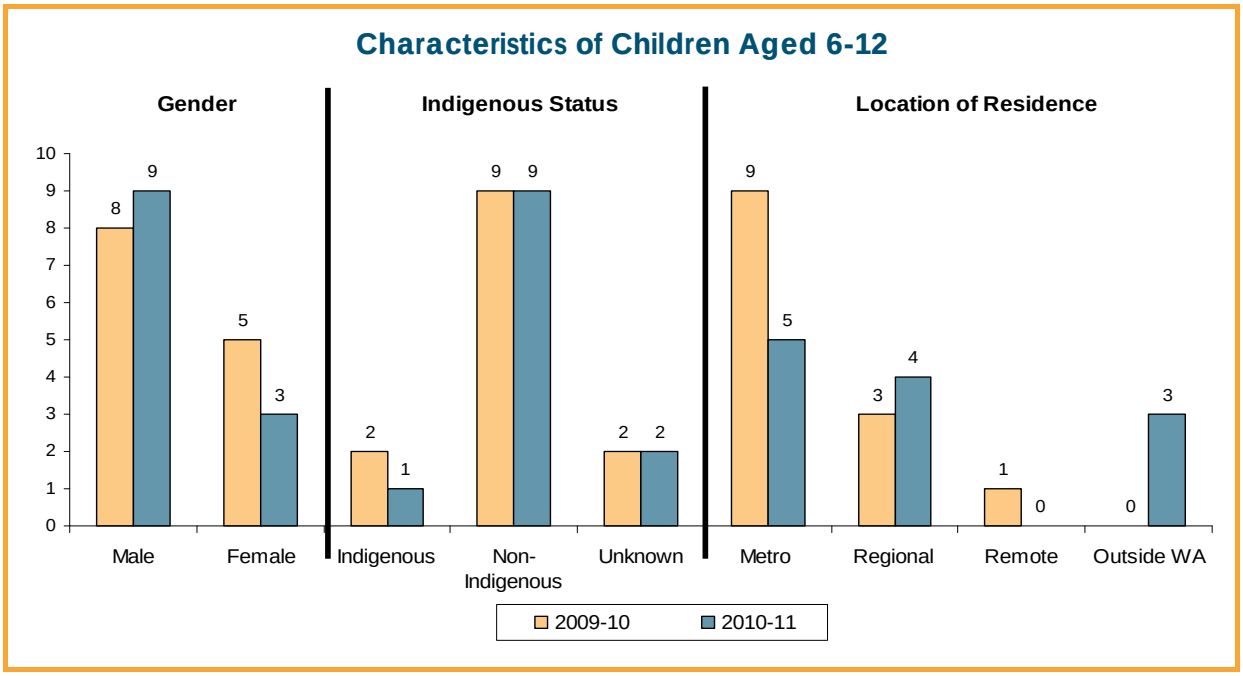




Nine deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of Children Aged 6 – 12 Years

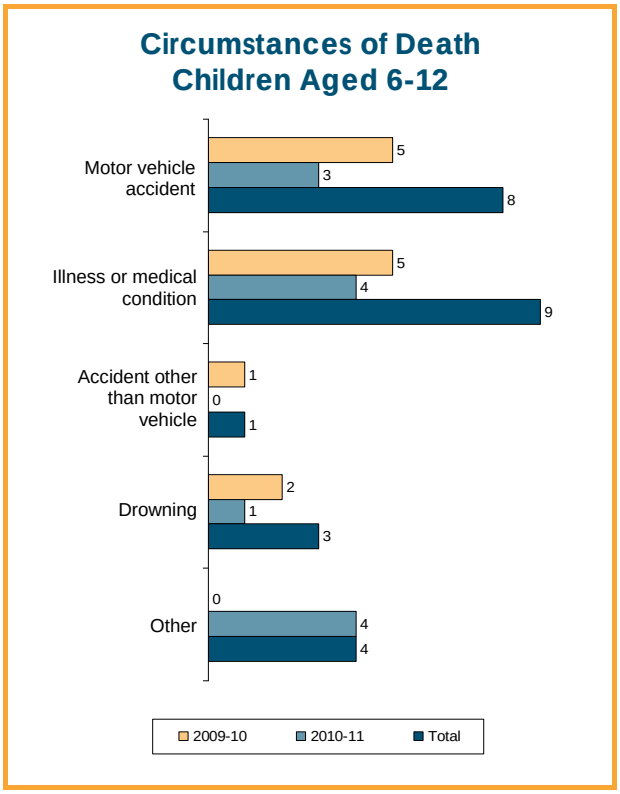
Of the 194 child death notifications the Ombudsman received from 30 June 2009 to 30 June 2011, 25 (13%) related to children from 6 to 12 years. The characteristics of children aged 6 to 12 are shown in the following chart.

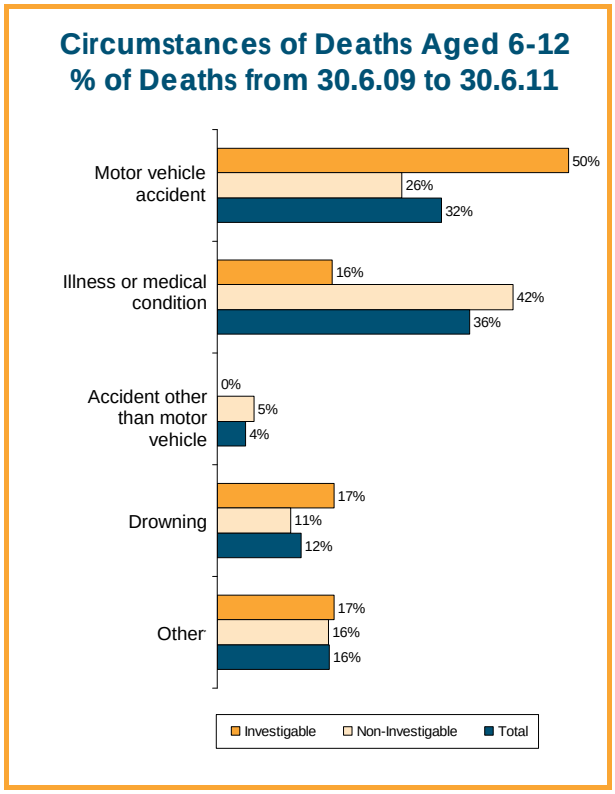


Further analysis of the data showed, for these deaths, there was an over-representation compared to the child population for:

- Males – 83% of investigable deaths and 63% of non-investigable deaths of children aged 6 to 12 were male compared to 52% in the child population;
- Indigenous children – 20% of investigable deaths and 13% of non-investigable deaths of children aged 6 to 12 were Indigenous children compared to 6% in the child population. However the discrepancy is less in this age group for Indigenous children than in other age groups; and
- Living in regional or remote locations – 50% of investigable deaths and 31% of non-investigable deaths of children aged 6 to 12, living in Western Australia, were children living in regional or remote locations compared to 28% in the child population.

The circumstances of death were varied with motor vehicle accidents and medical illness being the largest groupings as shown in the chart below.

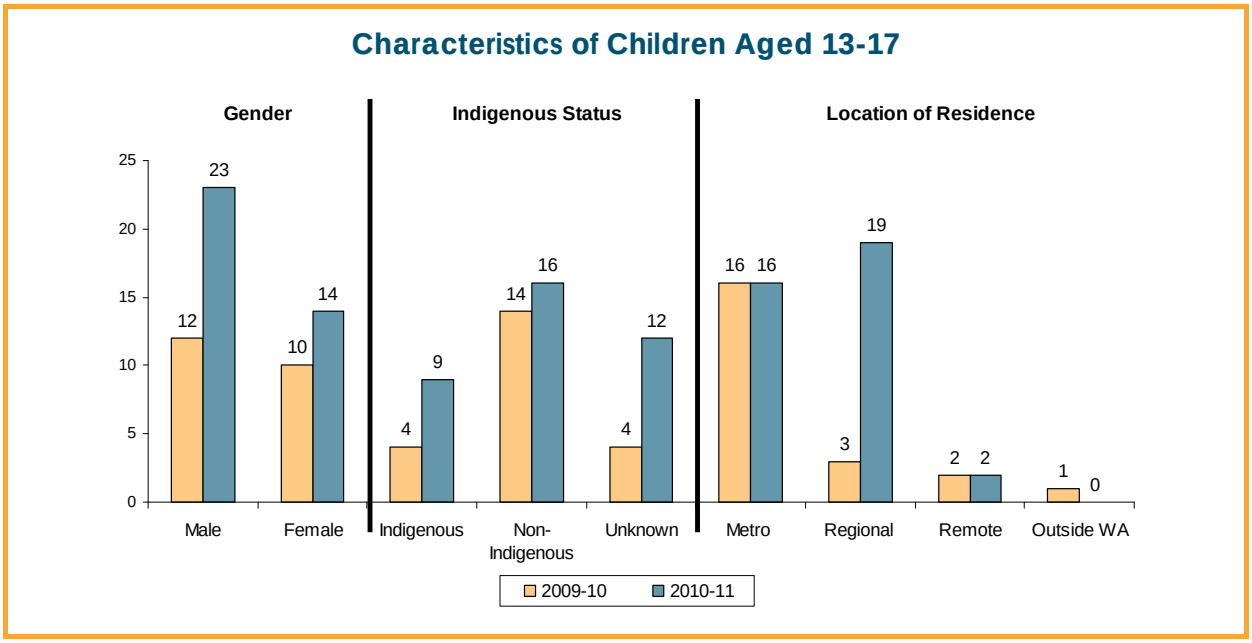




Six deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of Children Aged 13 – 17 Years

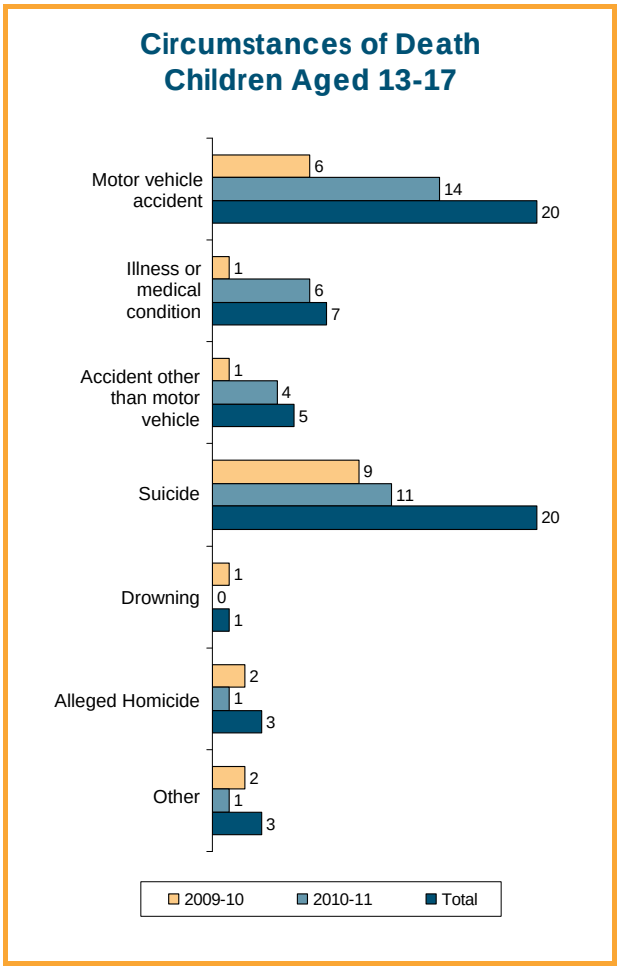
Of the 194 child death notifications the Ombudsman received from 1 July 2009 to 30 June 2011, 59 (30%) related to children aged from 13 to 17 years, which is the second largest age grouping. The characteristics of children aged 13 to 17 are shown in the following chart.

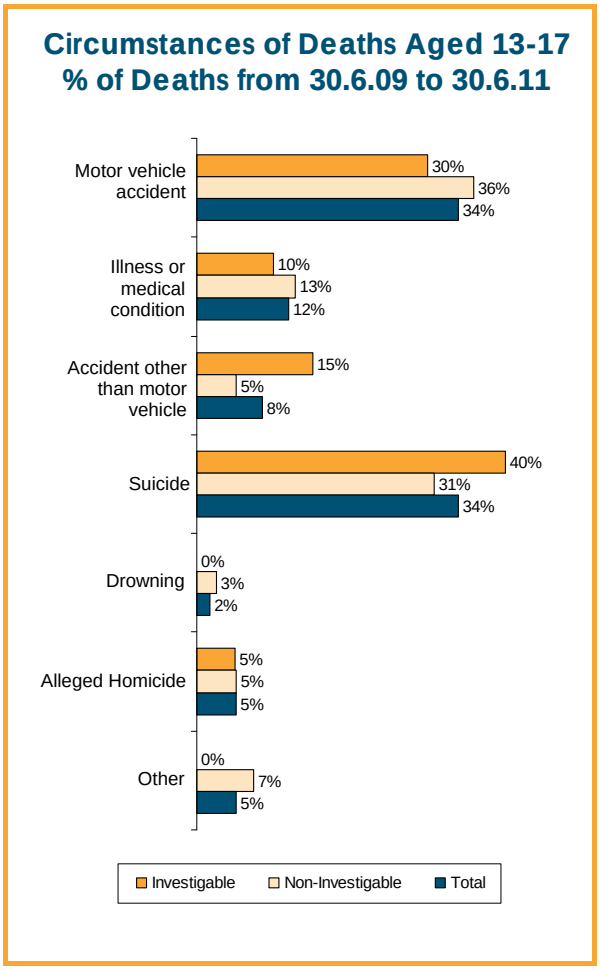


Further analysis of the data showed that, as with younger children, for the deaths of children aged 13 to 17, there was an over-representation compared to the child population for:

- Males – 60% of investigable deaths and 59% of non-investigable deaths of children aged 13-17 were male compared to 52% in the child population. However the difference between males and females is less in this group than for younger children;
- Indigenous children – 50% of investigable deaths and 19% of non-investigable deaths of children aged 13 to 17 were Indigenous compared to 6% in the child population; and
- Living in regional or remote locations – 50% of investigable deaths and 42% of non-investigable deaths of children aged 13 to 17, living in Western Australia, were living in regional or remote locations compared to 28% in the child population.

Suicide and motor vehicle accidents are the two most common circumstances of death, each representing 20 (34%) of the 59 deaths in this age group.





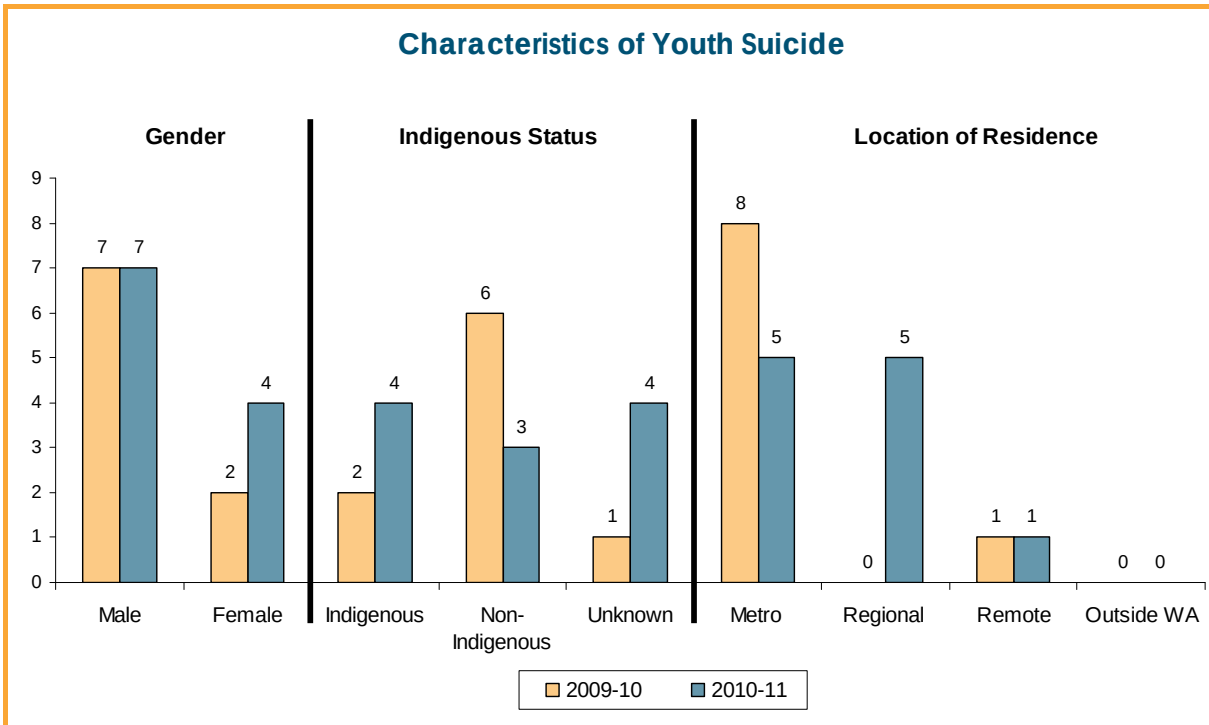
Twenty deaths of children aged 13 to 17 years were determined to be investigable deaths.

All children who took their own lives were in the 13 to 17 year age cohort. The 59 deaths in this age group included 20 (34%) young people who took their own lives. Of these:

- Two were 14 years old;
- Four were 15 years old;
- Six were 16 years old; and
- Eight were 17 years old.

The characteristics of the young people who took their own lives are shown in the following chart which shows that:

- For investigable deaths there are equal numbers of males and females but for non-investigable deaths there is a higher proportion of males (83%);
- Indigenous youths are over-represented in this group, accounting for 6 (40%) of the 15 youth suicides where information on the Indigenous status of the young person was available; and
- The majority of these youth suicides occurred in the metropolitan area, but regional or remote suicides were over-represented compared to the population as a whole with 38% of investigable youth suicides and 33% of non-investigable youth suicides being young people who were living in regional or remote locations compared to 28% in the child population.

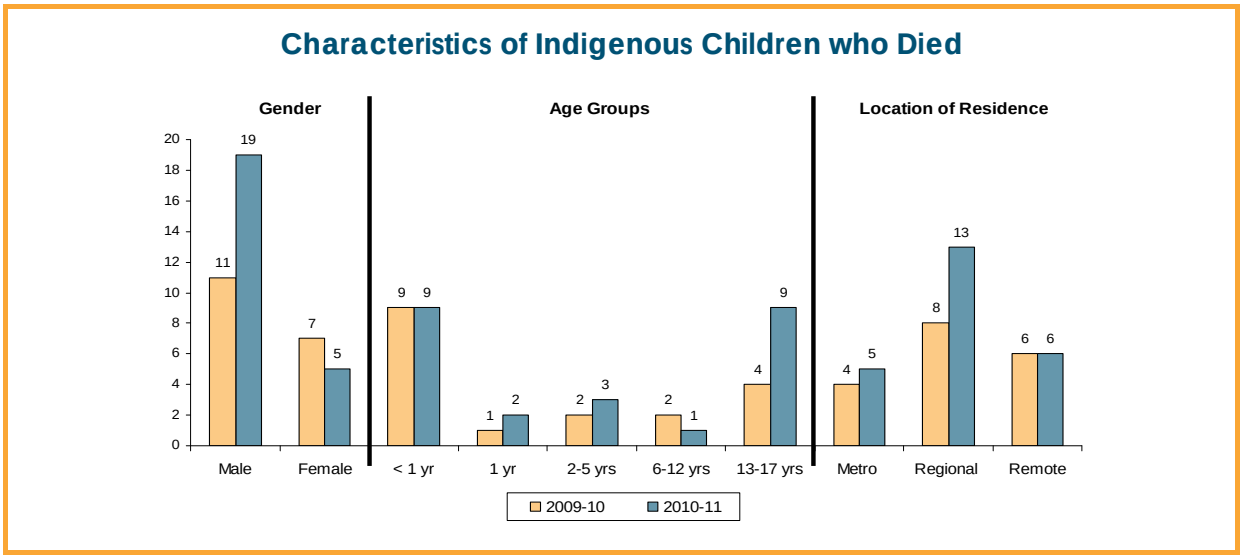


Deaths of Indigenous Children

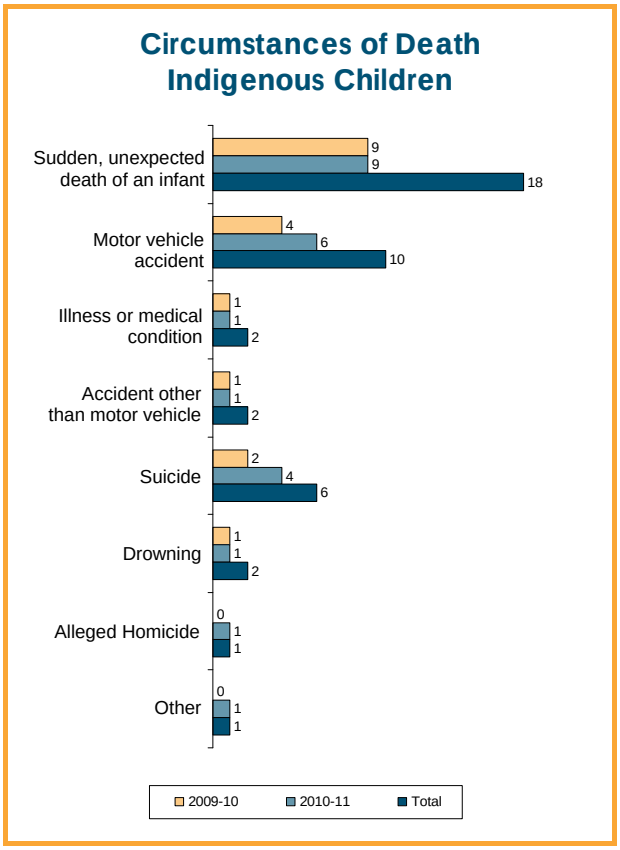
Of the 141 child death notifications received from 30 June 2009 to 30 June 2011, where the Indigenous status of the child was known, 42 (30%) of the children were identified as Indigenous.

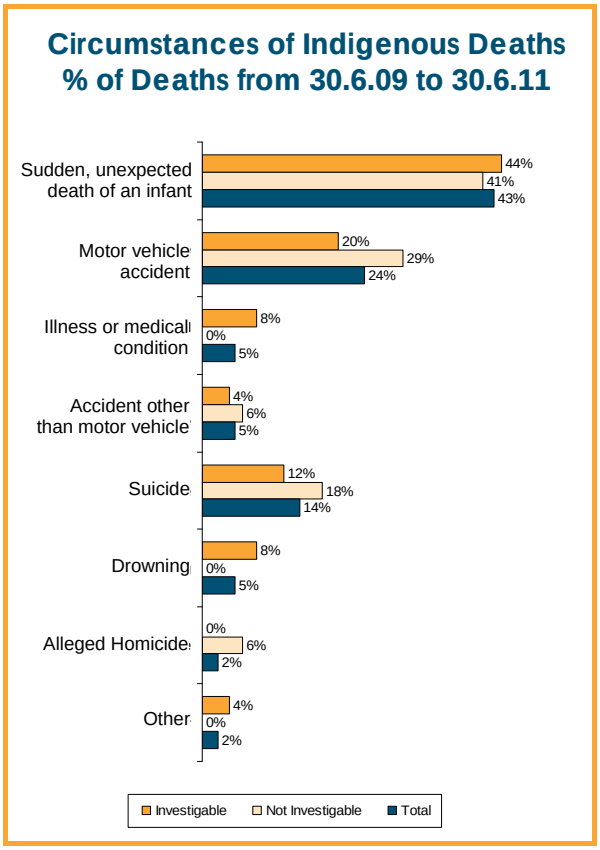
For the notifications received, the following chart demonstrates:

- The number of male Indigenous children is more than twice that of female Indigenous children;
- The infant and youth groupings are the largest age range categories; and
- Regional and remote Indigenous child deaths far outnumber metropolitan Indigenous child deaths.



Sudden, unexpected death of infants, motor vehicle accidents and suicide are the largest circumstance of death categories for Indigenous children as shown in the chart below.





Improvements to Public Administration to Prevent or Reduce Child Deaths

By undertaking child death reviews the Ombudsman seeks to improve public administration in order to prevent or reduce investigable child deaths in the future and to promote good decision making in those public authorities that provide services to children. Information has been set out as follows:

- Issues identified in child death reviews;
- Administrative improvements achieved to address issues identified;
- Outcomes of reviews and administrative improvements by age cohort;
- Identification of good practice and collaboration;
- Major own motion investigations;
- Monitoring of reviews for future own motion investigations;
- Other mechanisms to prevent or reduce child deaths; and
- Research into Foetal Alcohol Spectrum Disorder.

All administrative improvements are subject to ongoing monitoring and review as recommendations of the Ombudsman to ensure that they are, over time, leading to the prevention or reduction of child deaths.

Issues Identified in Child Death Reviews

The following are the types of issues that have been identified in undertaking child death reviews.

It is important to note that:

- Issues are not identified in every child death review; and
- When an issue has been identified, it does not necessarily mean that the issue is related to the death of a child.

- A practice not being sufficiently child focussed.
- Lack of a thorough safety assessment of a child.
- A lack of clear and comprehensive record keeping.
- Not identifying child wellbeing concerns at an assessment.
- No evidence of undertaking a safety assessment following referral of a child wellbeing concern.
- Where a family was involved with multiple District Offices, one district did not take responsibility to assess child wellbeing concerns.
- Not interviewing relevant parties in a timely manner when assessing child wellbeing concerns.
- Not making an appropriate assessment of an unborn child following a mother's disclosure of alcohol consumption and history of alcohol consumption.

Administrative Improvements Achieved to Address Issues Identified

To address concerns identified during the Ombudsman's reviews, the Department undertook to carry out a range of actions. The following are the types of administrative improvements that have been achieved:

- Undertaking quality assurance of case files and addressing issues of non-compliance;
- Restructured duty intake arrangements;
- Senior staff visiting District Offices to use a case as a learning and development opportunity;
- Referred the case and concerns to the District Director, Team Leaders and relevant staff for information and discussion;
- Implemented the close supervision of inexperienced staff on duty by a Senior Field Officer or Team Leader; and
- The Department including an additional prompt in its *Alcohol and Other Drugs* Prompt Sheet at intake, that parental alcohol and drug misuse during pregnancy may result in premature and underweight births and drug dependent newborns.

Outcomes of Reviews and Administrative Improvements by Age Cohort

Information on outcomes of reviews and the administrative improvements achieved as a result of reviews is set out below. The information has been structured under the various age cohorts identified earlier in the patterns and trends section of the report.

Deaths of Infants

The Ombudsman's examination of reviews of infant deaths undertaken in 2010-11 has highlighted two key issues:

- Promoting safe sleeping practices; and
- Alcohol consumption as a risk factor for the wellbeing of the unborn child, and the infant.

Promoting Safe Sleeping Practices

SIDS and Kids Australia identifies safe sleep risk factors that relate to the infant's sleeping position, the bedding, exposure to tobacco smoke and the infant's sleep location. The most common risk factor was co-sleeping in the parental bed where the parents had a background of alcohol consumption or smoking.

In response to the Ombudsman's reviews the Department amended its Casework Practice Manual, which outlines the legislative, policy and practice requirements to guide Departmental staff in their decisions and actions, to include information on co-sleeping that highlights the increased risk for infants when parents may be involved with substance use, smoking or on medication.

The pattern identified from the Ombudsman's reviews has led to a major own motion investigation by the Ombudsman in relation to sleep related infant deaths. Further details about this own motion investigation are set out in the next section.

Alcohol Consumption as a Risk Factor for the Wellbeing of the Unborn Child, and the Infant

Alcohol consumption during pregnancy has the potential to negatively impact on the wellbeing of the unborn child, resulting in Foetal Alcohol Spectrum Disorders (**FASD**). FASD describes a continuum of permanent birth defects caused by maternal consumption of alcohol during pregnancy. FASD is not in itself a clinical diagnosis but describes the full range of disabilities that may result from ante-natal alcohol exposure, that include lifelong physical, mental, behavioural and learning disabilities.

The following case study outlines the risk to the infant associated with parental alcohol consumption and the outcomes achieved from the Ombudsman's review.

Case Study

Infant A

Infant A came from a family with a long history of contact with the Department about child wellbeing concerns, related to the mother's chronic alcohol use and parental domestic violence. The Department responded to a domestic violence report that occurred when the mother was pregnant with Infant A. When interviewed by the Department, the mother stated that she and the father had been drinking alcohol prior to the violence.

As a result of this review, the Department has amended the *Alcohol and Other Drugs* Prompt Sheet, used by Field Workers as a guide to child wellbeing assessments, to include an additional prompt noting that parental alcohol and drug misuse during pregnancy may result in premature and underweight births and drug dependent newborns.

Deaths of Children Aged 1 – 5 Years

The Ombudsman's examination of reviews of deaths of children aged 1 to 5 years undertaken in 2010-11 has highlighted supervision of a child aged 1 to 5 years as a key issue in preventing fatal accidents.

Supervision of a Child Aged 1 to 5 Years

Kidsafe WA, an Australian non-government organisation dedicated to preventing unintentional childhood injuries and reducing deaths from childhood accidents in children under the age of 15 years, identifies that most injuries happen to children under the age of five, as this age group is curious and mobile but have little awareness of danger. As such, this age group is a particular risk group for fatalities associated with drowning or being run over in a driveway.

One review demonstrates a proactive response by a local government, as outlined in the case study below.

Case Study

Child B

Child B drowned in a residential pool.

The relevant local government inspected the pool area and noted several discrepancies with an inspection previously carried out at the property. While the fence did not contravene the compulsory standards for pool security, the local government undertook an audit of pool inspections to ensure any other discrepancies could be addressed.

Deaths of Children Aged 6 – 12 Years

The Ombudsman's examination of reviews of deaths of children aged 6 to 12 undertaken in 2010-11 has shown the critical nature of certain core health and education needs (such as attendance at school) and interagency cooperation between the Department, the Department of Health and the Department of Education as the involvement of all three agencies will generally be required if health and education needs are to be incorporated into the child's care planning.

This is of particular relevance for children in the care of the CEO of the Department. For this reason, the decision was made to undertake a major own motion investigation into the care planning provisions of the *Children and Community Services Act 2004* with a focus on care planning for these children.

Deaths of Children Aged 13 – 17 Years

The Ombudsman's examination of reviews of deaths of children aged 13 to 17 undertaken in 2010-11 has highlighted the following key factors:

- Youth suicides;
- Risk-taking behaviours;
- Public authorities engaging with the behaviour that may have brought the young person to their attention (for example, parent-teen conflict, truancy, criminal activity, homelessness) including underlying child protection concerns; and
- Interagency collaboration and communication.

Youth Suicide

Youth suicide is a challenging community issue and much is being done in Western Australia and nationally on this important topic.

In July 2011 the Parliament of Australia's Standing Committee on Health and Ageing released the report, *Before it's too late: Report on early intervention programs aimed at preventing youth suicides.* The report highlights some of the barriers to the prevention of youth suicide such as 'help negation' where the individual withdraws from help. In addition,

the report details prevention strategies such as the importance of continuity of care after discharge from hospital especially after one suicide attempt; the need for selective interventions based on groups seen to be at risk such as Indigenous children and gay young people; and universal programs such as school based programs promoting mental health, anti-bullying, physical wellbeing and training 'gatekeepers' to recognise mental health issues.

In Western Australia, the Commissioner for Children and Young People's *Report on the Inquiry into the Mental Health and Wellbeing of Children and Young People* in April 2011 and recent Coronial inquiries into suicide (including 'group' inquiries into suicides that occurred in the Kimberley (February 2008), Oombulgurri (July 2008) and the 2011 inquiry in Balgo), have identified strategies and made recommendations aimed at reducing the occurrence of these deaths. There is also work by other public authorities, such as the Department of Health and the Mental Health Commissioner, and non-government organisations to provide suicide prevention planning and services. This work, and other work, is reflected on in the reviews of youth suicide undertaken by the Ombudsman.

The reviews revealed the following:

- In eight cases there was a recorded history of family and domestic violence or parent-teen conflict;
- In seven cases there were allegations of sexual assault involving the youth;
- In four cases the youth had been known to be homeless at some stage, or moving between family members;
- In three cases there was a recorded history of alcohol and/or drug use by the youth; and
- In three cases the youth was not regularly attending school.

The issue of youth suicide is currently being considered for an Ombudsman's own motion investigation in 2012 to further consider ways to prevent or reduce these child deaths.

Identification of Good Practice and Collaboration

As demonstrated by the following case study, reviews regularly identify good practice by the Department and other public authorities as well as good interagency communication and cooperation.

Case Study

Child A

Child A's family had contact with the Department and the Department of Health due to child wellbeing concerns and domestic violence associated with alcohol consumption by Child A's father. The services working with Child A and his parents faced a number of challenges particularly as the family lived in, and were mobile between, different remote and regional communities.

Both the Department and the Department of Health demonstrated good practice working with the family and extended family to ensure the safety of Child A and his siblings and good interagency collaboration was evident. The child safety concerns were resolved when Child A's mother was supported to move with her children to live with her extended family. Child A died following an accident soon after the move by the family.

Major Own Motion Investigations

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 practice of public authorities that provide services to children and their families. During the year, the Ombudsman undertook significant work on two major own motion investigations with a view to improving public administration in order to prevent or reduce child deaths.

These own motion investigations explored:

- Deaths of Infants; and
- Planning for Children in Care.

Own Motion Investigation into Deaths of Infants

Through reviews of individual child deaths, the Ombudsman identified that there were a high proportion of child deaths that were sudden, unexpected deaths of infants (children under one year old), including infants who had been placed for sleep.

Over the two year period 30 June 2009 to 30 June 2011, the Ombudsman was notified of 68 deaths of infants. The Ombudsman undertook a broad, preliminary analysis of the circumstances surrounding these 68 infant deaths and found that 59 (87%) were categorised as the sudden, unexpected death of an infant. For 39 of these 59 deaths, the information provided in the notification to the Ombudsman indicated that the infant's death was sleep related. This includes all Sudden Infant Death Syndrome **(SIDS**) cases, fatal sleeping accidents (for example, accidental asphyxia) and deaths due to undetermined causes in the sleep environment.

The Ombudsman commenced an own motion investigation into the sudden, unexpected deaths of infants with the following objectives:

- To analyse the circumstances of, and risk factors reported in, cases of sudden, unexpected deaths of infants (including sleep related deaths) notified to the Ombudsman, to identify possible patterns and trends;
- To examine any identified patterns, including common risk factors, in sudden, unexpected deaths of infants generally and explore how they relate to the findings in the Ombudsman's cases;
- To identify and review current risk reduction activities to assess:
    - Whether identified risk factors are addressed;
    - The strengths and weaknesses of current strategies;
    - Whether improvements could be made to potentially reduce the number of sudden, unexpected deaths of infants, including sleep related infant deaths; and
- To identify options for government agencies to further reduce the number of sudden, unexpected deaths of infants.

The Ombudsman's office has conducted a major literature review and stakeholder consultation, and comprehensively analysed the information included in the notifications of infant deaths to the Ombudsman. During 2011-12 the result of this work will be the subject of further consultation with key stakeholders before preparing a final report to Parliament.

Own Motion Investigation into Planning for Children in Care

Ombudsman reviews of individual child deaths identified cases that gave rise to concerns regarding the administration of care planning for children in care. Care planning is intended to provide for the protection and care of children in care and contributes to the prevention or reduction of child deaths.

For the majority of Western Australian children, their parents and family network provide for their protection and care. However, at the commencement of this own motion investigation there were 3,356 children in the care of the Chief Executive Officer of the Department (referred to as 'children in care'). For these children, the State provides protection and care. The way in which the State is to perform this role is set out in the *Children and Community Services Act 2004* which contains a number of provisions requiring care planning for children in care.

These include:

- Requirements for the preparation, timing, content and review of care plans; and
- Principles for participation by the child, their families and carers in care planning, and principles that apply to Aboriginal and Torres Strait Islander children in care.

The *Children and Community Services Act 2004* promotes cooperation between the Department and other public authorities in relation to the protection and care of children. Cooperation between the Department, the Department of Health and the Department of Education is a critical aspect of the care planning system.

This cooperation is consistent with the recommendations of the Ford report which were endorsed by the (then) Western Australian Government in 2007. Recommendation 63, in particular, recommended that *'the Departments of Health and Education and Training (now the Department of Education and the Department of Training and Workforce Development) respectively be required to develop a Health Plan (covering physical, mental and dental health) and an Educational Plan respectively for each child or young person in care.'*

Other provisions regulating the administration of care planning responsibilities in Western Australia include the policies and procedures established by the Department.

The objective of the Ombudsman's own motion investigation into care planning is to examine how public authorities have administered the requirements of the *Children and Community Services Act 2004* regarding care planning for children in care. It is anticipated that the report of this own motion investigation will be tabled in Parliament in November 2011.

Monitoring of Child Death Reviews for Future Own Motion Investigations

The Ombudsman has identified key issues out of child death reviews that are being considered for further own motion investigations including:

- Youth suicide;
- Adolescent behaviours that raise child wellbeing concerns;
- Interagency collaboration working with adolescents engaged in risk taking behaviours;
- The impact of alcohol and foetal alcohol spectrum disorder on preventable child deaths; and
- The effectiveness of current child protection practice when working with Indigenous families from regional and remote communities, who are mobile and travel their lands.

Other Mechanisms to Prevent or Reduce Child Deaths

In addition to major own motion investigations, the Ombudsman 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's siblings;
- Through the Child Death Review Advisory Panel, and other mechanisms, working with public authorities and communities where children may be at risk to consider child safety issues and potential areas for improvement, and highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information with other accountability and oversight agencies including Ombudsmen in other States to facilitate consistent approaches and shared learning; and
- Undertaking or supporting research that may assist to identify good practices that may assist in the prevention or reduction of child deaths, as shown in the example below.

Research into Foetal Alcohol Spectrum Disorder (FASD)

Foetal Alcohol Spectrum Disorder (**FASD**) is the term used to describe a range of disabilities caused from prenatal alcohol exposure. FASD is a risk to the unborn child of a woman that consumes alcohol during pregnancy. A child born with FASD will have lifelong effects including deficits in executive functioning, such as memory loss, retrieval of information, difficulty understanding concepts or that actions have consequences. They may also have physical defects such as a small head and heart and/or kidney problems. They may require lifelong support from services in all areas of health and wellbeing, education, child protection, disability services, corrective services, justice, police and employment.

To date, the office has undertaken a number of activities in relation to FASD given its relevance to child deaths reviewed by the Ombudsman including:

- In 2009, Ms June Councillor was awarded a Churchill Fellowship on FASD sponsored by the Department for Child Protection to travel to Canada and the United States of America to research the effects of FASD, how it can be prevented and the implications for individuals, families and communities. In December 2009, when Ms Councillor was appointed to the position of Principal Indigenous Liaison Officer (**PILO**) at the Ombudsman's office, the office supported Ms Councillor to complete the work for the Fellowship. The report of this research is available on the Winston Churchill Memorial Trust website.
- Ms Councillor has delivered presentations about FASD to Ombudsman staff and to the Ombudsman's Child Death Review Advisory Panel;
- Presentations about FASD and the implications for public authorities have been delivered to public authorities within the Ombudsman's jurisdiction including the Department for Child Protection, the Department of Health, the Department of Indigenous Affairs, the Department of Corrective Services, the Department for Communities and Curtin University; and
- Ms Councillor has given expert advice to a number of bodies established to address the issues associated with FASD including the Key Aboriginal Advisory Group for the Drug and Alcohol Office.

Stakeholder Liaison

The Department for Child Protection

Efficient and effective liaison has been established with the Department to support the child death review process and objectives. Regular liaison occurs between the Ombudsman and the CEO of the Department together with regular liaison at senior executive level to discuss issues being raised in child death reviews and how positive change can be achieved. Meetings with Departmental staff have been held in a number of districts in the metropolitan, regional and remote areas.

The Child Death Review Advisory Panel

The Child Death Review Advisory Panel (**the Panel**) is an advisory body established to provide independent advice to the Ombudsman:

- On issues and trends that fall within the scope of the child death review function;
- On contemporary professional practice relating to the wellbeing of children and their families; and
- About issues that impact on the capacity of public authorities to ensure the safety and wellbeing of children.

The Panel met three times this year and is comprised of seven members who provide a range of expertise:

- Professor Steve Allsop (Director, National Drug Research Institute of Curtin University);
- Ms Sue Ash (Chief Executive Officer, Uniting Care West);
- Professor Colleen Haywood (Head of Edith Cowan University's Kurongkurl Katitjin Centre for Indigenous Australian Education and Research);
- Ms Glenda Kickett (Executive Manager, Centrecare Djooraminda);
- Professor Helen Milroy (Director, Centre for Aboriginal Medical and Dental Health, University of Western Australia);
- Ms Cissy Cox (Group Coordinator, Social Outreach and Advocacy, St John of God Health Care); and
- Ms Monica McDougall (Nganggawili Health Service, Wiluna Child Health Centre).

Observers from the Department, the Department of Health, Department of Indigenous Affairs, Department of Education, Department of Corrective Services, Western Australia Police and a representative of the Minister for Child Protection also attended the meetings.

This year, among other things, the Panel provided valuable advice to the Ombudsman regarding the two major administrative improvement projects which are in progress.

The Panel and staff of the Ombudsman also heard presentations from David Price of the Department of Education about *The Pipeline Project Trajectories of Classroom Behaviour and Academic Progress: A study of student engagement with learning*; and Professor Helen Milroy on *Child and Adolescent Mental Health: Issues and Trends*.

In addition, June Councillor, the Ombudsman's Principal Indigenous Liaison (**PILO**) officer gave a presentation on *Foetal Alcohol Spectrum Disorder and the Implications for Child Wellbeing and Child Protection*.

Following this presentation a number of the observers present indicated they would take the information provided back to their respective agencies to inform the work that they do that is relevant to this issue. Ms Councillor has subsequently been invited to provide presentations to a number of agencies keen to learn more about this significant issue and how they could respond.

Other Key Stakeholder Relationships

There are a number of public authorities and other organisations that interact with or deliver services to children and their families. Important stakeholders with which the office liaises as part of the child death review jurisdiction include:

- Other public authorities that have a role in relation to child deaths including:
    - The Coroner; and
    - Western Australia Police.
- Public authorities that provide services to children and their families including:
    - Department of Housing;
    - Department of Health;
    - Department of Education;
    - Department of Corrective Services;
    - Department of Indigenous Affairs; and
    - Department for Communities.
- Other accountability and similar agencies including the Commissioner for Children and Young People;
- Non-government agencies; 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.

Indigenous and Regional Communities

Significant work has been undertaken during the year to build relationships relating to the child death review jurisdiction with Indigenous and regional communities, for example by communicating with:

- Key public authorities that work in regional areas;
- Non-government agencies that provide key services; such as health services to Indigenous people; and
- Indigenous community leaders to increase the awareness of the child death review function and its purpose.

Additional networks and contacts have been established to support effective and efficient child death reviews. This has strengthened the office's understanding and knowledge of the issues faced by Indigenous and regional communities that impact on child wellbeing and service delivery in diverse and regional communities.

As part of this work, the PILO and the Assistant Ombudsman Child Death Reviews visited Kalgoorlie and Wiluna and surrounding communities during the year. Ombudsman staff met with a number of Indigenous community leaders, Aboriginal Health Services, local governments, Western Australia Police and Department staff and advocates in these regions. Planning is underway for a further visit in 2011-12 to Kalgoorlie and for a visit to Warburton in the Ngaanyatjarra Lands.

The PILO also travelled to the United States and Canada as part of a Churchill Fellowship to study Foetal Alcohol Spectrum Disorder and to examine ways of combating this issue which is a key issue in child death reviews for both Indigenous and non-Indigenous people.