Our Performance in 2011-12

This section of the report compares results with targets for both financial and non-financial indicators and explains significant variations.

It also provides information on achievements during the year, major initiatives and projects, and explains why this work was undertaken.

- Summary of Performance
  - Key Performance Indicators
  - Financial Performance
- Complaint Resolution
- Child Death Review
- Own Motion Investigations and Administrative Improvement
- Collaboration and Access to Services

Summary of Performance

Key Effectiveness Indicators

The Ombudsman aims to improve decision making and administrative practices in public authorities as a result of complaints handled by the Office, child death reviews and own motion investigations. Improvements may occur through action identified and implemented by agencies as a result of the Ombudsman's investigations and reviews, or as a result of the Ombudsman making specific recommendations and suggestions that are practical and effective. Key indicators are the percentage of these recommendations and suggestions accepted by public authorities and the number of improvements that occur as a result of Ombudsman action.

Key Effectiveness Indicators	2011-12 Target	2011-12 Actual	Variance
Of allegations where the Ombudsman made recommendations to improve practices or procedures, percentage of recommendations accepted by agencies	**100%**	**100%**	**0**
Number of improvements to practices or procedures as a result of Ombudsman action	**55**	**96**	**+41**

Another important role of the Ombudsman is to enable remedies to be provided to people who make complaints to the Office where service delivery by a public authority may have been inadequate. The remedies may include reconsideration of decisions, more timely decisions or action, financial remedies, better explanations and apologies. In 2011-12, there were 108 actions taken by public authorities to provide a remedy for people making complaints to the Office.

Comparison of Actual Results and Budget Targets

Commencing in 2007-08, the Office commenced a program to ensure that its work increasingly contributed to improvements to public administration. Consistent with this program, the number of improvements to practices and procedures of public authorities as a result of Ombudsman action in 2011-12 is a significant improvement on the 2011-12 budget target and 2010-11 actual results. The number of improvements to practices and procedures of public authorities as a result of Ombudsman action has now increased each year for the past three years and has nearly trebled from 2007-08.

For the fifth consecutive year, public authorities have accepted every recommendation made by the Ombudsman, matching the 2010-11 actual result and meeting the 2011-12 budget target.

The number of administrative improvements as a result of Ombudsman action has nearly trebled since 2007-08.

For the fifth consecutive year, public authorities have accepted every recommendation made by the Ombudsman.

Key Efficiency Indicators

The key efficiency indicators relate to timeliness of complaint handling, the cost per finalised allegation about public authorities and the cost per finalised child death notification.

Key Efficiency Indicators	2011-12 Target	2011-12 Actual	Variance
Percentage of allegations finalised within 3 months	**85%**	**72%**	**-13%**
Percentage of allegations finalised within 12 months	**98%**	**99%**	**+1%**
Percentage of allegations on hand at 30 June less than three months old	**68%**	**45%**	**-23%**
Percentage of allegations on hand at 30 June less than 12 months old	**97%**	**99%**	**+2%**
Average cost per finalised allegation	**$1,900**	**$1,866**	**-$34**
Average cost per finalised notification of the sudden or unexpected death of a child	**$9,500**	**$10,410**	**+$910**

Comparison of Actual Results and Budget Targets

Overall, the timeliness of complaint handling has substantially improved over the previous five years due to a major complaint handling improvement program introduced in 2007-08. An initial focus of the program was the elimination of aged complaints, including a high number of complaints older than twelve months of age and complaints as old as six years. In 2011-12, there has been a further reduction of aged cases with 99 per cent of allegations finalised in less than 12 months and 99 per cent of allegations on hand less than twelve months old. Both these figures exceed 2011-12 budget targets and 2010-11 actual results. For the fourth consecutive year, the cost per finalised allegation has reduced and the Office has exceeded the 2011-12 budget target, reflecting the efficiency dividends of the program.

The program has also ensured that, over the last five years, the Office has been able to manage successfully a very substantial increase in the level of complaints that commenced in mid 2009. Overall, the Office has experienced an 83 per cent increase in the average number of complaints received in the last three years (2009-10 to 2011-12), compared to the average for the previous three years (2006-07 to 2008-09). In this context, the actual percentages of allegations finalised within three months and the percentage of allegations on hand less than three months old have not met 2011-12 budget targets, reflecting the fact that the Office has been required to manage the further 23 per cent increase in complaints received in 2011-12. Pleasingly, however, despite this increase in complaints, nearly three quarters of all complaints received have been resolved in less than three months.

The Office has now developed and commenced a new organisational structure and processes to promote and support early resolution of complaints. The early resolution of complaints will be a principal focus in 2012-13 and the Office expects to meet or exceed both budget targets in 2012-13.

The average cost of $10,410 per finalised notification of the sudden or unexpected death of a child has moderately exceeded the 2011-12 budget target, reflecting an increased complexity of certain child death reviews.

Summary of Financial Performance

The majority of expenses for the Office (67%) relate to staffing costs. The remainder is primarily for accommodation, communications and office equipment.

Financial Performance	2011-12 Target ('000s)	2011-12 Actual ('000s)	Variance ('000s)
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	$8,012	**$9,424**	$1,412
Income other than income from State Government (sourced from Statement of Comprehensive Income)	$1,500	**$2,372**	$872
Net cost of services (sourced from Statement of Comprehensive Income)	$6,512	**$7,052**	$540
Total equity (sourced from Statement of Financial Position)	$1,439	**$1,604**	$165
Net increase in cash held (sourced from Statement of Cash Flows)	$17	**$367**	$350
Staff Numbers	**Number**	**Number**	**Number**
Full time equivalent (FTE) staff level	63	**64**	1

Comparison of Actual Results and Budget Targets

The variation in total cost of services of $1.412 million was mainly due to:

- Staffing costs for staff recruited to handle increased complaints in both the State and Energy jurisdictions, and work to develop the new function of family and domestic violence fatality reviews;
- Increased costs for accommodation, supplies, services and equipment related to the increase in staff and expenses resulting from a relocation to new accommodation during the year; and

- Increased expenses for fit-out depreciation associated with the refit of the Office's new accommodation (provided as resources free of charge by the Department of Finance - Building Management and Works).

Total income other than income from State Government increased due to an increase in funding approved by the Board of the Energy Ombudsman Western Australia to cover the staffing and other costs associated with the increased work in the Energy jurisdiction.

The increase in net cost of services was mainly due to staffing costs associated with a sustained increase in complaints in the State jurisdiction and preparatory work for the new family and domestic violence fatality review function, increased accommodation costs needed for the additional staffing and costs associated with moving to new accommodation. The increase was funded by increased appropriations and resources received free of charge.

The increase in total equity and cash held was primarily due to funds received in late June from appropriations and the revenue from the Energy jurisdiction, which will be used in early 2012-13. The increase in cash held is also partly due to invoices accrued but unpaid at the end of the reporting period.

The variation of one FTE is due to an approved FTE to undertake preparatory work for the new family and domestic violence fatality review function.

For further details see Note 27 'Explanatory Statement' in the Financial Statements section.

Complaint Resolution

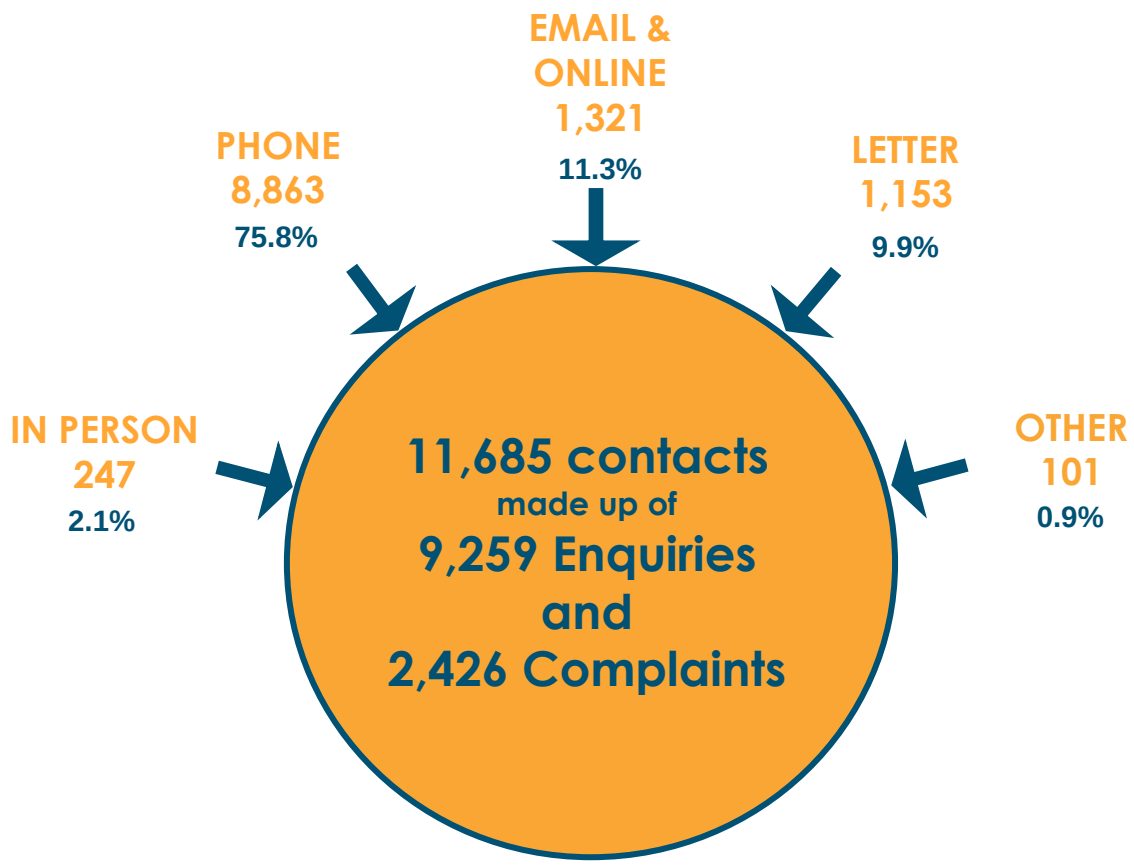
One of the core Ombudsman functions is to resolve complaints received from the public about State Government agencies, statutory authorities and boards, local governments and universities (commonly referred to as public authorities). This section of the report provides information about how the Office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

Contacts

In 2011-12, the Office received 11,685 contacts from members of the public consisting of:

- 9,259 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 2,426 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

Contacts to the Office in 2011-12



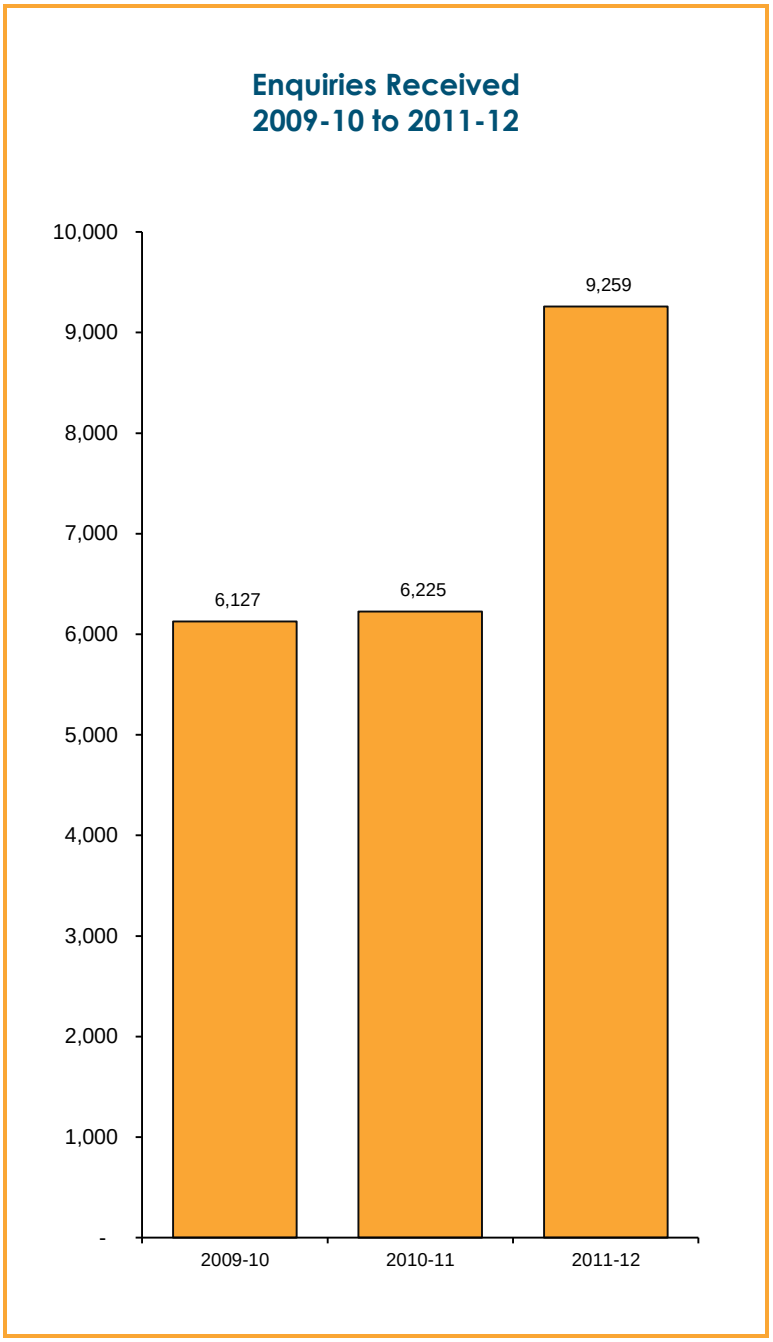
Enquiries Received

There were 9,259 enquiries received during 2011-12.

For enquiries that are within the Ombudsman's jurisdiction, staff provide information about the role of the Office and how to make a complaint.

Approximately half of all enquiries are referred back to the public authority in the first instance to give it the opportunity to hear about and deal with the issue. This is often the quickest and most effective way to have the issue dealt with. Enquirers are advised that if their issues are not resolved by the public authority, they can make a complaint to the Ombudsman.

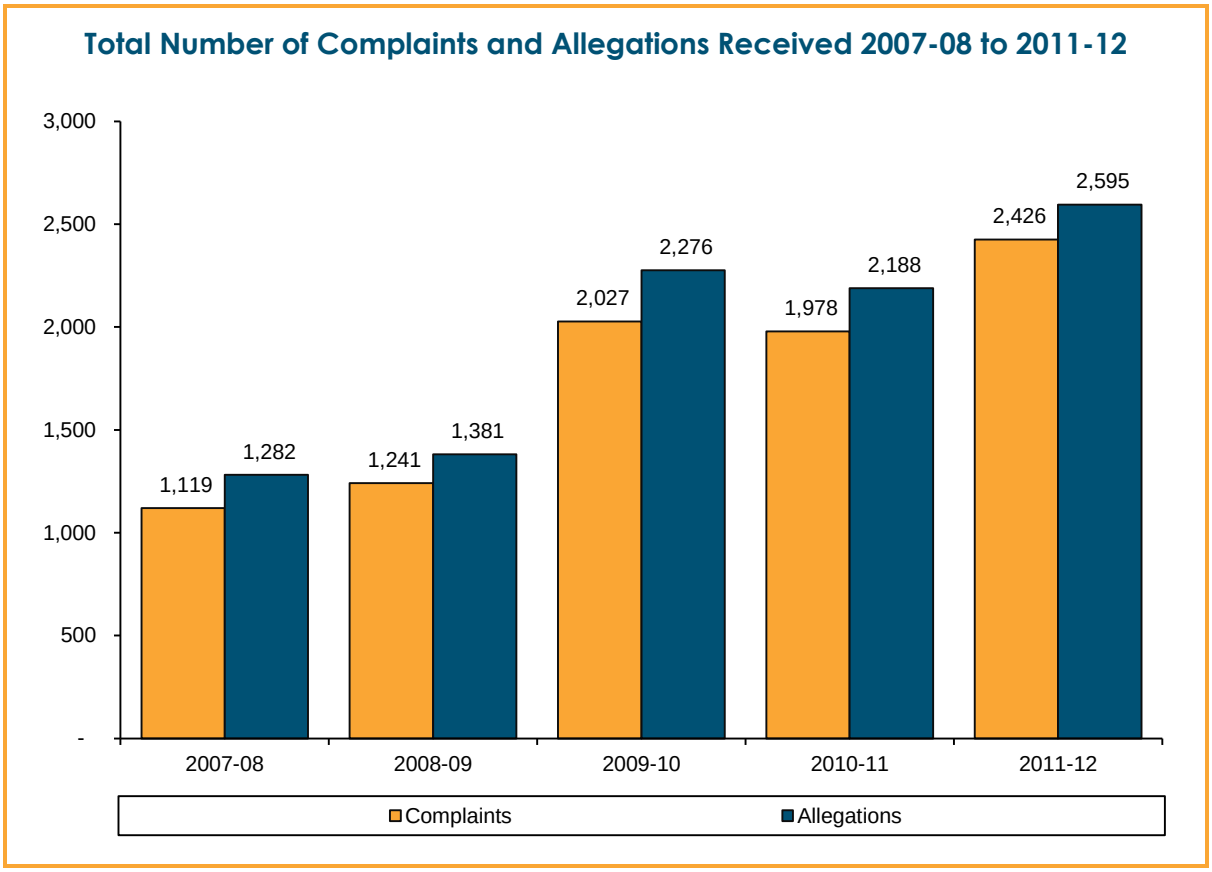
For enquiries that are outside the jurisdiction of the Ombudsman, staff assist members of the public by providing information about the appropriate body to handle the issues they have raised. In some cases, Ombudsman staff may be able to facilitate an early resolution of the matter by making informal contact with the public authority. One example of this is outlined in the following case.



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

Complaints Received

In 2011-12, the Office received 2,426 complaints, which included 2,595 separate allegations, and finalised 2,252. There are more allegations than complaints because one complaint may cover more than one issue. As shown in the chart below, the number of complaints received in 2011-12 is higher than that received in the previous four years.

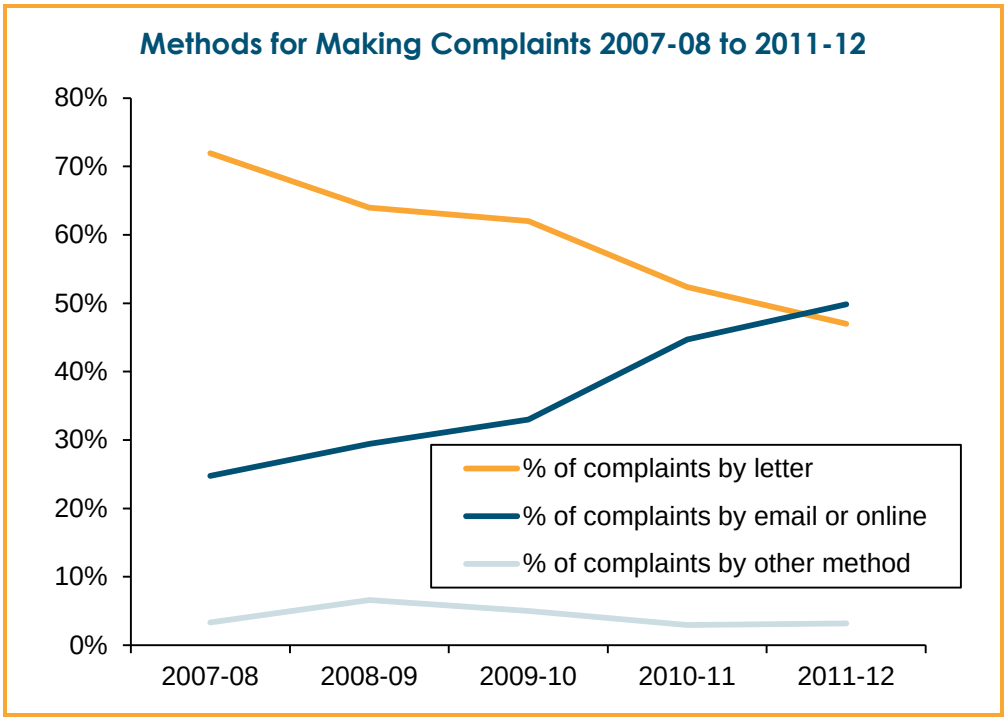


NOTE: The number of complaints and allegations shown for a year may vary, by a very small amount, from the number shown in previous annual reports. This occurs because, during the course of an investigation, it can become apparent that a complaint is about more than one public authority or there are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

The average number of complaints received in the last three years (2009-10 to 2011-12) was 2,144 compared with the average of 1,171 for the three previous years (from 2006-07 to 2008-09). This represents an increase of 83 per cent in complaint numbers. The increase is across all sectors and is not confined to one public authority. For further information on trends in complaint numbers, see the Significant Issues Impacting the Office section.

How Complaints are made

The increase in the use of email and online facilities to lodge complaints has continued in 2011-12, increasing from 45 per cent in 2010-11 to 50 per cent in 2011-12. For the first time, email and online facilities have exceeded letters as the preferred method of lodging complaints. The proportion of people using email and online facilities to lodge complaints has more than doubled since 2007-08 when less than 25 per cent were received in this way. During the same period, the proportion of people who lodge complaints by letter has reduced from 72 per cent to 47 per cent. The remaining complaints were received by a variety of means including by fax, during regional visits and in person.



Resolving Complaints

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

Where it is possible and appropriate, staff use an early resolution approach to resolve complaints. This approach is highly efficient and effective and results in timely resolution of complaints. It gives public authorities the opportunity to provide a quick response to the issues raised and to undertake timely action to resolve the matter for the complainant and prevent similar complaints arising again.

The outcomes of complaints may result in a remedy for the complainant or improvements to a public authority's administrative practices, or a combination of both. Complaint resolution staff also track recurring trends and issues in complaints and this information is used to inform broader administrative improvement in public authorities and investigations initiated by the Ombudsman (known as own motion investigations).

The following case study shows how early resolution can result in timely remedies for a complaint.

Case Study

Fence replaced through early resolution process

A man's property shared a portion of a back fence with a property owned by a public authority. In the course of installing a new fence at the public authority's property, the authority's contractor damaged seven panels of the man's fence.

The man complained to the public authority, which agreed that the actions of the contractor may have contributed to the damage to the fence. However, the public authority only offered to cover the cost of the replacement and installation of three of the panels.

The man contacted the Ombudsman complaining that the public authority was acting unreasonably by only offering to replace and install three of the fence panels and that it should replace all the damaged panels. As a result of contact from the Office, the public authority agreed to extend its offer and replace all the damaged fence panels.

Time Taken to Resolve Complaints

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

Timely complaint handling in 2011-12 meant that:

- 72% of allegations were finalised within 3 months and 99% were finalised within 12 months; and
- There has been a reduction of 10% in the average time to finalise complaints over the last year.

Over the last five years, very significant improvements have been achieved in timely complaint handling, including:

- The average time to finalise complaints decreased by 42% from 92 days in 2006-07 to 53 days in 2011-12; and
- Finalised complaints older than 12 months have decreased by 85% between 2006-07 and 2011-12.

In some cases, timely resolution of complaints is of the essence and public authorities can be quick to recognise this when there are risks to safety. This is illustrated in the following case study.

Case Study

Changes allow prisoner immediate access to medication

A prisoner suffered from an acute medical condition and was allowed to carry medication at all times to enable prompt treatment of a severe allergic reaction. When he was transferred to a different prison he was advised that this prison did not allow him to carry the medication, which he could only access at the prison's medical centre. The prison also restricted the prisoner's movements and activities within the prison to minimise the risk to his medical condition.

The prisoner complained to the Ombudsman that the different practices of this prison were unfair and unreasonable and compromised his physical wellbeing.

The Office wrote to the responsible public authority about the prisoner's complaint and the apparent inconsistencies in the authority's policy on access by prisoners to emergency medication at different prison sites.

As a result of the complaint the prison allowed the prisoner to carry his medication and the public authority took steps to ensure that all Western Australian prisons developed practices and procedures for the management of prisoners with a medical condition requiring immediate access to emergency medication.

Complaints Finalised in 2011-12

There were 2,252 complaints finalised during the year and, of these, 1,510 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about agencies within jurisdiction, 869 were finalised at initial assessment, 587 were finalised after an Ombudsman investigation and 54 were withdrawn.

Complaints finalised at initial assessment

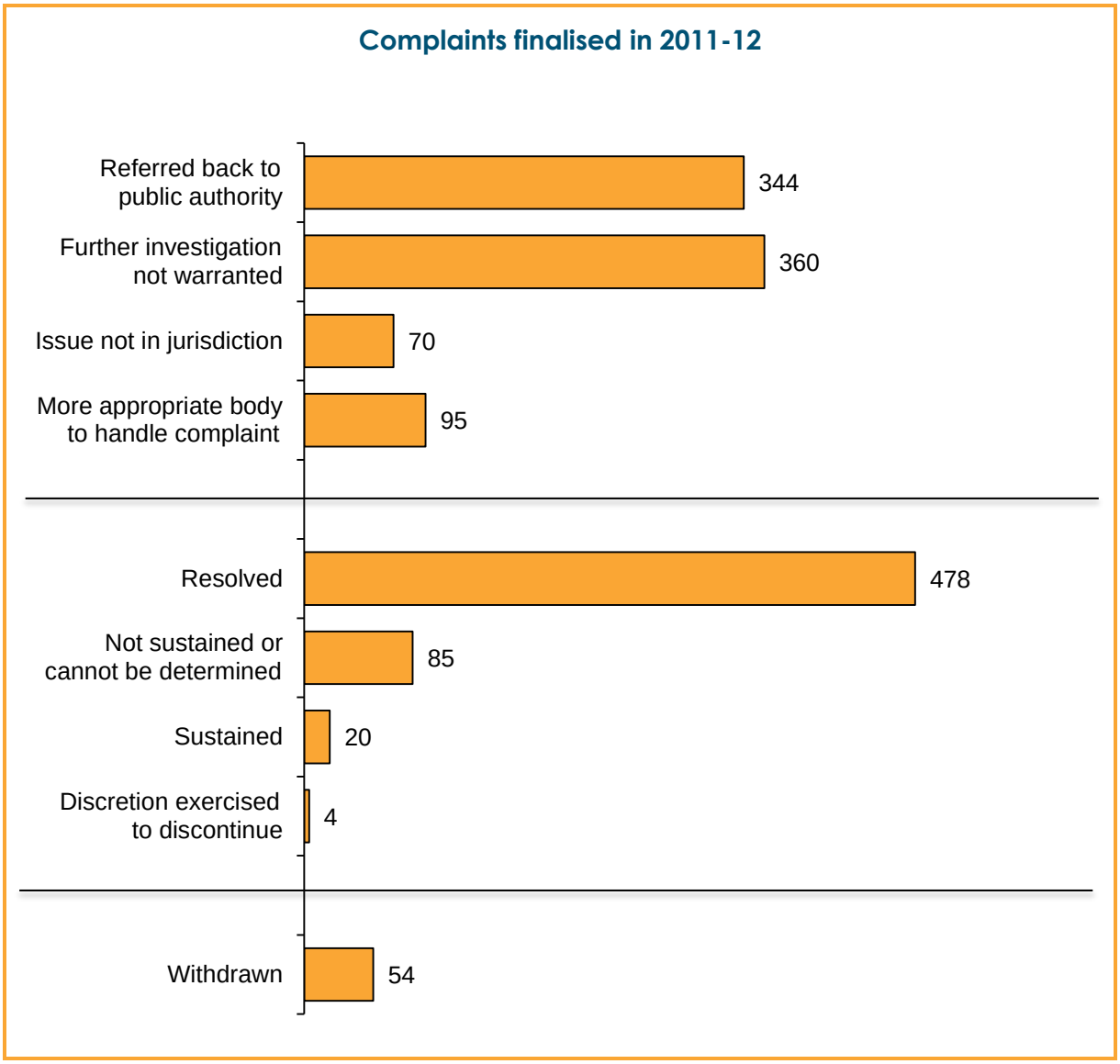
More than a third (40%) of the 869 complaints finalised at the initial assessment were referred back to the public authority to provide it with an opportunity to resolve the matter before involving the Ombudsman. This is a common and timely approach and often results in resolution of the matter. The person making the complaint is advised to contact the Office again if their complaint remains unresolved at the end of this referral process. In a further 11 per cent of complaints finalised at the initial assessment, it was determined that there was a more appropriate body to handle the complaint. In these cases, complainants are provided with contact details of the relevant body to assist them.

Complaints finalised after investigation

Of the 587 complaints finalised after investigation, 81 per cent were resolved through the Office's early resolution process. This involves Ombudsman staff contacting the public authority to progress a timely resolution of complaints that appear to be able to be resolved quickly and easily. Public authorities have shown a strong willingness to resolve complaints using this approach. There has been an increasing trend in early resolution through the use of this process (from 207 in 2009-10 to 478 in 2011-12),

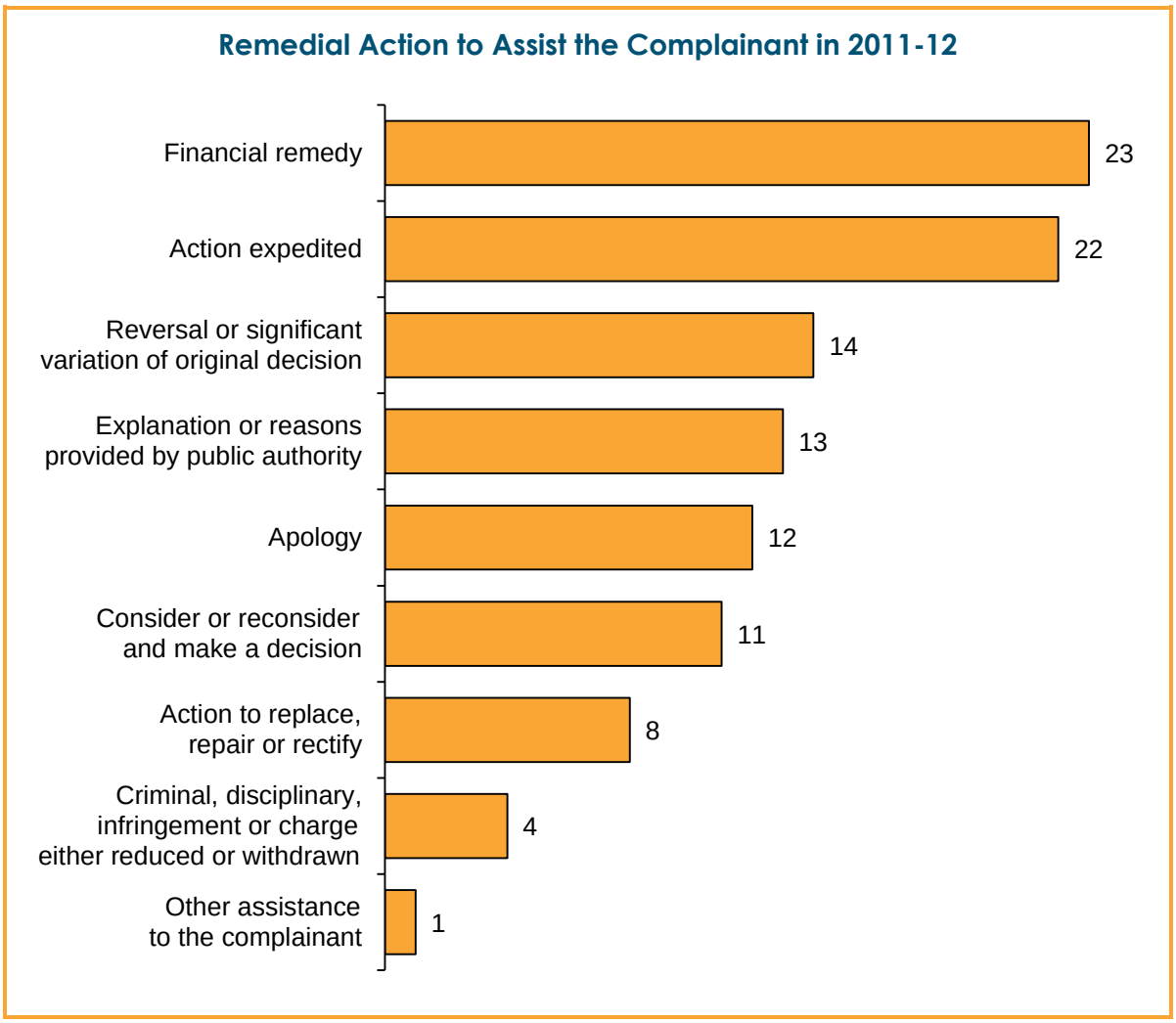
corresponding with a reduction in complaints finalised through more formal processes.

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



Outcomes to Assist the Complainant

Complainants look to the Ombudsman to facilitate some form of assistance or action to remedy their complaint. In 2011-12 there were 108 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman, as shown in the following chart.



Outcomes to Improve Public Administration

In addition to providing individual remedies, complaint resolution can also result in improved public administration. This occurs when the public authority takes action to improve its decision making and practices in order to address systemic issues and prevent similar complaints in the future.

Administrative improvements include changes to policy and procedures, changes to business systems or practices and staff development and training. The following case study illustrates how individual complaints can lead to improved public administration.

Further information on outcomes to improve public administration is provided in the Own Motion Investigations and Administrative Improvement section.

Case Study

Public authority improves procedures to prevent future errors

A woman wrote to the Ombudsman alleging that a public authority unreasonably provided her with inconsistent valuations of her property, resulting in receipt of invoices for two different amounts. The woman claimed that she had been overcharged because she had paid on the higher valuation.

The Office contacted the public authority, which investigated the complaint and found that both valuations were incorrect because of flaws in the assessment process.

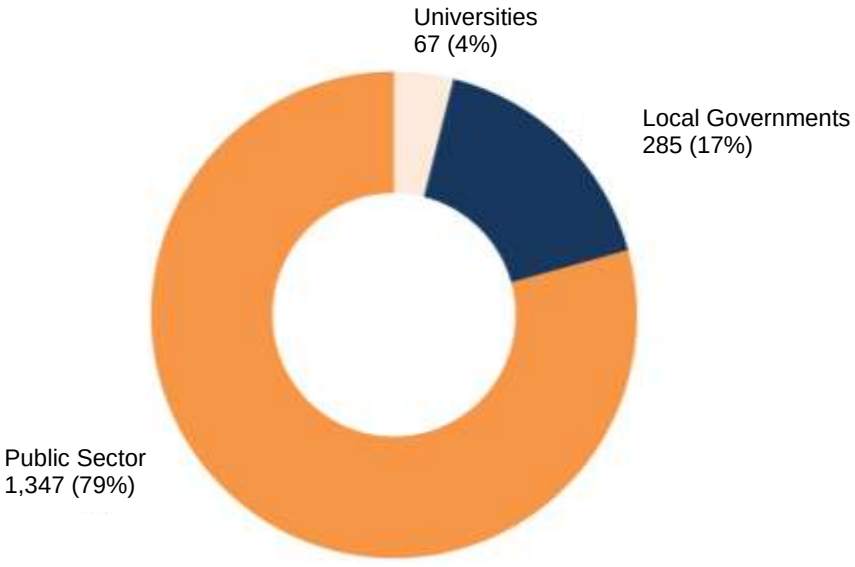
As a result of the complaint, the public authority wrote to the woman explaining what had occurred and apologising for the error. The authority invited her to apply for a refund of the overpayment. In addition, the authority took steps to improve its administrative procedures to ensure that the problem did not reoccur.

About the Complaints

Of the 2,426 complaints received, 1,699 were about public authorities that are in the Ombudsman's jurisdiction. The remaining 727 complaints were about bodies outside the Ombudsman's jurisdiction. In these cases, Ombudsman staff provided assistance to enable the people making the complaint to take the complaint to a more appropriate body.

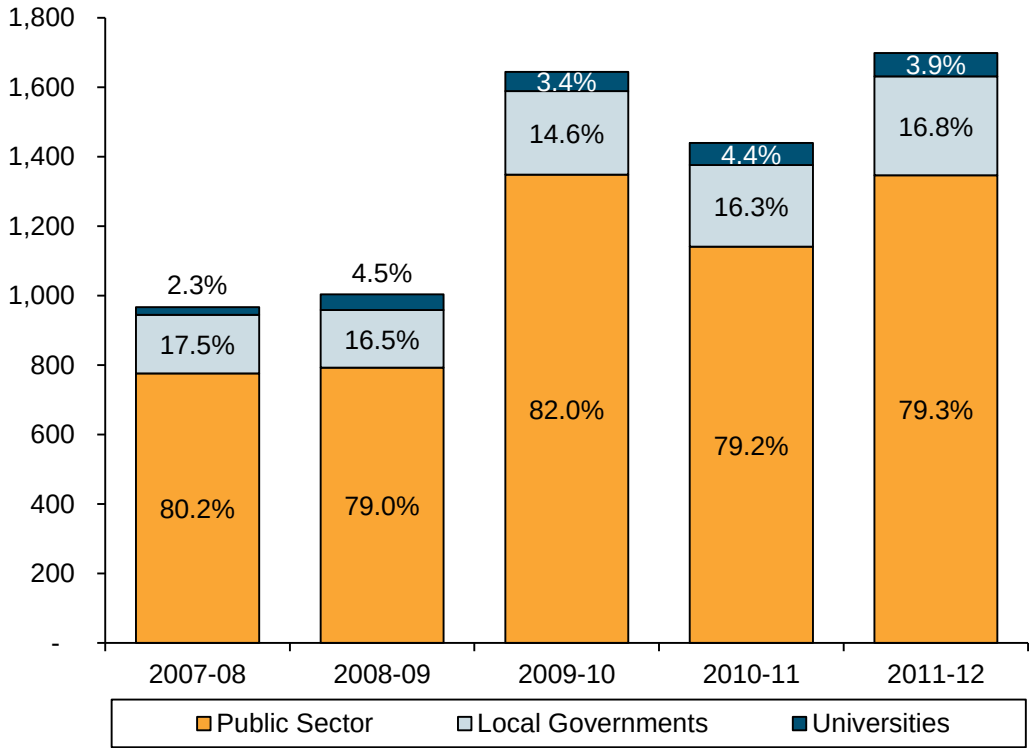
Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (1,347 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (285 complaints); and the university sector (67 complaints).

Complaints Received about Public Authorities Within the Ombudsman's Jurisdiction in 2011-12



While there has been an increase in complaints in all sectors over the last five years, the proportion of complaints about each sector has remained relatively steady over this period, as shown in the chart below.

Complaints Received about Public Authorities Within the Ombudsman's Jurisdiction between 2007-08 and 2011-12

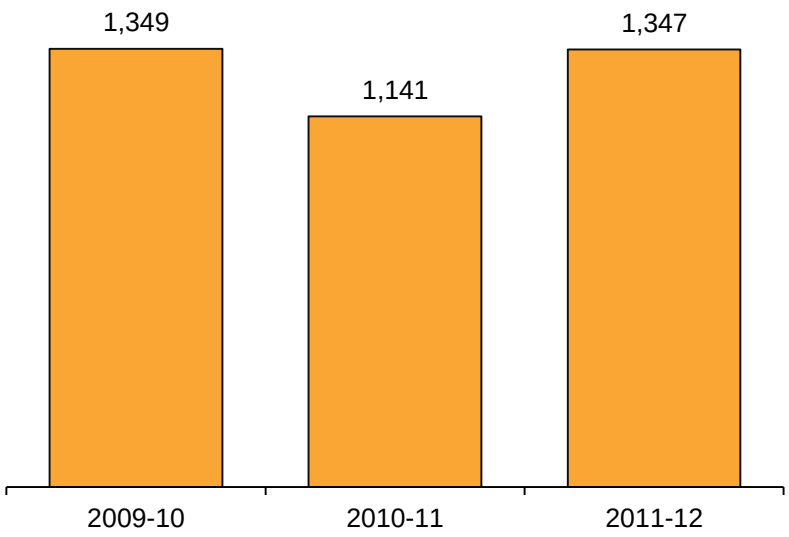


The Public Sector

In 2011-12, there were 1,347 complaints received about the public sector, an increase of 18 per cent compared to 2010-11, and 1,169 complaints were finalised.

The number of complaints about the public sector as a whole in the last three years is shown in the chart below.

Complaints Received About the Public Sector between 2007-08 and 2011-12



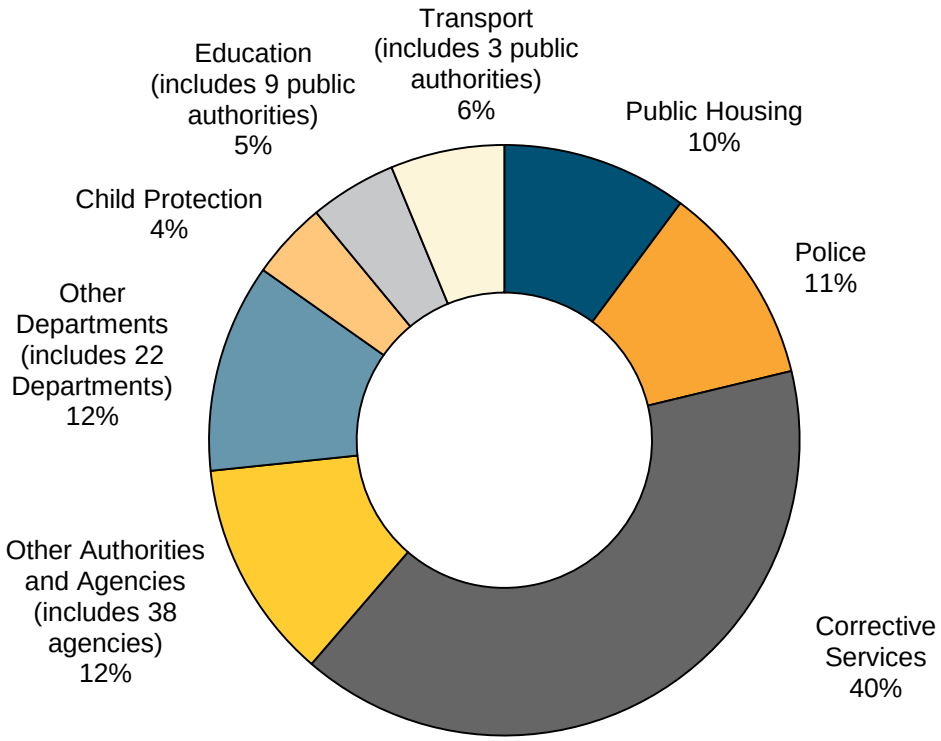
Of the 1,347 complaints received, 76 per cent were about six key areas covering:

- Corrective services, in particular prisons (540 or 40%);
- Police (149 or 11%);
- Public housing (137 or 10%);
- Transport (84 or 6%);
- Education - public schools and Technical and Further Education colleges (64 or 5%). Information about universities is shown separately under the University Sector; and
- Child protection (57 or 4%).

The remaining complaints about the public sector (316) were about 60 other State Government departments, statutory authorities and boards. Seventy two per cent (43) of these agencies received five complaints or less.

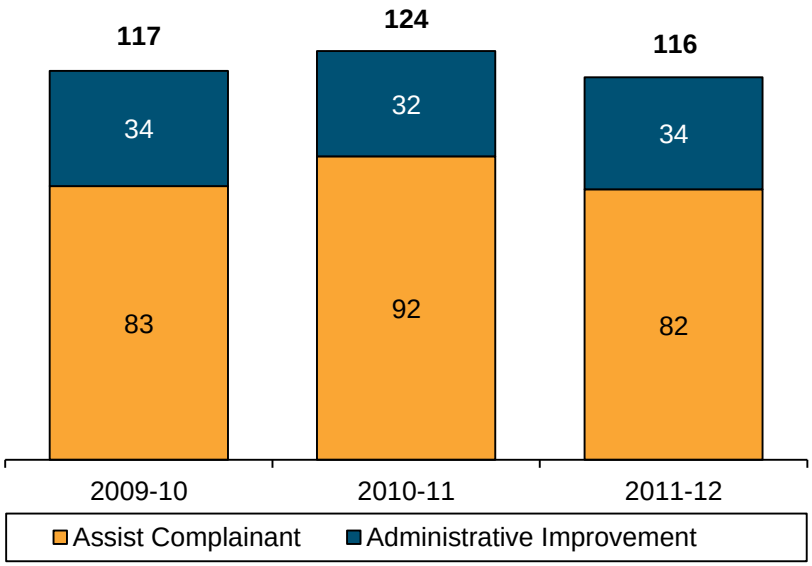
The following chart provides a breakdown of the complaints received.

Complaints Received About the Public Sector in 2011-12



There were 116 actions taken by public sector bodies as a result of complaints finalised in 2011-12. These resulted in 82 remedies being provided to complainants and 34 improvements to public sector practices.

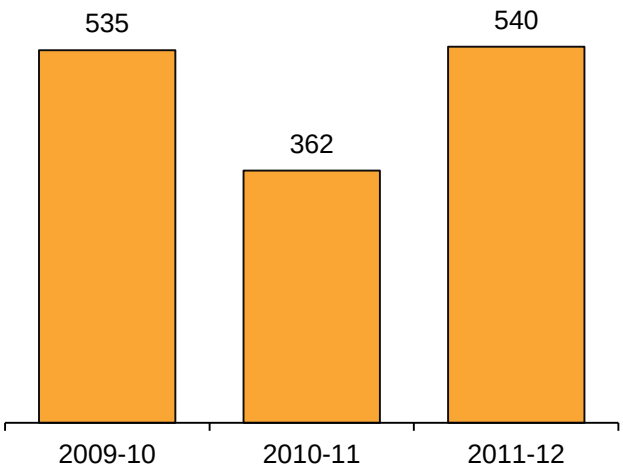
Actions Taken as a Result of Complaints Finalised about the Public Sector between 2009-10 and 2011-12



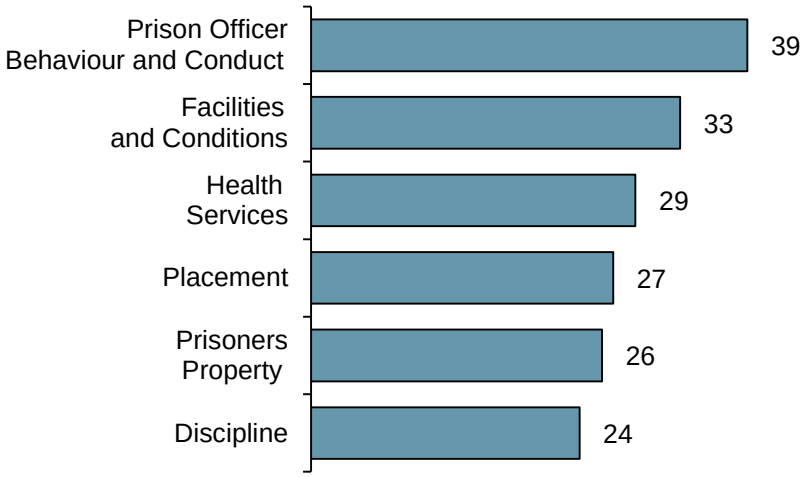
Public Sector Complaint Issues and Outcomes

Corrective Services

Complaints received



Most common allegations



Other types of allegations

- Sentencing and parole issues;
- Communication and visits;
- Drug detection for prisoners;
- Prisoner grievance procedure;
- Education courses and facilities;
- Food and diet; and
- Prisoner employment.

Outcomes achieved

- Changed policy or procedure;
- Punishment or charges reduced or withdrawn;
- Actions expedited;
- Explanations provided; and
- Reversal or significant variation of original decision.

Case Study

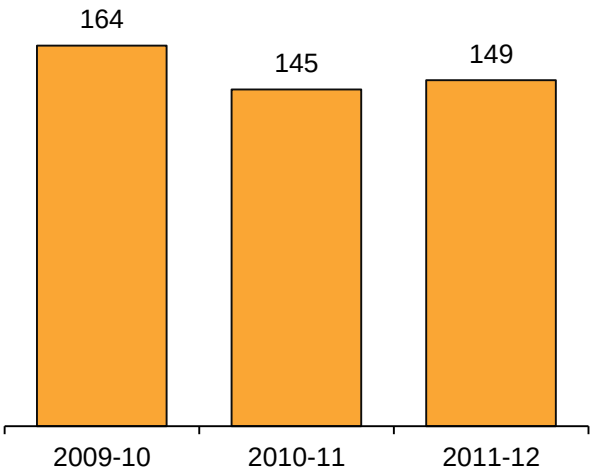
Better information for prisoners on remote telephone allowance

Prisoners in certain Western Australian prisons receive a 'remote telephone allowance' because they cannot receive visits from family or friends. A prisoner wrote to the Ombudsman claiming that the prison had not informed him about the allowance and that he only found about it from another prisoner after he had been in prison for some time and had borrowed money from his son to telephone his children. The prisoner said that the prison refused his request to have the allowance backdated to his admission to the prison because he would have been informed of his entitlement through the prisoner induction program and handbook.

The Office contacted the prison and found that its refusal to backdate the prisoner's remote telephone allowance was in line with the public authority's policy that the allowance could not be credited if not used. However, the enquiries also revealed that information about the allowance was not in the prisoners' handbook and that the prison could not confirm that prisoners were automatically informed of their entitlement during their induction. As a result of the enquiries, the prison produced a new prisoners' induction program and handbook to incorporate information about the allowance and took steps to ensure that officers also advised prisoners of their entitlement during the case management process.

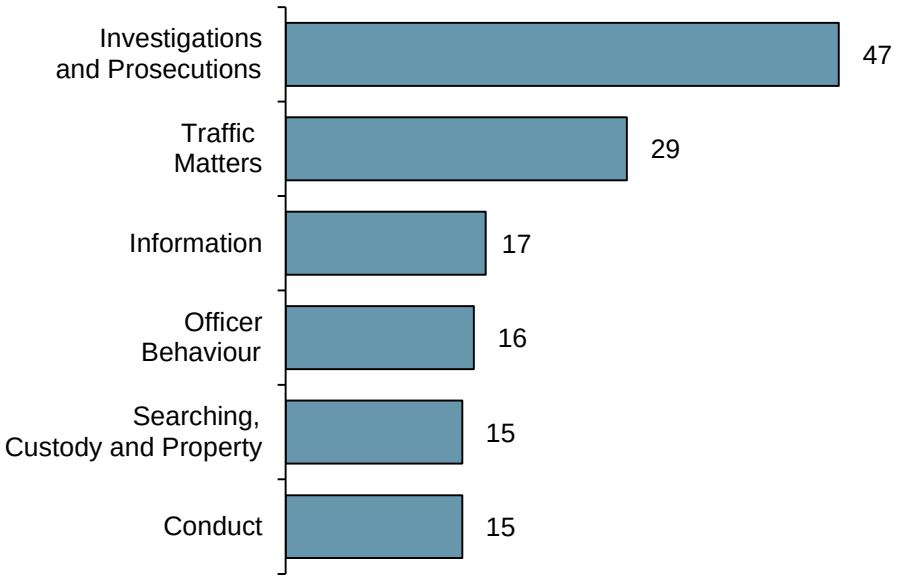
Police

Complaints received



Police

Most common allegations



Other types of allegations

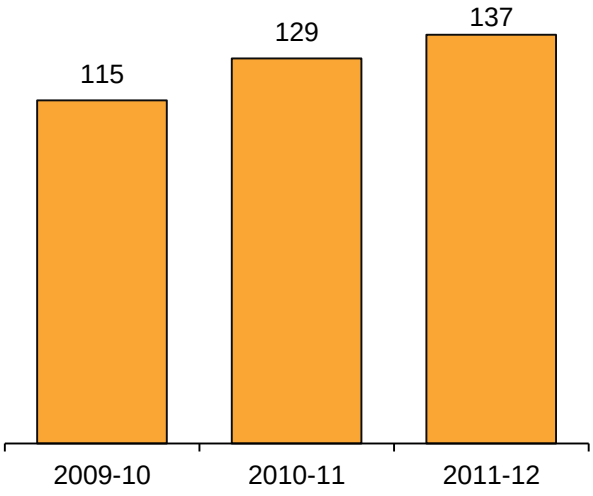
- Arrest and detention;
- Assault; and
- Internal investigation of complaints.

Outcomes achieved

- Refund for incorrect infringement payment.

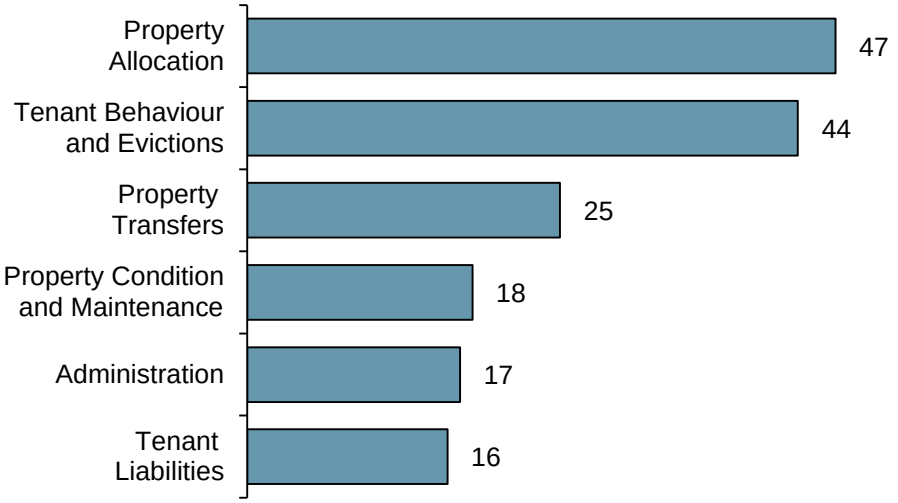
Public Housing

Complaints received



Public Housing

Most common allegations



Other types of allegations

- Debt repayments;
- Rental or bond assistance;
- Construction and development; and
- Rental sales.

Outcomes achieved

- Reversal or significant variation of original decision;
- Actions expedited;
- Apology given;
- Provide training to Officers; and
- Tenant liability waived.

Case Study

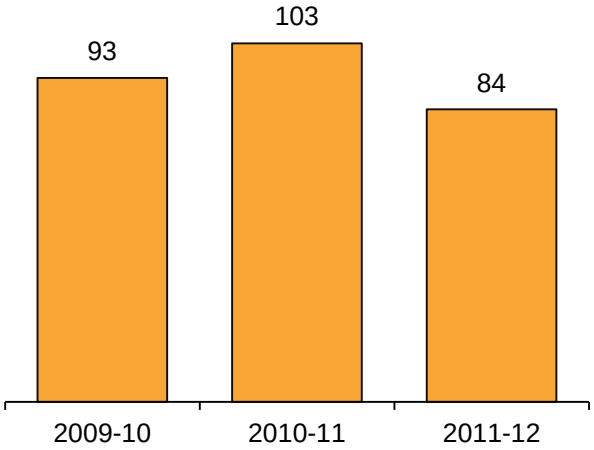
Changes to meet the needs of disabled complainant

A woman living in public housing contacted the Ombudsman complaining about the response to maintenance requirements at the property from the responsible public authority. The woman claimed that the public authority had failed to undertake changes to accommodate the physical disability of her husband. In addition she claimed that the public authority's decision to replace the current garage, which was in need of repair, with an open carport was unreasonable because it removed her access to waterproof storage.

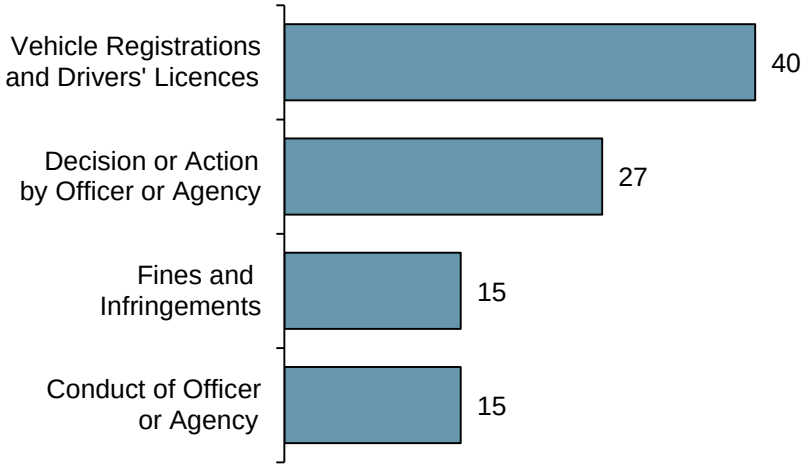
As a result of enquiries by the Office, the public authority arranged a property inspection to review the woman's property. Following this inspection, the public authority advised that it had made the changes recommended by an Occupational Therapist to accommodate the disability needs of the woman's husband and had agreed to replace the garage with another garage instead of an open carport.

Transport

Complaints received



Most common allegations



Other types of allegations

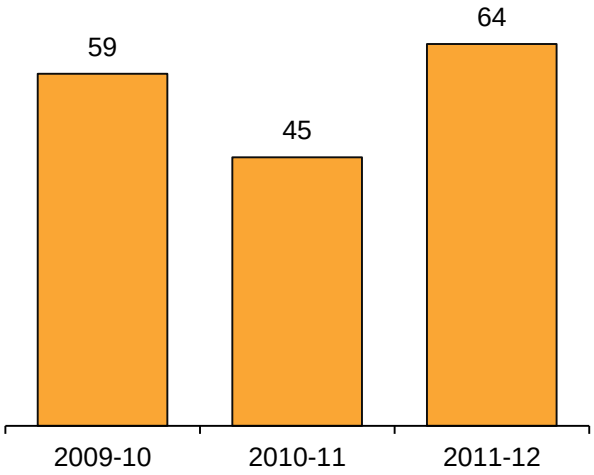
- Provision of information to the public, including on websites; and
- Accuracy of personal information.

Outcomes achieved

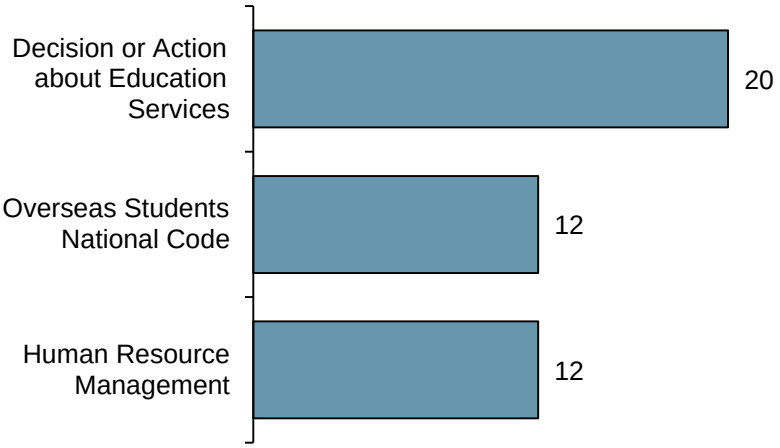
- Change systems;
- Agency officer training;
- Fees waived or penalties withdrawn;
- Refund of infringement payments;
- Apology;
- Act of Grace payment;
- Reversal or significant variation of original decision; and
- Explanation/reasons provided by Agency.

Education

Complaints received



Most common allegations



Other types of allegations

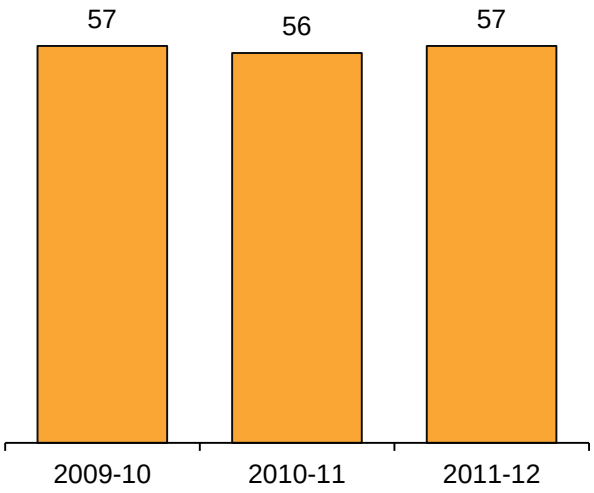
- Enrolment;
- School fees and charges; and
- Examinations, assessments and prizes.

Outcomes achieved

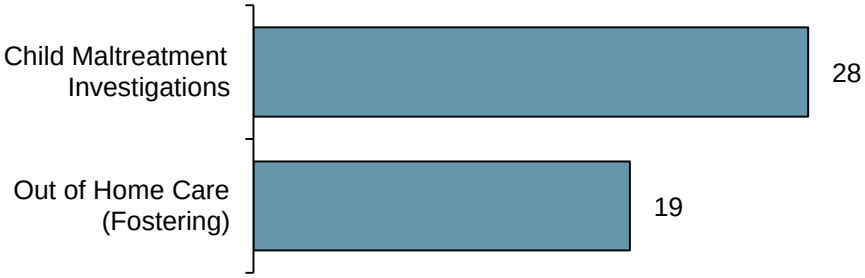
- Changed policy or procedure;
- Apology given;
- Explanation or reasons provided;
- Changed procedures; and
- Course fees refunded.

Child Protection

Complaints received



Most common allegations



Other types of allegations

- Human resource management
- Special assistance; and
- Adoption.

Outcomes achieved

- Improved record keeping; and
- Actions expedited.

Case Study

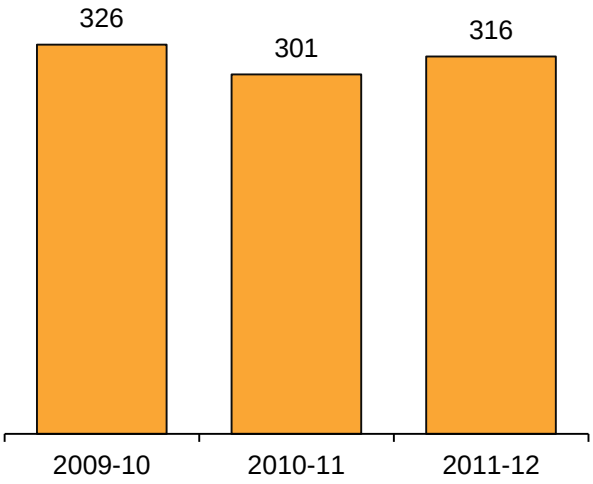
Explanation alleviates concerns of respite carer

A woman who provided monthly respite care to a teenage boy who usually resided with foster carers wrote to the Ombudsman after she had concerns about his development. The respite carer expressed her concerns that the boy did not communicate effectively, and that he may have difficulty when he leaves the care of his foster carers at the age of eighteen.

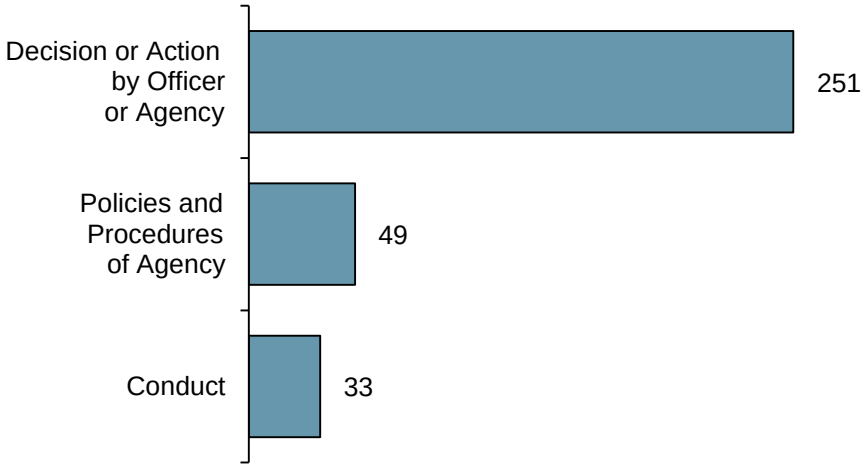
Enquiries made by the Office to the agency responsible for the care of the boy highlighted that the boy has a number of conditions which affect his learning and communication with others. The agency agreed to meet with the respite carer and explain his conditions in greater detail to alleviate her concerns, and to assist her in better understanding the boy's needs.

Other Public Authorities

Complaints received



Most common allegations



Other types of allegations

- Medical or allied health treatment; and
- Human resource issues.

Outcomes achieved

- Change policy or procedure;
- Change systems;
- Improve record keeping;
- Agency officer training;
- Apology;
- Action expedited;
- Explanation or reasons provided by agency;
- Refund of fines and fees; and
- Act of grace payment.

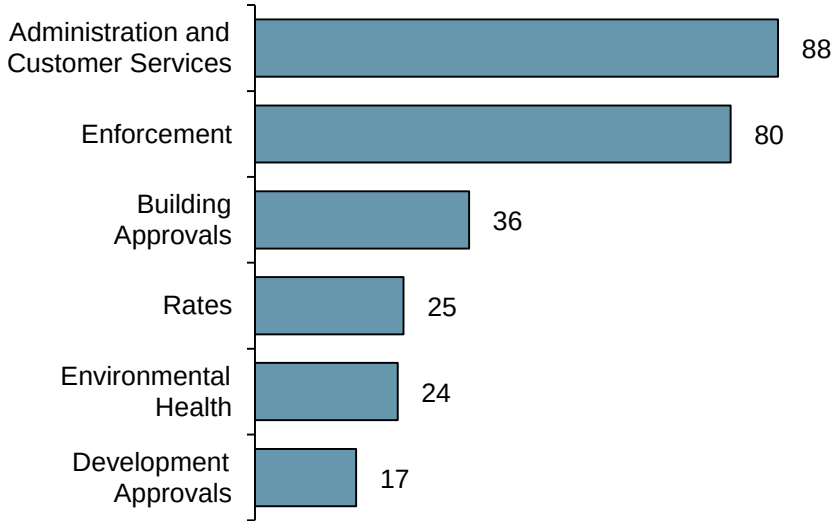
The Local Government Sector

In 2011-12, there were 285 complaints received about the local government sector, an increase of 21 per cent compared to 2010-11, and 272 complaints were finalised. There were 29 actions taken by local governments as a result of complaints finalised.

Local Government

Complaints received

Most common allegations



Other types of allegations

- Engineering;
- Community facilities;
- Planning;
- Contracts and property management;
- Decision or action by officer or local government;
- Investigations and prosecutions;
- Policies or procedures of local government; and
- Traffic Matters.

Local Government

Outcomes achieved

- Change policy/procedure;
- Provide officer training and informal counselling;
- Act of Grace payment;
- Reversal or significant variation of original decision;
- Action expedited;
- Refund of security deposits and write-off of minor debt;
- Explanation / Reasons provided by Agency; and
- Apology.

Case Study

Improved access for wheelchairs

A woman used a wheelchair for mobility purposes and had complained to the responsible local government that the unevenness of crossover from her driveway to the roadway interfered with her ability to use her wheelchair. The local government advised that it was unable to assist because of the drainage and road safety considerations caused by the location of the woman's property.

The woman wrote to the Ombudsman alleging that the local government's refusal to fix this problem had severely limited her ability to lead a reasonable lifestyle.

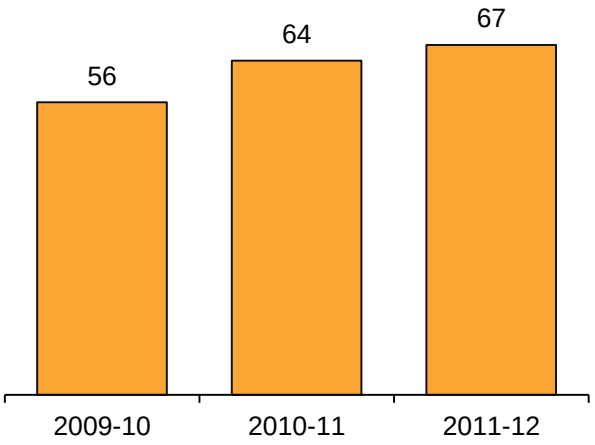
As a result of enquiries by the Office, the local government undertook an inspection of the property and advised that it would install a footpath across the front of the woman's property, together with suitable ramps to allow her to cross the road safely and join the current footpath network. The woman was happy with the local government's actions.

The University Sector

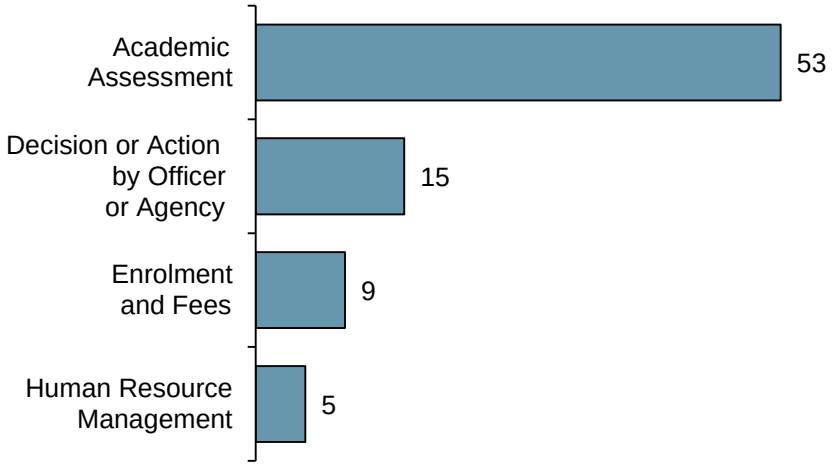
In 2011-12, there were 67 complaints received about the university sector, an increase of 5 per cent compared to 2010-11, and 69 complaints were finalised. There were six actions taken by universities as a result of complaints finalised.

Universities

Complaints received



Most common issues raised



Other types of issues raised

- Enrolment;
- Other dealings with the public; and
- Staff appointment and promotion.
- Complaints include appeals by overseas students under the *National Code of Practice for Registration Authorities and Providers of Education and Training to Overseas Students 2007*.

Outcomes Achieved

- Change policy or procedure;
- Reversal or significant variation of original decision;
- Apology; and
- Action expedited.

Case Study

Decision to refuse a student's withdrawal due to illness reversed

An overseas student at a Western Australian University had her enrolment terminated on the basis of poor academic results. In the appeal against the University's decision, the student submitted medical evidence that a medical condition had impacted upon her academic progress and results.

The student subsequently contacted the Office complaining that the University's decision to terminate her enrolment was unfair and unreasonable because it had not taken the medical evidence into account and because decisions about the impact of medical considerations on a student's academic progress were not made by qualified health practitioners.

As a result of enquiries by the Office and discussions with University staff, the University agreed to review its decision and subsequently advised that it had re-enrolled the student who was allowed to continue in the course, subject to a number of conditions.

Other Complaint Related Functions

Reviewing Appeals by Overseas Students

The *National Code of Practice for Registration Authorities and Providers of Education and Training to Overseas Students 2007* (**the Code**) sets out standards required of registered providers who deliver education and training to overseas students studying in Australia. It provides overseas students with rights of appeal to external, independent bodies if their internal appeal with their education or training provider is unsuccessful. Overseas students studying with both public and private education providers have access to an Ombudsman who:

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

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

Complaints Lodged with the Office under the Code

Education and training providers are required to comply with 15 standards under the Code. In dealing with these complaints, the Ombudsman considers whether the decisions or actions of the agency complained about comply with the requirements of the Code and if they are fair and reasonable in the circumstances.

During 2011-12, the Office received 37 complaints about public education and training providers from overseas students under the Code, and finalised 37 complaints about 54 issues. Thirty of the finalised issues were about termination of enrolment decisions made by universities and public training providers and 24 were about other issues such as course transfers and marking. These complaints and issues can be further broken down as follows:

- **Universities** - 26 complaints about 42 issues with 25 issues about termination of enrolment decisions.
- **TAFEs -** 8 complaints about 9 issues with 4 issues about termination of enrolment decisions.
- **Other Education agencies** - 3 complaints about 3 issues with 1 issue about termination of enrolment decisions.

Public Interest Disclosures

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

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

During the year, the Ombudsman completed the investigation of one disclosure and three new disclosures were received.

Indian Ocean Territories

Under a service delivery arrangement between the Ombudsman and the Commonwealth Government, the Ombudsman handles complaints from residents of the Indian Ocean Territories about public authorities in the Ombudsman's jurisdiction. In 2011-12, the Office received two complaints from the Indian Ocean Territories and finalised three.

Terrorism

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

Requests for Review

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

Thirty seven requests for review were received in 2011-12, less than two per cent of the total number of complaints finalised. Two reviews resulted in the original decision being amended in part or in whole. In all other cases where a review was undertaken, the original decision was upheld.

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.

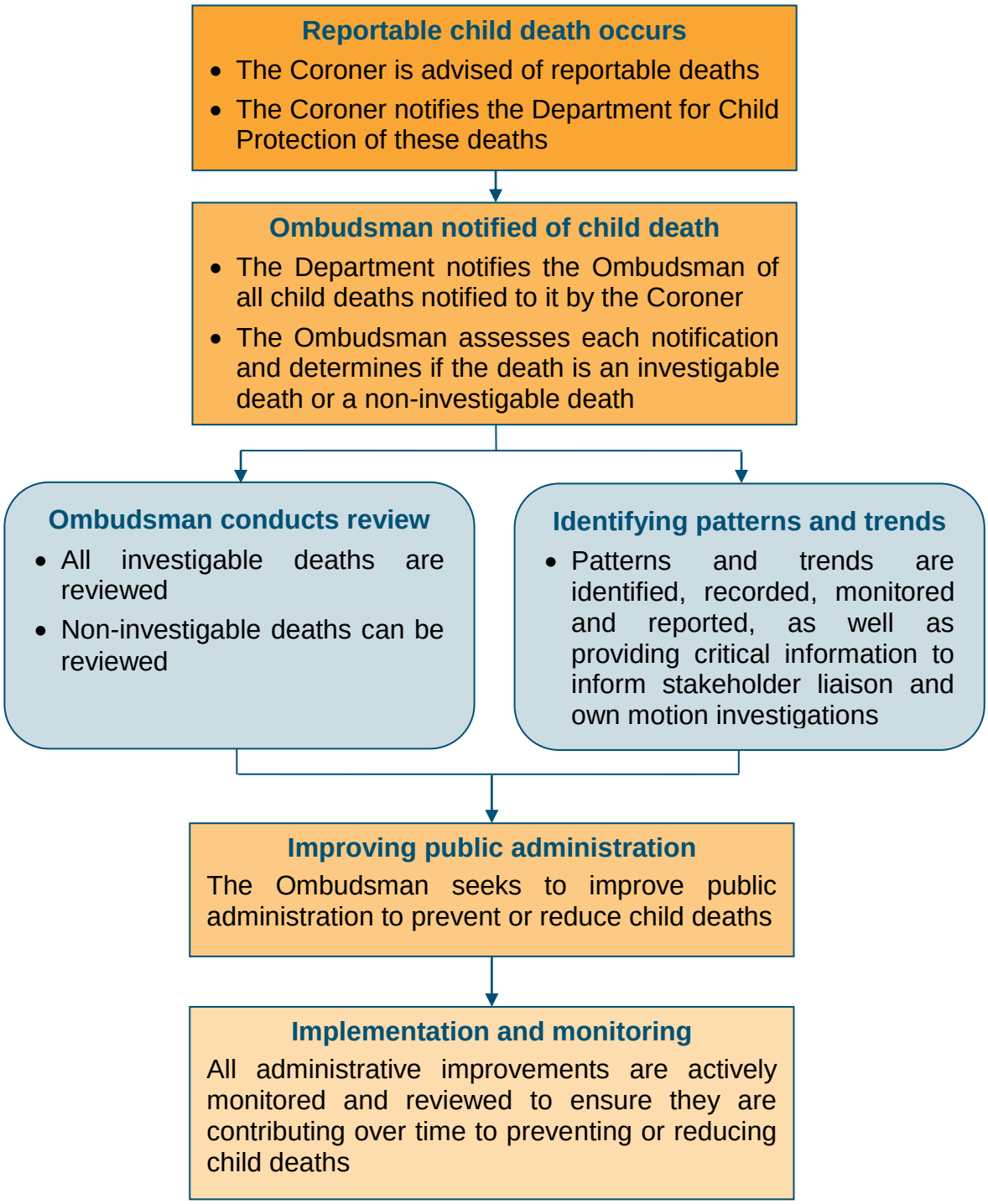
In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

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

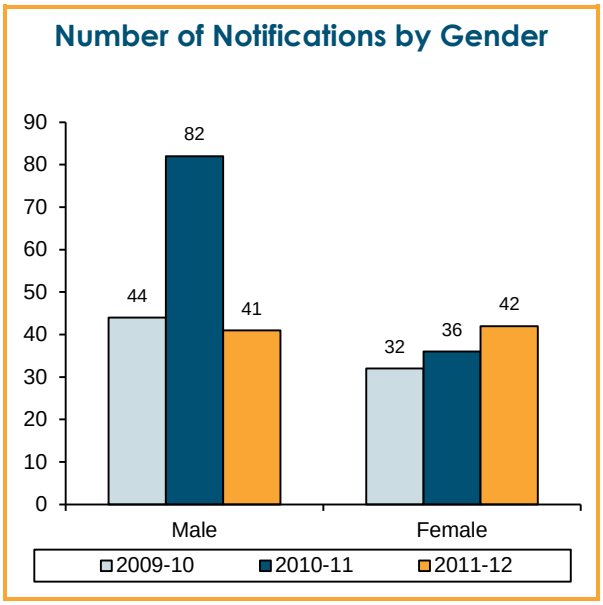
Information is obtained on a range of characteristics of the children who have died including gender, Indigenous status, various age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able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

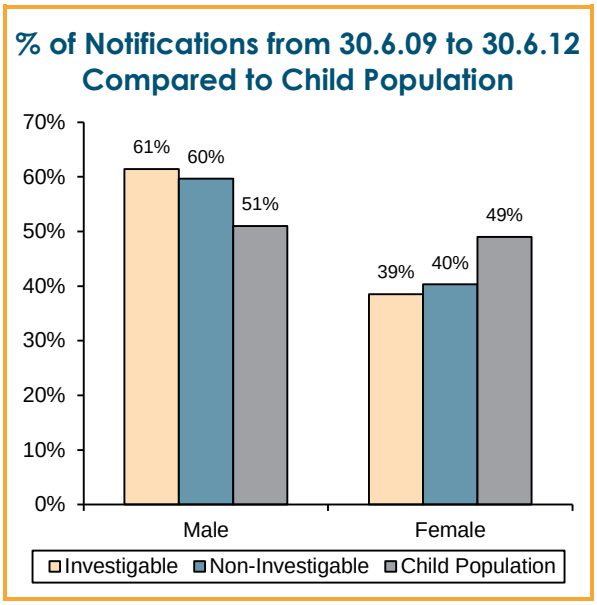
The following charts show:

- 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.

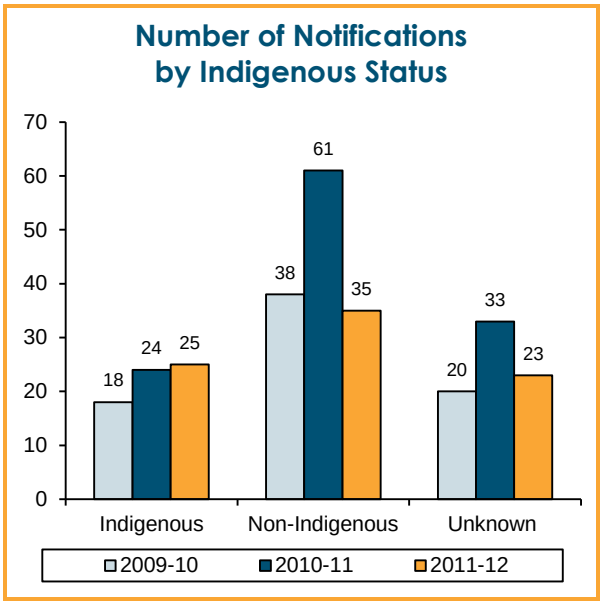


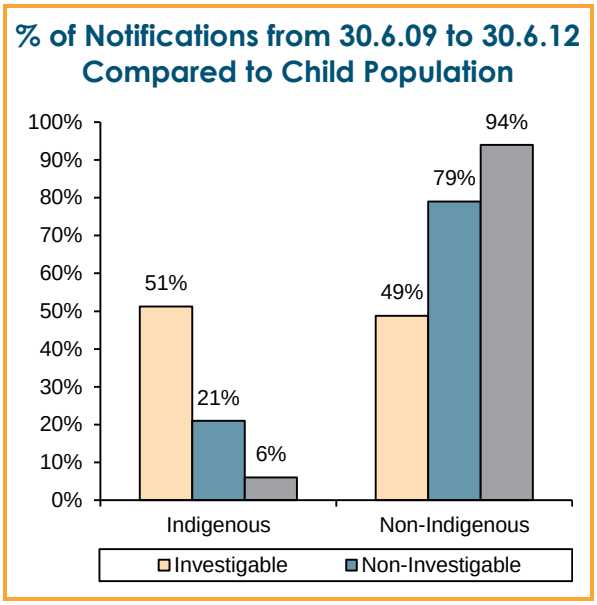


Further analysis of the data shows that, considering all three years, male children who die are more likely than females to be Indigenous and living in regional areas.

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.



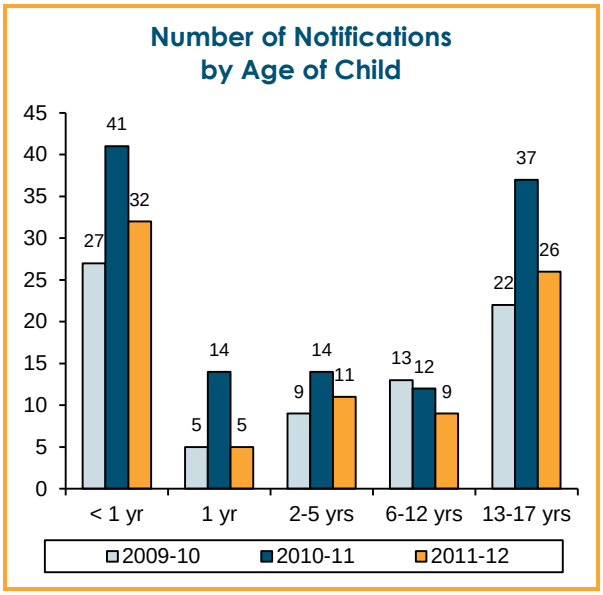


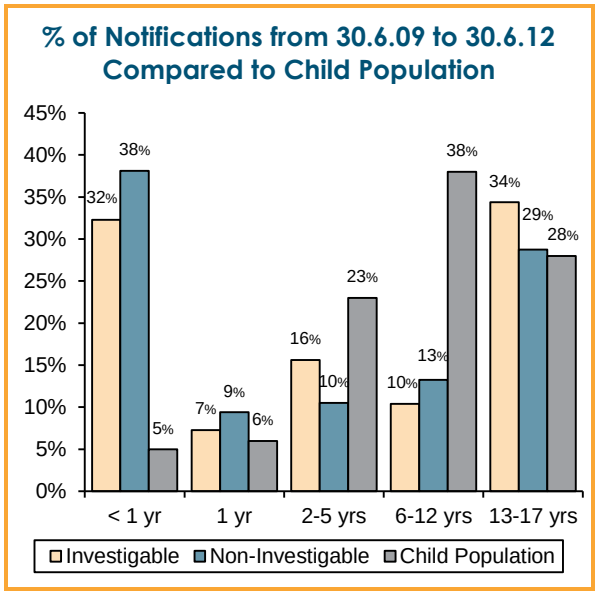
Note: Percentages for each group are based on the percentage of children whose Indigenous status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Indigenous status of the child.

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.

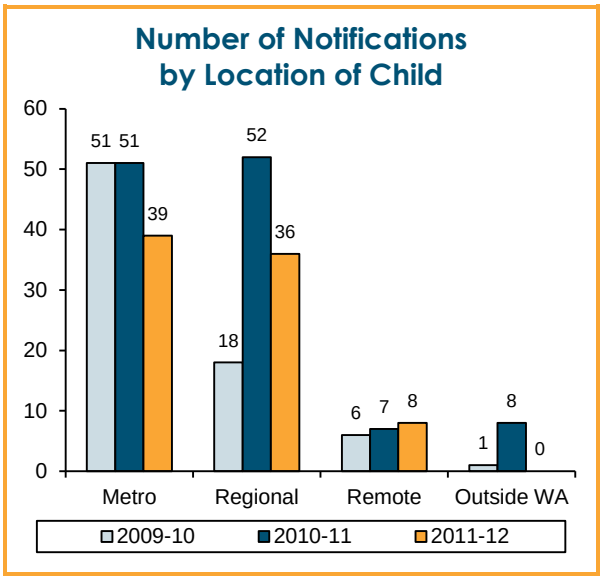


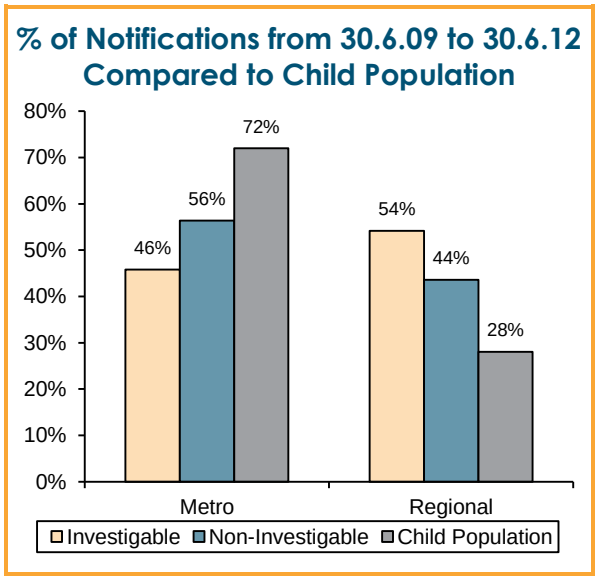


Further analysis of the data shows that a higher proportion of Indigenous children and children living in remote locations are under the age of one compared to other groups. A more detailed analysis by age group is provided later in this section.

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.

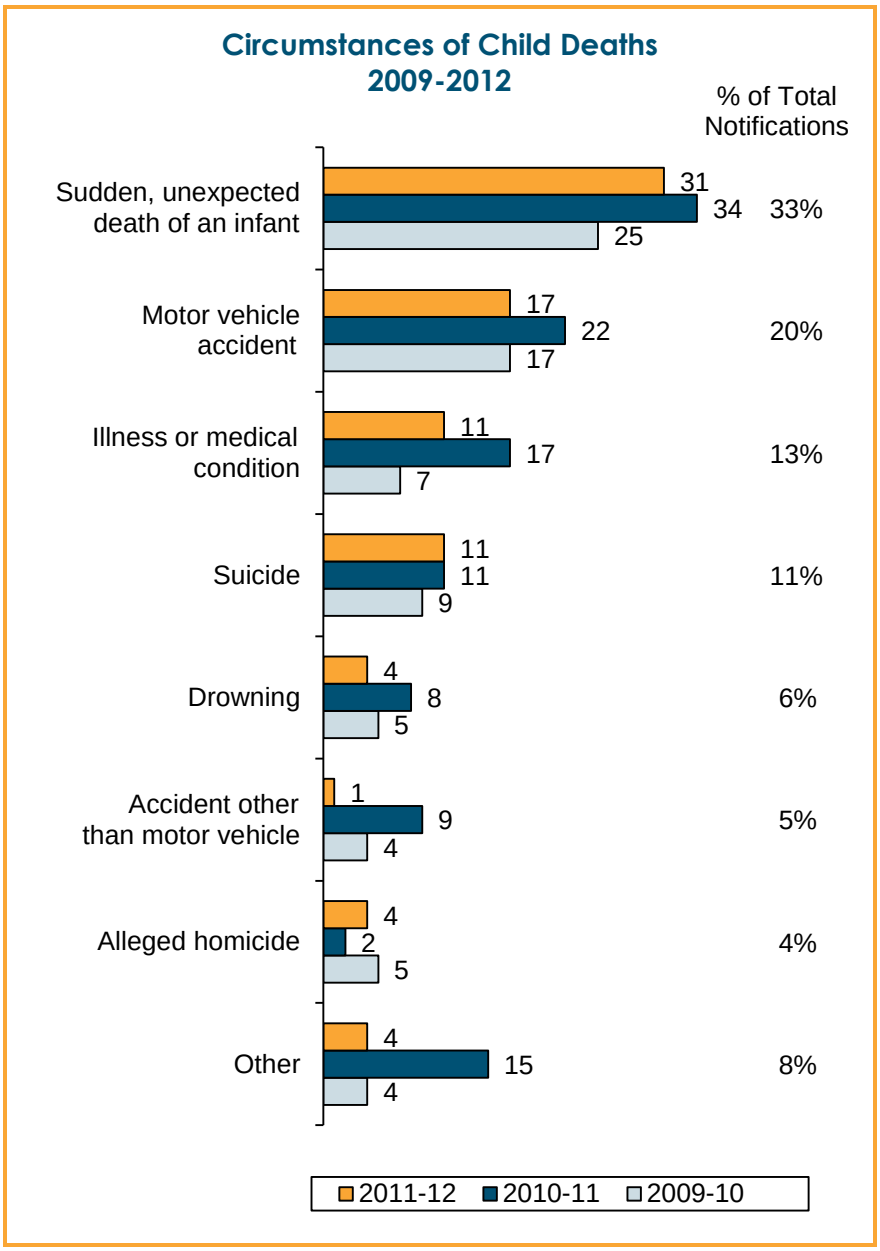
Circumstances of Child Deaths

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.



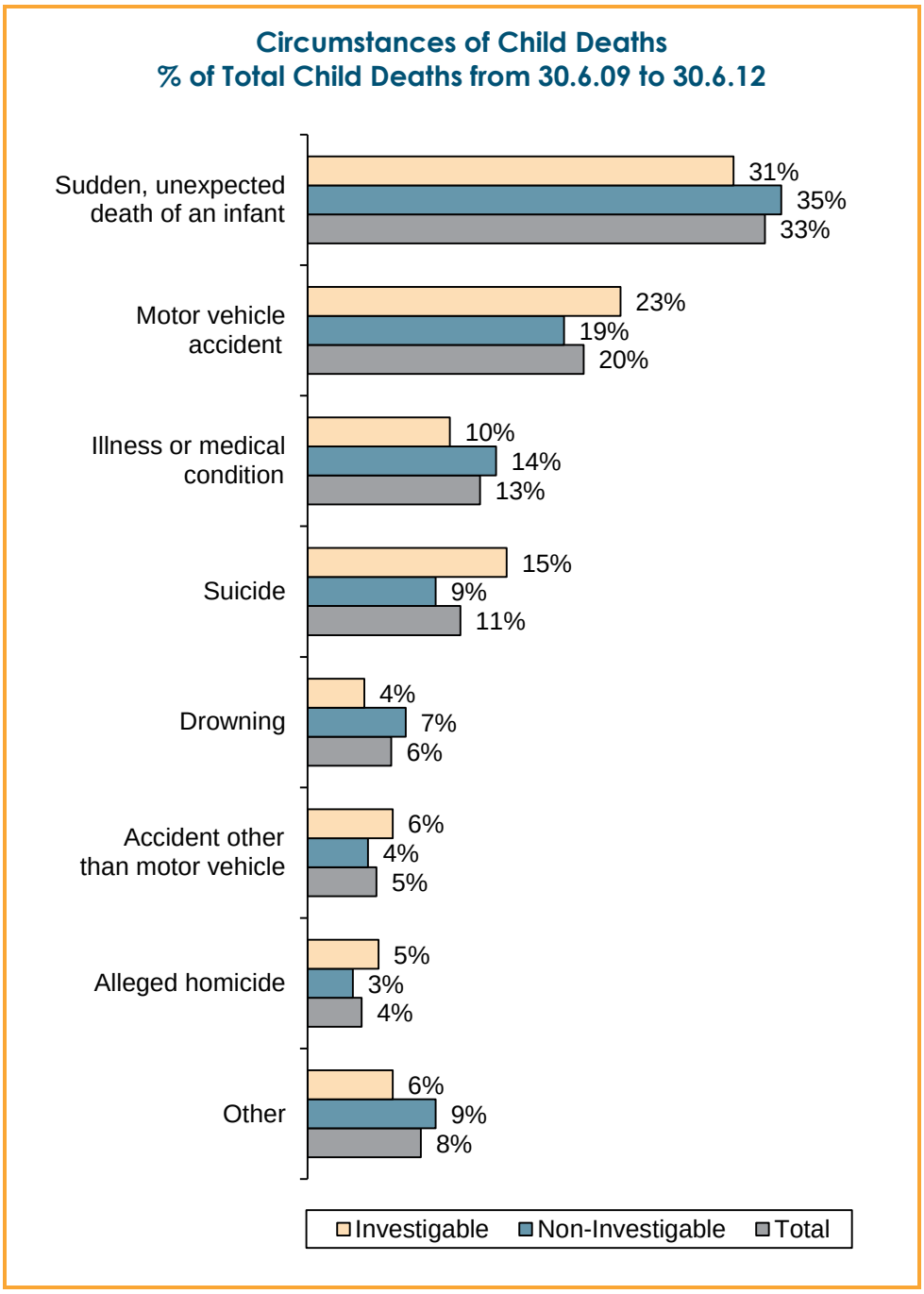
Note 1: In 2010-11 the 'Other' category includes eight children who died in the SIEV (Suspect Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

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.

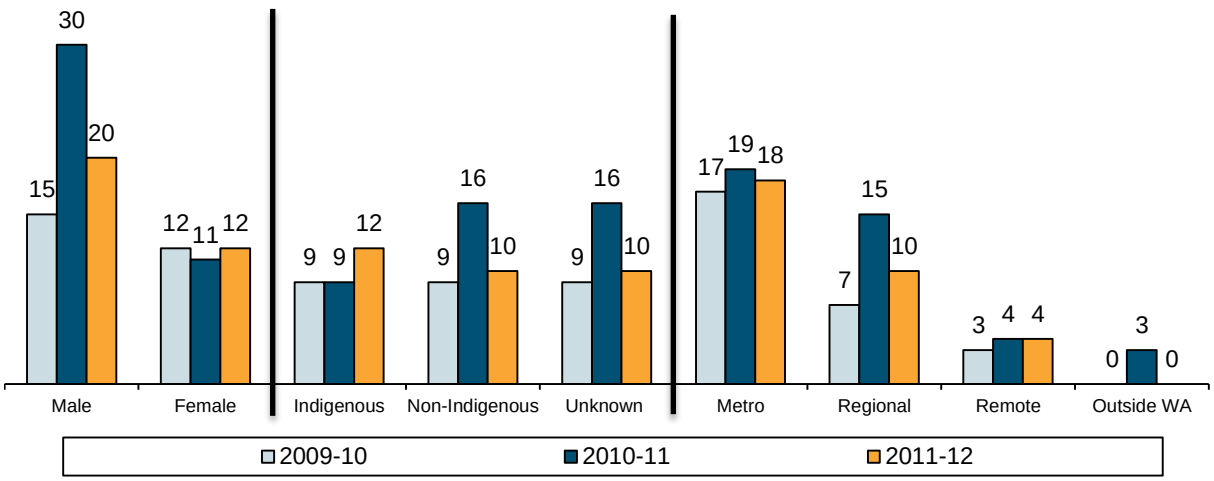
Patterns and Trends of Children in Particular Age Groups

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)



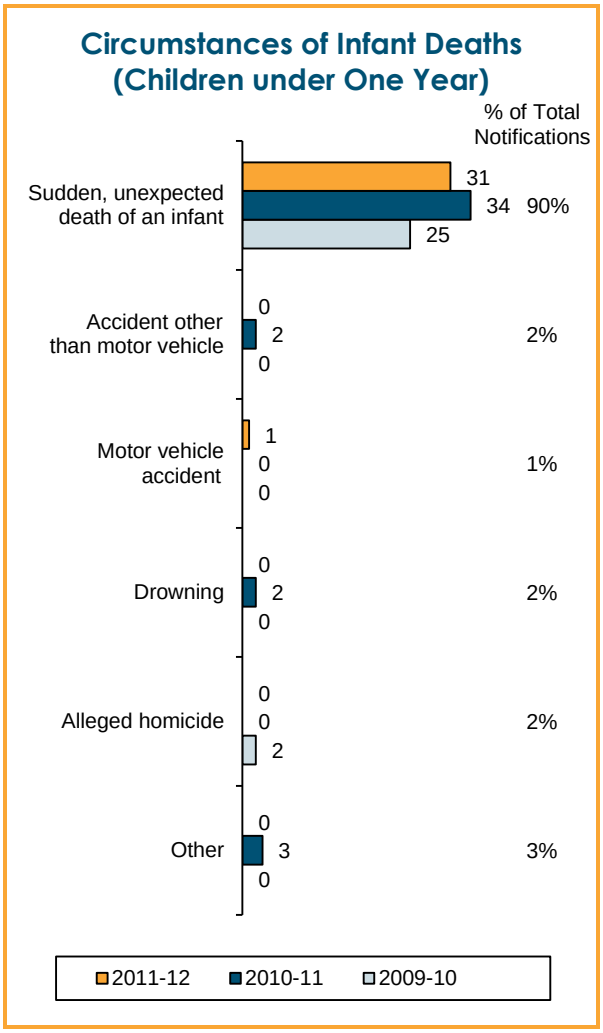
Further analysis of the data showed that, for these infant deaths, there was an over-representation compared to the child population for:

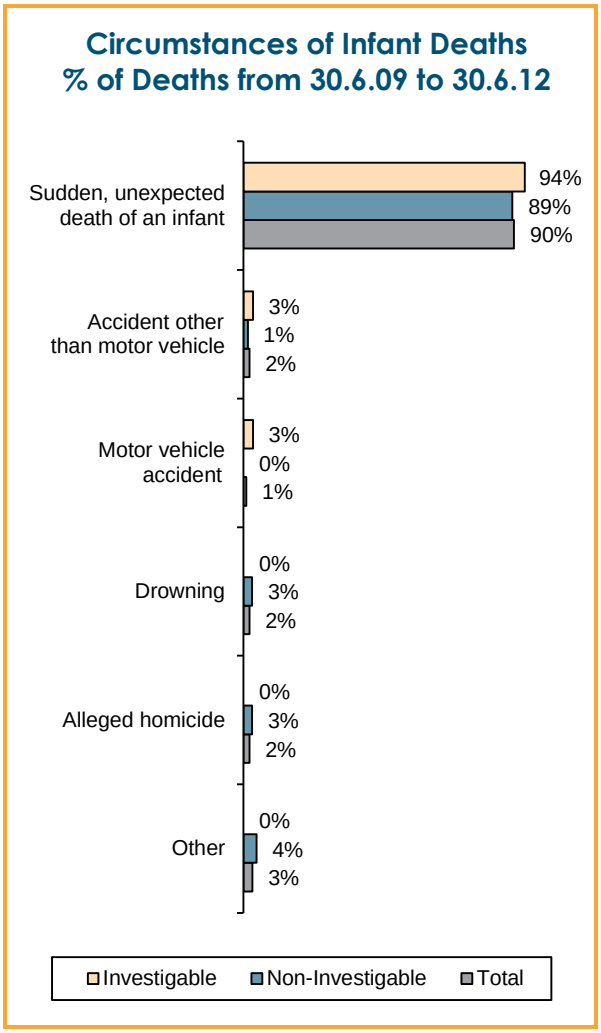
- Males – 87% of investigable infant deaths and 55% of non-investigable infant deaths were male compared to 51% in the child population;
- Indigenous children – 64% of investigable deaths and 35% of non-investigable deaths were Indigenous children compared to 6% in the child population; and

- 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.



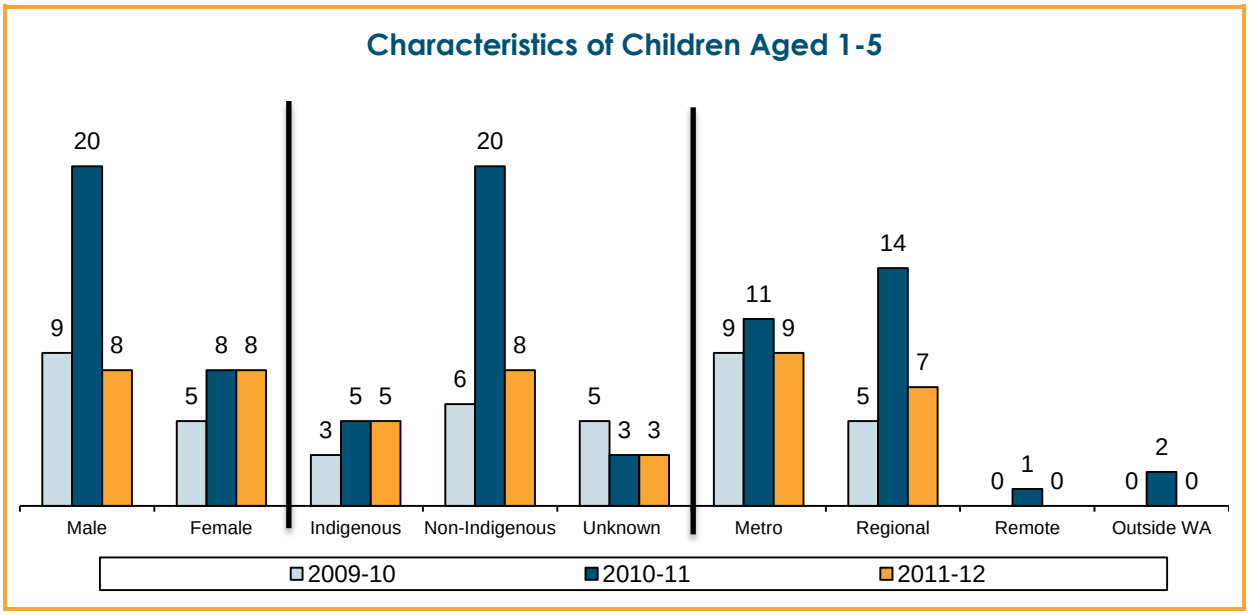


Thirty one infant death notifications received from 30 June 2009 to 30 June 2012 were determined to be investigable deaths.

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.

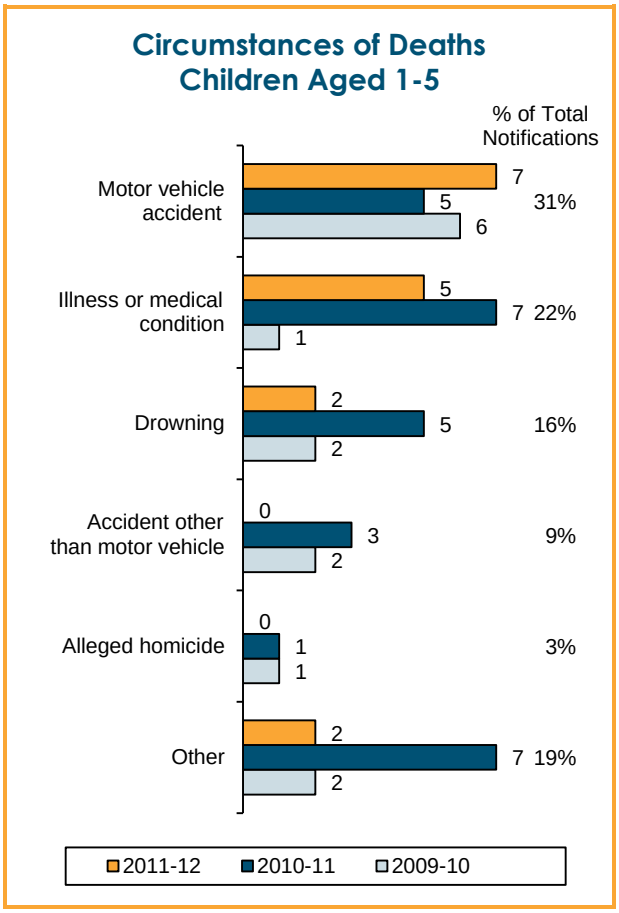
The characteristics of children aged 1-5 are shown in the following chart.

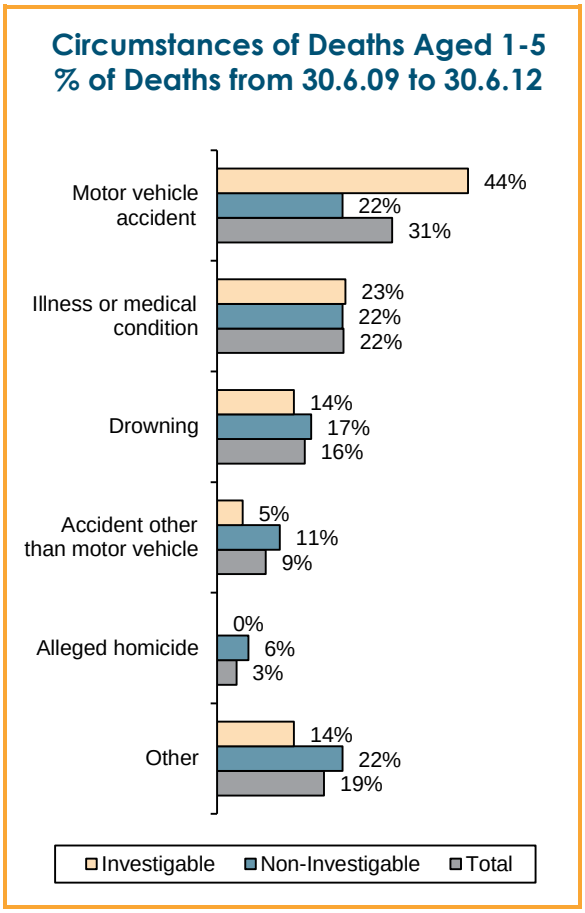


Further analysis of the data showed that, for these deaths, there was an over-representation compared to the child population for:

- 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%).

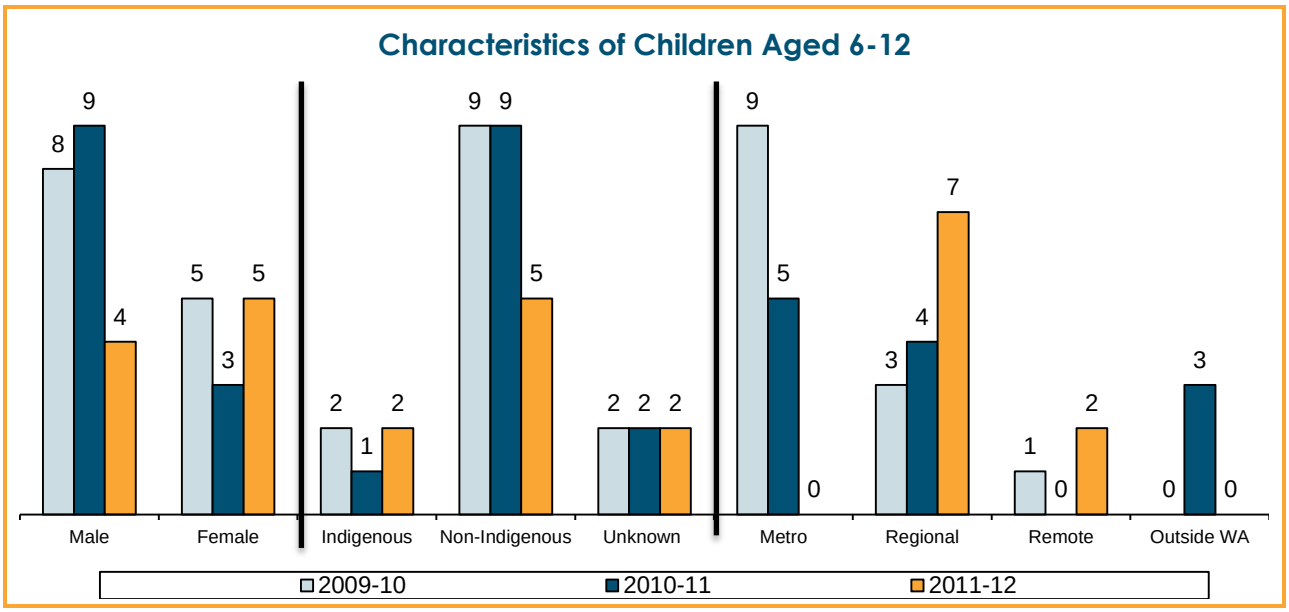




Twenty one deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of Children Aged 6 to 12 Years

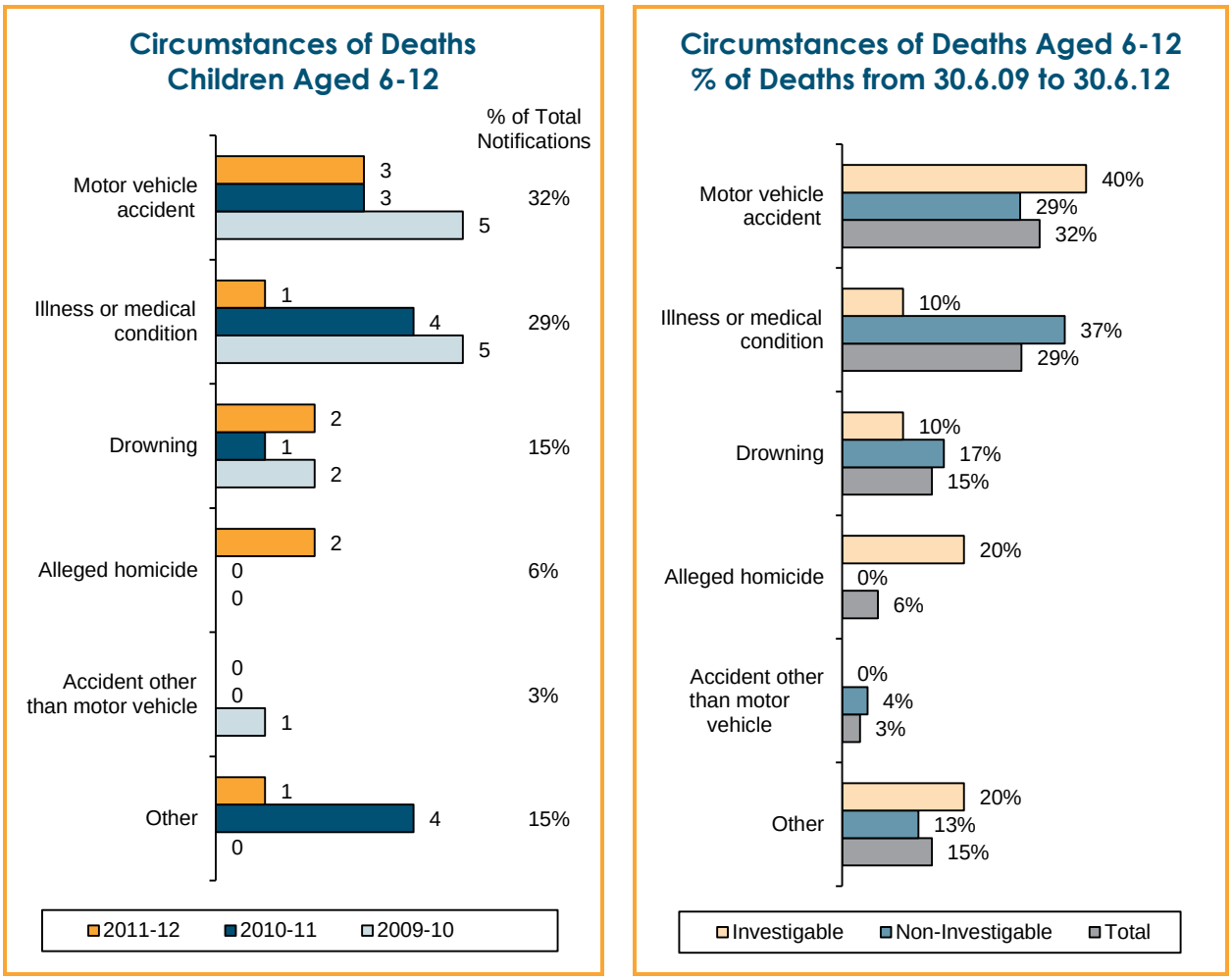
Of the 277 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2012 there were 34 (12%) related to children aged from 6 to 12 years The characteristics of children aged 6 to 12 are shown in the following chart.



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.

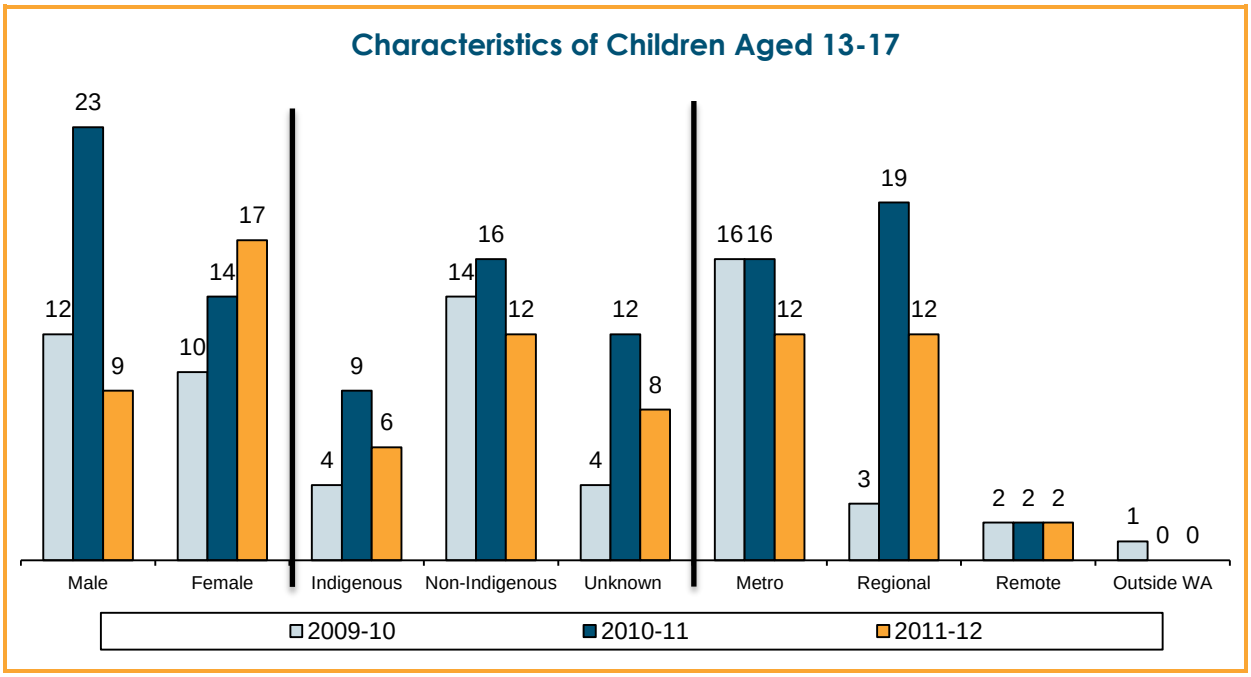
As shown in the chart below, motor vehicle accidents are the most common circumstance of death for this age group (32%), particularly for investigable deaths, followed by illness or medical conditions (29%) and drowning (15%).



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.

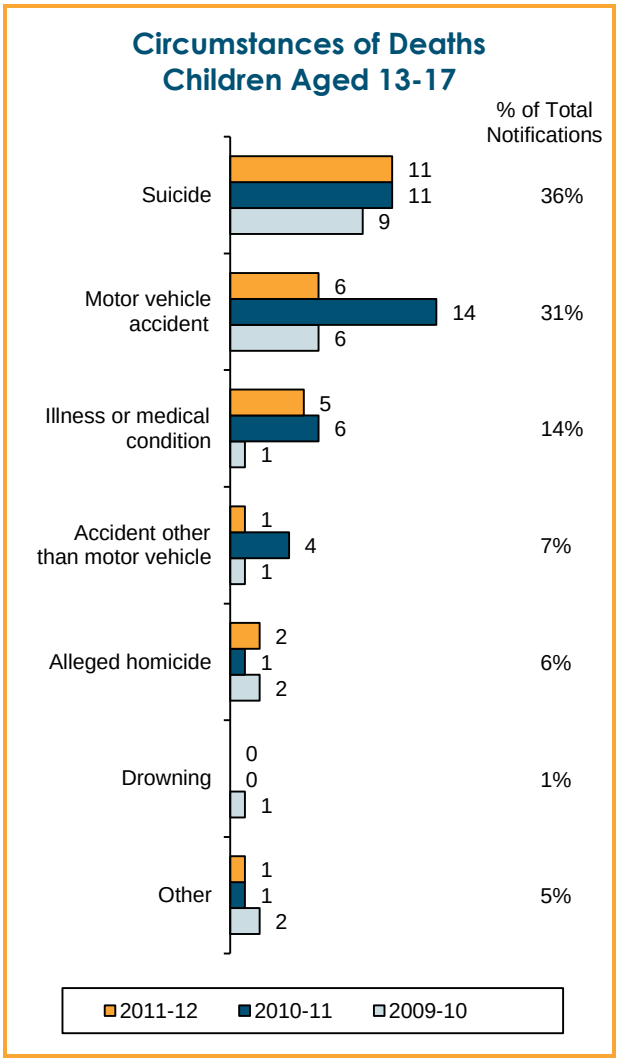


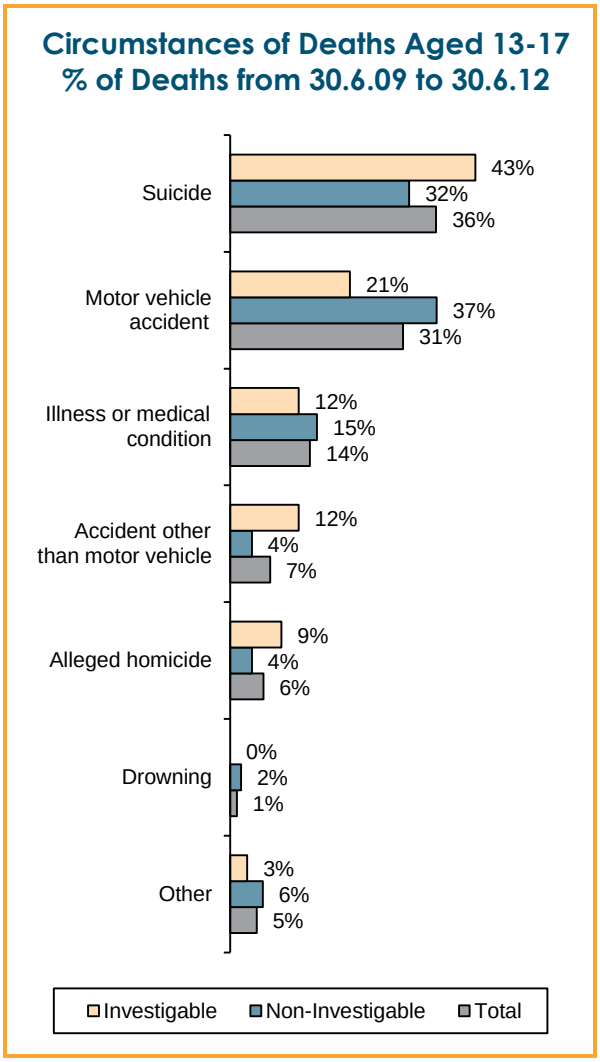
Further analysis of the data showed that, for these deaths, there was an over-representation compared to the child population for:

- 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%).





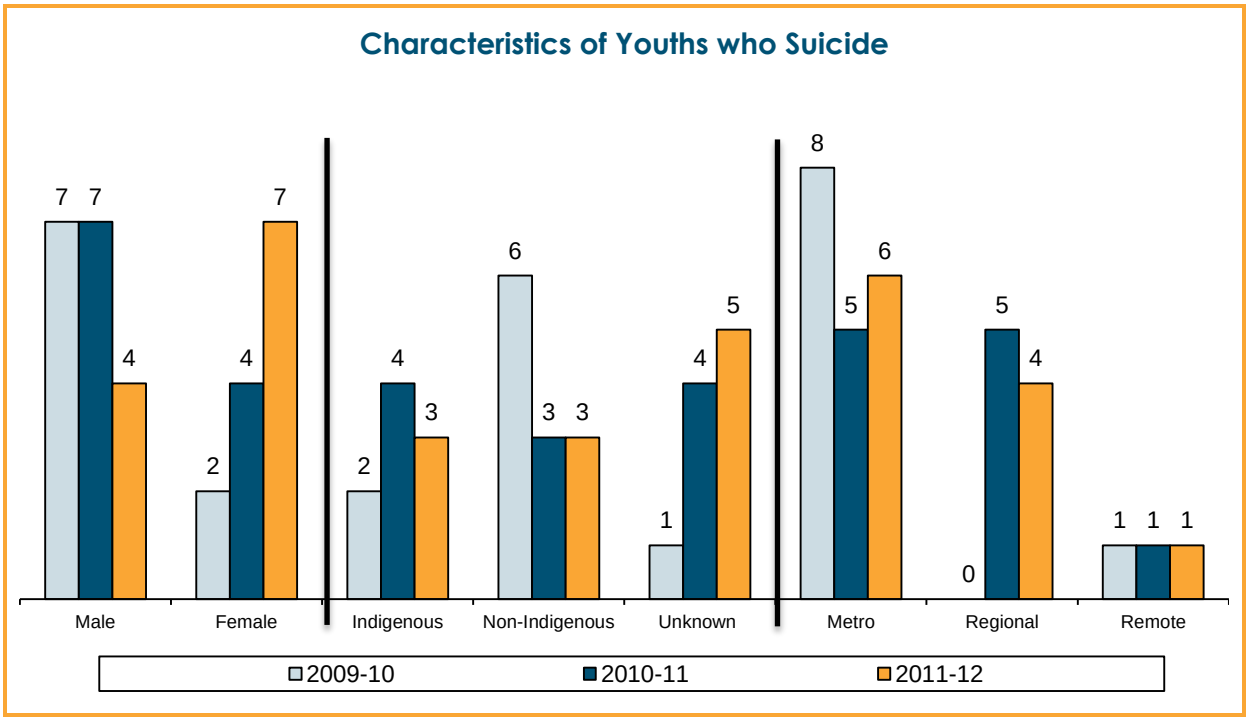
Thirty three deaths of children aged 13 to 17 years were determined to be investigable deaths.

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.

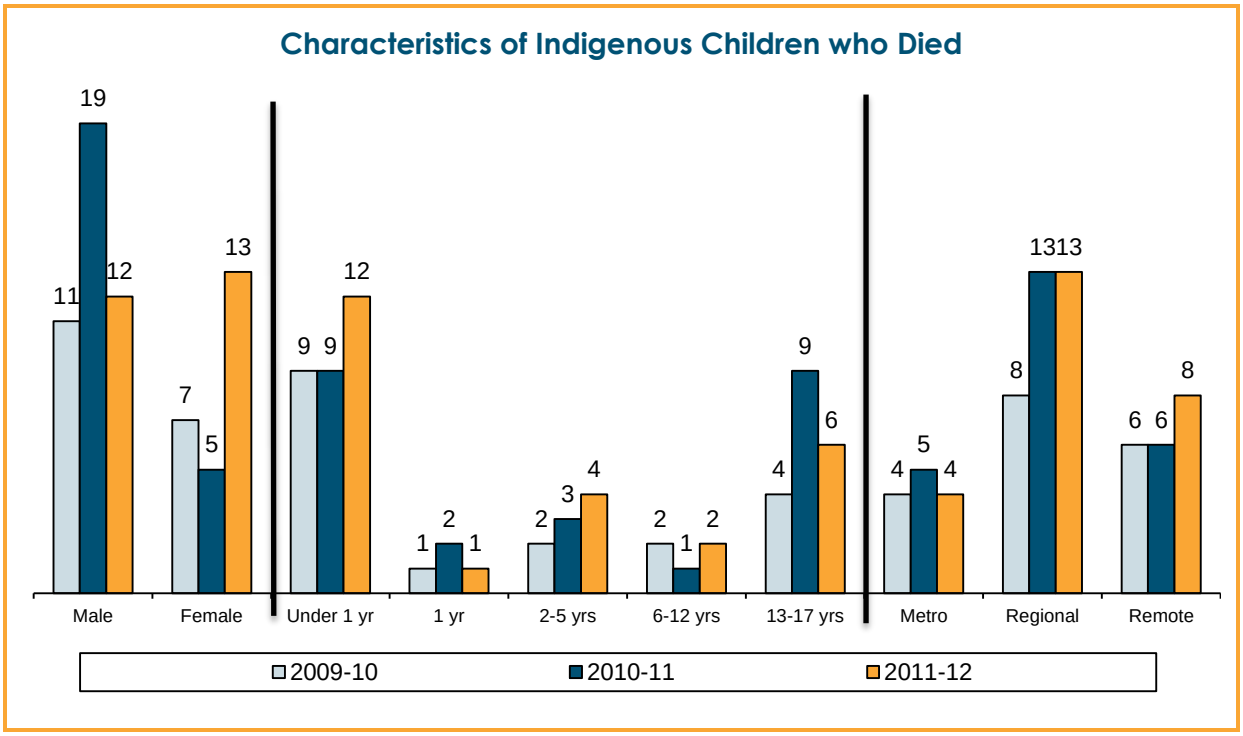


Deaths of Indigenous Children

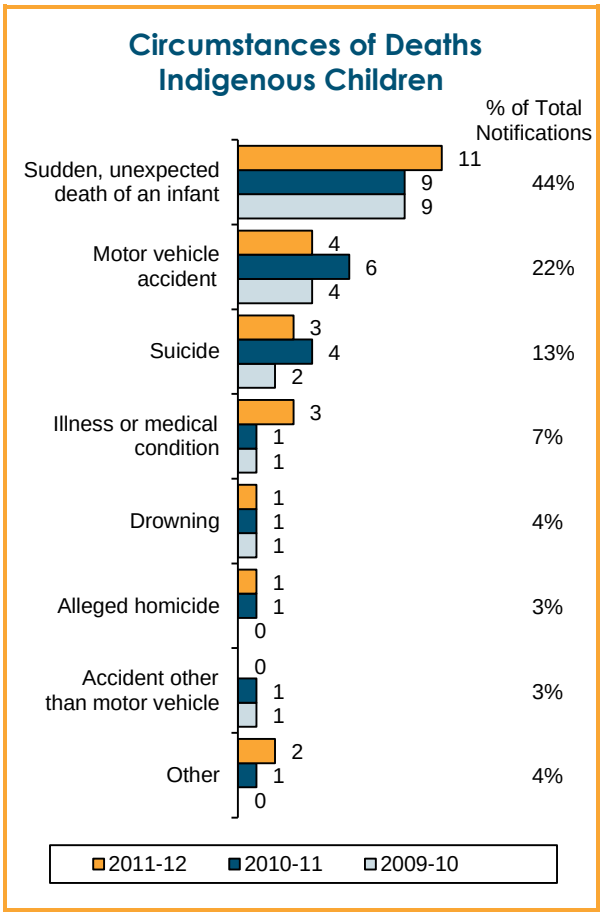
Of the 201 child death notifications received from 30 June 2009 to 30 June 2012, where the Indigenous status of the child was known, 67 (33%) of the children were identified as Indigenous.

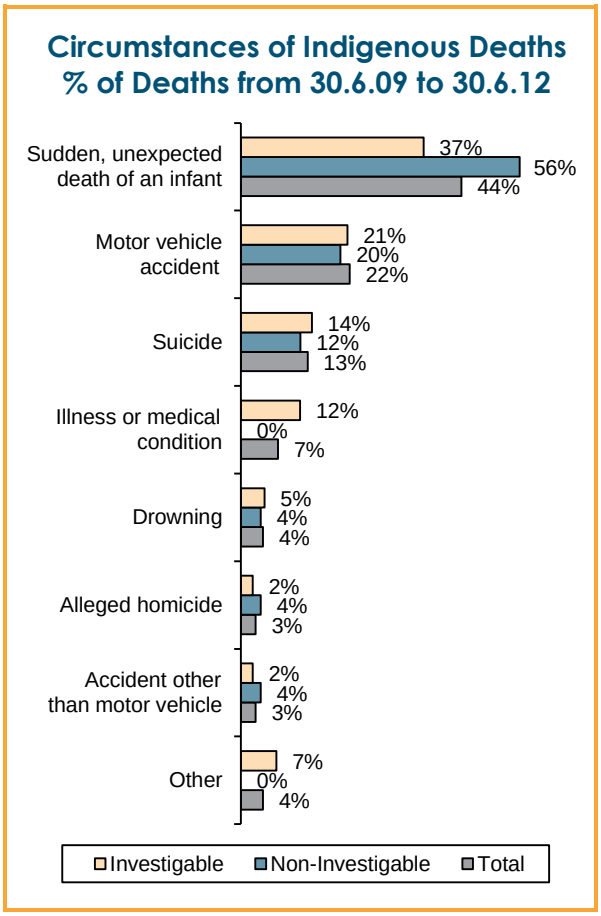
For the notifications received, the following chart demonstrates:

- 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.

Own Motion Investigations and Administrative Improvement

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

- Making recommendations and suggestions to improve public administration as a result of:
  - The investigation of complaints; and
  - Reviews of child deaths.
- Undertaking own motion investigations that are based on the patterns, trends and themes that arise from the resolution of individual complaints and child death reviews, referred to as own motion investigations;
- Providing guidance to public authorities on decision making and complaint handling through continuous liaison, publications, presentations and workshops;
- Working collaboratively with other integrity and accountability agencies to encourage best practice and leadership in public authorities; and
- Undertaking inspection and monitoring functions.

Improvements from Complaints and Reviews

In addition to outcomes which result in some form of assistance for the complainant, the Ombudsman also achieves outcomes which are aimed at improving a public authority's administrative practices. This reduces the likelihood of the same or similar issues which gave rise to the complaint occurring again in the future. Further details of the improvements arising from complaint resolution are shown in the Complaint Resolution section.

Child death reviews also result in improvements to administrative practices as a result of the review of individual child deaths. Further details of the improvements arising from complaint resolution are shown in the Child Death Review section.

Own Motion Investigations

One of the ways that the Office endeavours to improve public administration is to undertake investigations of systemic and thematic patterns and trends arising from complaints made to the Ombudsman and from child death reviews. These investigations are referred to as own motion investigations.

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

Own motion investigations that arise out of child death reviews focus on the practices of agencies that provide services to children and their families and aim to improve the administration of these services so as to prevent or reduce child deaths.

Selecting Topics for Own Motion Investigations

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

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

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

Monitoring the implementation of recommendations

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

Own Motion Investigations in 2011-12

In 2011-12, two major own motion investigations were conducted relating to:

- Planning for children in care; and
- Sleep-related deaths of infants.

Planning For Children in Care Report

In November 2011, the Planning for Children in Care report was tabled in Parliament. The full report, entitled *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*, is available on the Ombudsman's website.

Reasons for the investigation

For the majority of Western Australian children, their parents and family network provide for their protection and care. However, at the commencement of this investigation there were 3,356 children in the care of the Chief Executive Officer (**CEO**) of the Department for Child Protection (**DCP**). For these children (referred to as 'children in care'), 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* (**CCS Act**), the objects of which include 'to provide for the protection and care of children in circumstances where their parents have not given, or are unlikely to give that protection and care…' (s.6(d)).

As part of providing for the protection and care of children in care, the CCS Act 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, as well as provisions specific to participation by the child, their family and carers in care planning, and to Aboriginal and Torres Strait Islander children in care. There are also further instruments that have the effect of regulating the administration of care planning responsibilities in Western Australia, in particular the policies and procedures established by DCP.

Cooperation between DCP, the Department of Health and the Department of Education is a critical aspect of the care planning system and is promoted by the CCS Act.

This cooperation is consistent with the recommendations of the Department for Community Development: Review Report, presented by the independent reviewer Ms Prudence Ford (**the Ford Review**). The Ford Review report recommendations 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.'

Objectives of the investigation

The objective of the investigation was to examine how State Government agencies have administered the requirements of the CCS Act regarding care planning for children in care, in particular whether:

- DCP has established policies and procedures for care planning that are consistent with the requirements of the CCS Act;
- DCP is appropriately complying with the requirements for the preparation, timing and review of provisional care plans and care plans, set out in the CCS Act and its own policies and procedures;
- Care plans address the areas that the CCS Act and DCP's policies and procedures identify as necessary to ensure a child's wellbeing; and

- Health care planning and education planning are undertaken in accordance with the agreements that DCP has established with the Department of Health and the Department of Education, and in accordance with the related policies and procedures of the three agencies.

The investigation examined the administration of care planning for those children in care who were of primary school age at the commencement of the investigation, had been taken into care after 1 July 2008, and were still in care when the investigation commenced. This cohort numbered 443 children in total.

Key messages from the investigation

Significant and pleasing progress on improved planning for children in care has been achieved, however, there is still work to be done, particularly in relation to the timeliness of preparing care plans and ensuring that care plans fully incorporate health and education needs, other wellbeing issues, the wishes and views of children in care and are regularly reviewed.

There has been significant and pleasing progress on improved planning for children in care but there is still work to be done.

The key messages arising from the investigation, and set out in the report are:

- In the five years since the proclamation of the CCS Act, the three State Government agencies that are primarily responsible for planning for children in care have cooperated to operationalise the requirements of the CCS Act. This work has resulted in the agencies redesigning the system for care planning, as follows:
    - DCP has developed a series of policies and procedures for care planning that are consistent with the CCS Act;
    - DCP and the Department of Health have agreed and developed a comprehensive strategy for health care planning that addresses the Ford Review recommendations regarding health care planning for children in care; and
    - DCP and the Department of Education have taken initial steps to address the Ford Review recommendations regarding education planning for children in care.
- DCP had prepared provisional care plans and/or care plans for nearly all children included in the investigation, as required by the CCS Act, however:
    - In most instances examined, DCP did not achieve the timeframes for care planning as required by the CCS Act and its own policies and procedures, although timeliness varied widely across DCP districts; and
    - In many instances examined, DCP had not conducted reviews of care plans, as required by the CCS Act.

- Many of the children in care included in the investigation had not received appropriate health care and education planning. More particularly:
    - Although DCP and the Department of Health have commenced a comprehensive strategy for health care planning, only one third of children included in the investigation had received health assessments and/or medical examinations, as agreed in the strategy; and
    - Although DCP and the Department of Education have taken initial steps to establish a strategy for education planning, they have not yet implemented the education component of care planning and therefore few *Documented Education Plans* had been prepared for children included in the investigation.
- Many care plans did not record or otherwise demonstrate that the children in care included in the investigation were given the opportunity to express their wishes and views about their own care planning, as required by the CCS Act.
- Only half of the care plans we examined in detail covered all of the areas of child wellbeing identified in the CCS Act and DCP's policies and procedures.

All 23 recommendations for administrative improvement arising from the planning for children in care report were accepted by the agencies involved.

The report also identified 23 recommendations for improvement in care planning for children in care. Agencies have agreed to these recommendations and monitoring of their implementation and effectiveness is discussed further below.

Monitoring the implementation and effectiveness of report recommendations

Each of the recommendations arising from own motion investigations is being monitored by the Office to ensure its implementation and effectiveness in relation to the observations made in the investigation.

Relevant agencies have provided reports on their progress to date in implementing the recommendations arising from the report on planning for children in care. These reports indicate that, to date, satisfactory progress has been made in implementing the recommendations. The Ombudsman will undertake further work in 2012-13 to confirm the implementation of the recommendations and the extent to which this action by agencies has resulted in the intended administrative improvements.

The Ombudsman monitors recommendations to ensure their implementation and effectiveness.

The Ombudsman also monitors improvements in care planning through the review of individual child deaths. These reviews identified good practice by DCP and other public authorities, as well as good interagency communication and cooperation, in relation to care planning.

Investigation into ways to prevent or reduce sleep-related infant deaths

Investigation rationale and objectives

Own motion investigations are informed by patterns and trends arising from child death notifications to the Ombudsman. The Ombudsman identified a high proportion of cases in which infants (defined as children under the age of 12 months) died during their sleep. For this reason, the Ombudsman decided to undertake an investigation of these sleep-related infant deaths with a view to determining whether it was appropriate to make recommendations to any department or agency about ways to prevent or reduce such deaths.

The objectives of the investigation are to:

- Analyse all sleep-related infant deaths notified to the Ombudsman between 1 July 2009 and 31 December 2011;
- Undertake research, including a comprehensive literature and practice review, in relation to sleep-related infant deaths;
- Undertake consultation with key stakeholders;
- Identify patterns and trends specifically in relation to sleep-related infant deaths; and
- From this analysis, pattern and trend identification, research and consultation, identify opportunities for State government agencies to prevent or reduce sleep-related infant deaths and make recommendations to these agencies accordingly.

A full report of the investigation will be tabled in Parliament in November 2012 and, once tabled, will be available from the Ombudsman's website.

Continuous Administrative Improvement

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

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

Guidance for Public Authorities

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

Publications

The Ombudsman has a range of guidelines available for public authorities in the areas of effective complaint handling, conducting administrative investigations and administrative decision making. These guidelines aim to assist public authorities in strengthening their administrative and decision making practices.

Workshops for Public Authorities

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

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

The workshops are tailored to the organisation or sector by using case studies and practical exercises. Workshops and presentations conducted during the year include:

- Various presentations on the role of the Ombudsman to:
    - Local government governance specialists at the Western Australian Local Government Association 2011 State Conference;
    - Local government managers at the Local Government Managers Australia Customer Service Forum;
    - Aged care and disability service providers and relevant government agencies at a Seniors Forum coordinated by Centrelink;
    - Department for Child Protection staff at their complaint forum;
    - New public sector officers at the Public Sector Commission's Ethics and Integrity Induction Program; and
    - Prison Officers, as part of the Department of Corrective Services induction program.
- *Good Administrative Decision Making* to Department of Housing staff; and
- *Managing Unreasonable Complainant Conduct* to members of the State Administrative Tribunal.

Working Collaboratively

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

Inspection and Monitoring Functions

Telecommunications Interception Inspections

The *Telecommunications (Interception and Access) Western Australia Act 1996*, the *Telecommunications (Interception and Access) Western Australia Regulations 1996* and the *Telecommunications (Interception and Access) Act 1979 (Commonwealth)* permit designated 'eligible authorities' to carry out telecommunications interceptions. Western Australia Police and the Corruption and Crime Commission are eligible authorities in Western Australia. The Ombudsman is appointed as the Principal Inspector to inspect relevant records of both agencies to ascertain the extent of their compliance with the legislation. The Ombudsman must inspect the telecommunications interception records at least twice during each financial year and must report to the responsible Ministers about the results of those inspections within three months of the end of the financial year.

Monitoring of Criminal Penalty Infringement Notices

The *Criminal Code Amendment (Infringement Notices) Act 2011* (**the Act**) amends the *Criminal Code* and introduces a new scheme into Western Australia for the issue of Criminal Penalty Infringement Notices by Western Australia Police for certain *Criminal Code* offences.

The Act will require the Ombudsman to keep under scrutiny the operation of relevant parts of the *Criminal Code* and regulations and relevant parts of the *Criminal Investigation (Identifying People) Act 2002* for a period of 12 months. The scrutiny is to include the impact on Aboriginal and Torres Strait Islander communities. The Ombudsman will have to report to the Minister for Police and the Commissioner of Police as soon as practicable after this time and the Minister is to table the report in both Houses of Parliament as soon as practicable after receiving the report.

Collaboration and Access to Services

Effective engagement with key stakeholder groups is essential to the Office's achievement of positive complaint outcomes and improved public administration. The Office does this through:

- Working collaboratively with other integrity and accountability agencies - locally, nationally and internationally - to encourage best practice and leadership in the sector;
- Ensuring ongoing accessibility to its services for public authorities and the community; and
- Developing, maintaining and supporting relationships with public authorities and community groups.

Working Collaboratively

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

Integrity Coordinating Group

Members:

Western Australian Ombudsman

Public Sector Commissioner

Corruption and Crime Commissioner

Auditor General

Information Commissioner

Background:

The Group was formed to promote and strengthen integrity in Western Australian public bodies.

The Office's involvement:

The Ombudsman participates as a member of the Group and the Office has nominated senior representatives who sit on the Group's joint working party to collaborate on shared initiatives.

2011-12 initiatives:

The Ombudsman's workshops on Good Administrative Decision making were revised during 2011-12 to incorporate the key principles in the *Integrity in Decision Making* product developed by the Group and ensure consistent information is provided to public authorities. The Office also coordinated the graduate program, which involves a graduate working in each of the member agencies over a two year period in total.

Public Sector Commission's Induction: Your Guide to Ethics and Integrity in the Public Sector Program	**Background:** As part of the induction process for all new public officers, the Public Sector Commission holds a half-day module on ethics and integrity in the public sector. The sessions are available to all new public officers. Staff from the Public Sector Commission, the Ombudsman's office, the Corruption and Crime Commission and the Office of the Information Commissioner present at these sessions. **2010-11 Initiatives:** As a key integrity agency, the Office presented on four occasions during the year. The Office provides information to new public sector employees on *The Role of the Ombudsman* and how the Office may be able to assist them in their work. This program will continue into 2012-13.
Australia and New Zealand Ombudsman Association **Members:** Western Australian Ombudsman & Energy Ombudsman Western Australia 16 Parliamentary and industry-based Ombudsmen from Australia and New Zealand	**Background:** The Association is a peak body industry group for Parliamentary and industry-based Ombudsmen in Australia and New Zealand. It acts as a network for consultation and discussion for Ombudsmen on matters of interest, concern or common experience. **The Office's involvement:** The Ombudsman sits on the Association's Executive. The Office regularly reports on its activities to the Association and also has nominated representatives who sit on interest groups in the areas of policy and research, first contact, public relations and communications and business services. **2011-12 initiatives:** The Ombudsman was involved in four scheduled meetings via teleconference during the year, attended the Association's Annual General Meeting and Executive Committee meeting. The Ombudsman also gave a presentation, *Growing pains – large increases in complaints and substantial variation in demand for Ombudsman services*, chaired a session and was a panel member in the plenary closing session at the Association's 2012 conference in Melbourne in May 2012.

Information sharing with Ombudsmen from other jurisdictions	**Background:** Where possible and practical, the Office aims to share information and insights about its work with Ombudsmen from other jurisdictions, as well as with other accountability and integrity agencies. **2011-12 Initiatives:** In November 2011, the Office hosted the annual Deputy Ombudsman's meeting attended by Deputy Ombudsmen from across Australia and in October 2011 the Office hosted a visit by the British Columbia Deputy Representative for Children and Youth. The Tasmanian Ombudsman's office also travelled to Western Australia to examine the Western Australian Ombudsman's complaint resolution processes and how these processes might be applied in Tasmania. Materials on the Office's complaint handling improvement program were shared with the Tasmanian Ombudsman's office.
Indonesian/ Australian Ombudsman Linkages and Strengthening Program **Members:** Western Australian Ombudsman Commonwealth Ombudsman New South Wales Ombudsman Ombudsmen of the Republic of Indonesia	**Background:** The program aims to provide access across a larger portion of Indonesia to more effective and sustainable Ombudsman and complaint management services. **The Office's involvement:** The Office has been involved with the program since 2005 and supports the program through staff placements in Indonesia and Australia. **2011-12 initiatives:** In July 2011, the Assistant Ombudsman Complaints Resolution visited Indonesia. The purpose of the visit was to work with Indonesia's incoming Ombudsmen, to develop a work program for the next phase of the program and to continue to evaluate outcomes from earlier program activities. In March 2012, the Indonesian anti-corruption body, KPK, visited the Western Australian Ombudsman to understand more about our role in handling complaints and accountable and transparent decision making in the public sector.

Providing Access to Key Stakeholders

Access to the Ombudsman's Services

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

Access to the Office through online services is popular. This is further demonstrated by the increased use of online access this year. This year, for the first time, the number of people using email and on-line services to make a complaint is higher than those using letters.

Significant work was undertaken in relation to a series of new measures to ensure that the Office's services are as accessible as possible to children and young people.

Communicating with Complainants

The Office provides a range of information and services to assist specific groups and the public more generally to understand the role of the Ombudsman and the complaint process. Many people find the Office's enquiry service assists them to make their complaint. Other initiatives in 2011-12 include:

- Promotion of the Ombudsman's translated information sheets *How to complain to the Ombudsman* and *Complaints by overseas students*. Information is already available in a number of community languages and can be made available in specific languages on request;
- Ongoing promotion of the role of the Office and the type of complaints the Office handles through 'Ask the Ombudsman' on 6PR's Nightline Program; and
- Regular updating and simplification of the Ombudsman's website to provide easy access to information for people wishing to make a complaint and those undertaking the complaint process.

Liaison with Public Authorities

The Office liaises with various public authorities throughout the year to discuss case-specific information and to track issues and trends occurring within different sectors.

Liaison with the Public Sector

Corrective Services

Regular meetings were held with the Director General of Corrective Services and senior representatives of the Department's Professional Standards and Adult Custodial Divisions. In addition, the Office attended quarterly meetings with representatives of the Office of the Inspector of Custodial Services. These meetings have proved useful in allowing both offices to become better informed of issues affecting the corrective services sector in Western Australia.

Department of Housing

During the year, discussions were held with senior staff within the Department of Housing to exchange information about the Office's own motion investigation on sleep related infant deaths. The Office also conducted a workshop on *Effective Decision Making* to Department of Housing staff in August 2011.

Department for Child Protection

Regular meetings were held with the Director General of the Department for Child Protection as well as monthly discussions with senior representatives from the Ombudsman's office and the Department for Child Protection. Discussions were also held during the year with senior staff within the Department to exchange information about the Office's own motion investigation on sleep related infant deaths

Liaison with the Local Government Sector

The Office continued to work on strengthening its liaison with the local government sector. Initiatives undertaken during the year include:

- In August 2011, the Office gave a presentation titled, *Overview of the Role of the Ombudsman* at the Western Australian Local Government Association Conference; and
- The Office also presented at the Local Government Managers Australia Customer Service Forum on *The Ombudsman's Role in Resolving Complaints*.

Liaison with the University Sector

A number of meetings and teleconferences were held with senior representatives from Curtin University, University of Western Australia and Murdoch University as well as interstate University representatives.

'Ask the Ombudsman' on *Nightline*

The Office continues to provide access to its services through the Ombudsman's regular appearances on Radio 6PR's *Nightline* program. Listeners who have complaints about public authorities or want to make enquiries have the opportunity to call in and speak with the Ombudsman live on air. The segment allows the public to communicate a range of concerns with the Ombudsman. The segment also allows the Office to communicate key messages about the State Ombudsman and Energy Ombudsman jurisdictions, the outcomes that can be achieved for members of the public and how public administration can be improved. The Ombudsman appeared on the 'Ask the Ombudsman' segment in September and November 2011 and March and June 2012.

Ombudsman Website

The Western Australian Ombudsman website provides a wide range of information and resources for:

- Members of the public on the complaint handling services provided by the Office as well as links to other complaint bodies for issues outside the Ombudsman's jurisdiction;

- Public sector agencies on decision making, complaint handling and conducting investigations;
- Access to the Ombudsman's investigation reports such as the Report on *Planning for Children in Care;*
- The latest news on events and collaborative initiatives such as the Regional Awareness and Accessibility Program; and
- Links to other key functions undertaken by the Office such as the Energy Ombudsman website and related bodies including the Integrity Coordinating Group.

The website continues to be a valuable resource for the community and public sector as shown by the increased use of the website this year. In 2011-12:

- The number of hits to the website increased by 25% to 1,264,215 in 2011-12;
- The number of visitors also increased, particularly around the time of publication of Ombudsman investigation reports such as the Report on Planning for Children in Care;
- The top two most visited pages (besides the homepage) on the site were *What you can complain about* and *How to make a complaint*; and
- The Office's *Procedural Fairness* guidelines and *Guidelines on Complaint Handling* were the top two most viewed documents.

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

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**), with preparation underway for our visit to the Pilbara towns of South Hedland, Karratha, Roebourne and Marble Bar in August 2012. The Program is an important way for the Office to raise awareness of, access to, and use of, its services, for regional and Indigenous Western Australians.

While the Program is coordinated by the Ombudsman's Office, it generally incorporates the work of other integrity and accountability agencies including the Health and Disability Services Complaints Office, the Office of the Information Commissioner and the Commonwealth Ombudsman's office.

The Program enables the Office to deliver key messages about the Ombudsman's work and services, and also provides a valuable opportunity for staff to strengthen

their understanding of the issues affecting people in regional and Indigenous communities. The visits also highlight the important interaction of State and local governments in the provision of services to the communities.

Complaint forums enable members of local communities to speak with Ombudsman staff face-to-face about their issues and concerns and the Office provides advice about, and assists in resolving, many of the complaints made during the visit. The collaboration with other integrity and accountability agencies during regional visits and complaint clinics also assists in ensuring regional Western Australians can be easily referred to the most appropriate body to assist them.

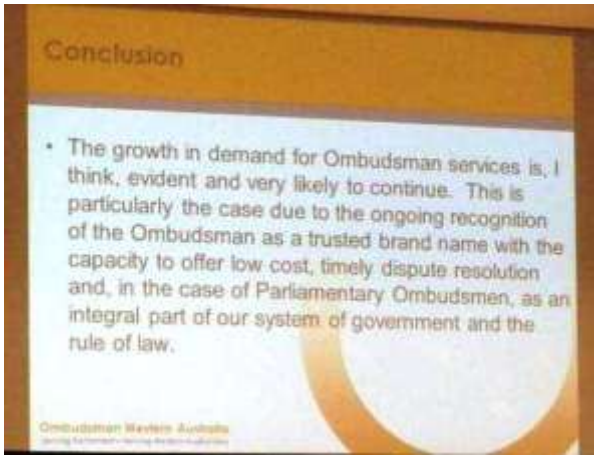
Presentations and Publications

Speeches and Presentations

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

As well as the presentations and workshops designed to support improvements to public administration, provided in the Own Motion Investigations and Administrative Improvement section, speeches and presentations by the Ombudsman and other staff of the Office included:

- A five day intensive unit 'Government Accountability – Law and Practice' co-coordinated by the Ombudsman and Professor Simon Young, Faculty of Law, University of Western Australia in February 2012;
- A presentation to the Public Sector Commission on achieving improved timeliness of complaint resolution in November 2011;



Above: an extract from Ombudsman, Chris Field's presentation at the 2012 ANZOA Conference in Melbourne. Photograph courtesy of ANZOA Secretariat.

- A presentation at the Australian Public Sector Anti Corruption Conference on complaint handling in November 2011;
- A presentation to the Indonesian anti-corruption body, KPK, on our role in handling complaints and accountable and transparent decision making in the public sector in March 2012; and
- A speech at the Australian and New Zealand Ombudsman Association (ANZOA) Conference on managing the large increases in complaints and variation in demand for Ombudsman services in May 2012.

The Ombudsman also delivered presentations in his role as the Energy Ombudsman including a speech at the Financial Counsellors' Association of Western Australia Annual Conference on the role of the Energy Ombudsman in September 2011.

Western Australian Ombudsman Newsletter

The *Western Australian Ombudsman Newsletter* is a key publication used by the Office to communicate information to its stakeholders about the Office's performance, achievements, events and resources. During the year, two editions of the newsletter were issued (July and December 2011).

The newsletter is distributed electronically to Members of Parliament, public authorities and interested members of the public and subscription to the newsletter from interested parties has increased steadily over the past year. The newsletter is published on the website after it is issued.

Publications

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

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