Child Death Review

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

- Background;
- The role of the 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 (**CDRC**), with its first meeting held in January 2003. The function of the CDRC was to review the operation of relevant policies, procedures and organisational systems of the (then) Department for Community Development in circumstances where a child had contact with the Department.

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

- The CDRC together with its current resources be relocated to the Ombudsman (Recommendation 31); and
- A small, specialist investigative unit be established in the 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 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.

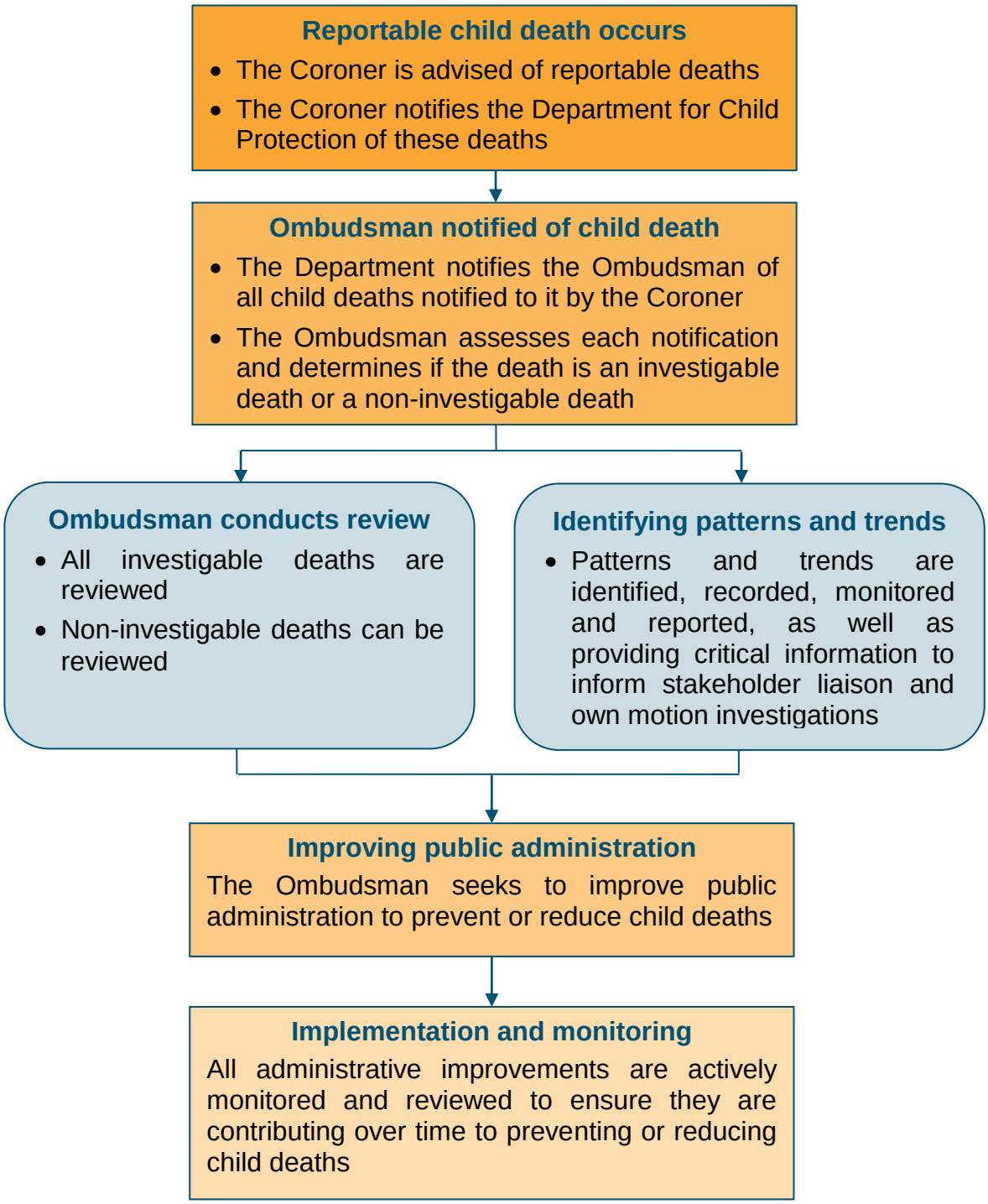
In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

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 Ombudsman reviews certain child deaths, identifies patterns and trends arising from these deaths and seeks to improve public administration to prevent or reduce child deaths.

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

Number of Child Death Notifications and Reviews

During 2011-12 there were 41 child deaths that were investigable and subject to review from a total of 83 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 nine years from 2003-04 to 2011-12. 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
2011-12	144	76	49	41

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

The 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. In 2011-12, timely review processes have resulted in 68 per cent of reviews being completed within three months and 77 per cent being completed 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 report, *Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004,* which was tabled in Parliament in November 2011 and the current own motion investigation on sleep related infant deaths.

Important Information on Interpretation of Data

Information in this section is presented across the first three 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 three 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

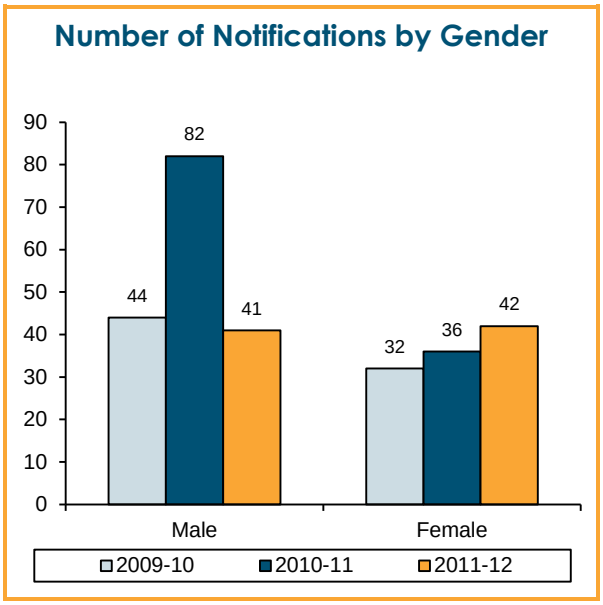
Information is obtained on a range of characteristics of the children who have died including gender, Indigenous status, various age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able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

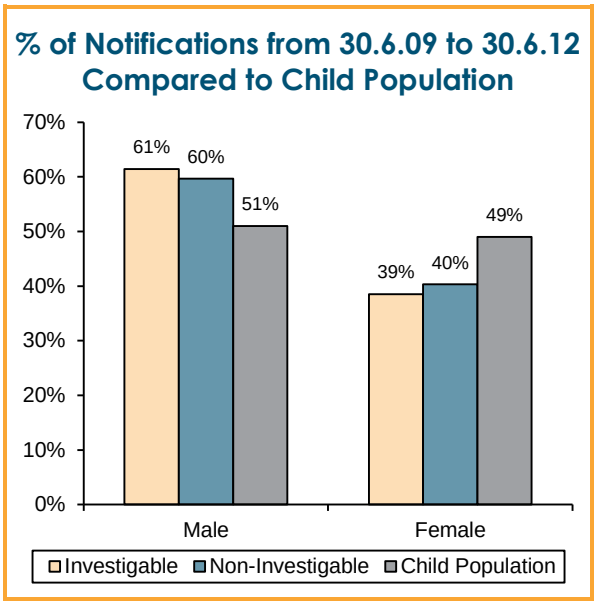
The following charts show:

- The number of children in each group for each year from 2009-10 to 2011-12; and
- For the period from 30 June 2009 to 30 June 2012, 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, considering all three years, male children are over-represented compared to the population for both investigable and non-investigable deaths. However, in 2011-2012 the number of male and female deaths were similar.

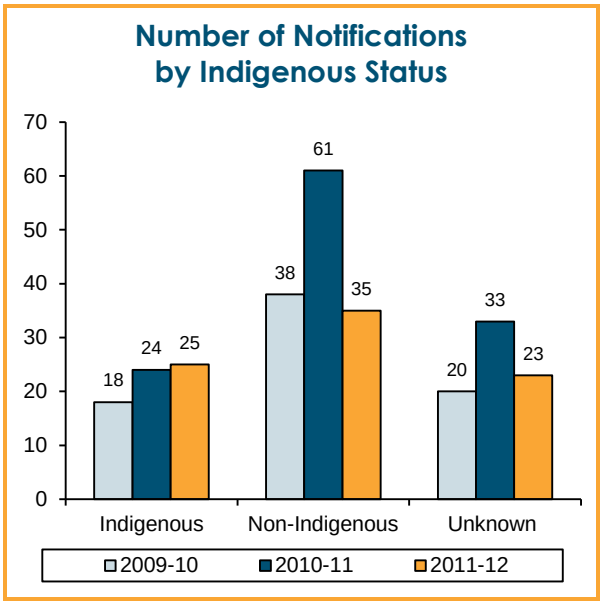


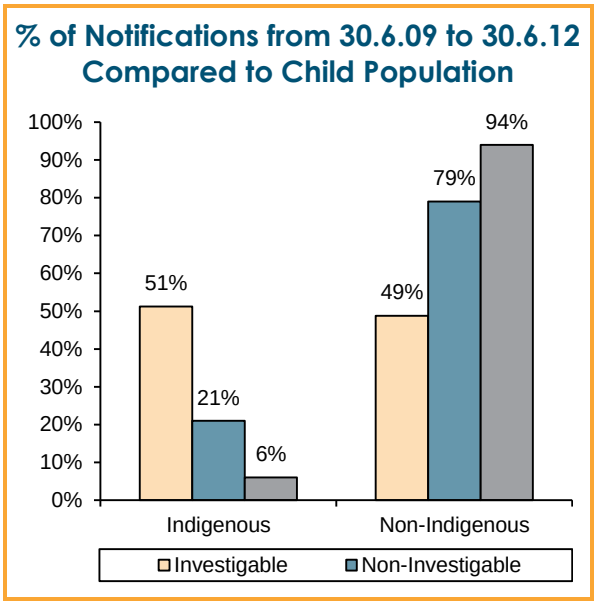


Further analysis of the data shows that, considering all three years, male children who die are more likely than females to be Indigenous and living in regional areas.

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.



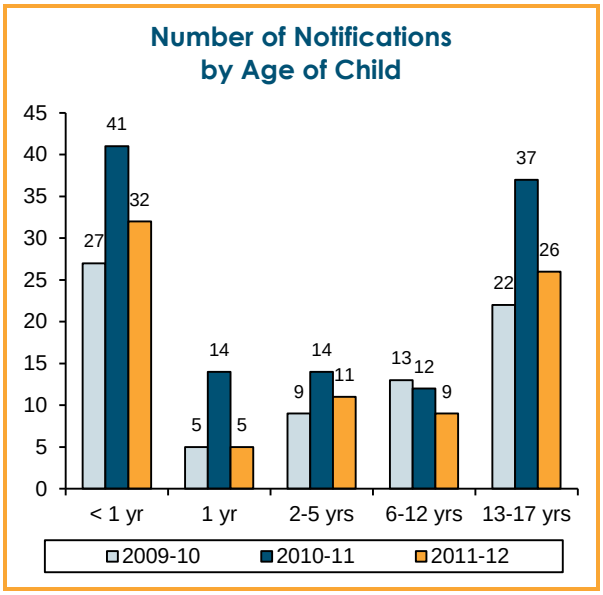


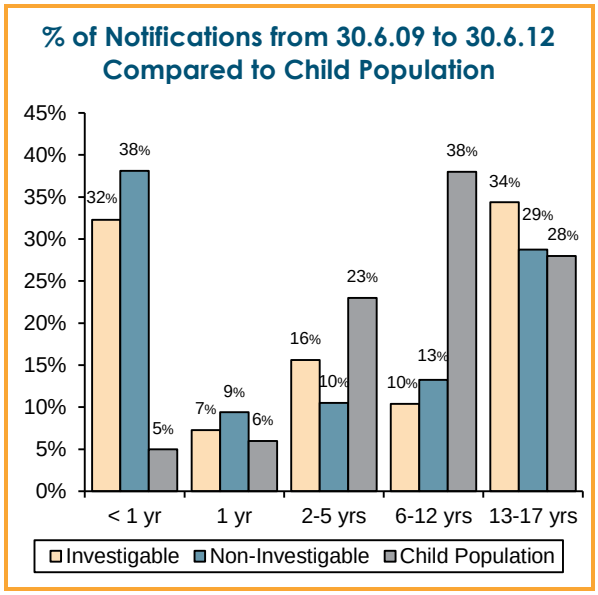
Note: Percentages for each group are based on the percentage of children whose Indigenous status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Indigenous status of the child.

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 for both investigable and non-investigable deaths.

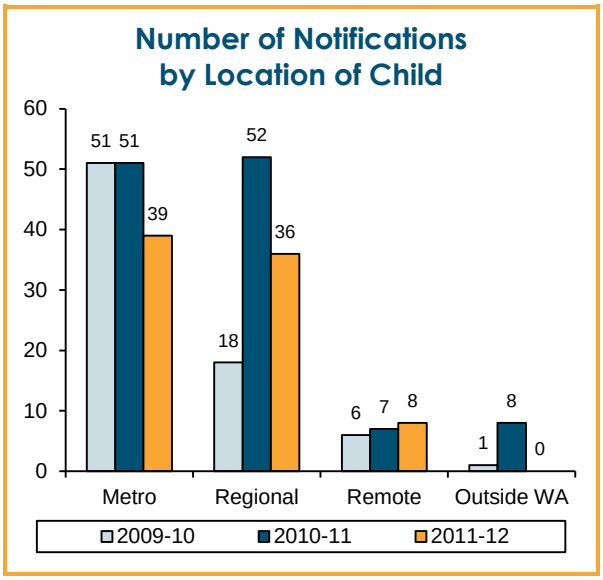


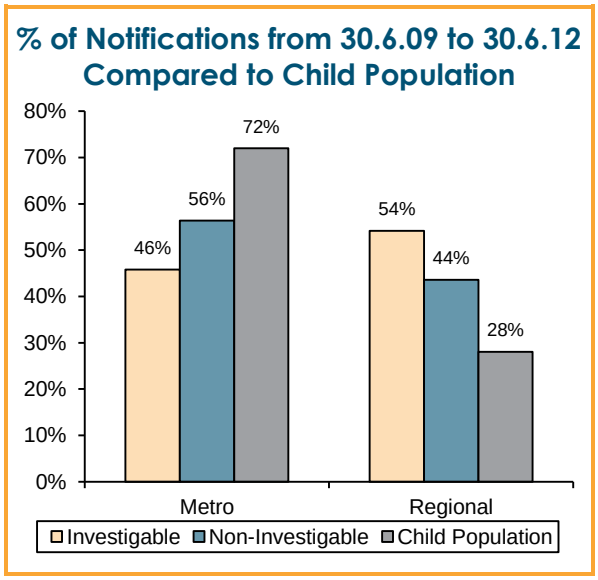


Further analysis of the data shows that a higher proportion of Indigenous children and children living in remote locations are under the age of one compared to other groups. A more detailed analysis by age group is provided later in this section.

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 81% of Indigenous children who died were living in regional or remote locations when they died. Most non-Indigenous children who died lived in the metropolitan area but the proportion of non-Indigenous children who died in regional areas is higher than would be expected based on the child population as a whole.

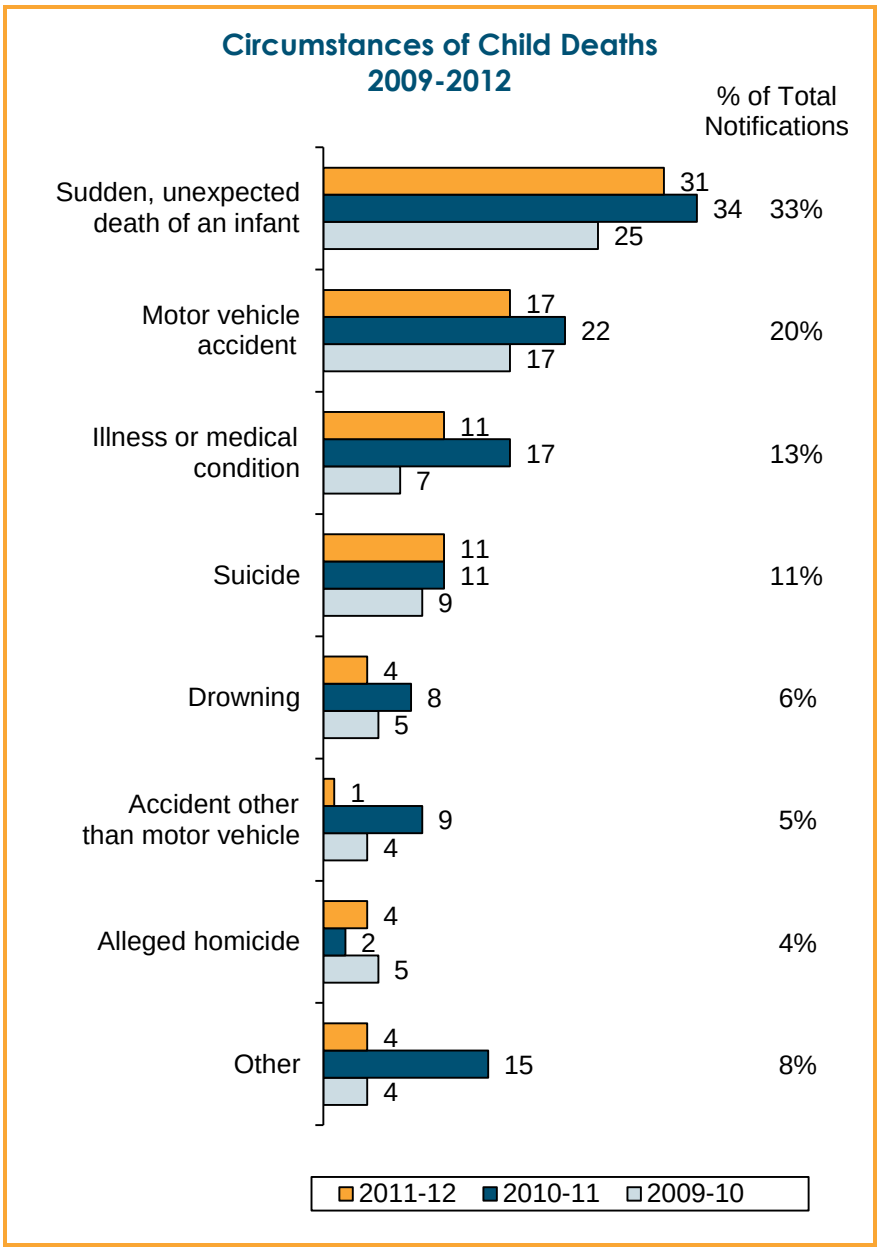
Circumstances of Child Deaths

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 motor vehicle – 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 three years.



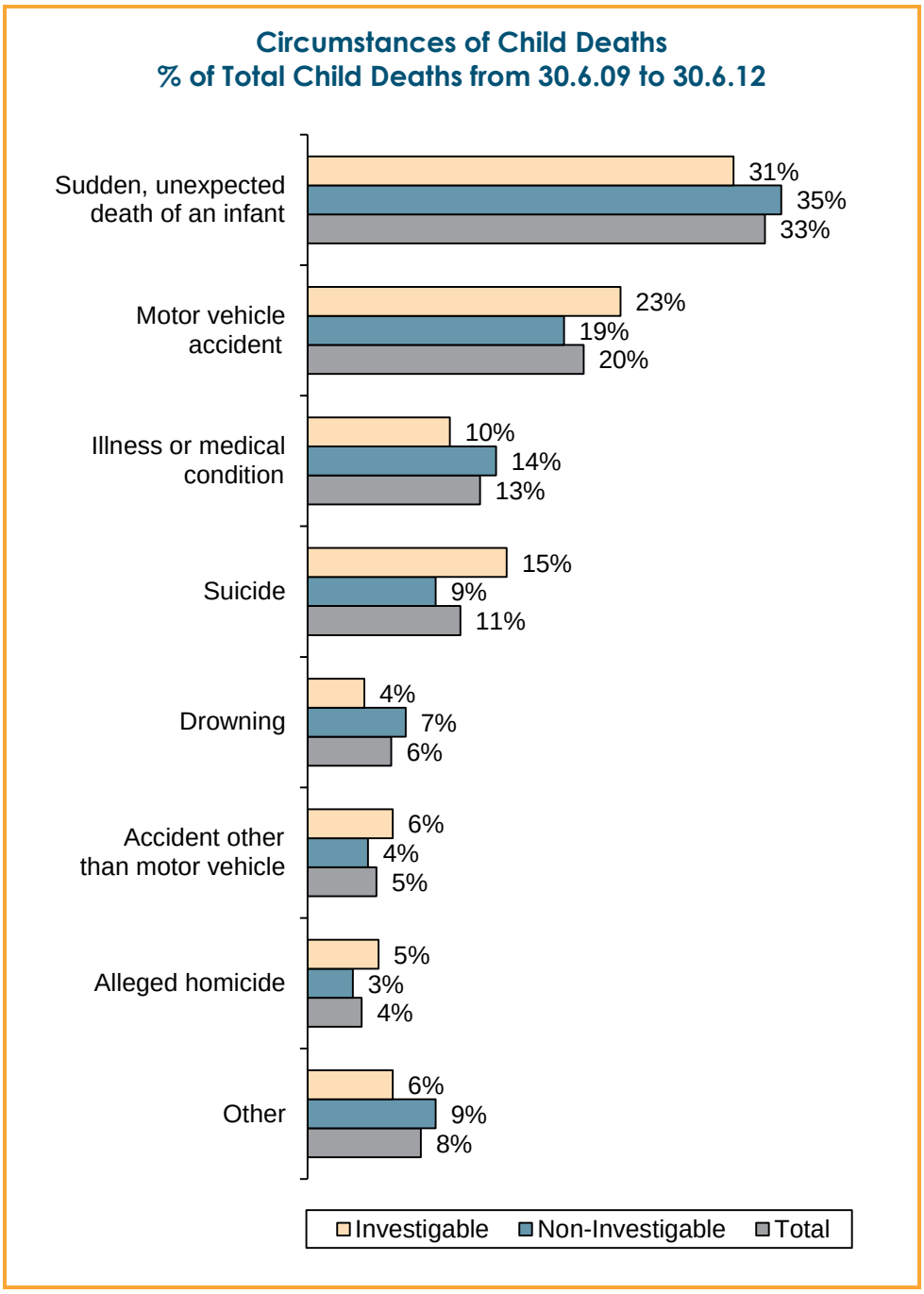
Note 1: In 2010-11 the 'Other' category includes eight children who died in the SIEV (Suspect Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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 for the 277 child death notifications received in the three years from 30 June 2009 to 30 June 2012 are:

- Sudden, unexpected deaths of infants, representing 33% of the total child death notifications received in 2009-10, 29% in 2010-11 and 37% in 2011-12; and
- Motor vehicle accidents, representing 24% of the total child death notifications received in 2009-10, 19% in 2010-11 and 20% in 2011-12.

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:

- Motor vehicle accidents;
- Suicide;
- Accidents other than motor vehicle; and
- Alleged homicide.

Longer Term Trends in the Circumstances of Death

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

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

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

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

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

Ombudsman from 30 June 2009 – See Note 2

The figures on the circumstances of death 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
2011-12	1	17	11		4	4	31	11	4

* 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;
- Parental mental health issues;
- 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	38%
Alcohol use	38%
Parental supervision	76%
Parental mental health issues	10%
Drug or substance use	10%
Homelessness	14%

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 two thirds of the cases; and
  - Parental supervision was a co-existing factor in over 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 over two thirds of the cases.

Reasons for Contact with the Department

In 2011-12 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.

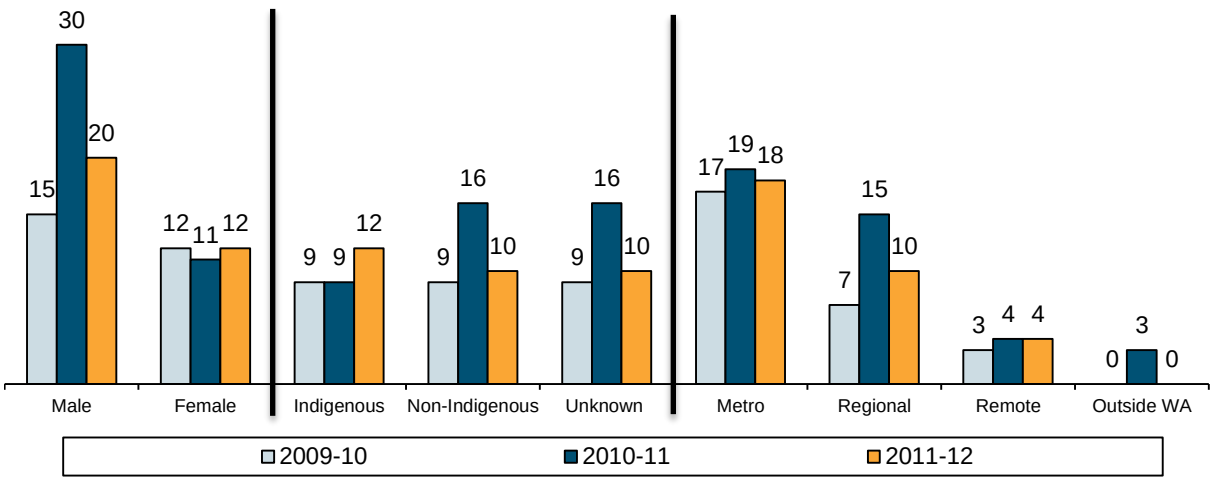
Patterns and Trends of Children in Particular Age Groups

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 277 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2012, there were 100 (36%) related to deaths of children aged less than one year **(infants).** The characteristics of infants who died are shown below.

Characteristics of Infants (Children under One Year)



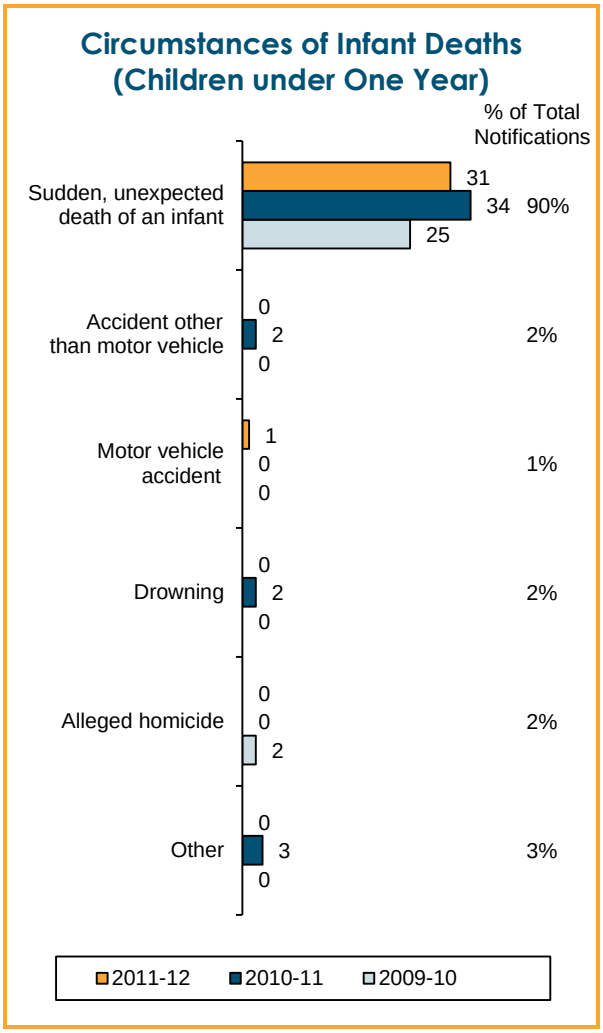
Further analysis of the data showed that, for these infant deaths, there was an over-representation compared to the child population for:

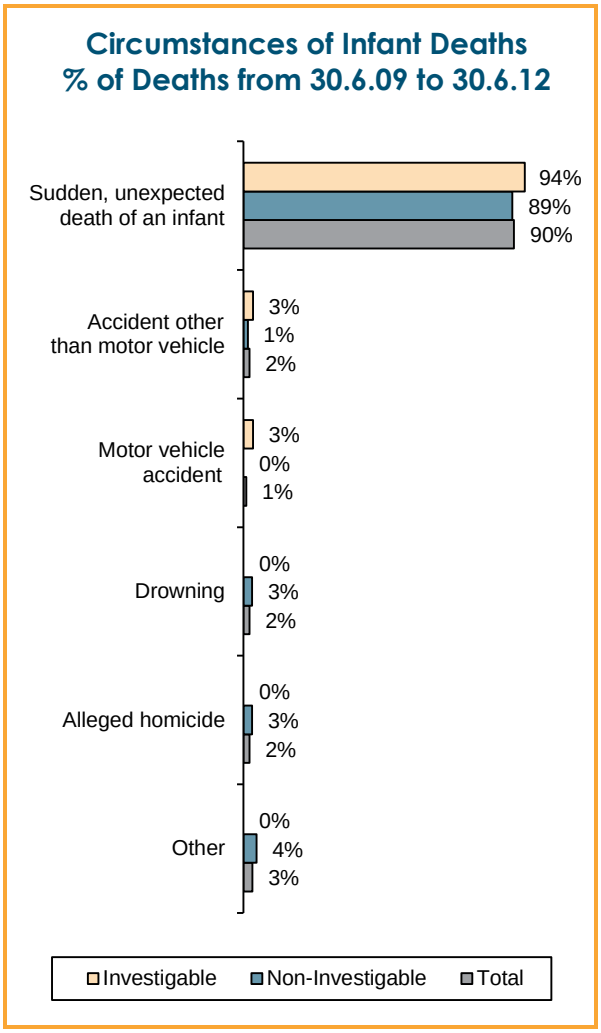
- Males – 87% of investigable infant deaths and 55% of non-investigable infant deaths were male compared to 51% in the child population;
- Indigenous children – 64% of investigable deaths and 35% of non-investigable deaths were Indigenous children compared to 6% in the child population; and

- Children living in regional or remote locations – 52% of investigable infant deaths and 41% 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 100 infant deaths, 90 (90%) were categorised as sudden, unexpected deaths of an infant and the majority of these (60) appear to have occurred while the infant had been placed for sleep.

There were a small number of other deaths as shown in the following charts.



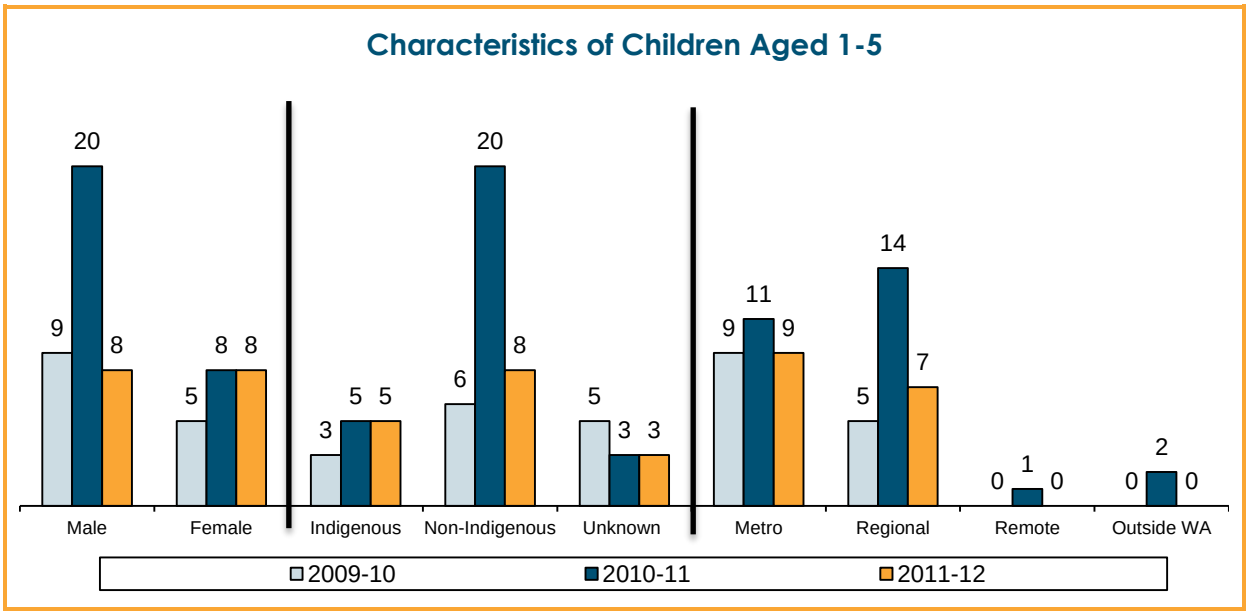


Thirty one infant death notifications received from 30 June 2009 to 30 June 2012 were determined to be investigable deaths.

Deaths of Children Aged 1 to 5 Years

Of the 277 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2012, there were 58 (21%) related to children aged from one to five years.

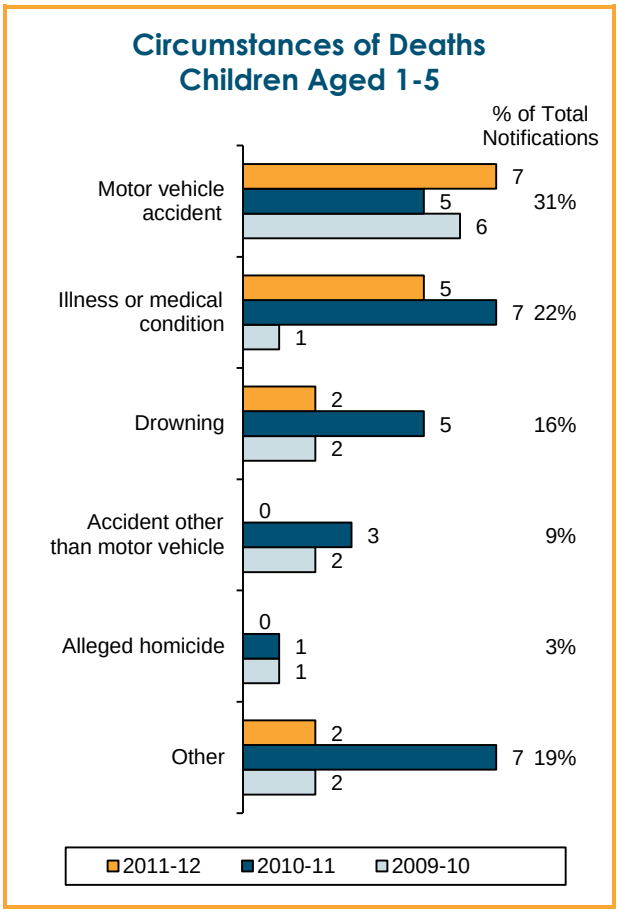
The characteristics of children aged 1-5 are shown in the following chart.

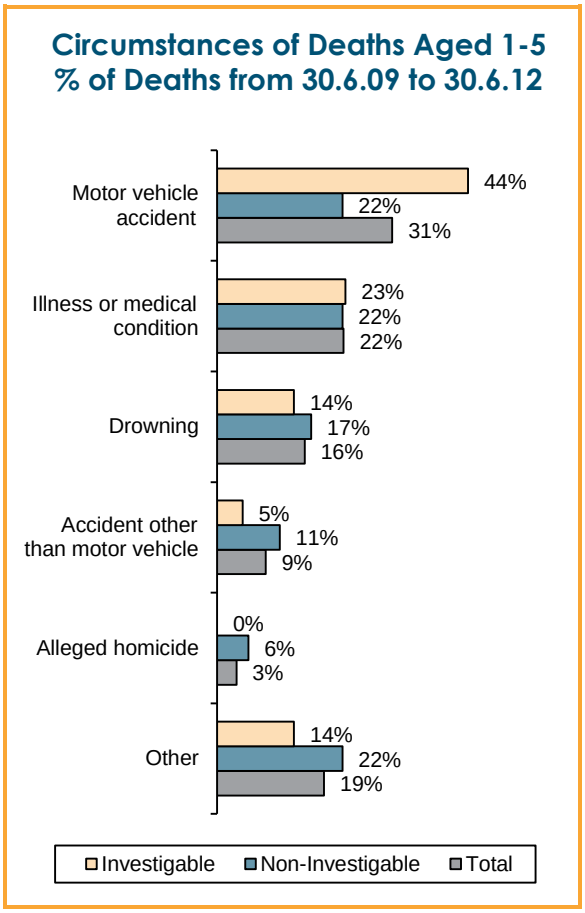


Further analysis of the data showed that, for these deaths, there was an over-representation compared to the child population for:

- Males – 55% of investigable deaths and 69% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Indigenous children – 50% of investigable deaths and 11% of non-investigable deaths of children aged 1 to 5 were Indigenous children compared to 6% in the child population; and
- Children living in regional or remote locations – 45% of investigable deaths and 50% 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 are the most common circumstance of death for this age group (31%), particularly for investigable deaths, followed by illness or medical conditions (22%) and drowning (16%).

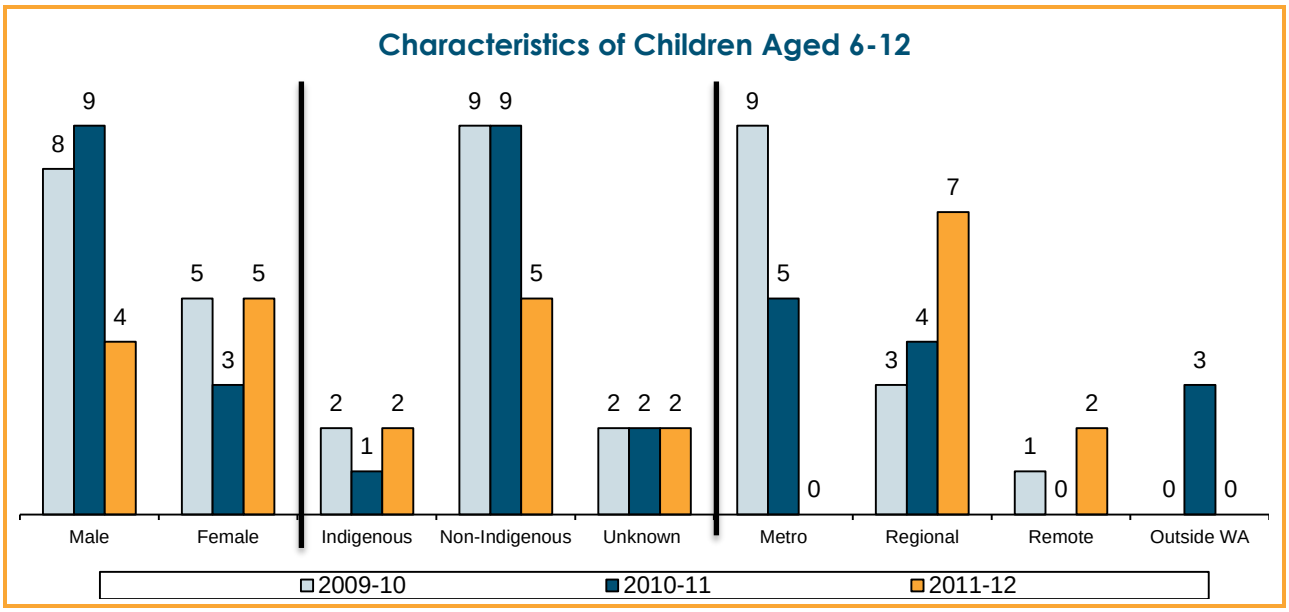




Twenty one deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of Children Aged 6 to 12 Years

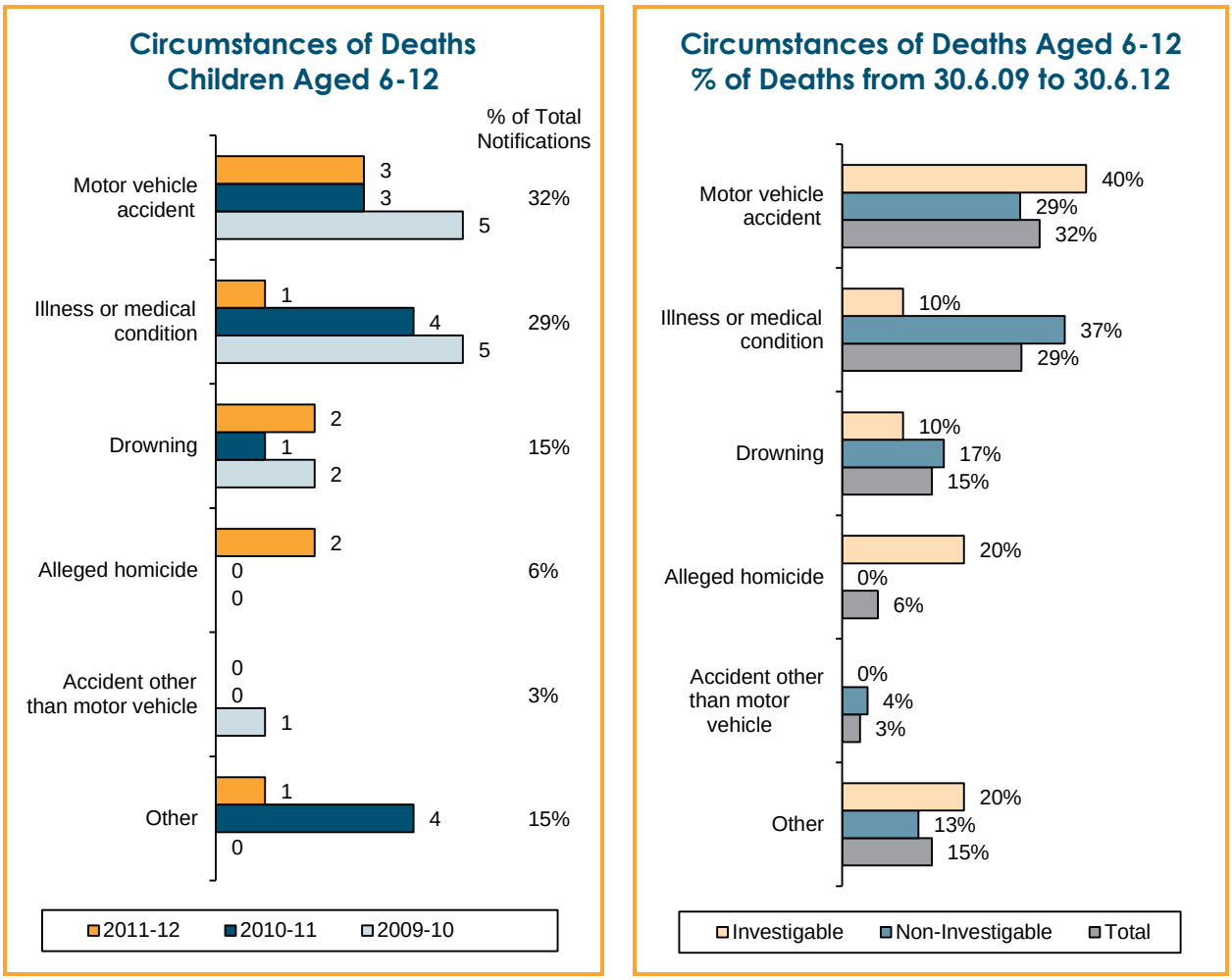
Of the 277 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2012 there were 34 (12%) related to children aged from 6 to 12 years The characteristics of children aged 6 to 12 are shown in the following chart.



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

- Males – 67% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population, but this over-representation was not present in investigable deaths as 50% of investigable deaths were male;
- Indigenous children – 22% of investigable deaths and 16% of non-investigable deaths of children aged 6 to 12 were Indigenous children compared to 6% in the child population. However the discrepancy for Indigenous children is less in this age group than in other age groups; and
- Children living in regional or remote locations – 70% of investigable deaths and 48% 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.

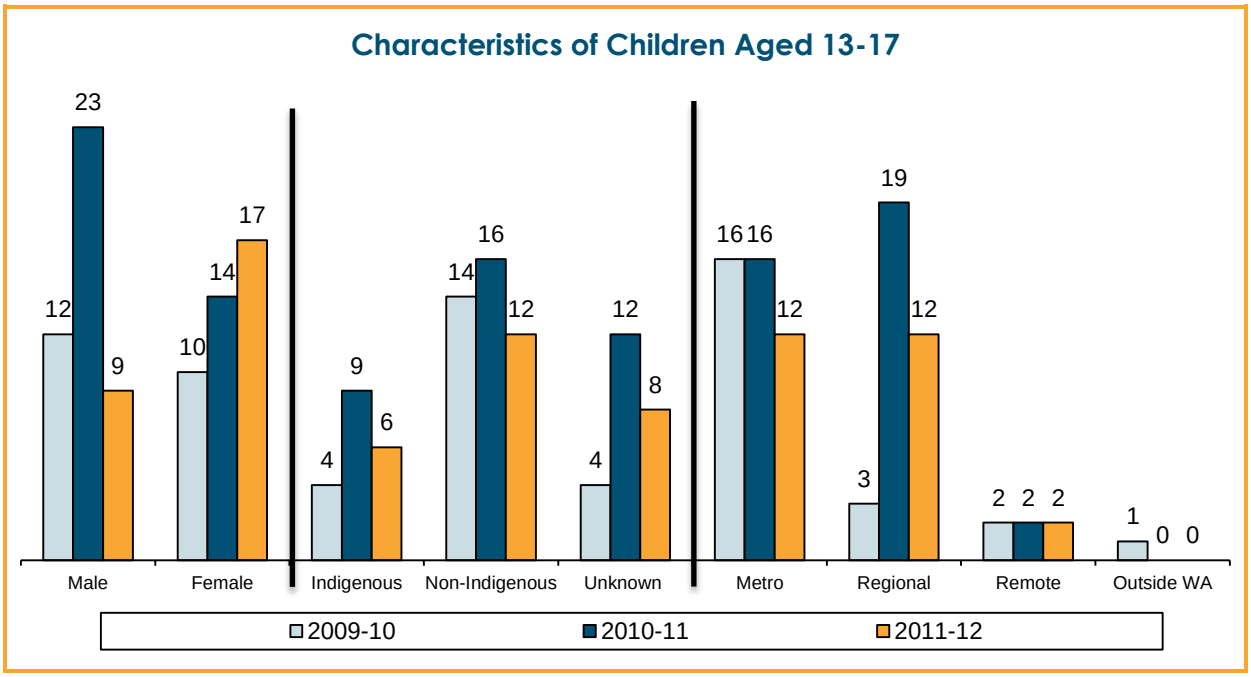
As shown in the chart below, motor vehicle accidents are the most common circumstance of death for this age group (32%), particularly for investigable deaths, followed by illness or medical conditions (29%) and drowning (15%).



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

Deaths of Children Aged 13 – 17 Years

Of the 277 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2012, there were 85 (31%) related to children aged from 13 to 17 years The characteristics of children aged 13 to 17 are shown in the following chart.

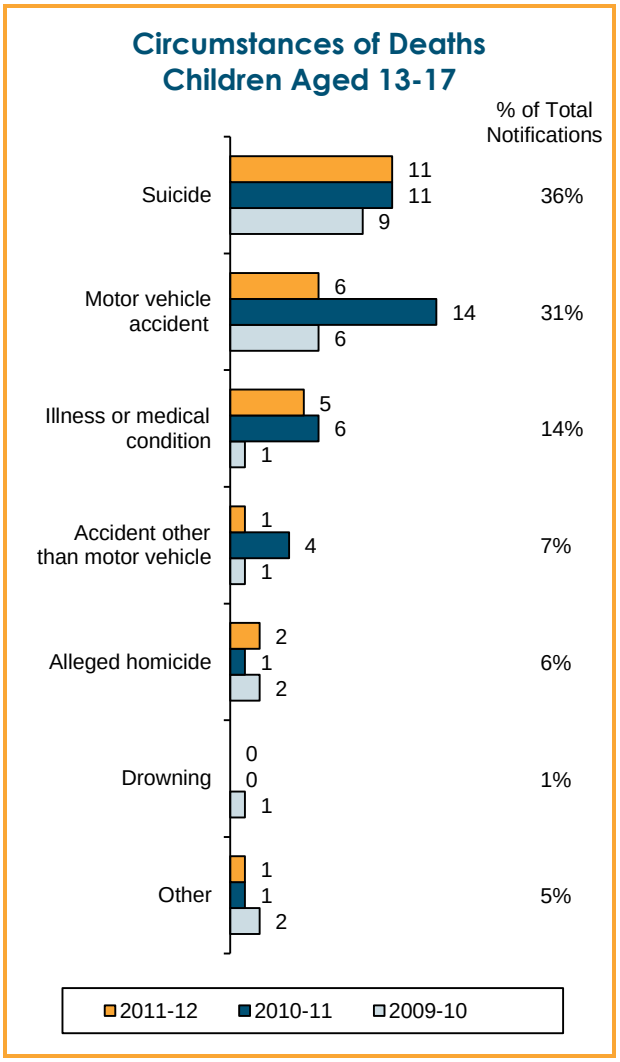


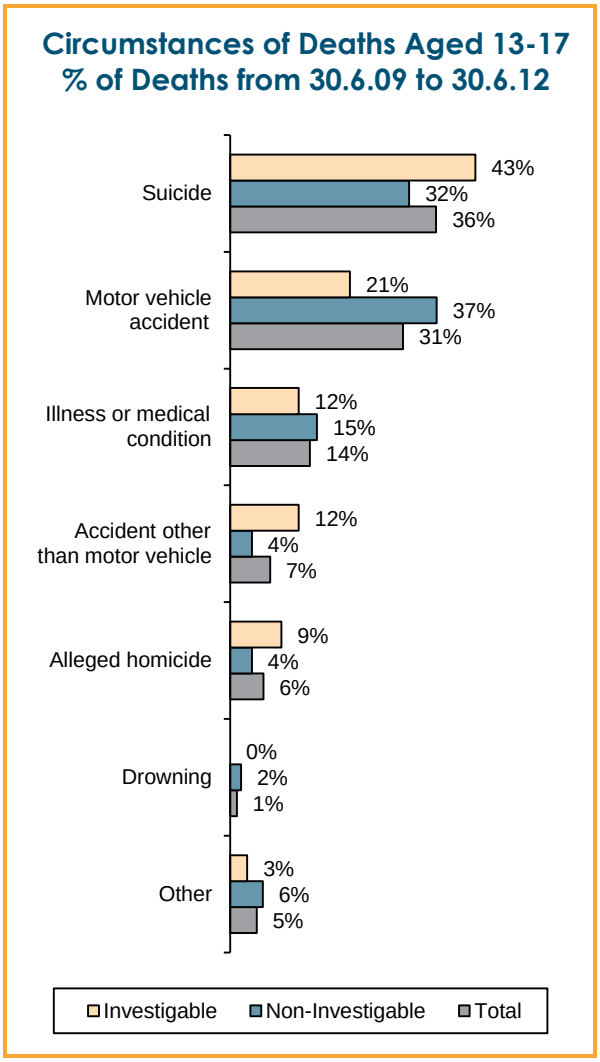
Further analysis of the data showed that, for these deaths, there was an over-representation compared to the child population for:

- Indigenous children – 50% of investigable deaths and 15% of non-investigable deaths of children aged 13 to 17 were Indigenous compared to 6% in the child population; and

- Children living in regional or remote locations – 58% of investigable deaths and 41% 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.

As shown in the chart below, suicide is the most common circumstance of death for this age group (36%), particularly for investigable deaths, followed by motor vehicle accidents (31%) and illness or medical conditions (14%).





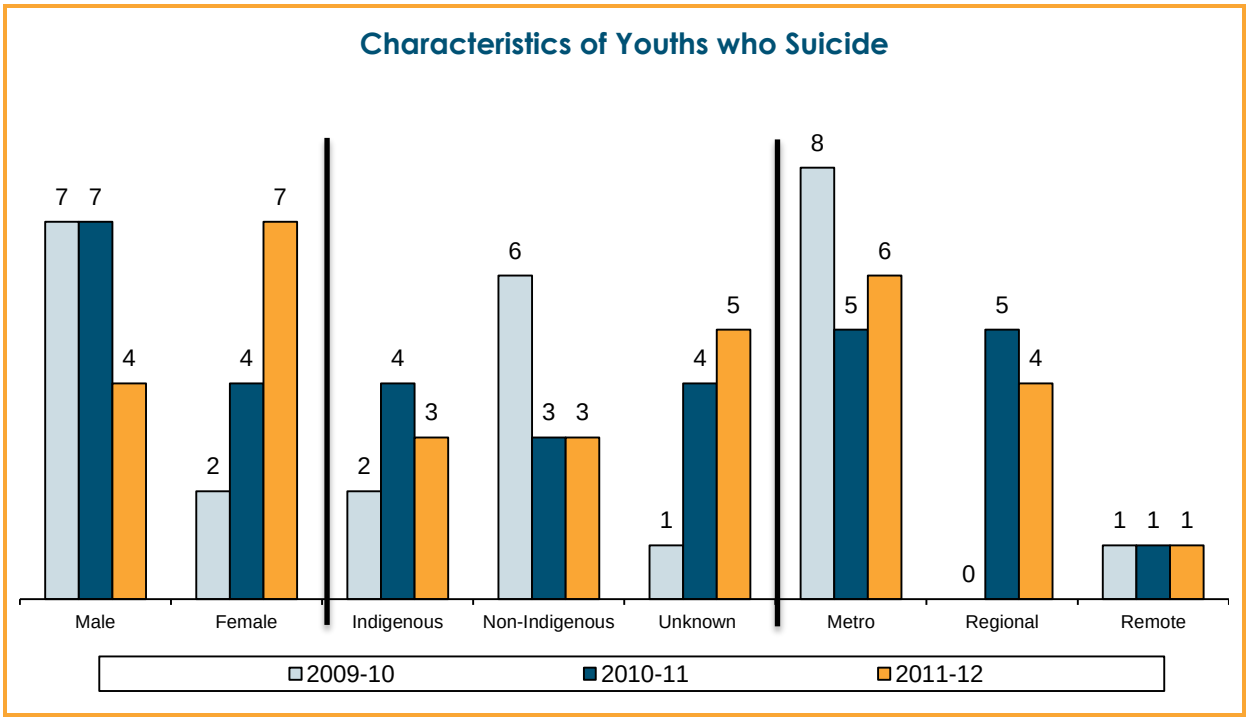
Thirty three deaths of children aged 13 to 17 years were determined to be investigable deaths.

All children who took their own lives were in the 13 to 17 year age cohort. Of the 31 young people who took their own lives from 30 June 2009 to 30 June 2012:

- Three were 14 years old;
- Nine were 15 years old;
- Eight were 16 years old; and
- Eleven 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 were equal numbers of males and females but for non-investigable deaths there was a higher proportion of males (65%);
- Indigenous youths are over-represented in this group, accounting for 9 (43%) of the 21 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 50% of investigable youth suicides and 29% of non-investigable youth suicides being young people who were living in regional or remote locations compared to 28% in the child population.

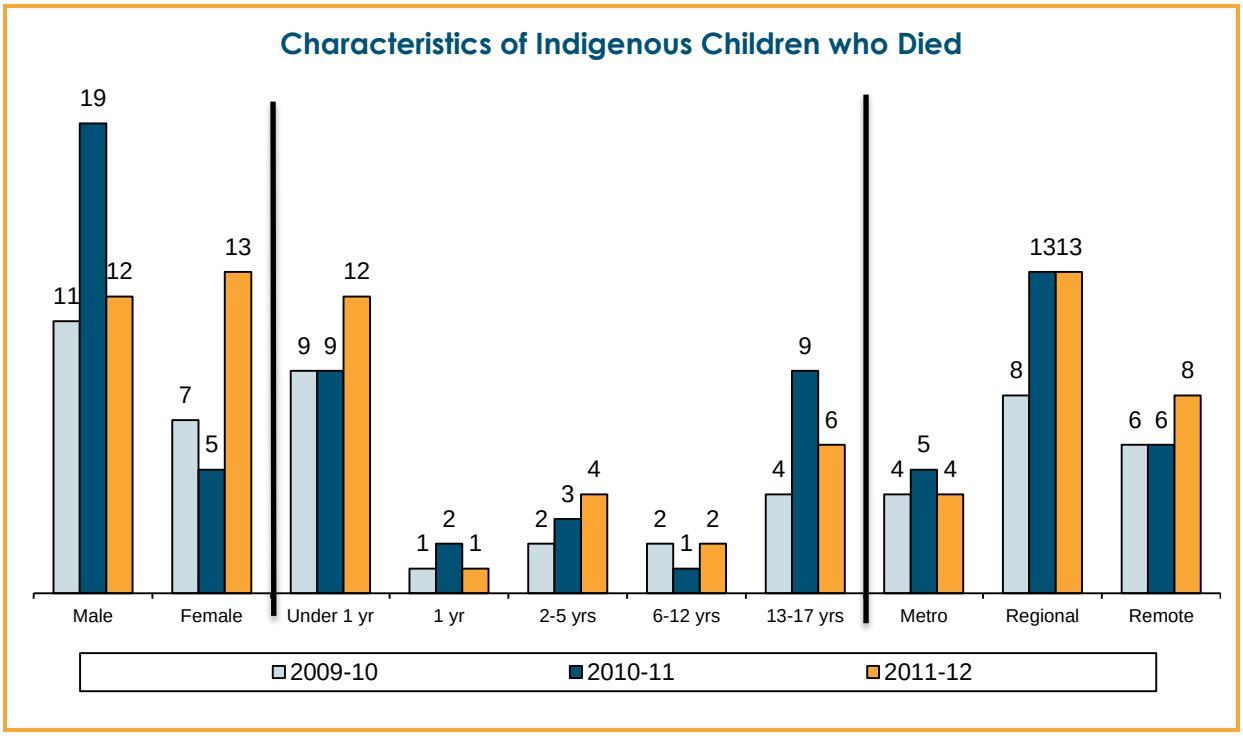


Deaths of Indigenous Children

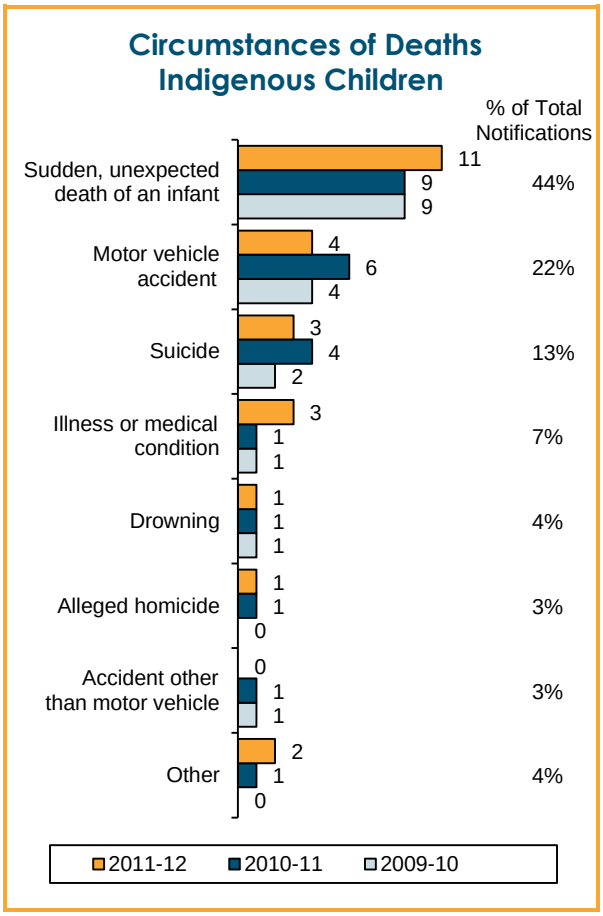
Of the 201 child death notifications received from 30 June 2009 to 30 June 2012, where the Indigenous status of the child was known, 67 (33%) of the children were identified as Indigenous.

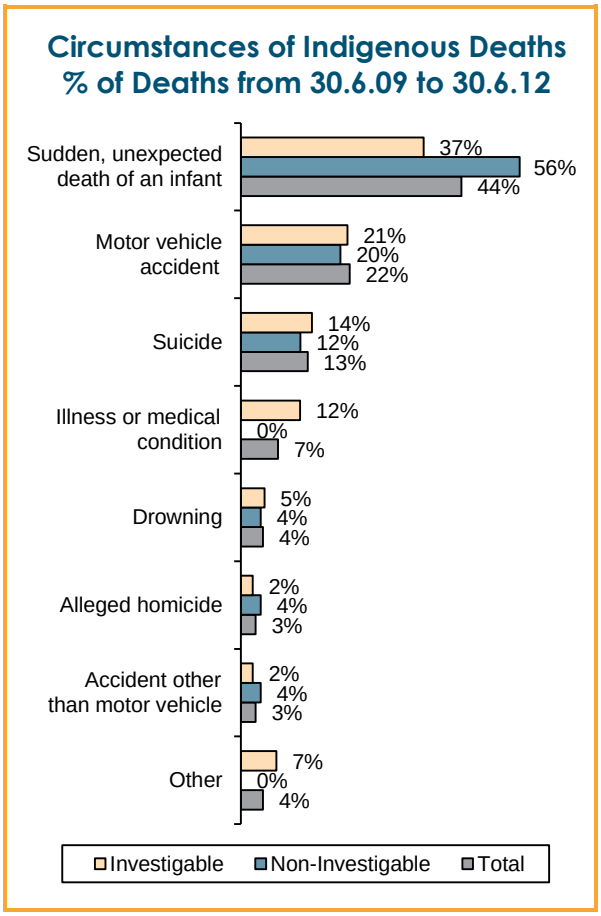
For the notifications received, the following chart demonstrates:

- Over the three year period from 30 June 2009 to 30 June 2012, the majority of Indigenous children who died were male (63%) but for 2011-12 the numbers of male and female Indigenous children who died are similar;
- The infant and youth groupings are the largest age range categories; and
- Regional and remote Indigenous child deaths far outnumber the deaths of the Indigenous children living in the metropolitan area. Over the three year period, 81% of Indigenous children who died lived in regional or remote communities.



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





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 to address issues;
- Outcomes of reviews by age cohort;
- Identification of good practice and collaboration;
- Major own motion investigations (including future own motion investigations arising from the monitoring of reviews);
- 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 identified when undertaking child death reviews:

It is important to note that:

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

- Not responding to child wellbeing concerns within required timeframes.
- Not appropriately identifying child wellbeing concerns at assessment.
- Not consulting with an Aboriginal Practice Leader as required by policy.
- Lack of appropriate communication and planning when co-working of cases across multiple districts as required by policy.
- Limited policy or practice guidance in identifying the possible existence of Foetal Alcohol Spectrum Disorder and its impact on child wellbeing.
- Insufficient collaboration when multiple agencies are, or should be, involved with the child.
- Inadequate record keeping practices, in particular, recording of decisions made.
- Not appropriately using the Signs of Safety framework.
- Not undertaking adequate Pre-birth safety planning.

Administrative Improvements to Address Issues

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

- Reiterating the importance of consultation with Aboriginal Practice Leaders.
- Reiterating the requirements relating to child wellbeing concerns, including appropriate identification and assessment of child wellbeing concerns.
- Improved interagency collaboration in relation to pre-birth protocols.
- Using a child death review as a case example in Signs of Safety training for staff.
- Considering the issue of Foetal Alcohol Spectrum Disorder (**FASD**), both in relation to prevention during pregnancy and the needs of children living with FASD, as they relate to child safety and wellbeing, and considering FASD in relation to policy development, practice requirements and training.

- Reiterating requirements in relation to the recording of decisions made and actions taken.
- Reviewing intake and assessment process and current response times.
- A review of cases being 'co-worked' across multiple districts to assess if the decisions in regard to case management, case transfer and 'co-working' have been made in accordance with the child's best interests.

Outcomes of Reviews 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 has highlighted promoting safe sleeping practices as a key issue. This issue 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 Own Motion Investigations and Administrative Improvement section.

Promoting safe sleeping practices

In considering the information available through the infant death reviews, it became apparent that a number of environmental factors were present that are identified by *SIDS and Kids Australia* as safe sleep risk factors that relate to the infant's sleeping position, the bedding, exposure to tobacco smoke, the infant's sleep location and sharing a sleep surface with an adult who is under the influence of alcohol or drugs that cause sedation. As these environmental factors can potentially be modified, there is potential to reduce these risk factors.

The Ombudsman's review of these infant deaths has identified that where public sector agencies, particularly the Department of Health and the Department for Child Protection, come into contact with the family of infants exposed to these risk factors, there is opportunity to promote safe practices and reduce the risks to the infant.

Deaths of Children Aged 1 to 5 Years

The Ombudsman's examination of reviews of deaths of children aged 1 to 5 years, undertaken in 2011-12, has highlighted supervision of the child 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. Kidsafe WA identifies supervision as an important factor in reducing the risk of injury and death for this age group.

In 2011-12 a review highlighted the potential for foetal alcohol spectrum disorder (**FASD**) to impact on parenting and supervision of a child aged 1 to 5 years, as outlined in the case study below.

Child A

The Department for Child Protection was working with Child A's family, assisting the parents to improve their parenting skills and address their alleged drinking problems. Child A's parents spoke of the difficulty they had in controlling Child A's impulsive behavior, saying Child A did not follow instructions. The review highlighted that the Department's work with this family was positive and proactive. However, the review identified that Child A's impulsive behaviour could have been indicating potential FASD, and consideration should have been given to this possibility.

As a result of the Ombudsman's review, the Department agreed to consider the issues of FASD, both in relation to prevention during pregnancy and the needs of children living with FASD, as they relate to child safety and wellbeing, and consider FASD in relation to policy development, practice requirements and training across the Department.

Deaths of Children Aged 6 to 12 Years

The Ombudsman's examination of reviews of deaths of children aged 6 to 12 years have identified 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.

The resulting major own motion investigation into care planning for these children was completed in 2011-12 and the report, *Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004*, was tabled in

Parliament in November 2011. Further details about own motion investigations are set out in the Own Motion Investigations and Administrative Improvement section.

Deaths of Children Aged 13 to 17 Years

The Ombudsman's examination of reviews of deaths of children aged 13 to 17 undertaken in 2011-12 has highlighted the following key factors:

- Youth suicide; and
- Risk taking behaviours.

The reviews have identified trends in the presence of risk factors such as:

- Self-harm or suicidal behaviours;
- Chronic school truancy and behavioural issues;
- Adolescent homelessness; and
- Criminal behaviour.

There is often multiple agency involvement (including child protection, health, education, police and juvenile justice services) in the lives of these adolescents. These cases also identify issues relating to interagency communication and collaboration, and engagement with the adolescent.

Youth Suicide

In 2011-12, there were 26 child death notifications for children aged 13-17, of which 11 (42%) were apparent suicides. As identified by the *Western Australian Suicide Prevention Strategy*, there are a number of 'risk and protective factors that are related to suicide' such as 'individual, social and contextual factors' and 'suicide is rarely the result of a single cause'. This is reflected in the examination of child death notifications related to youth suicide.

Youth suicide notifications received by the Ombudsman can generally be separated into two key groupings:

- Young people who have had little or no contact with government services; and
- Young people with concerning social and environmental factors that put them at risk, who have consequently had significant contact with public sector agencies.

The following case study highlights issues identified in reviews of youth suicides.

Case Study

Adolescent B

Adolescent B came from a complex family system, with a history of alleged domestic violence and parental drug use, and Adolescent B had experienced neglect and abuse. Adolescent B was aggressive and problematic at school, and her attendance was poor. Adolescent B experienced emotional difficulties, which were evident in her history of self-harming and suicide attempts. Adolescent B would often abscond from home and come to the attention of police and juvenile justice services for her behaviour.

Following Adolescent B's suicide, the Ombudsman reviewed the decisions and actions by the public sector agencies involved with Adolescent B in the two years prior to her death. It became apparent that while the agencies individually attempted to assist Adolescent B, there were missed opportunities for interagency collaboration and communication. Following the Ombudsman's review, the relevant departments are implementing a range of ways to improve their communication and collaboration with other agencies when working with children and young people in these circumstances.

Due to the number of youth suicide notifications to the Ombudsman, and the issues identified through the reviews undertaken, the Ombudsman will undertake an own motion investigation into youth suicides, to commence in 2012-13.

Identification of Good Practice and Collaboration

The following case study sets out good practice by the Department and other public sector agencies, as well as good interagency communication and cooperation, in relation to care planning.

Case Study

Child C

Child C was placed in the care of the Department at an early age due to concerns her family was unable to meet her extensive health needs, which included physical and intellectual disabilities. Child C experienced a long term successful foster placement with carers who were able to effectively manage all her care needs.

A number of services worked collaboratively with Child C to support her in the stable foster placement and ensure that all her complex health needs were met. The Department demonstrated good practice in undertaking Care Planning associated with her social, health and education needs while in foster care. In addition, good interagency collaboration was evident between the Department, the Department of Health and the Department of Education with respect to Child C's care planning.

Major Own Motion Investigations

In addition to taking action on individual child deaths, the Ombudsman's 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 were:

- Sleep-related deaths of infants; and
- Planning for Children in Care.

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

In 2012-13, the Ombudsman will commence a major own motion investigation in relation to youth suicide.

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 provide an opportunity to identify good practices that may assist in the prevention or reduction of child deaths, as shown in the following example.

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, and 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. People with FASD require lifelong support from services in all areas of health and wellbeing, education, child protection, disability services, corrective services, justice, police and employment.

This year the Ombudsman's office has undertaken a number of activities in relation to FASD, given its relevance to child deaths reviewed by the Ombudsman.

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 raised in child death reviews and how positive change can be achieved. Since the jurisdiction commenced, meetings with Departmental staff have been held in all districts in the metropolitan area, and in 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;
- Contemporary professional practice relating to the wellbeing of children and their families; and
- Issues that impact on the capacity of public sector agencies to ensure the safety and wellbeing of children.

The Panel met four times this year and is comprised of five 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 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 own motion investigations undertaken during the year.

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 Ombudsman's office liaises as part of the child death review jurisdiction include:

- Public authorities that have a role in relation to child deaths including:
  - The Coroner; and
  - The 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 continued throughout 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 and the family and domestic violence fatality review function, commencing in 2012-13. This has strengthened the Office's understanding and knowledge of the issues faced by Indigenous and regional communities that impact on child and family wellbeing and service delivery in diverse and regional communities.

As part of this work, the Office's Principal Indigenous Liaison Officer 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 community advocates in these regions.

Family and Domestic Violence Fatality Reviews

The Office will commence family and domestic violence fatality reviews on 1 July 2012 and during 2011-12 undertook significant work to prepare for the new function.