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, inter-agency 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.

Child Death Review

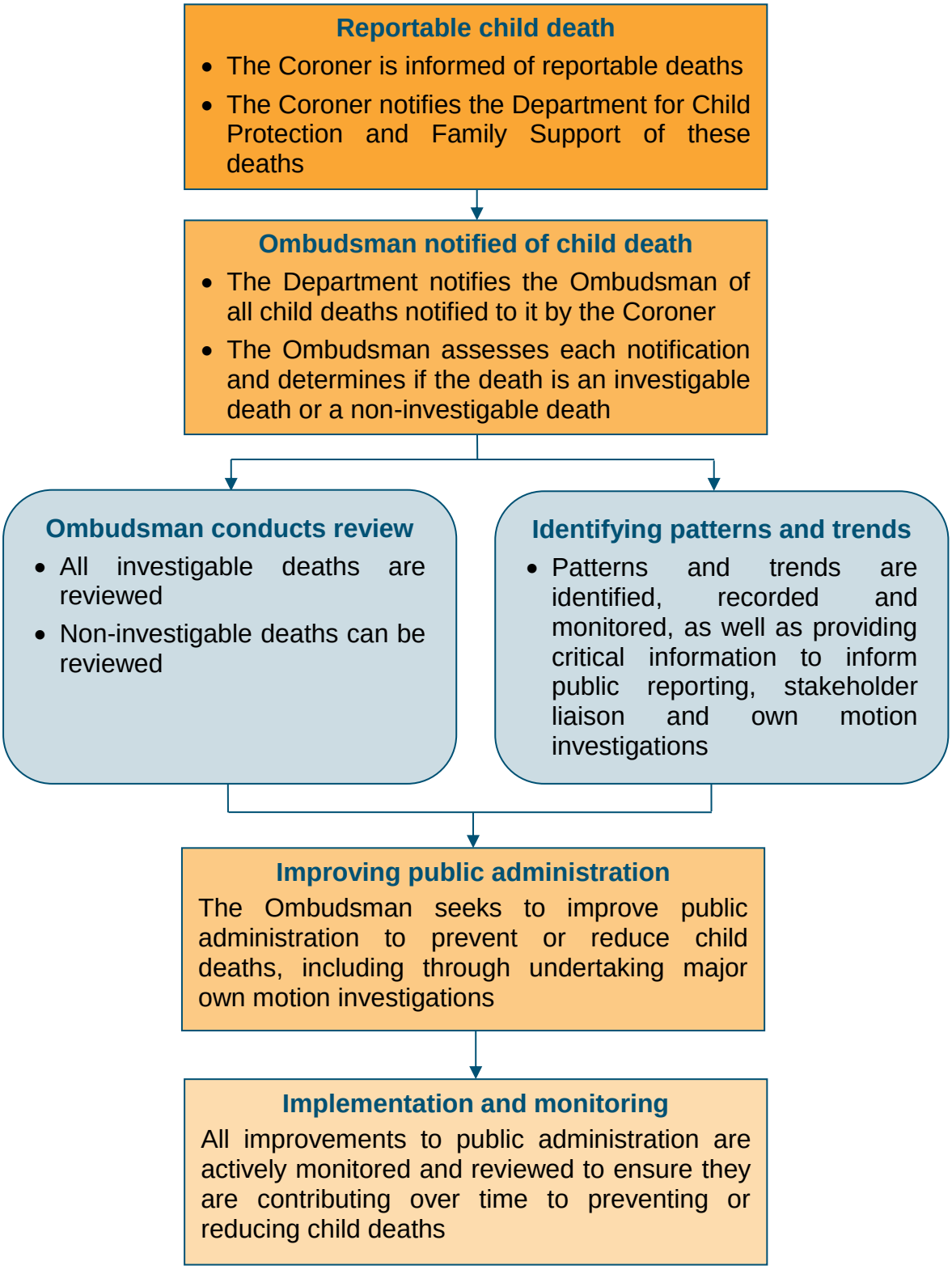
In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

In addition to reviewing investigable deaths, the Ombudsman can review other notified deaths. The Ombudsman also undertakes major own motion investigations arising from child death reviews.

In reviewing child deaths the Ombudsman has wide powers of investigation, including powers to obtain information relevant to the death of a child and powers to recommend improvements to public administration about ways to prevent or reduce child deaths across all agencies within the Ombudsman's jurisdiction.

The Ombudsman reviews certain child deaths, identifies patterns and trends arising from these deaths and seeks to improve public administration to prevent or reduce child deaths, including through the undertaking of major own motion investigations.

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.

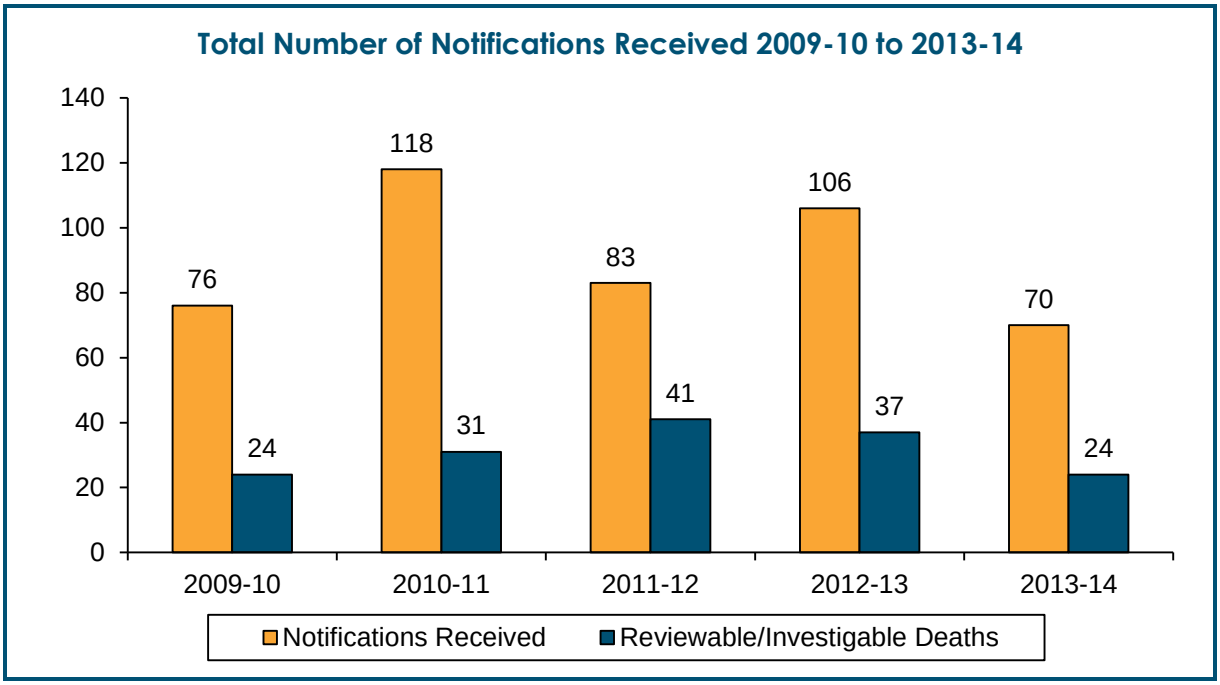
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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 2013-14, there were 24 child deaths that were investigable and subject to review from a total of 70 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 11 years from 2003-04 to 2013-14. 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
2013-14	151	75	40	24

Abbreviations

Department: Department for Child Protection and Family Support from 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 contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2013-14, timely review processes have resulted in half of all reviews being completed within six 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, including *Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004*, which was tabled in Parliament in November 2011, *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 *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people,* which was tabled in Parliament in April 2014.

Important information on interpretation of data

Information in this section is presented across the first five years of the operation of the Ombudsman's child death review function to provide an understanding of developing patterns and trends over time. Care should be undertaken in interpreting any possible trends from year to year.

Characteristics of children who have died

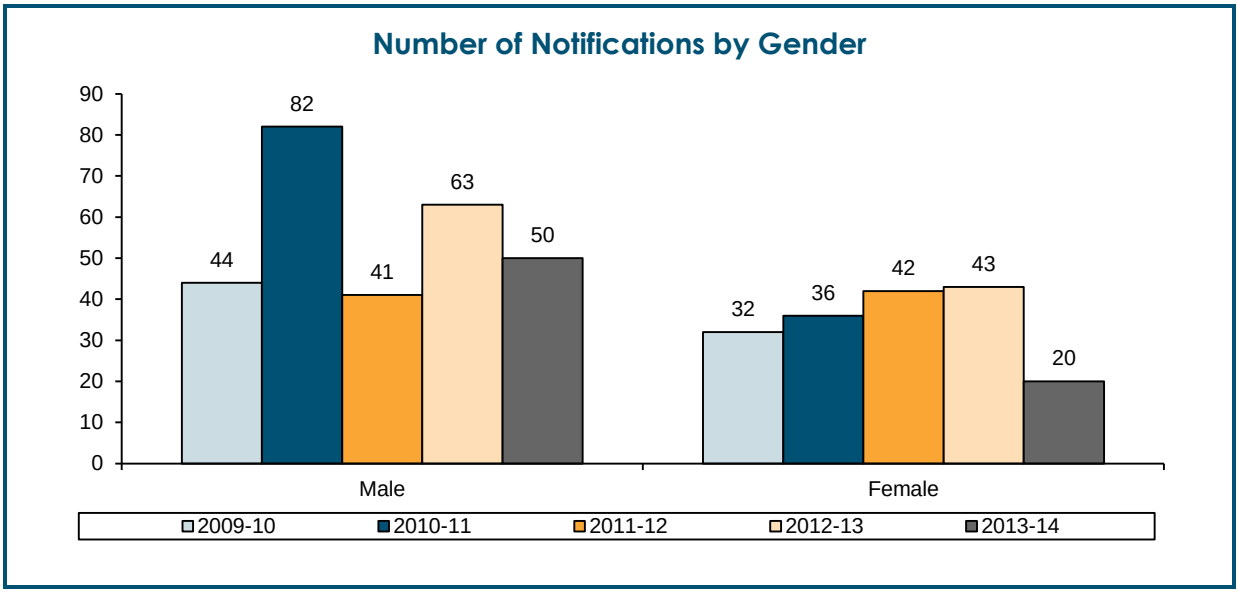
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

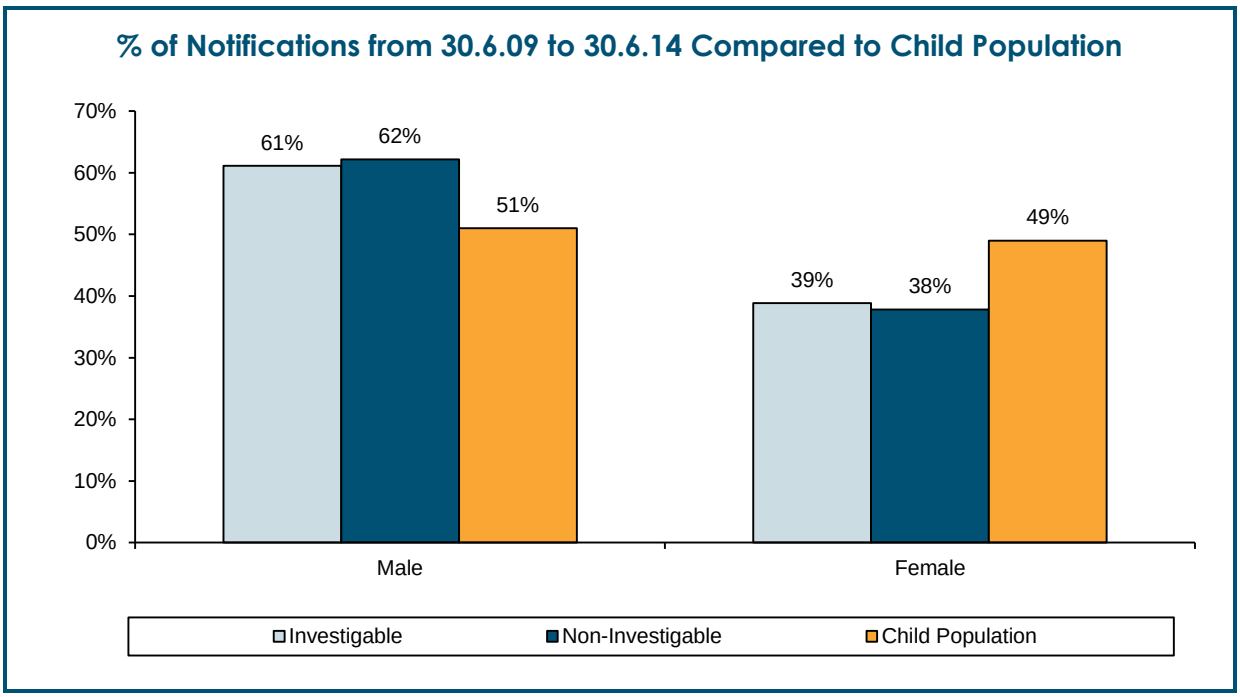
The following charts show:

- The number of children in each group for each year from 2009-10 to 2013-14; and
- For the period from 30 June 2009 to 30 June 2014, 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 five years, male children are over-represented compared to the population for both investigable and non-investigable deaths.

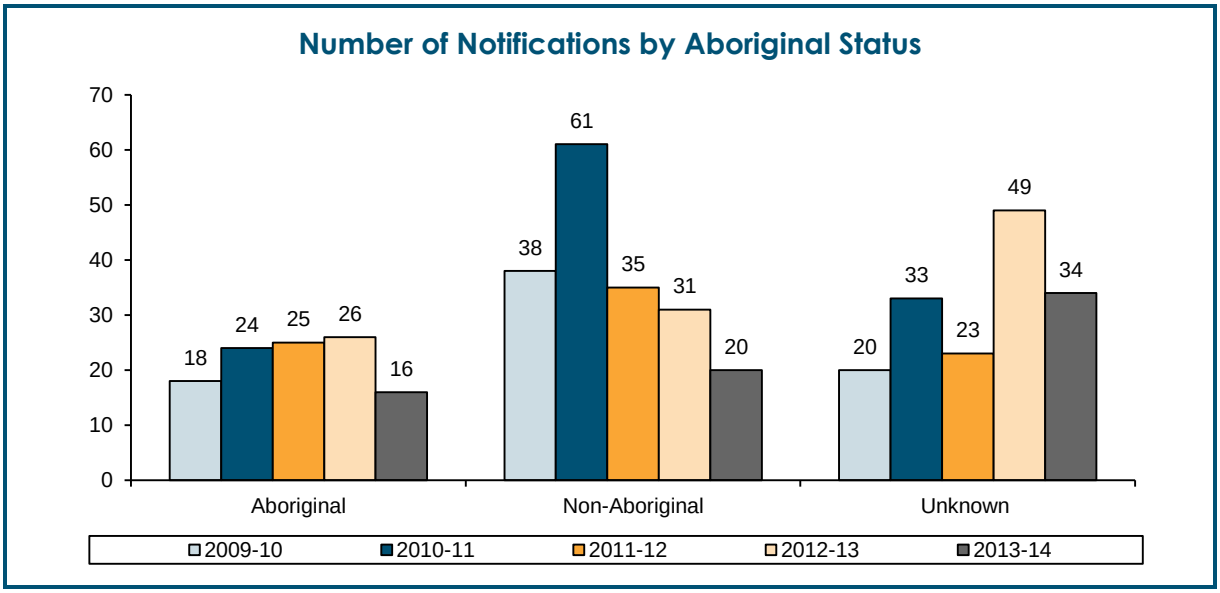


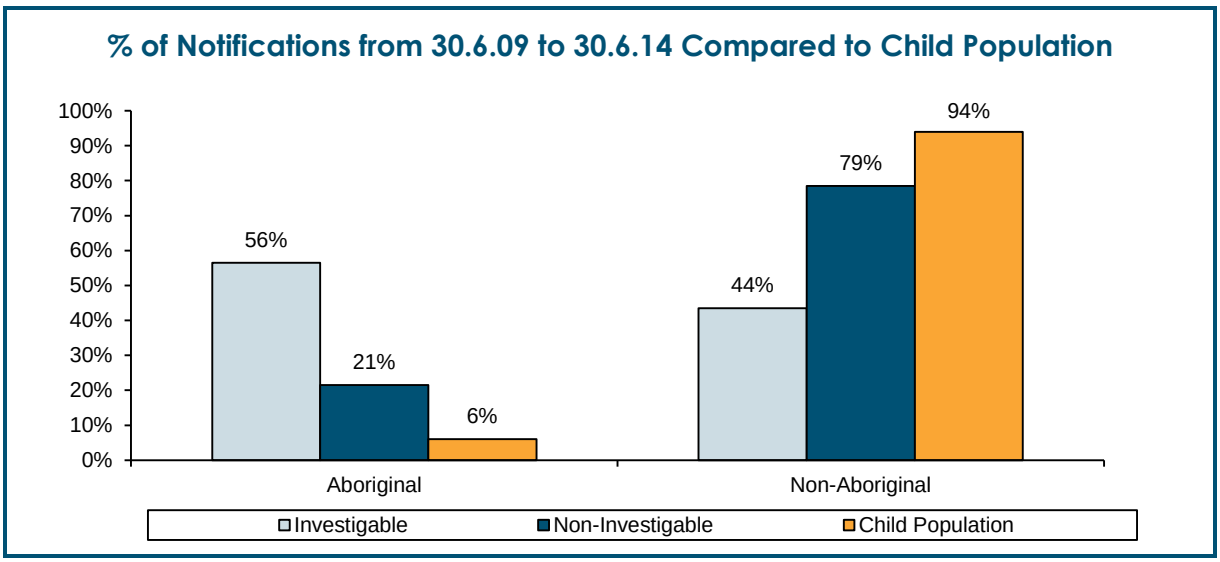


Further analysis of the data shows that, considering all five years, male children are over-represented for all age groups, but particularly for children under the age of one.

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.



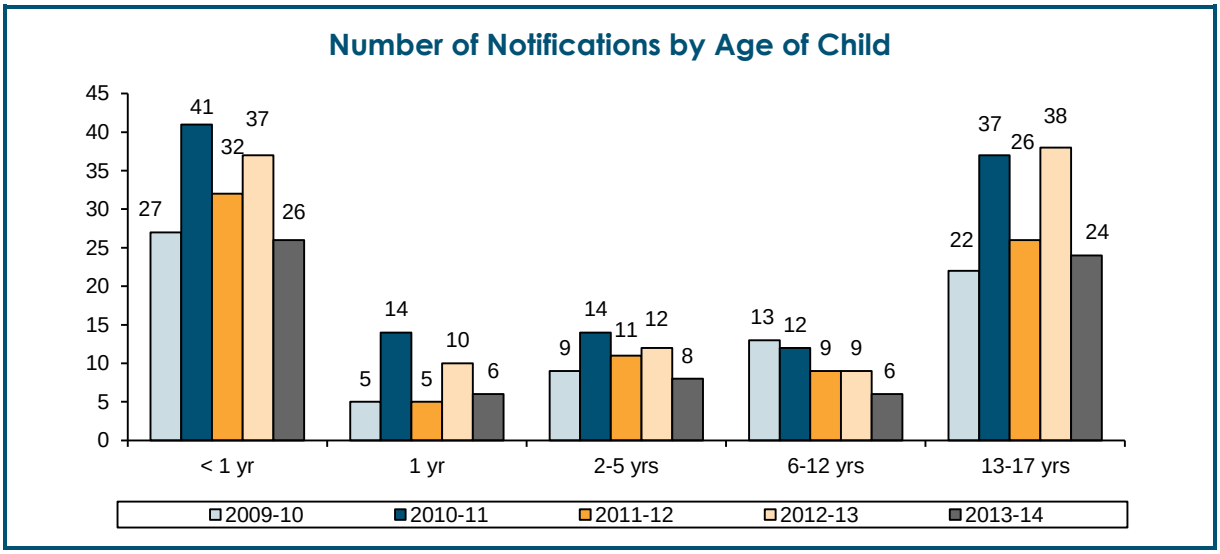


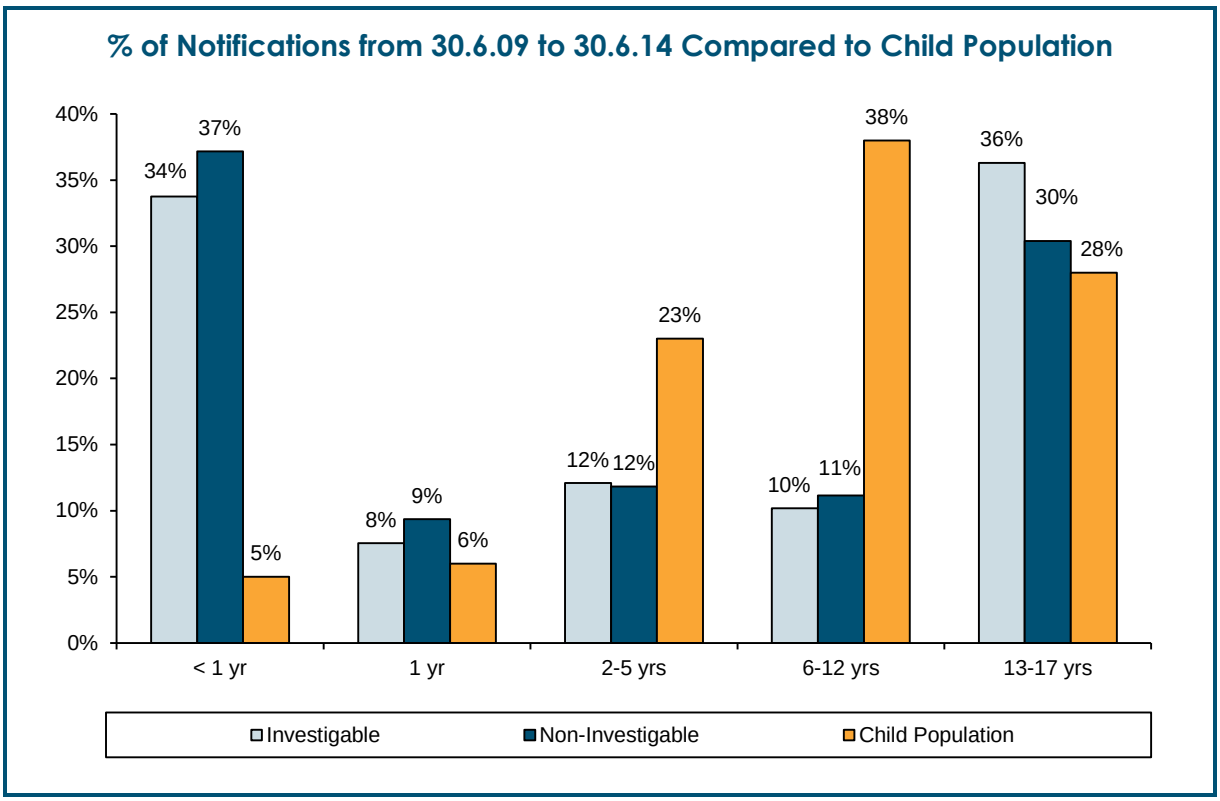
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

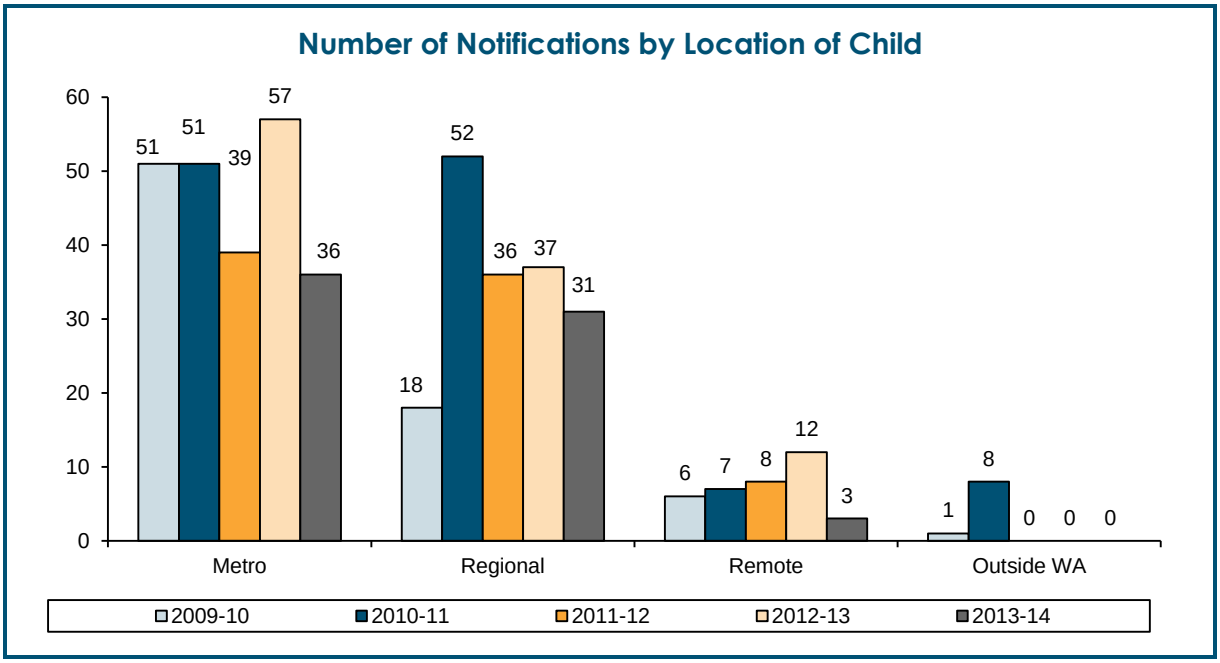


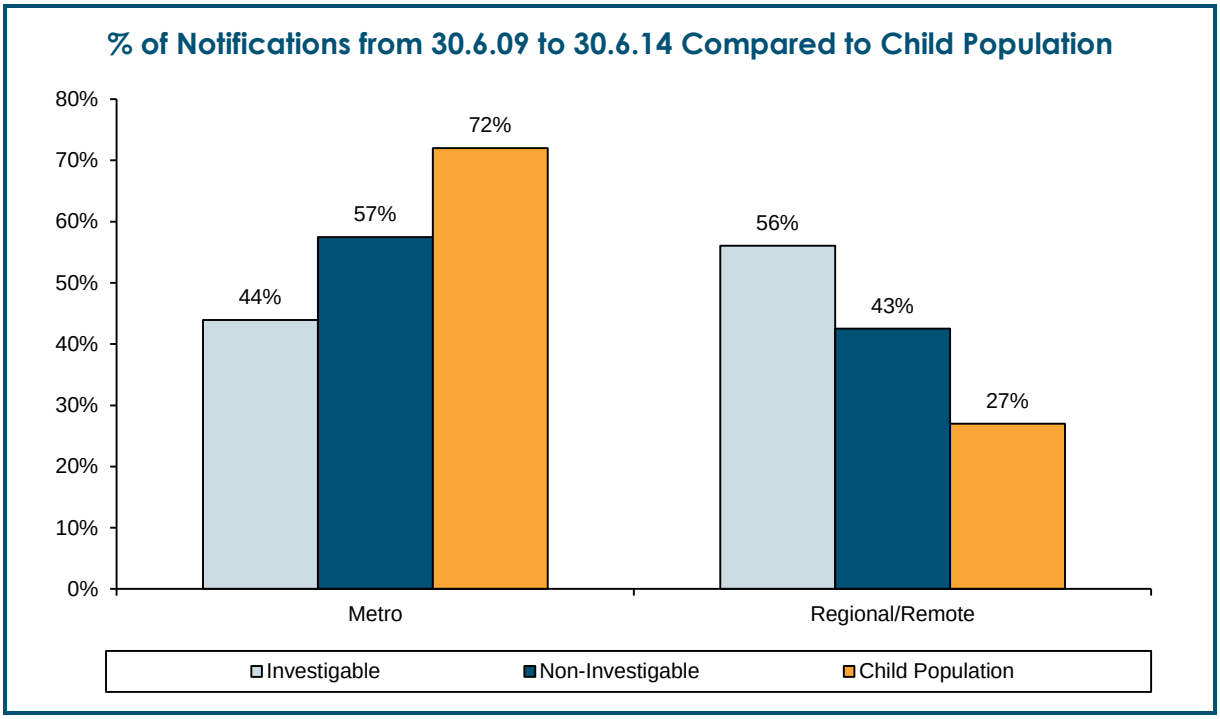


Further analysis of the data shows that a higher proportion of Aboriginal children are under the age of one compared to other age groups. A more detailed analysis by age group is provided later in this section.

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 83% 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.

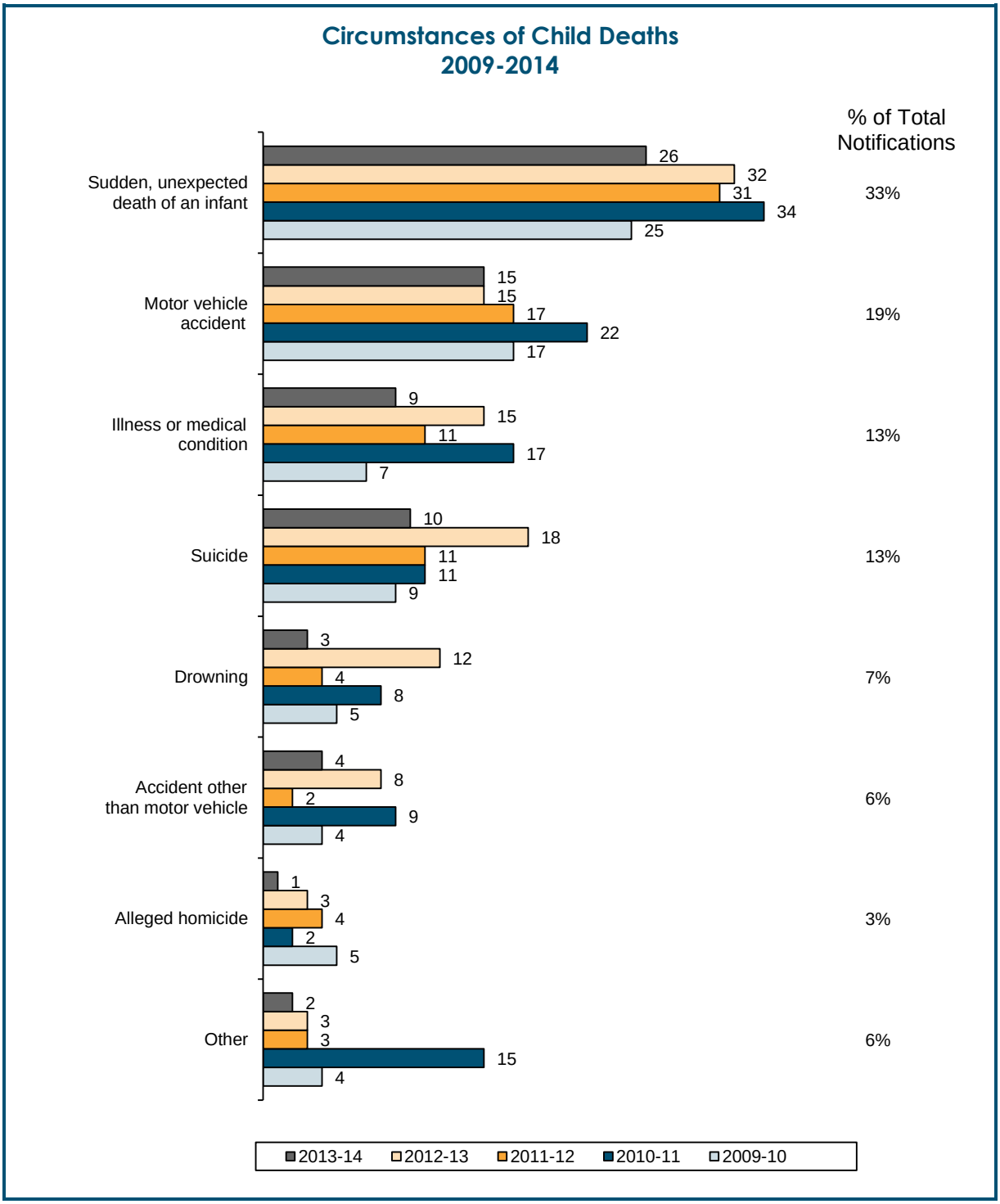
Circumstances of child deaths

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 five years.



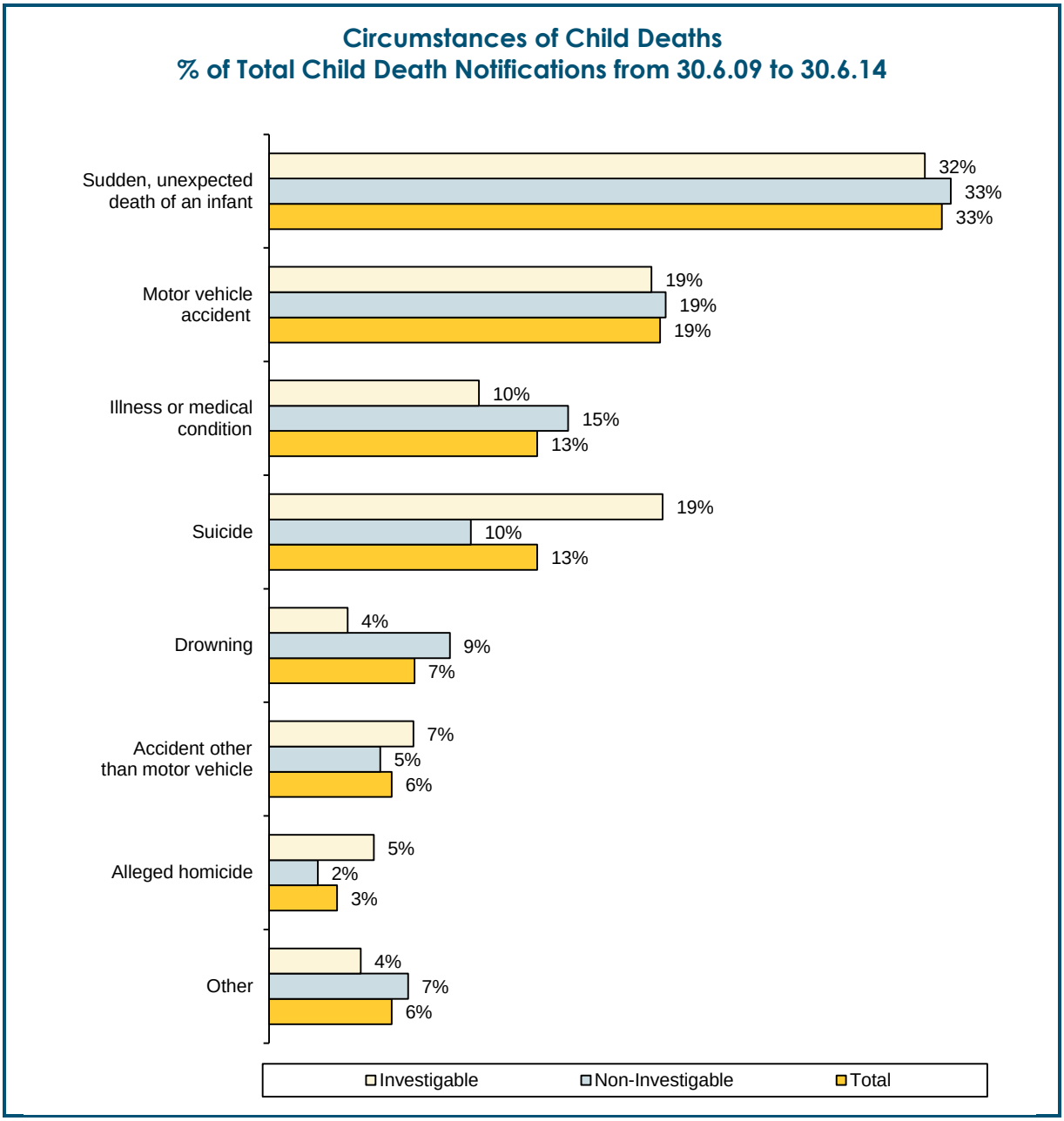
Note: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

The two main circumstances of death for the 453 child death notifications received in the five years from 30 June 2009 to 30 June 2014 are:

- Sudden, unexpected deaths of infants, representing 33% of the total child death notifications from 30 June 2009 to 30 June 2014 (33% of the child death notifications received in 2009-10, 29% in 2010-11, 37% in 2011-12, 30% in 2012-13 and 37% in 2013-14); and

- Motor vehicle accidents, representing 19% of the total child death notifications from 30 June 2009 to 30 June 2014 (22% of the child death notifications received in 2009-10, 19% in 2010-11, 20% in 2011-12, 14% in 2012-13 and 21% in 2013-14).

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



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

- Suicide;
- Accident 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 from 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	18	3
2013-14	4	15	9		1	3	26	10	2

* 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. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

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 the child, such as:

- Family and domestic violence;
- 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 in 2013-14
Family and domestic violence	71%
Alcohol use	57%
Drug or substance use	58%
Homelessness	43%
Parental mental health issues	31%

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

Reasons for contact with the Department

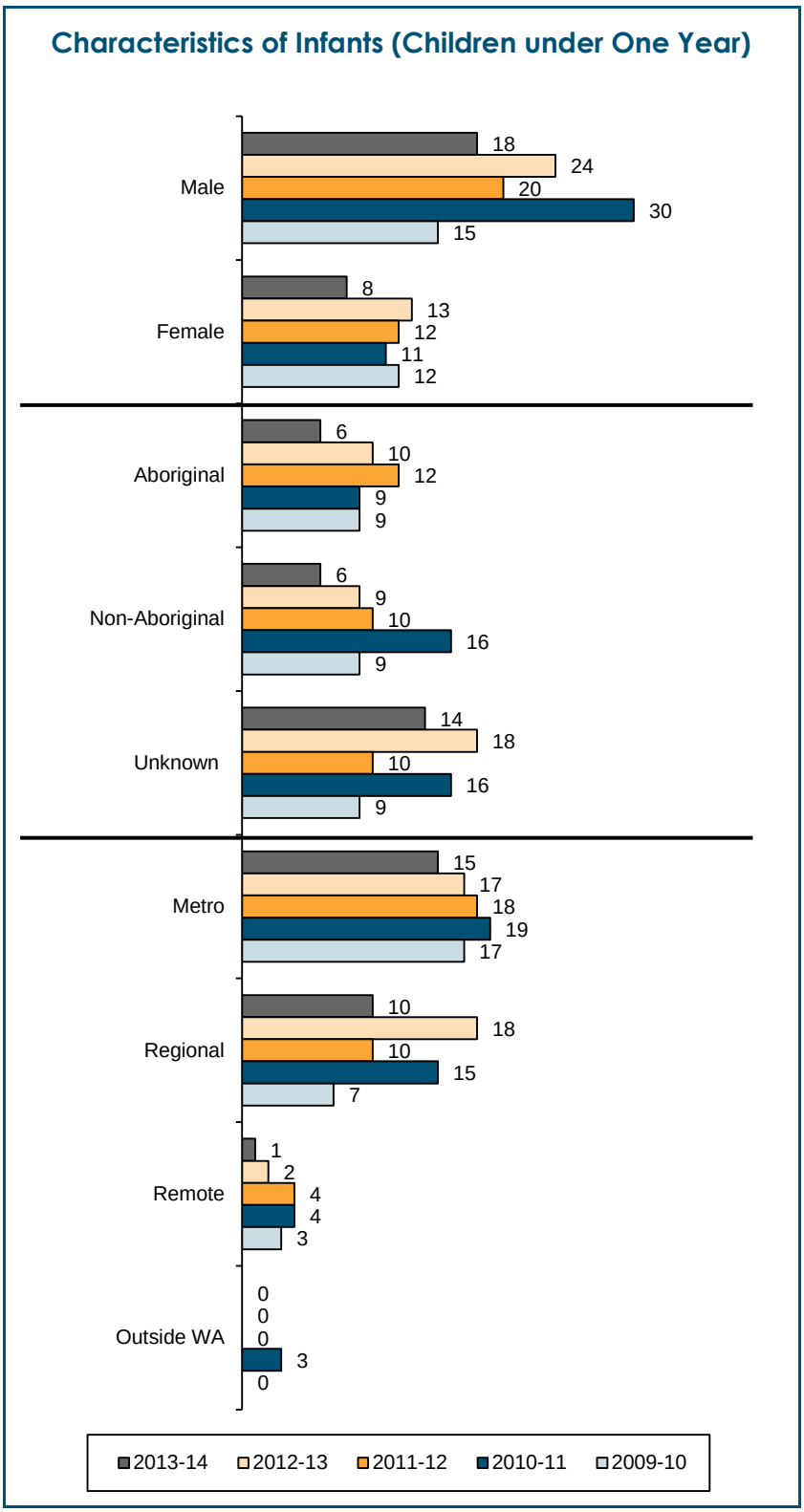
In 2013-14, the majority of children who were known to the Department were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support and access, foster or adoption enquiries.

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 453 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2014, there were 163 (36%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.



Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

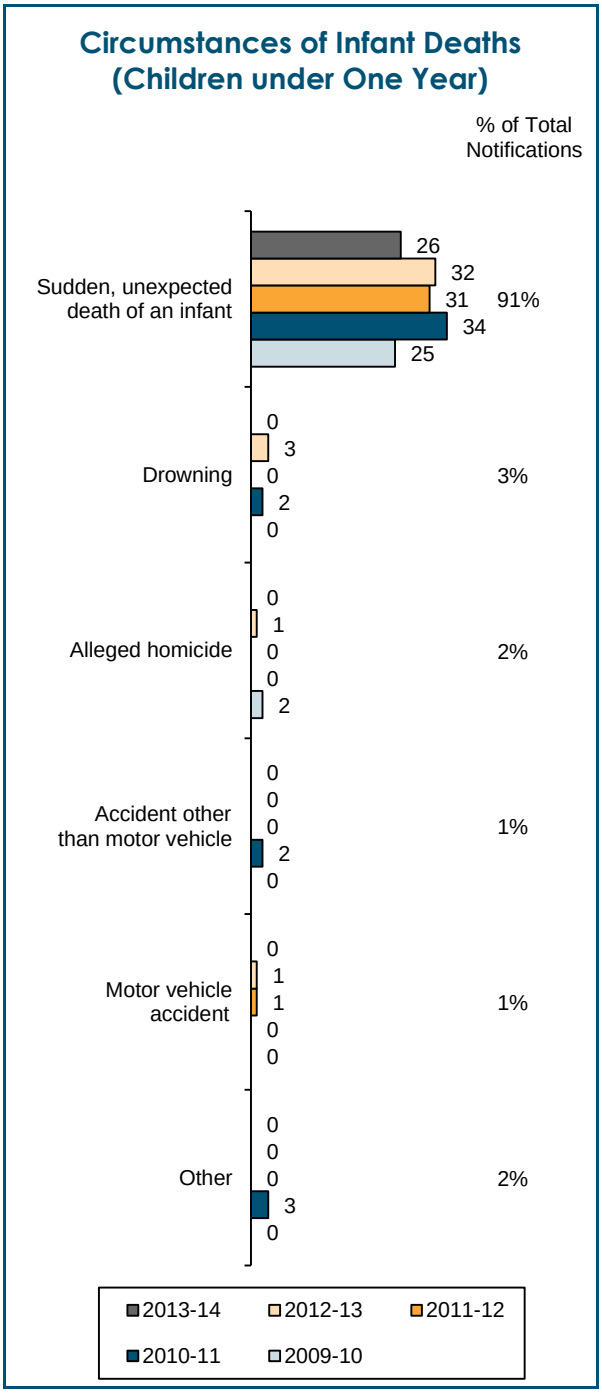
Further analysis of the data showed that, for these infant deaths, there was an over-representation compared to the child population for:

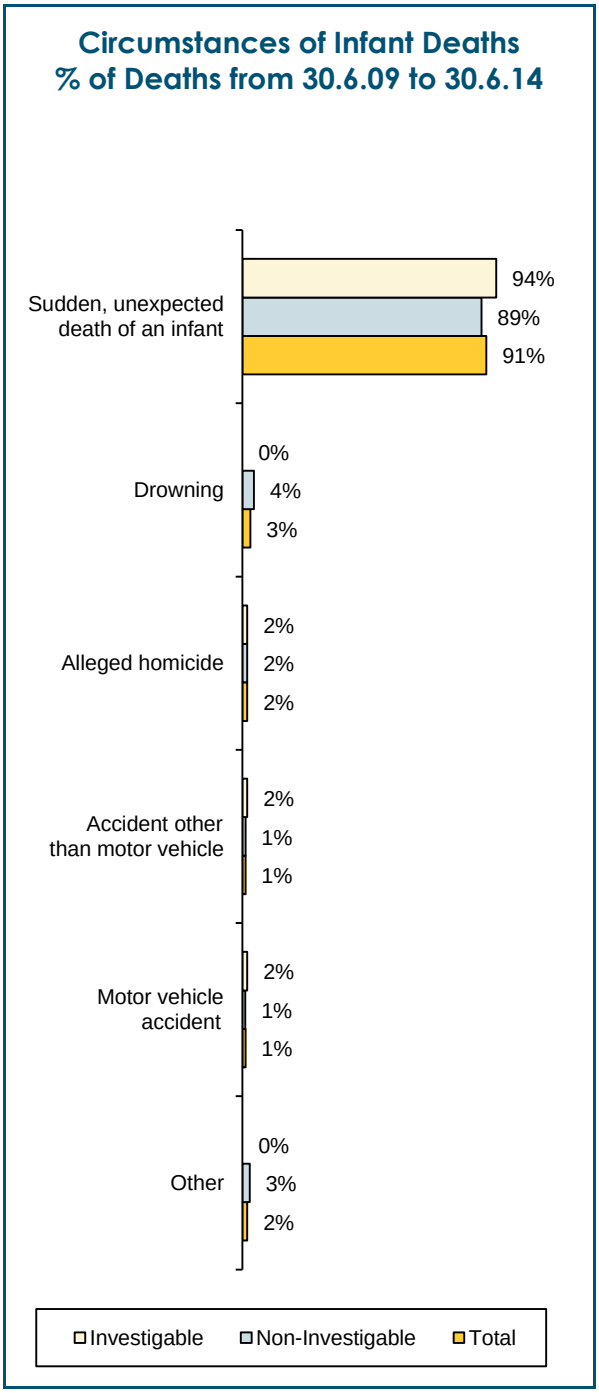
- Males – 77% of investigable infant deaths and 60% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 67% of investigable deaths and 35% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and

- Children living in regional or remote locations – 53% of investigable infant deaths and 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 163 infant deaths, 148 (91%) were categorised as sudden, unexpected deaths of an infant and the majority of these (95) 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.





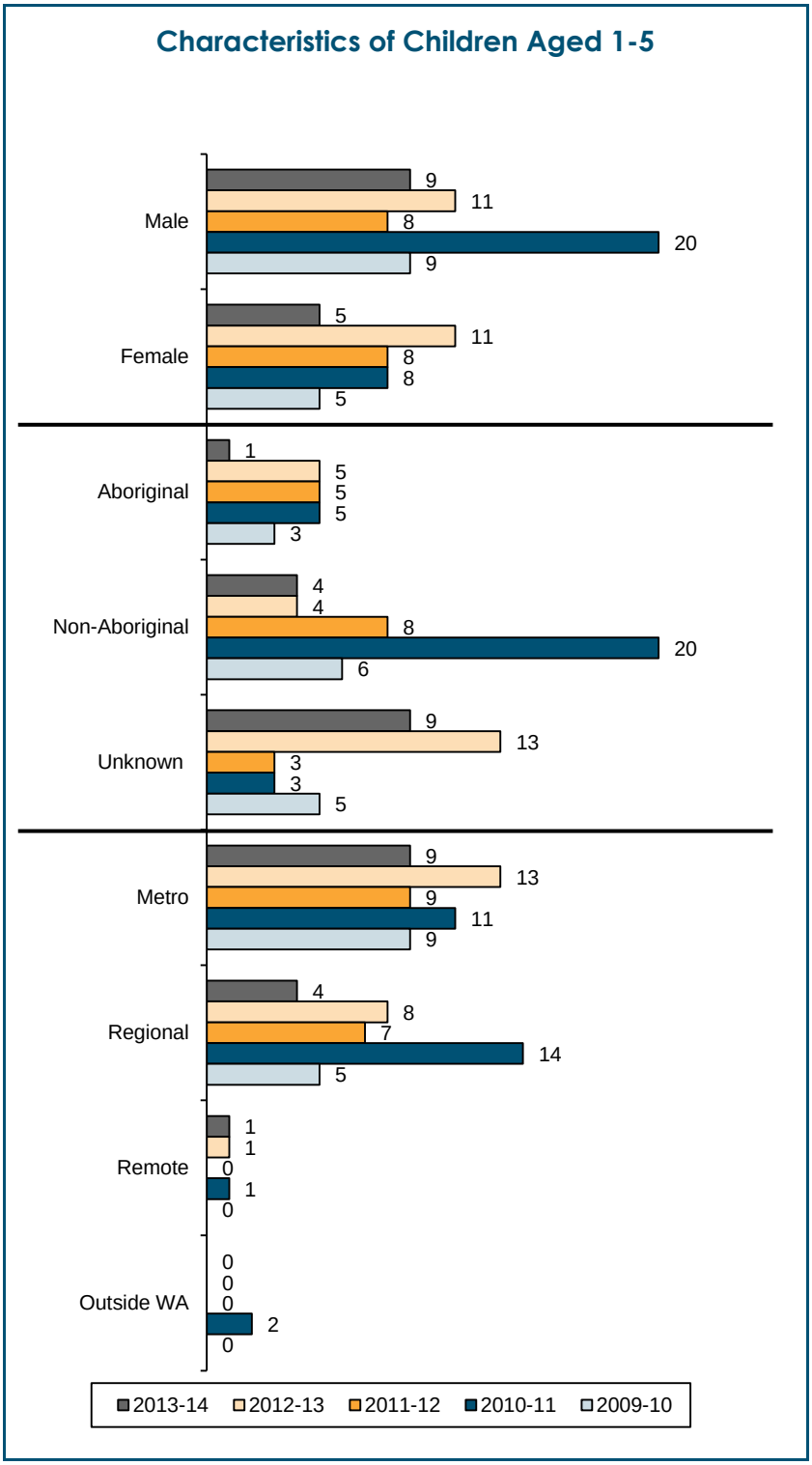
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Fifty three infant death notifications received from 30 June 2009 to 30 June 2014 were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 453 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2014, there were 94 (21%) related to children aged from 1 to 5 years.

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

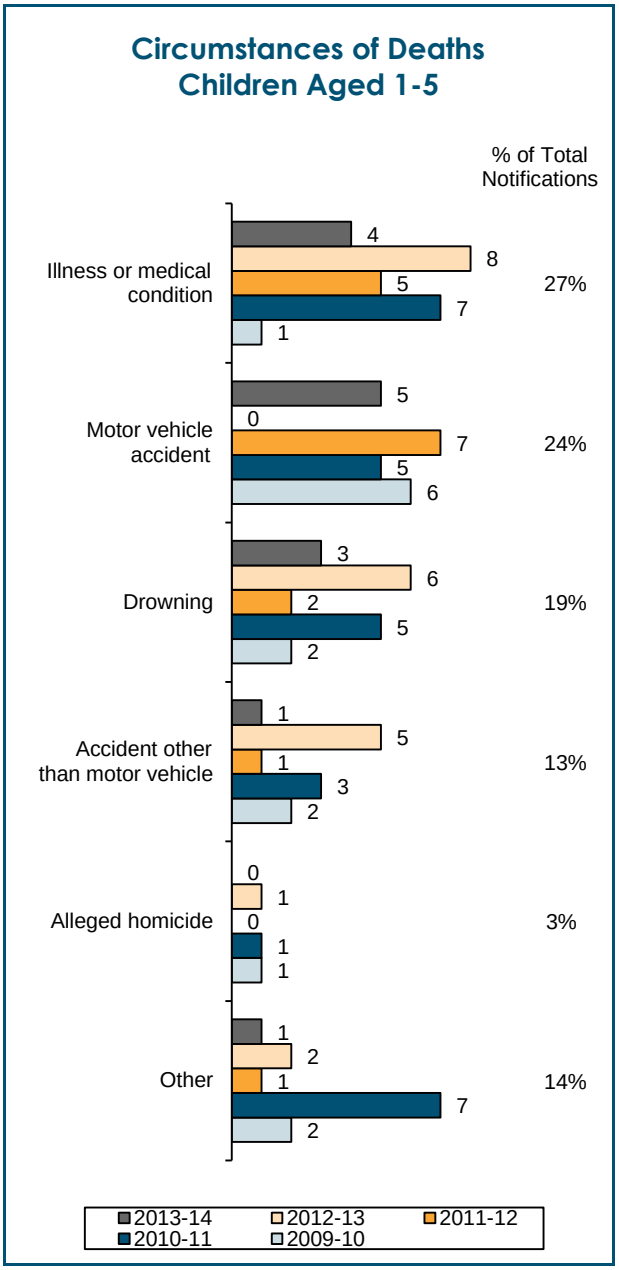


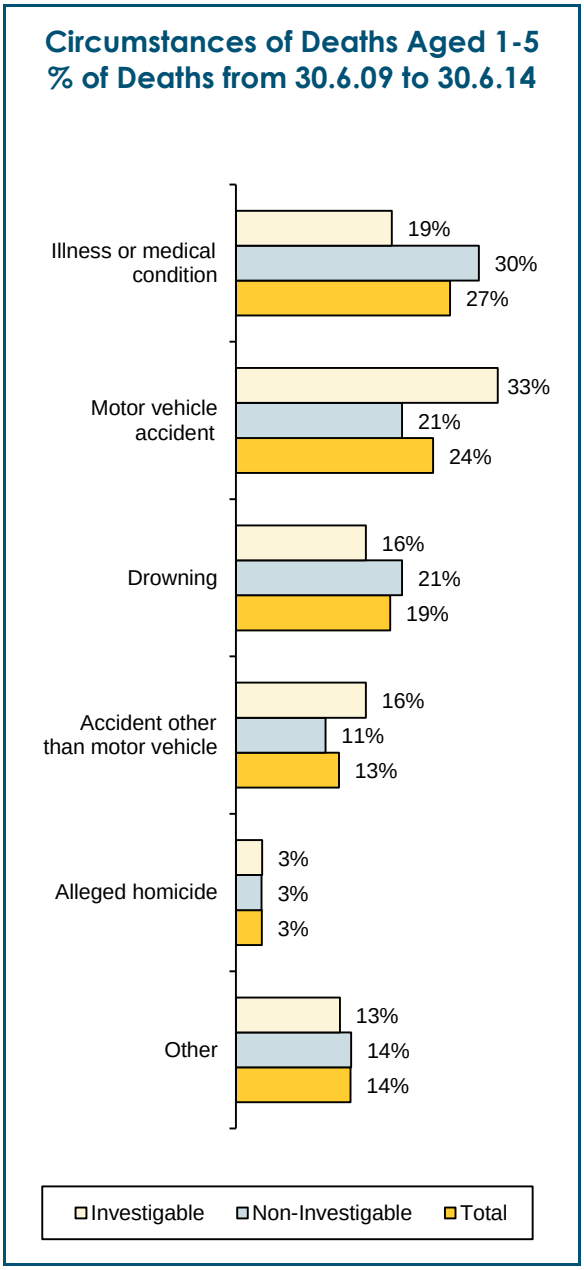
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 61% 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 – 54% of investigable deaths and 12% of non-investigable deaths of children aged 1 to 5 were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 48% of investigable deaths and 43% 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 (27%), particularly for investigable deaths, followed by motor vehicle accidents (24%) and drowning (19%).





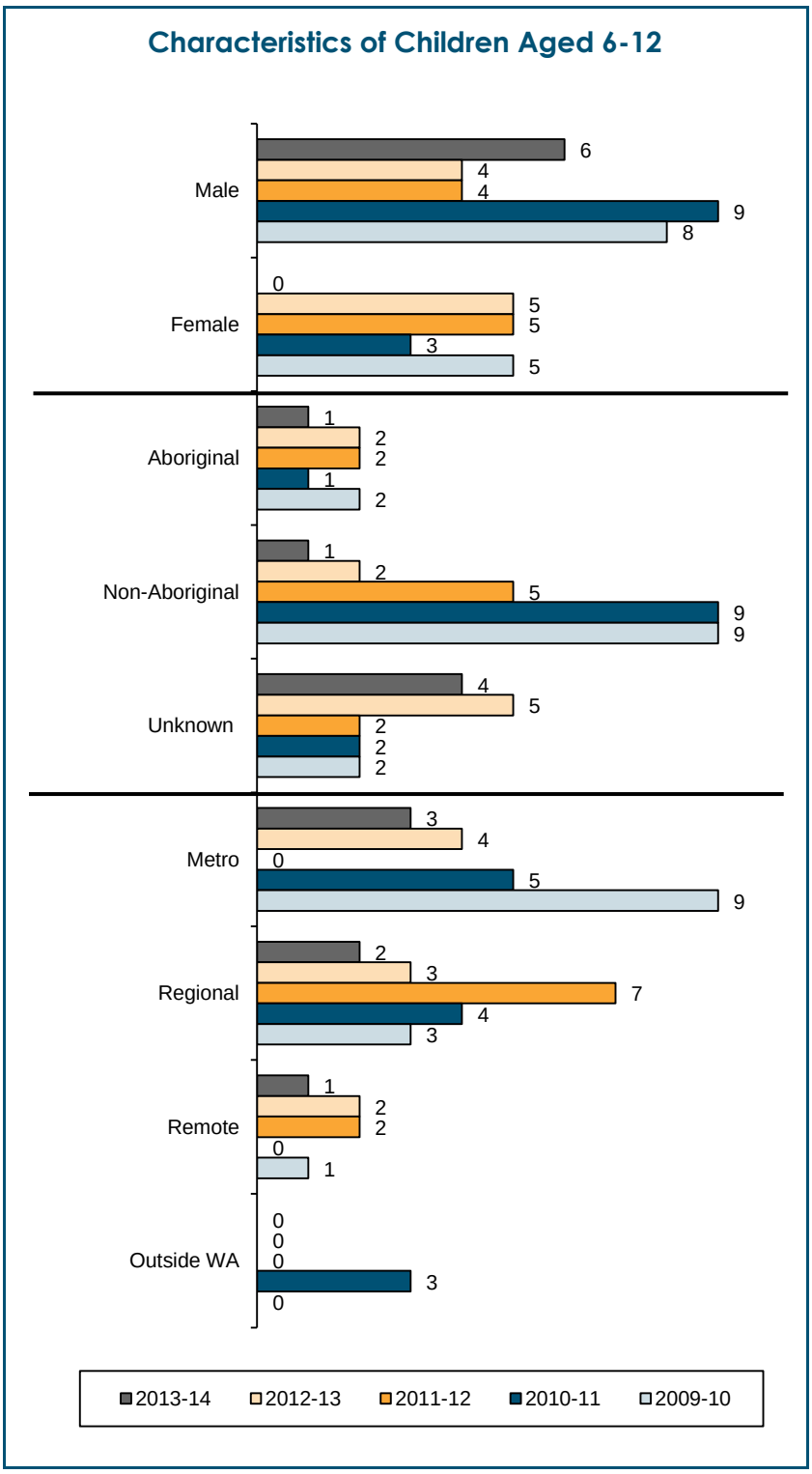
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

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

Deaths of children aged 6 to 12 years

Of the 453 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2014 there were 49 (11%) related to children aged from 6 to 12 years.

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

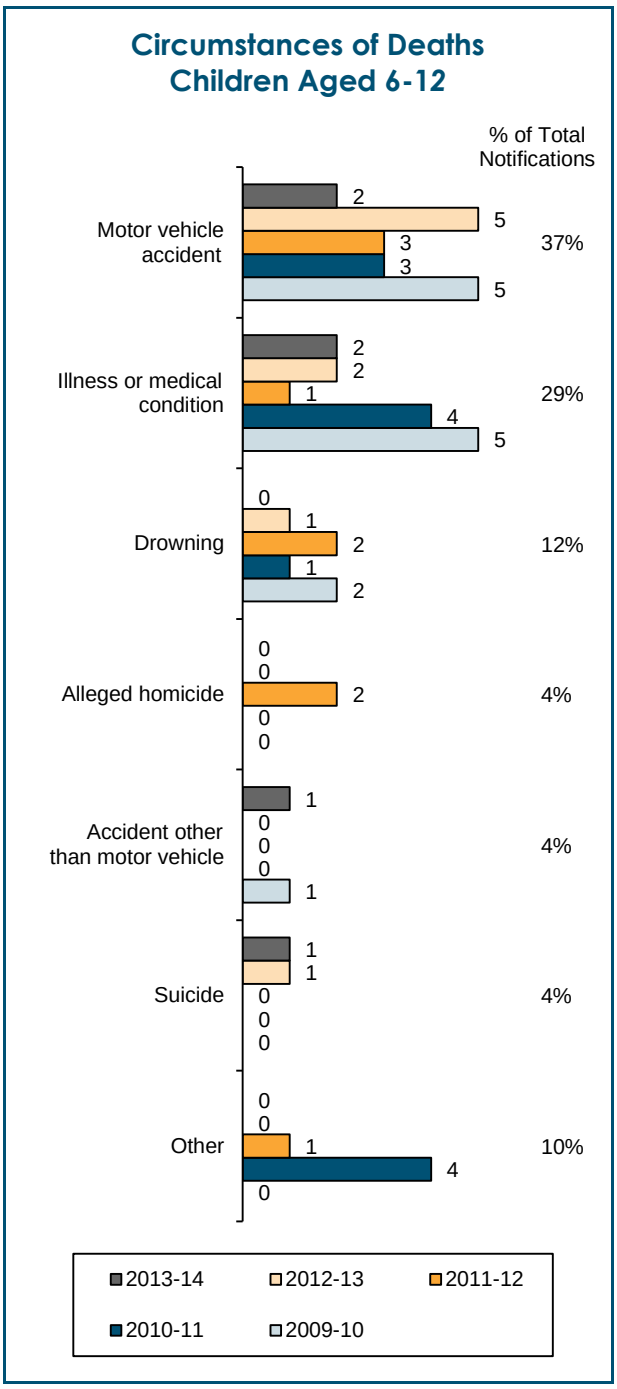


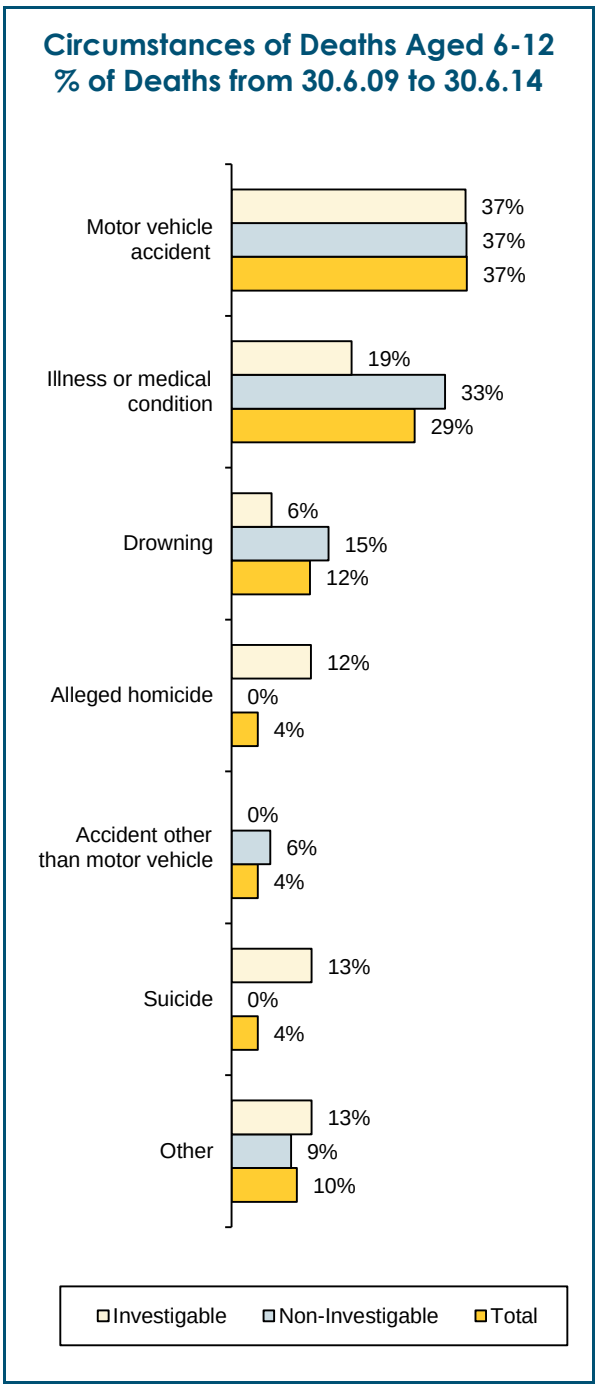
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 73% 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 44% of investigable deaths were male;
- Aboriginal children – 36% of investigable deaths and 15% 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 – 69% of investigable deaths and 47% 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 condition (29%) and drowning (12%).





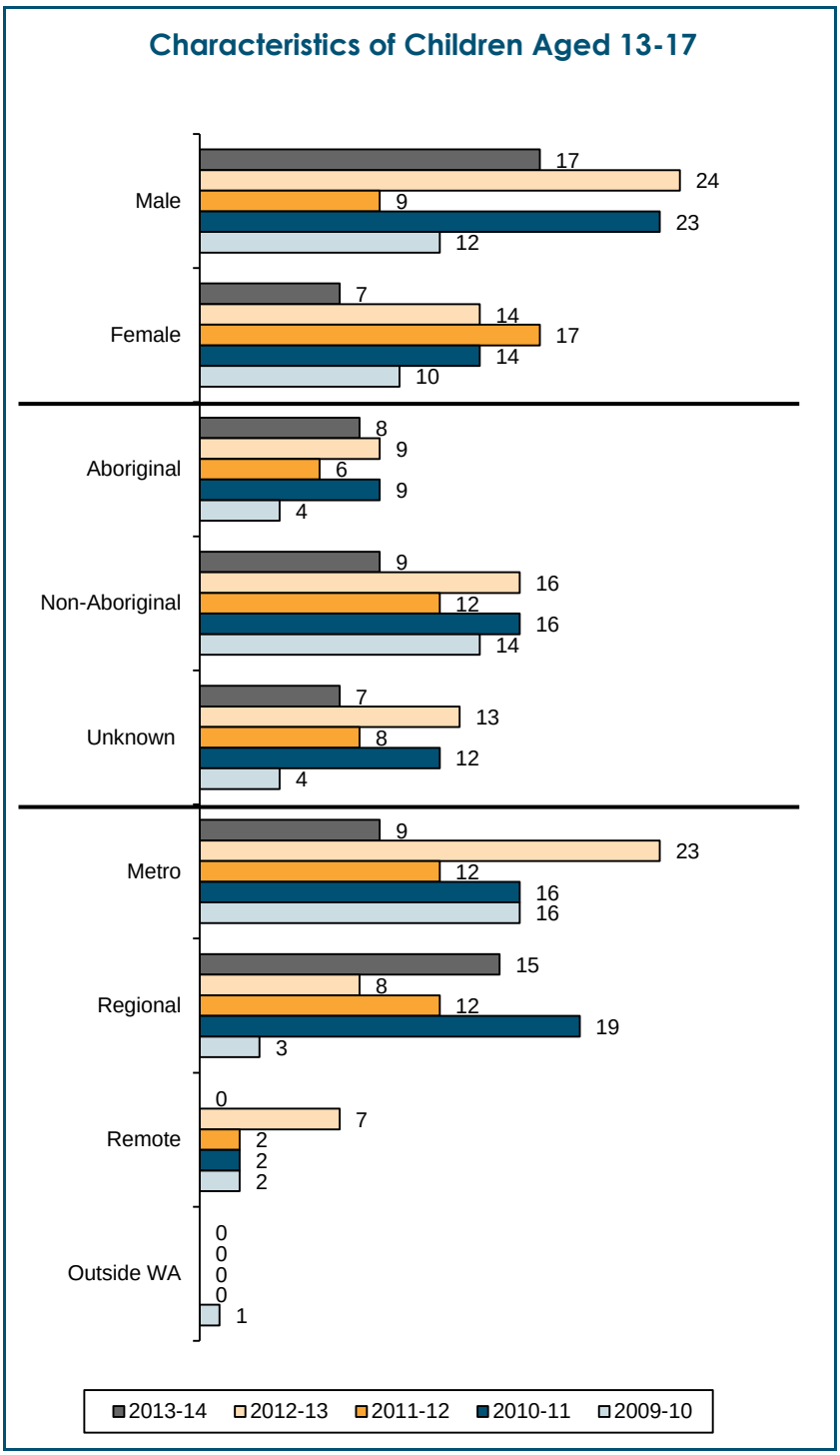
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

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

Deaths of children aged 13 – 17 years

Of the 453 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2014, there were 147 (32%) related to children aged from 13 to 17 years.

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

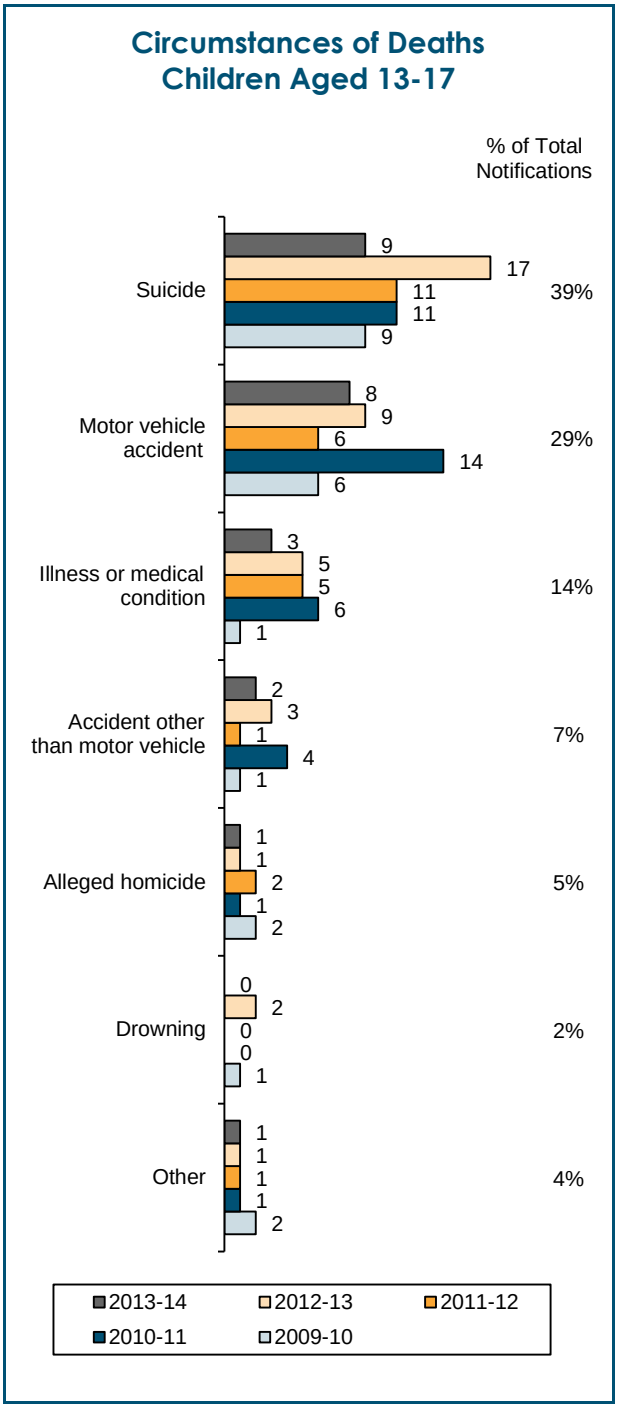


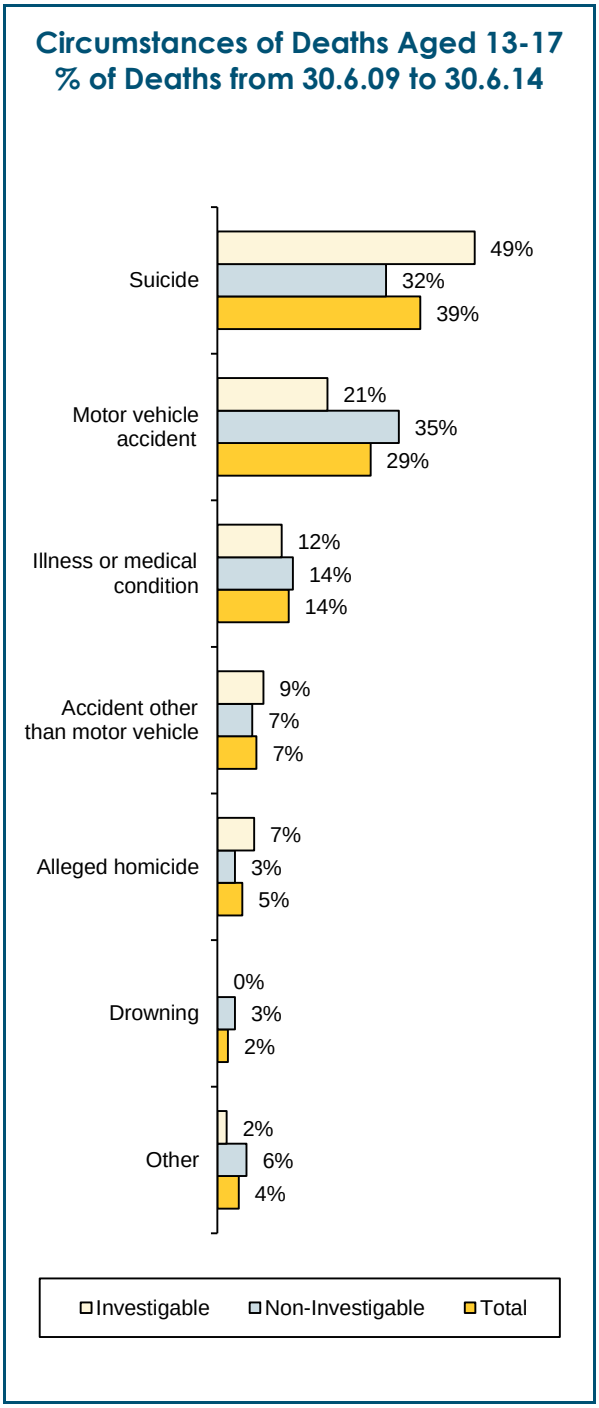
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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 15% 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 – 60% of investigable deaths and 40% 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 (29%) and illness or medical condition (14%).





Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

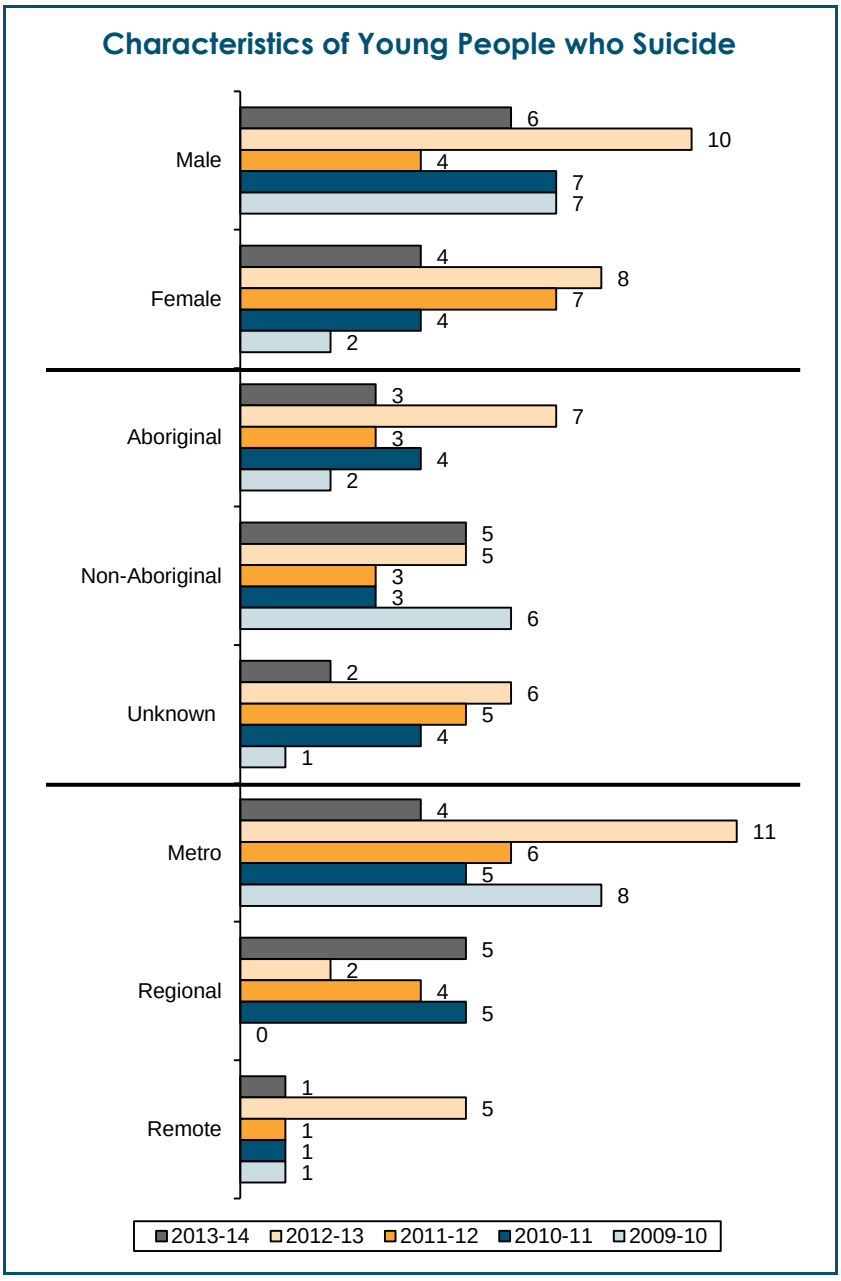
Fifty seven deaths of children aged 13 to 17 years were determined to be investigable deaths.

Suicide by young people

Of the 59 young people who apparently took their own lives from 30 June 2009 to 30 June 2014:

- Two were 12 years old;
- Two were 13 years old;
- Five were 14 years old;
- Sixteen were 15 years old;
- Fifteen were 16 years old; and
- Nineteen were 17 years old.

The characteristics of the young people who apparently took their own lives are shown in the following chart.



Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 53% of investigable deaths, and 62% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – For the 41 apparent suicides by young people where information on the Aboriginal status of the young person was available, 59% of the investigable deaths and 21% 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 60% of investigable youth suicides and 24% of non-investigable youth suicides were young people who were living in regional or remote locations compared to 27% in the child population.

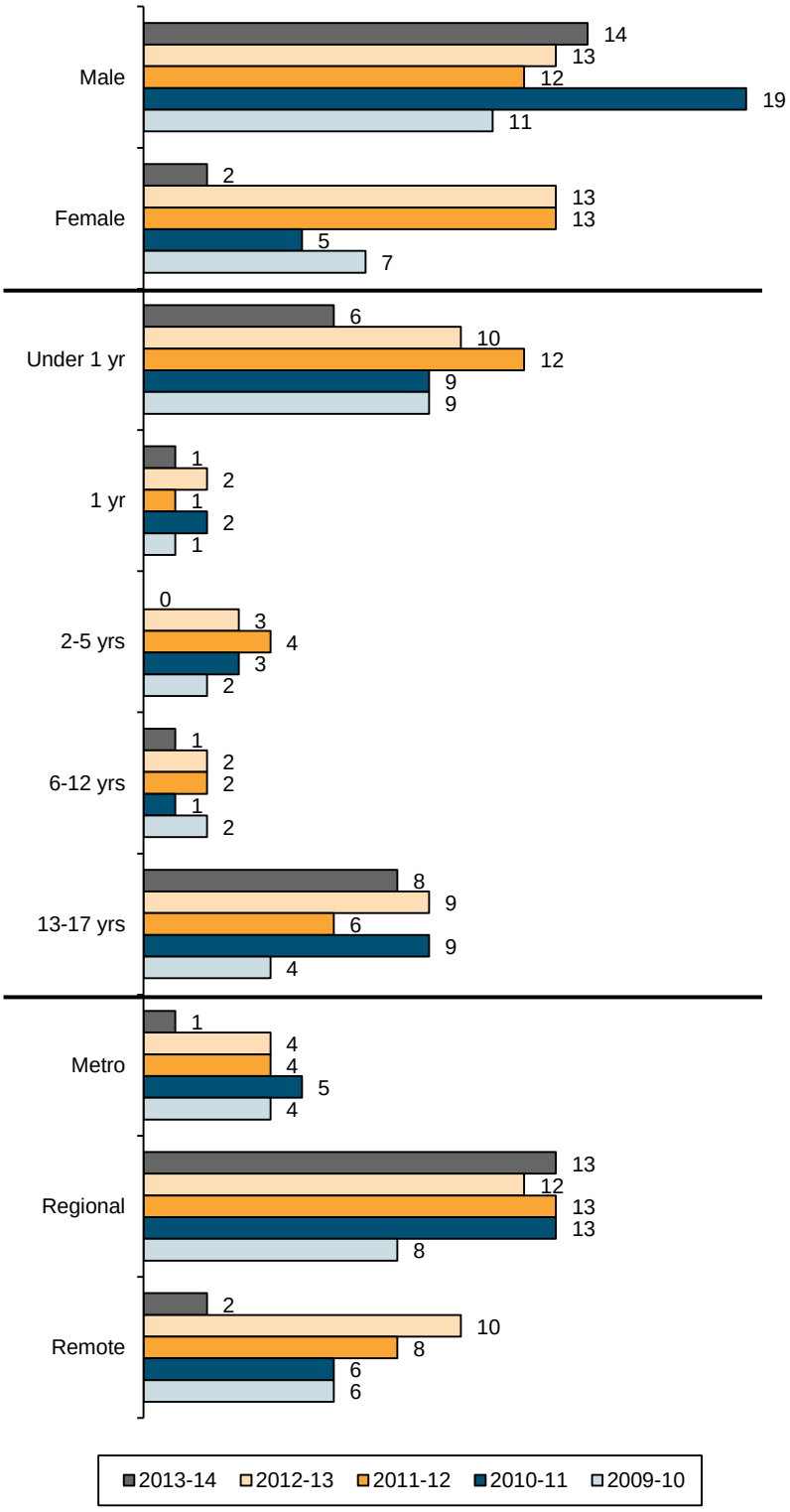
Deaths of Aboriginal children

Of the 294 child death notifications received from 30 June 2009 to 30 June 2014, where the Aboriginal status of the child was known, 109 (37%) of the children were identified as Aboriginal.

For the notifications received, the following chart demonstrates:

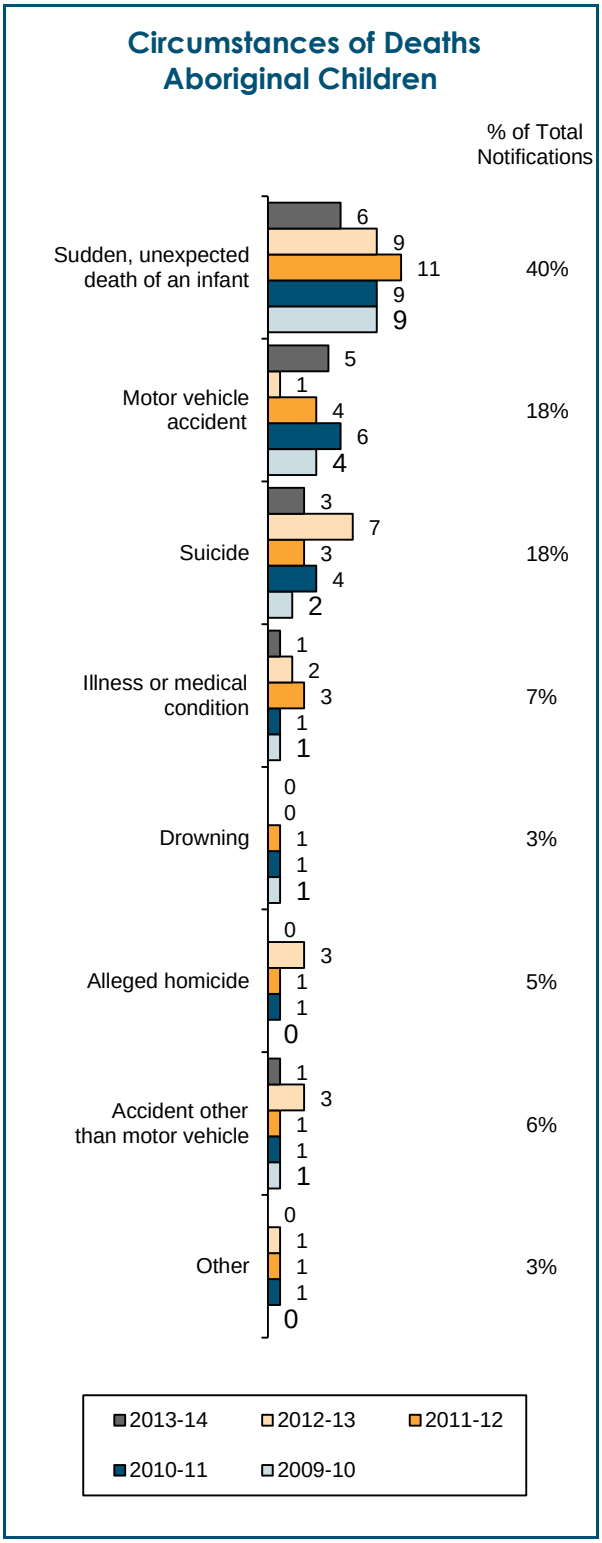
- Over the five year period from 30 June 2009 to 30 June 2014, the majority of Aboriginal children who died were male (63%). For 2013-14, 88% of Aboriginal children who died were male;
- Most of the Aboriginal children who died were under the age of one and children aged 13-17; and
- The deaths of Aboriginal children living in regional communities far outnumber the deaths of Aboriginal children living in the metropolitan area. Over the five year period, 83% of Aboriginal children who died lived in regional or remote communities.

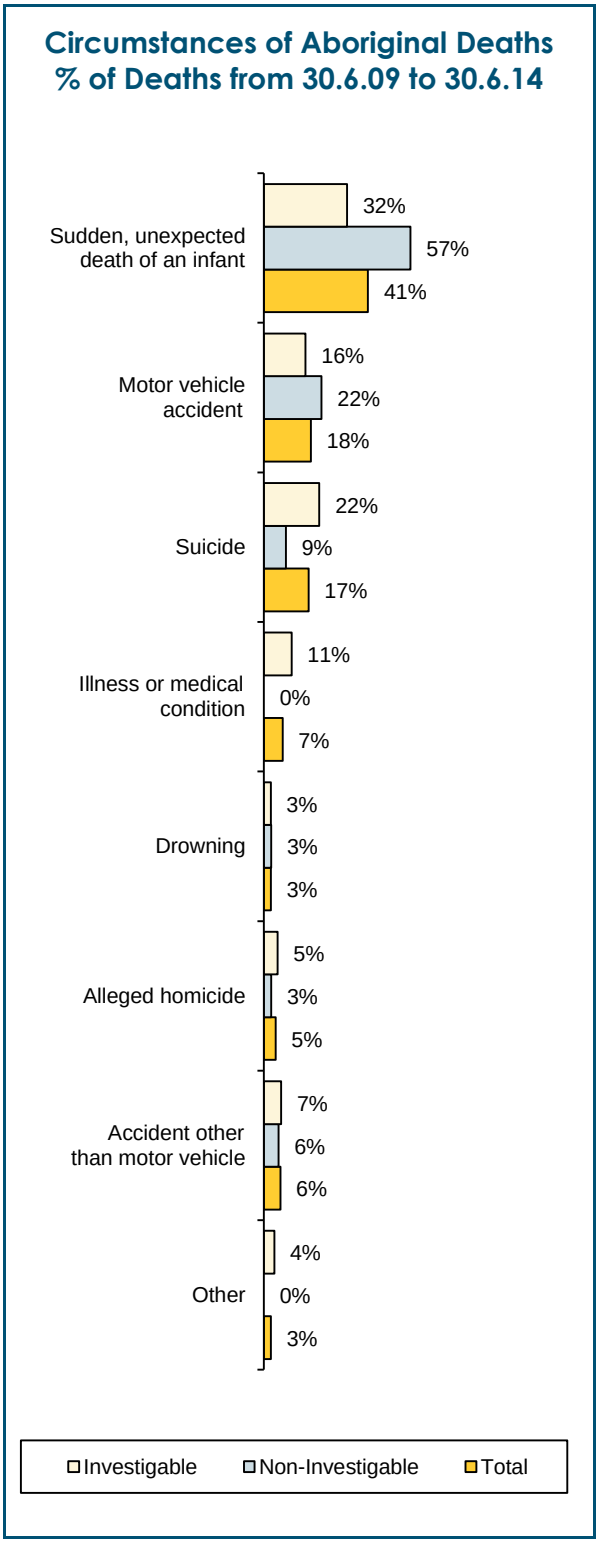
Characteristics of Aboriginal Children who Died



Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

As shown in the following chart, sudden, unexpected death of infants (40%), motor vehicle accidents (18%) and suicide (18%) are the largest circumstance of death categories for the 109 Aboriginal child death notifications received in the five years from 30 June 2009 to 30 June 2014.





Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Improvements to Public Administration to Prevent or Reduce Child Deaths

By undertaking child death reviews the Ombudsman seeks to improve public administration and promote good decision making in those public authorities that provide services to children and families. All improvements are subject to ongoing monitoring and review, to ensure that they are, over time, contributing to the prevention or reduction of child deaths. Information in this section has been set out as follows:

- Issues identified in child death reviews;
- Improvements to public administration, to address issues;
- Outcomes of reviews by age cohort;
- Major own motion investigations arising from child death reviews (including future own motion investigations); and
- Other mechanisms to prevent or reduce 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 appropriately assessing risks and providing support to homeless adolescents.
- Not undertaking sufficient intra-agency communication to enable effective case management.
- Not providing sufficiently effective policies, procedures and guidance to staff in undertaking assessments to meet legislative responsibilities when approving relative carers.
- Not undertaking consultation with an Aboriginal Practice Leader.
- Not adequately providing comprehensive response and management of young people exhibiting self-harming behaviour, substance use and mental health concerns.
- Not adequately meeting policies and procedures relating to care planning and ongoing management of children in the care of the Chief Executive Officer of the Department.
- Not adequately meeting policies and procedures regarding management of case allocation.

- Not adequately meeting policies and procedures relating to child health, safety and wellbeing concerns.
- Not adequately meeting policies and procedures relating to Safety and Wellbeing Assessments.
- Not meeting policies and procedures relating to the Signs of Safety Framework.
- Missed opportunities to promote public safety regarding water hazards.
- Missed opportunities to actively promote infant safe sleeping by providing appropriate information, including the provision of culturally appropriate advice to Aboriginal families and education to foster carers.
- Missed opportunities for inter-agency communication and collaboration, including opportunities to promote the safety and wellbeing of adolescents by re-engaging them in education.
- Not meeting recordkeeping requirements.

Improvements to public administration to address issues

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

- Developing strategies for effective intra-agency communication and collaboration when working with children and their families who reside in more than one district.
- Identifying opportunities for effective inter-agency collaboration to locate children who are on the Department of Education's *Students Whose Whereabouts are Unknown List*.
- Improving compliance with a range of policies and procedures relating to:
    - youth homelessness;
    - care planning and management of children in care;
    - supervised access management;
    - case allocations;
    - Signs of Safety Framework;
    - Safety and Wellbeing Assessments; and
    - Child wellbeing concerns.
- Revising policies, procedures and guidance to improve compliance with legislation in relation to the approval of relative carers.
- Improving provision of support to relative carers in accordance with policy requirements.

- Revising policies to improve the provision of infant safe sleeping information and education.
- Promoting effective supervision and training to support staff to implement policy and legislative requirements.
- Improving signage to inform the public of risks related to diving into potentially dangerous waters.
- Re-inspecting pool fencing and providing information to residents regarding fencing requirements for private portable swimming pools.
- Improving recordkeeping 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

Sleep related infant deaths

In November 2012, the Ombudsman tabled in Parliament a report of an own motion investigation titled *Investigation into ways that State Government departments and authorities can prevent or reduce sleep-related infant deaths*. The report made 23 recommendations about ways to prevent or reduce sleep-related infant deaths, all of which were accepted by the agencies involved.

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. In 2013-14, the Office also commenced an own motion investigation into the implementation and effectiveness of Ombudsman recommendations, including those arising from the report.

Promoting the health and wellbeing of Aboriginal infants in regional and remote communities

The 2008 Council of Australian Governments' *National Indigenous Reform Agreement (Closing the Gap)*, https://www.coag.gov.au/ states (at page 16):

> In 2007-08, the Council of Australian Governments (COAG) agreed to a number of ambitious targets to Close the Gap in Indigenous disadvantage by improving outcomes between Indigenous and non-Indigenous Australians in the areas of life expectancy, health, education and employment.

The *National Indigenous Reform Agreement* identifies six specific targets, including (at page 8) to 'halve the gap in mortality rates for Indigenous children under five years of age within a decade'.

Public authorities play a part in working to reduce the mortality rate for Aboriginal children under five years of age. Aboriginal infants are over-represented in child

death notifications, and the Ombudsman's reviews examine how the health and wellbeing of Aboriginal infants can be promoted, particularly those living in regional and remote Western Australia, as shown in the following case study.

Case Study

Infant A

Infant A's older siblings had been placed in foster care by the Department. During Infant A's gestation and following Infant A's birth, assessment and planning occurred so that Infant A could remain in the care of one of Infant A's parents with the necessary supports and monitoring in place. Infant A experienced illness during early infancy that required management at a metropolitan hospital and, upon discharge to home, outpatient follow-up was planned at a regional hospital. Infant A did not attend this regional hospital outpatient appointment, and subsequently the parent and Infant A travelled to a remote community to visit with family. Infant A became unwell in the remote community and subsequently died in hospital.

While there had been inter-agency communication during the metropolitan hospital admission, inter-agency communication did not occur in relation to outpatient follow-up at the regional hospital, in accordance with practice guidelines.

This case highlights the importance of effective inter-agency communication and collaboration in decision making to promote the health and wellbeing of Aboriginal infants in regional and remote communities.

As a result of the review, it was agreed that inter-agency communication would result in an agreed documented plan that has been confirmed by all agencies party to the plan.

Deaths of children aged 1 to 5 years

Deaths from drowning

The *Royal Life Saving Society – Australia: National Drowning Report 2013* (available at www.royallifesaving.com.au) examined drowning deaths across Australia between 1 July 2012 and 30 June 2013 and reported (at page 10) a 48% national increase in deaths of children under 5 years of age from drowning since the previous year, the 'first increase since a steady decline from 2009-10'. The report noted that, for this age group, swimming pools account for the largest proportion of drowning deaths and an absence of supervision was identified in 94% of cases.

In 2013-14, the Ombudsman's review of deaths of children aged 1 to 5 years who drowned reinforced the importance of maintaining barriers to residential swimming pools, and the importance of local government authorities providing information in relation to pool fencing requirements, as highlighted in the following case study.

Case Study

Child B

Child B died by drowning in a portable swimming pool at the family home. There was no fence or safety barrier to enclose the swimming pool.

The local government authority provided residents with information in relation to compliance with relevant fencing requirements. The Ombudsman's review of this case identified that there could be additional information provided to residents in relation to private portable swimming pools containing water more than 300mm deep.

The review of this case highlighted the importance of ensuring appropriate barriers for portable swimming pools and the role local government authorities can play in informing residents of this requirement.

The *Consumer Goods (Portable Swimming Pools) Safety Standard* requires the labelling of portable swimming pools with a warning message to alert consumers of the drowning hazard, the need for active adult supervision, and applicable pool fencing laws.

In 2013-14, the Ombudsman finalised four reviews relating to deaths of children aged 1 to 5 years who drowned in residential swimming pools. In these four cases, the child was able to access the swimming pool because either fencing requirements were not met or the self-closing mechanisms on gates or doors were not functional. In 2014-15, the Ombudsman will commence an own motion investigation into deaths from drowning.

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, inter-agency 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 children in the care of the CEO 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 the ways that public authorities are working to strengthen and enhance care planning for children in the CEO's care, is actively monitored in individual child death reviews, and through the Ombudsman's monitoring of the actions taken by public authorities to implement recommendations made by the Ombudsman.

In addition, in 2013-14, the Ombudsman commenced an own motion investigation into the implementation and effectiveness of Ombudsman recommendations, including the recommendations arising from the report.

Deaths of children aged 13 to 17 years

Suicide by young people

Apparent suicide has been identified as the primary circumstance of death for young people aged 13 to 17. This issue was examined in depth by the Ombudsman's major own motion investigation into suicide by young people, and the report, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* was tabled in Parliament in April 2014. The report is available on the Ombudsman's website.

The Ombudsman undertook the own motion investigation into suicide by young people to develop an understanding of young people's involvement with public authorities, identify patterns and trends including risk factors for suicide and identify ways that agencies can prevent or reduce suicide by young people. In summary, the investigation found that State government departments and authorities have already undertaken a significant amount of work that aims to prevent and reduce suicide by young people in Western Australia; however, there is still more work to be done. The report recommended practical opportunities for individual agencies to enhance their provision of services to young people and, critically, as the reasons for suicide by young people are multi-factorial and cross a range of government agencies, recommended development of a collaborative, inter-agency approach to preventing suicide by young people. Further details on the investigation and report are set out in the Own Motion Investigations and Administrative Improvement section.

Inter-agency collaboration

Schools are well placed to identify children whose wellbeing may be 'at risk' and to take action to provide support and referral. The Ombudsman's major own motion investigation into suicide by young people and individual reviews of the deaths of young people have examined the strategies in place to address poor school attendance and the inter-agency collaboration to re-engage these young people in schooling, as highlighted in the case below.

Case Study

Adolescent C

Adolescent C came from a home environment of alleged family and domestic violence and child wellbeing concerns. Adolescent C did not attend school in the two years prior to death by apparent suicide.

The school had been unable to locate Adolescent C, and in accordance with policy, had placed Adolescent C on the Department of Education's *Students Whose Whereabouts is Unknown List*. The Department of Education followed the strategies identified by the policy of that time, but was unable to locate Adolescent C. However, during the two year period that Adolescent C was on the *Students Whose Whereabouts is Unknown List*, Adolescent C had multiple contacts with a range of other government departments.

As a result of the review, it was agreed that work between agencies would be undertaken to consider appropriate opportunities for inter-agency collaboration at a District level to locate children on the *Students Whose Whereabouts is Unknown List*.

Identification of good practice

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

Case Study

Infant D

Infant D died at the age of three months having been positioned to sleep in a manner that was inconsistent with recommended safe infant sleeping practices.

During the birth admission, Infant D's family was provided with safe infant sleeping education consistent with the Department of Health's policy requirements. In addition, following discharge to home the child health nurse visited the family and safe infant sleeping practices were reviewed and re-enforced. The Ombudsman's review of this case identified good practice by the health services involved in providing Infant D's family with safe infant sleeping education.

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 tabled in Parliament a report, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*.

The Ombudsman also monitored the implementation of recommendations from the own motion investigations:

- *Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004*, which was tabled in Parliament in November 2011; and
- *Investigation into ways that State Government departments can prevent or reduce sleep-related infants deaths,* which was tabled in Parliament in November 2012.

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 the Department's 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 2013-14 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 (Head of the Department of Social Work, Curtin University);
- Ms Dorinda Cox (Consultant);
- Ms Angela Hartwig (Women's Council for Domestic and Family Violence Services WA);
- Ms Victoria Hovane (Consultant); and
- Associate Professor Carolyn Johnson (School of Population Health, University of Western Australia).

Observers from the Department, the Department of Health, Department of Aboriginal Affairs, Department of Education, Department of Corrective Services, Department of the Attorney General and Western Australia Police also attended the meetings.

This year, among other things, the Panel provided valuable advice to the Ombudsman regarding the report, *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 liaise with Aboriginal community leaders, Aboriginal Health Services, local governments, regional offices of Western Australia Police and the Department, and community advocates.