Our Performance in 2013-14

This section of the report compares results with targets for both financial and non-financial indicators and explains significant variations. It also provides information on achievements during the year, major initiatives and projects, and explains why this work was undertaken.

Summary of Performance

Key Effectiveness Indicators

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

Key Effectiveness Indicators	2012-13 Actual	2013-14 Target	2013-14 Actual	Variance
Where the Ombudsman made recommendations to improve practices or procedures, percentage of recommendations accepted by agencies	100%	100%	**100%**	Nil
Number of improvements to practices or procedures as a result of Ombudsman action	72	100	**152**	+52

Another important role of the Ombudsman is to enable remedies to be provided to people who make complaints to the Office where service delivery by a public authority may have been inadequate. The remedies may include reconsideration of decisions, more timely decisions or action, financial remedies, better explanations and apologies. In 2013-14, there were 199 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman.

Comparison of Actual Results and Budget Targets

For the fifth consecutive year, public authorities have accepted every recommendation made by the Ombudsman, matching the 2012-13 actual result and meeting the 2013-14 Target.

In 2007-08, the Office commenced a program to ensure that its work increasingly contributed to improvements to public administration. Consistent with this program, the number of improvements to practices and procedures of public authorities as a result of Ombudsman action has, in 2013-14, more than tripled since 2009-10. There may, however, be fluctuations from year to year, related to the number and nature of complaints and reviews finalised by the Office in any given year.

Key Efficiency Indicators

The key efficiency indicators relate to timeliness of complaint handling, the cost per finalised allegation about public authorities and the cost per finalised notification of child deaths and family and domestic violence fatalities.

Key Efficiency Indicators	2012-13 Actual	2013-14 Target	2013-14 Actual	Variance from Target
Percentage of allegations finalised within 3 months	83%	85%	**98%**	+13%
Percentage of allegations finalised within 12 months	99%	100%	**100%**	Nil
Percentage of allegations on hand at 30 June less than three months old	94%	85%	**98%**	+13%
Percentage of allegations on hand at 30 June less than 12 months old	96%	100%	**100%**	Nil
Average cost per finalised allegation	$1,821	$1,825	**$1,858**	+$33
Average cost per finalised notification of death	$12,281	$12,325	**$18,407**	+$6,082

Comparison of Actual Results and Budget Targets

The timeliness and efficiency of complaint handling has substantially improved over the past five years due to a major complaint handling improvement program introduced in 2007-08. An initial focus of the program was the elimination of aged complaints. Building on the program, the Office developed and commenced a new organisational structure and processes in 2011-12 to promote and support early resolution of complaints. As a result of the program, the Office has reduced the average age of complaints from 173 days on 30 June 2007 to 23 days on 30 June 2014 while over the same period significantly reducing the average cost of finalised allegations from $2,941 in 2007-08 to $1,858 in 2013-14. These improvements are in the context of a significant increase in the number of complaints across all sectors that occurred in 2009-10.

In 2013-14, substantially improved complaint handling has resulted in the following actual results compared to budget targets.

- The percentage of allegations finalised within three months (98%) is the highest figure in the past five years, very significantly improving on the 2012-13 actual result (83%), and significantly exceeding the 2013-14 Target (85%). The 2014-15 Target has been adjusted accordingly to 95%.
- The percentage of allegations finalised within 12 months (100%) has exceeded the 2012-13 actual result and matched the 2013-14 Target.
- The percentage of allegations on hand at 30 June less than three months old (98%) has improved from the 2012-13 actual result (94%) and has significantly bettered the 2013-14 Target (85%). The 2014-15 Target has been adjusted accordingly to 90%.
- The percentage of allegations on hand at 30 June less than 12 months old (100%) has improved from the 2012-13 actual result (96%) and met the 2013-14 Target (100%). Pleasingly, the Office has achieved, and has been able to maintain, not having any complaints on hand over 12 months.

Since the commencement of the complaint handling improvement program in 2007-08, the average cost per finalised allegation has reduced by a total of 37% from $2,941 in 2007-08 to $1,858 in 2013-14. The average cost per finalised allegation in 2013-14 is comparable to the 2012-13 actual result ($1,821) and the 2013-14 Target ($1,825).

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

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

The average cost per finalised notification of death exceeded the 2012-13 actual result and the 2013-14 Target, reflecting the staffing required for:

- The investigation of complex reviews undertaken in 2013-14; and
- The commencement in 2012-13, and development during 2013-14, of an important new initiative to review family and domestic violence fatalities.

Summary of Financial Performance

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

Financial Performance	2013-14 Target ('000s)	2013-14 Actual ('000s)	Variance ('000s)
Total cost of services (sourced from Statement of Comprehensive Income)	$10,625	$10,551	-$74
Income other than income from State Government (sourced from Statement of Comprehensive Income)	$2,462	$2,506	+$44
Net cost of services (sourced from Statement of Comprehensive Income)	$8,163	$8,045	-$118
Total equity (sourced from Statement of Financial Position)	$1,881	$1,531	-$350
Net increase in cash held (sourced from Statement of Cash Flows)	$19	-$65	-$84
Staff Numbers	**Number**	**Number**	**Number**
Full time equivalent (FTE) staff level at 30 June 2014	70	63	-7

Comparison of Actual Results and Budget Targets

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

For both, the small decrease in the actual result compared to the budget target was mainly due to the deferral of the commencement, from 2013-14 to 2014-15, of the function to scrutinise and report on the Criminal Penalty Infringement Notices scheme. This was partially offset by a one-off voluntary separation payment, higher depreciation of the fit-out of office accommodation provided as services free of charge through the Department of Finance (Building Management and Works) and amortisation of the finance system, that was commissioned in early 2013 to support the financial operations of the Office, following the decommissioning of the Office of Shared Services.

For total equity, the decrease in the actual result compared to the budget target was primarily due to a reduction in cash due to a one-off voluntary separation payment, using cash on hand, and a reduction in the net value of assets because depreciation and amortisation exceeded the value of additional assets purchased.

For cash held, the decrease in the actual result compared to the budget target was primarily due to a one-off voluntary separation payment.

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

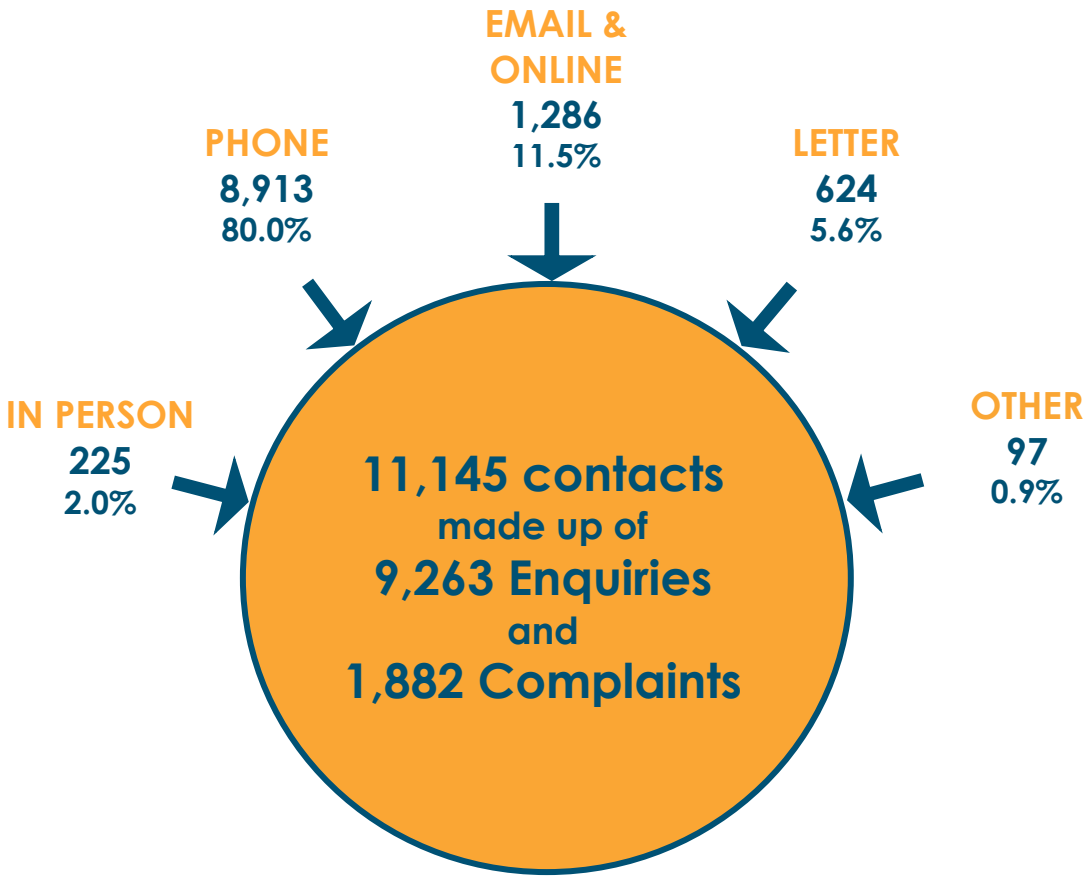
Complaint Resolution

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

Contacts

In 2013-14, the Office received 11,145 contacts from members of the public consisting of:

- 9,263 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 1,882 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.



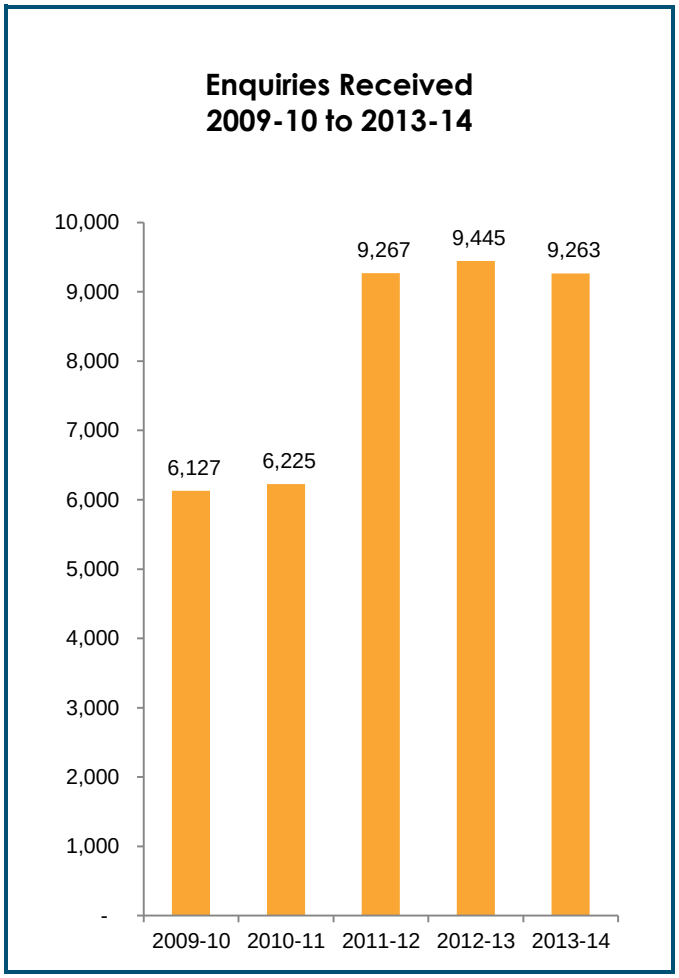
Enquiries Received

There were 9,263 enquiries received during the year.

For enquiries about matters that are within the Ombudsman's jurisdiction, staff provide information about the role of the Office and how to make a complaint. For approximately half of these enquiries, the enquirer is referred back to the public authority in the first instance to give it the opportunity to hear about and deal with the issue. This is often the quickest and most effective way to have the issue dealt with. Enquirers are advised that if their issues are not resolved by the public authority, they can make a complaint to the Ombudsman.

For enquiries that are outside the jurisdiction of the Ombudsman, staff assist members of the public by providing information about the appropriate body to handle the issues they have raised.

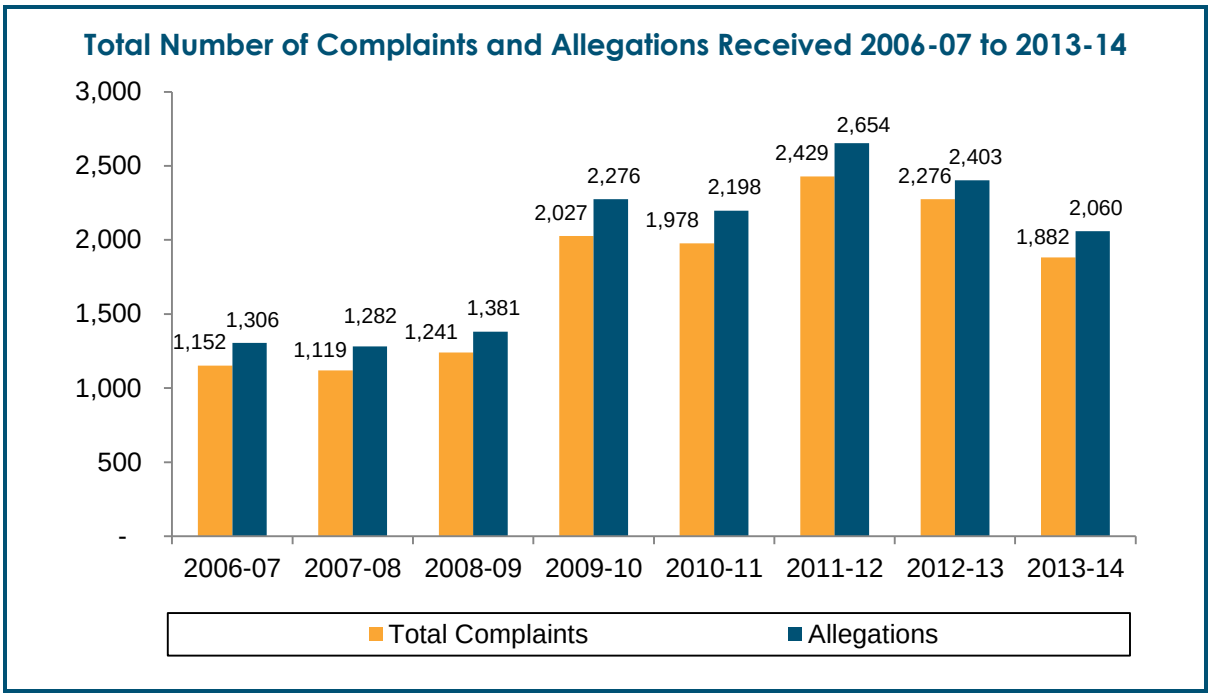
In some cases, Ombudsman staff may be able to assist the person making the enquiry by making informal contact with the public authority.



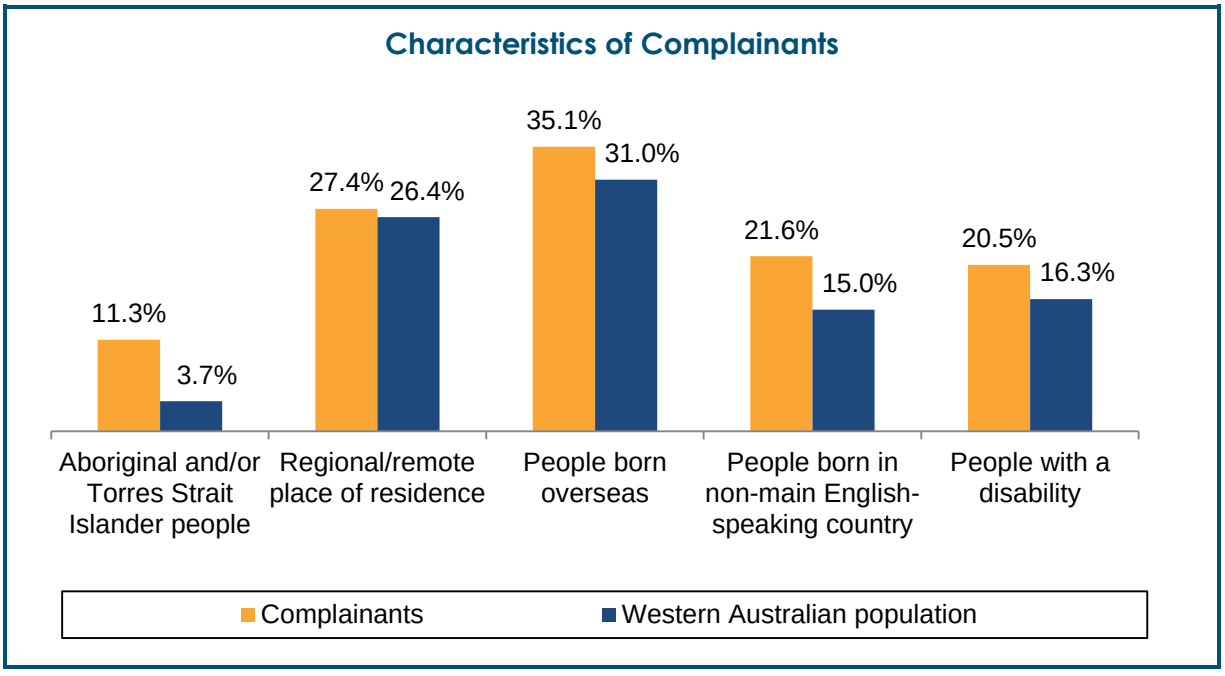
Enquirers are encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

Complaints Received

In 2013-14, the Office received 1,882 complaints, with 2,060 separate allegations, and finalised 1,910 complaints. There are more allegations than complaints because one complaint may cover more than one issue.



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

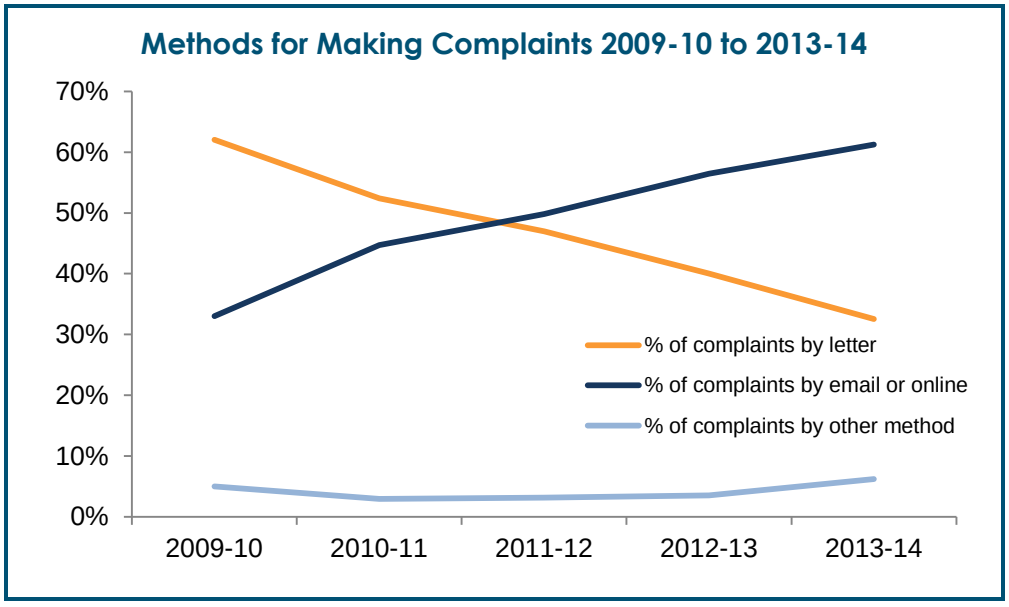


NOTE: Non-main English-speaking countries as defined by the Australian Bureau of Statistics are countries other than Australia, United Kingdom, the Republic of Ireland, New Zealand, Canada, South Africa and the United States of America. Being from a non-main English-speaking country does not imply a lack of proficiency in English.

How Complaints Were Made

The increase in the use of email and online facilities to lodge complaints has continued in 2013-14, increasing from 56% in 2012-13 to 61% in 2013-14. Over the last five years the proportion of people using email and online facilities to lodge complaints has nearly doubled since 2009-10 when 33% were received in this way.

During the same period, the proportion of people who lodge complaints by letter has reduced from 62% to 33%. The remaining complaints were received by a variety of means including by fax, during regional visits and in person.



Resolving Complaints

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

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

Time Taken to Resolve Complaints

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

complaint resolution has resulted in ongoing improvements in the time taken to handle complaints.

Timeliness and efficiency of complaint handling has substantially improved over time due to a major complaint handling improvement program introduced in 2007-08. An initial focus of the program was the elimination of aged complaints.

Building on the program, the Office developed and commenced a new organisational structure and processes in 2011-12 to promote and support early resolution of complaints. There have been further enhancements to complaint handling processes in 2013-14, in particular in relation to the early resolution of complaints.

Together, these initiatives have resulted in substantial improvements in the timeliness of complaint handling.

Over the last year:

- The percentage of allegations finalised within 3 months improved from 83% to 98%; and
- At 30 June 2014 the Office has no complaints over 6 months old.

Aged cases have been eliminated. There are no complaints over 6 months old.

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

- The average age of complaints has decreased from 173 days to 23 days; and
- Complaints older than six months have decreased from 40 to none.

Complaints Finalised in 2013-14

There were 1,910 complaints finalised during the year and, of these, 1,375 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 830 were finalised at initial assessment, 513 were finalised after an Ombudsman investigation and 32 were withdrawn.

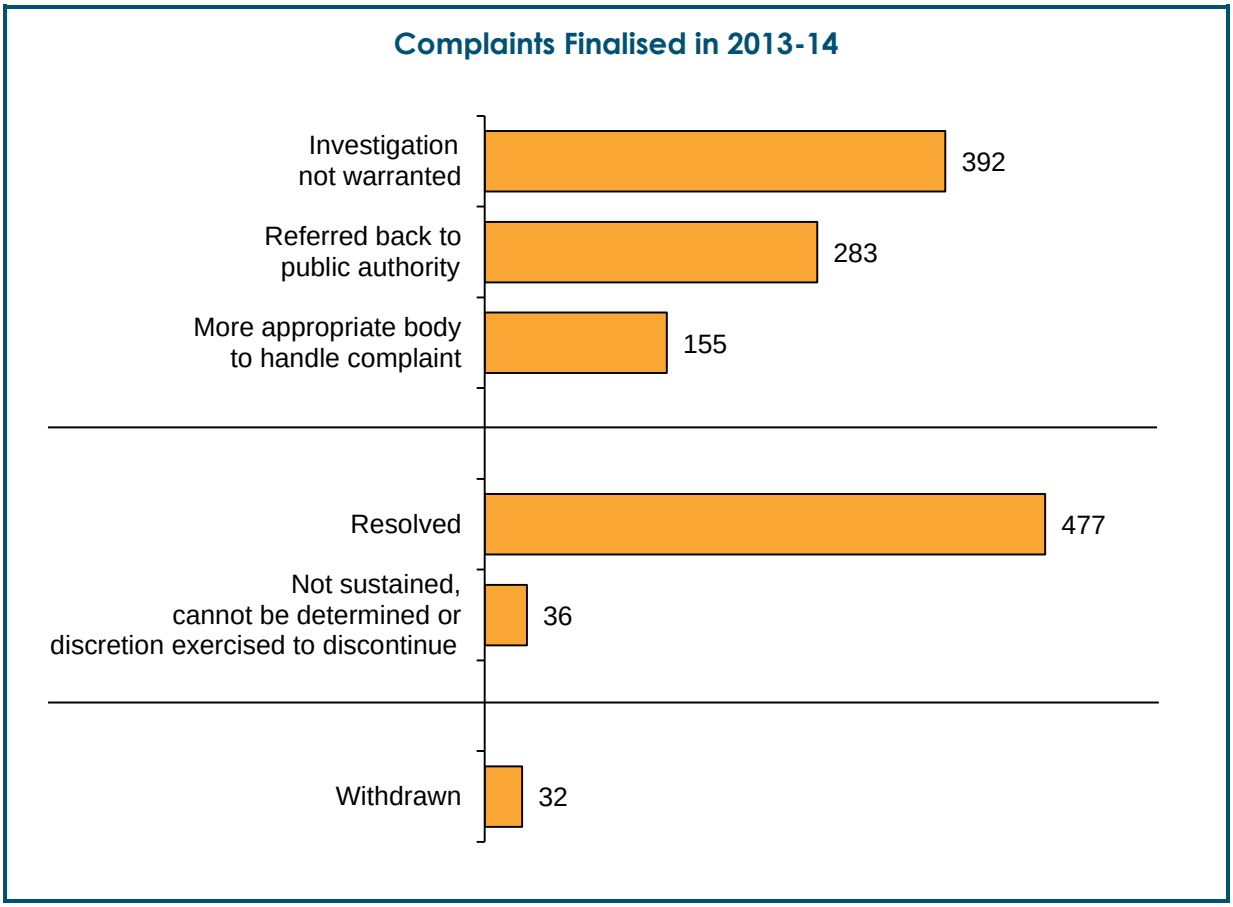
Complaints finalised at initial assessment

Over a third (34%) of the 830 complaints finalised at initial assessment were referred back to the public authority to provide it with an opportunity to resolve the matter before investigation by the Ombudsman. This is a common and timely approach and often results in resolution of the matter. The person making the complaint is asked to contact the Office again if their complaint remains unresolved. In a further 155 (19%) complaints finalised at the initial assessment, it was determined that there was a more appropriate body to handle the complaint. In these cases, complainants are provided with contact details of the relevant body to assist them.

Complaints finalised after investigation

Of the 513 complaints finalised after investigation, 91% were resolved through the Office's early resolution approach. This involves Ombudsman staff contacting the public authority to progress a timely resolution of complaints that appear to be able to be resolved quickly and easily. Public authorities have shown a strong willingness to resolve complaints using this approach and frequently offer practical and timely remedies to resolve matters in dispute, together with information about administrative improvements to be put in place to avoid similar complaints in the future.

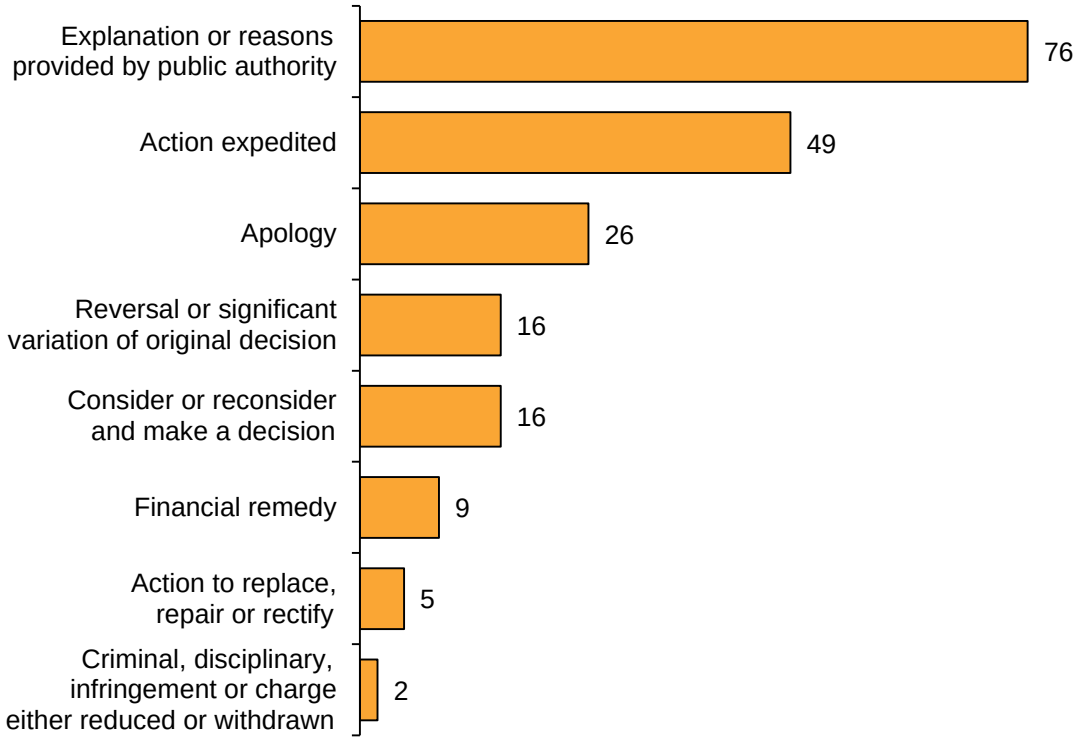
The following chart shows how complaints about public authorities in the Ombudsman's jurisdiction were finalised.



Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2013-14, there were 199 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman, an increase of 43% from 139 in 2012-13. In some cases there is more than one action to resolve a complaint. For example, the public authority may apologise and reverse their original decision. The following chart shows the types of remedies provided to complainants.

Remedial Action to Assist the Complainant in 2013-14



Case Study

Documents found and returned

A person complained that they had been required to provide personal documents to a public authority for safe keeping as required under its policies and procedures. However, when they requested their return, the public authority informed the person that it no longer had them in its possession.

Following enquiries by the Office, the public authority undertook a more detailed search and found that the documents had been incorrectly entered into its system and incorrectly stored. It located the documents and returned them. The public authority also corrected its records relating to the documents and, to prevent a reoccurrence, reinforced with staff the correct procedure for recording and storing personal documents.

In a further 53 instances, the Office referred the complaint to the public authority following its agreement to expedite examination of the issues and to deal directly with the person to resolve their complaint. In these cases, the Office follows up with the public authority to confirm the outcome and any further action the public authority has taken to assist the individual or to improve their administrative practices.

Outcomes to improve public administration

In addition to providing individual remedies, complaint resolution can also result in improved public administration. This occurs when the public authority takes action to improve its decision making and practices in order to address systemic issues and prevent similar complaints in the future. Administrative improvements include changes to policy and procedures, changes to business systems or practices and staff development and training.

Case Study

Decision reversed and system changed

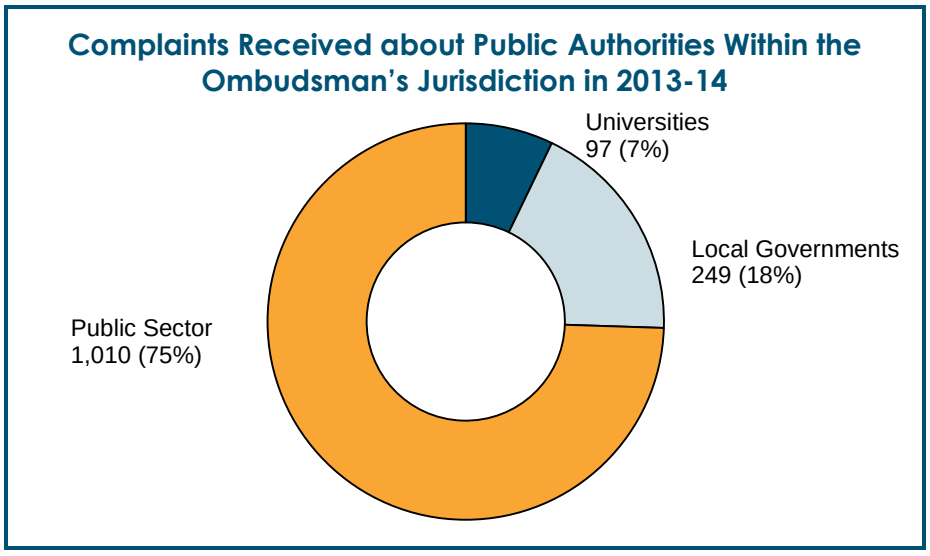
A public authority has an online booking system for the public. Cancellation of a booking with less than two working days' notice results in a fee for late cancellation. A person complained that, when they used the public authority's online booking system on a weekend to cancel a booking, they were not notified that they had not provided sufficient notice of two working days for the cancellation and would be charge a fee. Consequently they proceeded with the cancellation and were charged a fee for a late cancellation.

Following enquiries by the Office, the public authority found that its online booking system was providing notifications in relation to cancellations on week days but not on weekends or public holidays. Subsequently the public authority took steps to rectify this so that notifications would be provided in such situations and, given that the person had not been notified of the consequences of the cancellation, they were not required to pay the fee.

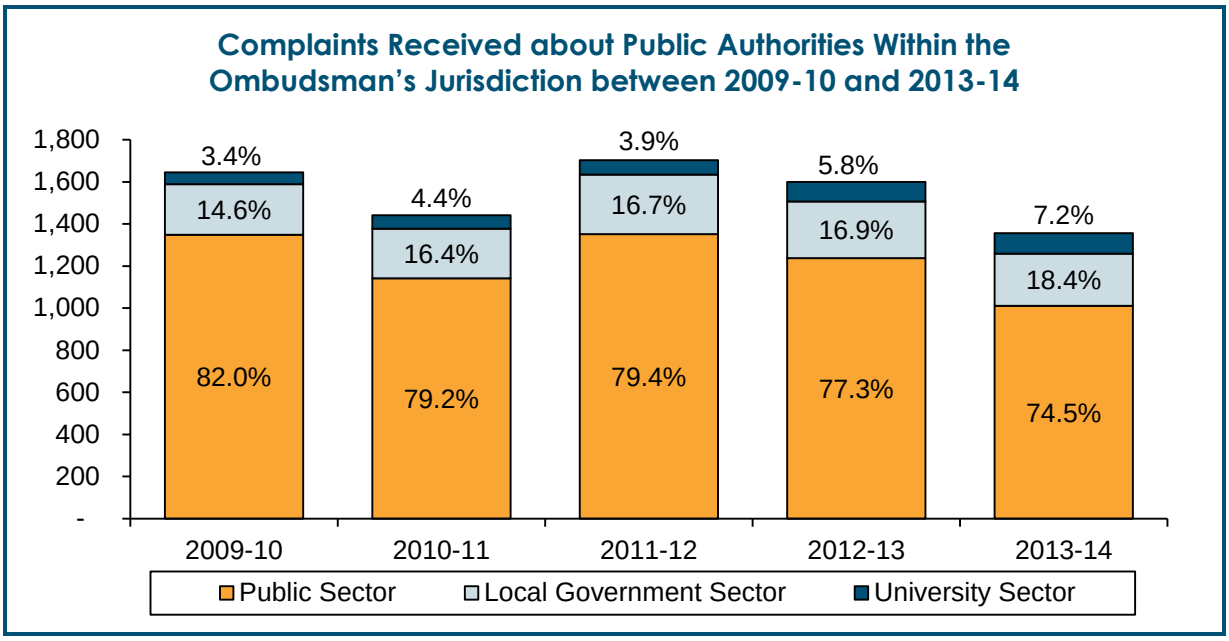
About the Complaints

Of the 1,882 complaints received, 1,356 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 526 complaints were about bodies outside the Ombudsman's jurisdiction. In these cases, Ombudsman staff provided assistance to enable the people making the complaint to take the complaint to a more appropriate body.

Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (1,010 complaints) which includes State government departments, statutory authorities and boards; the local government sector (249 complaints); and the university sector (97 complaints).



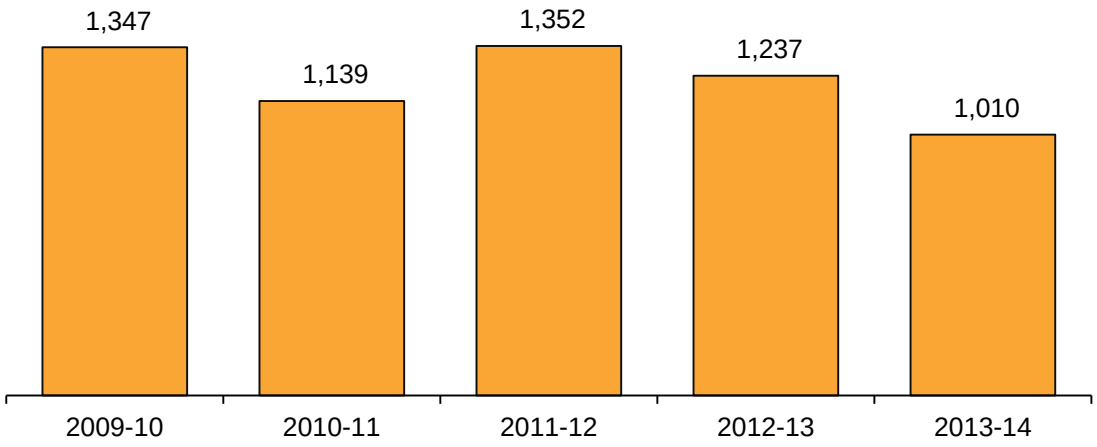
The proportion of complaints about each sector has remained relatively steady.



The Public Sector

In 2013-14, there were 1,010 complaints received about the public sector and 1,029 complaints were finalised. The number of complaints about the public sector as a whole since 2009-10 is shown in the chart below.

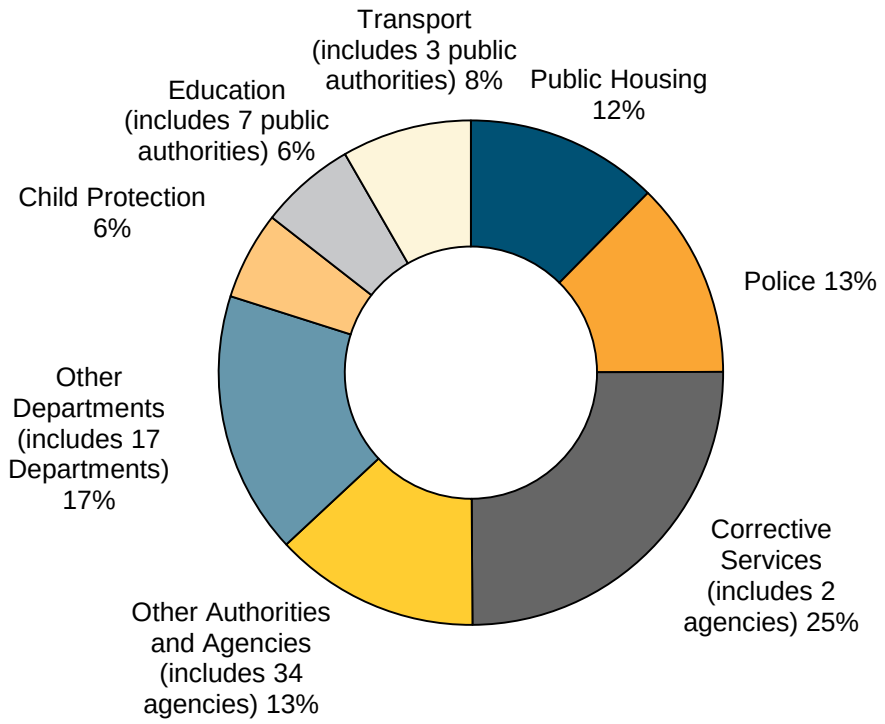
Complaints Received About the Public Sector between 2009-10 and 2013-14



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

Public sector agencies are very diverse. In 2013-14, complaints were received about 66 agencies as shown in the following chart.

Complaints Received About the Public Sector in 2013-14



Of the 1,010 complaints received about the public sector in 2013-14, 70% were about six key areas covering:

- Corrective services, in particular prisons (252 or 25%);
- Police (126 or 13%);
- Public housing (125 or 12%);
- Transport (84 or 8%);
- Child protection (62 or 6%): and
- Education - public schools and Technical and Further Education (**TAFE**) colleges (57 or 6%). Information about universities is shown separately under the University Sector.

The remaining complaints about the public sector (304) were about 51 other State Government departments, statutory authorities and boards. For 38 (75%) of these agencies, the Office received five complaints or less.

Outcomes of complaints about the public sector

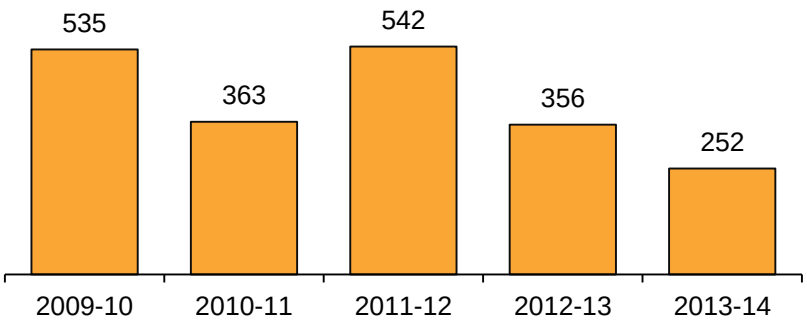
There were 187 actions taken by public sector bodies as a result of complaints finalised in 2013-14. These resulted in 151 remedies being provided to complainants and 36 improvements to public sector practices.

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

Public Sector Complaint Issues and Outcomes

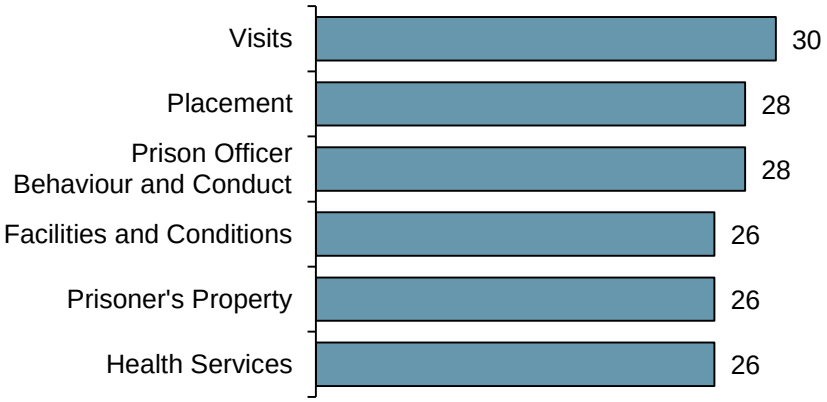
Corrective Services

Complaints received



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

Most common allegations



Other types of allegations

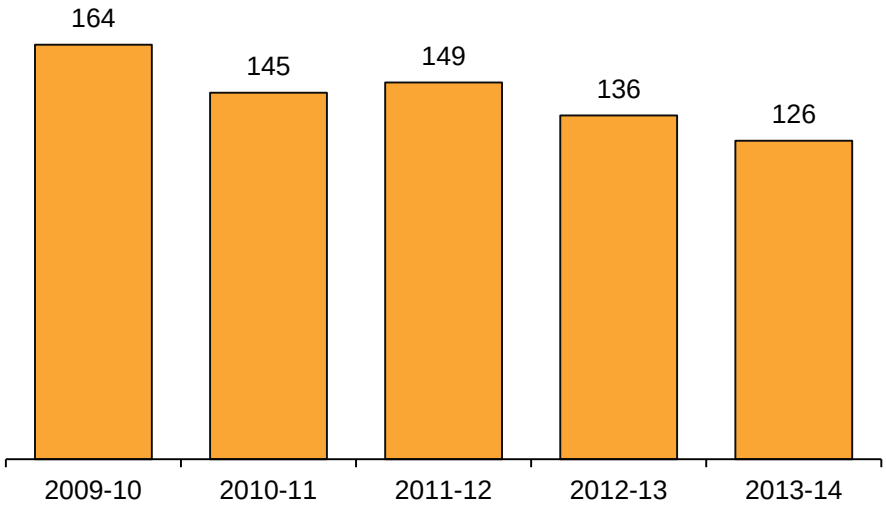
- Food and diet;
- Communication;
- Sentencing, parole and reintegration issues;
- Security classification;
- Discipline;
- Education courses and facilities; and
- Rehabilitation programs.

Outcomes achieved

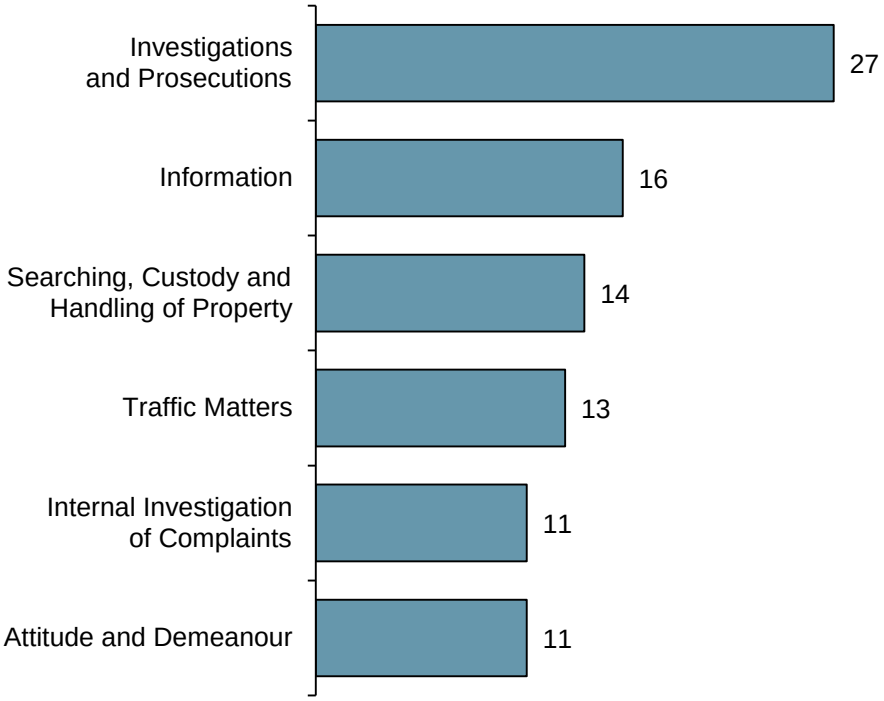
- Consider or reconsider a matter and make a decision;
- Action to replace, repair or rectify a matter;
- Action expedited;
- Explanation given or reasons provided;
- Apology given;
- Change to policy or procedure;
- Change to business system or practices;
- Conduct an audit or review; and
- Staff training.

Police

Complaints received



Most common allegations



Other types of allegations

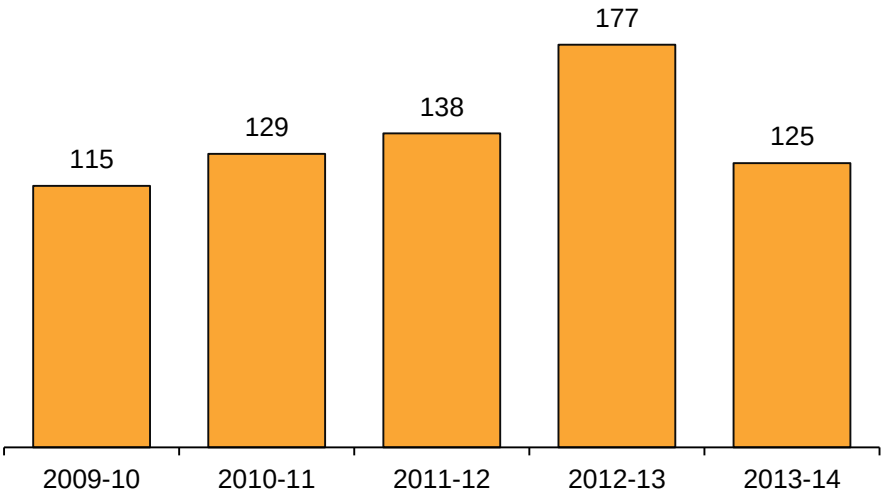
- Assault;
- Arrest and detention;
- Improper conduct; and
- Management issues.

Outcomes achieved

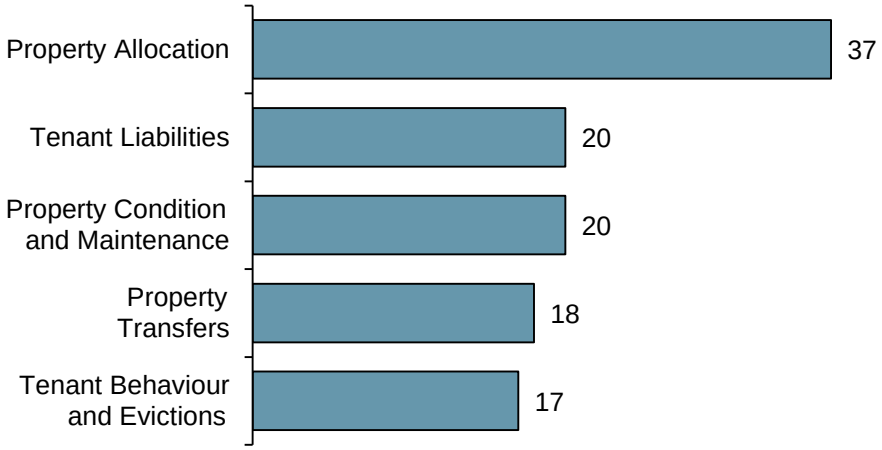
- Infringement reduced or withdrawn;
- Action expedited;
- Apology given;
- Explanation given or reasons provided; and
- Staff training.

Public Housing

Complaints received



Most common allegations



Other types of allegations

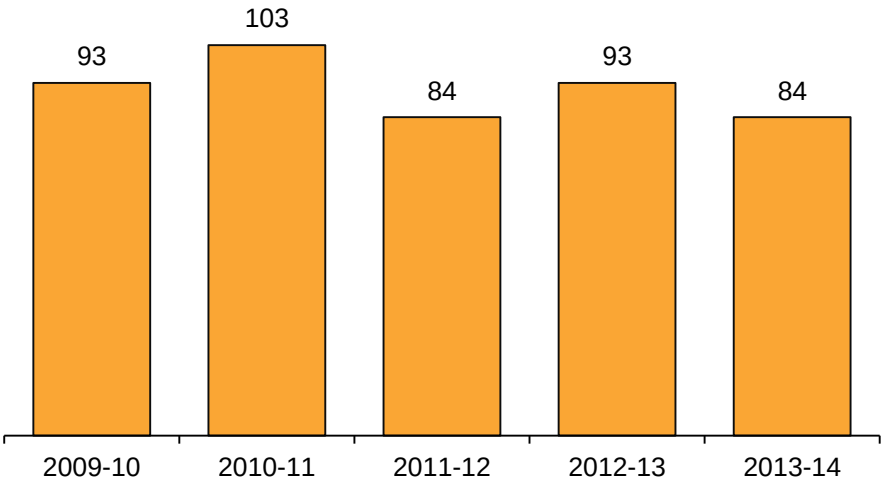
- Rental sales;
- Debt repayments;
- Rental or bond assistance; and
- Construction and development.

Outcomes achieved

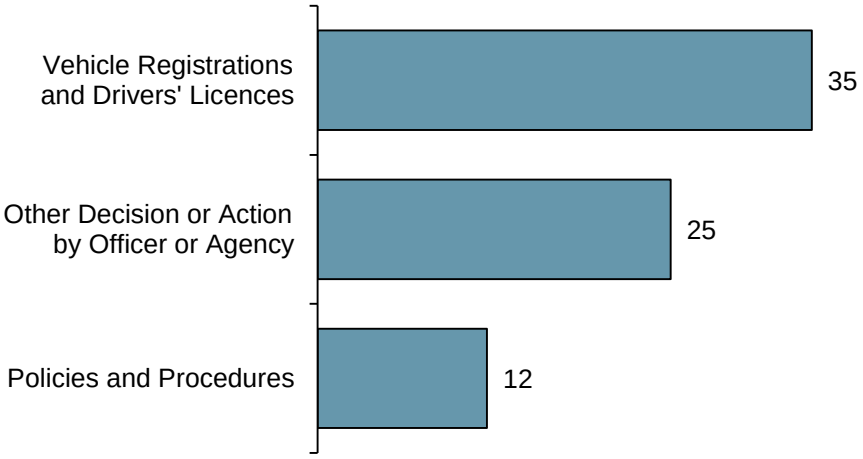
- Consider or reconsider a matter and make a decision;
- Reversal or significant variation of original decision;
- Tenant liability waived;
- Action to replace, repair or rectify a matter;
- Action expedited;
- Apology given;
- Explanation given or reasons provided;
- Change to policy or procedure; and
- Conduct an audit or review.

Transport

Complaints received



Most common allegations



Other types of allegations

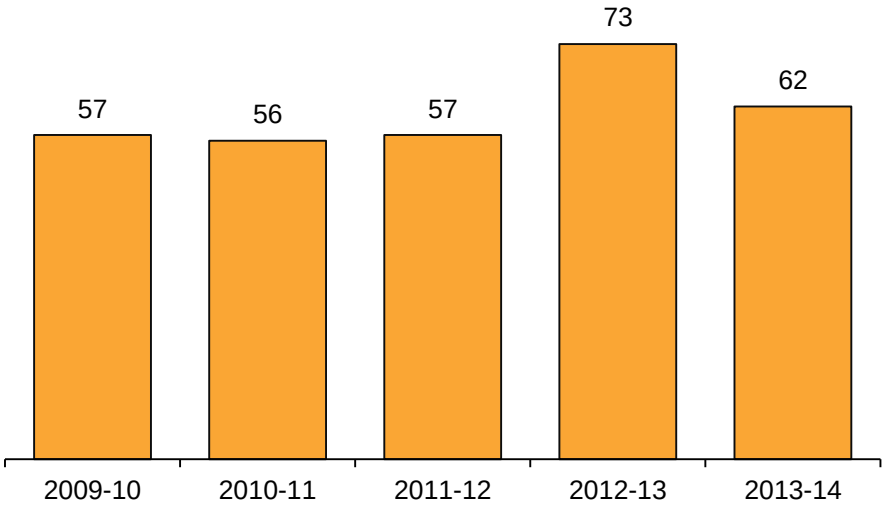
- Conduct of officer; and
- Fines and infringements.

Outcomes achieved

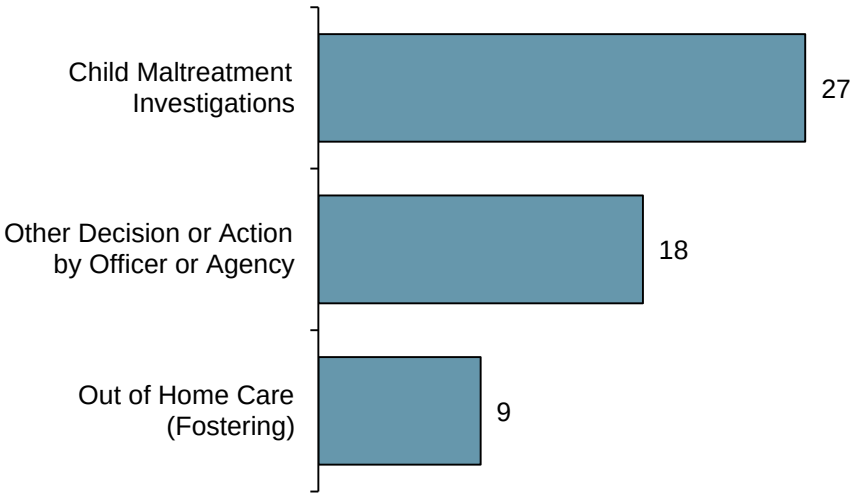
- Monetary charge withdrawn;
- Consider or reconsider a matter and make a decision;
- Reversal or significant variation of original decision;
- Action expedited;
- Explanation given or reasons provided;
- Apology given;
- Conduct an audit or review;
- Change to policy or procedure;
- Change to business system or practices; and
- Staff training.

Child Protection

Complaints received



Most common allegations



Other types of allegations

- Family court proceedings;
- Adoption;
- Human resource management issues; and
- Complaint management.

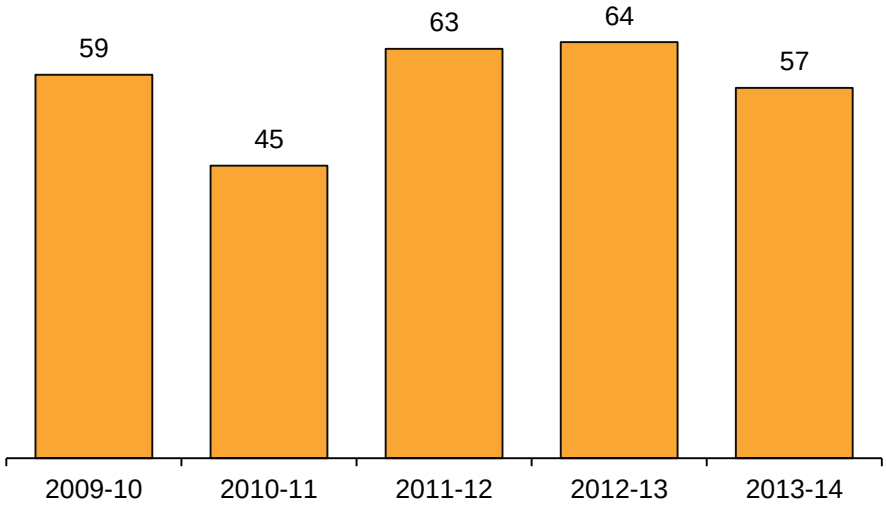
Outcomes achieved

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

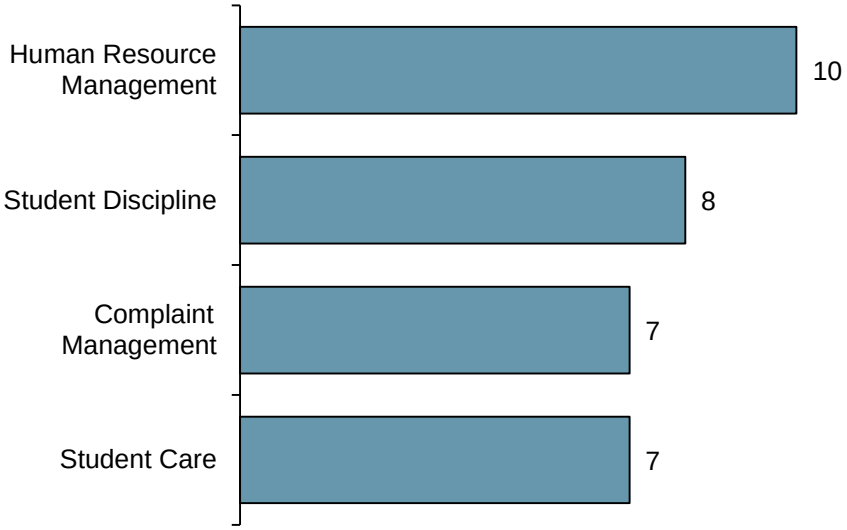
Complaint Resolution

Education

Complaints received



Most common allegations



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

Other types of allegations

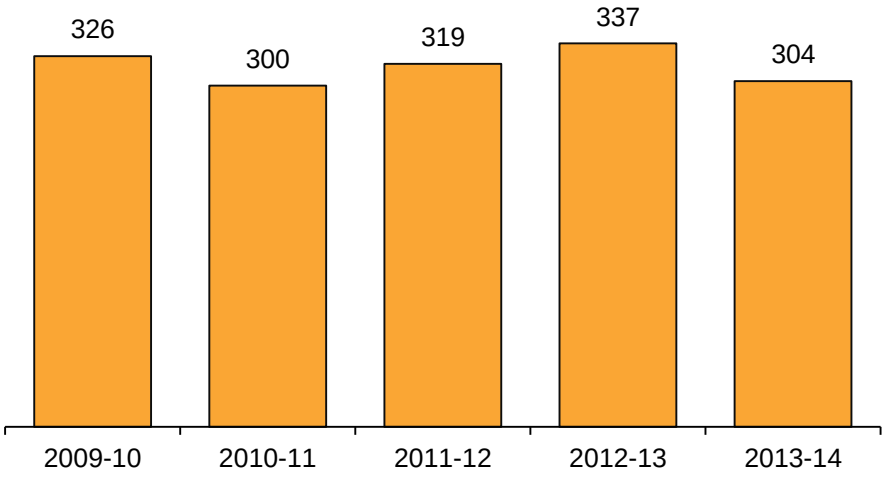
- Enrolment;
- Examinations, assessments and prizes;
- Fees; and
- Staff conduct.

Outcomes achieved

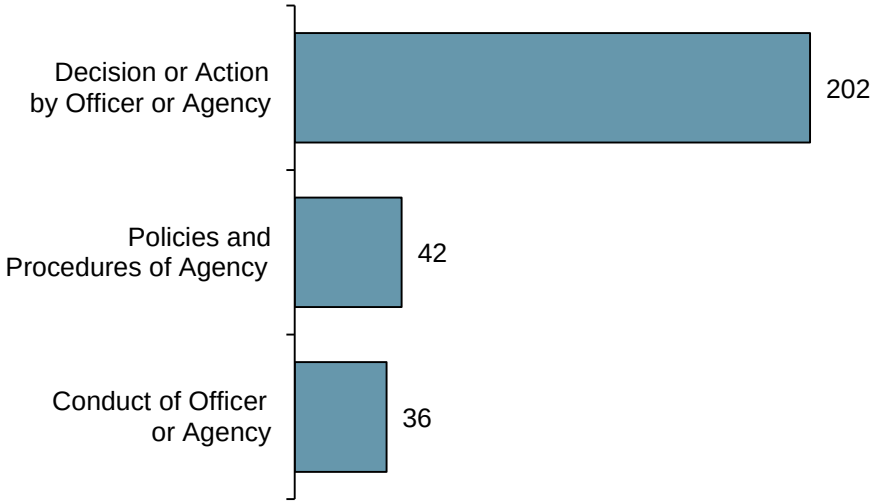
- Action expedited;
- Explanation given or reasons provided;
- Reversal or significant variation of original decision;
- Change to policy or procedure; and
- Staff training.

Other Public Sector Agencies

Complaints received



Most common allegations



Other types of allegations

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

Outcomes achieved

- Monetary charges reduced or withdrawn;
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Reversal or significant variation of original decision;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Apology given;
- Conduct an audit or review; and
- Staff training.

The following case study provides an example of action taken by public sector agencies as a result of the involvement of the Ombudsman.

Case Study

Correction of personal information

A person complained that a public authority had written to them about a tenancy matter and had provided them with private third party information about a tenant when they were neither the tenant nor the landlord of the property. The person was concerned that they had received someone else's private information and that their details may be wrongly entered into the public authority's database.

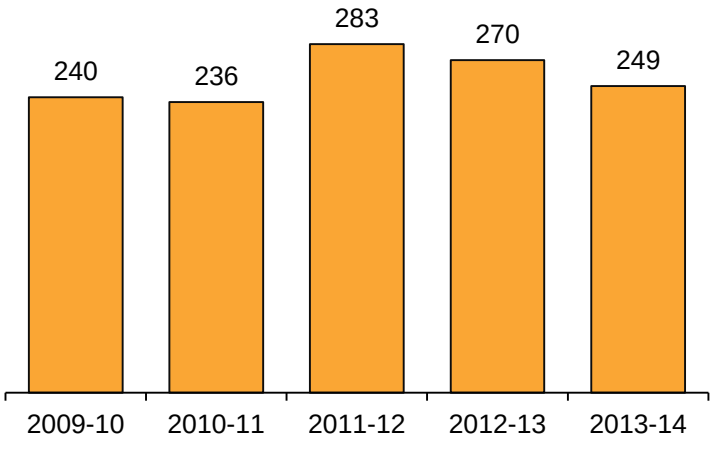
Following contact by the Office, the public authority investigated the matter and found that the person had an identical name to the tenant and the person's details were incorrectly attached to a system generated letter due to a system error. The public authority informed them that the postal addresses would be removed from its system. The public authority also confirmed that its system was being audited for duplicate names and to correct any errors.

The Local Government Sector

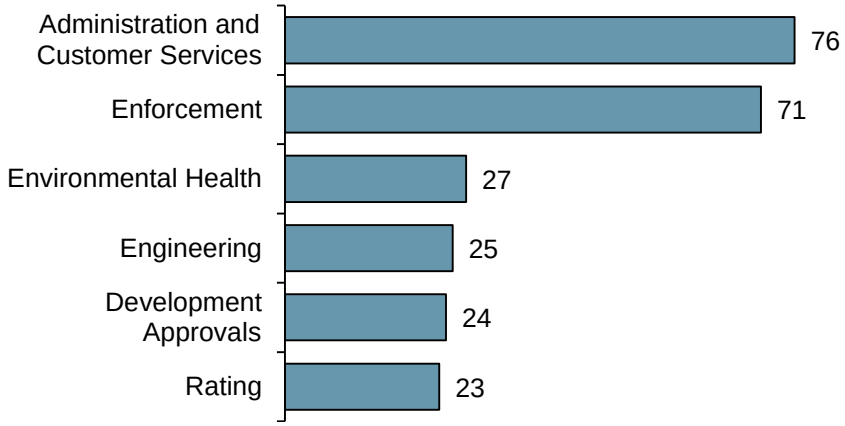
The following section provides further details about the issues and outcomes of complaints for the local government sector.

Local Government

Complaints received



Most common allegations



Other types of allegations

- Building approvals;
- Planning;
- Community facilities;
- Other approvals and licences; and
- Contracts and property management.

Outcomes achieved

- Consider or reconsider a matter and make a decision;
- Reversal or significant variation of original decision;
- Action expedited;
- Infringement reduced or withdrawn;
- Change to policy or procedure;
- Conduct an audit or review;
- Apology given;
- Explanation given or reasons provided; and
- Staff training.

Complaint Resolution

Case Study

Improved contractor registration and customer service

A person complained that they had been removed from a local government's Contractor Register and had not been able to resolve the matter satisfactorily with the local government. The person was also dissatisfied with the time taken by the local government in responding to their enquiries, the reasons it gave for removing them from the Register, and the handling of their request to be reinstated on the Register.

Following enquiries by the Office, a senior officer of the local government personally met with the individual to discuss their concerns and subsequently, the person was reinstated on the Register. The local government also provided the person with contractor induction paperwork to complete as part of the registration process.

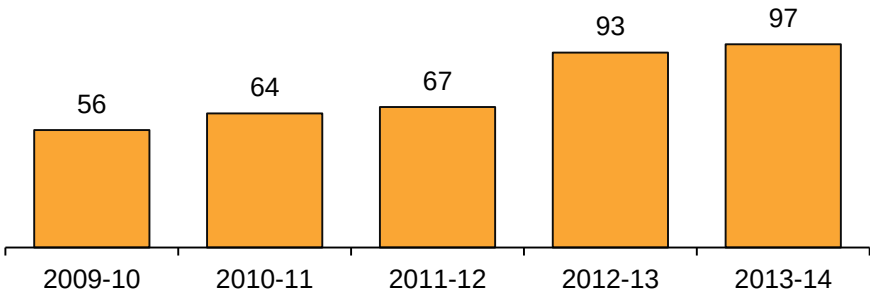
The local government then took steps to finalise a Customer Service Charter and Policy which outlined the obligations on staff to respond to enquiries. In addition, the local government reviewed its contractor induction and management processes and took steps to implement the new processes.

The University Sector

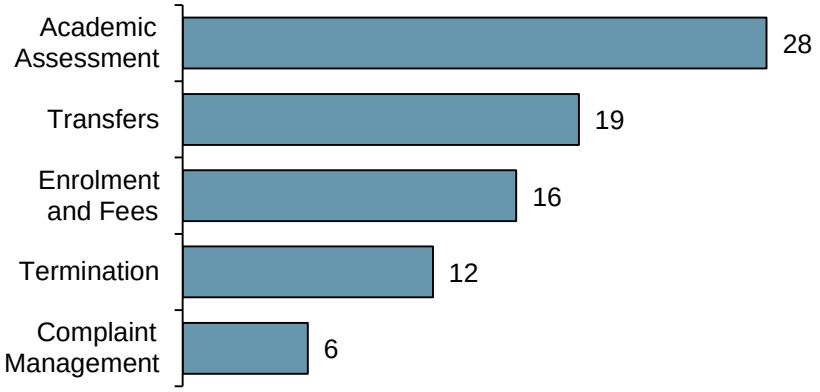
The following section provides further details about the issues and outcomes of complaints for the university sector.

Universities

Complaints received



Most common allegations



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

Other types of allegations

- Human resource management issues;
- Academic misconduct;
- Personal information and privacy;
- Examinations; and
- Other dealings with the public.

Outcomes Achieved

- Apology given;
- Monetary charge reduced;
- Explanation given or reasons provided;
- Reversal or significant variation of original decision;
- Change to policy or procedure;
- Consider or reconsider a matter and make a decision;
- Action expedited; and
- Conduct an audit or review.

Case Study

University changes complaints procedure

A university student, who had complained to the University about a number of administrative issues affecting their studies, complained to the Ombudsman that the University had failed to resolve their complaints, one of which was almost two years old.

As a result of the Office's enquiries, the University recognised that there were deficiencies in its complaints process which had resulted in the University not addressing the oldest complaint and a delay in the processing of other complaints.

The University apologised to the student and informed them of the outcome of their complaints. The University also improved its complaints process by requesting progress reports and final outcomes for each complaint to improve its timeliness when addressing future complaints.

Other Complaint Related Functions

Reviewing appeals by overseas students

The *National Code of Practice for Registration Authorities and Providers of Education and Training to Overseas Students 2007* (**the National Code**) sets out standards required of registered providers who deliver education and training to overseas students studying in Australian universities. It provides overseas students with rights of appeal to external, independent bodies if the student is not satisfied with the result or conduct of the internal complaint handling and appeals process.

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

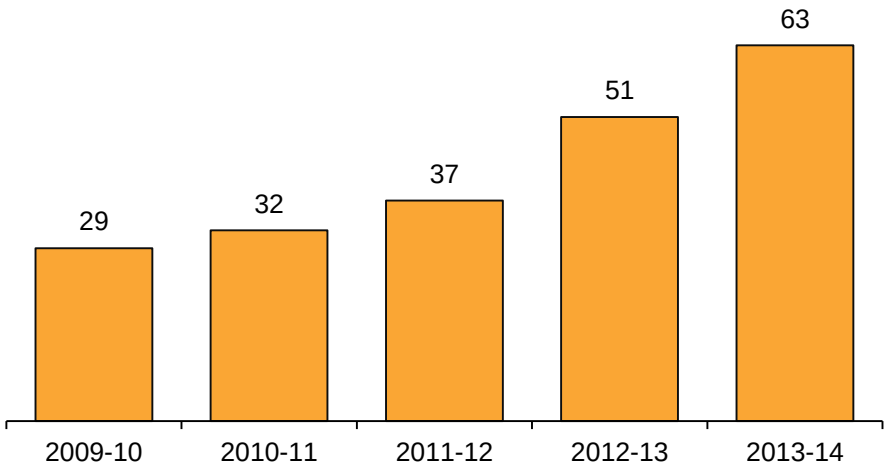
- Provides a free complaint resolution service;
- Is independent and impartial and does not represent either the overseas students or education and training providers; and
- Can make recommendations arising out of investigations.

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

Complaints lodged with the Office under the National Code

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

Complaints Received from Overseas Students under the National Code between 2009-10 and 2013-14



During 2013-14, the Office received 62 complaints about public education and training providers from overseas students. Fifty one complaints were about universities, seven were about TAFEs and four were about other education agencies. The Office also received one complaint that, after initial assessment, was found to be about a private education provider. The Office referred this person to the Overseas Students Ombudsman.

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

- Transfers between education and training providers (20).
- Termination of enrolment (13);
- Academic assessment (12); and
- Fees (8).

During the year, the Office finalised 71 complaints about 82 issues.

Case Study

New investigation conducted

An overseas student at a Western Australian University was expelled from the university following an investigation of an allegation of academic misconduct. The student complained to the Ombudsman that the University's decision was unreasonable and unfair because it was based on a flawed investigation process.

As a result of the Office's investigation, which found defects in the University's process, the University agreed to conduct a new investigation of the allegation and to ensure that the student was given the opportunity to respond to any adverse material arising in the course of the new investigation.

Public Interest Disclosures

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

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

During the year, five new disclosures were received.

Indian Ocean Territories

Under a service delivery arrangement between the Ombudsman and the Australian Government, the Ombudsman handles complaints from residents of the Indian Ocean Territories about public authorities in the Ombudsman's jurisdiction. There were three complaints received during the year.

Terrorism

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

Requests for Review

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

Seven requests for review were received in 2013-14, compared to 24 in 2012-13, representing less than one tenth of one per cent of the total number of complaints received by the Office. In all cases where a review was undertaken, the original decision was upheld.

Child Death Review

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

- Background;
- The role of the Office in child death reviews;
- The child death review process;
- Notifications and reviews;
- Patterns and trends identified from child death reviews;
- Improvements to public administration to prevent or reduce child deaths; and
- Stakeholder liaison.

Background

In November 2001, prompted by the coronial inquest into the death of a 15 year old Aboriginal girl at the Swan Valley Nyoongar Community in 1999, the (then) Government announced a special inquiry into the response by Government agencies to complaints of family violence and child abuse in Aboriginal communities.

The resultant 2002 report, *Putting the Picture Together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities*, recommended that a Child Death Review Team be formed to review the deaths of children in Western Australia (Recommendation 146). Responding to the report the (then) Government established the Child Death Review Committee (**CDRC**), with its first meeting held in January 2003. The function of the CDRC was to review the operation of relevant policies, procedures and organisational systems of the (then) Department for Community Development in circumstances where a child had contact with the Department.

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

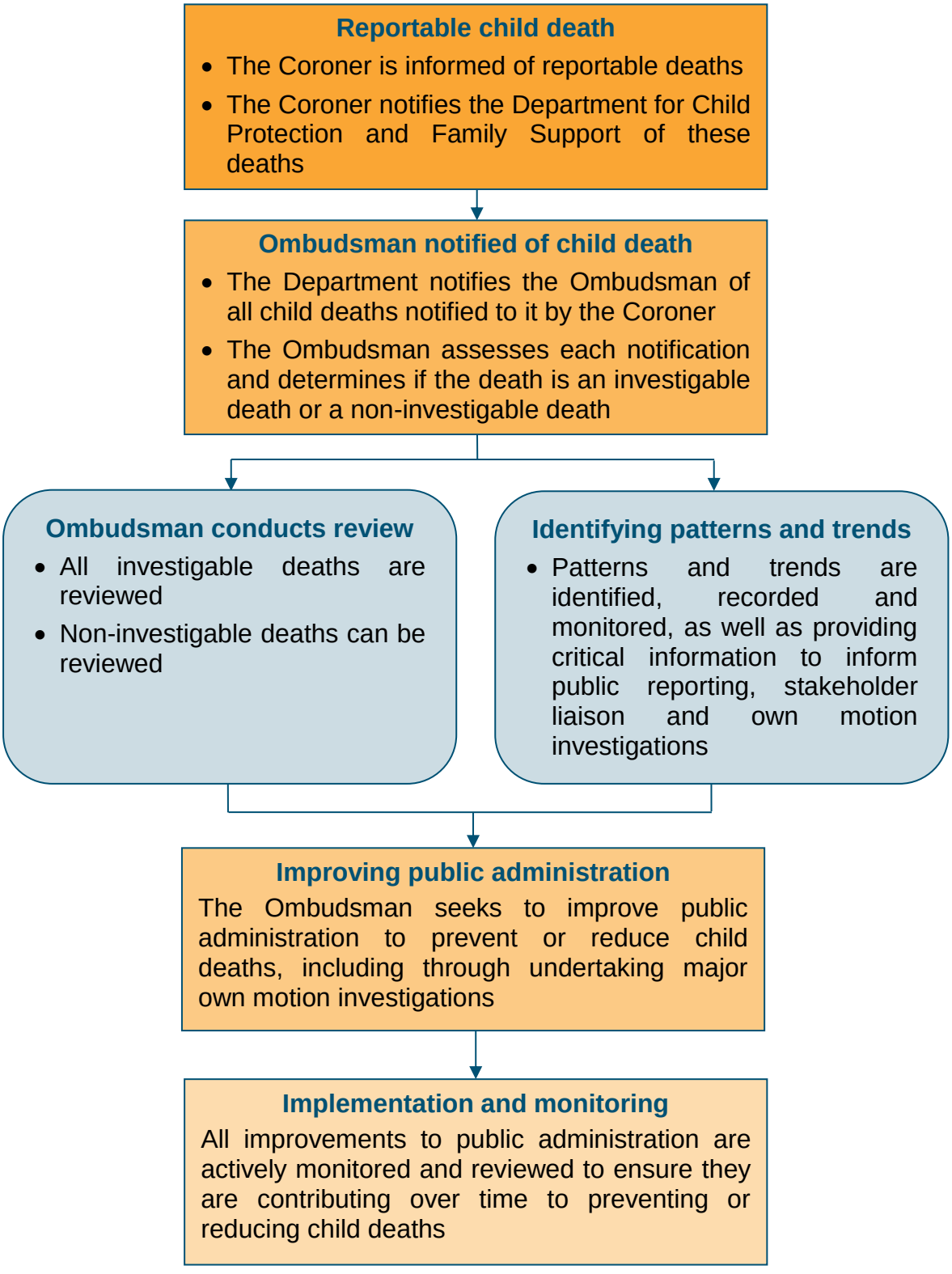
In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

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.

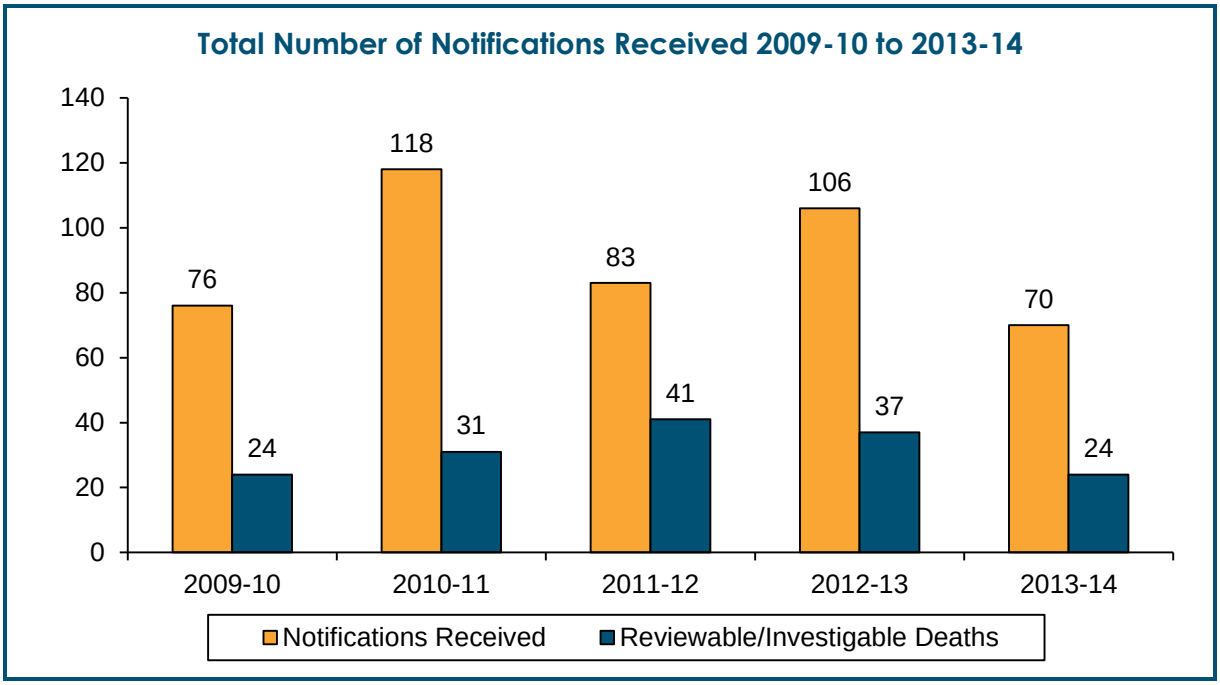
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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

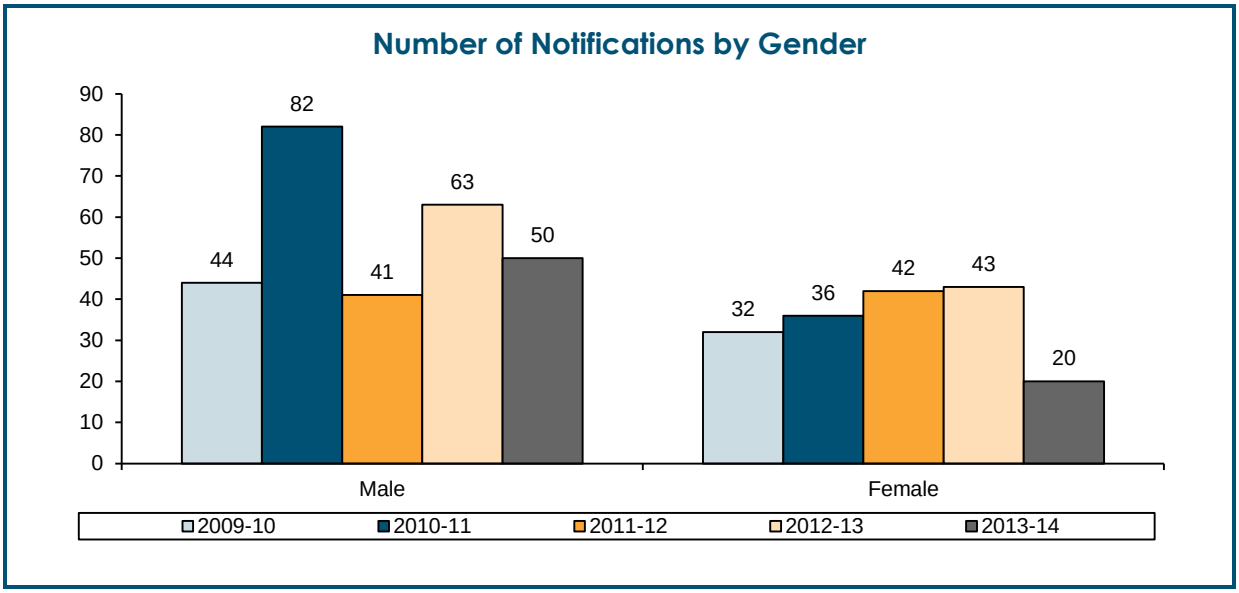
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

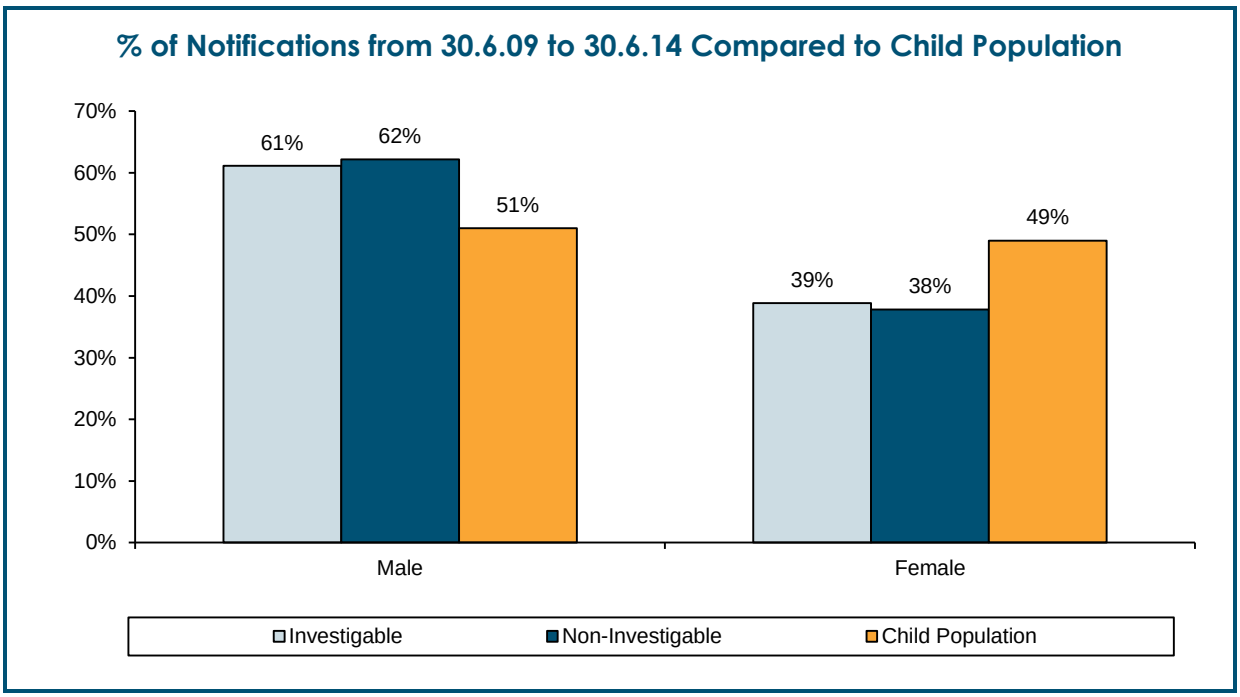
The following charts show:

- 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.

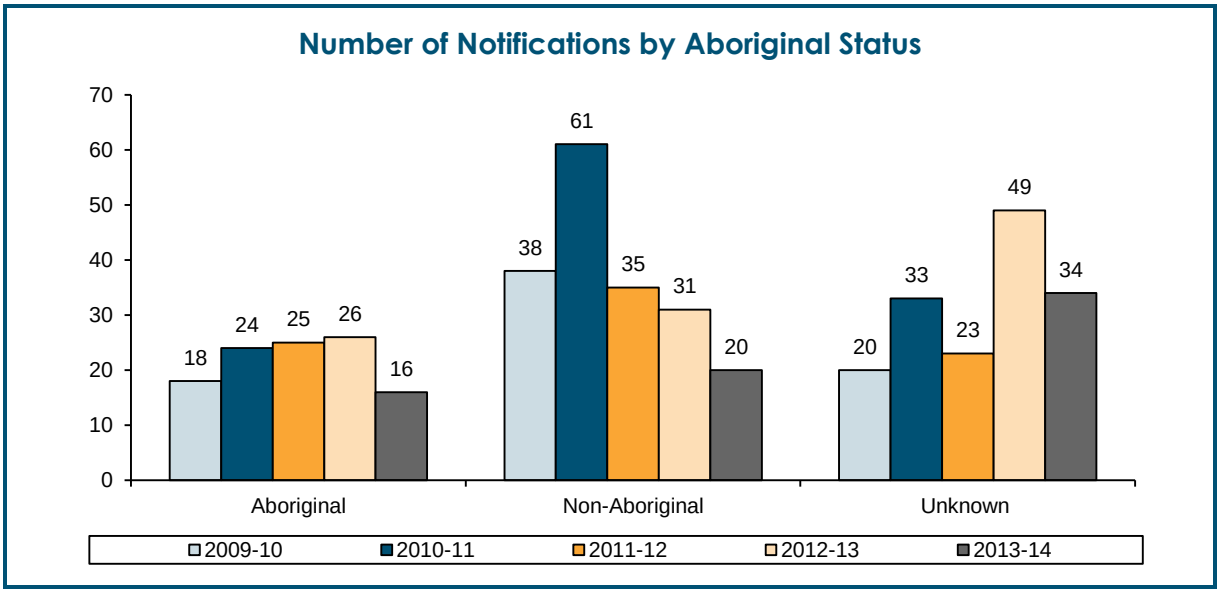


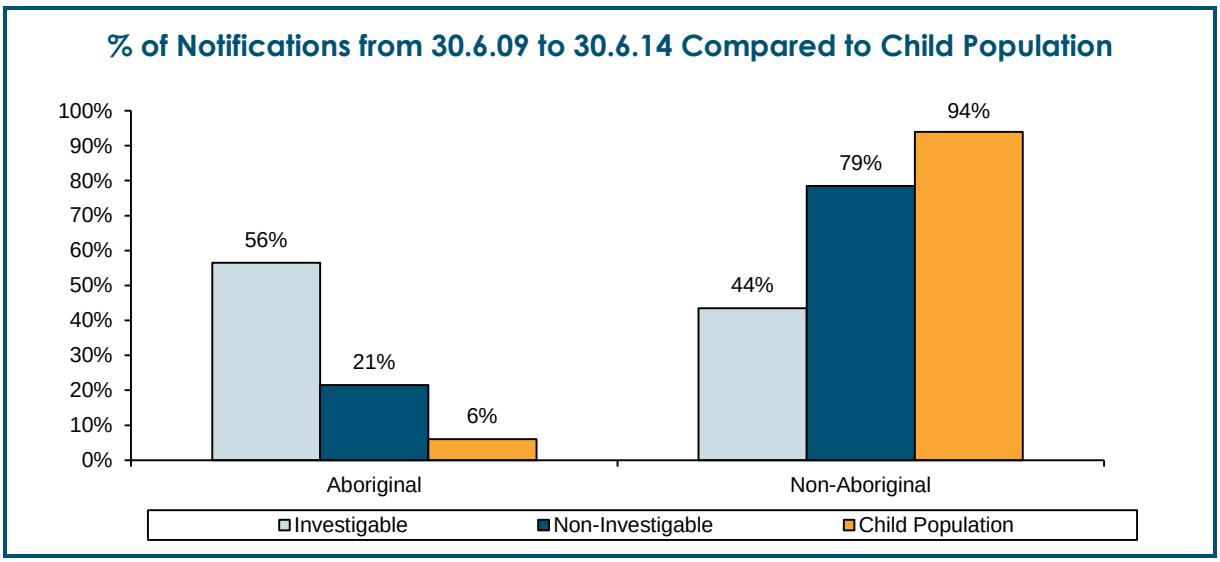


Further analysis of the data shows that, considering all five years, male children are over-represented for all age groups, but particularly for children under the age of one.

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.



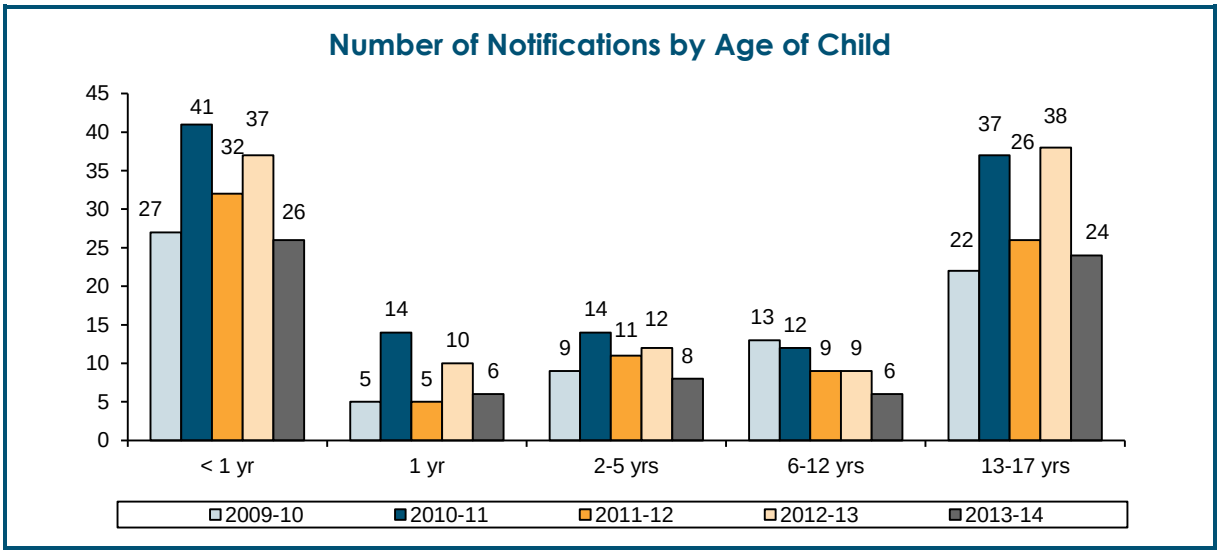


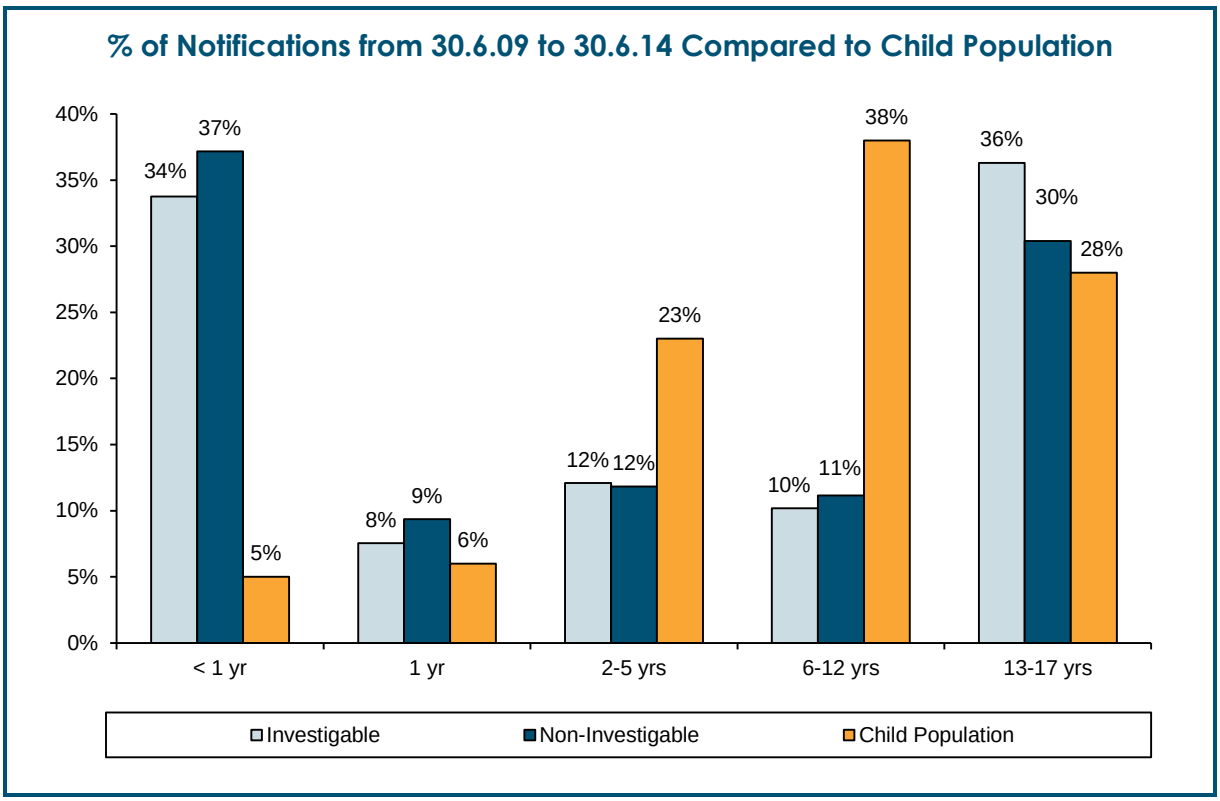
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

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.

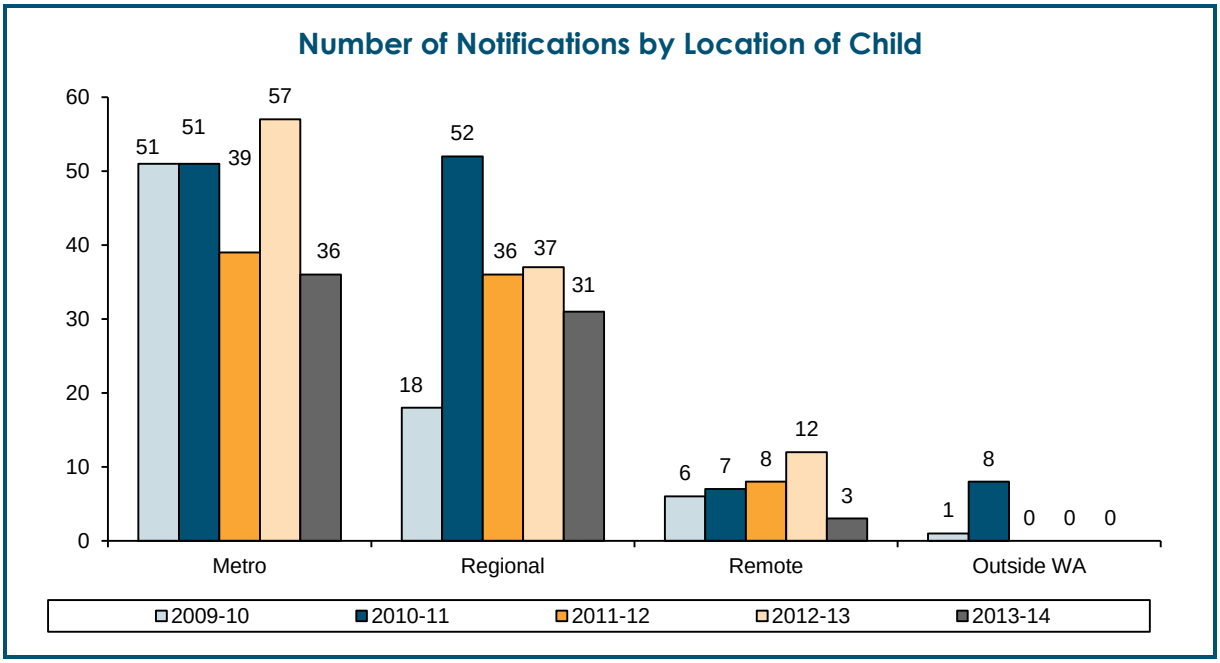


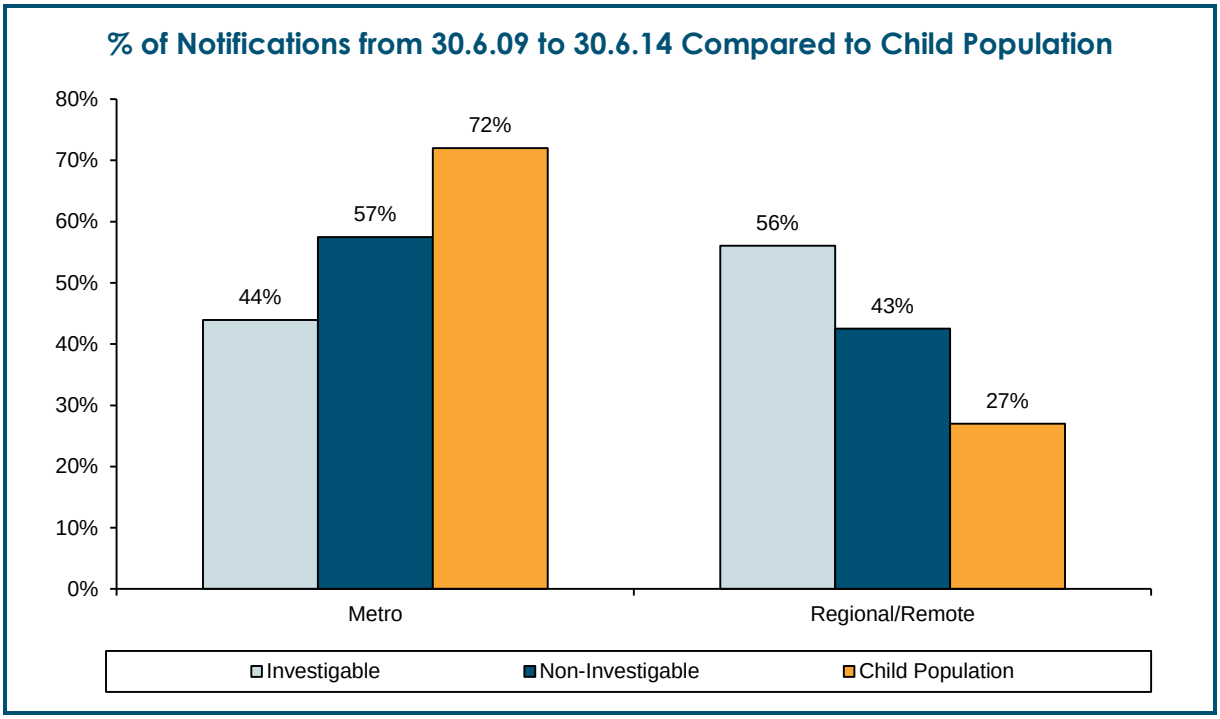


Further analysis of the data shows that a higher proportion of Aboriginal children are under the age of one compared to other age groups. A more detailed analysis by age group is provided later in this section.

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.

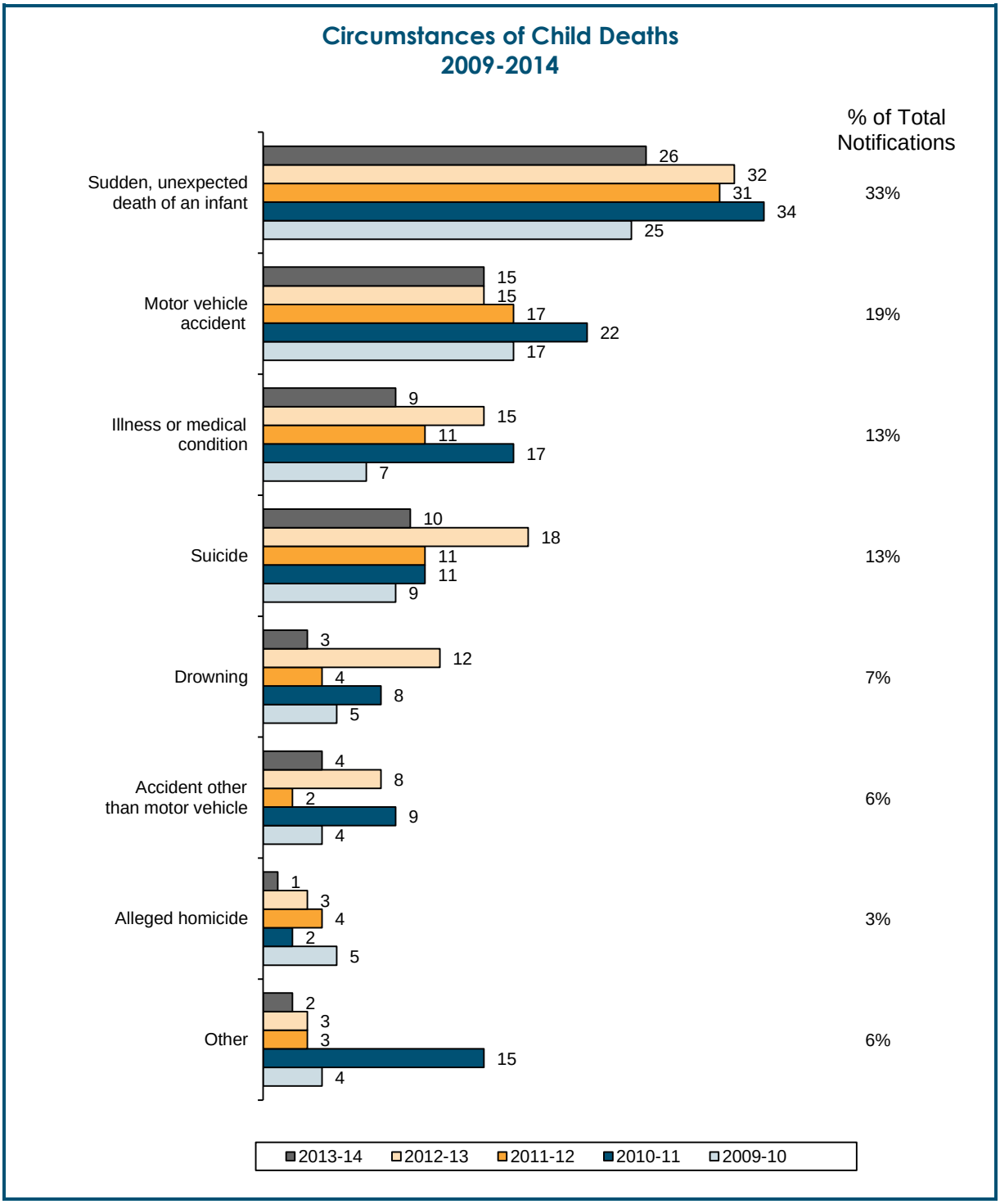
Circumstances of child deaths

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.



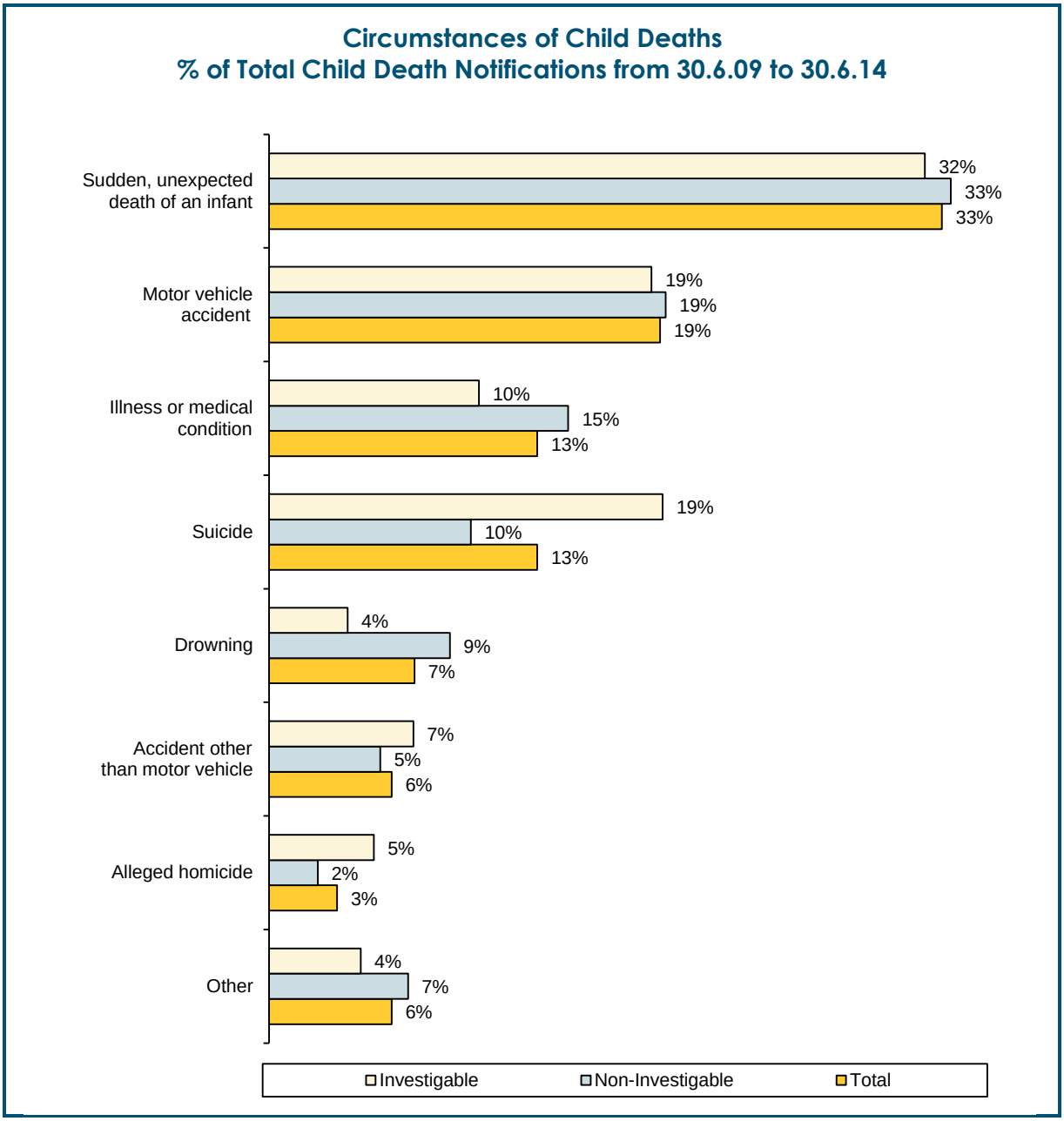
Note: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010. Numbers may vary slightly from those previously reported as, during the course of a review, further information may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

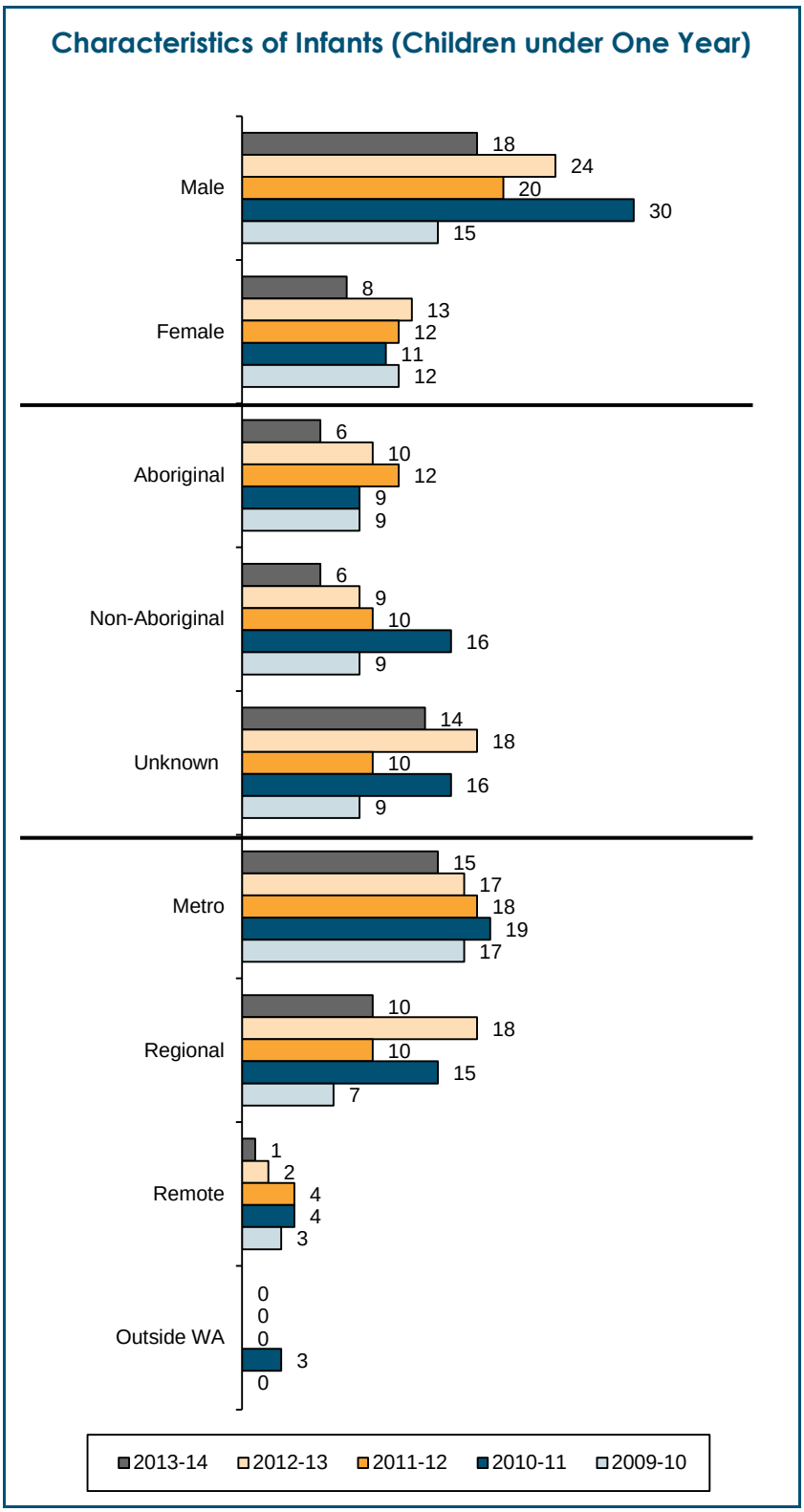
In 2013-14, the majority of children who were known to the Department were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support and access, foster or adoption enquiries.

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.

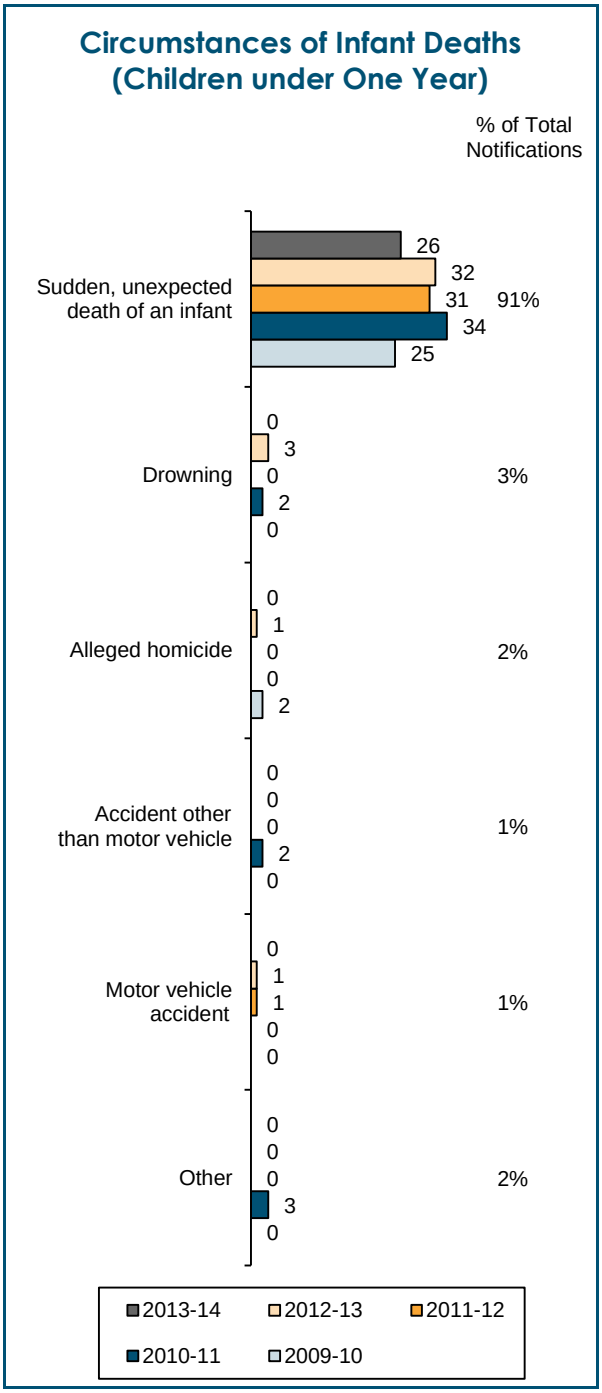
Further analysis of the data showed that, for these infant deaths, there was an over-representation compared to the child population for:

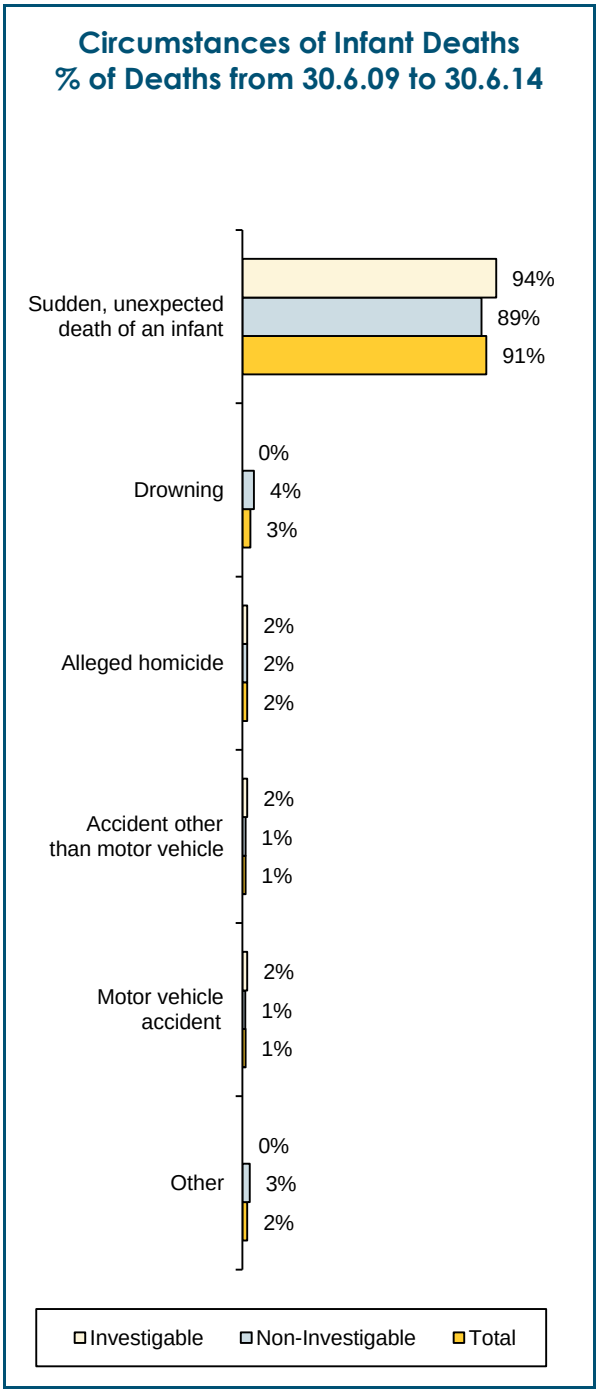
- Males – 77% of investigable infant deaths and 60% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 67% of investigable deaths and 35% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and

- 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.





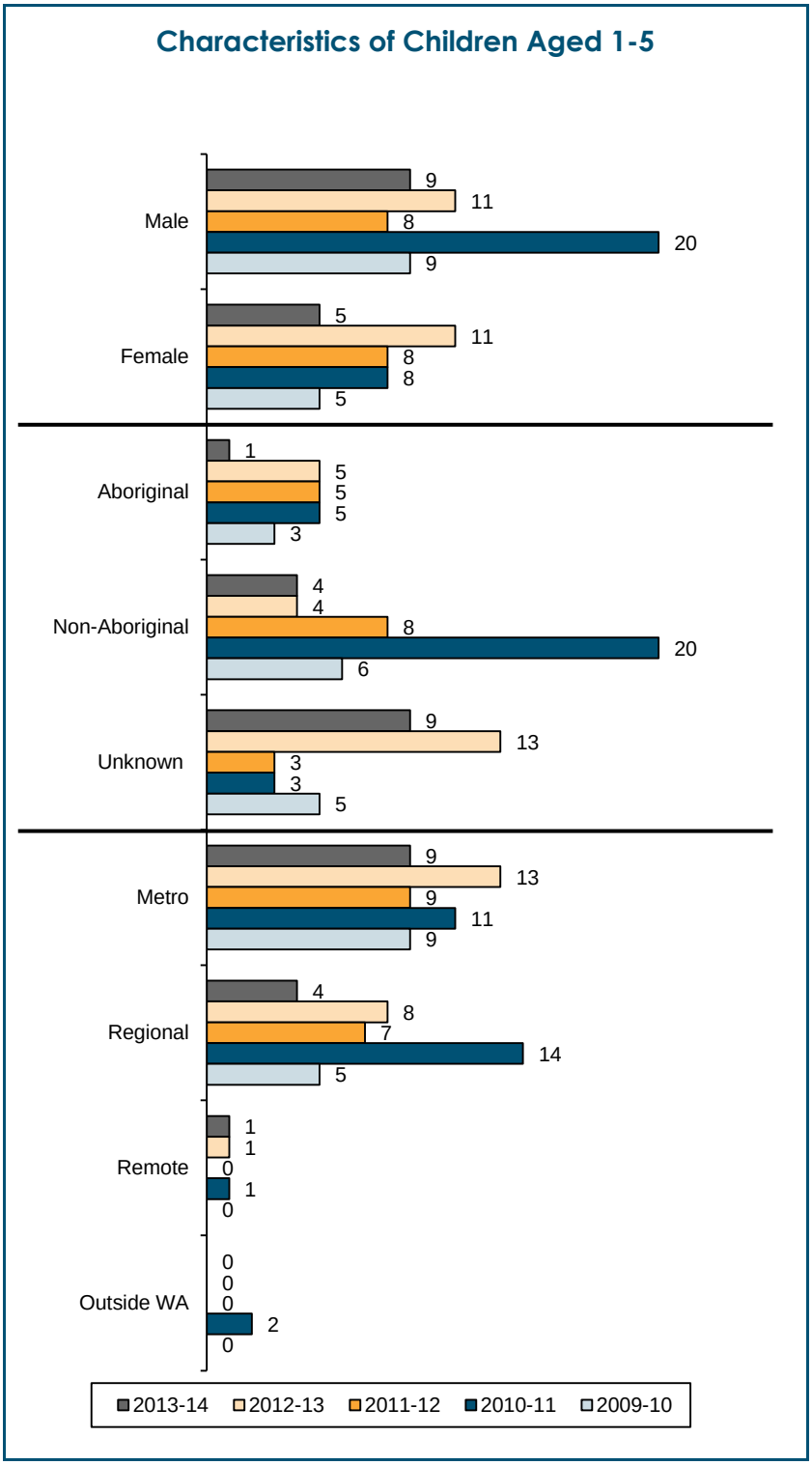
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

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.

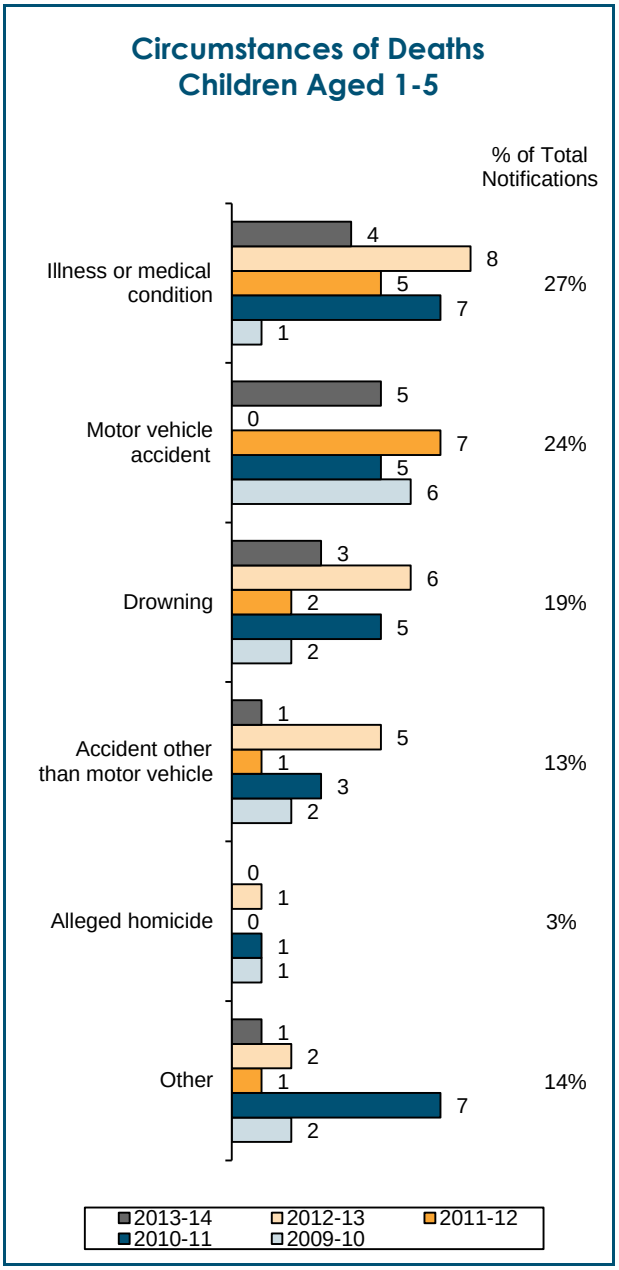


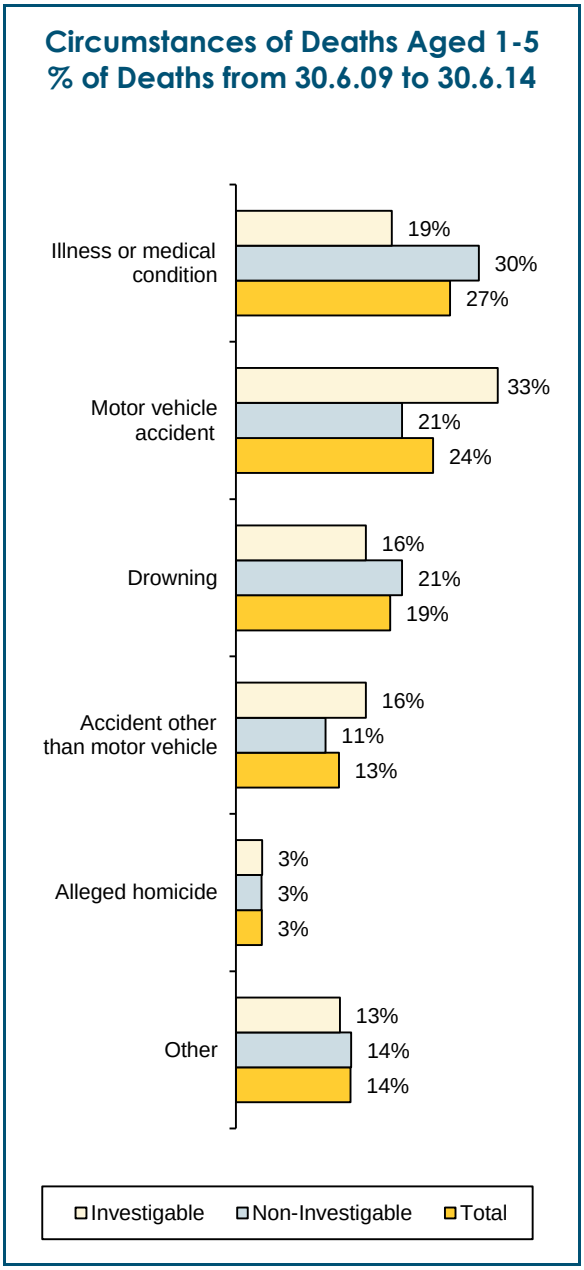
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).





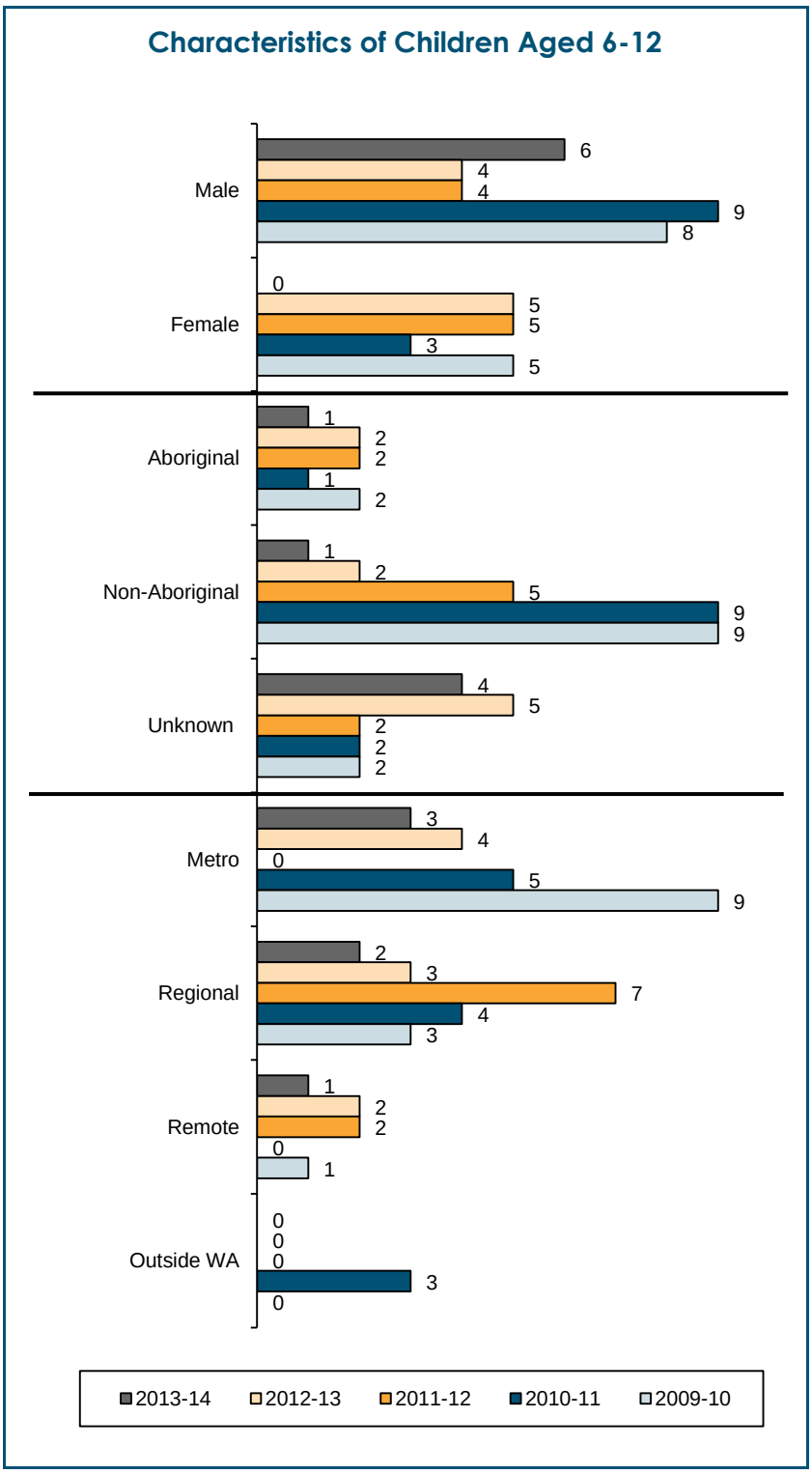
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

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.

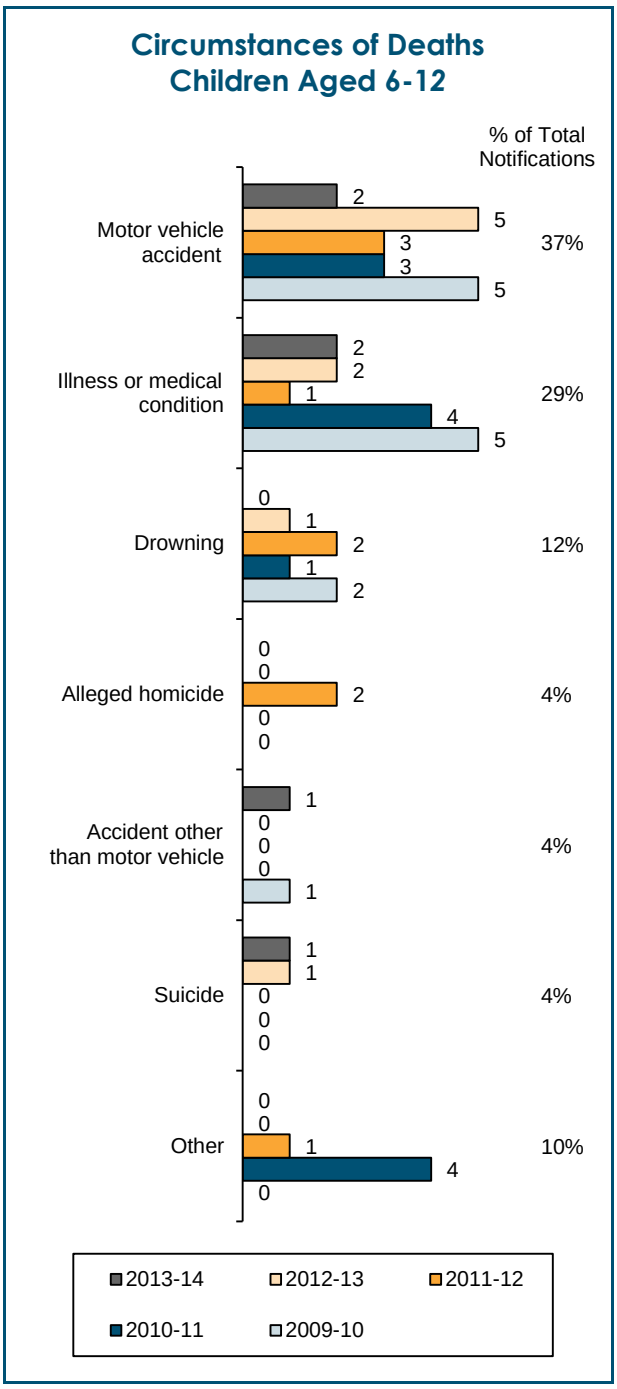


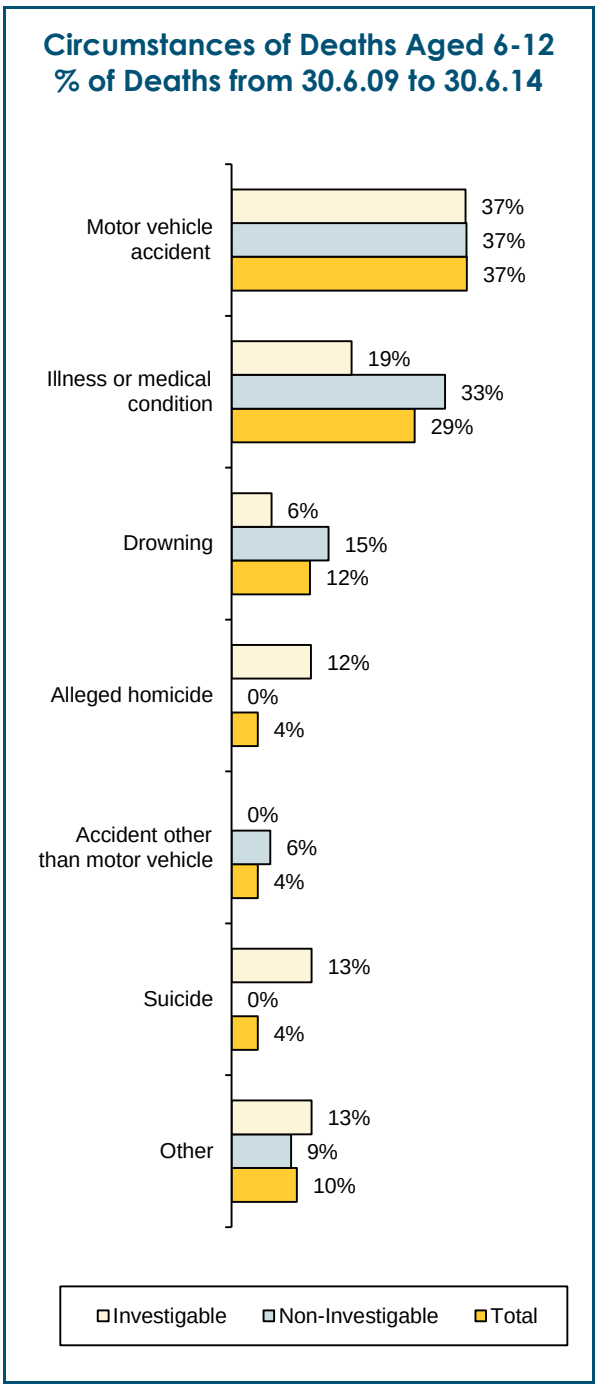
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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%).





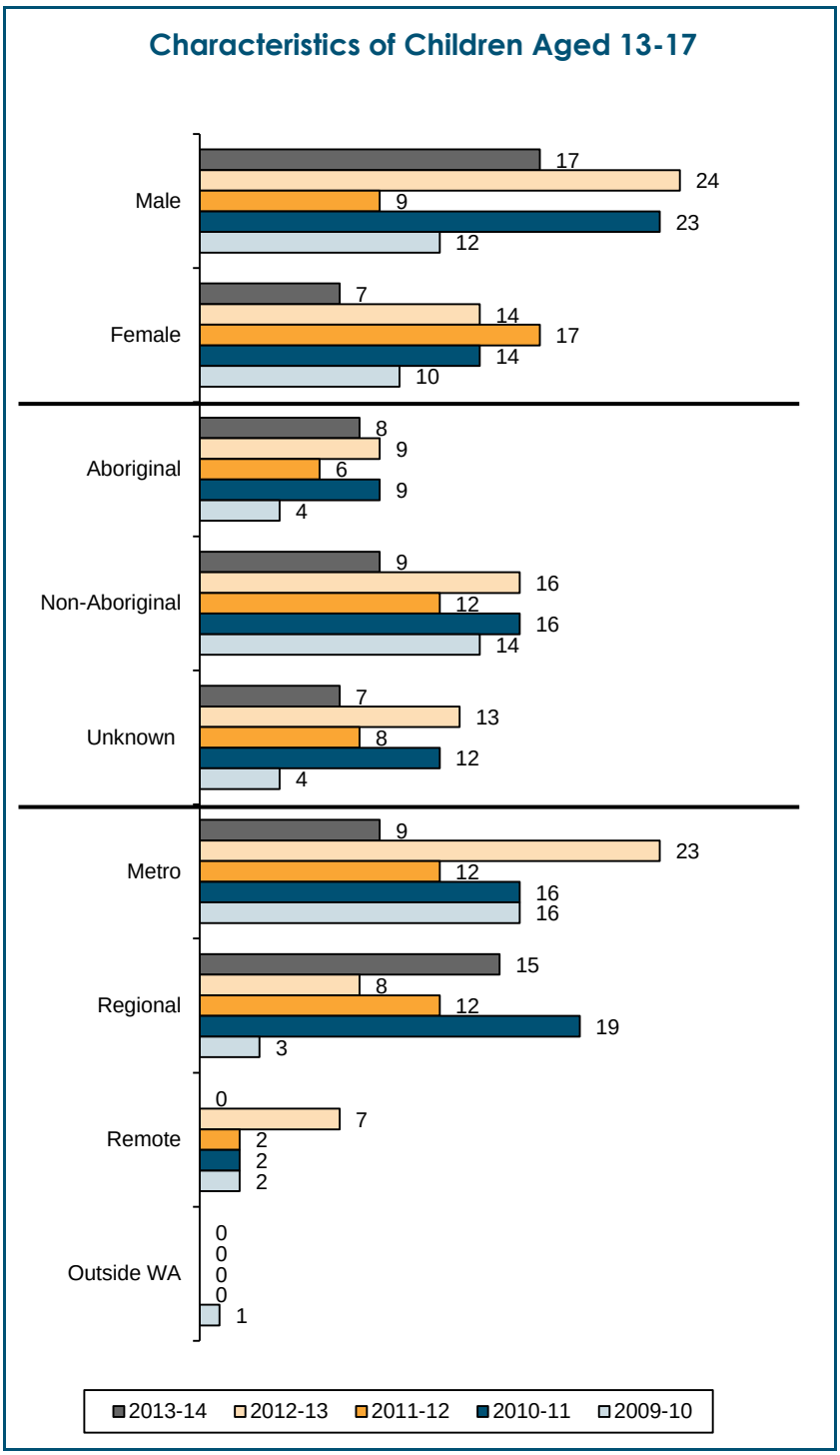
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

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.

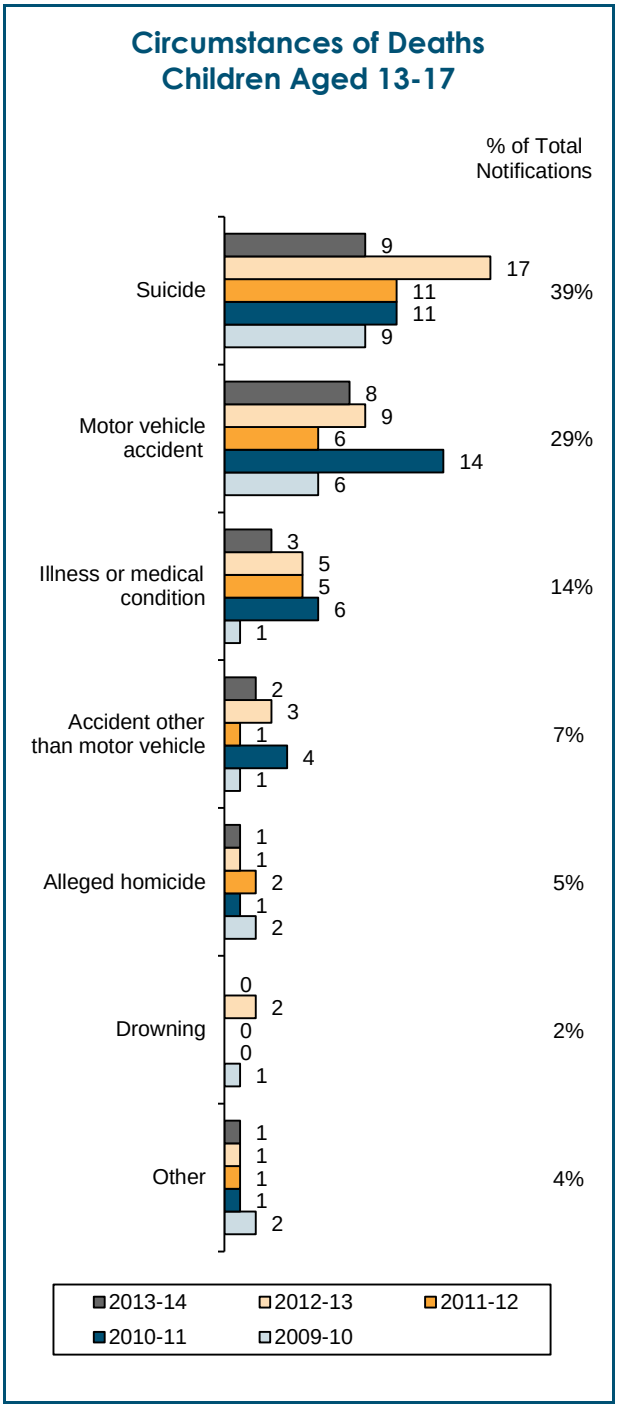


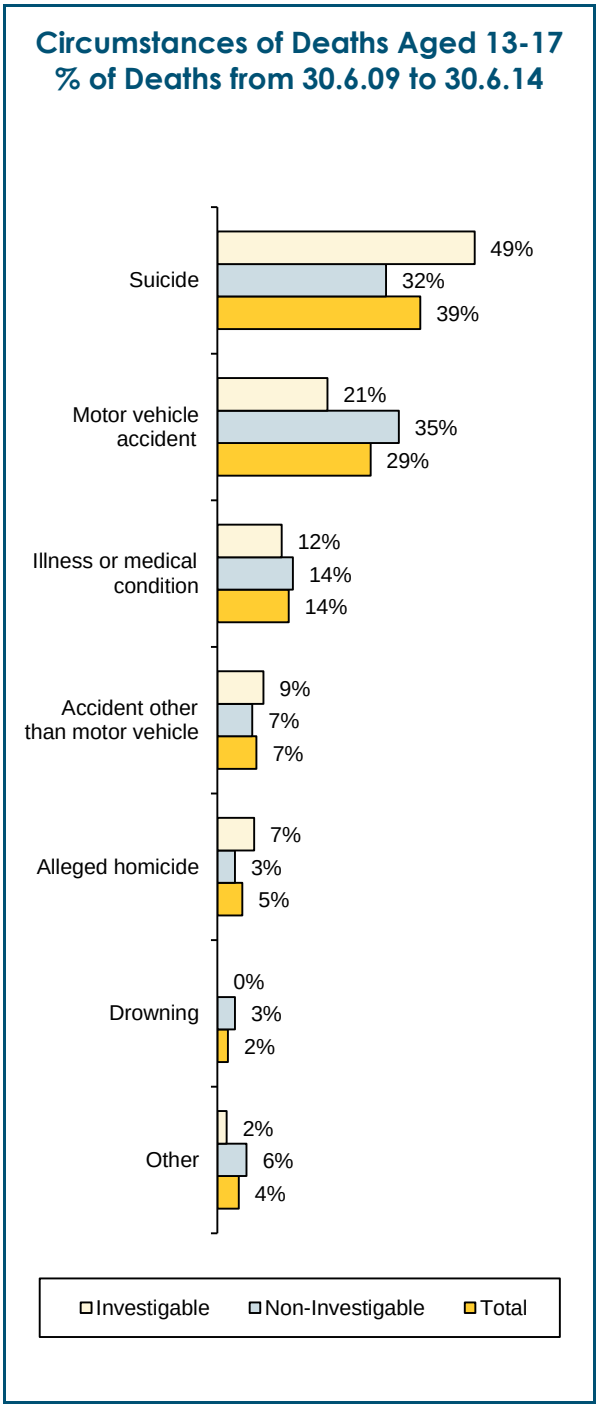
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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.

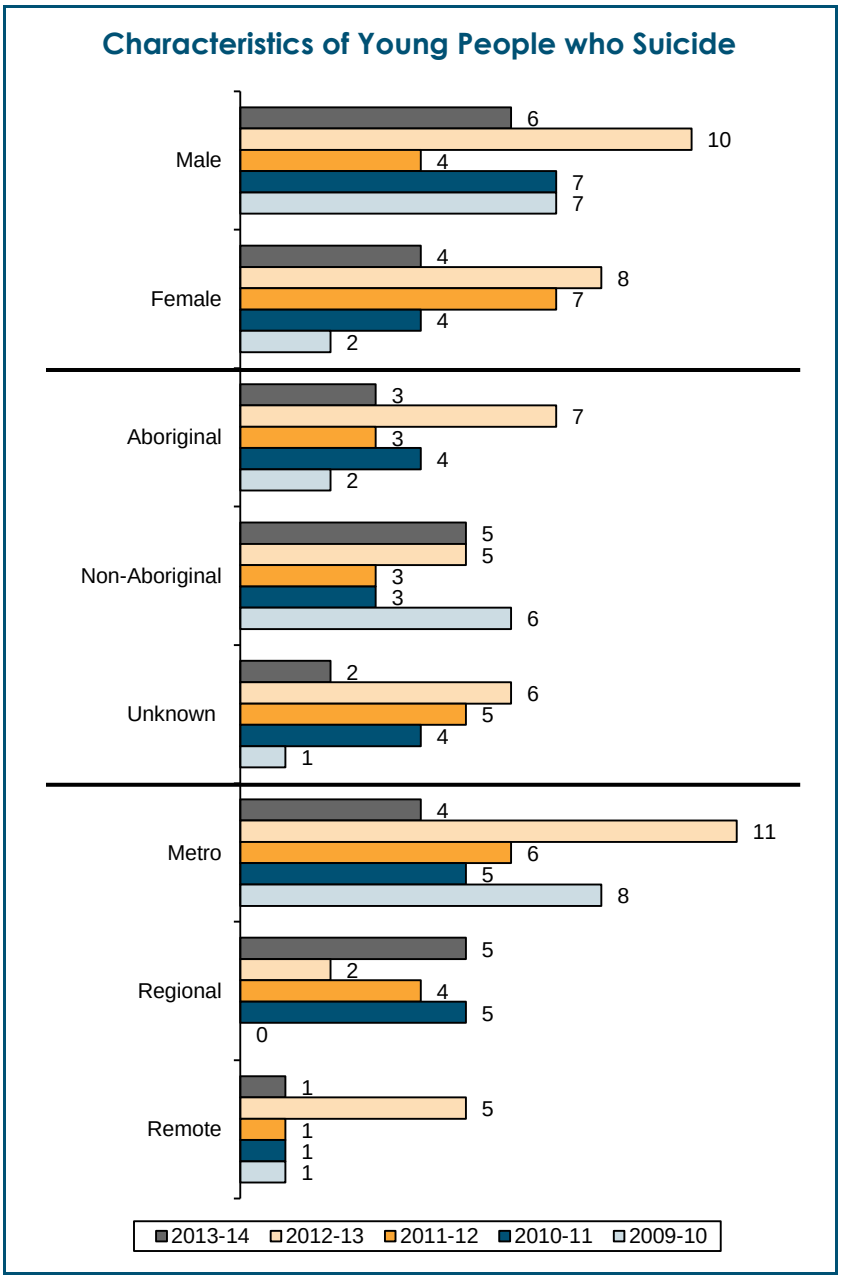
Fifty seven deaths of children aged 13 to 17 years were determined to be investigable deaths.

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.

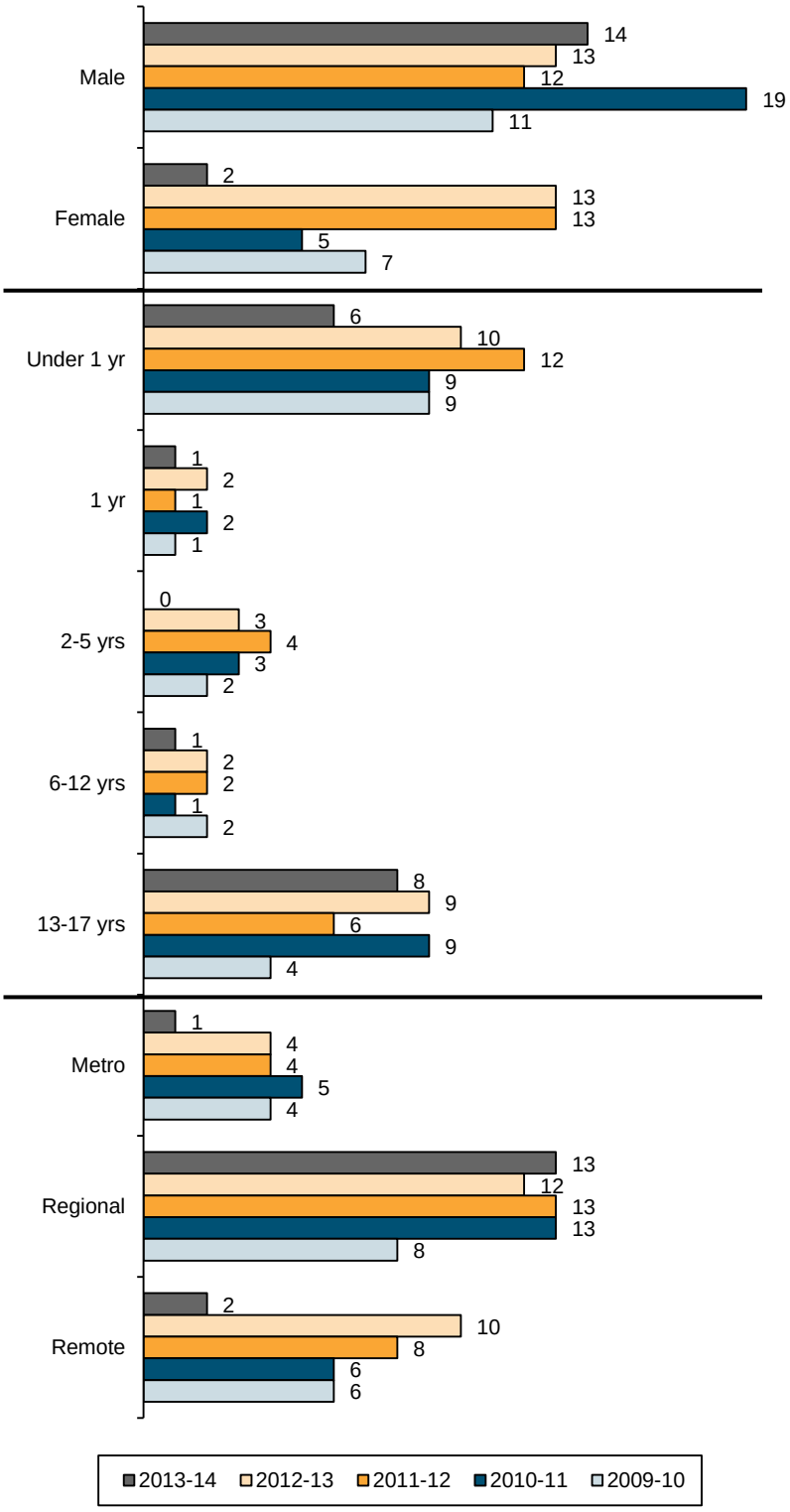
Deaths of Aboriginal children

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:

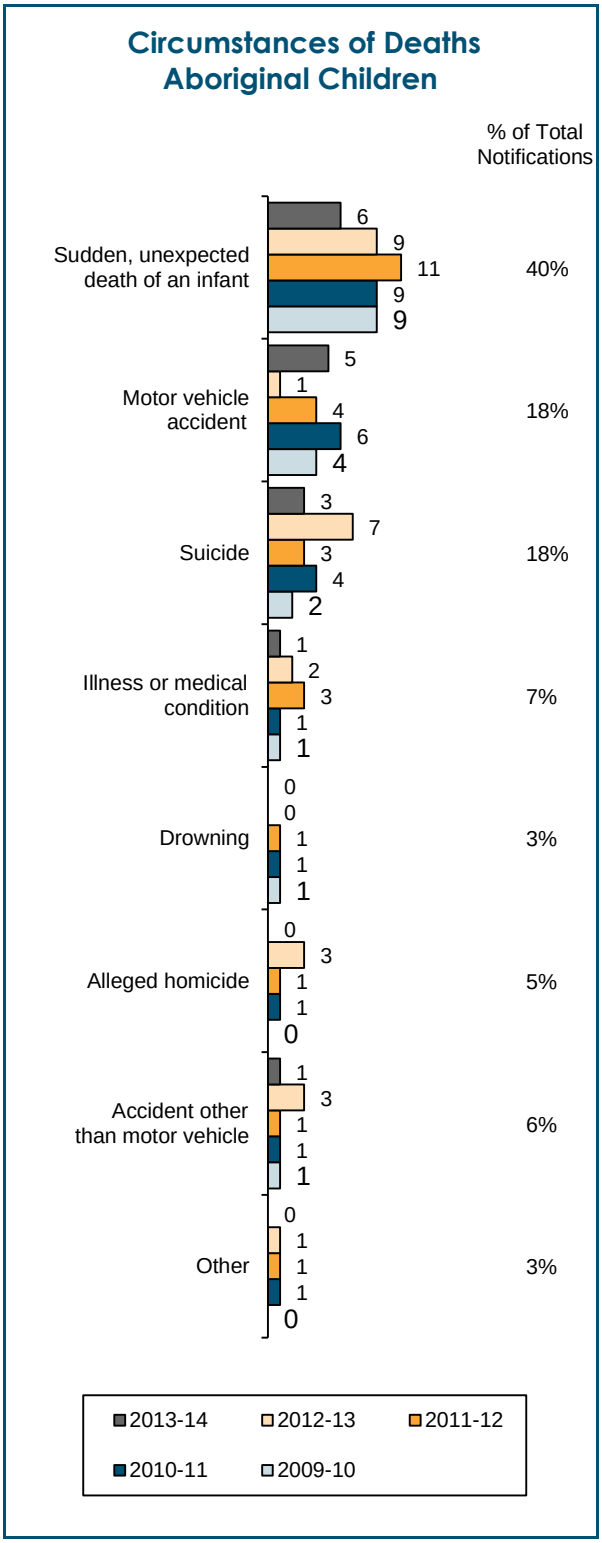
- Over the five year period from 30 June 2009 to 30 June 2014, the majority of Aboriginal children who died were male (63%). For 2013-14, 88% of Aboriginal children who died were male;
- Most of the Aboriginal children who died were under the age of one and children aged 13-17; and
- The deaths of Aboriginal 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.

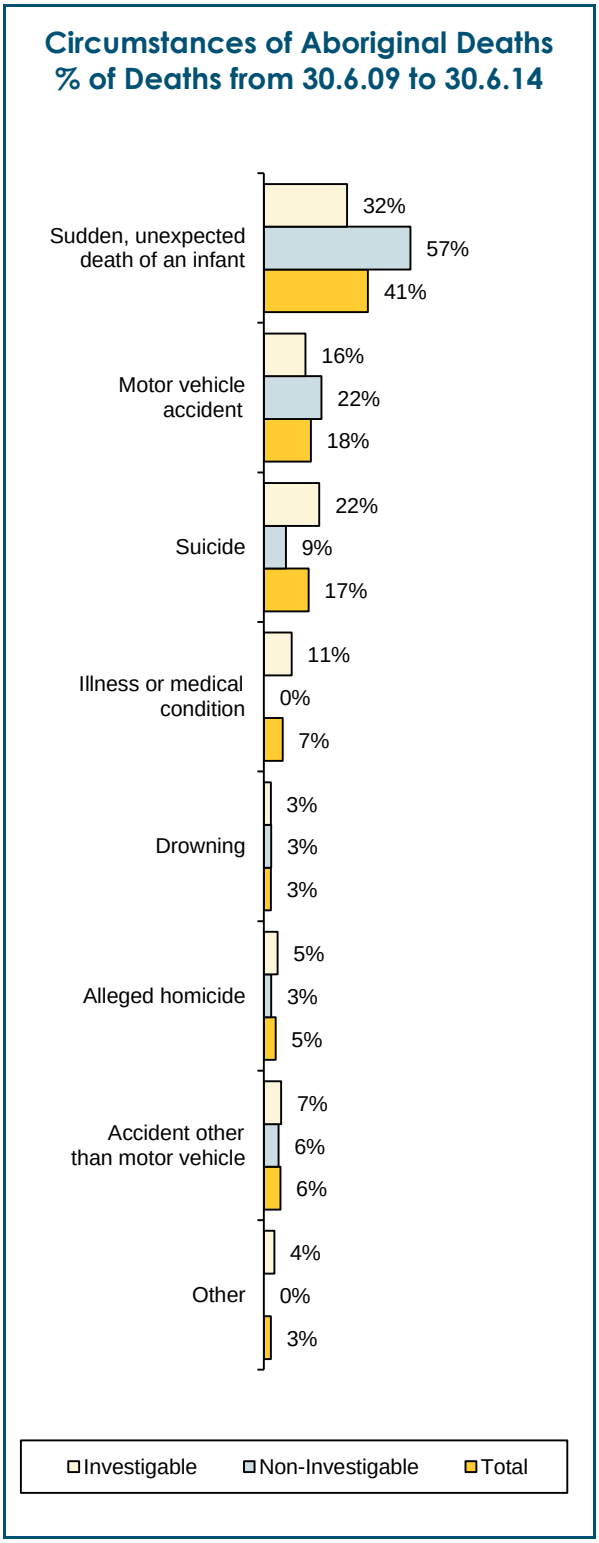
Characteristics of Aboriginal Children who Died



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.

Family & Domestic Violence Fatality Review

On 1 July 2012, the Office commenced an important new function to review family and domestic violence fatalities.

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

- Background;
- The role of the Ombudsman in relation to family and domestic violence fatalities;
- Patterns and trends identified from family and domestic violence fatality reviews;
- Issues identified from family and domestic violence fatalities;
- Emerging themes from family and domestic violence fatality reviews; and
- Stakeholder liaison.

Background

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

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

The National Plan is endorsed by the Council of Australian Governments. The *WA Strategic Plan for Family and Domestic Violence 2009-13* and *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating safer communities* include the following principles:

1. Family and domestic violence and abuse is a fundamental violation of human rights and will not be tolerated in any community or culture.
2. Preventing family and domestic violence and abuse is the responsibility of the whole community and requires a shared understanding that it must not be tolerated under any circumstance.
3. The safety and wellbeing of those affected by family and domestic violence and abuse will be the first priority of any response.
4. Children have unique vulnerabilities in family and domestic violence situations, and all efforts must be made to protect them from short and long term harm.

5. Perpetrators of family and domestic violence and abuse will be held accountable for their behaviour and acts that constitute a criminal offence will be dealt with accordingly.

6. Responses to family and domestic violence and abuse can be improved through the development of an all-inclusive approach in which responses are integrated and specifically designed to address safety and accountability.

7. An effective system will acknowledge that to achieve substantive equality, partnerships must be developed in consultation with specific communities of interest including people with a disability, people from diverse sexualities and/or gender, people from Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds.

8. Victims of family and domestic violence and abuse will not be held responsible for the perpetrator's behaviour.

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

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

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

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

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

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

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

Information regarding reporting

The annual reporting of the work of the Office on its family and domestic violence fatality review responsibility will be developed over future annual reports, in accordance with information identified from undertaking reviews over multiple years. This will include case studies and further information and analysis on underlying patterns and trends over time arising from family and domestic violence fatality reviews.

There will also be reporting to Parliament of major own motion investigations, the first of which is examining issues associated with Violence Restraining Orders and their relationship with family and domestic violence fatalities. The investigation commenced in 2013-14 and the report of the investigation will be tabled in Parliament in 2014-15.

The Role of the Ombudsman in Relation to Family and Domestic Violence Fatalities

Information regarding the use of terms

Information in relation to those fatalities that are suspected by WAPOL to have occurred in circumstances of family and domestic violence are described in this report as family and domestic violence fatalities. For the purposes of this report the person who has died due to suspected family and domestic violence will be referred to as 'the person who died' and the person whose actions are suspected of causing the death will be referred to as the 'suspected perpetrator' or, if the person has been convicted of causing the death, 'the perpetrator'.

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

WAPOL informs the Office of all family and domestic violence fatalities and provides information about the circumstances of the death together with any relevant information of prior WAPOL contact with the person who died and the suspected perpetrator. A family and domestic violence fatality involves persons apparently in a 'family and domestic relationship' as defined by section 4 of the *Restraining Orders Act 1997*. More specifically, the relationship between the person who died and the suspected perpetrator is a relationship between two people:

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

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

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

(d) One of whom is a child who —

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

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

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

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

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

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

(b) Is related to the person's —

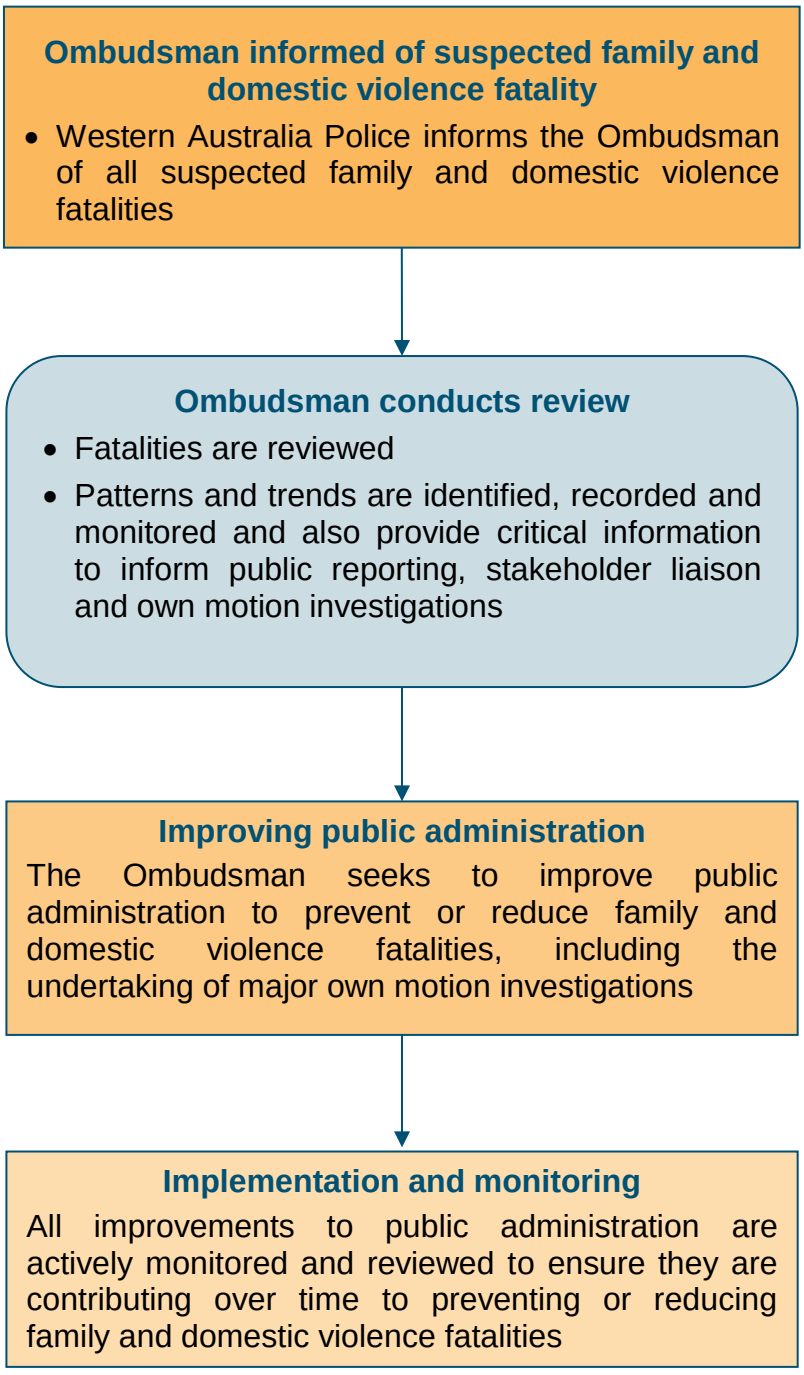
(i) Spouse or former spouse; or

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

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

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

The Family and Domestic Violence Fatality Review Process



Number of family and domestic violence fatality reviews

In 2013-14, the number of reviewable family and domestic violence fatalities received was 15, compared to 20 in 2012-13.

Patterns and Trends Identified from Family and Domestic Violence Fatality Reviews

Information on interpretation of data

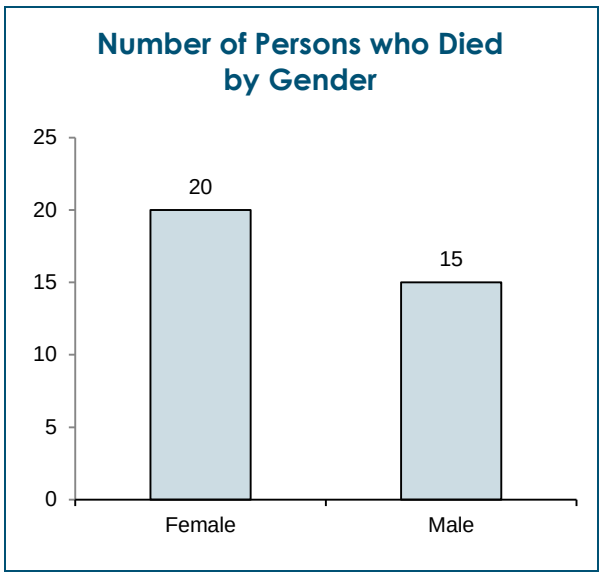
Information in this section is presented for the first two years of operation of the Ombudsman's family and domestic violence fatality review function. As the information in the following charts is based on two years of data only, very significant care should be undertaken in interpreting the data. In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

By examining family and domestic violence fatalities, the Ombudsman is able to capture data relating to demographics, risk factors and social and environmental characteristics and identify patterns and trends in relation to these deaths. When family and domestic violence fatality reviews are finalised, all relevant issues are identified and recorded and, over time, these issues indicate relevant patterns and trends in relation to family and domestic violence fatalities. These patterns and trends are identified, recorded, monitored, reported and analysed. The patterns and trends inform the Ombudsman's own motion investigations relating to family and domestic violence fatalities.

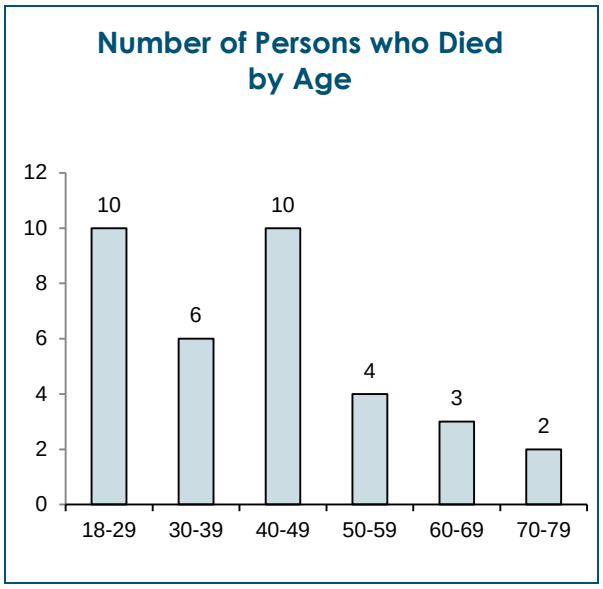
Characteristics of the persons who died

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

The following charts show characteristics for the persons who died for the 35 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2014. The numbers may vary from numbers previously reported as, during the course of a review, further information may become available.

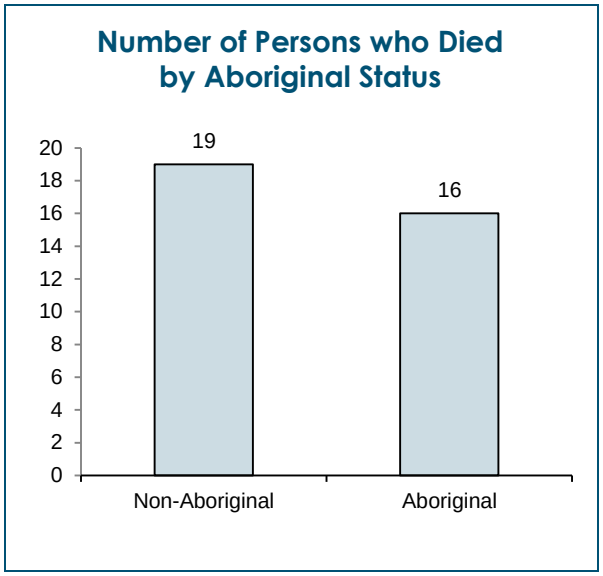


Compared to the Western Australian population, females who died in the two years from 1 July 2012 to 30 June 2014, were over-represented, with 57% of persons who died being female compared to 50% in the population.

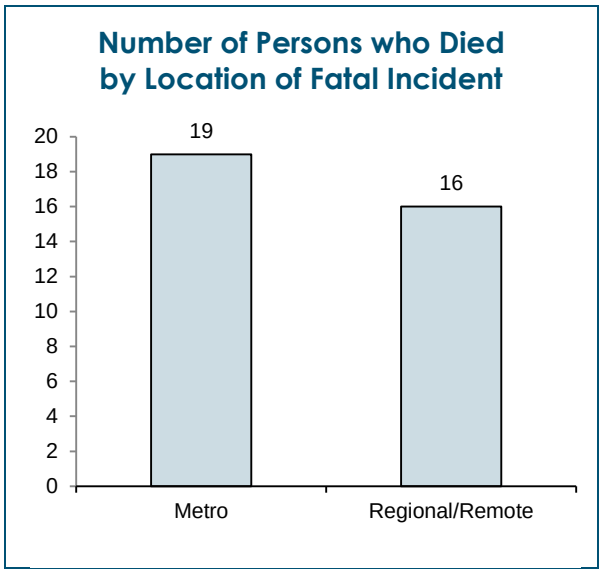


Compared to the Western Australian adult population, in the two years from 1 July 2012 to 30 June 2014:

- The age group 18-29 is over-represented, with 29% of people who died in this group compared to 17% in the population.
- The age group 40-49 is over-represented, with 29% of people who died in this group compared to 19% in the population.



Compared to the Western Australian population, Aboriginal persons who died were over-represented, with 46% of persons who died in the two years from 1 July 2012 to 30 June 2014 being Aboriginal compared to 3.1% in the population.



Compared to the Western Australian population, incidents in regional locations were over-represented, with 46% of fatal incidents occurring in regional or remote locations in the two years from 1 July 2012 to 30 June 2014, compared to 27% of the population living in those locations.

The *WA Strategic Plan for Family and Domestic Violence 2009-13* notes that:

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

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

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

In the two years from 1 July 2012 to 30 June 2014, the Office reviewed 35 family and domestic violence fatalities. From information provided by WAPOL relating to the fatality:

- 20 persons who died (57%) were females (compared with 50% of the Western Australian population);
- 16 persons who died (46%) were identified as Aboriginal (compared to 3.1% of the Western Australian population); and
- 16 family and domestic violence fatalities (46%) occurred in regional areas (compared to 27% of the Western Australian population living in regional areas).

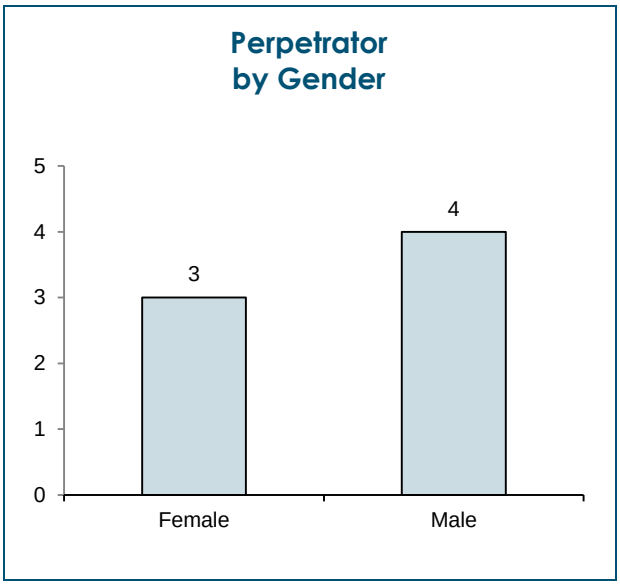
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Characteristics of the perpetrators

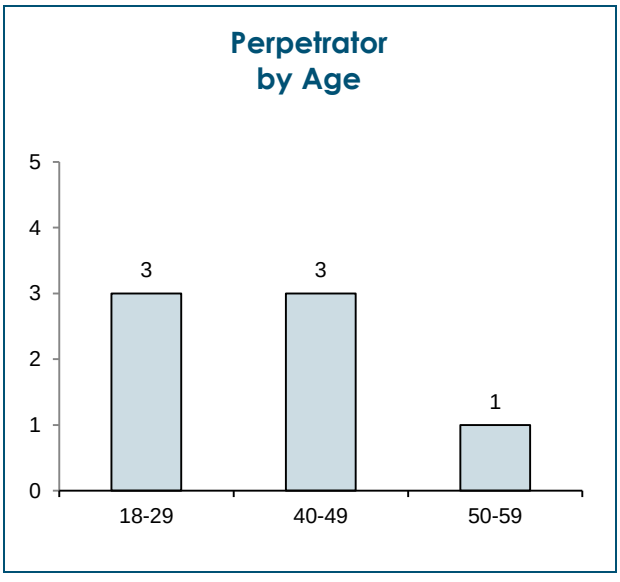
Information in this section relates only to family and domestic violence fatalities reviewed between 1 July 2012 and 30 June 2014 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2014.

Of the 35 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2014, coronial and criminal proceedings were finalised in seven cases.

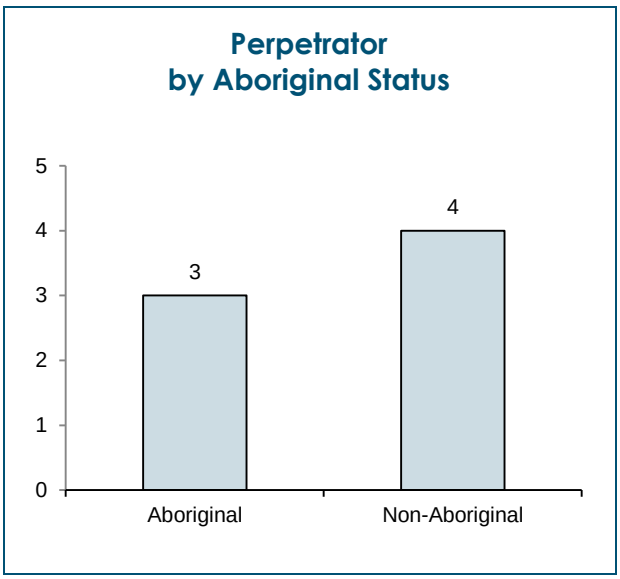
Information is obtained on a range of characteristics of the perpetrator including gender, age group and Aboriginal status. The following charts show characteristics for the seven perpetrators where both the criminal proceedings and the Coronial process have been finalised.



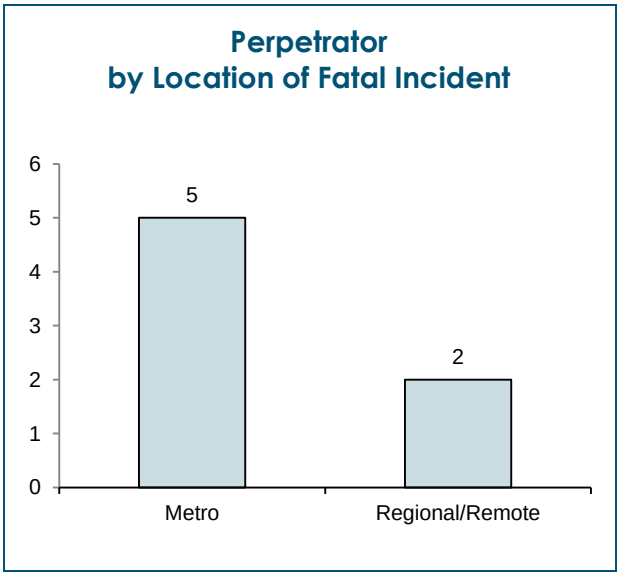
Two of the male perpetrators pleaded guilty to Manslaughter and two pleaded guilty to Murder. All three female perpetrators pleaded guilty to Manslaughter. Of the three female perpetrators, two had previously reported family and domestic violence against them by the person who died. None of the male perpetrators had previously reported family and domestic violence against them by the person who died.



The most common age groups for perpetrators were 18-29 and 40-49. These are also the most common age groups of the people who died.



In all cases, the perpetrator had the same Aboriginal status as the person who died.



The majority of fatal incidents occured in the metropolitan area.

Circumstances of family and domestic violence fatalities

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

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

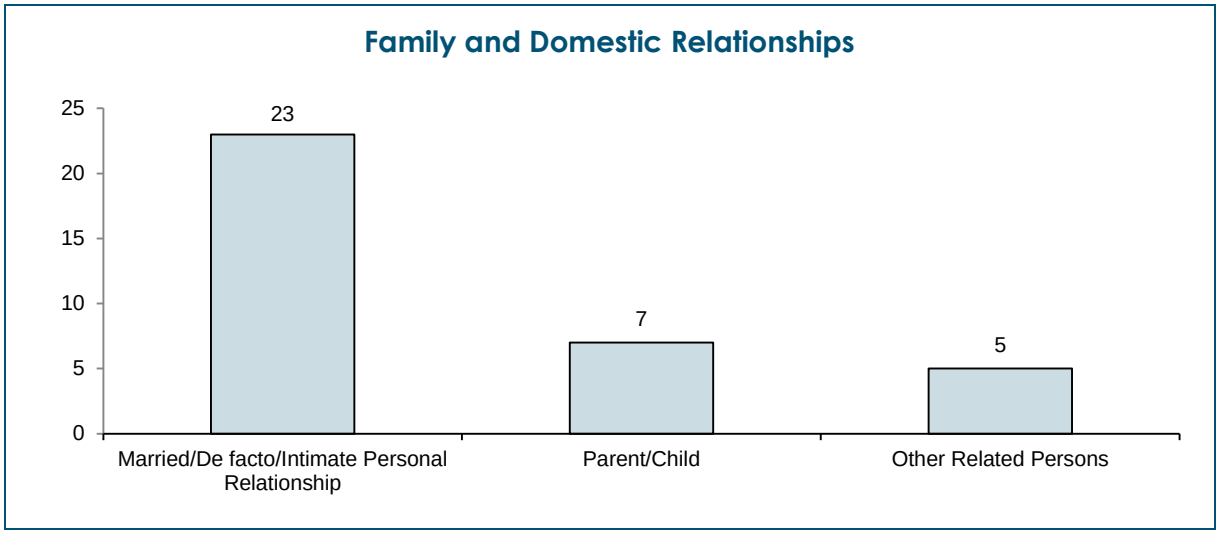
- Alleged homicide, including:
  - Stabbing;
  - Physical assault;
  - Gunshot wound;
  - Asphyxiation/suffocation;
  - Drowning; and
  - Other.

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

The principal circumstances of death in 2013-14 were stabbing and physical assault.

Family and domestic relationships

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



Of the 35 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2014:

- 23 persons who died (66%) were the past or present partner of the suspected perpetrator, in a married, de facto or intimate personal relationship. Of these, 16 (70%) were female and 7 (30%) were male;
- 7 persons who died (20%) were either the parent or adult child of the suspected perpetrator. Of these, 3 (43%) were female and 4 (57%) were male. In three cases the person who died was the parent and in four cases the person who died was the adult child; and
- 5 persons who died (14%) were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, 1 was female and 4 were male.

Issues identified in Family and Domestic Violence Fatalities

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

It is important to note that:

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

- Not identifying incidents as family and domestic violence.
- Not adequately implementing family and domestic violence policy and procedures.
- Not utilising appropriate mechanisms to ensure effective responses to family and domestic violence incidents and compliance with policy.
- Missed opportunities to promote victim and child safety.
- Missed opportunities for safety planning and use of protection orders including Violence Restraining Orders and Police Orders.
- Missed opportunities for inter-agency communication and collaboration to address family and domestic violence in regional and remote Aboriginal communities.
- Inaccurate recordkeeping.

Emerging themes from family and domestic violence fatality reviews

Information on interpretation of emerging themes

Information in this section is presented for the first two years of operation of the Ombudsman's family and domestic violence fatality review function. As the information in the following section is based on two years of data, care should be undertaken in interpreting the emerging themes.

Type of relationships

As identified above, the majority of family and domestic violence fatalities (23 or 66%) occurred between persons who, either at the time of death or at some earlier time, had been involved in a married, de facto or intimate personal relationship with the other person. The remainder of family and domestic violence fatalities (12 or 34%) occurred between persons where the relationship was between a parent and their adult child or persons otherwise related (such as siblings and extended family relationships). These two groups will be referred to as 'intimate partner fatalities' and 'non-intimate partner fatalities'.

Response to previous reported incidents of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reported incidents of family and domestic violence between the parties. In 16 out of 23 intimate partner fatalities (69%), family and domestic violence incidents between the parties had been reported to WAPOL and, in some instances, to other public authorities, such as the Department of Health (**DOH**) and DCPFS. In three out of 12 of the non-intimate partner fatalities (25%), family and domestic violence incidents between the parties had been reported to WAPOL or other public authorities.

Cases with no previous reported incidents of family and domestic violence

In seven out of 23 intimate partner fatalities (30%), the fatal incident was the only family and domestic violence incident between the parties reported to WAPOL. It is important to note, however, research indicating under-reporting of family and domestic violence. The Australian Bureau of Statistics' *Personal Safety Survey 2012* 'collected information about a person's help seeking behaviours in relation to their experience of partner violence'. For example, this research found that (emphasis in original text):

> An estimated 190,100 women (80% of the 237,100 women who had experienced current partner violence) had **never** contacted the police about the violence by their current partner.

Non-intimate partner relationships

While the majority of family and domestic violence fatalities were intimate partner fatalities, the remainder (12 or 34%) occurred between persons who were related but not involved in an intimate partner relationship. Within this group there were seven parent/adult child fatalities and five fatalities where the parties were otherwise related.

Of the 12 non-intimate partner fatalities, five involved Aboriginal people, including three from regional and remote areas. In all three cases alcohol use was identified as a factor associated with violence.

Family and domestic violence involving Aboriginal people in regional and remote communities

Of the 35 family and domestic violence fatalities received, Aboriginal Western Australians who died were over-represented, with 16 (46%) persons who died being Aboriginal. In each case, the suspected perpetrator was also Aboriginal. Thirteen of these fatalities occurred in a regional or remote area of Western Australia, of which 10 were intimate partner fatalities.

The Ombudsman's review of family and domestic violence fatalities will continue to focus particular attention on the effectiveness of the administration of the responsibilities of public authorities in relation to reducing and preventing family and domestic violence involving Aboriginal people in regional communities.

Major own motion investigations

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

Own Motion Investigation into Family and Domestic Violence Fatalities

Through the review of family and domestic violence fatalities, the Ombudsman identified a pattern of cases in which Violence Restraining Orders (VROs) were in place.

For this reason, the Ombudsman has commenced a major own motion investigation into issues associated with VROs and their relationship with family and domestic violence fatalities, with a view to determining whether it may be appropriate to make recommendations to any public authority about ways to prevent or reduce family and domestic violence fatalities.

The report of this major own motion investigation will be tabled in Parliament in 2015.

Other mechanisms to prevent or reduce family and domestic violence fatalities

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

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through the Panel, and other mechanisms, working with public authorities and communities where individuals may be at risk of family and domestic violence to consider safety issues and potential areas for improvement, and to highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information, where appropriate, with other accountability and oversight agencies including Ombudsmen and family and domestic violence fatality review bodies in other States to facilitate consistent approaches and shared learning;

- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

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

The Ombudsman's Advisory Panel

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

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

The Panel met four times in 2013-14 and during the year the following members provided a range of expertise:

- Professor Steve Allsop (Director, National Drug Research Institute, Curtin University);
- Ms Sue Ash (Chief Executive Officer, Uniting Care West);
- Professor Donna Chung (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 WAPOL, DCPFS, DOH, Department of Education, DCS, DOTAG and the Department of Aboriginal Affairs also attended the meetings.

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

Other key stakeholder relationships

There are a number of public authorities and other organisations that interact with or deliver services to those who are at risk of family and domestic violence or who have

experienced family and domestic violence. Important stakeholders, with which the Office liaises as part of the family and domestic violence fatality review function, include:

- The Coroner;
- Relevant public authorities including:
  - Western Australia Police;
  - The Department of Health;
  - The Department of Education;
  - The Department of Corrective Services;
  - The Department for Child Protection and Family Support;
  - The Department of Housing;
  - The Department of the Attorney General;
  - The Department of Aboriginal Affairs; and
  - Other accountability and similar agencies including the Commissioner for Children and Young People;
- The Women's Council for Domestic and Family Violence Services WA and relevant non-government organisations; and
- Research institutions, including universities.

Aboriginal and regional communities

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

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

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

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.

Collaboration and Access to Services

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

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

Working Collaboratively

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

Integrity Coordinating Group

Members:

Western Australian Ombudsman

Public Sector Commissioner

Corruption and Crime Commissioner

Auditor General

Information Commissioner

Background:

The Integrity Coordinating Group (**ICG**) was formed to promote and strengthen integrity in Western Australian public bodies.

The Office's involvement:

The Ombudsman participates as a member of the ICG and the Office has nominated senior representatives who sit on the ICG's joint working party.

2013-14 initiatives:

The Ombudsman joined his ICG colleagues at a forum in Perth in July 2013. The forum was attended by 280 representatives from State Government agencies and local governments and provided attendees with information on identifying risks associated with gifts, benefits and hospitality and considering how they can minimise those risks through sound policies, transparent recordkeeping, communication and review activities.

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

Public Sector Commission's Induction: Your Guide to Ethics and Integrity in the Public Sector Program	**Background:** As part of the induction process for all new public officers, the Public Sector Commission holds a half-day module on ethics and integrity in the public sector. The sessions are available to all new public officers. Staff from the Public Sector Commission, the office of the Ombudsman, the Corruption and Crime Commission and the Office of the Information Commissioner present at these sessions. **2013-14 initiatives:** The Office presented on eight occasions during the year. The Office provides information to new public sector employees on *The Role of the Ombudsman* and how the Office may be able to assist them in their work. This program will continue into 2014-15.
International Ombudsman Institute	**Background:** The International Ombudsman Institute (**IOI**), established in 1978, is the only global organisation for the cooperation of more than 150 Ombudsman institutions. **The Office's involvement:** The Office is a member of the IOI. The Ombudsman was elected to the position of IOI Treasurer and as a member of the Executive Committee of the Board of Directors of the IOI in March 2014. The Ombudsman previously served as the President of the Australasian and Pacific Ombudsman Region (**APOR**) of the IOI from November 2012 until March 2014. APOR is comprised of Australia, China/Hong Kong, Cook Islands, New Zealand, Papua New Guinea, Samoa, Solomon Islands, Taiwan, Tonga and Vanuatu. **2013-14 initiatives:** In April 2014, the Ombudsman attended the APOR Conference and, as outgoing Regional President, chaired the APOR Business Meeting. The Ombudsman also attended the IOI Board of Directors meeting in September 2013.
Information sharing with Ombudsmen from other jurisdictions	**Background:** Where appropriate, the Office shares information and insights about its work with Ombudsmen from other jurisdictions, as well as with other accountability and integrity bodies. **2013-14 initiatives:** The Office exchanged information with a number of Parliamentary Ombudsmen and industry-based Ombudsmen during the year.

Australia and New Zealand Ombudsman Association **Members:** Parliamentary and industry-based Ombudsmen from Australia and New Zealand	**Background:** The Australia and New Zealand Ombudsman Association (**ANZOA**) is the peak body for Parliamentary and industry-based Ombudsmen from Australia and New Zealand **The Office's involvement:** The Office is a member of ANZOA. The Office periodically provides general updates on its activities and also has nominated representatives who participate in interest groups in the areas of public relations, first contact teams, business improvement and communications. **2013-14 initiatives:** The Ombudsman participated in three ANZOA Executive Committee meetings during the year and attended the ANZOA Annual General Meeting, Executive Committee meeting and Strategic Planning session in November 2013. The Ombudsman also participated in ANZOA's Special General Meeting in December 2013. The Ombudsman and Deputy Ombudsman attended, and presented at, the ANZOA 4th Biennial Conference in April 2014.
Indonesian/ Australian Ombudsman Linkages and Strengthening Program **Members:** Western Australian Ombudsman Commonwealth Ombudsman New South Wales Ombudsman Ombudsman Republik Indonesia	**Background:** The Indonesian/Australasian Ombudsman Linkages and Strengthening Program (**Program**) aims to provide greater access across Indonesia to more effective and sustainable Ombudsman services. **The Office's involvement:** The Office has been involved with the Program since 2005 and supports the Program through staff placements in Indonesia and Australia. **2013-14 initiatives:** In July 2013, the Ombudsman, together with the New South Wales Ombudsman, Commonwealth Ombudsman and the Chief Ombudsman of the Ombudsman Republik Indonesia, attended a leadership dialogue and training program over two days with Ombudsmen and senior staff of the Ombudsman Republik Indonesia.

Providing Access to the Community

Communicating with complainants

The Office provides a range of information and services to assist specific groups, and the public more generally, to understand the role of the Ombudsman and the complaint process. Many people find the Office's enquiry service assists them to make their complaint. Other initiatives in 2013-14 include:

- Regular updating and simplification of the Ombudsman's website to provide easy access to information for people wishing to make a complaint and those undertaking the complaint process; and
- Ongoing promotion of the role of the Office and the type of complaints the Office handles through 'Ask the Ombudsman' on 6PR's Nightline Program.

Access to the Ombudsman's services

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

- Access to the Office through a toll free number for country callers;
- Access to the Office through email and online services. The importance of email and online access is demonstrated by its further increased use this year from 56% to 61% of all complaints received;
- Information on how to make a complaint to the Ombudsman is available in 15 languages and features on the homepage of the Ombudsman's website. People may also contact the Office with the assistance of an interpreter by using the Translating and Interpreting Service;
- The Office's accommodation, building and facilities provide access for people with disabilities, including lifts that accommodate wheelchairs and feature braille on the access buttons and people with hearing and speech impairments can contact the Office using the National Relay Service;
- The Office's Regional Awareness and Accessibility Program targets awareness and accessibility for regional and Aboriginal Western Australians;
- The Office attends events to raise community awareness of, and access to, its service, such as the Financial Counsellors' Association conference in October 2013, and Homeless Connect in August 2013 and June 2014; and
- The Office's visits to adult prisons and juvenile custodial facilities provide an opportunity for people detained in custody to meet with representatives of the Office and lodge complaints in person.

Ombudsman website

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

- Members of the public on the complaint handling services provided by the Office as well as links to other complaint bodies for issues outside the Ombudsman's jurisdiction;
- Public authorities on decision making, complaint handling and conducting investigations;
- Access to the Ombudsman's investigation reports such as the *Investigation into ways that State government departments and authorities*

can prevent or reduce suicide by young people;

- The latest news on events and collaborative initiatives such as the Regional Awareness and Accessibility Program; and
- Links to other key functions undertaken by the Office such as the Energy and Water Ombudsman website and other related bodies including other Ombudsmen and other Western Australian accountability agencies.

The website continues to be a valuable resource for the community and public sector as shown by the increased use of the website this year. In 2013-14:

- The total number of visits to the website has increased by 14% to 72,363 page visits compared to 63,517 page visits in 2012-13.
- The number of unique visitors peaked at 4,772 in May 2014, the greatest number of visitors in a month ever recorded, following the publication in April 2014 of the Ombudsman's report, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*;
- The top two most visited pages (besides the homepage and the Contact Us page) on the site were How to make a complaint and The role of the Ombudsman; and
- The Office's Guidelines on Complaint Handling, and Procedural Fairness Guidelines were the two most viewed documents.

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

'Ask the Ombudsman' on Nightline

The Office continues to provide access to its services through the Ombudsman's regular appearances on Radio 6PR's *Nightline* program. Listeners who have complaints about public authorities or want to make enquiries have the opportunity to call in and speak with the Ombudsman live on air. The segment allows the public to communicate a range of concerns with the Ombudsman. The segment also allows the Office to communicate key messages about the State Ombudsman and Energy and Water Ombudsman jurisdictions, the outcomes that can be achieved for members of the public and how public administration can be improved. The Ombudsman appeared on the 'Ask the Ombudsman' segment in September and December 2013 and March and June 2014.

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2013-14. One regional visit was conducted to Kununurra in November 2013 and included the following activities:

- A seminar for regionally-based public authorities to discuss good administrative practice, effective complaint resolution and appropriate access to information;
- Complaints clinics, which provided an opportunity for members of the local community to raise their concerns face-to-face with the staff of the Office. The Office resolved many of the complaints made during the time of the visits;

- Individual meetings with Aboriginal community members to discuss government service delivery and where the Office may be able to assist; and
- Training and workshops for regionally-based public authorities.

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

Preparation is underway for a visit to Kalgoorlie-Boulder in July and August 2014. The Program is an important way for the Office to raise awareness of, access to, and use of, its services for regional and Aboriginal Western Australians. While the Program is coordinated by the Office, the Office collaborates with other integrity and accountability agencies including the Health and Disability Services Complaints Office, the Office of the Information Commissioner , the Commissioner for Victims of Crime, and the Commonwealth Ombudsman's office.

The Program enables the Office to:

- Deliver key services directly to regional communities, particularly through complaints clinics;
- Increase awareness and accessibility among regional and Aboriginal Western Australians (who were historically under-represented in complaints to the Office); and
- Deliver key messages about the Office's work and services.

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

The collaboration with other integrity and accountability agencies during regional visits and complaints clinics also assists in ensuring regional and Aboriginal Western Australians can be easily referred to the most appropriate body to assist them.

Speeches and Presentations

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

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

Ombudsman's speeches and presentations

- *The Role of the Ombudsman and Integrity Coordination in Western Australia* to the Accounting and Finance Association of Australia and New Zealand Conference in July 2013;
- *The Fourth Arm of Government* as part of the Constitutional Centre Lecture Series 2013 in August 2013;

- *A Fourth Branch of Government? The Evolution and Role of Parliamentary Statutory Officers* at the Australasian Study of Parliament Group Annual Conference in October 2013;
- A presentation to University of Western Australia Administrative Law Students on *The Role of the Ombudsman* in October 2013;
- A panel discussion on *Good governance principles and practice — the perspectives from the 'watchdogs'* at the (then) Chartered Secretaries Australia Public Sector Update in October 2013;
- Presentations and a chaired session at the *Government Accountability: Law and Practice* unit at the Faculty of Law, University of Western Australia in January 2014; and
- *Meeting the challenge: How successful have operational reforms been for Ombudsman offices?*, a chaired session and a panel discussion on examining the Ombudsman and integrity in government, at the ANZOA 4th Biennial Conference in April 2014.

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

Speeches and presentations by other staff

- A workshop on *The Role of the Ombudsman* and *Complaint Handling* at the Local Government Western Australian Rangers Conference in September 2013;
- A workshop on *The Role of the Ombudsman* and *Complaint Handling* at the Shire of Mundaring in December 2013;
- A presentation to participants of the Public Sector Management Program on *The Role of the Ombudsman* in March 2014;
- A presentation on *The Ombudsman and University Complaints* to Heads of School, Executive Deans and Directors at Edith Cowan University's Student Complaints Investigation Forum in May 2014;
- A presentation to the Society for Consumer Affairs Professionals on *Managing Unreasonable Complainant Conduct* in March 2014;
- Presentations to youth custodial officer recruits at the Department of Corrective Services Bentley Training Academy in relation to *Complaint Handling and the Role of the Ombudsman* in December 2013 and May 2014;
- *How Ombudsman's offices are bringing key performance indcators to life* at the ANZOA 4th Biennial Conference in April 2014; and
- *Public Sector Accountability, Governance & Performance Reporting* to students from Curtin University's School of Accounting in October 2013.

Staff of the Office also regularly present on the role of the Ombudsman at the Public Sector Commission's *Induction to the Western Australian Public Sector* seminars for public sector employees.

Liaison with Public Authorities

Liaison relating to complaint resolution

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

The Office also attended Banksia Hill Detention Centre in November 2013 and the temporary juvenile custodial facility in Hakea Prison in January and February 2013 to observe conditions, meet with staff and detainees and provide an opportunity for detainees to make complaints to the Office if they wished to do so.

In addition, the Office attended regular meetings with representatives of the Office of the Inspector of Custodial Services. These meetings have proved useful in allowing both offices to become better informed of issues affecting the corrective services sector in Western Australia.

Other liaison with public authorities

The Office liaised with a range of other public sector agencies in 2013-14, including:

- The Department of Housing;
- The Department of Transport;
- The Department of Education;
- The Department of Health;
- The Department for Child Protection and Family Support;
- Western Australia Police;
- The Corruption and Crime Commission;
- Various universities; and
- Various local governments.

Liaison relating to own motion investigations

The Office undertook a range of liaison activities in relation to its own motion investigations.

See further details in the Child Death Review section, the Family and Domestic Violence Fatality Review section, and Own Motion Investigations section.

Publications

Western Australian Ombudsman newsletter

The *Western Australian Ombudsman Newsletter* is a key publication used by the Office to communicate information to its stakeholders about the Office's performance, achievements, events and resources. Newsletters were issued in August and December 2013.

The newsletter is distributed electronically to Members of Parliament, public authorities and interested members of the public. The newsletter is published on the website after it is issued.

Guidelines and information sheets

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

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