Own Motion Investigations and Administrative Improvement

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

- Improvements to public administration as a result of:
  - The investigation of complaints;
  - Reviews of child deaths and family and domestic violence fatalities; and
  - Undertaking own motion investigations that are based on the patterns, trends and themes that arise from the investigation of complaints, and the review of certain 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 public administration. Among other things, 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 public administration 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 informed 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.

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

Own Motion Investigations in 2013-14

In 2013-14, an own motion investigation into ways that State government departments and authorities can prevent or reduce suicide by young people was finalised and work was undertaken on three further own motion investigations, regarding:

- Issues associated with Violence Restraining Orders and their relationship with family and domestic violence fatalities;
- Local government collection of outstanding rates; and
- The implementation and effectiveness of Ombudsman recommendations.

Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people

In April 2014, the Ombudsman tabled in Parliament a report of an own motion investigation entitled *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*. The report is available on the Ombudsman's website.

Reasons for the investigation

Of the child death notifications received by the Office since the commencement of the Office's child death review responsibility, nearly a third related to children aged 13 to 17 years old. Of these children, suicide was the most common circumstance of death, accounting for nearly 40% of deaths. Furthermore, and of serious concern, Aboriginal children were very significantly over-represented in the number of young people who died by suicide.

For these reasons, it was decided to undertake an investigation of these young people who died by suicide with a view to determining whether it may be appropriate to make recommendations to any State government department or authority about ways to prevent or reduce such deaths.

Objectives of the investigation

The objectives of the investigation were to:

- Develop a detailed understanding of young people's involvement with State government departments and authorities before their deaths, including the nature and extent of their involvement;
- Identify any patterns and trends in: demographic characteristics and social circumstances of young people who died by suicide; the circumstances of the suicides; the risk factors for suicide demonstrated by the young people; and their involvement with State government departments and authorities; and
- Based on this understanding, identify ways that State government departments and authorities can prevent or reduce suicide by young people, and make recommendations to these departments and authorities accordingly.

The investigation considered young people who died by suicide who were aged between 13 and 17 years. The Office analysed 36 deaths in which a young person had either died by suicide or was suspected of having died by suicide.

Key findings and messages of the investigation

In summary, the report 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. This work includes practical opportunities for individual agencies to enhance their provision of services to young people. Critically, as the reasons for suicide by young people are multi-factorial and cross a range of government agencies, this work includes the development of a collaborative, inter-agency approach to preventing suicide by young people.

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.

In addition to the findings and recommendations, the comprehensive level of data and analysis contained in the report will, we believe, be a valuable new resource for State government departments and authorities to inform their planning and work with young people. In particular, the analysis suggests this planning and work target four groups of young people that were identified.

Detailed findings of the investigation

Demographic characteristics of the 36 young people

- The 36 young people ranged in age from 14 to 17 years at time of death. Four young people were aged 14 years, 10 were aged 15 years, 11 were aged 16 years and 11 were aged 17 years at time of death.
- Among the 36 young people, 22 (61%) were male and 14 (39%) were female.
- Thirty-three (92%) of the 36 young people were born in Australia. Three young people were born outside Australia.
- Aboriginal young people were significantly over-represented among the 36 young people. Thirteen (36%) of the 36 young people were identified as Aboriginal and 23 (64%) young people were identified as non-Aboriginal. For comparison, six per cent of children and young people aged 0 to 17 years in Western Australia are Aboriginal.
- The majority of the 36 young people were residing in the metropolitan area of Perth at the time of their death. Using regions defined by the Australian Bureau of Statistics, 21 young people were residing in a major city, six young people were residing in an inner regional area, three young people were residing in an outer regional area and six young people were residing in a remote or very remote region. Taking into account the numbers of young people residing in each of these regions, the mortality rates for the 36 young people who died by suicide were as follows:
    - 2.4 per 10 000 young people resided in a major city;
    - 5.4 per 10 000 young people resided in an inner regional area;
    - 3.2 per 10 000 young people resided in an outer regional area; and
    - 10.6 per 10 000 young people resided in a remote or very remote region.

- Applying the Australian Bureau of Statistics' definition of homelessness, eight (22%) of the 36 young people experienced at least one form of homelessness at some time in their lives. For comparison, Australian Bureau of Statistics census data reports that in 2011 less than 0.6% of children aged 12 to 18 years were homeless at the census date.

Factors associated with suicide for the 36 young people

- The research literature identifies a range of risk factors, warning signs and precipitating events associated with suicide by young people. These are referred to here as **factors associated with suicide**. While no single cause of suicide has been identified, the factors associated with suicide have been shown to increase the risk of suicide, particularly when multiple factors are present and interact with each other. It is important to note that these factors are considered to be correlative, not causal.

- Several factors associated with suicide have already been discussed above as demographic characteristics of the 36 young people, namely, being male and experiencing homelessness.

- Records indicate that mental health problems were prevalent among the 36 young people:

    - Twelve (33%) young people were recorded as having had a diagnosis of mental illness; and

    - Fifteen (42%) young people were recorded as having demonstrated self-harming behaviour.

- Records indicate that suicidal ideation and behaviour were also prevalent among the 36 young people:

    - Twenty two (61%) young people were recorded as having had thoughts about attempting or completing suicide;

    - Twenty (56%) young people were recorded as having communicated their intention to commit suicide to a friend, family member or health professional; and

    - Sixteen (44%) young people were recorded as having previously attempted suicide, with six of these young people recorded as having attempted suicide on more than one occasion.

- Child maltreatment consists of any act of commission or omission by a parent or caregiver that results in harm, the potential for harm or the threat of harm to a child, even if the harm is unintentional. The Office examined allegations of child maltreatment of the 36 young people and found:

    - Sixteen (44%) young people were said to have experienced family and domestic violence;

    - Nine (25%) young people were recorded as having allegedly experienced sexual abuse;

    - Eight (22%) young people were recorded as having allegedly experienced physical abuse; and

- Twelve (33%) young people were recorded as having allegedly experienced one or more elements of neglect during their childhood.

- Records indicate that, among the 36 young people, the frequency of adverse family experiences was:
  - Thirteen (33%) young people were recorded as having a parent who had been diagnosed with a mental illness;
  - Eight (22%) young people were recorded as having a parent with alleged problematic alcohol or other drug use;
  - Five (14%) young people were recorded as having a parent who had been imprisoned; and
  - Three (8%) young people were recorded as having a family member who died by suicide and four (11%) had a friend who died by suicide or knew a person who had died by suicide.

Among the 36 young people who died by suicide, the Office identified four distinct groups of young people

- To analyse the factors associated with suicide, the Office grouped them into the following categories:
  - **Mental health problems**, which included having a diagnosed mental illness and/or self-harming behaviour;
  - **Suicidal ideation and behaviour**, which included suicidal ideation, previous suicide attempts or communicated suicidal intent;
  - **Substance use**, which included alcohol or other drug use;
  - **Experiencing child maltreatment**, which included family and domestic violence, sexual abuse, physical abuse and neglect; and
  - **Adverse family experiences**, which included having a parent with a mental illness, having a parent with alleged problematic alcohol or other drug use, having a parent who had been imprisoned and having a family member, friend or person known to the young person who died by suicide.

- Through the analysis of the factors associated with suicide experienced by the 36 young people, the Office identified four groupings of young people, distinguished from each other by patterns in the factors associated with suicide that each group experienced. The four groups of young people also demonstrated distinct patterns of contact with State government departments and authorities. In brief, the four groups of young people are:
  - **Group 1** - 20 young people who all were recorded as having allegedly experienced one or more forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse or neglect. Most of the 20 young people in Group 1 were also recorded as having experienced mental health problems and/or suicidal ideation and behaviour.

    Records indicate that, as a group, the 20 young people in Group 1 had extensive contact with State government departments and authorities, schools and registered training organisations. All of the young people in

Group 1 were known to the Department for Child Protection and Family Support (**DCPFS**). All had contact with WA Health, with eight young people having contact with the Child and Adolescent Mental Health Service (**CAMHS**). Eighteen of the young people had contact with a government school and seven had contact with a registered training organisation. The 20 young people in Group 1 had significant contact with the State government departments and authorities associated with the justice system. The majority also had contact with the Department of Housing.

- **Group 2** - five young people who were recorded as having been diagnosed with one or more mental illnesses, as having a parent who had been diagnosed with a mental illness and/or demonstrated significant planning of their suicide. None of the five young people were recorded as having allegedly experienced child maltreatment.

  Records indicate that four out of the five young people in Group 2 had contact with WA Health and CAMHS. Three of the five young people had contact with a government school and two had contact with a registered training organisation. Records indicate that none of the young people in Group 2 had contact with DCPFS, Department of Corrective Services, Department of Housing, Department of the Attorney General or Western Australia Police.

- **Group 3** – six young people who were recorded as having experienced few factors associated with suicide. None of these six young people was recorded as having allegedly experienced any element of child maltreatment, a mental health problem or adverse family experiences. All six young people were recorded as being highly engaged in school and highly involved in sport.

  Records indicate that the six young people in Group 3 had minimal contact with State government departments and authorities. Four young people in Group 3 had contact with one State government department, namely WA Health. One young person had contact with a government school and three had contact with registered training organisations. None of the young people in Group 3 had contact with CAMHS, DCPFS, Department of Corrective Services, Department of Housing, Department of the Attorney General or Western Australia Police.

- **Group 4** - five young people who, like the young people in Group 3, were recorded as having experienced few factors associated with suicide, except for four young people who was recorded as having demonstrated suicidal ideation and behaviour and/or engaged in substance use. Although none of the five young people was recorded as having allegedly experienced any elements of child maltreatment, a mental health problem or adverse family experiences, the Office observed that all five young people were recorded as having demonstrated impulsive or risk taking behaviour.

  Records indicate that the five young people in Group 4 all had contact with WA Health, plus government schools. Four young people had contact with DCPFS and registered training organisations. As a group, the five young people in Group 4 had some contact with the State government departments and authorities associated with the justice system. Two young people had

contact with the Department of Housing. None of the five young people in Group 4 had contact with CAMHS.

The patterns identified by the Office may have implications for Western Australia's suicide prevention framework

Different suicide prevention activities may be relevant to each of the four groups of young people

- The research literature refers to a model of interventions for mental health problems developed by Mrazek and Haggerty in 1994 entitled *The spectrum of interventions for mental health problems and mental disorders* (**the Mrazek and Haggerty model**). This model continues to underpin current thinking about suicide prevention strategies. The Mrazek and Haggerty model divides interventions for mental health problems into three categories - Prevention, Treatment and Continuing Care – and further into eight domains within these categories. The Western Australian *Suicide Prevention Strategy 2009-2013: Everybody's Business* (**the State Strategy**) is informed by the Mrazek and Haggerty model.

- The Office analysed how the patterns in the factors associated with suicide experienced by the 36 young people aligned with the categories and domains of suicide prevention activities as set out in the State Strategy. The Office found that the patterns in the factors associated with suicide experienced by each of the four groups of young people may be aligned with different, albeit overlapping domains of suicide prevention activities. This means that different suicide prevention activities may be relevant to each of the four groups of young people.

Preventing and reducing suicide by young people may involve symptom identification, treatment and continuing care for young people who have experienced child maltreatment and mental health problems

- The State Strategy identifies that it is focused on the Prevention category of the Mrazek and Haggerty model, which comprises activities that '… can be targeted universally at the general population, they can focus on selective at-risk groups or they can be directed to those at risk as required.' The Office's analysis also indicates that suicide prevention activities in the Prevention category may be important and should continue.

- In addition, the Office found that the factors associated with suicide experienced by 25 (69%) of the 36 young people may align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model.

State government departments and authorities potentially have an important role to play in preventing suicide by young people, including the Department of Health, the Department for Child Protection and Family Support and the Department of Education

- Records indicate that all of the 36 young people had contact with State government departments and authorities at some point in their lives. Records indicate that 31 of the 36 young people (86%) had contact with multiple State government departments and authorities. These 31 young people were across Groups 1 to 4.

- Chapters 7 to 9 of this report contain detailed analysis of the contact by the 36 young people with three State government departments and authorities. These are CAMHS, DCPFS and the Department of Education. The findings and recommendations in these chapters largely concern activities that align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model. These recommendations could be considered as part of the development of the State Strategy past 2013.

The patterns identified by the Office may have implications for the Department of Health

Twelve of the 36 young people were recorded as having been diagnosed with a mental illness and all were referred for assessment by the Child and Adolescent Mental Health Service at some point in their lives

- The research literature identifies mental illness as a factor associated with suicide. Twelve of the 36 young people were recorded as having been diagnosed with a mental illness. All 12 young people were referred to CAMHS at some point in their lives. This contact presents an important opportunity to identify and treat mental illness and, in doing so, assist in preventing and reducing suicide by young people.

- Eight of the 12 young people were also recorded as having allegedly experienced at least one form of child maltreatment. These young people have been included in Group 1. The remaining four young people who were recorded as having been diagnosed with a mental illness was also recorded as having experienced self-harming behaviour, suicidal ideation and previous suicide attempts. However, none of these four young people were recorded as having allegedly experienced child maltreatment or any adverse family experiences other than a parent with a mental illness. These young people have been included in Group 2.

- The Office examined referrals to CAMHS, acceptance of referrals by CAMHS, risk assessments, treatment and discharge planning for the 12 young people who were recorded as having been diagnosed with a mental illness. The Office found differences between the experiences of the young people in Group 1 and Group 2, particularly with respect to acceptance of referrals by CAMHS and risk assessments. These patterns are discussed below.

By ensuring that the priorities for acceptance of referrals by CAMHS are applied more consistently for all young people, the Department of Health can assist in preventing and reducing youth suicide

- Of the 20 young people in Group 1, eight young people were recorded as having been diagnosed with a mental illness. All eight young people had been referred to CAMHS and, for six young people, these referrals had been accepted by CAMHS at some point in their lives.

- During the last year of their lives, six of the eight young people were referred to CAMHS again. However, three young people were not accepted by CAMHS even though they met the priorities for acceptance set out in the *WA Country Health Service Child and Adolescent Mental Health Services Access Criteria Policy.* The remaining three young people either received services from CAMHS or were waitlisted. Of the five young people in Group 2, four were recorded as

having been diagnosed with a mental illness. Records indicate that these four young people were diagnosed with a mental illness during the last two years of their lives. All four of these young people were referred to CAMHS. All referrals were accepted by CAMHS and the young people referred received services from CAMHS or were waitlisted to receive CAMHS services.

By ensuring that risk assessments are conducted more consistently for all young people across WA Health's hospitals and health services, the Department of Health can assist in preventing and reducing youth suicide

- Risk assessments, including risk of harm to self (self-harm and suicide), are required by WA Health's *Clinical Risk Assessment and Management in Western Australian Mental Health Services: Policy and Standards* (**the CRAM Policy**).
- For the eight young people in Group 1 who had been recorded as having been diagnosed with a mental illness, risk assessments were not generally undertaken at the points where they were required by the CRAM policy, as follows:
    - Two risk assessments were undertaken as part of four admissions to an inpatient mental health unit; and
    - Six risk assessments were undertaken on 14 presentations to an emergency department with self-harm, suicidal ideation and/or behaviour.
- For the four young people in Group 2 who had been recorded as having been diagnosed with a mental illness, risk assessments were generally undertaken in accordance with the CRAM policy, as follows:
    - Three risk assessments were undertaken on four admissions to an inpatient mental health unit;
    - Five risk assessments were undertaken for six presentations to an emergency department with self-harm, suicidal ideation and/or behaviour; and
    - CAMHS undertook three risk assessments after accepting five referrals. These three risk assessments undertaken by CAMHS included a psychosocial and biological component. All three young people for whom a risk assessment had been conducted also had a risk management plan in place.

Aboriginal young people

- Three of the eight young people in Group 1 who had been recorded as having been diagnosed with a mental health illness were Aboriginal. For these three young Aboriginal people:
    - All had been referred to CAMHS and for two young people the referral had been accepted by CAMHS, at some point in their lives;
    - All had been referred to CAMHS on more than one occasion, with a total of 11 referrals for the three young people; and

- During the last year of their lives, two Aboriginal young people were referred again to CAMHS. Neither of these young people received services from CAMHS as a result of these referrals.

- The research literature has shown the effectiveness of culturally appropriate mental health services successfully engaging Aboriginal young people. This was also recognised in the 2012 *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, which recommended that government:

  > *Continue to resource the currently COAG Closing the Gap funded Specialist Aboriginal Mental Health Services to assist Aboriginal people to access culturally secure Mental Health Services.*

- The findings of this investigation support this recommendation.

The patterns identified by the Office may have implications for the Department for Child Protection and Family Support

Twenty of the 36 young people were recorded as having allegedly experienced one or more forms of child maltreatment, and all of these young people had contact with the Department for Child Protection and Family Support

- Twenty of the 36 young people were recorded as having allegedly experienced one or more forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse or neglect. On the basis of this distinguishing factor, for the purposes of further analysis, these 20 young people are referred to as Group 1.

- Child maltreatment, and its individual forms, has been identified in the research literature as a factor associated with suicide. All of the 20 young people in Group 1 had contact with DCPFS. This contact provides DCPFS with opportunities to recognise and respond to child maltreatment and, in doing so, assist in preventing and reducing suicide by young people.

Seventeen of the 20 young people were recorded as having allegedly experienced more than one form of child maltreatment, and are therefore likely to have suffered cumulative harm

- Different forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse and neglect, often co-occur. The effect of experiencing multiple forms of child maltreatment is referred to in the research literature as cumulative harm. Of the 20 young people in Group 1, 17 (85%) were recorded as having allegedly experienced more than one form of child maltreatment, and are therefore likely to have suffered cumulative harm.

- The research literature also identifies that, when responding to child maltreatment, child protection authorities need to undertake holistic assessments so as to recognise cumulative harm.

- Legislation and policies in some other states and territories explicitly identify that child protection authorities need to undertake holistic assessments so as to recognise cumulative harm. However, there are no explicit legislative requirements in Western Australia for undertaking holistic assessments so as to recognise cumulative harm.

- Some DCPFS policies for responding to child maltreatment address the need to undertake holistic assessments so as to recognise cumulative harm. DCPFS's *Policy on Neglect* explicitly identifies cumulative harm in its operational description of neglect and two further elements of DCPFS's policy framework contain indirect references to cumulative harm. However, the explicit or indirect recognition of cumulative harm has not been extended to other relevant elements of DCPFS's policy framework.

- DCPFS procedures for responding to information that raises concerns about a child's wellbeing make one direct reference to recognising and responding to cumulative harm. This is contained in DCPFS's Casework Practice Manual, which explicitly identifies that a Safety and Wellbeing Assessment should involve 'some or all' of a number of tasks, including 'assess(ing) for the presence or risk of cumulative harm.'

By assessing the potential for cumulative harm more effectively, DCPFS can assist in preventing or reducing suicide by young people

- All of the 17 young people in Group 1 who were likely to have suffered cumulative harm were known to DCPFS, many through multiple interactions. The Office examined whether, for these 17 young people, DCPFS considered the potential for cumulative harm to have occurred by undertaking holistic assessments.

- The three key stages of DCPFS's procedures are: duty interactions; initial inquiries; and Safety and Wellbeing Assessments. The Office examined the assessments undertaken by DCPFS staff at each of these three stages and found:

    - For the 17 young people who were recorded as having allegedly experienced more than one form of maltreatment, DCPFS received information that raised concerns about the wellbeing of the young person through 257 duty interactions, and for 251 duty interactions, conducted an assessment of this information;

    - It was not possible to examine whether DCPFS assessed the potential for cumulative harm during the duty interaction process as information which would allow such an assessment to take place is not recorded by DCPFS;

    - For 12 young people in Group 1 there were 27 instances of intake and initial inquiries. During these initial inquiries there is evidence that DCPFS assessed the potential for cumulative harm, or progressed to a Safety and Wellbeing Assessment to enable this to be done, in 17 instances. DCPFS did not progress to a Safety and Wellbeing Assessment in two instances. In these two instances, DCPFS did not assess for the potential for cumulative harm; and

    - As part of 25 Safety and Wellbeing Assessments, there is evidence that DCPFS assessed the potential for cumulative harm in two Safety and Wellbeing Assessments.

Aboriginal young people

- Of the young people in Group 1, Aboriginal young people had higher levels of contact with DCPFS than non-Aboriginal young people, as follows:

- Of the 17 young people in Group 1 who were recorded as having allegedly experienced more than one form of child maltreatment, nine were Aboriginal and eight were non-Aboriginal;
- 198 (77%) of duty interactions for the young people in Group 1 concerned Aboriginal young people; and
- Of the 12 young people who were the subject of initial inquiries or a Safety and Wellbeing Assessment, seven were Aboriginal and five were non-Aboriginal.

- DCPFS currently engages as a specialist position, Aboriginal Practice Leaders to assist with matters relating to Aboriginal young people. The Case Work Practice Manual sets out specific requirements when the Aboriginal Practice Leader should be consulted. However, this requirement for consultation is generally limited to interactions involving children in the care of the Chief Executive Officer.
- The findings of this investigation indicated that it is also important that Aboriginal Practice Leaders are consulted when the potential for cumulative harm is being assessed for Aboriginal young people, to ensure responses to this are culturally appropriate.

The patterns identified by the Office may have implications for the Department of Education

- The research literature identifies that educational institutions have an important role to play in reducing the incidence of suicide by young people as education professionals are in a unique position to identify and prevent the suicide of young people. The research literature further identifies that educational institutions are particularly important for children and young people from certain groups, including young people who have experienced child maltreatment, and Aboriginal young people.
- All of the 20 young people in Group 1 were recorded as having allegedly experienced child maltreatment. Nineteen (95%) of the 20 young people were enrolled in an educational program at the time of their death. Of these 19 young people, 17 young people were enrolled in government schools and two were enrolled in non-government schools at the time of their death.

By responding to persistent non-attendance and behaviour management problems more effectively, the Department of Education can assist in preventing or reducing suicide by young people

- During the last year of their lives, 14 of the 19 young people enrolled at school attended less than 60% of the time.
- For the 14 young people who attended school less than 60% of the time, limited actions pursuant to the *School Education Act 1999* and the *Student Attendance* policy were taken to remedy this persistent non-attendance. However a range of other actions, not required by the legislation or policy, were undertaken by schools.
- Ten of the 19 young people enrolled at school had been suspended from school.

- Five of the 19 young people enrolled at school had been suspended from school for more than 10 days during a school year, and three young people went on to be suspended for more than 20 days during a school year.

- For the five young people who had been suspended from school for more than 10 days during a school year, the *Behaviour Management in Schools* policy was not consistently applied. However, a range of other actions, not required by policy were undertaken by schools.

Aboriginal young people

- Ten of the 20 young people in Group 1 were Aboriginal. Nine of the ten Aboriginal young people were enrolled with government schools at the time of their death.

- Nine of the ten Aboriginal young people attended school less than 60% of the time in their last year of life. Attendance records for one young person were not available. The attendance patterns of the nine Aboriginal young people where records were available were as follows:

    - Three effectively did not attend school in the last year of their life; and

    - Six attended school less than 60% of the time in the last year of their life.

- Of the nine Aboriginal young people who attended school less than 60% of the time, limited action was taken to remedy this persistent non-attendance, pursuant to the *School Education Act 1999* and the *Student Attendance* policy. However, a range of other actions, not required by the legislation or policy were undertaken by schools.

- Of the ten Aboriginal young people in Group 1 who were enrolled at school or a relevant registered training organisation, two were suspended from school for more than 10 days in a school year or excluded from school and limited action was taken under the *Behaviour Management in Schools* policy.

State government departments and authorities will need to work together, as well as separately, to prevent and reduce suicide by young people

The importance of sharing information to effective identification of young people at risk of suicide

- In Western Australia, the primary piece of legislation regarding the safety and wellbeing of children is the *Children and Community Services Act 2004* (**the CCS Act**). As identified in a review of the CCS Act, sections 23 and 24A of the CCS Act 'enable agencies to share information, without consent where necessary, in the interests of the wellbeing of a child or class or group of children.'

- Some State government departments and authorities indicated that they were aware that information could be shared with DCPFS under the CCS Act and were cooperating with requests for information from DCPFS. However, some State government departments and authorities also reported that they believed the information sharing provisions of the CCS Act only related to exchanges with DCPFS.

- Action Area 4 of the State Strategy identifies the need for practical tools for information sharing. In implementing Action Area 4, the Mental Health

Commission could bring together CAMHS, DCPFS and the Department of Education to develop a tool for identifying young people at risk of suicide, which involves the sharing of information between these three departments in particular, as well as other relevant State government departments and authorities.

The importance of inter-agency collaboration in preventing and reducing suicide by young people who experience multiple risk factors and have contact with multiple State government departments

- Nineteen of the 36 young people (53%) were recorded as having experienced multiple factors associated with suicide and were recorded as having allegedly experienced one or more forms of child maltreatment. Most of these young people were also recorded as having experienced mental health problems and suicidal ideation and behaviour. These 19 young people were all in Group 1. The young people in this group had contact with multiple State government departments and authorities over their lifetime.

- The research literature identifies that young people who have multiple risk factors and a long history of involvement with multiple agencies are often 'hard to help', and agencies face challenges in providing services to these young people. The profile of 'hard to help' young people described in the research literature was similar to those young people in Group 1.

- Preventing or reducing suicide among young people, such as those in Group 1, who experience multiple risk factors is likely to involve a range of actions by a range of State government departments and authorities, which will need to be coordinated so that each action reinforces the others. One accepted way that such coordination can be achieved is through a case management approach. The young people in Group 1 had significant levels of contact with CAMHS, DCPFS and the Department of Education. These departments could be important parties to a case management approach.

Recommendations

The report makes 22 recommendations to four government agencies about ways to prevent or reduce suicide by young people. Each agency has agreed to the recommendations and was highly co-operative and positively engaged with the investigation.

Own Motion Investigations in 2014-15

During 2013-14, the Ombudsman undertook work on three further own motion investigations to be finalised in 2014-15:

- Issues associated with Violence Restraining Orders and their relationship with family and domestic violence fatalities;

- Local government collection of outstanding rates; and

- The implementation and effectiveness of Ombudsman recommendations.

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. Details of workshops conducted during the year are provided 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.

Criminal Penalty Infringement Notices Scheme

The *Criminal Code Amendment (Infringement Notices) Act 2011* introduces a new scheme into Western Australia for the issue of Criminal Penalty Infringement Notices by Western Australia Police for certain offences. The Act requires the Ombudsman to scrutinise and report on the first 12 months of the operation of the scheme.

Control of criminal organisations

Under the *Criminal Organisations Control Act 2012*, the Ombudsman scrutinises and reports on the exercise of certain powers by Western Australia Police, for a five year period commencing in November 2013.