# Our Performance in 2012-13

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 Effectiveness Indicators

The Ombudsman aims to improve decision making and administrative practices in public authorities as a result of complaints handled by the Office, reviews of certain child deaths and family and domestic violence fatalities 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 effectiveness indicators are the percentage of these recommendations and suggestions accepted by public authorities and the number of improvements that occur as a result of Ombudsman action.

| Key Effectiveness Indicators | 2012-13 Target | 2012-13 Actual | Variance |
|---|---|---|---|
| Of allegations where the Ombudsman made recommendations to improve practices or procedures, percentage of recommendations accepted by agencies | 100% | **100%** | Nil |
| Number of improvements to practices or procedures as a result of Ombudsman action | 100 | **72** | -28 |

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 2012-13, there were 139 actions taken by public authorities to provide a remedy for people making complaints to the Office.

### Comparison of Actual Results and Budget Targets

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, have risen significantly since the commencement of the program, but there may be fluctuations from year to year.

For the fifth consecutive year, public authorities have accepted every recommendation made by the Ombudsman, matching the 2011-12 actual result and meeting the 2012-13 target.

## 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 notification of child deaths and family and domestic violence fatalities.

| Key Efficiency Indicators | 2012-13 Target | 2012-13 Actual | Variance |
|---|---|---|---|
| Percentage of allegations finalised within 3 months | 85% | **83%** | -2% |
| Percentage of allegations finalised within 12 months | 99% | **99%** | Nil |
| Percentage of allegations on hand at 30 June less than three months old | 70% | **94%** | +24% |
| Percentage of allegations on hand at 30 June less than 12 months old | 99% | **96%** | -3% |
| Average cost per finalised allegation | $1,875 | **$1,821** | -$54 |
| Average cost per finalised notification of death | $9,600 | **$12,281** | +$2,681 |

### Comparison of Actual Results and Budget Targets

The timeliness and efficiency of complaint handling has substantially improved over the past five years due to a major complaint handling improvement program introduced in 2007-08. Building on the program, the Office developed and commenced a new organisational structure and processes in 2011-12 to promote and support early resolution of complaints. As a result of the program, the Office has reduced the average age of complaints from 173 days on 30 June 2007 to 33 days on 30 June 2013 while at the same time reducing the average cost per finalised allegation for five consecutive years. These improvements are in the context of a significant increase in the number of complaints across all sectors that occurred in 2009-10, that has been maintained for the last three financial years.

In 2012-13, substantially improved complaint handling has resulted in the following actual results compared to budget targets. The percentage of allegations finalised within three months (83%) is the highest figure in the past five years, very significantly improving on the 2011-12 actual result (72%), and only slightly less than the target (85%). The percentage of allegations finalised within 12 months (99%), has matched the target. The percentage of allegations on hand at 30 June less than three months old (94%) has improved very significantly from the 2011-12 actual result (45%) and has significantly bettered the 2012-13 target (70%). The percentage of allegations on hand at 30 June less than 12 months old (96%) has not matched the 2011-12 actual result (99%) or met the 2012-13 target (99%), however, it is anticipated that, early in 2013-14, the Office will achieve, and then maintain, not having any complaints on hand over 12 months. The average cost per finalised allegation bettered the 2011-12 actual result and the 2012-13 target.

The Ombudsman reviews certain child deaths and family and domestic violence fatalities. This involves:

- Reviewing the circumstances in which and why child deaths and family and domestic violence fatalities occur;
- Identifying patterns and trends that arise from reviews of child deaths and family and domestic violence fatalities; and
- Making recommendations to public authorities about ways to prevent or reduce child deaths and family and domestic violence fatalities.

The average cost per finalised notification of death exceeded the 2011-12 actual result and the 2012-13 target, reflecting the complexity of this function, including the complexity of reviews of family and domestic violence fatalities, that commenced in 2012-13.

## Summary of Financial Performance

The majority of expenses for the Office (70%) relate to staffing costs. The remainder is primarily for accommodation, communications and office equipment.

| Financial Performance | 2012-13 Target ('000s) | 2012-13 Actual ('000s) | Variance ('000s) |
|---|---|---|---|
| Total cost of services (expense limit) (sourced from Statement of Comprehensive Income) | $10,311 | **$10,398** | +$87 |
| Income other than income from State Government (sourced from Statement of Comprehensive Income) | $2,368 | **$2,615** | +$247 |
| Net cost of services (sourced from Statement of Comprehensive Income) | $7,943 | **$7,782** | -$161 |
| Total equity (sourced from Statement of Financial Position) | $1,245 | **$1,783** | +$538 |
| Net increase in cash held (sourced from Statement of Cash Flows) | $18 | **-$204** | -$222 |
| **Staff Numbers** | **Number** | **Number** | **Number** |
| Full time equivalent (FTE) staff level | 63 | **62** | -1 |

## Comparison of Actual Results and Budget Targets

There was no significant variation between the actual results and the budget target for the Office's total cost of services.

For income, the increase in the actual result compared to the budget target and, for net cost of services, the decrease in the actual result compared to the budget target was mainly due to income recognised in the period to offset prior year uncleared purchase orders.

For total equity, the increase in the actual result compared to the budget target was primarily due to the purchase of a finance system to support the financial operations of the Office, following the decommissioning of the Office of Shared Services, along with higher than anticipated cash assets at the end of the period, due to the timing of capital purchases under the asset investment program and income recognised in the period as outlined above.

For cash held, the decrease in the actual result compared to the budget target reflects the payment of expenditure committed in 2011-12 but not paid until 2012-13.

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

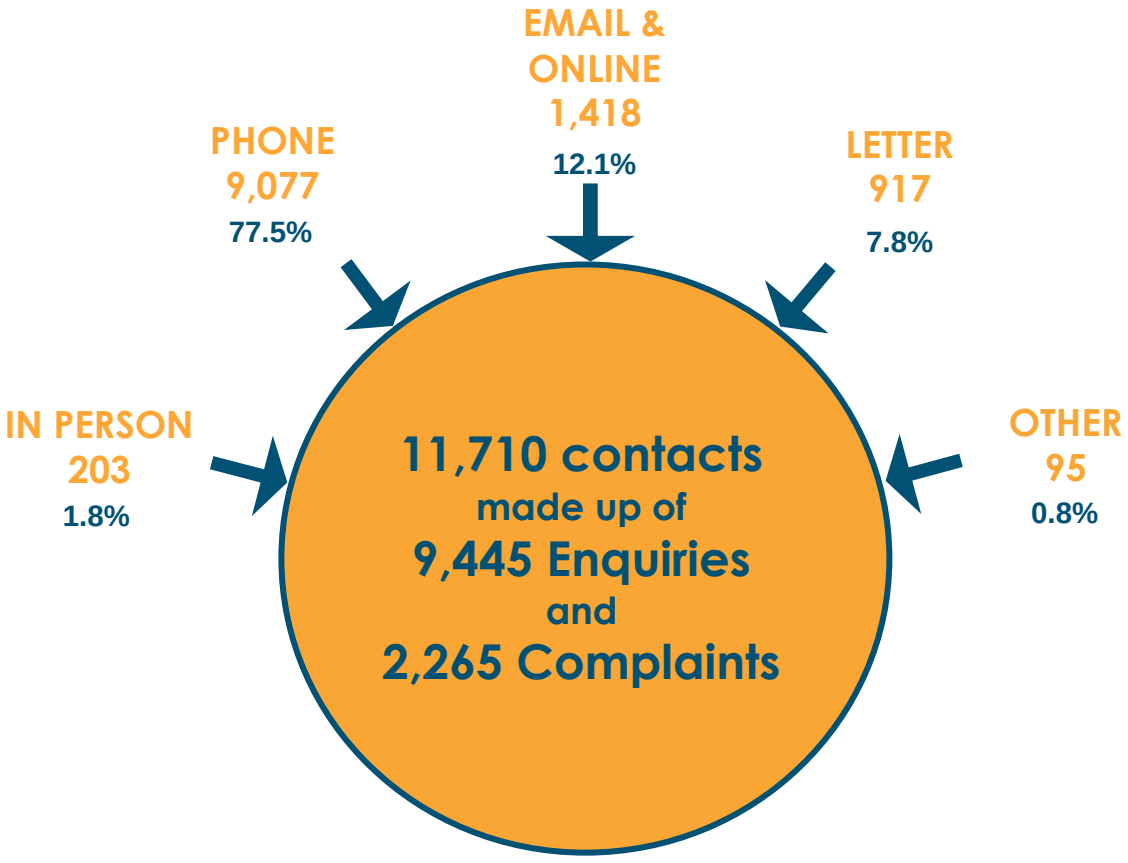
# Complaint Resolution

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

## Contacts

In 2012-13, the Office received 11,710 contacts from members of the public consisting of:

- 9,445 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 2,265 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.



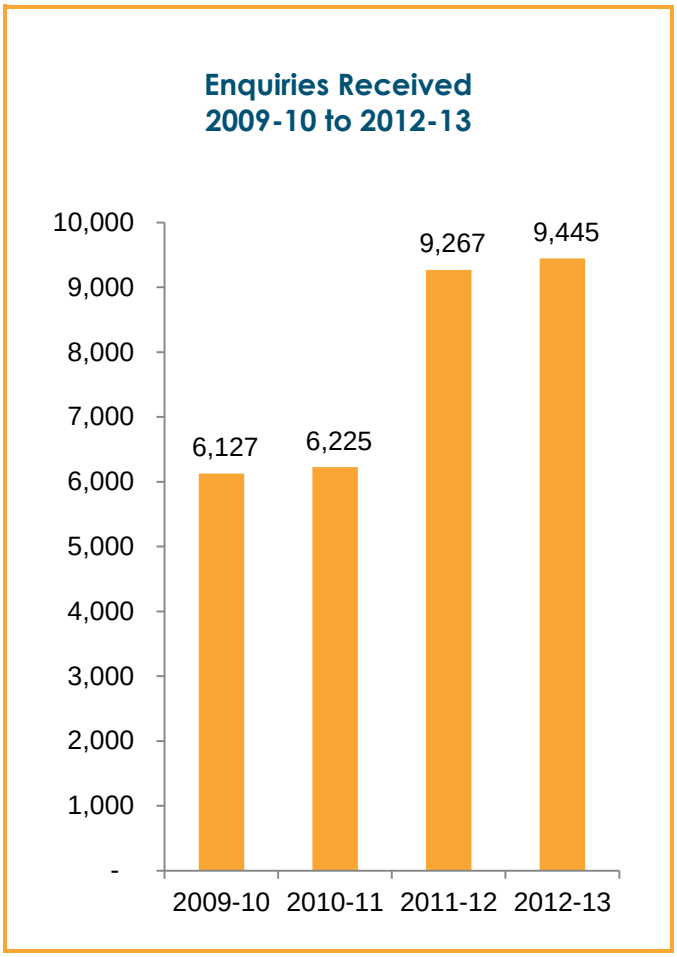
## Enquiries Received

There were 9,445 enquiries received during the year.

For enquiries about matters that are within the Ombudsman's jurisdiction, staff provide information about the role of the Office and how to make a complaint. For approximately half of these enquiries, the enquirer is referred back to the public authority in the first instance to give it the opportunity to hear about and deal with the issue. This is often the quickest and most effective way to 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.

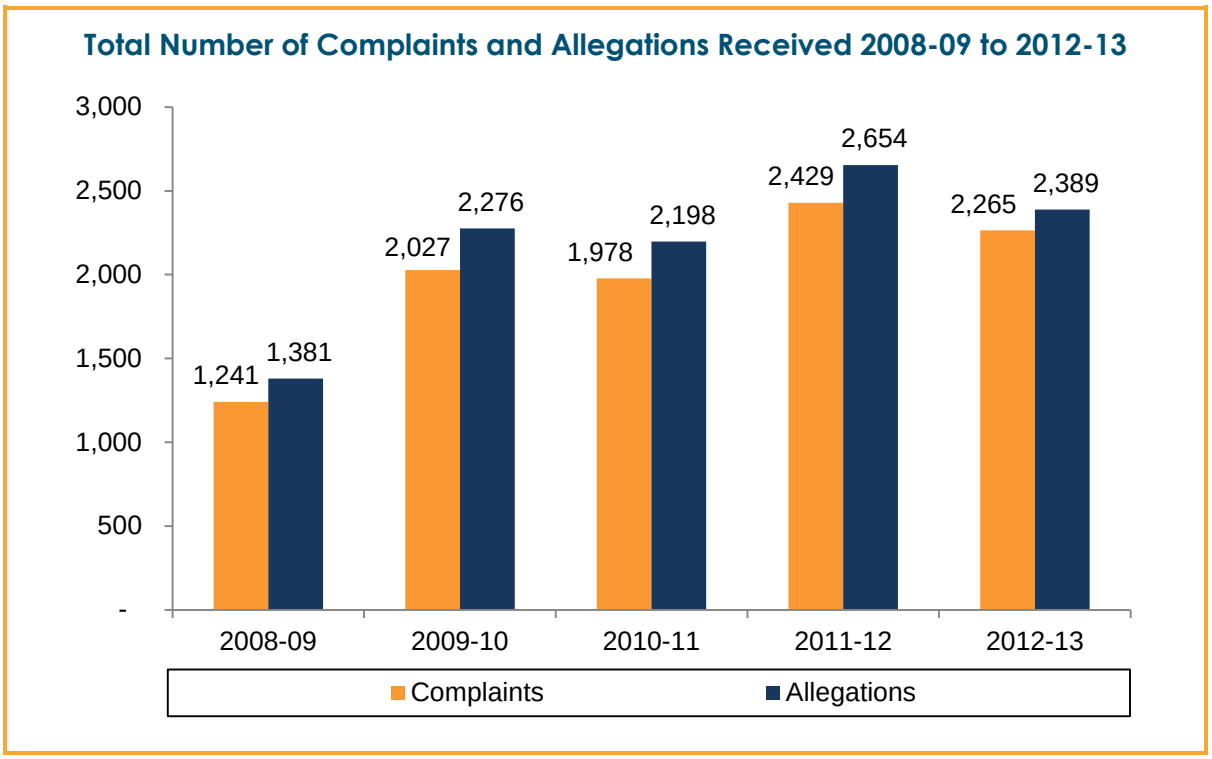
In some cases, Ombudsman staff may be able to assist the person making the enquiry by making informal contact with the public authority.




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

## Complaints Received

In 2012-13, the Office received 2,265 complaints, which included 2,389 separate allegations, and finalised 2,675 complaints. There are more allegations than complaints because one complaint may cover more than one issue.



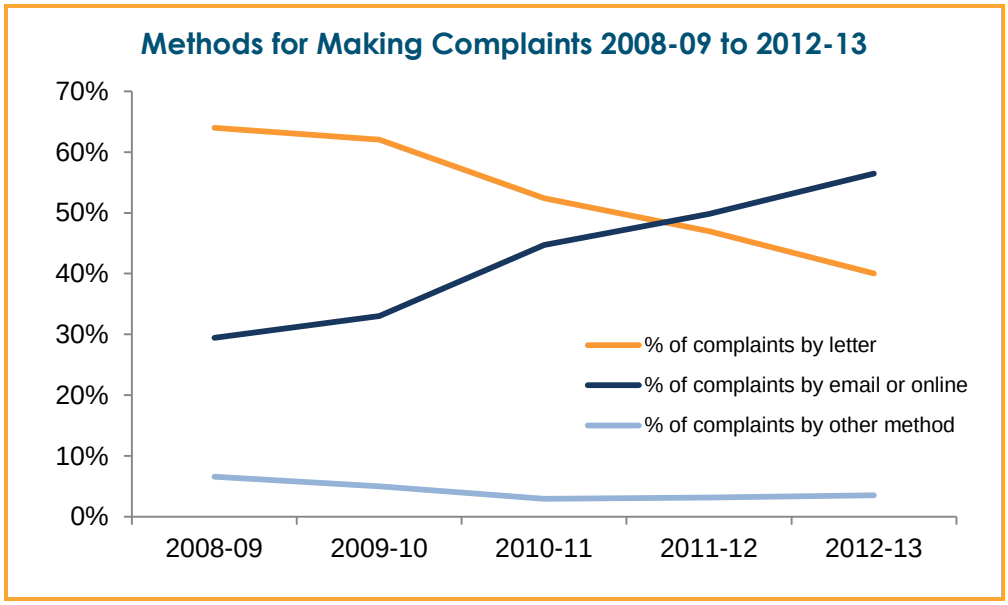

NOTE: The number of complaints and allegations shown for a year may vary, by a small amount, from the number shown in previous annual reports. This occurs because, during the course of an investigation, it can become apparent that a complaint is about more than one public authority or there are additional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

The average number of complaints received in the last four years (2009-10 to 2012-13) was 2,175 compared with the average of 1,171 for the three previous years (from 2006-07 to 2008-09). This represents an increase of 86% in complaint numbers. The increase is across all sectors and is not confined to one public authority.

## How Complaints are made

The increase in the use of email and online facilities to lodge complaints has continued in 2012-13, increasing from 50% in 2011-12 to 56% in 2012-13. The proportion of people using email and online facilities to lodge complaints has nearly doubled since 2008-09 when less than 30% were received in this way.

During the same period, the proportion of people who lodge complaints by letter has reduced from 64% to 40%. The remaining complaints were received by a variety of means including by fax, during regional visits and in person.




## Resolving Complaints

Where it is possible and appropriate, staff use an early resolution approach to investigate and resolve complaints. This approach is highly efficient and effective and results in timely resolution of complaints. It gives public authorities the opportunity to provide a quick response to the issues raised and to undertake timely action to resolve the matter for the complainant and prevent similar complaints arising again. The outcomes of complaints may result in a remedy for the complainant or improvements to a public authority's administrative practices, or a combination of both. Complaint resolution staff also track recurring trends and issues in complaints and this information is used to inform broader administrative improvement in public authorities and investigations initiated by the Ombudsman (known as own motion investigations).

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

## 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.

Timeliness and efficiency of complaint handling has substantially improved over time 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 complaints as old as six years. Building on the program, the Office developed and

commenced a new organisational structure and processes in 2011-12 to promote and support early resolution of complaints. Together, these initiatives have resulted in substantial improvements in the timeliness of complaint handling in 2012-13. Over the last year:

- The percentage of allegations finalised within 3 months improved from 72% to 83% and the percentage of allegations on hand less than 3 months old at 30 June significantly improved from 45% to 94%;
- There has been a reduction from 53 days to 46 days (13%) in the average time to finalise complaints and a reduction from 99 days to 33 days (67%) in the average age of complaints on hand at 30 June; and
- The Office has maintained its low level of aged cases with 99% of allegations finalised within 12 months and 96% of allegations on hand less than 12 months old at 30 June.

Following the introduction of the Office's complaint handling improvement program in 2007-08, very significant improvements have been achieved in timely complaint handling over the last six years including:

- The percentage of allegations finalised within 3 months improved from 69% in 2006-07 to 83% in 2012-13 and the percentage of allegations on hand less than 3 months old improved from 33% at 30 June 2007 to 94% at 30 June 2013;
- There has been a reduction in the average time to finalise complaints from 92 days in 2006-07 to 46 days in 2012-13 and a reduction in the average age of complaints on hand from 173 days at 30 June 2007 to 33 days at 30 June 2013; and
- Finalised complaints older than 12 months have decreased from 80 to 14 (83%) and complaints on hand more than 12 months old have decreased from 20 at 30 June 2007 to 2 at 30 June 2013 (90%).

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.

## Complaints Finalised in 2012-13

There were 2,675 complaints finalised during the year and, of these, 2,001 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 1,105 were finalised at initial assessment, 855 were finalised after an Ombudsman investigation and 41 were withdrawn.

### Complaints finalised at initial assessment

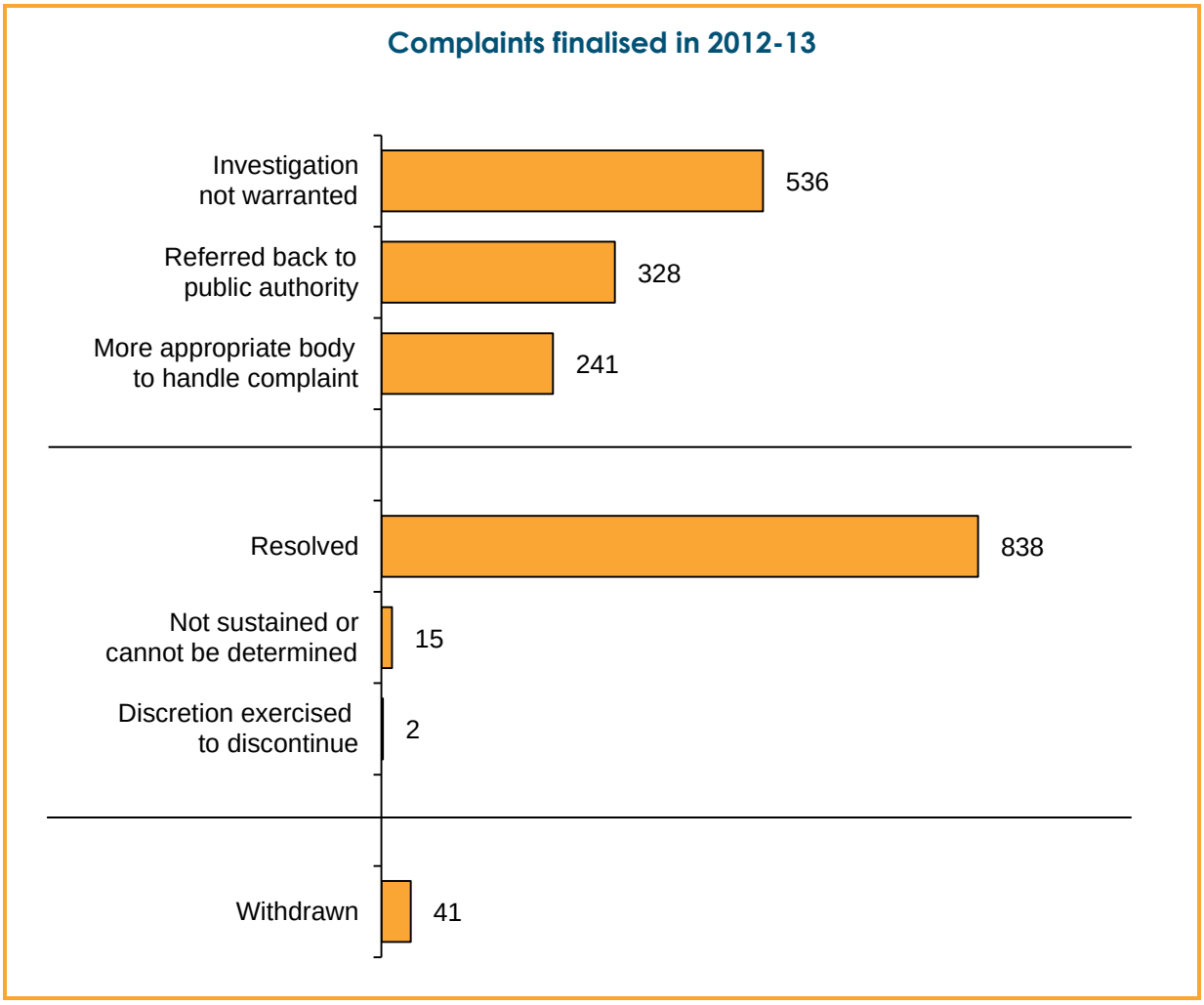
Almost a third (30%) of the 1,105 complaints finalised at initial assessment were referred back to the public authority to provide it with an opportunity to resolve the matter before further involvement of the Ombudsman. This is a common and timely approach and often results in resolution of the matter. 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 241 (22%) 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 855 complaints finalised after investigation, 98% were resolved through the Office's early resolution approach. This involves Ombudsman staff contacting the public authority to progress a timely resolution of complaints that appear to be able to be resolved quickly and easily. Public authorities have shown a strong willingness to resolve complaints using this approach and frequently offer practical and timely remedies to resolve matters in dispute, together with information about administrative improvements to be put in place to avoid similar complaints in the future. There has been an increasing trend in early resolution through the use of this process (from 202 complaints in 2009-10 to 838 in 2012-13).

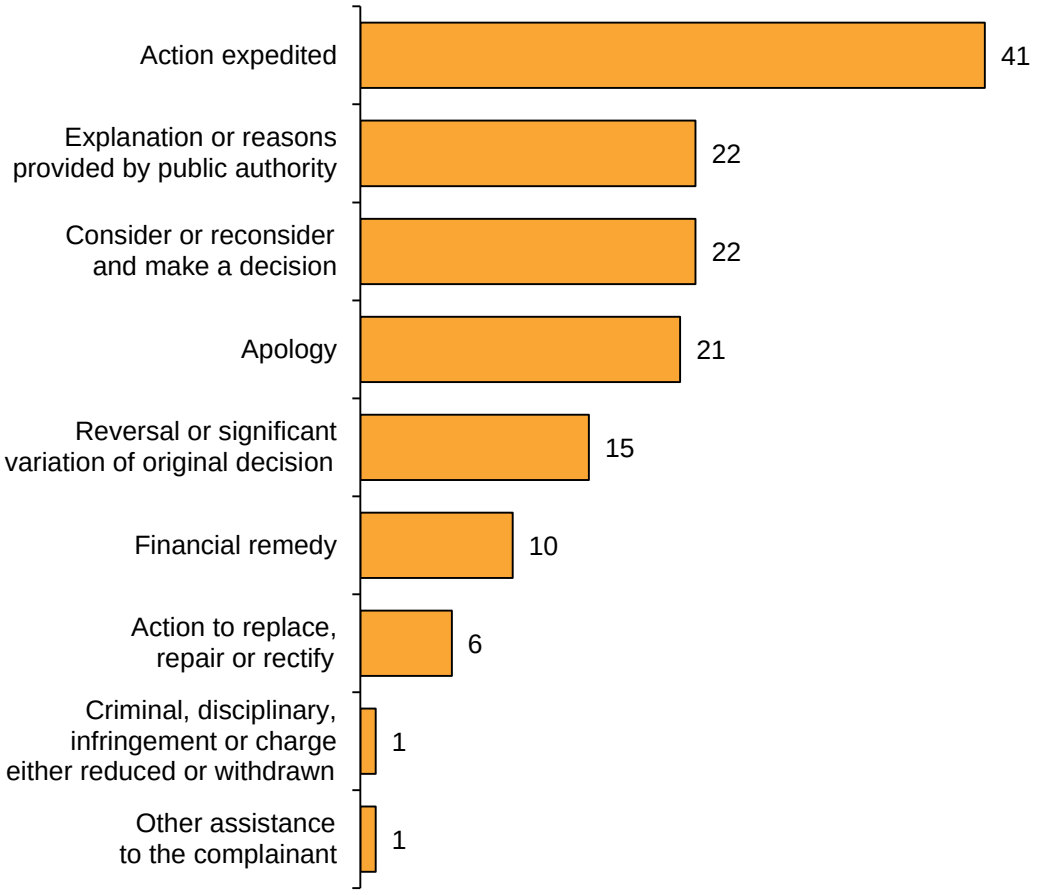
The following chart shows how complaints about public authorities in the Ombudsman's jurisdiction were finalised.



## Outcomes to Assist the Complainant

Complainants look to the Ombudsman to facilitate some form of assistance or action to remedy their complaint. In 2012-13, there were 139 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman, as shown in the following chart.

### Remedial Action to Assist the Complainant in 2012-13



Case Study

## Correction of fine and apology for delay

A man was given an infringement that incurred a fine of $150 and other penalties. The man paid the fine within the required time period because he was going overseas. On his return, he checked his status on-line and saw that he had been fined $300 and had received a further penalty. The man contacted the relevant public authority but did not receive a reply. He then contacted their complaints section which investigated the matter and informed him that an error had been made.

After three months, the error did not appear to have been corrected and the man complained to the Ombudsman. Following enquiries by the Office about the apparent delay, the correction was made and the man received a letter to confirm his correct status and an apology for any inconvenience caused.

### 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.

Case Study

## Reversal of fine arising from a notice sent to the wrong address

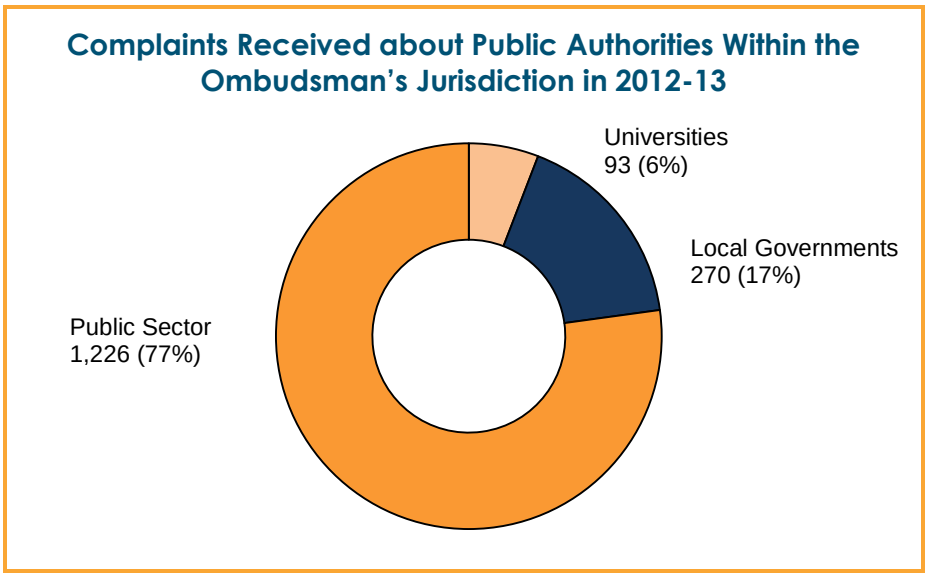
A resident of a rural area complained that a public authority had sent licence renewal notices to her residential address, despite the fact that there was no postal delivery to that address. The resident had a post office box in the nearest town and previous renewals had been successfully delivered to that post office box. As a result of not receiving the renewal notice, the resident had become unregistered and the public authority imposed a fine.

When the Office made inquiries the public authority found that the situation had arisen because of a problem with its database which meant that a previous address had been incorrectly retained and used on renewal notices. The public authority agreed to reverse the fine, assist the resident to obtain a new licence and to take action to rectify the error on its database that had caused the problem.

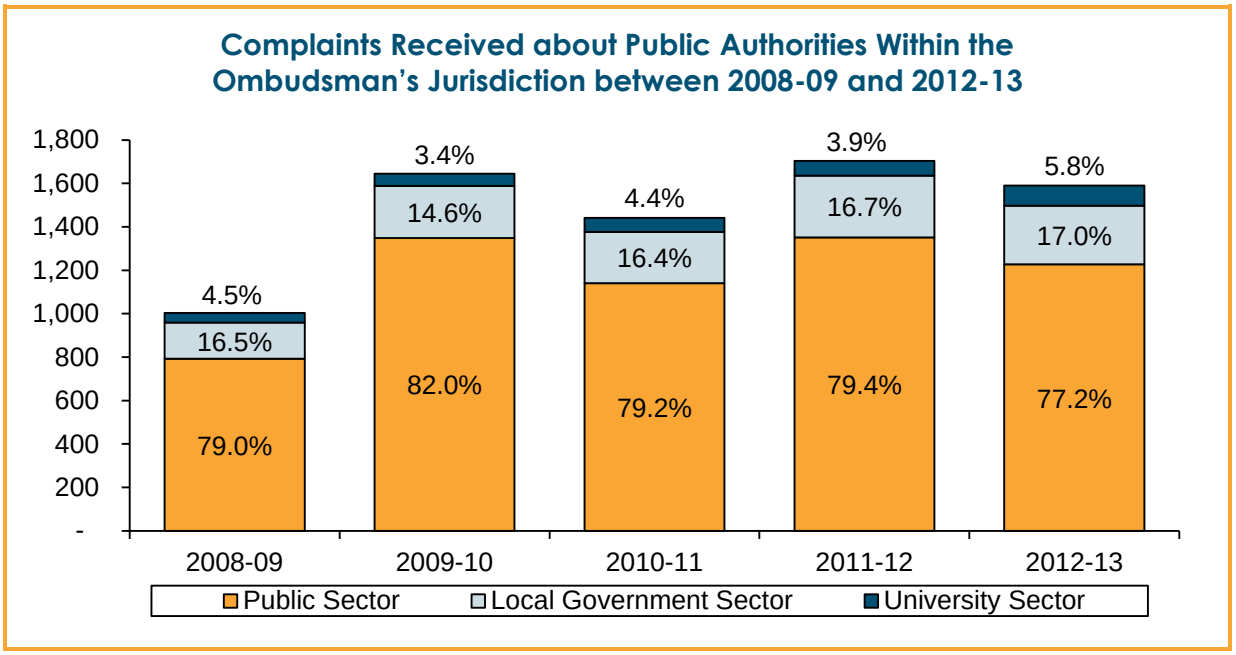
## About the Complaints

Of the 2,265 complaints received, 1,589 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 676 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 (1,226 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (270 complaints); and the university sector (93 complaints).



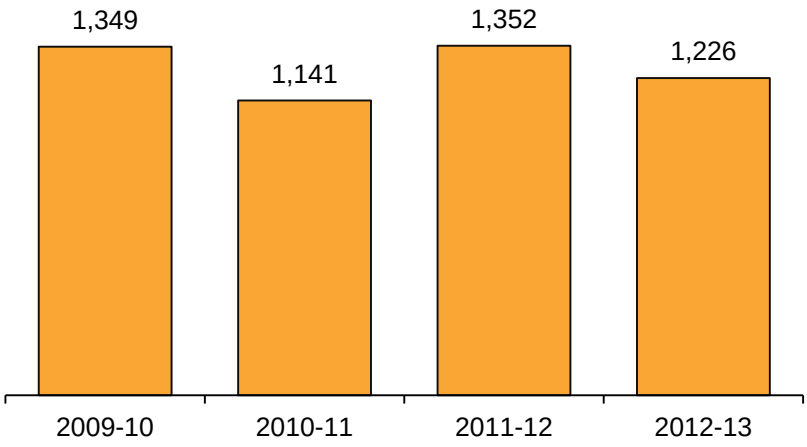

While there has been an increase in complaints in all sectors since 2008-09, the proportion of complaints about each sector has remained relatively steady, as shown in the following chart.



## The Public Sector

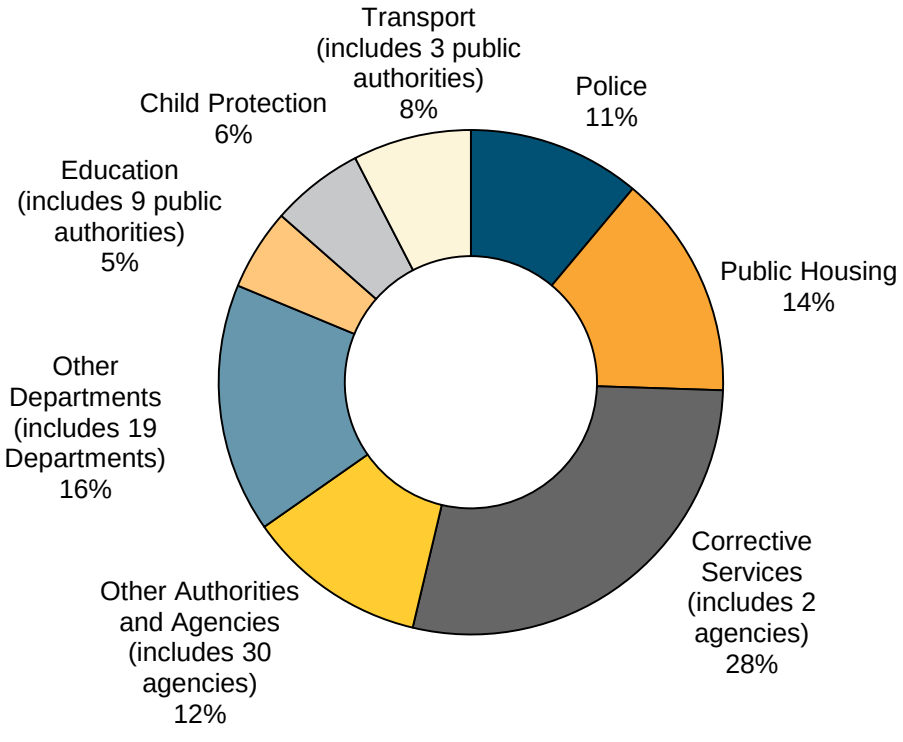
In 2012-13, there were 1,226 complaints received about the public sector and 1,593 complaints were finalised. The number of complaints about the public sector as a whole in the last four years is shown in the chart below.

**Complaints Received About the Public Sector between 2009-10 and 2012-13**




Public sector agencies are very diverse. In 2012-13, complaints were received about 66 agencies as shown in the following chart.

**Complaints Received About the Public Sector in 2012-13**



Of the 1,226 complaints received about the public sector in 2012-13, 72% were about six key areas covering:

- Corrective services, in particular prisons (346 or 28%);
- Public housing (177 or 14%);
- Police (136 or 11%);
- Transport (93 or 8%);
- Child protection (73 or 6%): and
- Education - public schools and Technical and Further Education (**TAFE**) colleges (64 or 5%). Information about universities is shown separately under the University Sector.

The remaining complaints about the public sector (337) were about 49 other State Government departments, statutory authorities and boards. For 31 (65%) of these agencies, the Office received five complaints or less.

### Outcomes of Complaints Received about the Public Sector

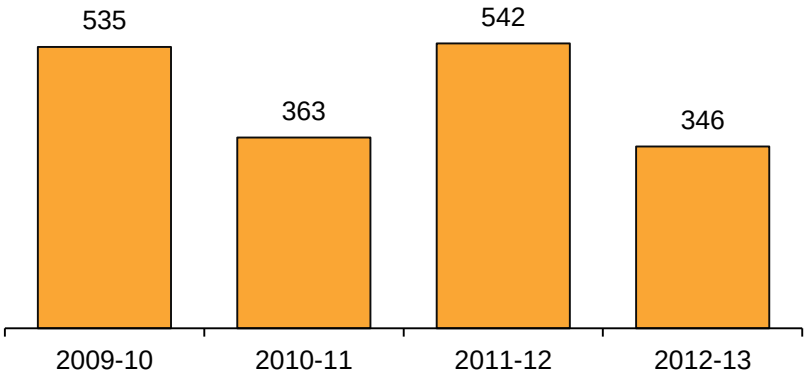
There were 156 actions taken by public sector bodies as a result of complaints finalised in 2012-13. These resulted in 117 remedies being provided to complainants and 39 improvements to public sector practices.

Further information about the issues raised in complaints and the outcomes of complaints is shown in the following tables for each of the six key areas and for the other public sector agencies as a group.

# Public Sector Complaint Issues and Outcomes

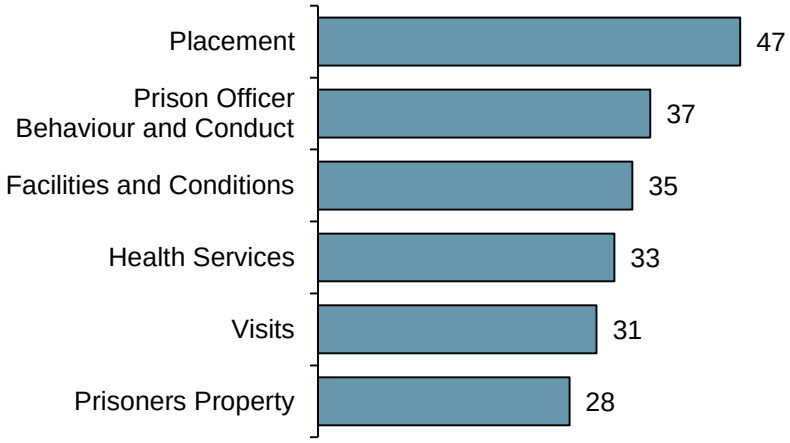
## Corrective Services

### Complaints received




Fluctuations in the numbers from year to year are primarily due to complaints where an issue is raised by multiple complainants using a petition or identical complaints signed by different people.

### Most common allegations




### Other types of allegations

- Prisoner employment;
- Communication;
- Sentencing and parole issues;
- Security classification;
- Discipline;
- Education courses and facilities; and
- Rehabilitation programs.

### Outcomes achieved

- Consider or reconsider a matter and make a decision;
- Action expedited;
- Change to policy or procedure;
- Change to business system or practices;
- Apology given;
- Explanation given or reasons provided; and
- Staff training.

Case Study

## Assistance to young people in detention

The Office undertook a proactive approach to the incident that occurred at Banksia Hill Detention Centre (**Banksia Hill**) on 20 January 2013, including attending Banksia Hill and Hakea Prison (**Hakea**) on 31 January and 22 February 2013 to:

- Observe conditions at Banksia Hill and Hakea;
- Meet with staff and detainees; and
- Provide an opportunity for detainees to make complaints to the Office if they wished to do so.

In particular on 22 February 2013, three staff members from the Office, accompanied by an Aboriginal consultant, met with detainees at Banksia Hill and Hakea to receive complaints.

Additionally, the Office also provided relevant information to the Inspector of Custodial Services as part of the Inspector's Directed Review of the incident at Banksia Hill and arranged, in conjunction with the Inspector, the secondment to the Office of the Inspector of Custodial Services, for the duration of the Inspector's inquiry, the Ombudsman's Principal Legal and Investigating Officer.

Case Study

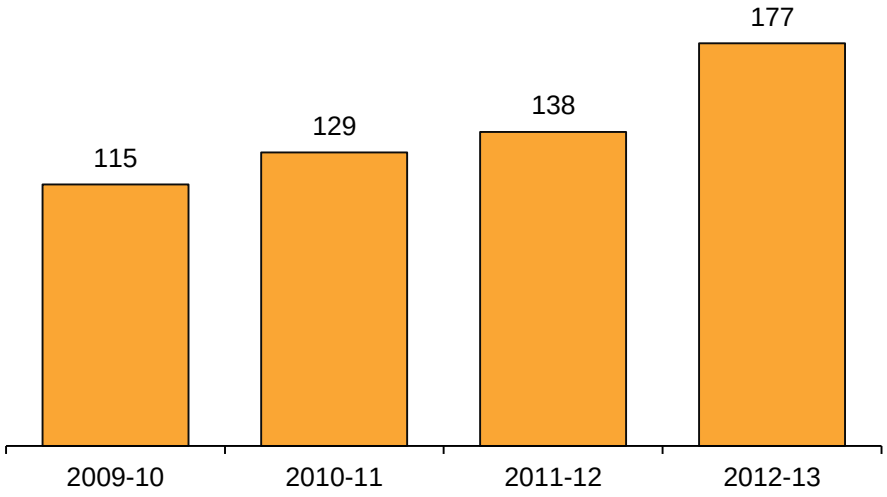
## Temporary transfer meets prisoner's medical needs

A prisoner contacted the Ombudsman complaining that the prison had refused her application for a temporary transfer to a regional prison for a family visit. The prisoner said that the reason she was given by the prison was that she had particular medical needs that could not be met at the regional prison.

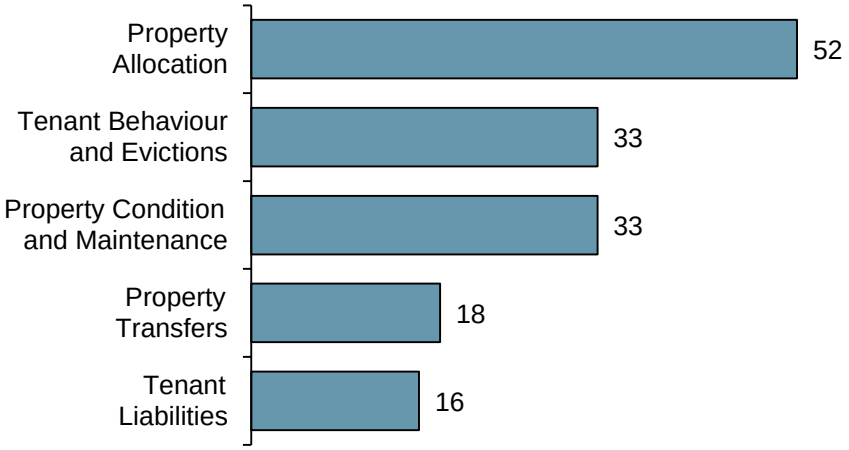
Following contact by the Office, the prison administration agreed to review the complainant's request. The matter was resolved by the prison sending the complainant's medication, in advance, to medical staff at the regional prison, so that they could manage her medical needs when she arrived.

# Public Housing

## Complaints received




## Most common allegations




## Other types of allegations

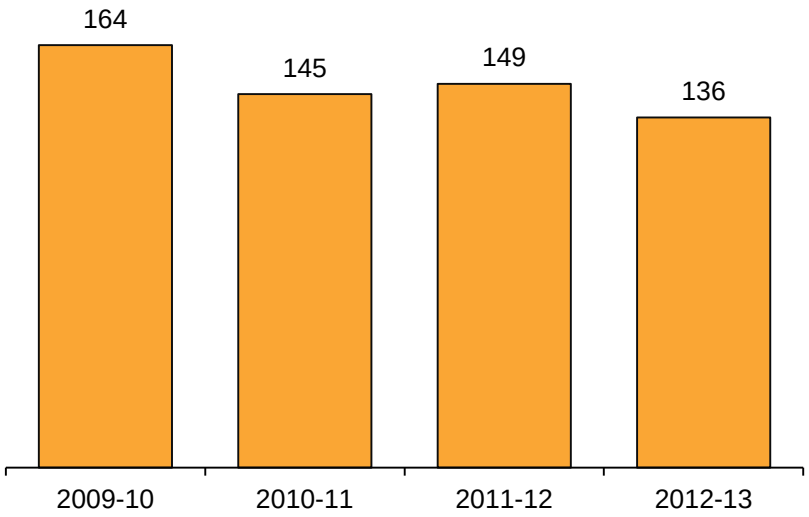
- Rental sales;
- Debt repayments;
- Rental or bond assistance; and
- Construction and development.

## Outcomes achieved

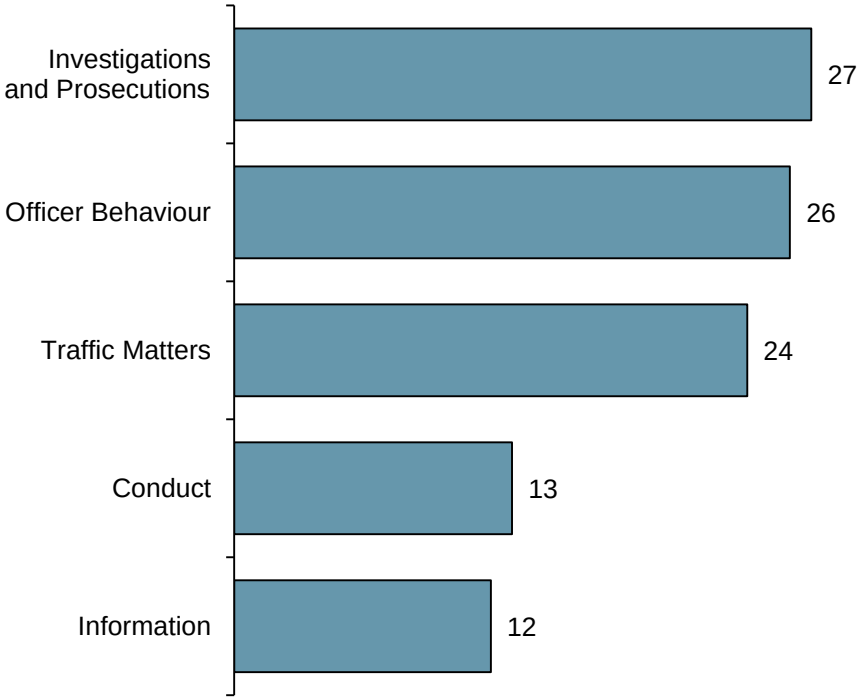
- Consider or reconsider a matter and make a decision;
- Reversal or significant variation of original decision;
- Action expedited;
- Action to replace, repair or rectify a matter;
- Tenant liability waived;
- Change to policy or procedure;
- Improved record keeping;
- Apology given;
- Explanation given or reasons provided; and
- Staff training.

# Police

## Complaints received




## Most common allegations




## Other types of allegations

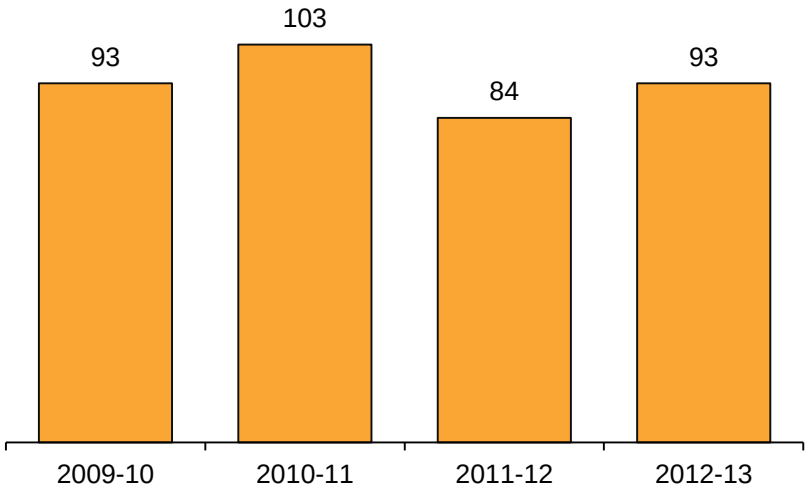
- Internal investigation of complaints;
- Arrest and detention;
- Searching, custody and property; and
- Management issues.

## Outcomes achieved

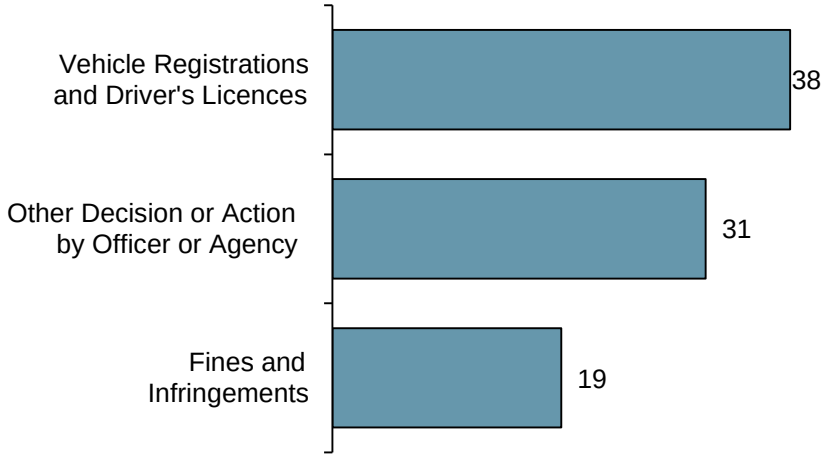
- Reversal or significant variation of original decision;
- Action expedited;
- Apology given; and
- Explanation given or reasons provided.

# Transport

## Complaints received




## Most common allegations




## Other types of allegations

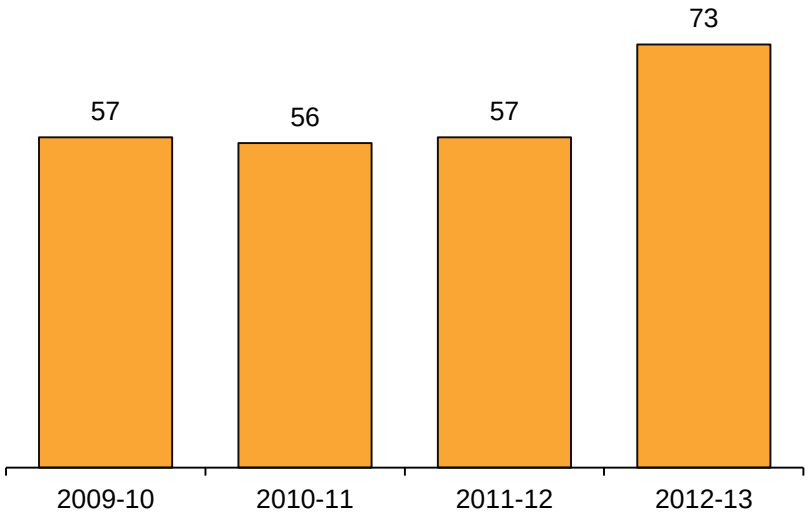
- Conduct of officer;
- Accuracy of personal information; and
- Policies and procedures.

## Outcomes achieved

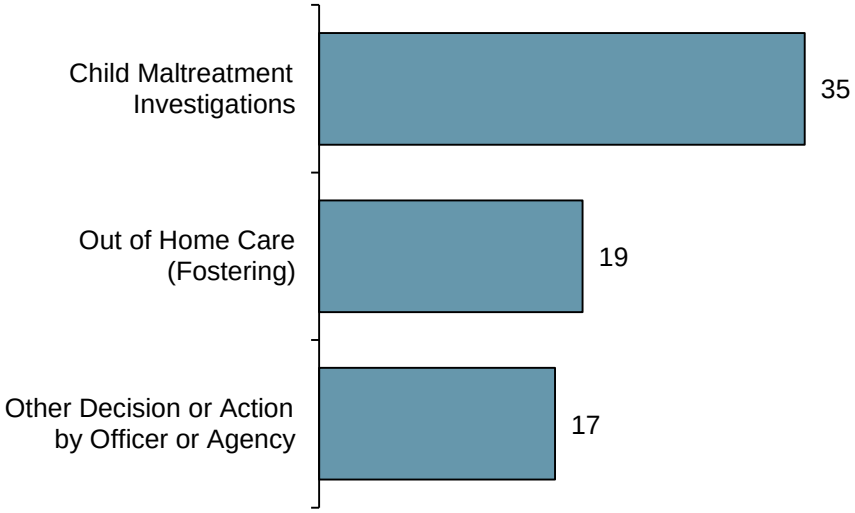
- Consider or reconsider a matter and make a decision;
- Reversal or significant variation of original decision;
- Action expedited;
- Fees waived;
- Act of grace payment;
- Explanation given or reasons provided; and
- Staff training.

# Child Protection

## Complaints received




## Most common allegations




## Other types of allegations

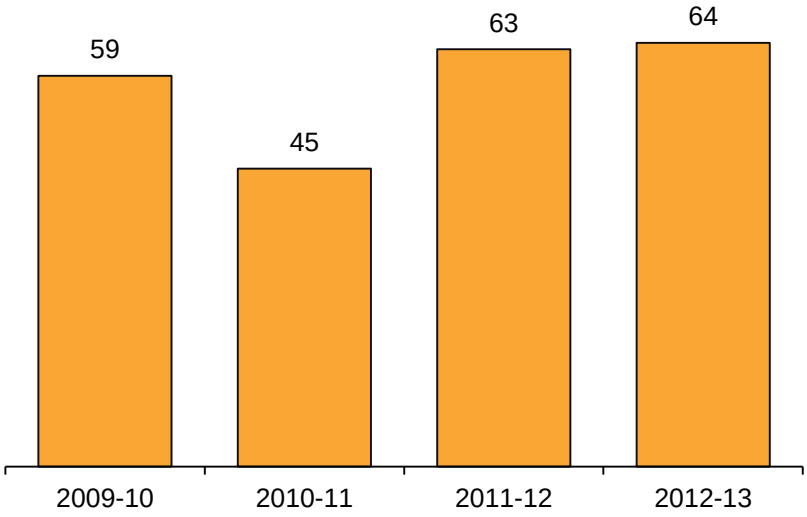
- Special assistance;
- Human resource management issues; and
- Complaint handling.

## Outcomes achieved

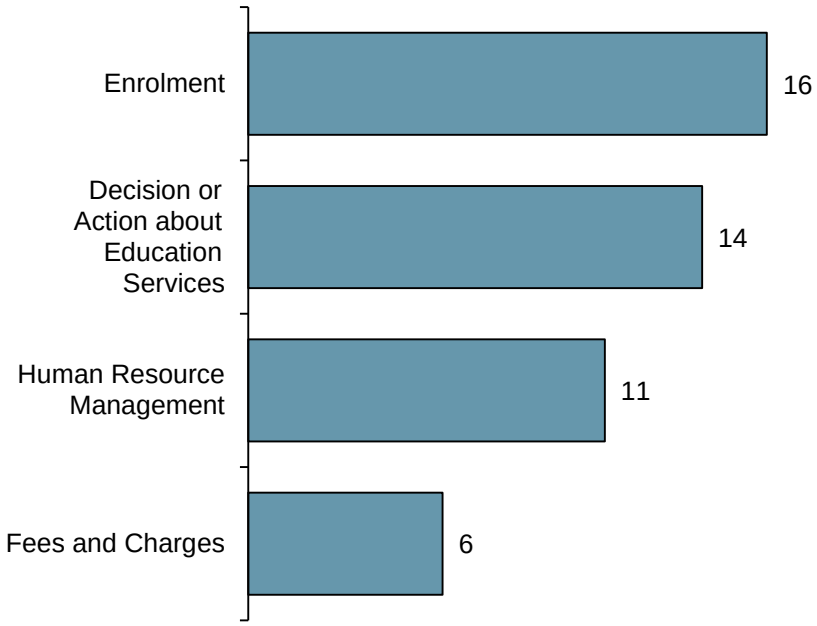
- Consider or reconsider a matter and make a decision;
- Action expedited; and
- Explanation given or reasons provided.

# Education

## Complaints received




## Most common allegations




These figures include appeals by overseas students under the *National Code of Practice for Registration Authorities and Providers of Education and Training to Overseas Students 2007.* Further details on these appeals are included later in this section.

## Other types of allegations

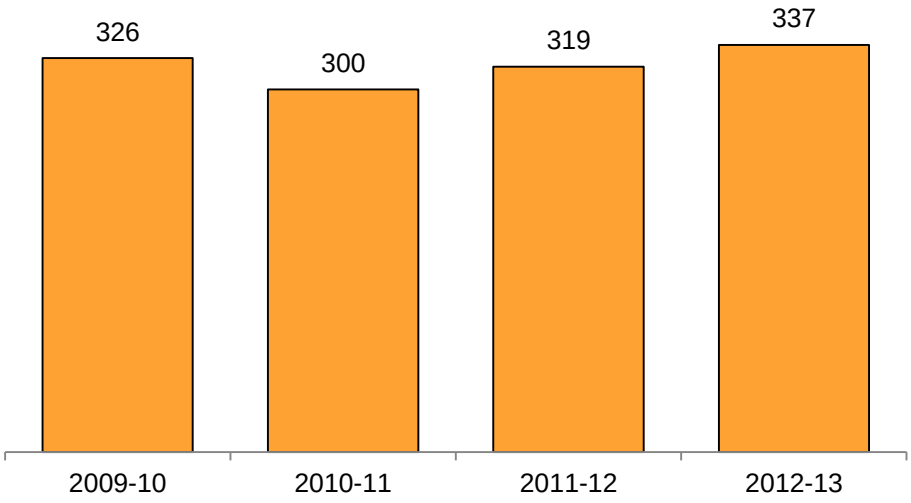
- Examinations, assessments and prizes; and
- Student discipline.

## Outcomes achieved

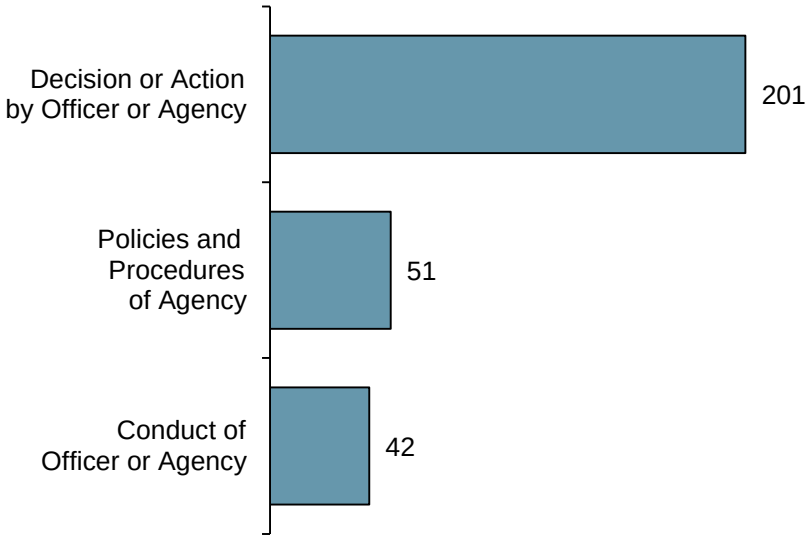
- Action expedited;
- Course fees and other costs refunded;
- Change to policy or procedure;
- Change to business system or practices; and
- Apology given.

# Other Public Sector Agencies

## Complaints received




## Most common allegations




## Other types of allegations

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

## Outcomes achieved

- Consider or reconsider a matter and make a decision;
- Reversal or significant variation of original decisions;
- Action expedited;
- Act of grace payment;
- Change to policy or procedure;
- Change to business system or practices;
- Apology given;
- Explanation given or reasons provided; and
- Staff training.

Case Study

## Certificate provided to family member

A woman complained that she had been trying for over six months to obtain a certificate relating to a family member but, although she had provided relevant information about her identity and relationship to the family member, the certificate had not been provided.

The Office made enquiries with the public authority and was told that it had replied to the woman on numerous occasions and had asked for family information from the woman to determine whether or not she met the policy for access to the certificate but had not received it.

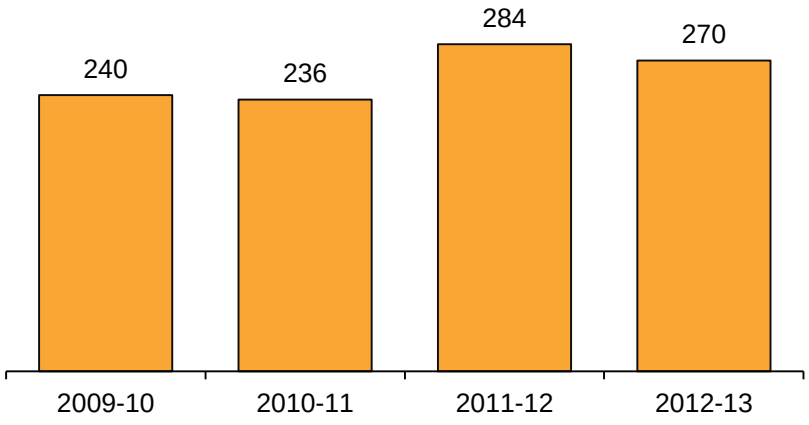
As a result of the Office's enquiries, the public authority reviewed the case and found that the relevant information had been sent by the woman but the certificate had not been issued. The public authority issued the certificate and sent it to the woman by express post. It also undertook staff training to ensure correct procedures were followed in future.

# The Local Government Sector

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

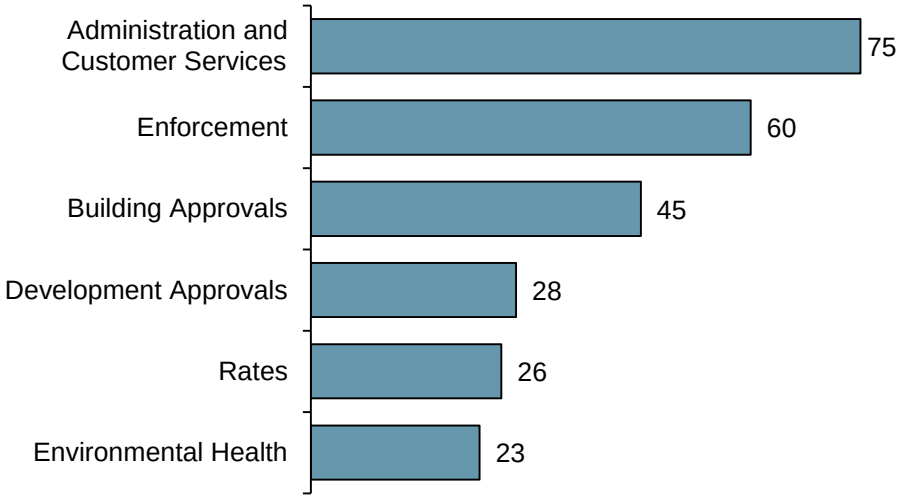
## Local Government

**Complaints received**



## Local Government

### Most common allegations




### Other types of allegations

- Engineering;
- Planning;
- Community Facilities;
- Other approvals and licences; and
- Contracts and property management.

### Outcomes achieved

- Consider or reconsider a matter and make a decision;
- Reversal or significant variation of original decision;
- Action expedited;
- Waiver of fees and charges;
- Change to policy or procedure;
- Change to business system or practices;
- Apology given; and
- Explanation or reasons provided.

Case Study

### Refund of duplicate fee

A woman complained to the Ombudsman that a local government had made an error regarding an application she lodged for planning approval and as a result she was required to lodge another planning application and pay a second application fee.

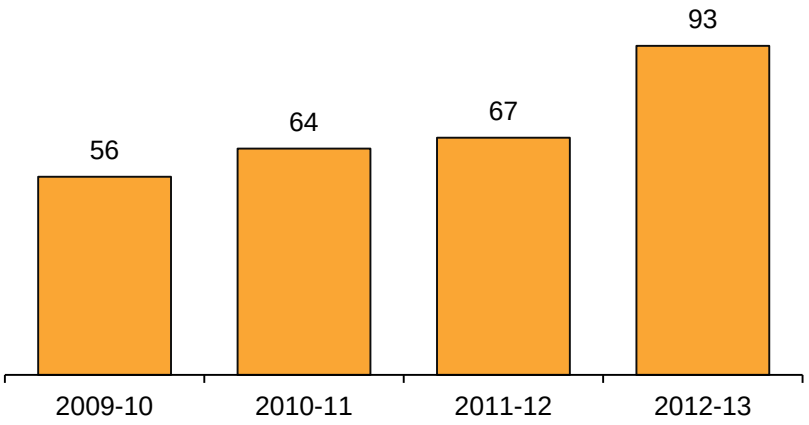
Following enquiries by the Office, the local government found that, in administering its responsibilities under its Planning Scheme, it had made an error to the detriment of the woman. As a result, the local government agreed to provide the woman with a refund in relation to the second application fee.

# The University Sector

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

## Universities

### Complaints received




### Most common allegations


These figures include appeals by overseas students under the *National Code of Practice for Registration Authorities and Providers of Education and Training to Overseas Students 2007.* Further details on these appeals are included later in this section.

### Other types of allegations

- Human resource management issues;
- Parking infringements; and
- Other dealings with the public.

## Universities

**Outcomes Achieved**

- Reversal or significant variation of original decision;
- Completion of units at no charge;
- Change to business system or practices;
- Apology given;
- Explanation given or reasons provided; and
- Staff training.

Case Study

### Retrospective withdrawal granted

A university student complained about his attempt to withdraw from a practicum teaching unit. Due to a number of disruptions the student decided to withdraw from the unit so that it would not be recorded as a failure on his academic record and he would not be charged the cost of the unit. However, the university did not accept the withdrawal application on the basis that the withdrawal date for the unit had already passed.

From its enquiries, the Office became aware that the deadline for withdrawal had been set as the first day of the unit and, therefore, the student had little opportunity to withdraw without a penalty. The Office raised this issue with the University and the matter was reviewed. Following the University's review, the Office was informed that a change had occurred in the way practicum units were recorded affecting the withdrawal dates for these units and that this had not been applied to this student's case.

The University apologised to the student and granted him a retrospective withdrawal from the unit. The University also removed the unit from the student's academic record and gave him an updated transcript at no charge.

## 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 National Code**) sets out standards required of registered providers who deliver education and training to overseas students studying in Australian universities. It provides overseas students with rights of appeal to external, independent bodies if the student is not satisfied with the result or conduct of the internal complaint handling and appeals process.

Overseas students studying with both public and private education providers have access to an Ombudsman who:

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

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

### Complaints Lodged with the Office under the National Code

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

During 2012-13, the Office received 51 complaints about public education and training providers from overseas students. Forty five complaints were about universities, four were about TAFEs and two were about other education agencies.

The most common issues raised by overseas students were decisions about:

- Termination of enrolment (15);
- Fees (14); and
- Transfers between education and training providers (13).

During the year, the Office finalised 46 complaints about 48 issues.

Case Study

## University offers to sponsor student

An overseas student at a Western Australian University was informed by the university that he could not graduate because he had not completed electives at the correct year level. The student complained that the University had changed the structure of the course several times during his period of study and had failed to give him consistent advice as to what was required to complete the course.

As a result of the Office's investigation, the University reviewed the matter and, in acknowledgement of the number of course structural changes that had taken place, offered to sponsor the student to complete two of his three remaining units at no cost to the student.

## Public Interest Disclosures

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

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

During the year, three new disclosures were received.

## Indian Ocean Territories

Under a service delivery arrangement between the Ombudsman and the Australian Government, the Ombudsman handles complaints from residents of the Indian Ocean Territories about public authorities in the Ombudsman's jurisdiction. There were no complaints received during the year.

## Terrorism

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

## Requests for Review

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

Twenty four requests for review were received in 2012-13, less than 1% of the total number of complaints finalised. In all 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;
- The child death review process;
- Notifications and reviews;
- Patterns and trends identified from child death reviews;
- Improvements to public administration to prevent or reduce child deaths; 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 and Family Support (**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.

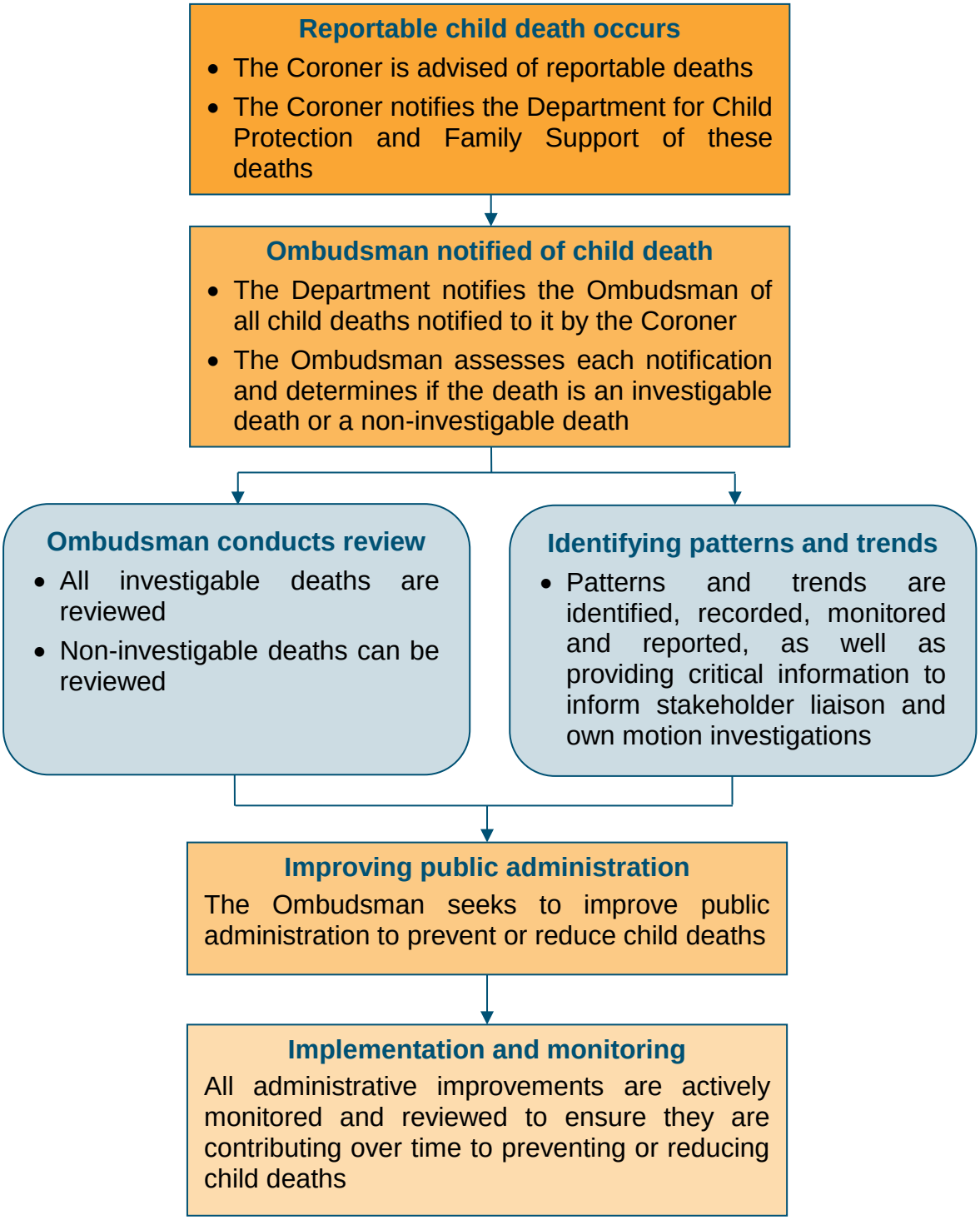
In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

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.

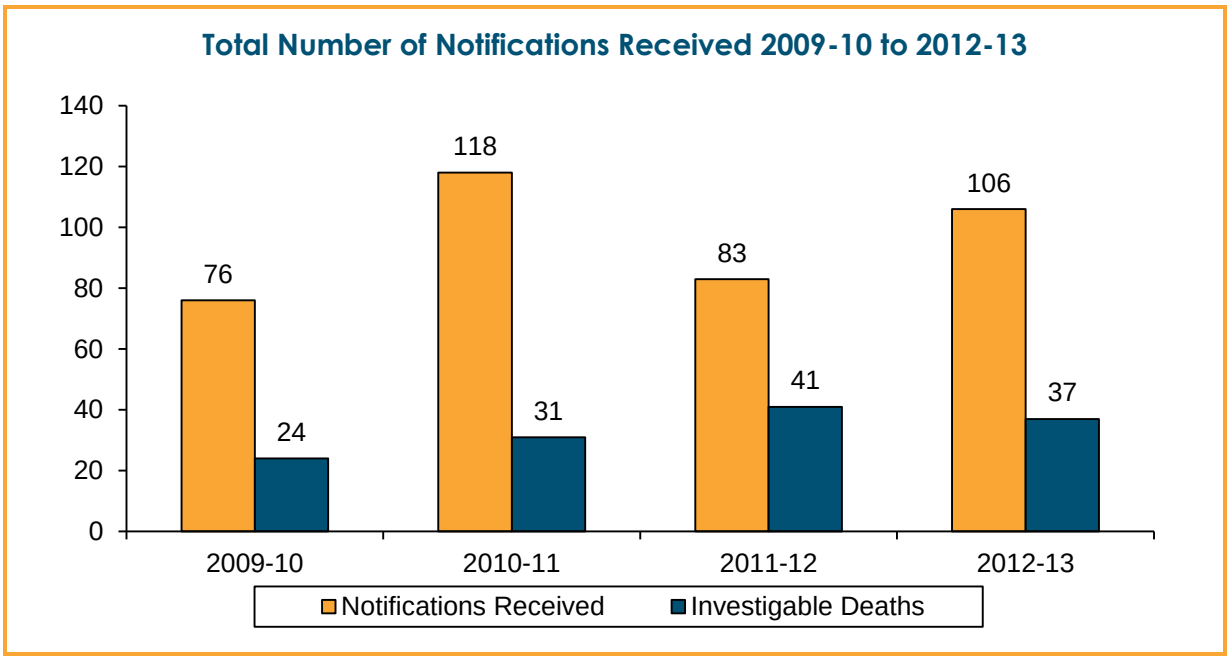
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

### 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 2012-13, there were 37 child deaths that were investigable and subject to review from a total of 106 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 ten years from 2003-04 to 2012-13. 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 | B | C | D |
|---|---|---|---|---|
| | Total WA child deaths (excluding stillbirths) (See Note 1) | Child deaths reported to the Coroner (See Note 2) | Child deaths where the child or a relative of the child was known to the Department (See Note 3) | Reviewable/ investigable child deaths (See Note 4 and Note 5) |
| 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 | 24 |
| 2010-11 | 199 | 118 | 60 | 31 |
| 2011-12 | 144 | 76 | 49 | 41 |
| 2012-13 | 189 | 121 | 62 | 37 |

**Abbreviations**

Department: Department for Child Protection and Family Support for 2012-13, Department for Child Protection for the years 2006-07 to 2011-12 and Department for Community Development (**DCD**) prior to 2006-07.

**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*.
5. The number of investigable child deaths shown in a year may vary, by a small amount, from the number shown in previous annual reports for that year. This occurs because, after the end of the reporting period, further information may become available that requires a reassessment of whether or not the death is an investigable death. Since the commencement of the child death review function this has occurred on one occasion resulting in the 2009-10 number of investigable deaths being revised from 23 to 24.

### 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 2012-13, timely review processes have resulted in 68% of reviews being completed within three months.

## Patterns and Trends Identified from Child Death Reviews

By examining all child death notifications, the Ombudsman is able to capture data relating to demographics, risk factors and 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 and, over time, indicate relevant patterns and trends in relation to the issues associated with child deaths. These patterns and trends are identified, recorded, monitored, reported and analysed. They also provide critical information for own motion investigations, such as the Ombudsman's report, *Investigation into ways that State Government departments can prevent or reduce sleep-related infants deaths,* which was tabled in Parliament in November 2012 and the current own motion investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people.

### Important Information on Interpretation of Data

Information in this section is presented across the first four 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 four 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

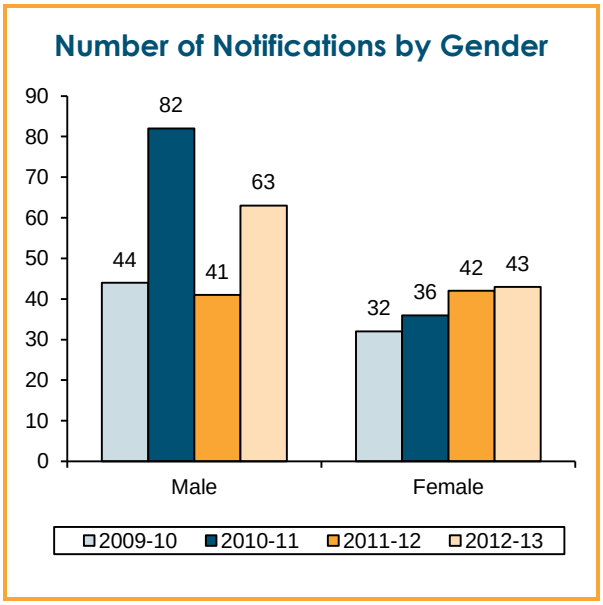
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

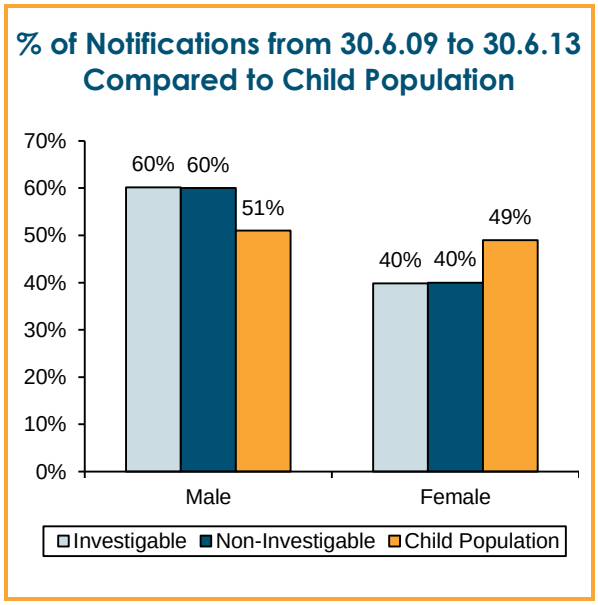
The following charts show:

- The number of children in each group for each year from 2009-10 to 2012-13; and
- For the period from 30 June 2009 to 30 June 2013, 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 four years, male children are over-represented compared to the population for both investigable and non-investigable deaths.

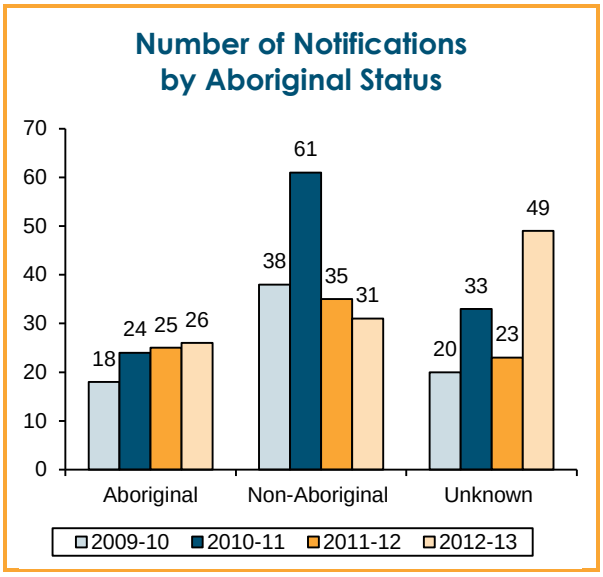


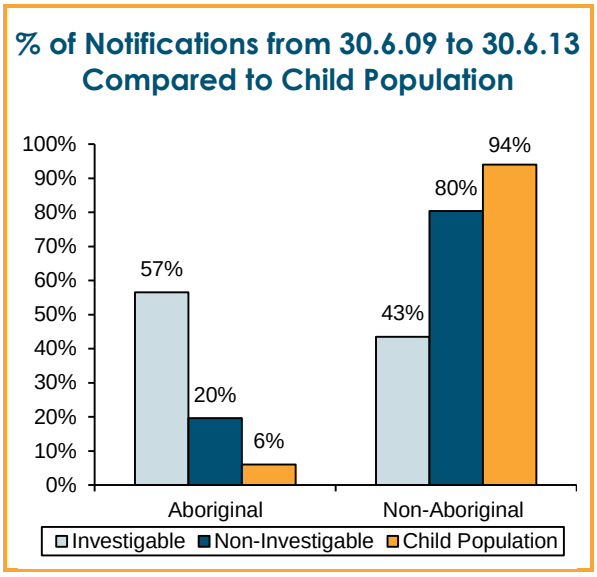




Further analysis of the data shows that, considering all four years, male children are over-represented for all age groups, but particularly for children under the age of one.

## Aboriginal Status

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



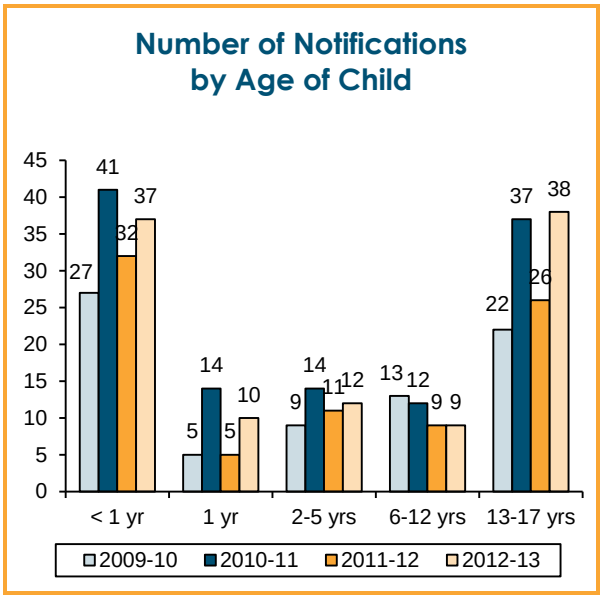



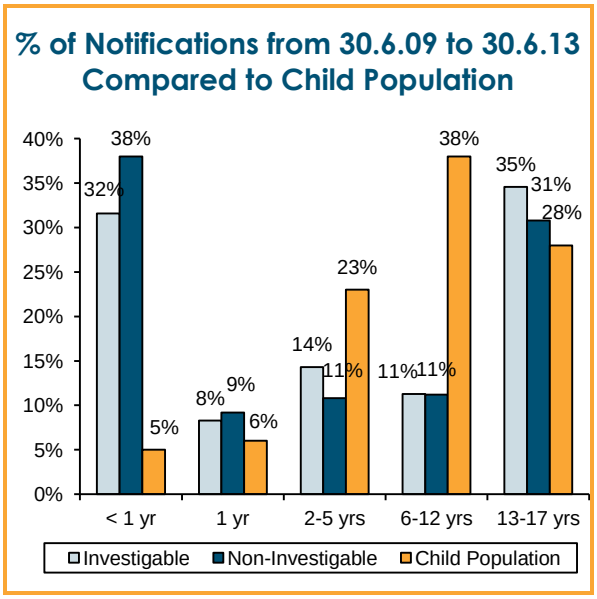

Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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

## Age Groups

As shown in the following charts, children under 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.

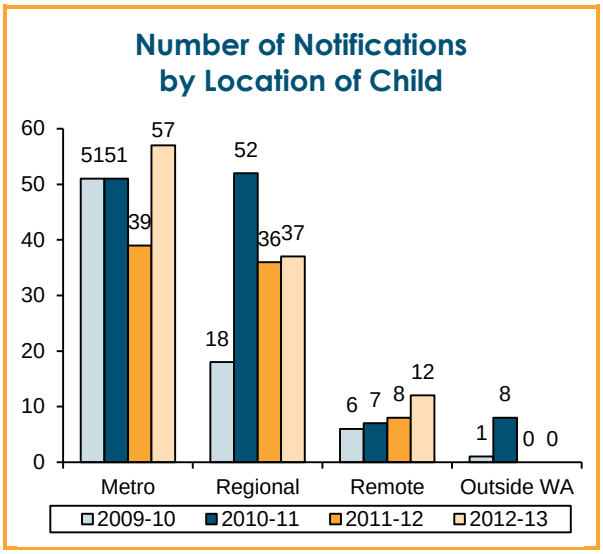


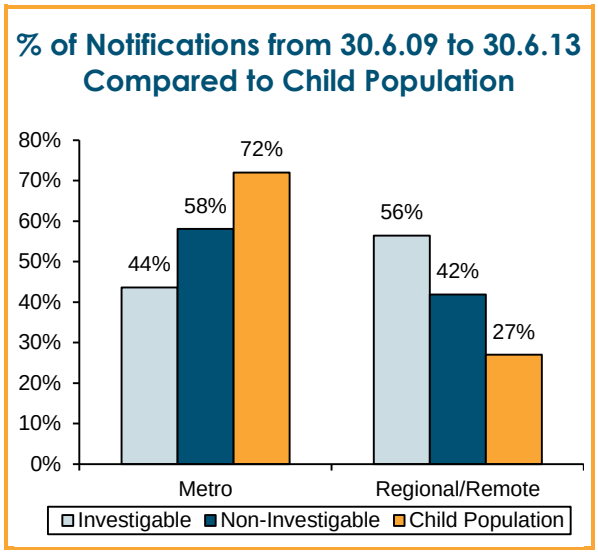




Further analysis of the data shows that a higher proportion of Aboriginal children are under the age of one compared to other age groups. A more detailed analysis by age group is provided later in this section.

## 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 the place of residence of the child.

Further analysis of the data shows that 82% of Aboriginal children who died were living in regional or remote locations when they died. Most non-Aboriginal children who died lived in the metropolitan area but the proportion of non-Aboriginal children who died in regional areas is higher than would be expected based on the child population as a whole.

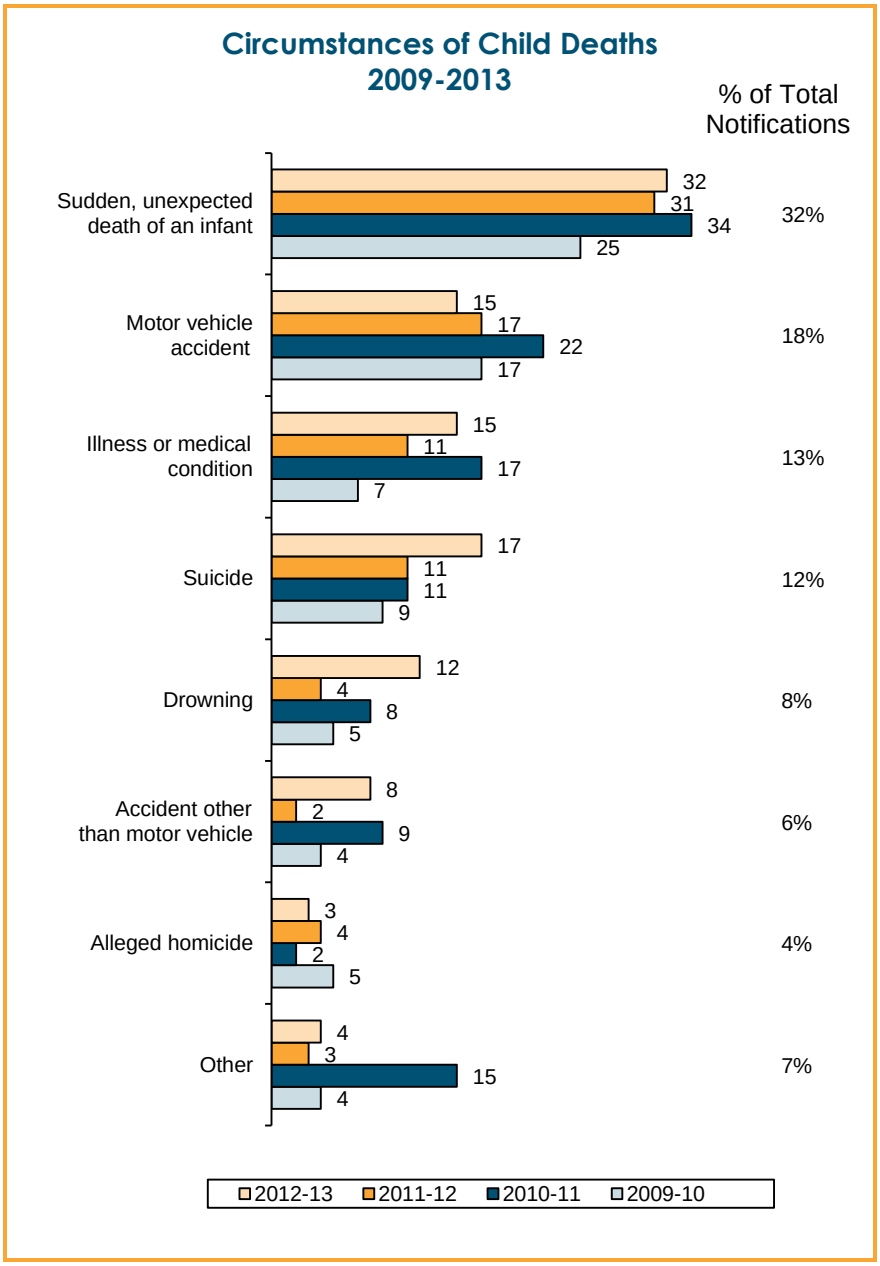
## Circumstances of Child Deaths

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;
- Suicide;
- Drowning;
- Accident other than motor vehicle – this includes accidents such as house fires, electrocution and falls;
- Alleged Homicide; and
- Other.

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



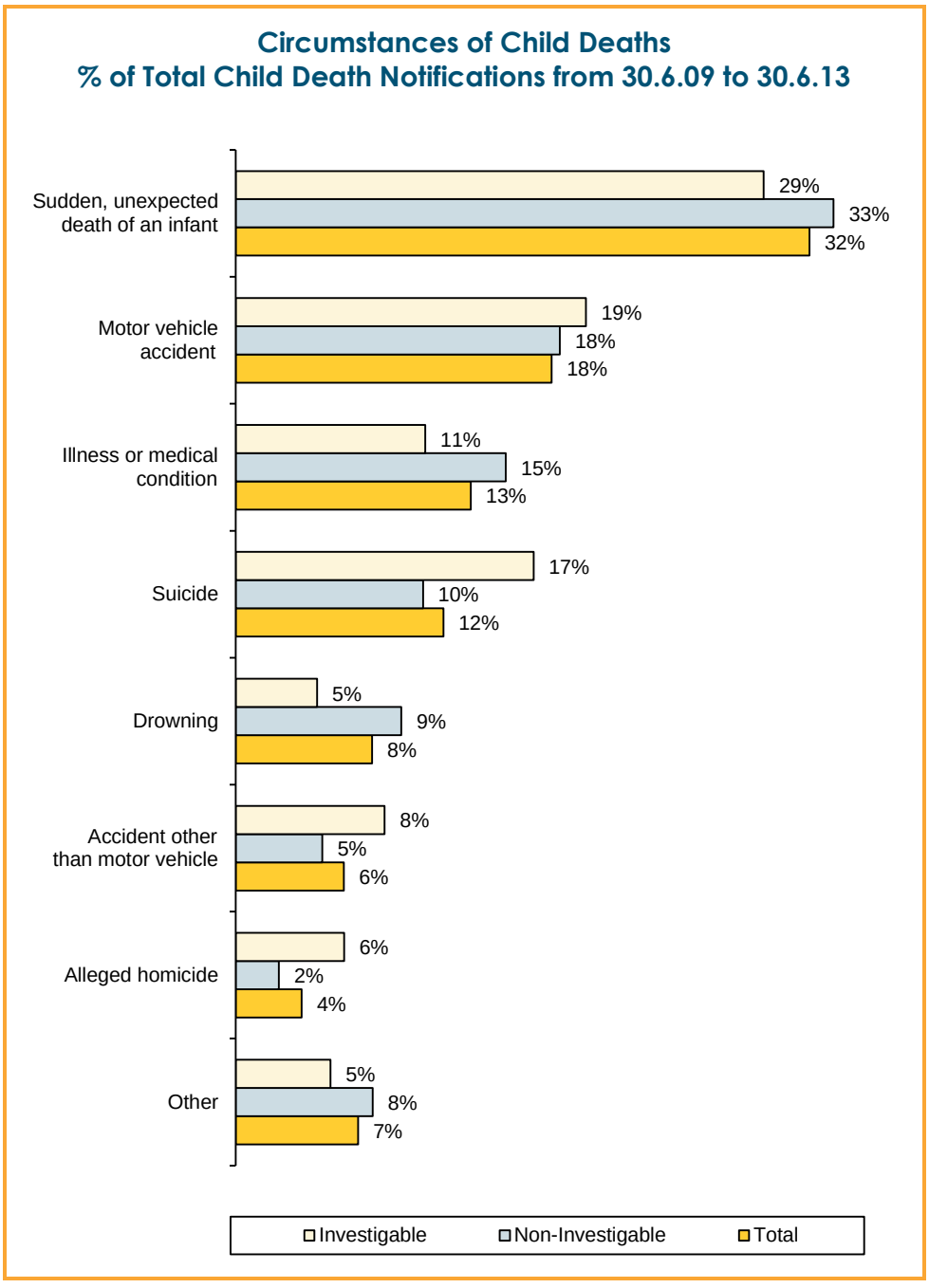

**Note 1:** In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

**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 383 child death notifications received in the four years from 30 June 2009 to 30 June 2013 are:

- Sudden, unexpected deaths of infants, representing 32% of the total child death notifications from 30 June 2009 to 30 June 2013 (33% of the child death notifications received in 2009-10, 29% in 2010-11, 37% in 2011-12 and 30% in 2012-13); and
- Motor vehicle accidents, representing 18% of the total child death notifications from 30 June 2009 to 30 June 2013 (22% of the child death notifications received in 2009-10, 19% in 2010-11, 20% in 2011-12 and 14% in 2012-13).

The following chart provides a breakdown of the circumstances of death for child death notifications 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 | 2 | 17 | 11 | | 4 | 4 | 31 | 11 | 3 |
| 2012-13 | 8 | 15 | 15 | | 3 | 12 | 32 | 17 | 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;
- Parenting/supervision;
- Drug or substance use;
- Alcohol use;
- Homelessness; and
- Parental mental health issues.

Reviews of investigable deaths often highlight the impact of these factors on the circumstances leading up to the child's death and, where this occurs, these factors are recorded to enable an analysis of patterns and trends to assist in considering ways to prevent or reduce future deaths.

It is important to note that the existence of these factors is associative. They do not necessarily mean that the removal of this factor would have prevented the death of a child or that the existence of the factor necessarily represents a failure by the Department or another public authority.

| Social or Environmental Factor | % of Finalised Investigable Deaths |
|---|---|
| Family and domestic violence | 69% |
| Parenting/supervision | 56% |
| Drug or substance use | 33% |
| Alcohol use | 31% |
| Homelessness | 24% |
| Parental mental health issues | 22% |

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 over a third of the cases;
  - Parental mental health issues were a factor in almost a third of the cases; and
  - Parenting/supervision was a co-existing factor in over two thirds of the cases.
- Where alcohol use was present:
  - Family and domestic violence was a co-existing factor in over three quarters of the cases;
  - Homelessness was a factor in almost half of the cases;
  - Parenting/supervision was a co-existing factor in over three quarters of the cases; and
  - Drug or substance use was a co-existing factor in over a quarter of the cases.

## Reasons for Contact with the Department

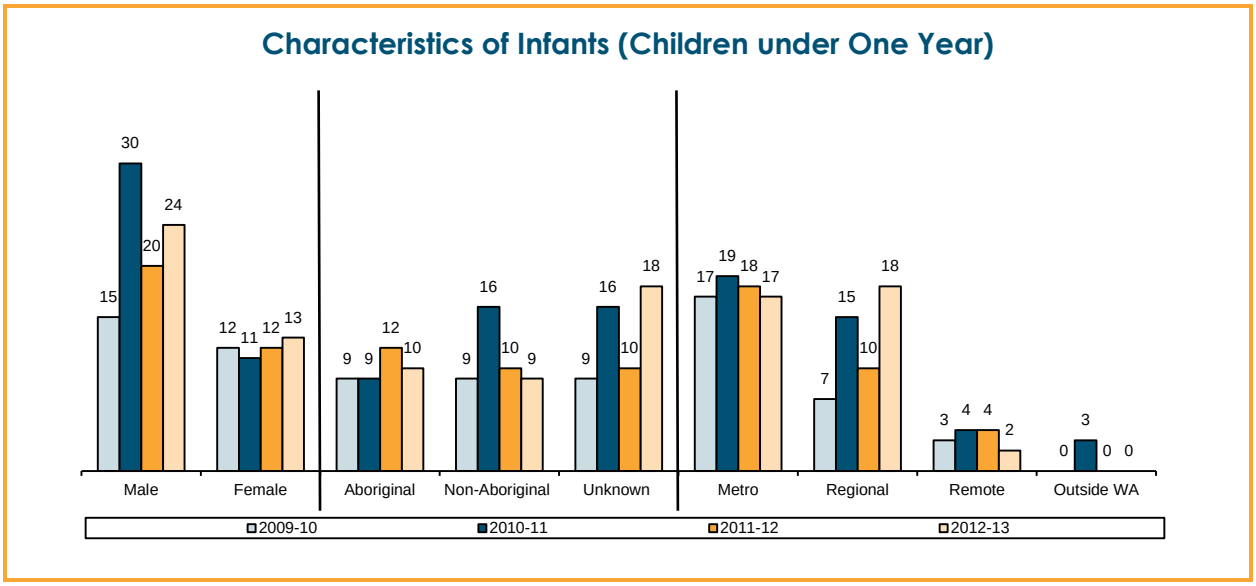
In 2012-13, the majority of children who were known to the Department were known because of contact relating to them or their family for financial problems or concerns for a child's wellbeing. Other reasons included family and domestic violence, parental support and access, foster or adoption enquiries.

## 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 four groupings of children under one year (**infants**), children aged 1 to 5, children aged 6 to 12 and children aged 13 to 17, and demonstrates the learning and outcomes from this age-related focus.

### Deaths of Infants

Of the 383 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2013, 137 (36%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.

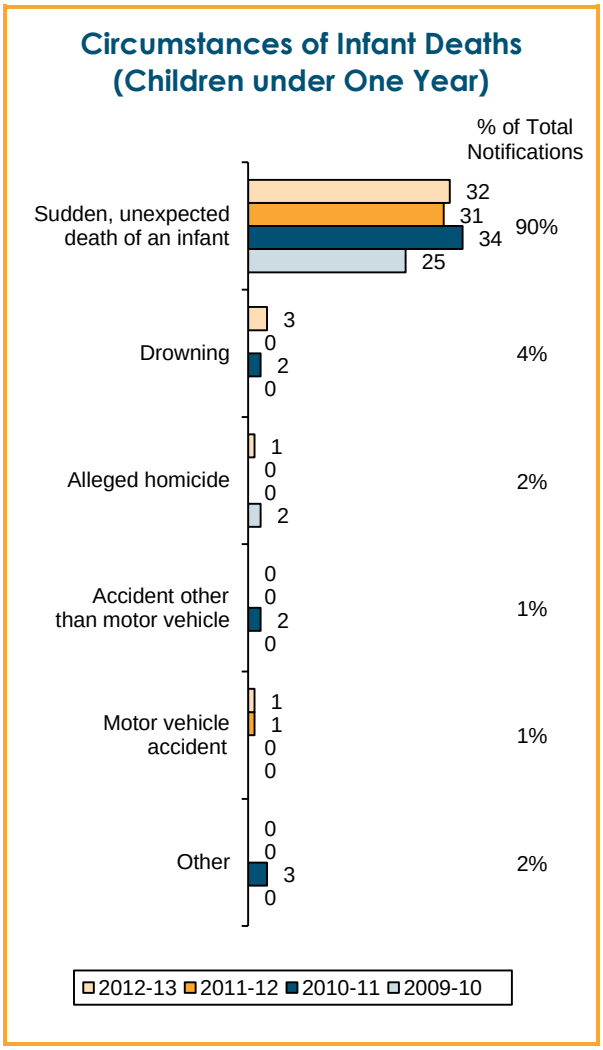


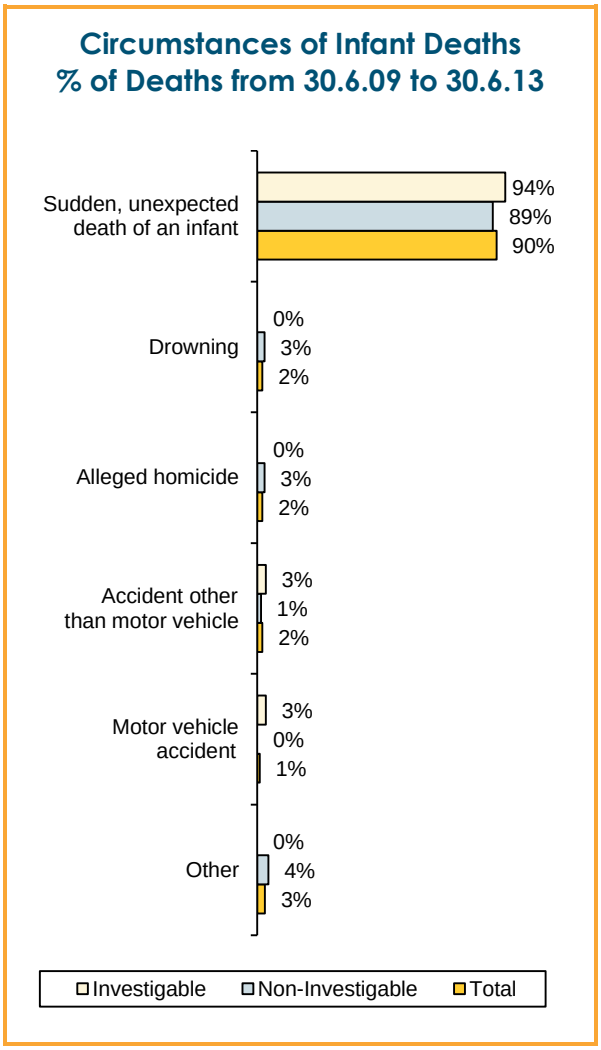

Further analysis of the data showed that, for these infant deaths, there was an over-representation compared to the child population for:

- Males – 81% of investigable infant deaths and 58% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 68% of investigable deaths and 34% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 57% of investigable infant deaths and 42% of non-investigable deaths of infants, living in Western Australia, were children living in regional or remote locations compared to 27% in the child population.

An examination of the patterns and trends of the circumstances of infant deaths showed that of the 137 infant deaths, 122 (89%) were categorised as sudden, unexpected deaths of an infant and the majority of these (80) 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.



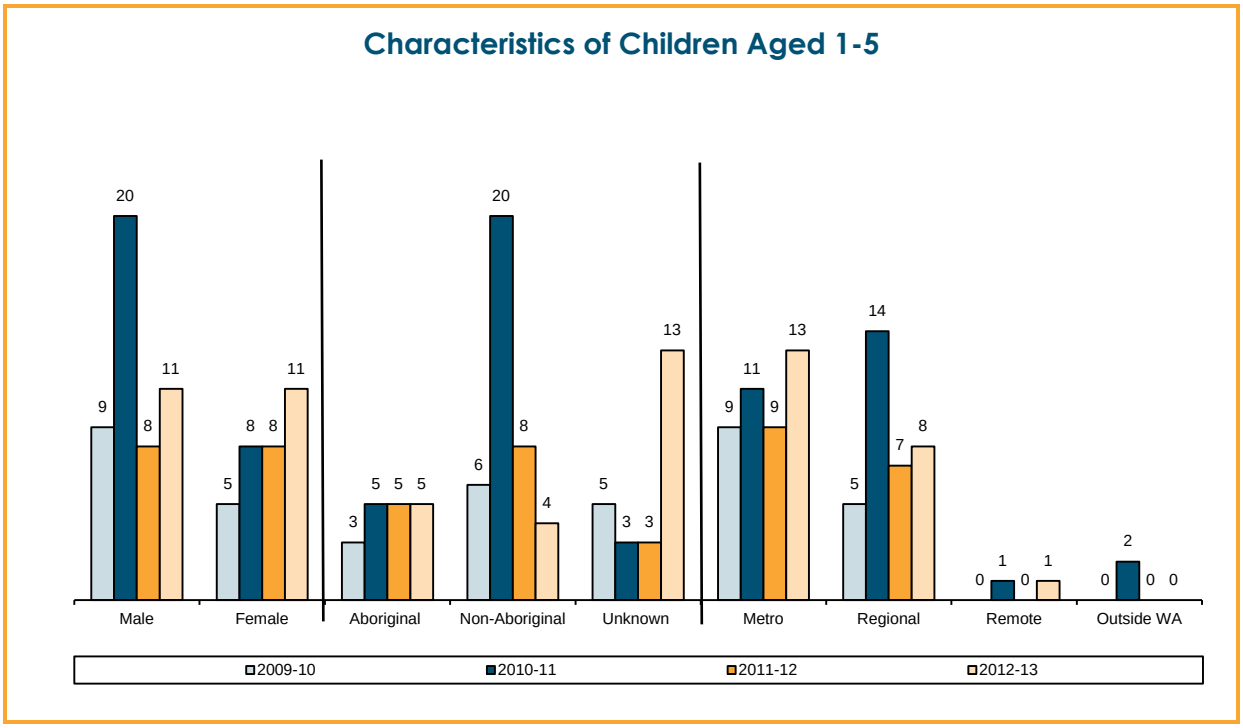




Forty two infant death notifications received from 30 June 2009 to 30 June 2013 were determined to be investigable deaths.

## Deaths of Children Aged 1 to 5 Years

Of the 383 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2013, 80 (21%) related to children aged from 1 to 5 years.

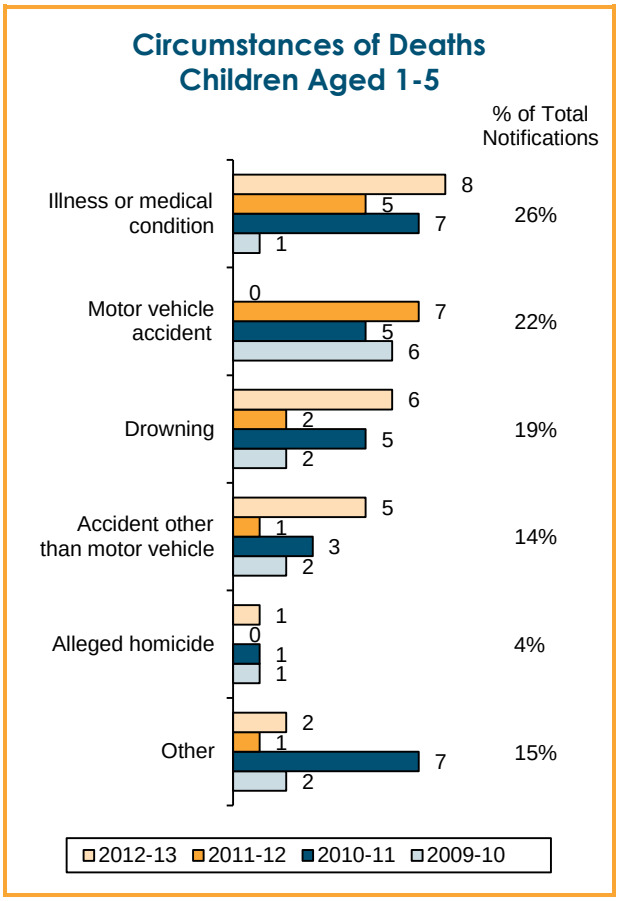
The characteristics of children aged 1 to 5 are shown in the following chart.

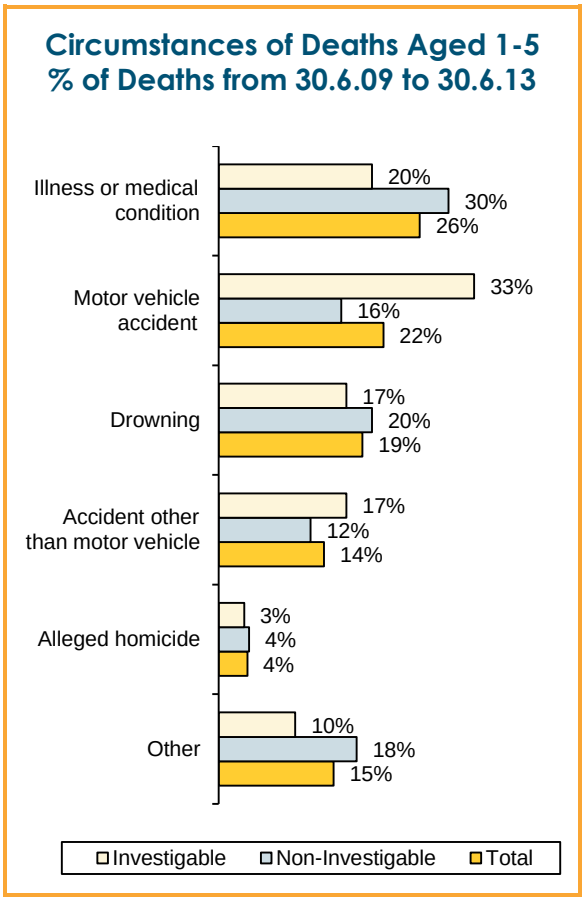



Further analysis of the data showed that, for these deaths, there was an over-representation compared to the child population for:

- Males – 60% of investigable deaths and 60% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Aboriginal children – 56% of investigable deaths and 10% of non-investigable deaths of children aged 1 to 5 were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 50% of investigable deaths and 42% of non-investigable deaths of children aged 1 to 5, living in Western Australia, were children living in regional or remote locations compared to 27% in the child population.

As shown in the following chart, illness or medical condition is the most common circumstance of death for this age group (26%), particularly for investigable deaths, followed by motor vehicle accidents (22%) and drowning (19%).



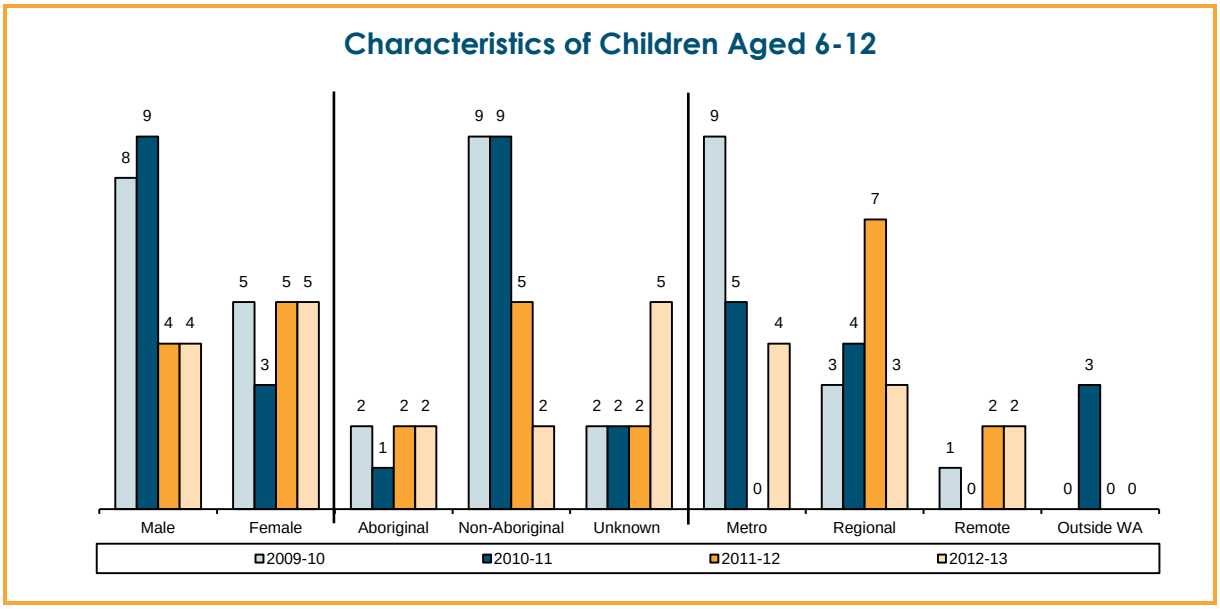




Thirty deaths of children aged 1 to 5 years were determined to be investigable deaths.

## Deaths of Children Aged 6 to 12 Years

Of the 383 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2013 there were 43 (11%) related to children aged from 6 to 12 years.

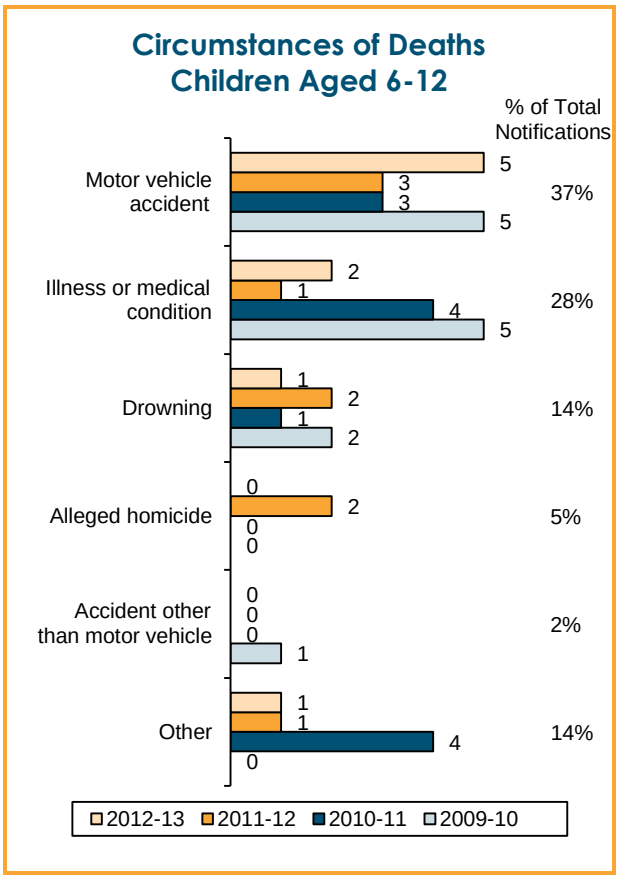
The characteristics of children aged 6 to 12 are shown in the following chart.

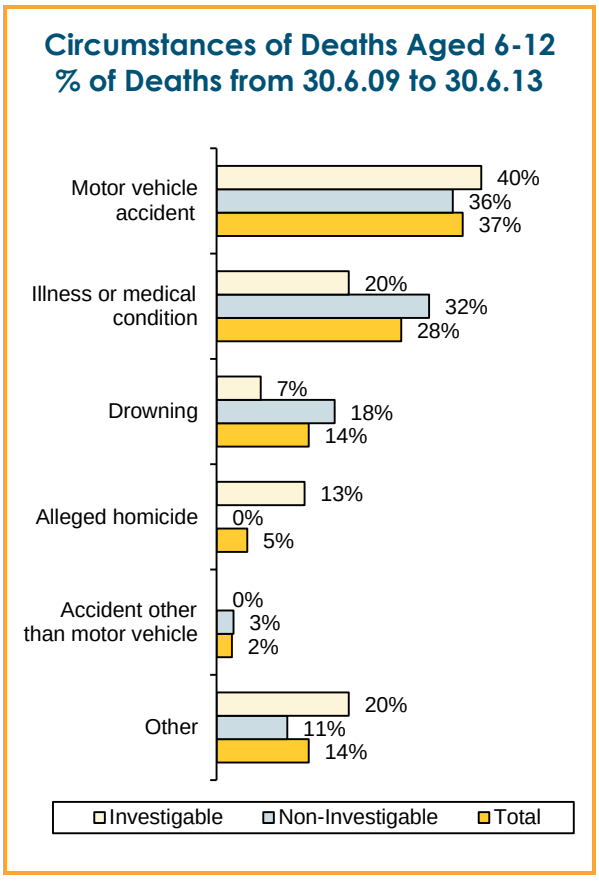


Further analysis of the data showed, for these deaths, there was an over-representation compared to the child population for:

- Males – 68% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population. However, this over-representation is not present in investigable deaths as 40% of investigable deaths were male;
- Aboriginal children – 31% of investigable deaths and 16% of non-investigable deaths of children aged 6 to 12 were Aboriginal children compared to 6% in the child population. However, the discrepancy for Aboriginal children is less in this age group than in other age groups; and
- Children living in regional or remote locations – 67% 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 27% in the child population.

As shown in the following chart, motor vehicle accidents are the most common circumstance of death for this age group (37%), particularly for investigable deaths, followed by illness or medical conditions (28%) and drowning (14%).



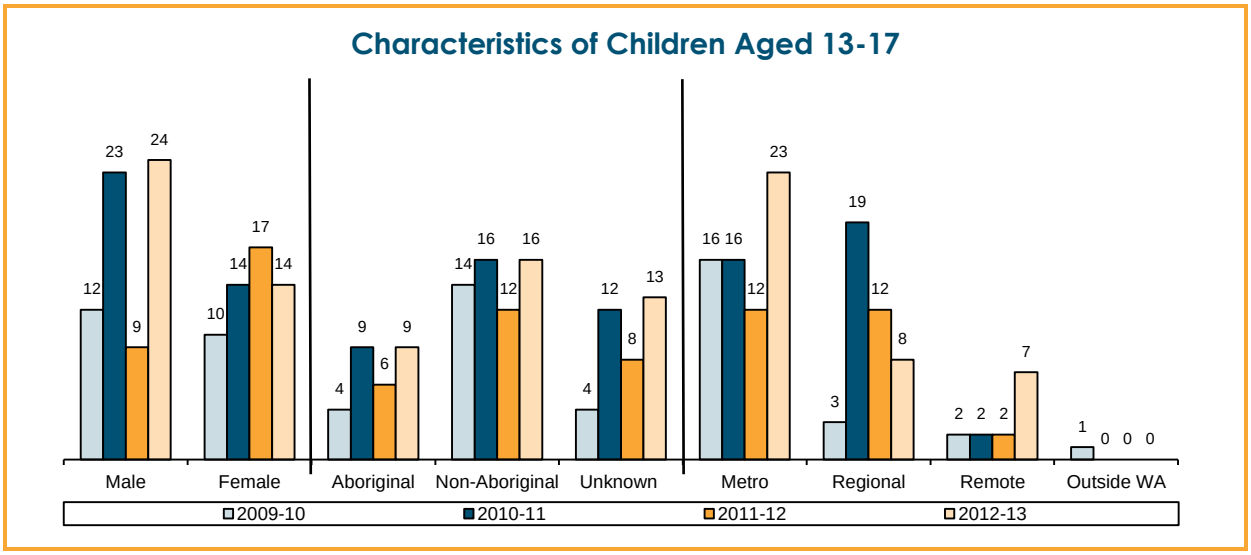




Fifteen deaths of children aged 6 to 12 years were determined to be investigable deaths.

## Deaths of Children Aged 13 – 17 Years

Of the 383 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2013, 123 (32%) related to children aged from 13 to 17 years.

The characteristics of children aged 13 to 17 are shown in the following chart.

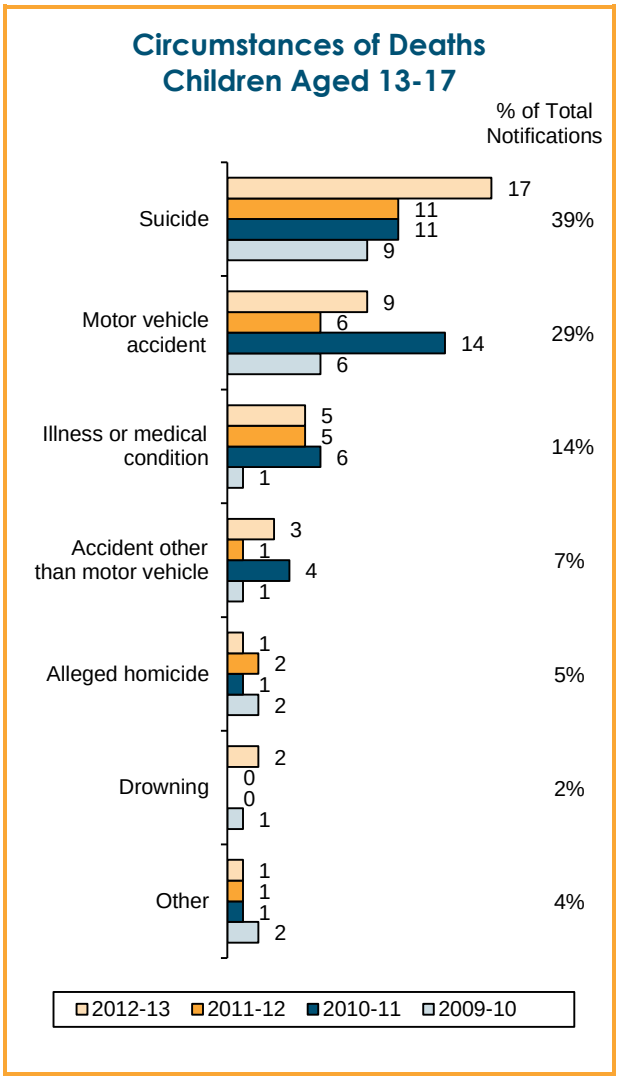


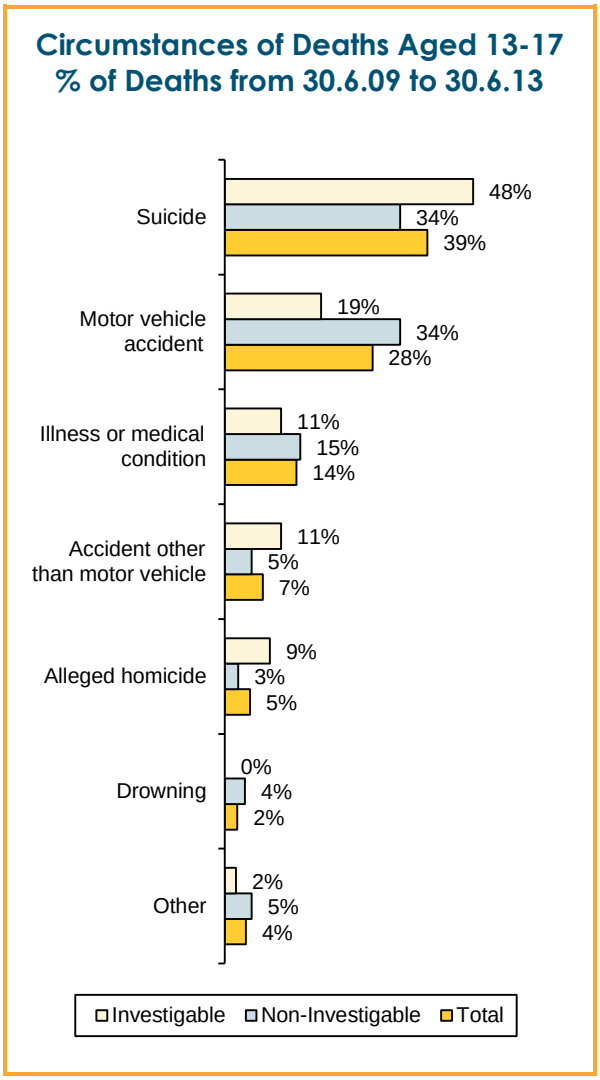

Further analysis of the data showed that, for these deaths, there was an over-representation compared to the child population for:

- Aboriginal children – 56% of investigable deaths and 11% of non-investigable deaths of children aged 13 to 17 were Aboriginal compared to 6% in the child population; and

- Children living in regional or remote locations – 57% of investigable deaths and 38% of non-investigable deaths of children aged 13 to 17, living in Western Australia, were living in regional or remote locations compared to 27% in the child population.

As shown in the following chart, suicide is the most common circumstance of death for this age group (39%), particularly for investigable deaths, followed by motor vehicle accidents (28%) and illness or medical conditions (14%).



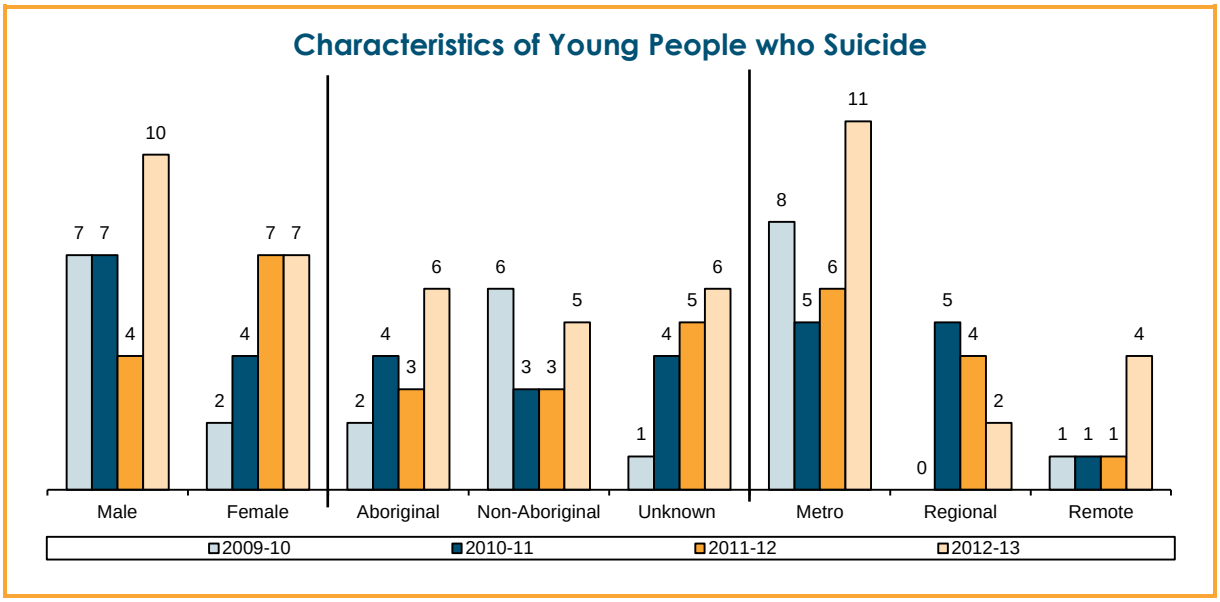

Forty six deaths of children aged 13 to 17 years were determined to be investigable deaths.

All children who apparently took their own lives were in the 13 to 17 year age cohort.

Of the 48 young people who apparently took their own lives from 30 June 2009 to 30 June 2013:

- One was 13 years old;
- Four were 14 years old;
- Fourteen were 15 years old;
- Twelve were 16 years old; and
- Seventeen were 17 years old.

The characteristics of the young people who took their own lives 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:

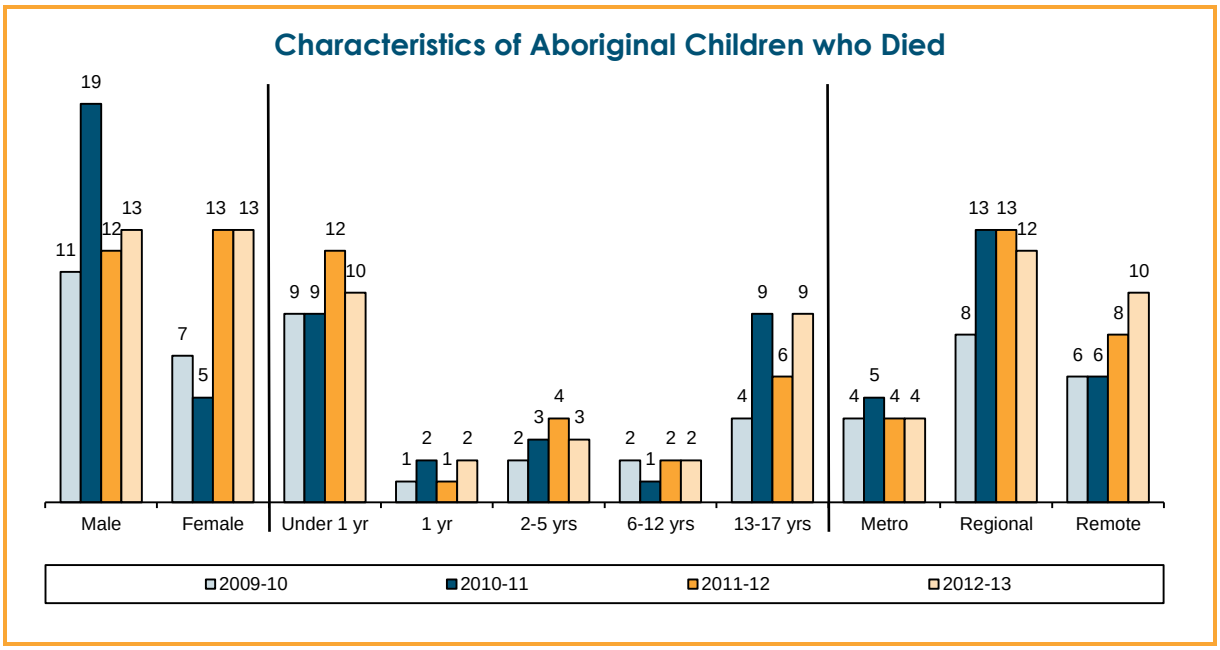
- Males – 50% of investigable deaths, and 65% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people - For the 32 apparent suicides by young people where information on the Aboriginal status of the young person was available, 12 (60%) of the investigable deaths and 25% of non-investigable deaths were Aboriginal young people compared to 6% in the child population; and
- Young people living in regional and remote locations - The majority of apparent suicides by young people occurred in the metropolitan area, but 55% of investigable youth suicides and 23% of non-investigable youth suicides were young people who were living in regional or remote locations compared to 27% in the child population.

**Deaths of Aboriginal Children**

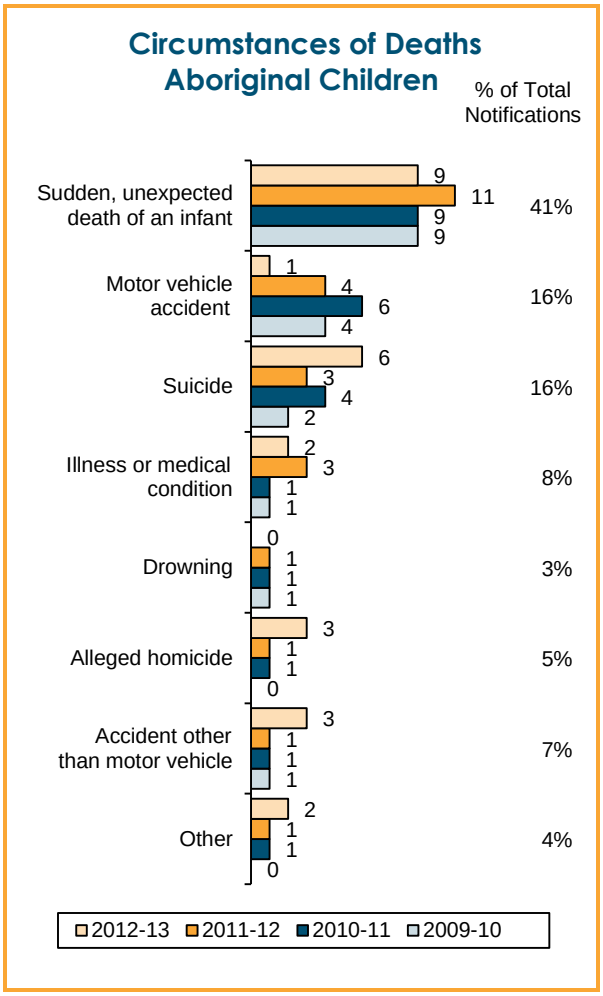
Of the 258 child death notifications received from 30 June 2009 to 30 June 2013, where the Aboriginal status of the child was known, 93 (36%) of the children were identified as Aboriginal.

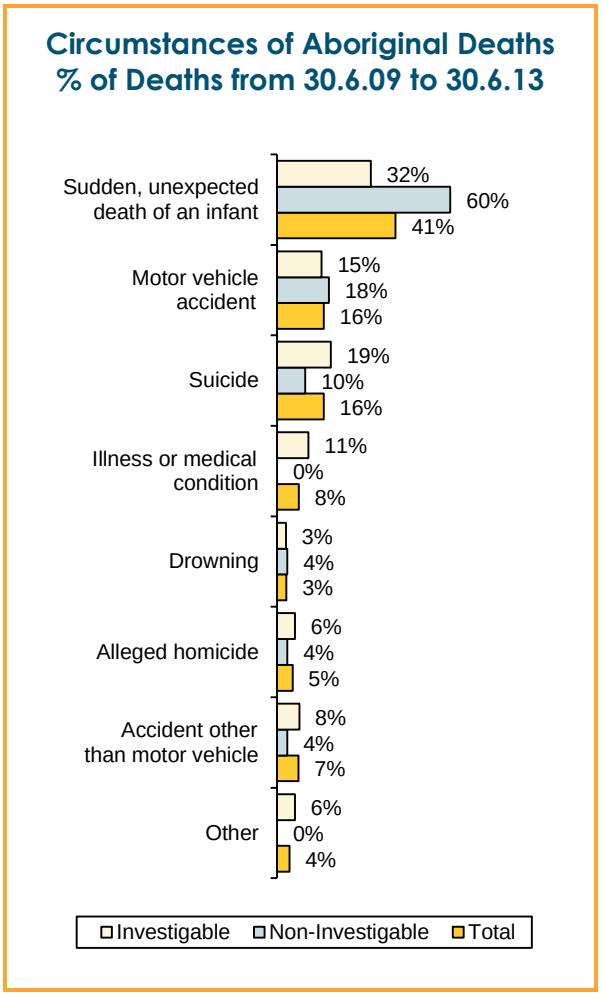
For the notifications received, the following chart demonstrates:

- Over the four year period from 30 June 2009 to 30 June 2013, the majority of Aboriginal children who died were male (59%) but for 2012-13 the numbers of male and female Aboriginal children who died are the same;
- The infant and youth groupings are the largest age range categories; and
- Regional and remote Aboriginal child deaths far outnumber the deaths of the Aboriginal children living in the metropolitan area. Over the four year period, 82% of Aboriginal 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 Aboriginal 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 in this section has been set out as follows:

- Issues identified in child death reviews;
- Administrative improvements to address issues;
- Outcomes of reviews by age cohort;
- Major own motion investigations arising from child death reviews (including future own motion investigations arising from the monitoring of reviews); and
- Other mechanisms to prevent or reduce child deaths.

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 conducting a thorough Safety and Wellbeing Assessment and as a result potentially not identifying future risks and working to reduce risks.
- Not using a trained Specialist Child Interviewer when conducting an interview related to an allegation of sexual abuse.
- Not undertaking an assessment of, and planning for support for, family placement arrangements.
- Not providing effective supervision and training to support staff in implementing policy requirements.
- Not meeting policies and procedures relating to Safety and Wellbeing Assessments.
- Not meeting policies and procedures relating to the Signs of Safety Framework.
- Missed opportunity to actively promote the parenting capacity of an adolescent parent, and as a result, promoting the safety and wellbeing of the unborn child.
- Missed opportunities to provide interagency responses.
- Not meeting record keeping requirements.

## Administrative Improvements to Address Issues

To address the types of issues identified during the Ombudsman's reviews, the agencies involved undertook to carry out a range of actions. The following are the types of administrative improvements arising from child death reviews:

- Developing policy to formalise the process for interviewing children following disclosure of sexual abuse.
- Enhancing practice guidelines to clarify the requirements for conducting Safety and Wellbeing Assessments.
- Establishing a fulltime 'Team Leader' position in a District Office to create effective and efficient supervision and support to staff including prioritising workload and embedding new practice requirements.
- Reiterating requirements, for reports of alleged sexual abuse, in relation to examining cumulative knowledge from past contacts when undertaking Safety and Wellbeing Assessments, and planning for reducing the risk of potential future abuse.
- Providing staff with guidance for working with pregnant adolescents, where there may be child protection concerns, to promote the safety and wellbeing of that adolescent and her future child.
- Improving record keeping practices.

## 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 review of infant deaths has again highlighted that promoting safe sleeping practices is a key issue. This issue was examined in depth by the Ombudsman's major own motion investigation in relation to sleep-related infant deaths, the details of which are set out in the Own Motion Investigations and Administrative Improvement section.

#### Promoting safe sleeping and wellbeing practices for vulnerable infants

The Ombudsman's examination of the reviews of infant deaths has highlighted the importance of public authorities, working collaboratively to address social and environmental risk factors, to promote the wellbeing of, and safe sleeping practices for, vulnerable infants. This issue was examined in depth by the Ombudsman's major own motion investigation in relation to sleep-related infant deaths, the details of which are set out in the Own Motion Investigations and Administrative Improvement section.

### Deaths of Children Aged 1 to 5 Years

As in previous years, the Ombudsman's examination of reviews of deaths of children aged 1 to 5 years has highlighted supervision of the child as a key issue in preventing fatal accidents.

#### Supervision of young children

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 has little awareness of danger. Kidsafe WA has identified supervision as an important factor in reducing the risk of injury and death for this age group.

### Deaths of Children Aged 6 to 12 Years

The Ombudsman's examination of reviews of deaths of children aged 6 to 12 years has identified the critical nature of certain core health and education needs. Where these children are in the CEO's care, interagency cooperation between the Department, the Department of Health and the Department of Education in care planning is necessary to ensure the child's health and education needs are met.

#### Care planning for children in the CEO's care

The Ombudsman's 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.

The implementation of the recommendations in the report, and improvement in care planning, is actively monitored in individual child death reviews, as outlined in the following case study.

Case Study

## Child A

Child A had been physically harmed as an infant, which had resulted in an acquired brain injury. Child A had subsequently been taken into the CEO's care and placed with a foster carer. Child A had high care needs associated with her physical and intellectual disabilities and complex medical history. Child A died, aged 7 years, from her complex medical condition.

Regular communication and collaboration with the foster carers, and with Child A's school, medical and therapy services was documented. Child A's care planning included a health care plan and an education plan. It was clear from the review of this case that there was a positive interagency partnership working to promote Child A's quality of life and wellbeing.

**Deaths of Children Aged 13 to 17 Years**

Youth suicide has been identified as the primary circumstance of death for young people aged 13 to 17. The Ombudsman has commenced a major own motion investigation into youth suicide in 2012-13, which will be finalised in 2013-14. Details of own motion investigations are provided in the Own Motion Investigations and Administrative Improvement section.

The Ombudsman's examination of reviews of deaths of young people aged 13 to 17 has identified a range of risk factors including criminal behaviours, school truancy, homelessness and isolation from supports.

Case Study

## Adolescent B

Adolescent B came from a home environment of alleged family and domestic violence and alcohol abuse. From an early age, Adolescent B moved around regional Western Australia, staying with different family members. Adolescent B died from apparent suicide.

Adolescent B was enrolled at four different schools in the last three years of his life, but his attendance was poor. At the school Adolescent B was enrolled in, during the last year of his life, school attendance had been identified as a broader community issue and the school was actively working with the community to develop strategies to improve attendance. Suicide was also an issue for the community and the school had developed a plan and actions to reduce the risk of suicide. These actions were still being implemented at the time of Adolescent B's death.

This case highlighted that a child's poor school attendance may indicate the existence of child wellbeing concerns, requiring a multi-agency and community response.

### Identification of Good Practice

Reviews may identify examples of good practice by agencies as shown in the following case study.

Case Study

## Adolescent C

Adolescent C's death in a motor vehicle accident was associated with risk taking behavior (speeding and alcohol consumption). Adolescent C grew up in a home environment where there was alleged family and domestic violence, and alcohol and drug abuse. Adolescent C had a history of conflict with his mother, and chose not to remain living at home. Adolescent C would stay with friends, where he was allegedly exposed to drug taking and criminal activity.

Adolescent C was enrolled at a regional high school, but it was noted that he was regularly absent. The review found that Adolescent C's school undertook a number of actions to re-engage Adolescent C in school and provide support. This included meetings with Adolescent C, liaison with Adolescent C's family, liaison with other agencies (including juvenile justice services, Centrelink and community accommodation agencies) and referral to the Department of Education's retention and participation services. The school explored traineeship options with Adolescent C and tried to engage him with counselling support but he declined. The school also identified that Adolescent C's truancy and behavioural issues were a result of underlying child protection risks, and referred their concerns appropriately.

Though Adolescent C did not attend class, he would attend school to speak with student support services, to discuss issues he was experiencing and seek help. It was clear from the review that Adolescent C was provided with a great deal of support from the school.

### Major Own Motion Investigations Arising from Child Death Reviews

In addition to taking action on individual child deaths, the Office identifies patterns and trends arising out of child death reviews to inform major own motion investigations that examine the practices of public authorities that provide services to children and their families. During the year, the Ombudsman undertook significant work on a major own motion investigation into suicide by young people and the report of this investigation is to be tabled in Parliament in 2013-14. Additionally, the Ombudsman tabled in Parliament the report of a major own motion investigation into sleep-related infant deaths.

The Ombudsman also monitored the completion of the recommendations from the own motion investigation on planning for children in care.

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

### Other Mechanisms to Prevent or Reduce Child Deaths

In addition to reviews of individual child deaths and 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.

## Stakeholder Liaison

### The Department for Child Protection and Family Support

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 Ombudsman's Advisory Panel

The Ombudsman's 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 in 2012-13 and during the year, the following members provided 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 Donna Chung (School of Population Health, University of Western Australia);
- Ms Cissy Cox (Group Coordinator, Social Outreach and Advocacy, St John of God Health Care);
- Ms Angela Hartwig (Women's Council for Domestic and Family Violence Services WA);
- Ms Vicky Hovane (Consultant);
- Ms Jocelyn Jones ( Health Sciences, Curtin University); and
- Professor Helen Milroy (Director, Centre for Aboriginal Medical and Dental Health, University of Western Australia).

Observers from the Department for Child Protection and Family Support, the Department of Health, Department of Aboriginal 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 two major own motion investigations:

- An investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths; and
- An investigation into ways State Government departments and authorities can prevent or reduce suicide by young people.

### Other Key Stakeholder Relationships

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

- The Coroner;
- Public authorities that have involvement with children and their families including:
  - Department of Housing;
  - Department of Health;
  - Department of Education;
  - Department of Corrective Services;
  - Department of Aboriginal Affairs;
  - Western Australia Police; and
  - 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.

## Aboriginal and Regional Communities

Significant work continued throughout the year to build relationships relating to the child death review jurisdiction with Aboriginal 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 Aboriginal people; and
- Aboriginal community leaders to increase the awareness of the child death review function and its purpose.

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

As part of this work, Ombudsman staff met with a number of Aboriginal community leaders, Aboriginal Health Services, local governments, Western Australia Police and Department staff and community advocates in these regions.

# Family and Domestic Violence Fatality Review

On 1 July 2012, the Office commenced an important new function to review family and domestic violence fatalities. This section sets out the work of the Office in its first year of operation in relation to its family and domestic violence fatality review function. During the first year of operation of this new function, significant work has been undertaken to develop structures and processes to ensure the function is undertaken effectively and efficiently. Information on this work has been divided as follows:

- Background;
- The role of the Office in family and domestic violence fatality reviews;
- The family and domestic violence fatality review process;
- Notifications and reviews;
- Patterns and trends identified from family and domestic violence fatality reviews;
- Issues arising from family and domestic violence fatality reviews;
- Major own motion investigations;
- Other mechanisms to prevent or reduce family and domestic violence fatalities; and
- Stakeholder liaison.

It is important to note that the annual reporting of the work of the Office on its family and domestic violence fatality review function will, in a very similar manner to annual reporting of the child death review function undertaken by the Office, develop over future annual reports, in accordance with information identified from undertaking reviews over multiple years. This will include case studies and further information and analysis on underlying patterns and trends over time arising from family and domestic violence fatality reviews.

Additionally, in 2013-14 the Office will commence its first major own motion investigation into family and domestic violence fatalities to be tabled in Parliament in 2014. This own motion investigation, the first of a series of major own motion investigations to be undertaken by the Office as part of its family and domestic violence fatality review function, will comprehensively examine critical issues, patterns or trends arising from individual reviews of family and domestic violence fatalities undertaken by the Office.

## Background

The *National Plan to Reduce Violence against Women and their Children 2010-2022* (**the National Plan**) identifies six key national outcomes:

- Communities are safe and free from violence;
- Relationships are respectful;
- Indigenous communities are strengthened;
- Services meet the needs of women and their children experiencing violence;
- Justice responses are effective; and
- Perpetrators stop their violence and are held to account.

The National Plan is endorsed by the Council of Australian Governments. The *WA Strategic Plan for Family and Domestic Violence 2009-13* (**WA Strategic Plan**) includes the following principles:

1. Family and domestic violence and abuse is a fundamental violation of human rights and will not be tolerated in any community or culture.
2. Preventing family and domestic violence and abuse is the responsibility of the whole community and requires a shared understanding that it must not be tolerated under any circumstance.
3. The safety and wellbeing of those affected by family and domestic violence and abuse will be the first priority of any response.
4. Perpetrators of family and domestic violence and abuse will be held accountable for their behaviour and acts that constitute a criminal offence will be dealt with accordingly.
5. Responses to family and domestic violence and abuse can be improved through the development of an all-inclusive approach in which responses are integrated and specifically designed to address safety and accountability.
6. An effective system will acknowledge that to achieve substantive equality, partnerships must be developed in consultation with specific communities of interest including people with a disability, people from diverse sexualities and/or gender, people from Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds.
7. Victims of family and domestic violence and abuse will not be held responsible for the perpetrator's behaviour.
8. Children have unique vulnerabilities in family and domestic violence situations, and all efforts must be made to protect them from short and long term harm.

The associated *Annual Action Plan 2009-10*, identified a range of strategies including a 'capacity to systematically review family and domestic violence deaths and improve the response system as a result'. The Annual Action Plan set out 10 key actions to progress the development and implementation of the integrated response in 2009-10, including the need to 'research models of operation for family and domestic violence fatality review committees to determine an appropriate model for Western Australia' (also see *Western Australia's Family and Domestic Violence Prevention Strategy to 2022*).

Following a Government working group process examining models for a family and domestic violence fatality review process, the Government requested that the Ombudsman undertake responsibility for the establishment of a family and domestic violence fatality review function.

On 1 July 2012 the Office commenced its family and domestic violence fatality review function.

### Establishment of the Family and Domestic Violence Fatality Review Role

It was essential to the success of the establishment of the family and domestic violence fatality review role that the Office identified and engaged with a range of key stakeholders in the implementation and ongoing operation of the role. It was important that stakeholders understood the role of the Ombudsman, and the Office was able to understand the critical work of all key stakeholders.

Working arrangements were established to support implementation of the role with Western Australia Police (**WAPOL**) and the Department for Child Protection and Family Support (**DCPFS**) and with other agencies, such as the Department of Corrective Services (**DCS**) and the Department of the Attorney General (**DOTAG**), and relevant courts.

The Office's Child Death Review Advisory Panel was expanded to include the new family and domestic violence fatality review role. Through the Ombudsman's Advisory Panel (**the Panel**), and regular liaison with key stakeholders, the Office gains valuable information to ensure its review processes are timely, effective and efficient.

The Office has also accepted invitations to speak at relevant seminars and events to explain its role in regard to family and domestic violence fatality reviews, engaged with other family and domestic violence fatality review bodies in Australia and New Zealand and, since 1 July 2012, has met regularly via teleconference with the Australian Domestic and Family Violence Death Review Network.

## The Role of the Office in Family and Domestic Violence Fatality Reviews

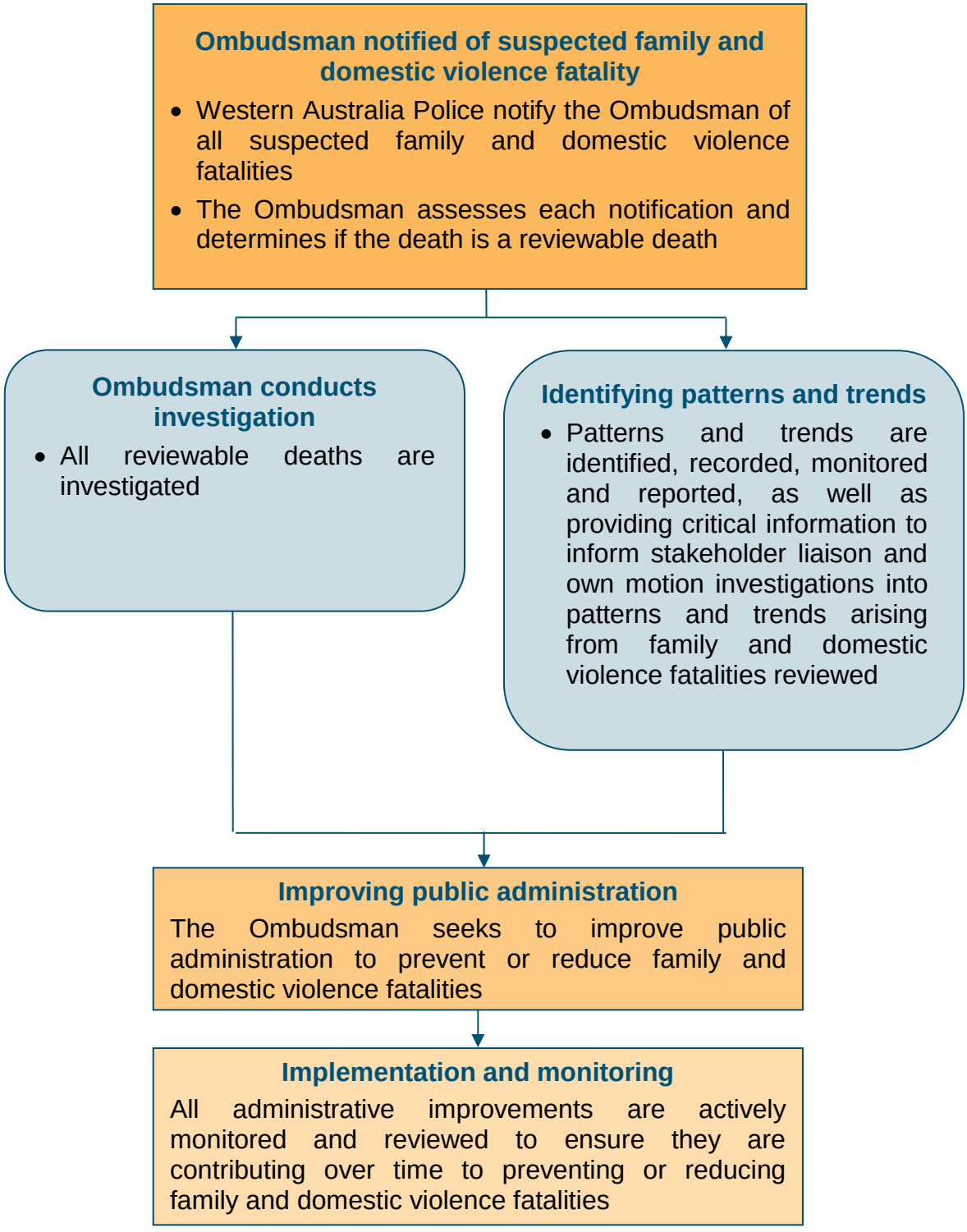
### Overview

The Office reviews certain deaths suspected to have occurred in the context of family and domestic violence to:

- identify the circumstances in which and why a person died;
- identify patterns and trends arising from fatalities; and
- to improve public administration to prevent or reduce family and domestic violence fatalities.

Where WAPOL suspects that a fatality has arisen in circumstances of family and domestic violence, the fatality is reported to the Ombudsman who conducts a review pursuant to his own motion investigation powers.

## The Family and Domestic Violence Fatality Review Process



## Notifications and Reviews

Information in relation to those fatalities that are suspected by WAPOL to have occurred in circumstances of family and domestic violence are described in this report as family and domestic violence fatalities. For the purposes of this report the person who has died due to family and domestic violence will be referred to as 'the person who died'.

Upon the finalisation of Coronial and court proceedings, the Ombudsman can, and will, report upon the demographics, risk factors and social and environmental characteristics, patterns and trends of the perpetrators of family and domestic violence as part of this report.

Additionally, following Coronial and court proceedings, it may be necessary to adjust relevant previously reported information if the outcome of such proceedings is that the death did not occur in the context of a family and domestic relationship.

WAPOL notify the Office of all suspected family and domestic violence fatalities. The notification provides the Ombudsman with information about the circumstances of the death together with any relevant information of prior WAPOL contact with the person who died.

The Ombudsman assesses all family and domestic violence fatality notifications to determine if the relationship between the deceased person and the suspected perpetrator is a family and domestic relationship, as defined by section 4 of the *Restraining Orders Act 1997*. More precisely, the Office considers whether the fatality involves persons apparently in a 'family and domestic relationship', being a relationship between two people:

(a) Who are, or were, married to each other;

(b) Who are, or were, in a de facto relationship with each other;

(c) Who are, or were, related to each other;

(d) One of whom is a child who —

  (i) Ordinarily resides, or resided, with the other person; or

  (ii) Regularly resides or stays, or resided or stayed, with the other person;

(e) One of whom is, or was, a child of whom the other person is a guardian; or

(f) Who have, or had, an intimate personal relationship, or other personal relationship, with each other.

'Other personal relationship' means a personal relationship of a domestic nature in which the lives of the persons are, or were, interrelated and the actions of one person affects, or affected the other person. Related, in relation to a person, means a person who —

(a) Is related to that person taking into consideration the cultural, social or religious backgrounds of the two people; or

(b) Is related to the person's —

(i) Spouse or former spouse; or

(ii) De facto partner or former de facto partner.

If the relationship meets these criteria, it is determined to be a reviewable death, and an investigation is conducted. The extent of an investigation depends on a number of factors, including the circumstances surrounding the death and the level of involvement of relevant public authorities in the life of the person who died or other relevant people in a family and domestic violence relationship with a person who died, including the suspected perpetrator. Confidentiality of all parties involved with the case is strictly observed.

The family and domestic violence fatality review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce family and domestic violence fatalities. The review does not set out to establish the cause of death of the deceased person; this is properly the role of the Coroner. Nor does the review seek to determine whether a suspected perpetrator has committed a criminal offence; this is only a role for a relevant court.

### Number of Family and Domestic Violence Fatality Notifications and Reviews

During 2012-13, there were 20 reviewable family and domestic violence fatalities from a total of 22 notifications.

## Patterns and Trends Identified from Family and Domestic Violence Fatality Reviews

**Important Information on Interpretation of Data**

Information in this section is presented for the commencement year of the operation of the Ombudsman's family and domestic violence fatality review function. As the information in the following charts is based on one year of data only, very significant care should be undertaken in interpreting the data. In subsequent reporting years, information will be presented across multiple years and include analysis of underlying patterns and trends.

By examining family and domestic violence fatalities, the Ombudsman is able to capture data relating to demographics, risk factors and social and environmental characteristics and identify patterns and trends in relation to these deaths. When family and domestic violence fatality reviews are finalised, all relevant issues are identified and recorded and, over time, these issues indicate relevant patterns and trends in relation to family and domestic violence fatalities.

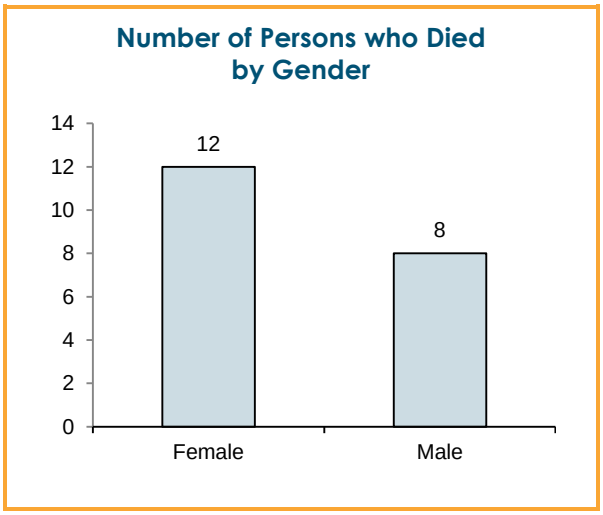
These patterns and trends are identified, recorded, monitored, reported and analysed. The patterns and trends also inform the Ombudsman's own motion investigations relating to family and domestic violence fatalities.

It is important to note that the Office, as part of undertaking its family and domestic violence fatality review function, will report information about demographics, risk factors, social and environmental characteristics and patterns and trends in relation to perpetrators of family and domestic violence following the finalisation of relevant Coronial and criminal proceedings.

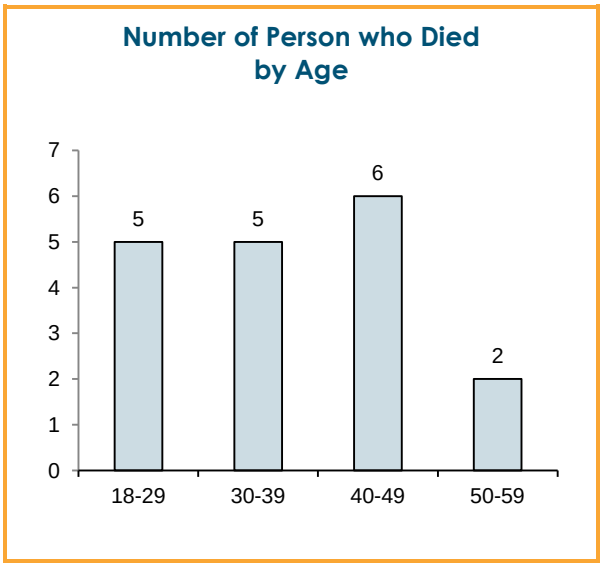
## Characteristics of the persons who died

Information is obtained on a range of characteristics of the person who died, including gender, Aboriginal status, age group and location of the incident in the metropolitan or regional areas.

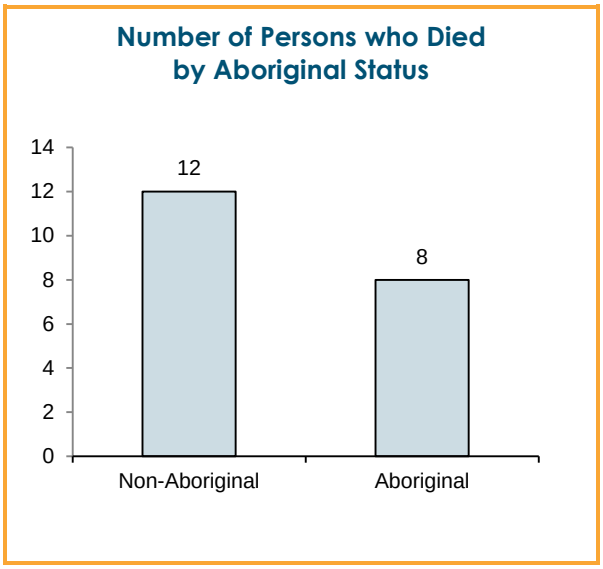
The following charts show characteristics for the persons who died for the 20 family and domestic violence fatality reviews in 2012-13.



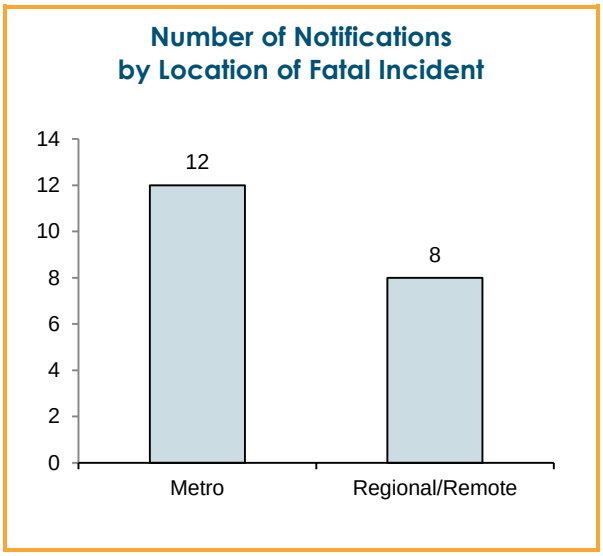

Compared to the Western Australian population, females who died were over-represented, with 60% of persons who died being female compared to 50% in the population.




Compared to the Western Australian adult population, the age group 40-49 is over-represented, with 30% of people who died in this age group compared to 19% in the population.




Compared to the Western Australian population, Aboriginal persons who died were over-represented, with 40% of persons who died being Aboriginal compared to 3.1% in the population.




Compared to the Western Australian population, incidents in regional locations were over-represented, with 40% of fatal incidents occurring in regional or remote locations compared to 27% of the population living in those locations.

The WA Strategic Plan notes that:

> *While there has been debate about the reliability of research that quantifies the incidence of family and domestic violence, there is general agreement that …*
>
> - *An overwhelming majority of people who experience family and domestic violence are women, and*
> - *Aboriginal women are more likely than non-Aboriginal women to be victims of family violence.*

More specifically, with respect to the impact on Aboriginal women in Western Australia, the WA Strategic Plan notes that:

> *Family and domestic violence is particularly acute in Aboriginal communities. In Western Australia, it is estimated that Aboriginal women are 45 times more likely to be the victim of family violence than non-Aboriginal women, accounting for almost 50 per cent of all victims.*

In 2012-13, the Office reviewed 20 family and domestic violence fatalities. From information provided by WAPOL as part of their notification of the fatality:

- 12 (or 60%) were females (compared with 50% of the Western Australian population);
- 8 (or 40%) of persons who died were identified as Aboriginal (compared to 3.1% of the Western Australian population); and
- 8 (or 40%) of family and domestic violence fatalities occurred in regional areas (compared to 27% of the Western Australian population living in regional areas).

In its work, the Office will place a focus on ways that government agencies can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration will also be given to issues relevant to regional and remote Western Australia.

## Circumstances of Family and Domestic Violence Fatalities

Family and domestic violence fatality notifications received by the Ombudsman include general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

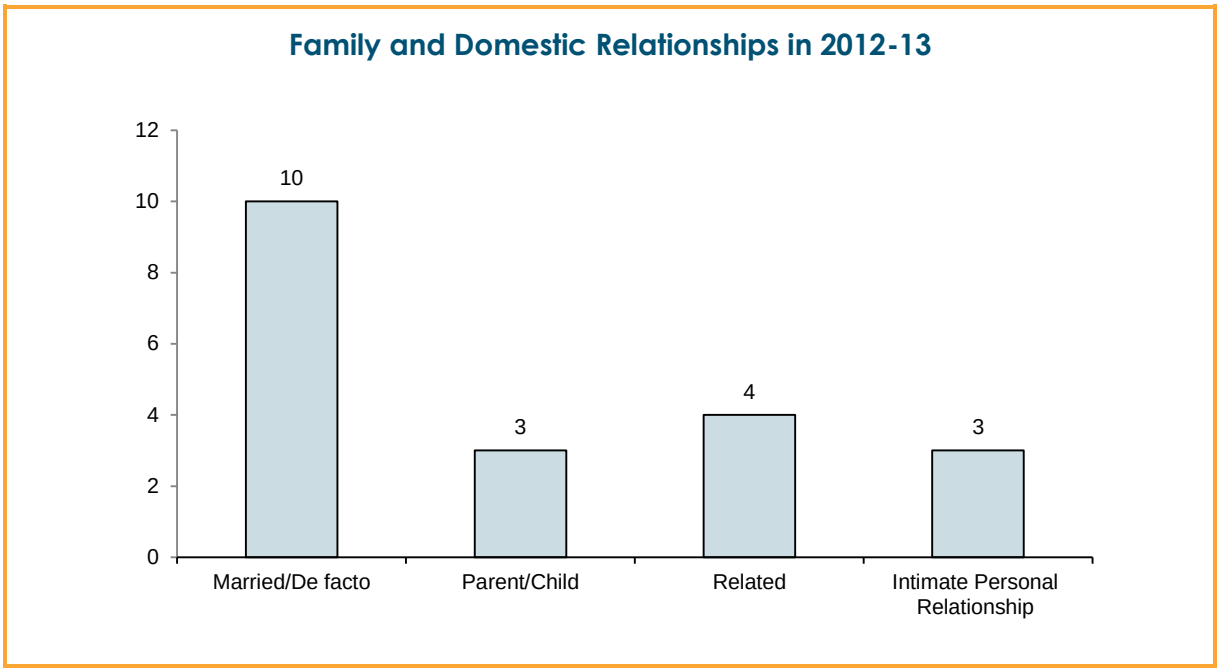
Family and domestic violence fatalities may occur through alleged homicide or apparent suicide and the circumstances of death are categorised by the Ombudsman as:

- Alleged homicide, including:
  - Stabbing;
  - Physical assault;
  - Gunshot wound;
  - Asphyxiation/suffocation;
  - Drowning; and
  - Other.
- Apparent suicide, including:
  - Overdose of prescription or other drugs;
  - Motor vehicle accident;
  - Hanging; and
  - Drowning.
- Other, including fatalities where it is not clear whether the circumstances of death are alleged homicide or apparent suicide.

The principal circumstances of death in 2012-13 were stabbing and physical assault.

### Family and Domestic Relationships

As shown in the following chart, married/de facto relationships are the most common relationship involved in family and domestic violence fatalities.




## Issues Identified in Family and Domestic Violence Fatalities

The following are the types of issues identified when undertaking family and domestic violence fatality reviews:

It is important to note that:

- Issues are not identified in every family and domestic violence fatality review; and
- When an issue has been identified, it does not necessarily mean that the issue is related to the death.

- Management of people who are subject to Community Based Orders.
- Rehabilitation of people with a history of convictions for family and domestic violence and non-family and domestic violence offences.
- Identification and management of repeated alleged family and domestic violence incidents.
- Responses to breaches of Violence Restraining Orders.
- Multiple agency cooperation and collaboration in the management of responses to family and domestic violence.

## Major Own Motion Investigations

In addition to investigations of individual family and domestic violence fatalities, the Office identifies patterns and trends arising out of reviews to inform major own motion investigations that examine the practice of public authorities that provide services to children, their families and their communities.

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

In 2013-14, the Ombudsman will commence a major own motion investigation in relation to family and domestic violence fatalities.

## Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

In addition to reviews of individual family and domestic violence fatalities and major own motion investigations, the Office uses a range of other mechanisms to improve public administration with a view to preventing or reducing family and domestic violence fatalities. These include:

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through the Panel, and other mechanisms, working with public authorities and communities where individuals may be at risk of family and domestic violence to consider safety issues and potential areas for improvement, and to highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information, where appropriate, with other accountability and oversight agencies including Ombudsmen and family and domestic violence fatality review bodies in other States to facilitate consistent approaches and shared learning;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

## Stakeholder Liaison

Efficient and effective liaison has been established with WAPOL to develop and support the implementation of the family and domestic violence fatality notification process. Regular liaison occurs at senior officer level between the Office and WAPOL.

### The Ombudsman's Advisory Panel

The Panel established for child death reviews has been expanded to provide independent advice to the Ombudsman on:

- Issues and trends that fall within the scope of the family and domestic violence fatality review function;
- Contemporary professional practice relating to the safety and wellbeing of people impacted by family and domestic violence; and
- Issues that impact on the capacity of public authorities to ensure the safety and wellbeing of individuals and families.

The Panel met four times in 2012-13 and during the year the following members provided a range of expertise:

- Professor Steve Allsop (Director, National Drug Research Institute, Curtin University);
- Ms Sue Ash (Chief Executive Officer, Uniting Care West);
- Professor Donna Chung (School of Population Health, University of Western Australia);
- Ms Cissy Cox (Group Coordinator, Social Outreach and Advocacy, St John of God Health Care);
- Ms Angela Hartwig (Women's Council for Domestic and Family Violence Services WA);
- Ms Vicky Hovane (Consultant);
- Ms Jocelyn Jones (Health Sciences, Curtin University); and
- Professor Helen Milroy (Director, Centre for Aboriginal Medical and Dental Health, University of Western Australia).

Observers from WAPOL, DCPFS, Department of Health (**DOH**), Department of Education (**DOE**), DCS and the Department of Aboriginal Affairs (**DAA**) and a representative of the Minister for Child Protection also attended the meetings.

In 2013-14, among other things, the Panel will be asked to provide advice to the Ombudsman regarding the first major own motion investigation in relation to family and domestic violence fatalities.

## Other Key Stakeholder Relationships

There are a number of public authorities and other organisations that interact with or deliver services to those who are at risk of family and domestic violence or who have experienced family and domestic violence. Important stakeholders, with which the Office liaises as part of the family and domestic violence fatality review function, include:

- The Coroner;
- Relevant public authorities including:
  - WAPOL;
  - The DOH;
  - The DOE;
  - The DCS;
  - The DCPFS;
  - The Department of Housing;
  - The DAA; and
  - Other accountability and similar agencies including the Commissioner for Children and Young People;
- The Women's Council for Domestic and Family Violence Services WA and relevant non-government organisations; and
- Research institutions, including universities.

## Aboriginal and Regional Communities

Through the Panel and outreach activities, work was undertaken through the year to build relationships relating to the family and domestic violence fatality review function with Aboriginal and regional communities, including by communicating with:

- Key public authorities that work in metropolitan and regional areas;
- Non-government agencies that provide key services; such as health services to Aboriginal people; and
- Aboriginal community leaders to increase the awareness of the family and domestic violence fatality review function and its purpose.

Building on the work already undertaken by the Office, as part of its other functions, including its child death review function, networks and contacts have been established to support effective and efficient family and domestic violence fatality reviews.

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# 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 to improve public administration as a result of:
  - The investigation of complaints; and
  - Reviews of child deaths and family and domestic violence fatalities.
- Undertaking own motion investigations that are based on the patterns, trends and themes that arise from the resolution of individual complaints, child deaths and family and domestic violence fatalities;
- Providing guidance to public authorities on good decision making and practices 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 and family and domestic violence fatality reviews also result in improvements to administrative practices as a result of the review of individual child deaths and family and domestic violence fatalities. Further details of the improvements arising from reviews are shown in the Child Death Review section and the Family and Domestic Violence Fatality 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 and family and domestic violence fatality reviews. These investigations are referred to as own motion investigations.

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

Own motion investigations that arise out of child death and family and domestic violence fatality reviews focus on the practices of agencies that interact with children and families and aim to improve the administration of these services to prevent or reduce child deaths and family and domestic violence fatalities.

### Selecting Topics for Own Motion Investigations

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

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

Having identified a topic, extensive preliminary research is carried out to assist in planning the scope and objectives of the investigation. A public authority selected to be part of an own motion investigation is 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 Office to ensure its implementation and effectiveness in relation to the observations made in the investigation.

## Own Motion Investigations in 2012-13

In 2012-13, a major own motion investigation relating to the sleep-related deaths of infants was conducted and two further own motion investigations were commenced relating to:

- Suicide by young people; and
- Local government collection of outstanding rates.

## Sleep-related Infant Deaths Report

In November 2012, the Ombudsman tabled in Parliament a report of an own motion investigation entitled *Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths.* The report is available on the Ombudsman's website.


### Reasons for the investigation

Infant deaths formed a significant proportion of the child deaths notified to the Ombudsman as part of the Ombudsman's child death review function. Over the period 1 July 2009 to 31 December 2011, the Chief Executive Officer of the Department for Child Protection and Family Support notified the Ombudsman of 242 child deaths. Ninety one (38%) of these deaths concerned infants (children under the age of 12 months).

Through the review of the circumstances in which and why child deaths occurred, the Ombudsman identified a pattern of cases in which infants appeared to die suddenly and unexpectedly during their sleep. This occurred in 54 (59%) of the 91 cases of infant death notified to the Ombudsman.

For this reason, the Ombudsman decided to undertake an investigation of these sleep-related infant deaths (**the Ombudsman's cases**) with a view to determining whether it was appropriate to make recommendations to any State Government department about ways to prevent or reduce such deaths.

### Objectives of the investigation

The objectives of the investigation were 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 departments to prevent or reduce sleep-related infant deaths, and make recommendations to these departments accordingly.

**Key findings and messages from the investigation**

**The Department of Health has undertaken work to contribute to safe sleeping practices but there is still important work to be done.**

In summary, the investigation found that the Department of Health has undertaken a range of work to contribute to safe sleeping practices in Western Australia, however, there is still important work to be done. This work includes, in particular, establishing a comprehensive statement on safe sleeping that will form the basis for safe sleeping advice to parents, including advice on modifiable risk factors, that is sensitive and appropriate to both Aboriginal and culturally and linguistically diverse communities and is consistently applied state-wide by health care professionals and non-government organisations at the ante-natal, hospital-care and post-hospital stages. This statement and concomitant policies and practices should also be adopted, as relevant, by the Department for Child Protection (as it then was) and the Department of Communities (as it then was).

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

- The most frequent cause of sleep-related infant deaths is likely to be Sudden Infant Death Syndrome (commonly referred to as SIDS). SIDS is a classification of the cause of death used by medical practitioners and coroners. A definition of SIDS that is widely accepted in Australia is:

  > The sudden and unexpected death of an infant, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history.

- The research literature identifies that certain factors increase the risk of SIDS, and refers to these as 'risk factors' for SIDS. Some of the identified risk factors concern infant characteristics (**infant risk factors**). It is important to note that these risk factors are correlative, not necessarily causal. The infant risk factors are:
  - Infant is aged older than one month and less than four months;
  - Infant is male;
  - Infant was born prematurely;
  - Infant had low birth weight; and
  - Infant's mother smoked during pregnancy.

  These infant risk factors for SIDS have also been found to be relevant to other types of sleep-related infant deaths. Our analysis found that these infant risk factors were also prominent among the Ombudsman's cases.

- Other identified risk factors for SIDS concern characteristics of the infant's sleeping environment (**environmental risk factors**). These environmental risk factors are:

- Prone sleeping position;
- Unsafe sleeping surface;
- Unsafe bedding; and
- Environmental tobacco smoke (within the infant's sleeping environment).

These environmental risk factors for SIDS have been found to be relevant to other types of sleep-related infant deaths. Our analysis found that these environmental risk factors were also prominent among the Ombudsman's cases.

- Forty eight (89%) of the Ombudsman's cases involved risk factors that are potentially modifiable. This indicates that, by assisting parents and carers in relation to the possible modification of these risk factors, there are potential opportunities for State Government departments and authorities to prevent or reduce the number of sleep-related infant deaths beyond that action which is currently undertaken.
- Thirty (56%) of the Ombudsman's cases involved one or more of the environmental risk factors that safe sleeping advice has traditionally and still commonly recommends should be avoided. These findings point to the continued relevance of the four key messages common to safe sleeping advice and the importance of continuing to assist parents and carers to follow this advice when placing their infants to sleep. The four key messages about how to avoid the environmental risk factors were:
  - Place an infant on its back to sleep;
  - Use a safe sleeping surface;
  - Use safe bedding, keep infant's head uncovered, and avoid soft toys and other items in the infant's sleeping environment; and
  - Avoid environmental tobacco smoke.
- In eight (15%) of the Ombudsman's cases, the infants were placed to sleep in a cot or bed somewhere other than their usual sleep location. Recent research has suggested that the risk of SIDS is higher when the infant sleeps in a different location than their usual place of sleep, particularly if at a friend or relative's house.
- Twenty nine (54%) of the Ombudsman's cases reportedly involved co-sleeping, and in all of these cases infant and/or environmental risk factors were also involved. Infant risk factors were involved in 28 (97%) of the 29 cases, and environmental risk factors were involved in 16 (55%) of the 29 cases. In 15 (52%) of the 29 Ombudsman's cases in which the infant was reportedly co-sleeping at the time of death, both infant and environmental risk factors featured in the circumstances of the infant's death.
- Twenty eight (52%) of the Ombudsman's cases involved infants whose mothers reported smoking during pregnancy. The Department of Health already has in place a range of policies and strategies designed to inform pregnant women of the dangers of smoking and to assist them to give up smoking where they choose to do so. Our analysis points to the continued importance of these policies and strategies, as well as to the importance of linking strategies to deliver safe

sleeping advice with the range of existing programs designed to assist people to give up smoking.

- Nineteen (35%) of the Ombudsman's cases involved Aboriginal infants, even though Aboriginal infants comprise only 6% of WA infants. This finding reflects the research literature, which has identified that Aboriginal infants are over-represented among infants whose death is diagnosed as SIDS, and that the decline in the rate of SIDS has not been as significant in the Aboriginal population as it has been in the non- Aboriginal population.
- At least three (6%) of the Ombudsman's cases involved infants from culturally and linguistically diverse backgrounds, and all of these cases involved modifiable risk factors. All three cases involved modifiable risk factors (apart from maternal smoking during pregnancy), and all three deaths occurred in circumstances that safe sleeping advice commonly recommends should be avoided.
- Twenty (37%) of the Ombudsman's cases involved infants from families whose children had already been the subject of concerns raised with the (then) Department for Child Protection. In 15 of these 20 cases, the Department for Child Protection had determined that some action should be taken in regard to the child or a child relative of the child, and that action was taken. These concerns and actions were not necessarily related to modifiable risk factors associated with sleep-related infant deaths.
- In 14 (26%) of the Ombudsman's cases, fathers or grandparents were immediately present at the time of the infant's death. In two of these 14 cases, the infant was in the primary care of the father, and in another two cases, the infant was in the primary care of a grandparent. The research literature and our consultations with stakeholders also identify that as well as playing the role of direct carer, fathers and grandparents may influence how mothers place infants to sleep.

The report identified 23 recommendations about ways to prevent or reduce sleep-related infant deaths and set out opportunities for the Departments involved to put the recommendations into practice. The Departments have agreed to the recommendations and were highly co-operative and positively engaged with the investigation.

**All 23 recommendations for administrative improvement arising from the sleep-related infant deaths report were accepted by the Departments.**

**Monitoring the implementation and effectiveness of report recommendations**

Each of the recommendations arising from own motion investigations is actively monitored by the Office to ensure its implementation and effectiveness in relation to the observations made in the investigation including, through:

- Whether child death reviews undertaken by the Office show evidence of improved practice in relation to the areas subject to own motion investigations (for further details see the Child Death Review section); and
- Reports by the relevant agencies on progress to date in the implementation of the recommendations made by the Ombudsman.

Further monitoring by the Office will be undertaken through an own motion investigation, commencing in 2013-14, to review the implementation and effectiveness of recommendations made by the Ombudsman.

## Own Motion Investigations in 2013-14

During 2012-13, the Ombudsman undertook two own motion investigations:

- Ways that State Government departments and authorities can prevent or reduce suicide by young people; and
- Local Government collection of outstanding rates.

Reports of each investigation will be tabled in Parliament in 2013-14.

In 2013-14, the Ombudsman will commence own motion investigations relating to:

- Family and domestic violence fatality reviews; and
- Implementation and effectiveness of recommendations made by the Ombudsman as a result of own motion investigations, and complaints and reviews.

## 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 assisting them to improve 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 whether 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:
    - New public sector officers at the Public Sector Commission's Ethics and Integrity Induction Program;
    - Members of the Bunbury Youth Advisory Council; and
    - Officers of the Health Complaints Advisory Group.
- The *Role of the Ombudsman* and *Ensuring your complaint handling system is accessible to children and young people* at the Commissioner for Children and Young People's *Making Complaints Processes Child-Friendly* Seminars;
- *The Ombudsman and Local Government - Resolving Complaints and Promoting Good Administrative Practice* at the Local Government Managers Australia Finance Conference; and
- *The Role of the Ombudsman* and training on *Good Decision Making* and *Effective Complaint Handling* for public authorities during the Office's Pilbara and Bunbury Regional Awareness and Accessibility Programs (see further details in the Collaboration and Access to Services section).

### 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 Collaboration and Access to Services section.

## 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. The 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.

# Collaboration and Access to Services

Engagement with key stakeholders is essential to the Office's achievement of the most efficient and effective outcomes. The Office does this through:

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

## Working Collaboratively

The Office works collaboratively with local, national and international integrity and accountability agencies to encourage best practice efficiency and leadership. 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.

**2012-13 initiatives:**

The Ombudsman joined his ICG colleagues in Geraldton during May for the inaugural ICG Regional Forum. More than 50 representatives from State Government agencies and local governments attended the Forum. The Forum provided attendees with information on the roles of each of the ICG members as well as discussion on conflicts of interest and the offer, acceptance and provision of gifts, benefits and hospitality.

The Office was involved in the Group's graduate program, which involves a graduate working in each of the member agencies over a two year period in total.

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| **Public Sector Commission's Induction: Your Guide to Ethics and Integrity in the Public Sector Program** | **Background:**<br>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.<br>**2012-13 initiatives:**<br>As a key integrity agency, the Office presented on seven 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 2013-14. |
| **Australia and New Zealand Ombudsman Association**<br>**Members:**<br>Western Australian Ombudsman & Energy Ombudsman Western Australia<br>Parliamentary and industry-based Ombudsmen from Australia and New Zealand | **Background:**<br>The Australia and New Zealand Ombudsman Association (**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 common interest.<br>**The Office's involvement:**<br>The Ombudsman sits on the Association's Executive. The Office regularly provides general updates 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.<br>**2012-13 initiatives:**<br>The Ombudsman was involved in four meetings via teleconference during the year, and attended the Association's Annual General Meeting and Executive Committee meeting. |
| **Information sharing with Ombudsmen from other jurisdictions** | **Background:**<br>Where appropriate, the Office shares information and insights about its work with Ombudsmen from other jurisdictions, as well as with other accountability and integrity agencies.<br>**2012-13 initiatives:**<br>The Ombudsman hosted the Australian and New Zealand Energy and Water Ombudsman Network (**ANZEWON**) meeting in April 2013 and met, and exchanged information with, a number of Parliamentary Ombudsmen and industry-based Ombudsmen during the year. |

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| **International Ombudsman Institute** | **Background:**<br>The International Ombudsman Institute (**IOI**), established in 1978, has over 150 institutions as members.<br><br>**The Office's involvement:**<br>In November 2012 the Ombudsman was elected President of the Australasian and Pacific Ombudsman Region and a Director of the Board of the IOI. The Australasian and Pacific Ombudsman Region is comprised of Australia, China/Hong Kong, Cook Islands, New Zealand, Papua New Guinea, Samoa, Taiwan, Tonga and Vanuatu. The Ombudsman was joined on the Board of the IOI by Ombudsmen drawn from around the world, including the Chief Ombudsman of New Zealand, the National Ombudsman of the Netherlands, the Parliamentary Ombudsman of Sweden, the Public Services Ombudsman for Wales and the Ombudsman for Namibia.<br><br>**2012-13 initiatives:**<br>The Ombudsman attended, and delivered an address titled, *The Western Australian Integrity Coordinating Group* at the 10th IOI World Conference in November 2012. The Ombudsman also attended the IOI Board of Directors mid-term meeting in April 2013. |
| **Indonesian/ Australian Ombudsman Linkages and Strengthening Program**<br><br>**Members:**<br>Western Australian Ombudsman<br>Commonwealth Ombudsman<br>New South Wales Ombudsman<br>Ombudsmen of the Republik of Indonesia | **Background:**<br>The program aims to provide access across a larger portion of Indonesia to more effective and sustainable Ombudsman and complaint management services.<br>**The Office's involvement:**<br>The Office has been involved with the program since 2005 and supports the program through staff placements in Indonesia and Australia.<br>**2012-13 initiatives:**<br>In January 2013, the Assistant Ombudsman Complaint Resolution visited Indonesia. The purpose of the visit was to provide training in more effective and sustainable ombudsman and complaint management services to the Office of the Ombudsman Republik Indonesia. The program covered modules on conducting investigations, dealing with complaints and complainants as well as agency relationships. |

# Providing Access to Key Stakeholders

## 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 2012-13 include:

- 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.

## 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 complaints clinics and delivers presentations to community groups, particularly through the Regional Awareness and Accessibility Program. Initiatives to make services accessible include:

- Access to the Office through a toll free number for country callers;
- Access to the Office through email and online services. The importance of email and online access is demonstrated by its further increased use this year from 50% to 56% of all complaints received;
- Information on how to make a complaint to the Ombudsman is available in 15 languages and features on the homepage of the Ombudsman's website. People may also contact us with the assistance of an interpreter by using the Translating and Interpreting Service;
- The Office's accommodation and building access provide access for people with disabilities, including lifts that accommodate wheelchairs and feature braille on the access buttons and people with hearing and speech impairments can contact the Office using the National Relay Service;
- The Office's Regional Awareness and Accessibility Program targets awareness and accessibility for regional and Aboriginal Western Australians; and
- 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 including activities such as a presentation on the *Role of the Ombudsman* for members of the Bunbury Youth Advisory Council and a presentation on making our services more accessible to children and young people at a workshop hosted by the Commissioner for Children and Young People.

## Liaison with Public Authorities

The Office liaises with a wide range of departments and authorities throughout the year.

### Liaison with the Public Sector

**Corrective Services**

Regular meetings were held between senior representatives of the Office and the Department of Corrective Services.

In addition, the Office attended regular 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 Health**

During the year, meetings were held with senior staff of the Department of Health, including in relation to the Office's own motion investigations on sleep-related infant deaths and suicide by young people.

**Department for Child Protection and Family Support**

Regular meetings were held between the Office and the Department for Child Protection and Family Support, including in relation to the Office's own motion investigations on sleep-related infant deaths and suicide by young people.

### 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:

- A meeting with representatives of the Finance Committee of the Local Government Managers Australia in February 2013; and
- A range of meetings in relation to the Office's own motion investigation into local government collection of outstanding rates.

### Liaison with the University Sector

A number of meetings were held with senior representatives of universities.

## '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 October and December 2012 and March and June 2013.

## Ombudsman Website

The Ombudsman's website provides a wide range of information and resources for:

- Members of the public on the complaint handling services provided by the Office as well as links to other complaint bodies for issues outside the Ombudsman's jurisdiction;
- Public sector agencies on decision making, complaint handling and conducting investigations;
- Access to the Ombudsman's investigation reports such as the *Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths;*
- 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 other related bodies including other Ombudsmen and other Western Australian accountability agencies.

The website continues to be a valuable resource for the community and public sector as shown by the increased use of the website this year. In 2012-13:


- The total number of hits has increased by more than 20% compared to 2011-12, with the number on hits peaking at 154,415 in May 2013, the greatest number of hits in a month ever recorded.
- The number of visitors also increased, particularly around the time of publication of news of public interest such as the *Guidelines on the Management of Personal Information* in May 2013;
- 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 guidelines, *Procedural fairness* and *Effective handling of complaints* were the 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**) during 2012-13. Two regional visits were conducted to the Pilbara in August 2012 and to the South West in March 2013, and included the following activities:

- A seminar for regionally-based public sector agencies and local governments to discuss good administrative practice, effective complaint resolution and appropriate access to information;
- An expo for community groups to discuss the role of each of the accountability agencies and how they can assist in complaint resolution;
- Complaints clinics, which provided an opportunity for members of the local community to raise their concerns face-to-face with the staff of the Office. The Office resolved many of the complaints made during the time of the visits;
- Individual meetings with Aboriginal community members to discuss government service delivery and where the Office may be able to assist; and
- Training and workshops for regionally-based public sector agencies and local governments.

Participants engage in an activity as part of a workshop on Effective Decision Making hosted by the Office of the Ombudsman.

Preparation is underway for a visit to Kununurra in November 2013. The Program is an important way for the Office to raise awareness of, access to, and use of, its services, for regional and Aboriginal Western Australians.

While the Program is coordinated by the Office, the Office collaborates with 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 services directly to regional communities, particularly through complaints clinics;
- increase awareness and accessibility among regional and Aboriginal Western Australians (who were historically under-represented in complaints to the Office); and
- deliver key messages about the Office's work and services.

The Program also provides a valuable opportunity for staff to strengthen their understanding of the issues affecting people in regional and Aboriginal communities.

The collaboration with other integrity and accountability agencies during regional visits and complaints 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 by public authorities, provided in the Own Motion Investigations and Administrative Improvement section, speeches and presentations by the Ombudsman and other staff of the Office included:

- A presentation, titled *The fourth branch of government: the evolution of integrity agencies and enhanced government accountability*, at the Australian Institute of Administrative Law National Forum in July 2012;
- A lecture, titled *UWA Public Policy Unit Accountability*, at the University of Western Australia in August 2012;
- A lecture at the University of Western Australia as part of the Public Sector Management Program in August 2012;
- A presentation on handling unreasonable complainant conduct at the Australasian Conference of Planning and Environment Courts and Tribunals in August 2012;
- A presentation, titled *Making your complaint handling system robust and child friendly*, at a workshop hosted by the Commissioner for Children and Young People in September 2012;
- A public lecture, titled *The integrity branch of government*, at La Trobe University in September 2012;
- A presentation, titled *The Western Australian Integrity Coordinating Group*, to the 10th International Ombudsman Institute World Conference in November 2012;
- A lecture, titled *Performance Reporting in the Public Sector*, at the School of Accounting at Curtin University in September 2012;
- An opening presentation, titled *Governance and Accountability in Government Departments*, to The Law Society of Western Australia's Government Lawyer's Conference in September 2012;
- A presentation on the role of the Ombudsman to University of Western Australia Administrative Law Students in October 2012;
- A presentation on the role of the Ombudsman to newly elected Members of Parliament in March 2013;

- A presentation, titled *Ensuring your complaint handling system is accessible to children and young people*, at a workshop hosted by the Commissioner for Children and Young People in March 2013;
- A co-presention of a session, titled *The Post-Kirk Ouster Debates and the Changing Face of Accountability,* at an Australian Institute of Administrative Law WA Chapter Seminar, with Professor Simon Young of the University of Western Australia, in May 2013 ; and
- Presentations to, and information exchange with, a number of agencies about the Office's own motion investigations into sleep-related infant deaths, suicide by young people and local government collection of outstanding rates.

The Ombudsman also delivered presentations in his role as the Energy Ombudsman including a keynote speech, titled *The role of the Energy Ombudsman and its relationship with regulators, industry and consumers*, to the Energy in Western Australia Conference in October 2012, and the opening of the afternoon session of the Economic Regulation Authority Consumer Consultative Committee Biennial Seminar in April 2013.

Speeches by the Ombudsman are available on the Ombudsman's website.

## 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. Newsletters were issued in August and December 2012.

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.


Ombudsman Western Australia
news
Edition 14
December 2012
Sleep-related infant deaths report tabled in Parliament

## 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.

### Guidelines on the Management of Personal Information

Following an own motion investigation of the management of personal information in three State Government agencies, the Ombudsman published a new guideline detailing good practice principles to assist agencies on how to effectively manage personal information.

The good practice principles in the guidelines detail how and when personal information can be collected, how it should be used and disclosed, and storage and security of electronic, paper and sensitive information.


The good practice principles also detail how individuals should be able to access that information and have it corrected if it is wrong and how agencies can ensure transparent management of personal information. The self-assessment checklist assists agencies to check their own management of personal information against the good practice principles.

The *Guidelines for the Management of Personal Information* are available on the Ombudsman's website.

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