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	2013-14 Actual	2014-15 Target	2014-15 Actual	Variance
Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies	100%	100%	**100%**	Nil
Number of improvements to practices or procedures as a result of Ombudsman action	152	100	**99**	-1

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 2014-15, there were 211 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman.

Comparison of Actual Results and Budget Targets

Public authorities have accepted every recommendation made by the Ombudsman, matching the actual results of the past four years and meeting the 2014-15 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 2014-15, almost doubled since 2010-11. 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. In 2014-15 the actual result is comparable to the 2014-15 target.

Key Efficiency Indicators

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

Key Efficiency Indicators	2013-14 Actual	2014-15 Target	2014-15 Actual	Variance from Target
Percentage of allegations finalised within three months	98%	95%	98%	+3%
Percentage of allegations finalised within 12 months	100%	100%	100%	Nil
Percentage of allegations on hand at 30 June less than three months old	98%	90%	96%	+6%
Percentage of allegations on hand at 30 June less than 12 months old	100%	100%	100%	Nil
Average cost per finalised allegation	$1,858	$1,820	$1,857	+$37
Average cost per finalised notification of death	$18,407	$12,325	$18,983	+$6,658
Cost to monitor the Infringement Notices provisions of *The Criminal Code*	N/A*	$723,000	$413,586	-$309,414

*As 2014-15 is the first year of the function, there is no comparable data in 2013-14.

Comparison of Actual Results and Budget Targets

The 2014-15 actual results for each of the key efficiency indicators relating to allegations on hand and allegations finalised matched or exceeded the 2014-15 target. Overall, all 2014-15 actual results represented significant improvement in the efficiency of complaint resolution over the last five years.

The average cost per finalised allegation in 2014-15 is comparable to the 2013-14 actual result ($1,858) and the 2014-15 target ($1,820). Since 2007-08, the efficiency of complaint resolution has improved significantly with the average cost per finalised allegation reduced by a total of 37% from $2,941 in 2007-08 to $1,857 in 2014-15.

The average cost per finalised notification of death ($18,983) is consistent with the 2013-14 actual result ($18,407) and exceeds the 2014-15 target ($12,235), reflecting the staffing required for:

- The investigation of complex reviews undertaken in 2014-15; and
- The commencement in 2012-13, and development during 2013-14 and 2014-15, of an important new initiative to review family and domestic violence fatalities.

The 2015-16 target has been adjusted to $18,950 accordingly.

The cost to monitor the Infringement Notices provisions of *The Criminal Code* ($413,586) is lower than the 2014-15 target ($723,000) due to the change in the commencement of the function to March 2015.

For further details, see the Key Performance Indicator section.

Summary of Financial Performance

The majority of expenses for the Office (73%) relate to staffing costs. The remainder is primarily for accommodation, communications and office equipment.

Financial Performance	2013-14 Actual	2014-15 Target ('000s)	2014-15 Actual ('000s)	Variance ('000s)
Total cost of services (sourced from Statement of Comprehensive Income)	$10,551	$11,218	$10,331	-$887
Income other than income from State Government (sourced from Statement of Comprehensive Income)	$2,506	$2,560	$2,463	-$97
Net cost of services (sourced from Statement of Comprehensive Income)	$8,045	$8,658	$7,867	-$791
Total equity (sourced from Statement of Financial Position)	$1,531	$1,628	$2,303	+$675
Net increase in cash held (sourced from Statement of Cash Flows)	($65)	$20	$873	+$853
Staff Numbers	**Number**	**Number**	**Number**	**Number**
Full time equivalent (FTE) staff level at 30 June 2015	63	70	60	-10

Comparison of Actual Results and Budget Targets

The variation between the 2014-15 actual results and the target for the Office's total cost of services and net cost of services is primarily due to the cost to monitor the Infringement Notices provisions of *The Criminal Code* being lower than the 2014-15 target, due to the change in the commencement of the function to March 2015 and temporary vacancies arising from staff movements during the year. There were no significant variations between the actual results for 2014-15 and 2013-14.

For total equity and cash held, the increase in the actual result compared to the target is primarily due to lower than expected payments due to the change in the commencement of the function to monitor the Infringement Notices provisions of *The Criminal Code* to March 2015, expenses incurred during 2014-15 but paid in 2015-16, and temporary vacancies arising from staff movements during the year.

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

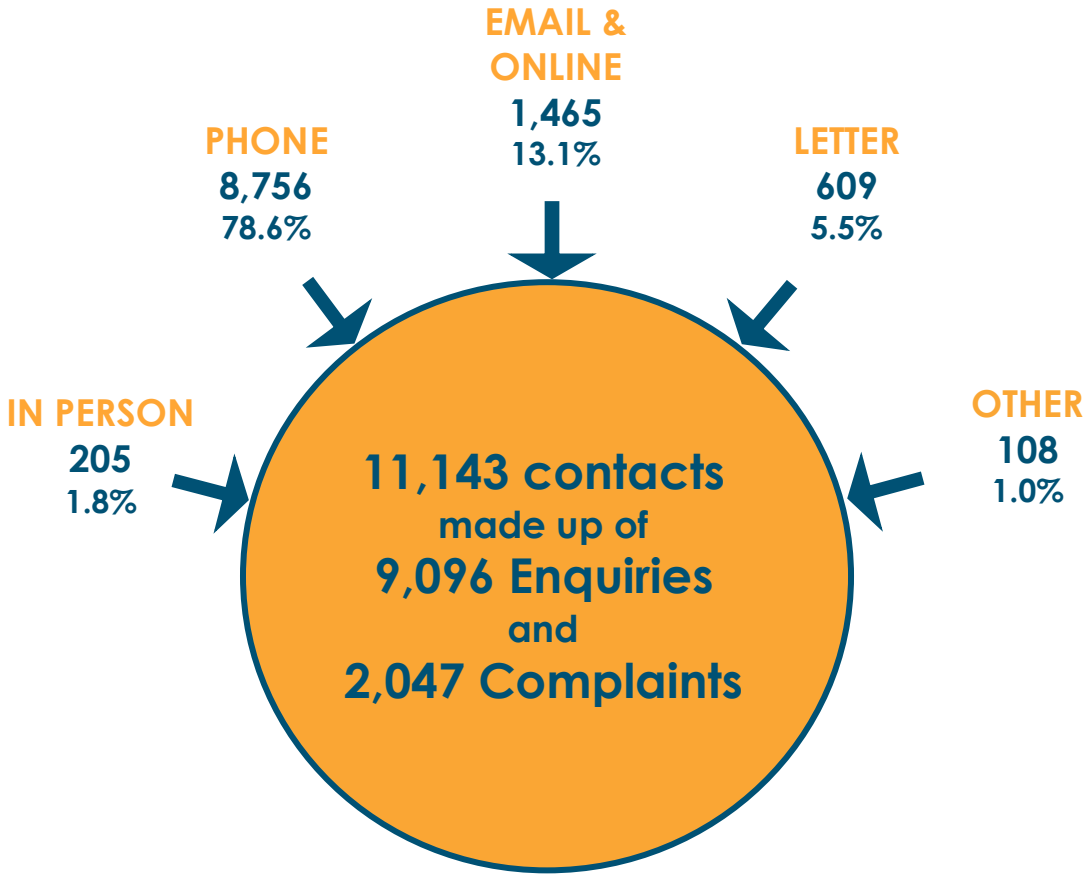
Complaint Resolution

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 2014-15, the Office received 11,143 contacts from members of the public consisting of:

- 9,096 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 2,047 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

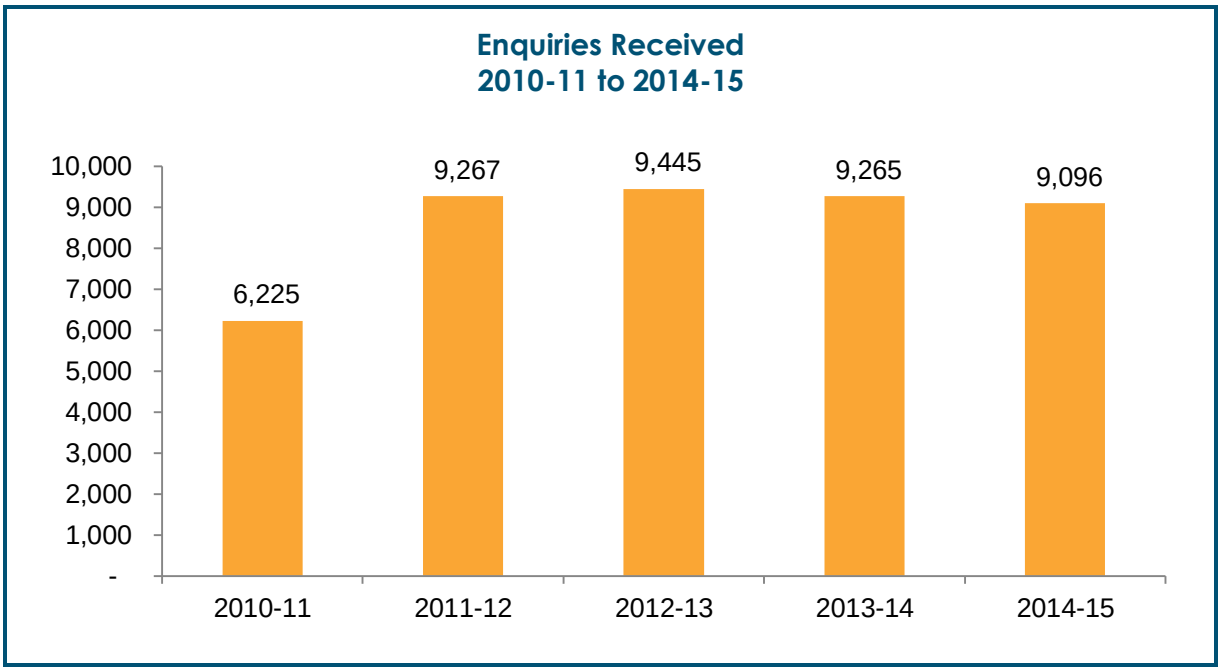


Enquiries Received

There were 9,096 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.

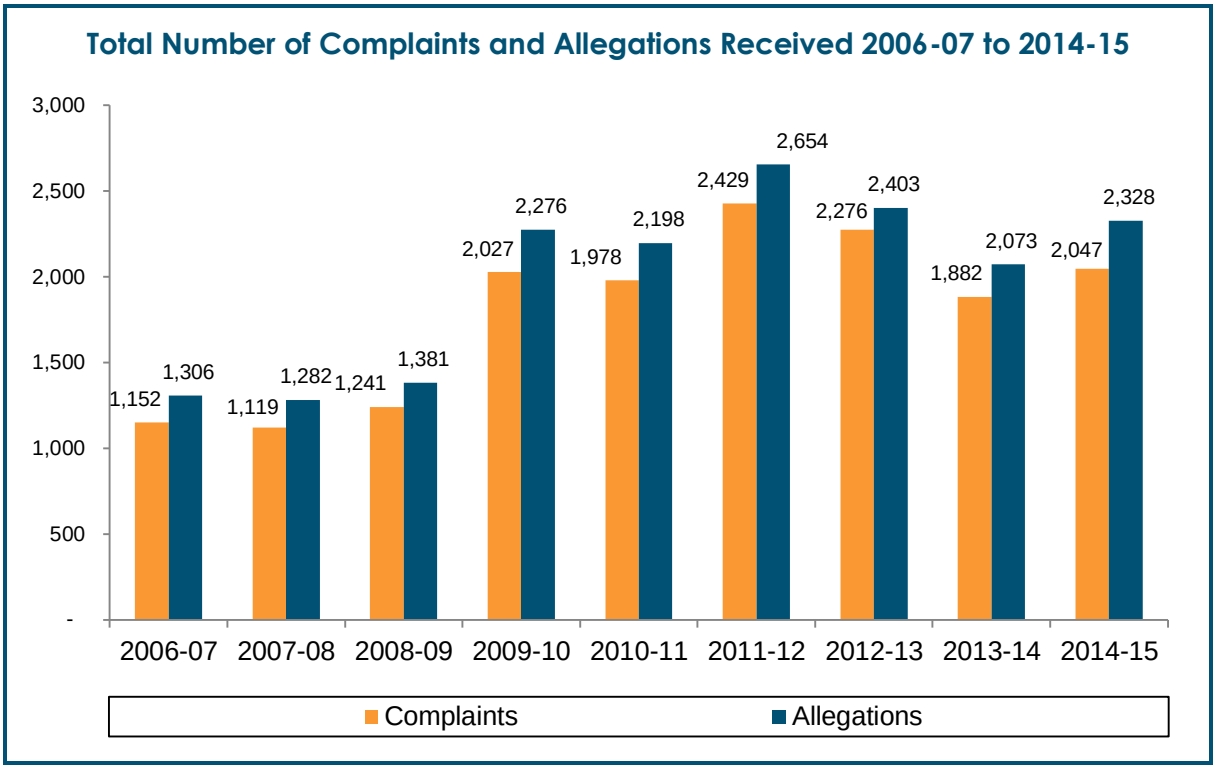
For enquiries that are outside the jurisdiction of the Ombudsman, staff assist members of the public by providing information about the appropriate body to handle the issues they have raised.



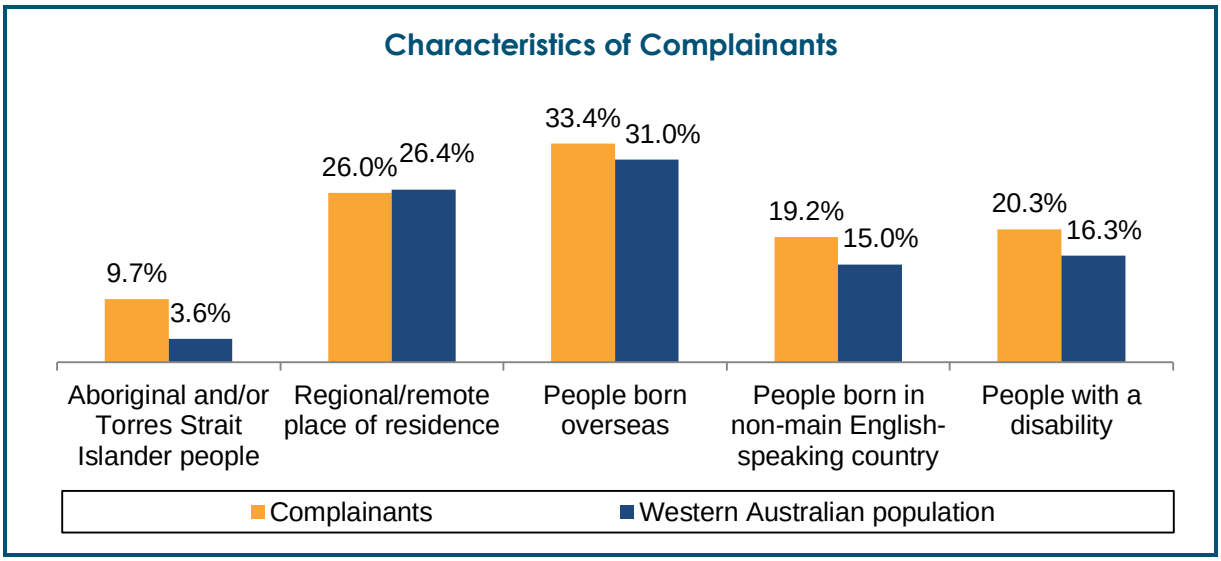
Enquirers are encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

Complaints Received

In 2014-15, the Office received 2,047 complaints, with 2,328 separate allegations, and finalised 2,060 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.

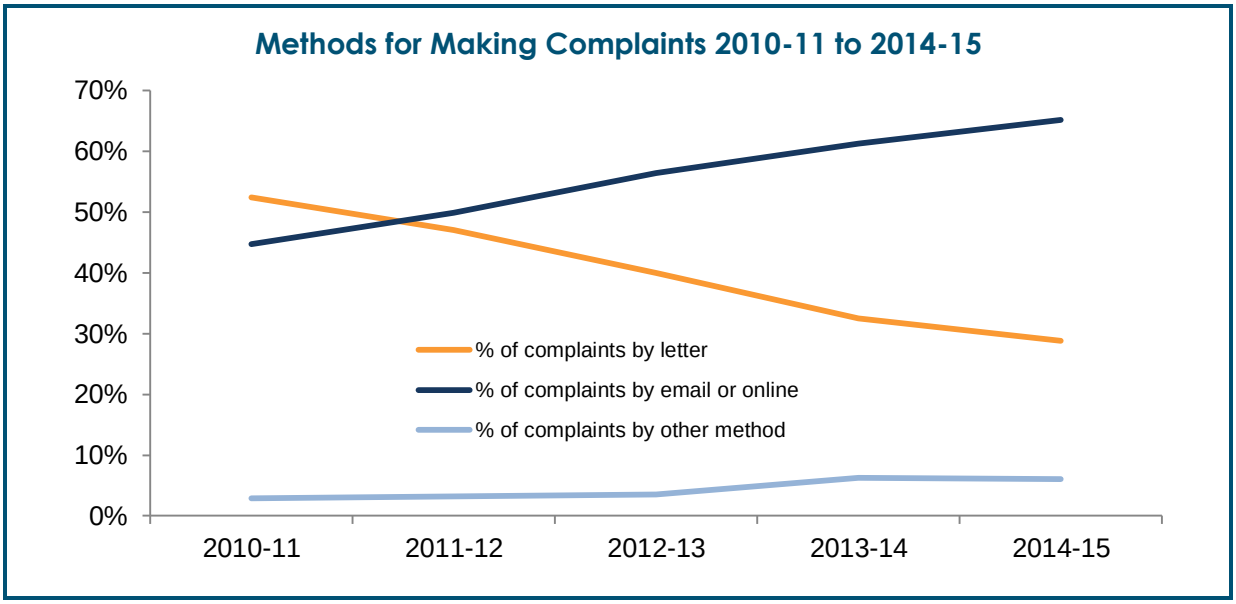


NOTE: Non-main English-speaking countries as defined by the Australian Bureau of Statistics are countries other than Australia, United Kingdom, the Republic of Ireland, New Zealand, Canada, South Africa and the United States of America. Being from a non-main English-speaking country does not imply a 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 2014-15, increasing from 61% in 2013-14 to 65% in 2014-15. The proportion of people using email and online facilities to lodge complaints has increased by 20% since 2010-11, when 45% were received in this way.

During the same period, the proportion of people who lodge complaints by letter has reduced from 52% to 29%. 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 2014-15, in particular in relation to the early resolution of complaints.

Together, these initiatives have enabled the Office to maintain substantial improvements in the timeliness of complaint handling.

Over the last year:

- The percentage of allegations finalised within 3 months was 98%; and
- We achieved a 21% reduction in the time taken to finalise complaints.

98% of allegations were finalised within 3 months.

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 21 days; and
- Complaints older than 6 months have decreased from 40 to 1.

Complaints Finalised in 2014-15

There were 2,060 complaints finalised during the year and, of these, 1,423 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 869 were finalised at initial assessment, 526 were finalised after an Ombudsman investigation and 28 were withdrawn.

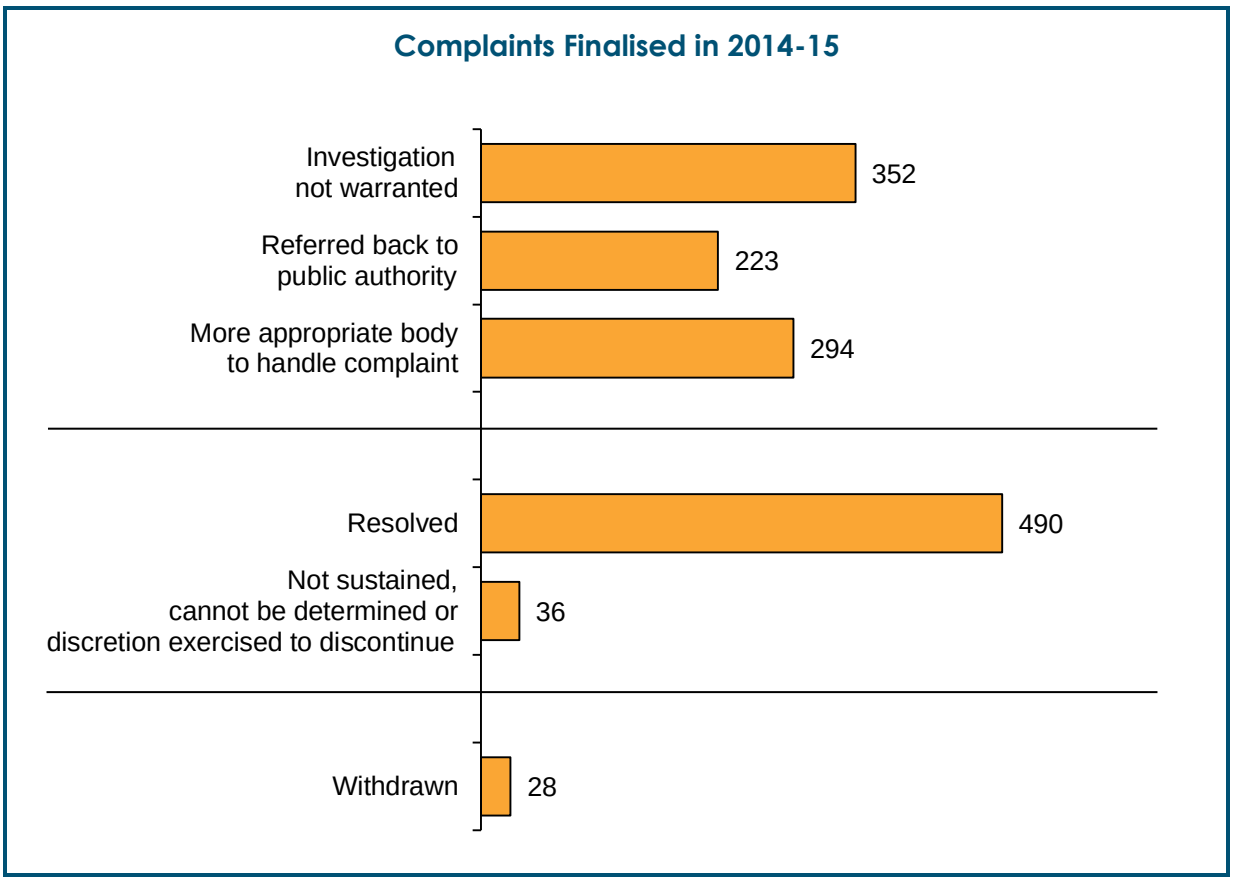
Complaints finalised at initial assessment

Over a quarter (26%) of the 869 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 294 (34%) 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 526 complaints finalised after investigation, 93% 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.



Note: Investigation not warranted includes complaints where the matter is not in the Ombudsman's jurisdiction.

Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2014-15, there were 211 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman, an increase of 6% from 199 in 2013-14. 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. In a further 72 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.

The following chart shows the types of remedies provided to complainants.

Remedial Action to Assist the Complainant in 2014-15

Case Study

Response to complaint expedited and staff reminded about complaints management process

A person complained to a public authority about alleged delays in relation to their deceased partner's estate. The person then complained to the Office that they had not received a response from the public authority to their complaint.

Following enquiries by the Office, the public authority acknowledged that its policy on complaints management had not been followed. It arranged for a letter to be sent to the person which contained an apology for the time taken to deal with the complaint, an explanation about the delays in administering the estate and action the public authority was taking.

Further, as a result of the Office's enquiries, the public authority reminded staff of the definition of a complaint and the correct complaint handling procedure to be followed. Emphasis was placed on the value of the complaint handling system, with reference to the system being instrumental in improving policies, procedures and business 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

Reversal of decision, monetary refund and website information updated

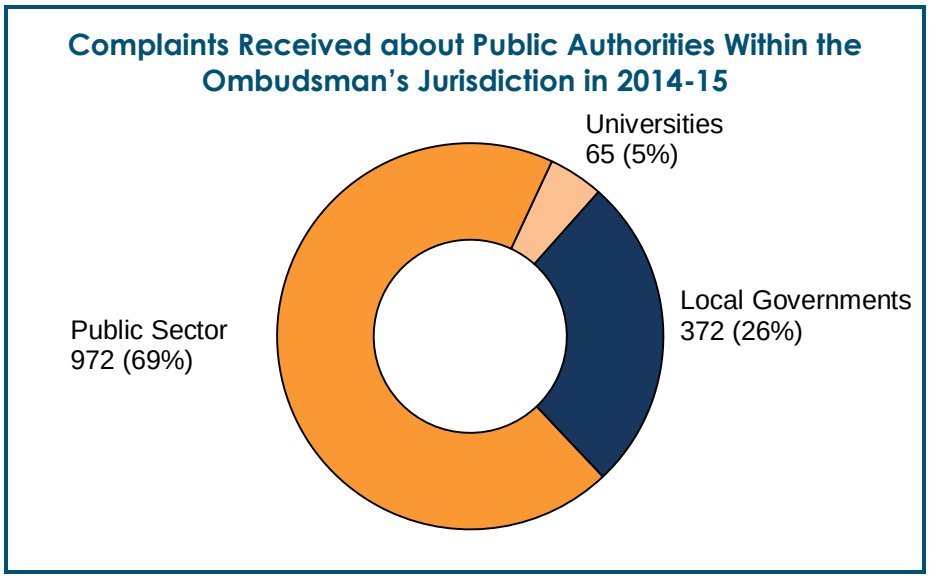
A person applied for professional registration to the Registration Board, which regulated their particular profession. The Registration Board invoiced the person for a fee to cover their requested period of registration and an additional fee for a period before they were registered. The person complained to the Office that they should not have been charged a fee for a period when they were not registered and had they realised that this fee would be charged, they would have delayed their registration until the new registration period commenced. The person also alleged that the wording of the fee structure on the Registration Board's website was not clear.

Following enquiries by the Office, the Registration Board reviewed the circumstances of the person's application, including the timing of the grant of registration. The Registration Board indicated that its decision to charge the fee was consistent with relevant regulations and that this information was reflected in the application the person had completed. However, the Registration Board took into account the information received that the person would have held off applying for the registration if they had understood an additional fee would be charged, and the person's view that information about the nature of the fee could be made clearer in the Registration Board's communications. The Registration Board decided to refund the additional fee and also undertook to improve the information available about the fees on its website and forms.

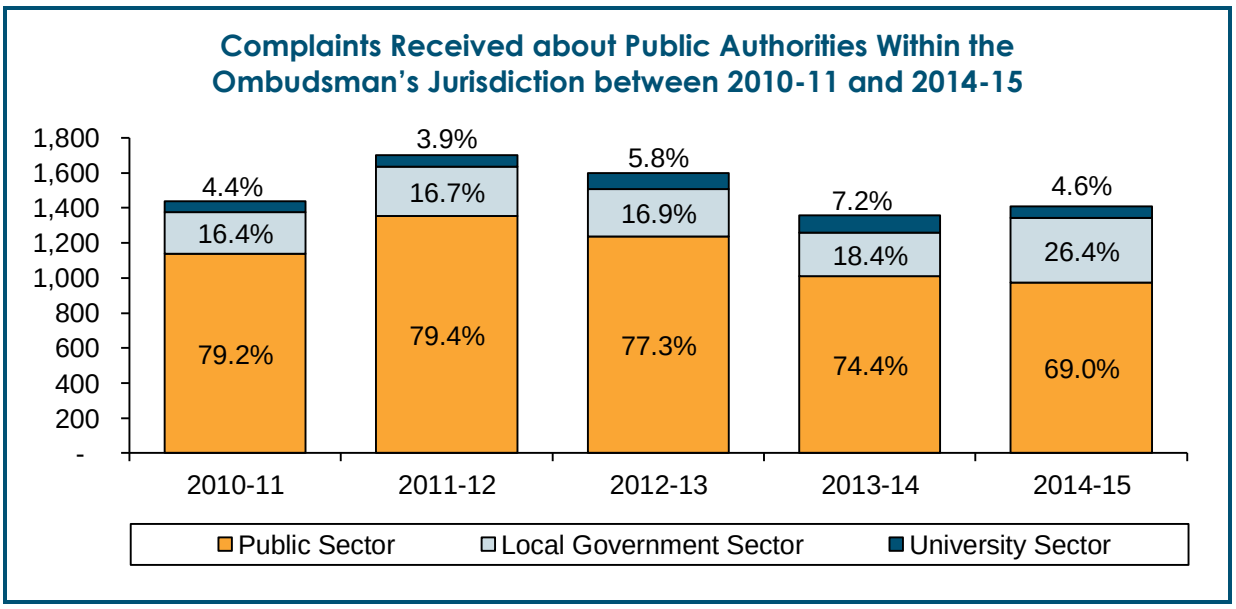
About the Complaints

Of the 2,047 complaints received, 1,409 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 638 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 (972 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (372 complaints); and the university sector (65 complaints).



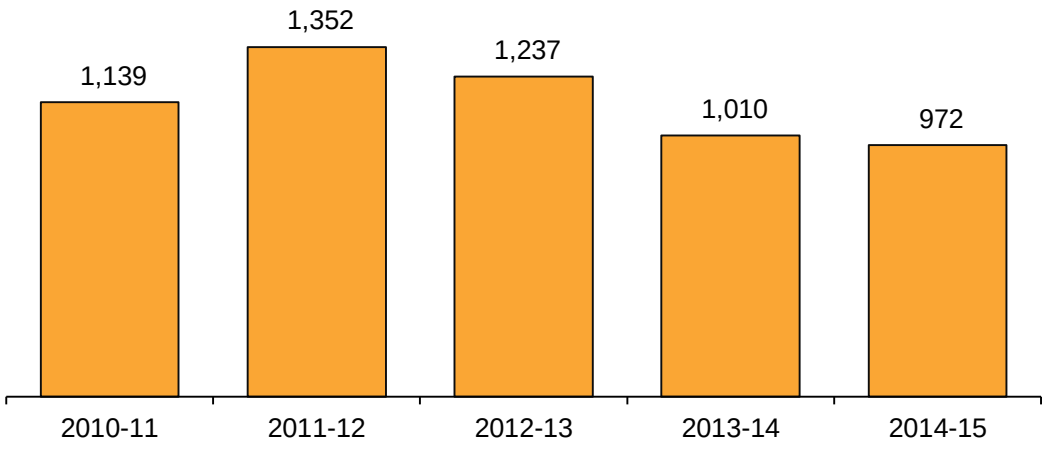
The proportion of complaints about each sector in the last five years is shown in the following chart.



The Public Sector

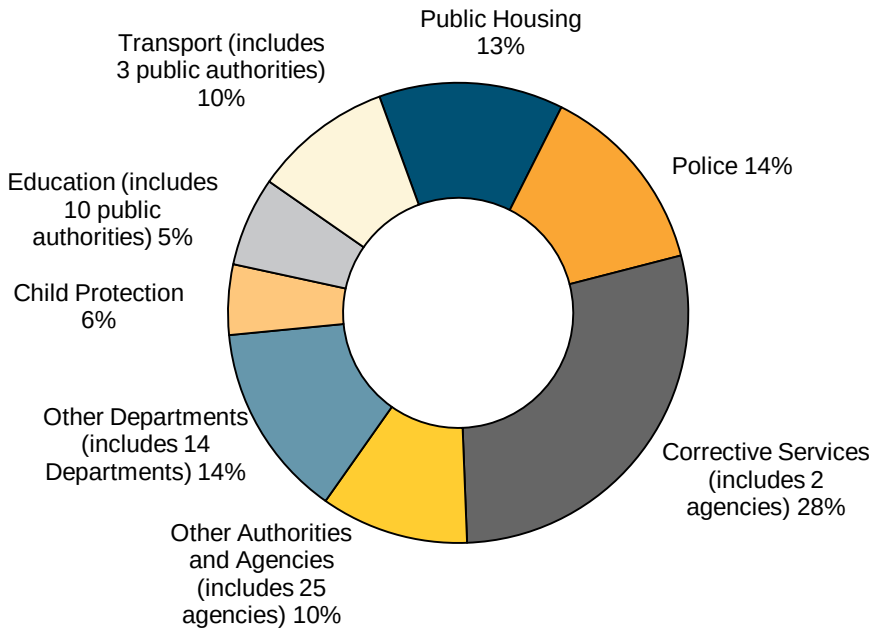
In 2014-15, there were 972 complaints received about the public sector and 979 complaints were finalised. The number of complaints about the public sector as a whole since 2010-11 is shown in the chart below.

Complaints Received About the Public Sector between 2010-11 and 2014-15



Public sector agencies are very diverse. In 2014-15, complaints were received about 57 agencies as shown in the following chart.

Complaints Received About the Public Sector in 2014-15



Of the 972 complaints received about the public sector in 2014-15, 76% were about six key areas covering:

- Corrective services, in particular prisons (276 or 28%);
- Police (132 or 14%);
- Public housing (126 or 13%);
- Transport (95 or 10%);
- Child protection (61 or 6%); and
- Education – public schools and institutes of technology (48 or 5%). Information about universities is shown separately under the University Sector.

The remaining complaints about the public sector (234) were about 39 other State Government departments, statutory authorities and boards. For 31 (79%) of these agencies, the Office received five complaints or less.

Outcomes of complaints about the public sector

There were 185 actions taken by public sector bodies as a result of complaints finalised in 2014-15. These resulted in 147 remedies being provided to complainants and 38 improvements to public sector practices.

The following case study illustrates the outcomes arising from complaints about the public sector. 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.

Case Study

Decision reconsidered and policy updated

A person had become eligible for an offer of public housing accommodation but the public authority was unable to make the offer because, due to the person's particular circumstances at the time, they could not take up the offer for several months. Rather than defer the offer to a later date, the applicant was withdrawn from the waiting list. The person complained to the Office about their removal from the waiting list.

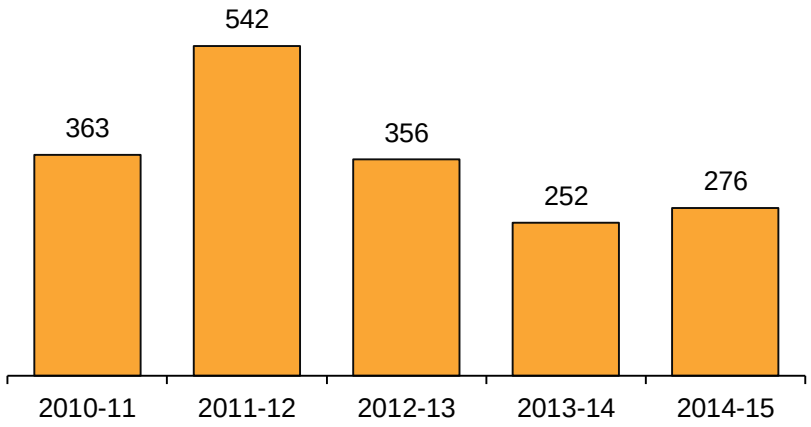
Following enquiries by the Office, the public authority agreed to reconsider its decision, including considering action to place the person back on the waiting list.

The public authority also updated its policy covering deferment of accommodation offers, to clarify that an applicant may request a one-off deferment of up to a maximum of six months due to extenuating circumstances.

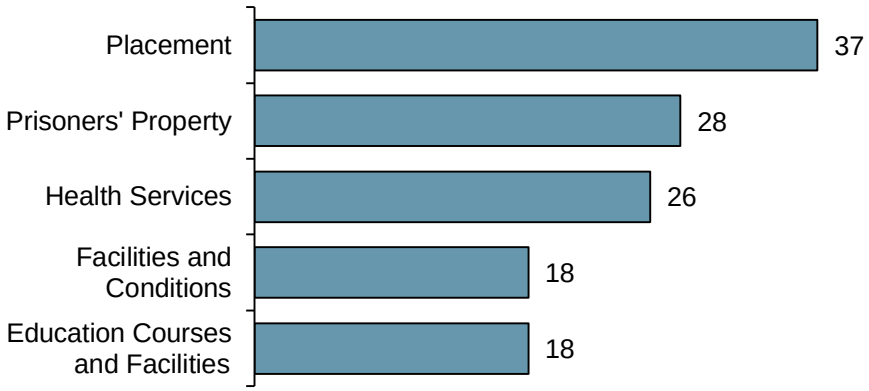
Public Sector Complaint Issues and Outcomes

Corrective Services

Complaints received



Most common allegations



Other types of allegations

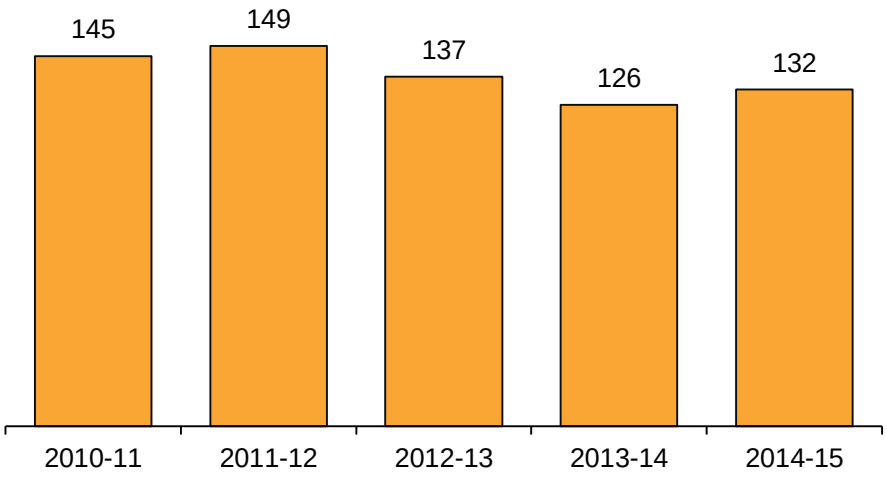
- Visits;
- Discipline;
- Rehabilitation programs;
- Prison Officer conduct;
- Complaint management; and
- Canteen and other spending.

Outcomes achieved

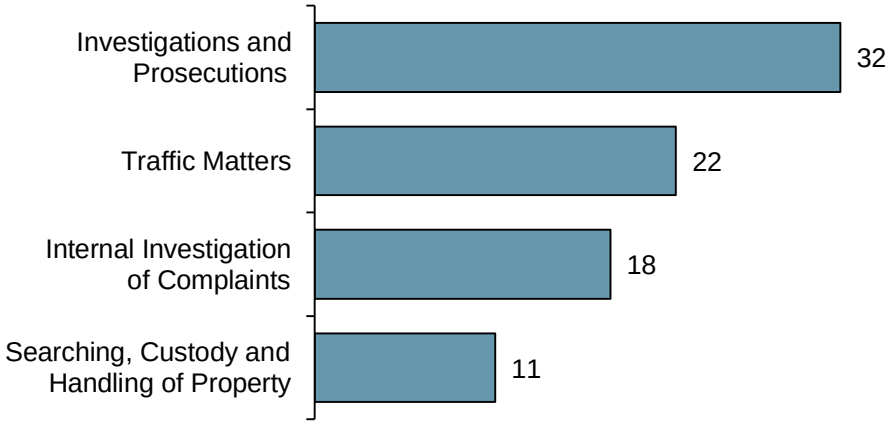
- Act of grace payment;
- Apology given;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Change to business system or practices;
- Conduct an audit or review;
- Improved record keeping; and
- Staff training.

Police

Complaints received



Most common allegations



Other types of allegations

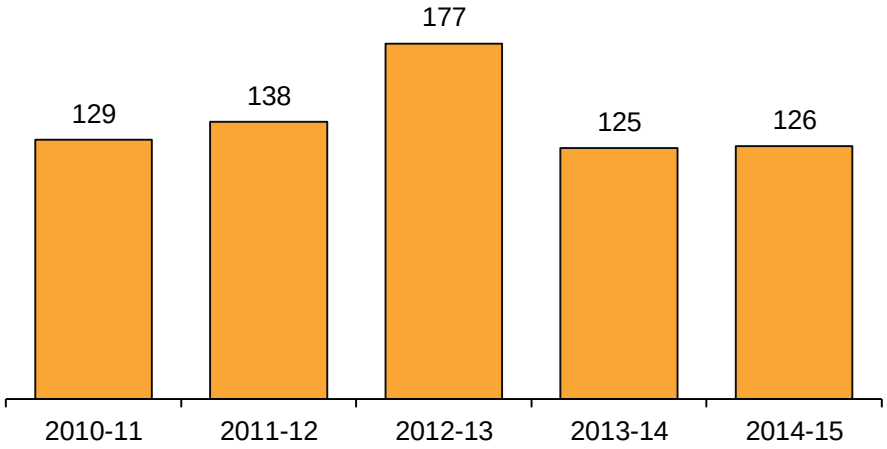
- Arrest and detention;
- Information;
- Improper conduct; and
- Management issues.

Outcomes achieved

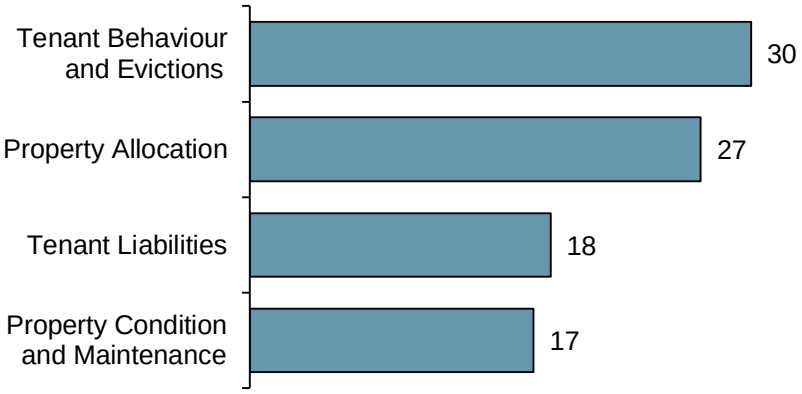
- Infringement withdrawn;
- Action expedited;
- Consider or reconsider a matter and make a decision; and
- Explanation given or reasons provided.

Public Housing

Complaints received



Most common allegations



Other types of allegations

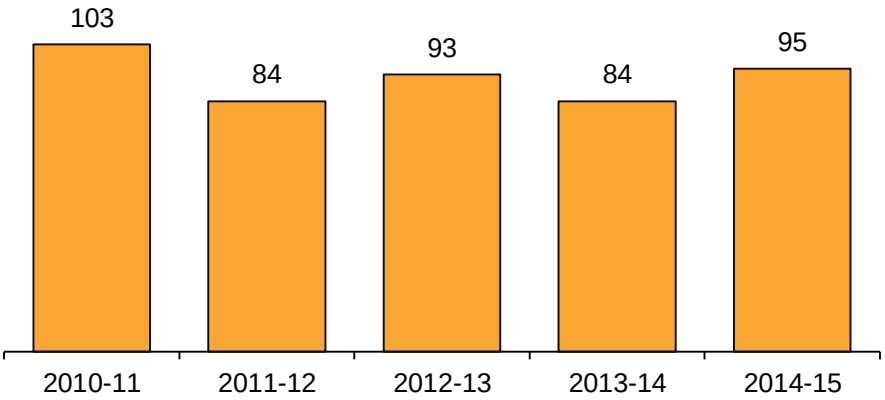
- Rental or bond assistance;
- Construction and development;
- Property transfers;
- Tenant's personal property;
- Rental sales; and
- Debt repayments.

Outcomes achieved

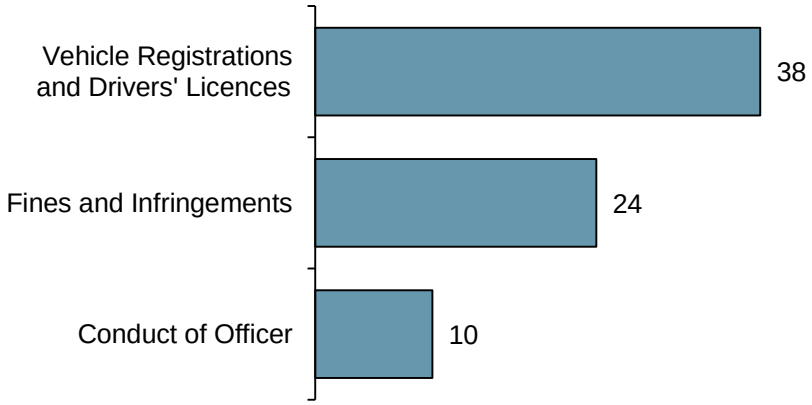
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Tenant liability waived or rebate given;
- Apology given;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to policy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

Transport

Complaints received



Most common allegations



Other types of allegations

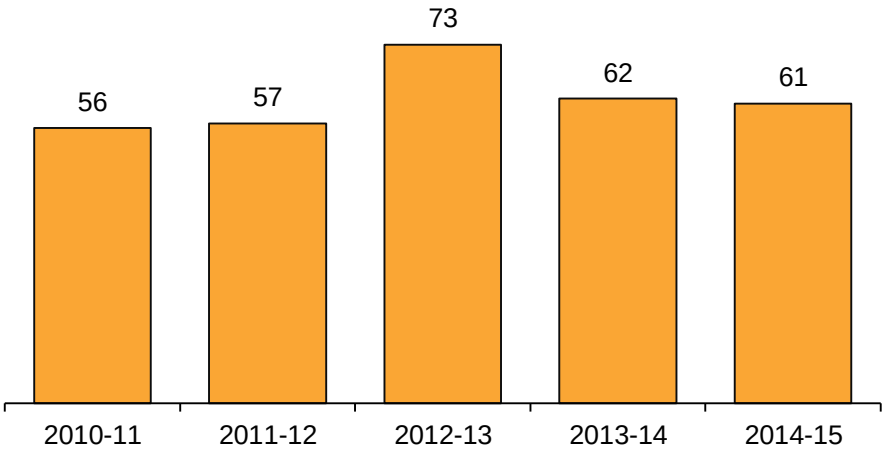
- Other decision or action by officer or agency;
- Complaint management; and
- Policies and procedures.

Outcomes achieved

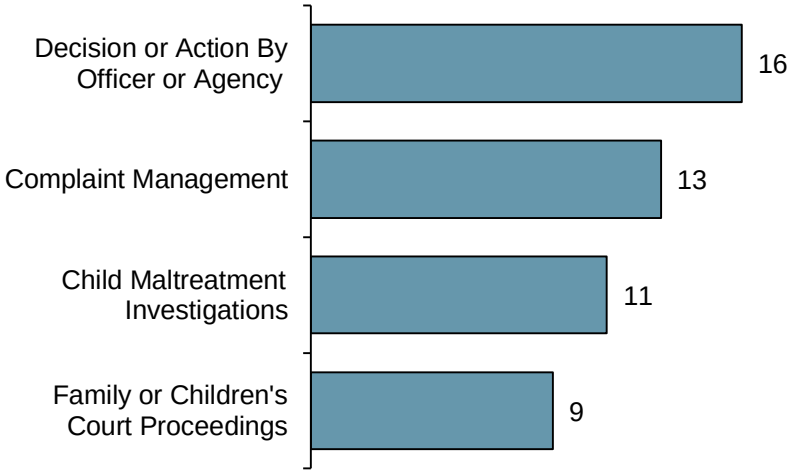
- Reversal or significant variation of original decision;
- Monetary charge refunded;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to business system or practices;
- Conduct an audit or review;
- Update to publications or website; and
- Staff training.

Child Protection

Complaints received



Most common allegations



Other types of allegations

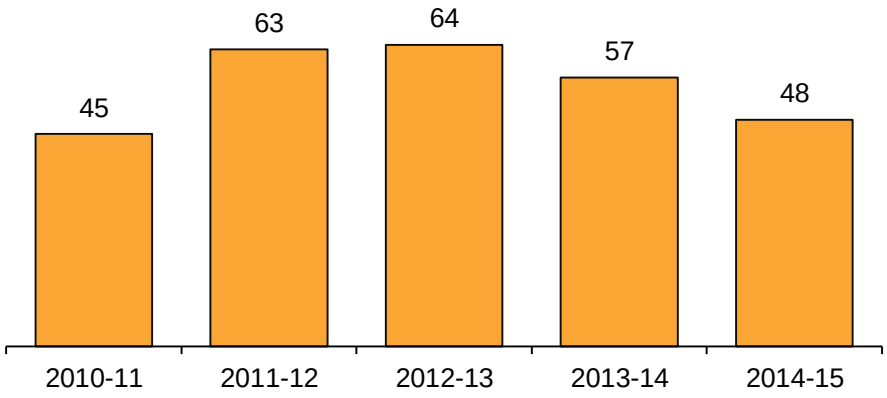
- Out of home care (fostering); and
- Adoption.

Outcomes achieved

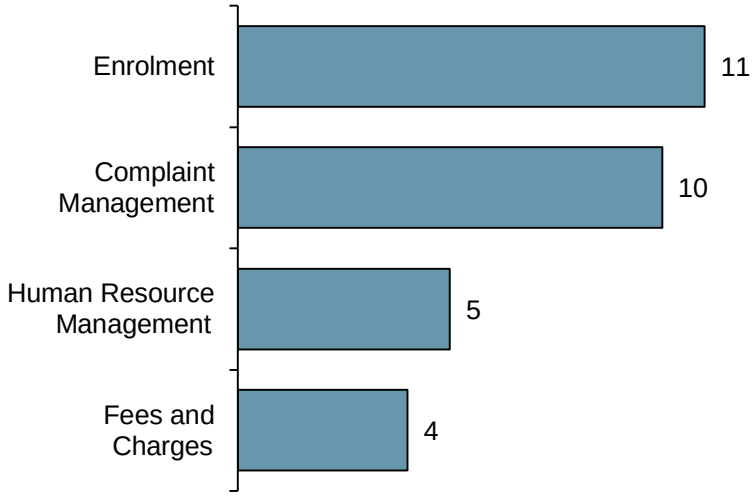
- Monetary charge refunded;
- Action expedited; and
- Explanation given or reasons provided.

Education

Complaints received



Most common allegations



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

Other types of allegations

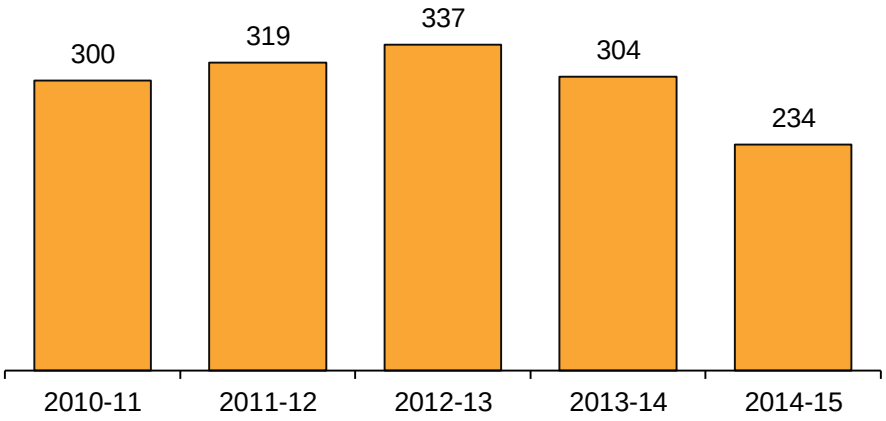
- Termination of enrolment;
- Student care;
- Staff conduct; and
- Examinations, assessments, prizes and awards.

Outcomes achieved

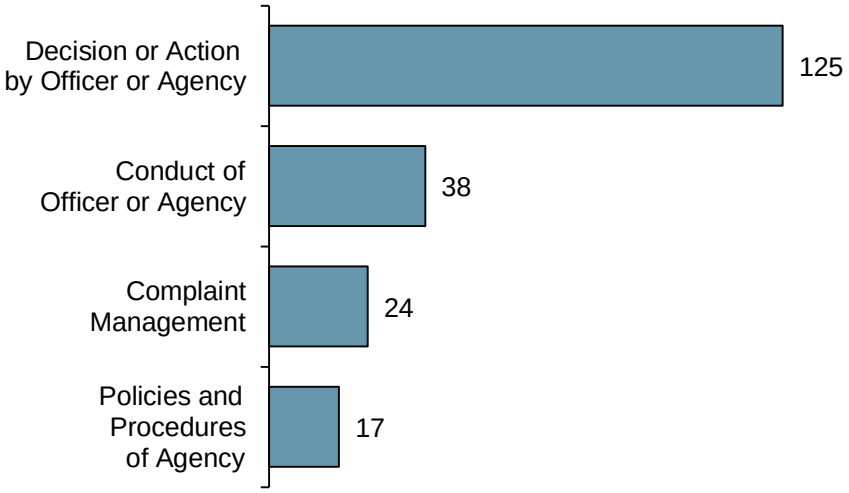
- Reversal or significant variation of original decision;
- Monetary charge withdrawn;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Update to publications and websites; and
- Improved record keeping.

Other Public Sector Agencies

Complaints received



Most common allegations



Other types of allegations

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

Outcomes achieved

- Monetary charges reduced or withdrawn;
- Apology given;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Conduct an audit or review;
- Update publications or website; and
- Staff training.

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

Case Study

Female prisoner transfer expedited to enable visits with her children

A female prisoner was in a prison located some distance from where her children lived and as a result she had not seen them for a considerable period of time. She requested a temporary transfer to a prison closer to her children to enable them to visit her. The prisoner later complained to the Office about the time taken by the prison to consider her request for the temporary transfer.

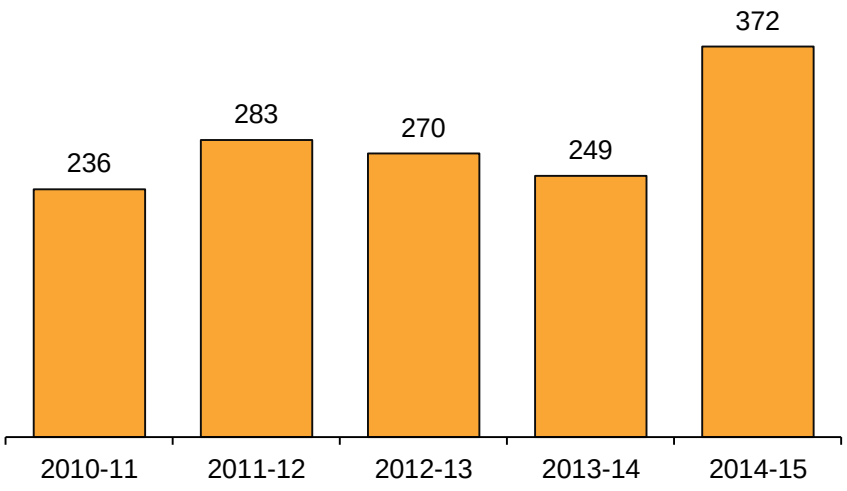
Following enquiries by the Office, the prison spoke with the prisoner and expedited arrangements for a two week temporary transfer to another prison to enable the visit. The transfer occurred within three weeks of her complaint to the Office.

The Local Government Sector

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

Local Government

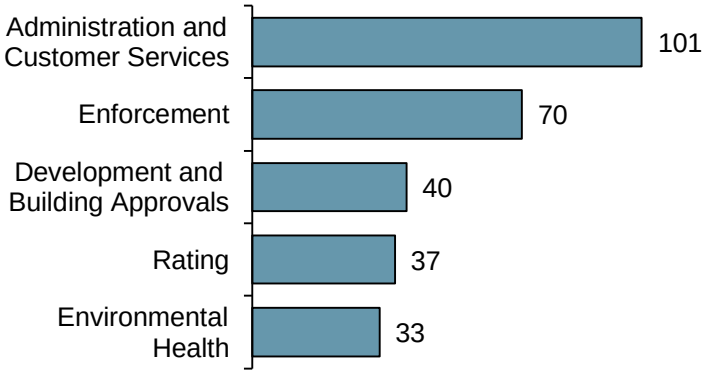
Complaints received



The fluctuation in the numbers in 2014-15 is partly due to complaints where identical or similar complaints were made by different people about the same issue.

Local Government

Most common allegations



Other types of allegations

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

Outcomes achieved

- Monetary charge or infringement reduced or withdrawn;
- Apology given;
- Action expedited;
- Consider or reconsider a matter and make a decision;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Change to business systems or practices;
- Update publications or website; and
- Staff training.

Case Study

Payment of damage bond supported and new bond process implemented

A person who was undertaking construction work at their property was required to pay a $10,000 damage bond to the local government for any potential damage to the adjacent road reserve during construction, including damage to the footpath. On completion of the works, the person applied for release of the bond which was denied due to apparent footpath damage. The person complained to the Office alleging that they were not responsible for the damage and the bond should be released.

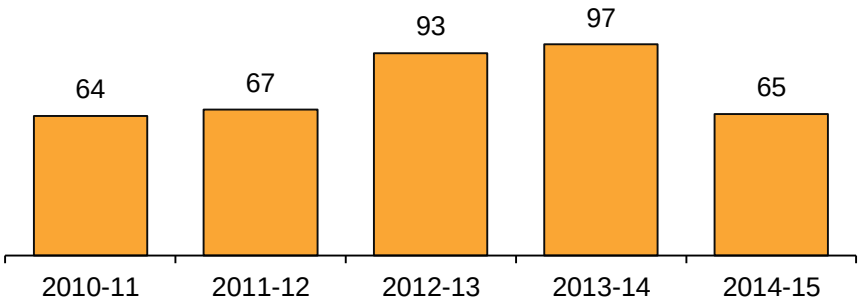
Following enquiries by the Office, the local government reviewed its decision and released the bond as there was no photographic record of the pre-construction state of the footpath. The local government also implemented a new process for managing the receipt and release of damage bonds to ensure that a site inspection occurs prior to construction commencing and a photographic record is made of the pre-construction status.

The University Sector

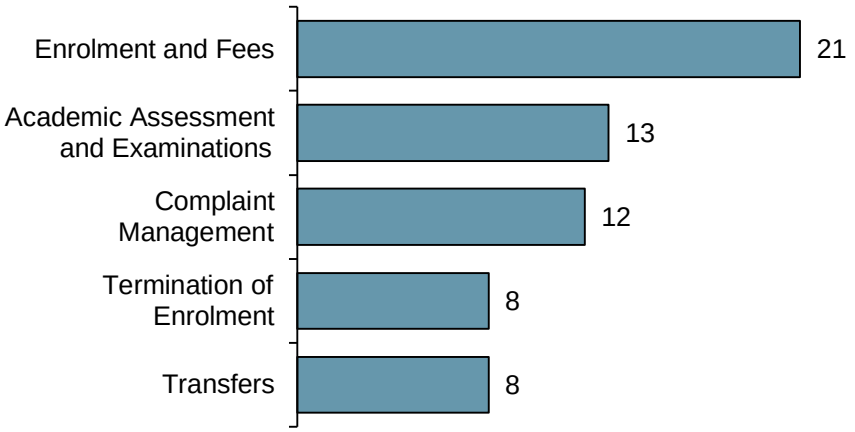
The following section provides further details about the issues and outcomes of complaints for the university sector.

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

- Staff appointments and promotions;
- Academic misconduct;
- Scholarships and prizes;
- Human resource management issues; and
- Staff conduct.

Outcomes Achieved

- Action to replace, repair or rectify;
- Reversal or significant variation of original decision;
- Monetary charge reduced or refunded;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy or procedure;
- Change to business systems or practices;
- Conduct an audit or review;
- Update publications or website; and
- Improve record keeping.

Case Study

Revised system for collection of portfolios

A person complained to the Office that a university had not been able to locate their portfolio of work which had been stored at the university after it was marked.

Following enquiries by the Office, the university arranged for a letter to be sent to the person which provided an explanation about the process for the submission of portfolios, the investigation undertaken by the university into the missing work, and action being taken by the university for the storage of portfolios in the future. The university also offered to print missing images for inclusion in the student's portfolio and undertook to develop and implement a revised system for the collection of portfolios by students.

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:

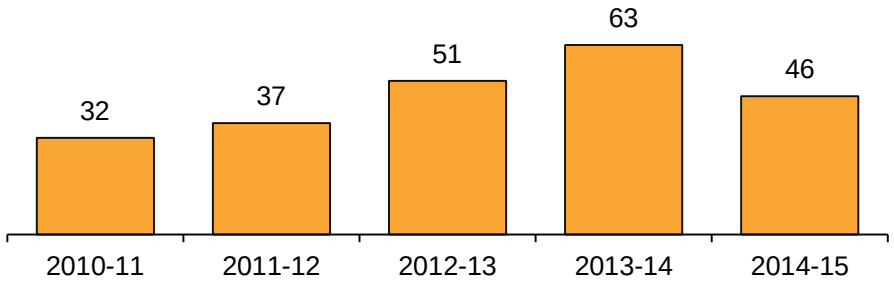
- Provides a free complaint resolution service;
- Is independent and impartial and does not represent either the overseas students or education and training providers; and
- Can make recommendations arising out of investigations.

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 2010-11 and 2014-15



During 2014-15, the Office received 46 complaints about public education and training providers from overseas students. Thirty two complaints were about universities, four were about institutes of technology and four were about other education agencies. The Office also received six complaints that, after initial assessment, were found to be about a private education provider. The Office referred these complaints to the Overseas Students Ombudsman.

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

- Termination of enrolment (14);
- Transfers between education and training providers (9); and
- Fees (9).

During the year, the Office finalised 48 complaints about 49 issues.

Case Study

University provides refund of tuition fees in full and improves documentation relating to refunds

An overseas university student was enrolled in a course at a Western Australian university to commence studies in February 2014 and paid the required tuition fees. When the student was unable to obtain a student visa, they requested a refund of the fees. The university refunded the student 50% of the fees, retaining the remainder of the fees as a deposit towards the next semester. The student complained to the Office that the university did not refund their fees in full.

The Office's investigation found that the university had failed to refund the fees in accordance with its refund policy. As a result, the university reviewed and updated relevant sections of its refund policy and agreed to return and release the remaining 50% of the student's fees.

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, four disclosures were received.

Indian Ocean Territories

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

Terrorism

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

Requests for Review

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

Ten requests for review were received in 2014-15, compared to seven in 2013-14, representing less than half 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 and, in one case, a complaint was reopened due to new information provided by the complainant.

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 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 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 (**DCPFS**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children and Community Services Act 2004*, the CEO had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child; and
    - Any of the actions listed in section 32(1) of the *Children and Community Services Act 2004* was done in respect of the child or a child relative of the child.
- The child or a child relative of the child is in the CEO's care or protection proceedings are pending in respect of the child or a child relative of the child.

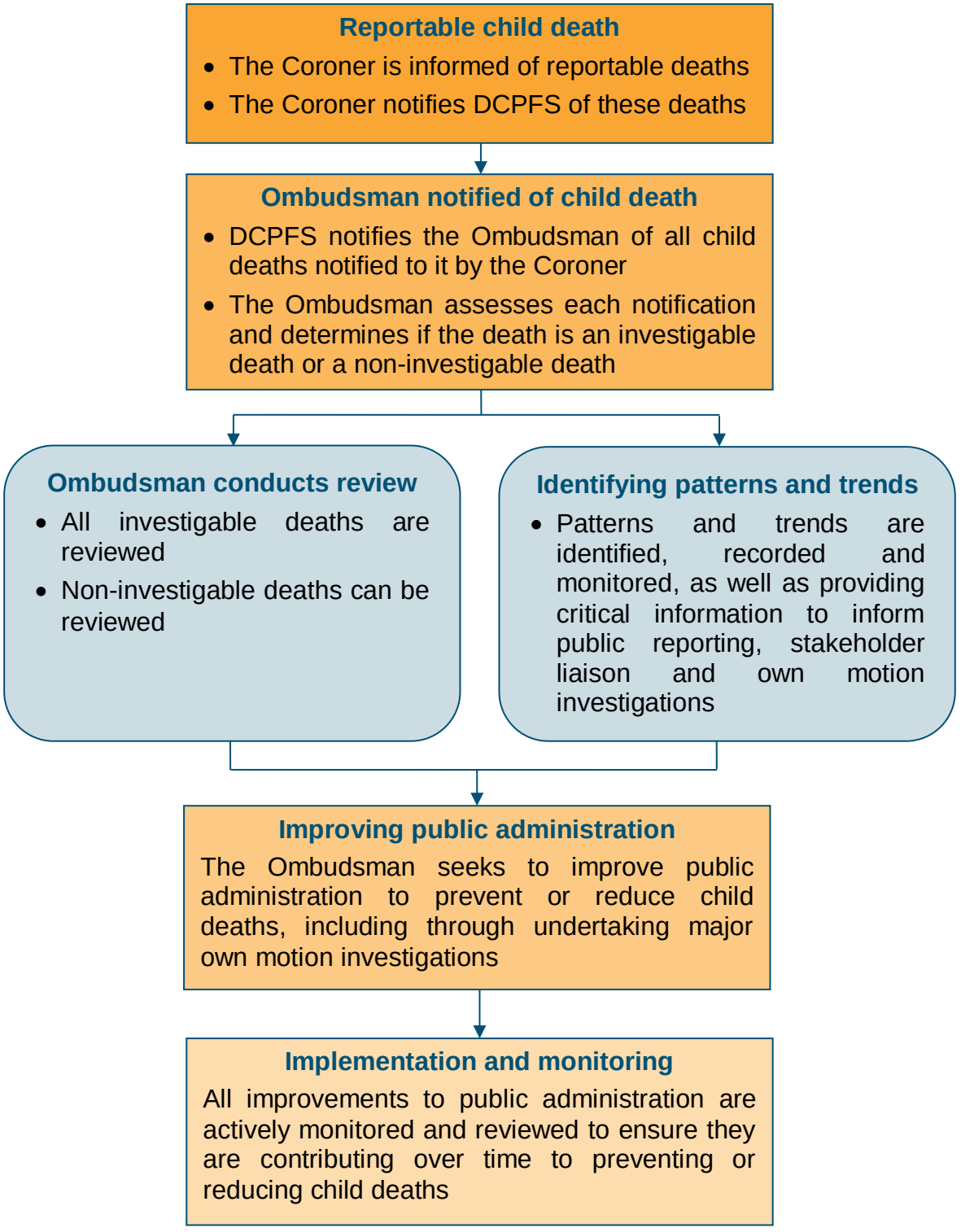
In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

In addition to reviewing investigable deaths, the Ombudsman can 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

DCPFS 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 DCPFS by the Coroner about the circumstances of the child's death together with a summary outlining the past involvement of DCPFS 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 DCPFS 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.

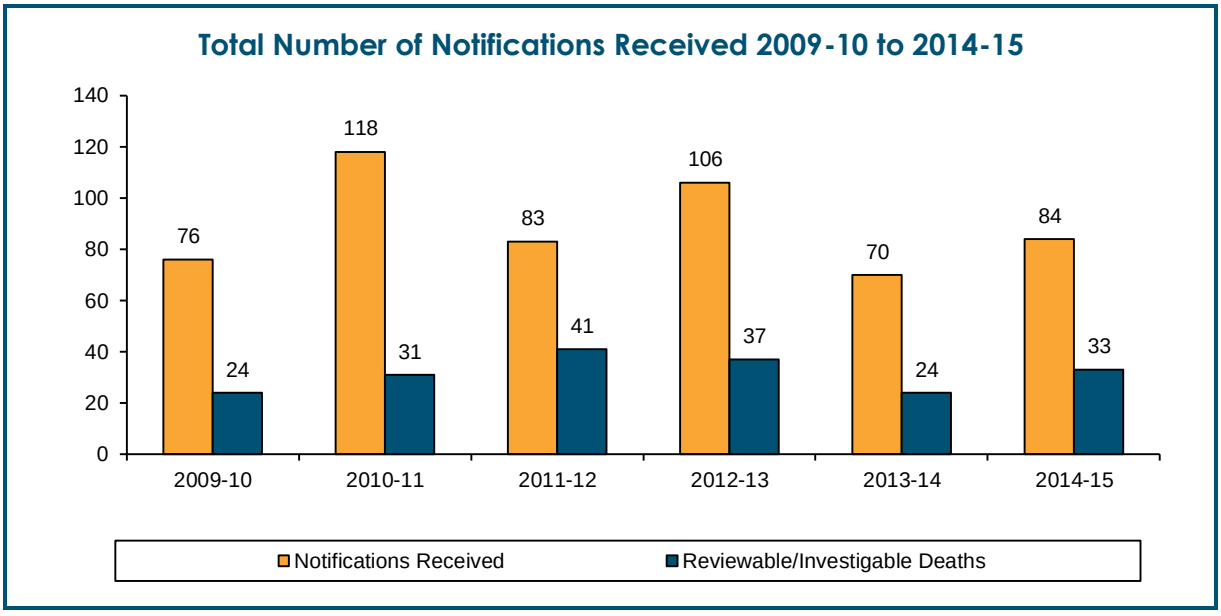
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner.

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 2014-15, there were 33 child deaths that were investigable and subject to review from a total of 84 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 12 years from 2003-04 to 2014-15. 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 DCPFS.

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 DCPFS. It should be noted that children or their relatives may be known to DCPFS 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 DCPFS (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
2014-15	157	93	48	33

Abbreviations

DCPFS: 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 DCPFS and is based on the date the notification was received by DCPFS. 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 DCPFS: 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 2014-15, timely review processes have resulted in nearly 90% 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 infant 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. In 2014-15, the Office commenced a major own motion investigation into ways to prevent or reduce child deaths by drowning.

Characteristics of children who have died

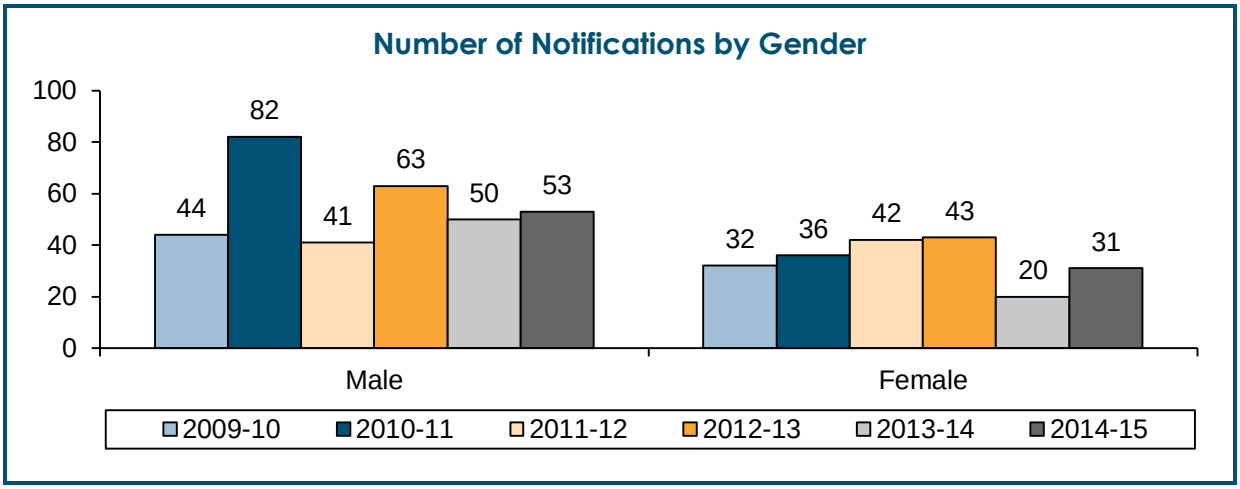
Information is obtained on a range of characteristics of the children who have died including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected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

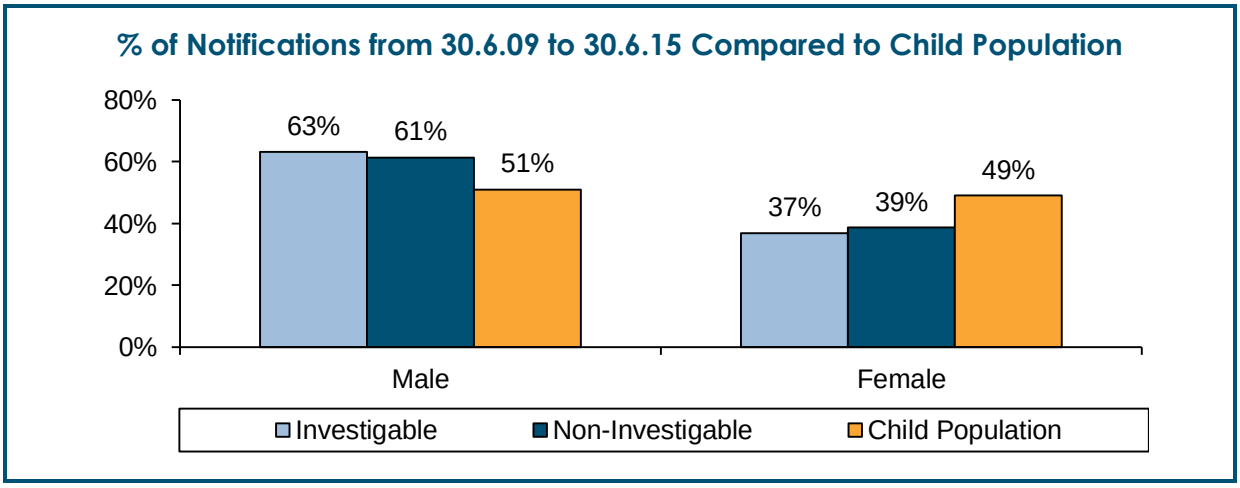
The following charts show:

- The number of children in each group for each year from 2009-10 to 2014-15; and
- For the period from 30 June 2009 to 30 June 2015, 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 six years, male children are over-represented compared to the population for both investigable and non-investigable deaths.

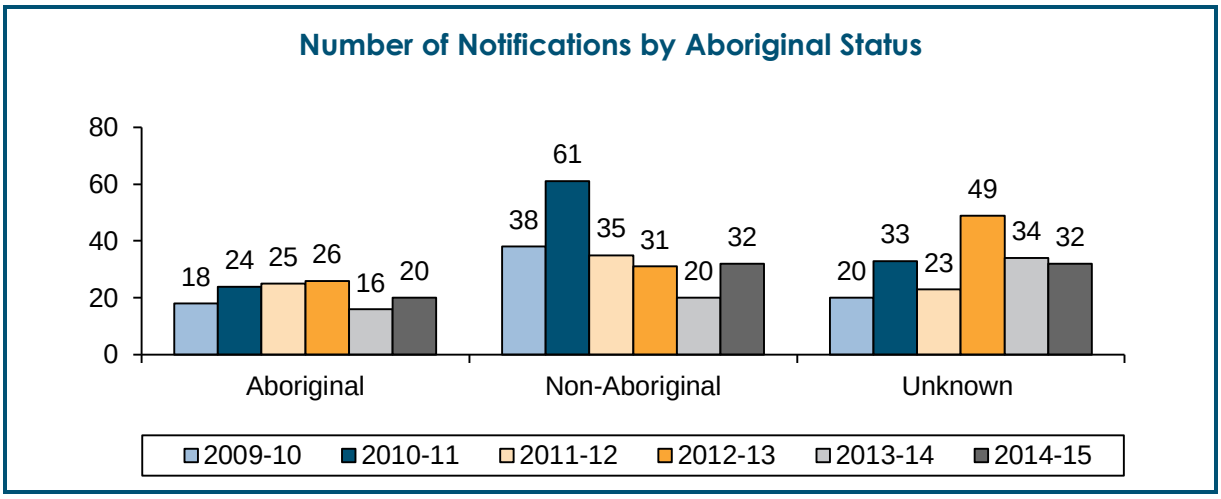


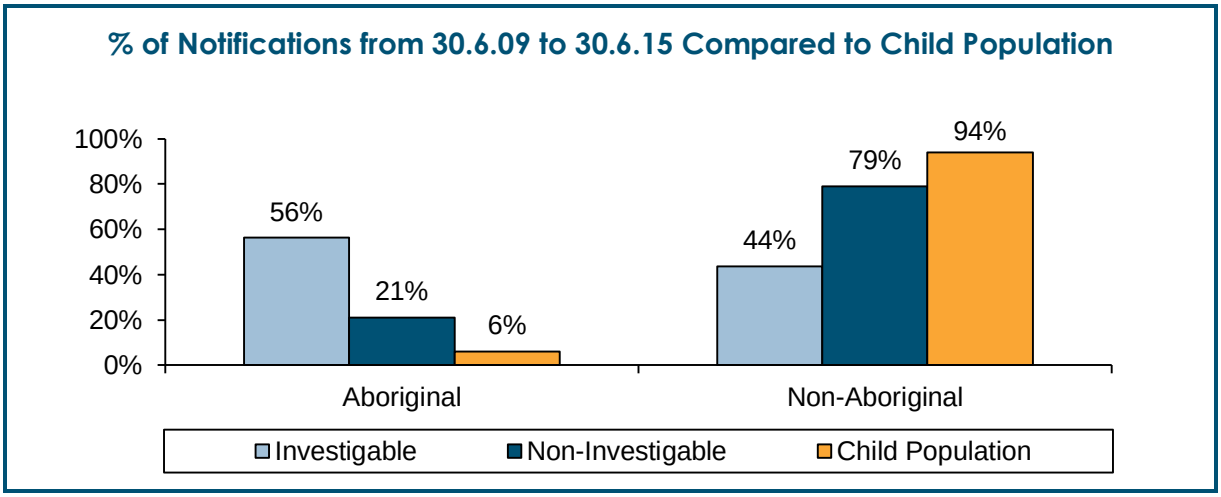


Further analysis of the data shows that, considering all six years, male children are over-represented for all age groups, but particularly for children under the age of one and children aged between six and 12 years.

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.



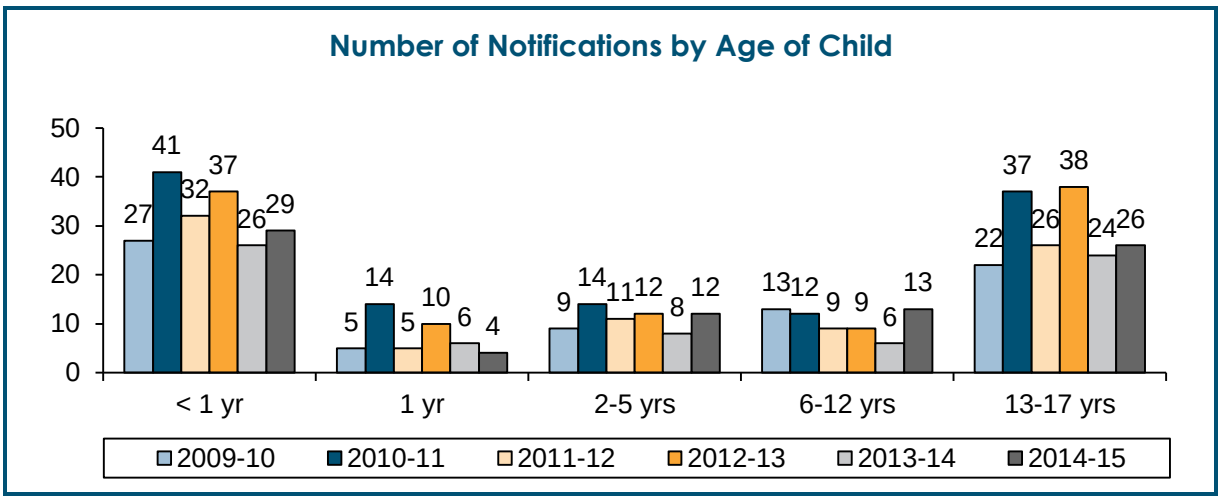


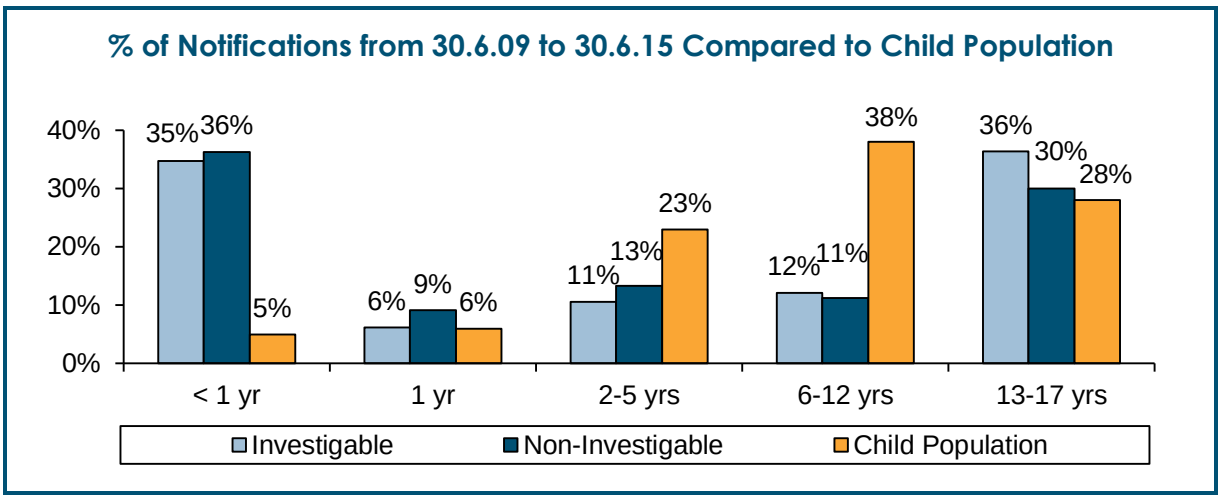
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

Further analysis of the data shows that Aboriginal children 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 one year 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.

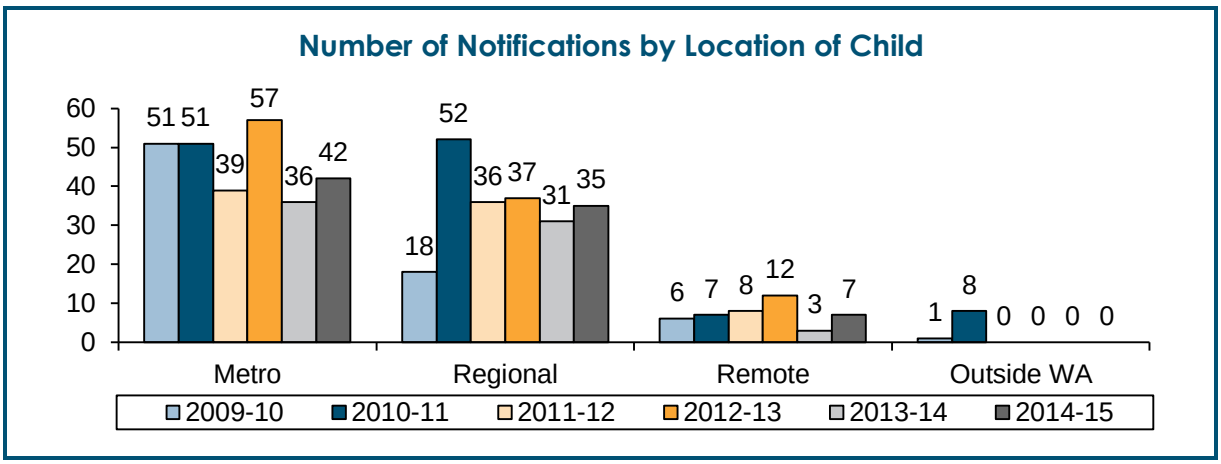




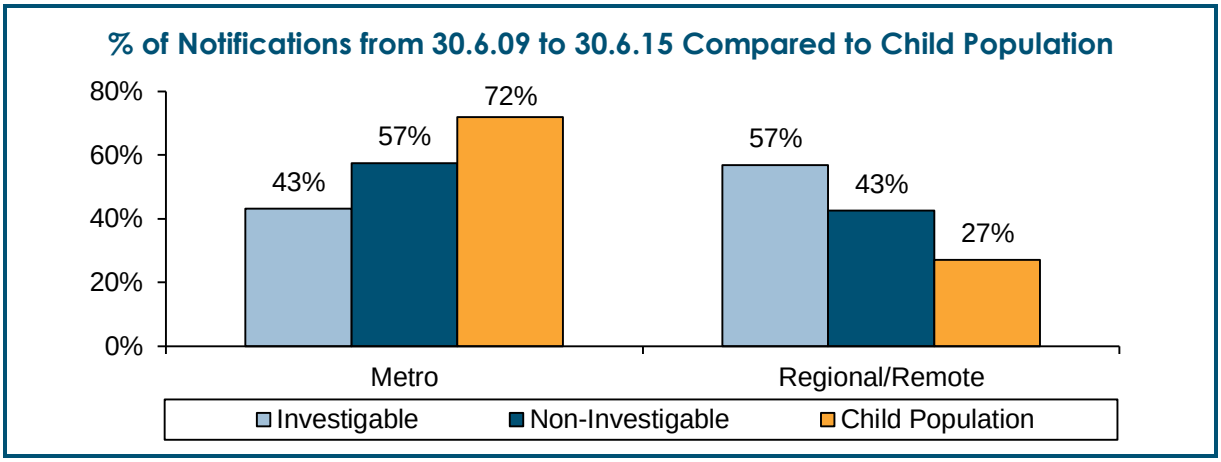
Further analysis of the data shows that Aboriginal children are more likely to be under the age of one than non-Aboriginal children. A more detailed analysis by age group is provided later in this section.

Location of residence

As shown in the following charts, children in regional locations are over-represented compared to the child population as a whole, and more so for investigable deaths.



Note: Outside WA includes children whose residence is not in Western Australia, but the child died in Western Australia. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the place of residence of the child.



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

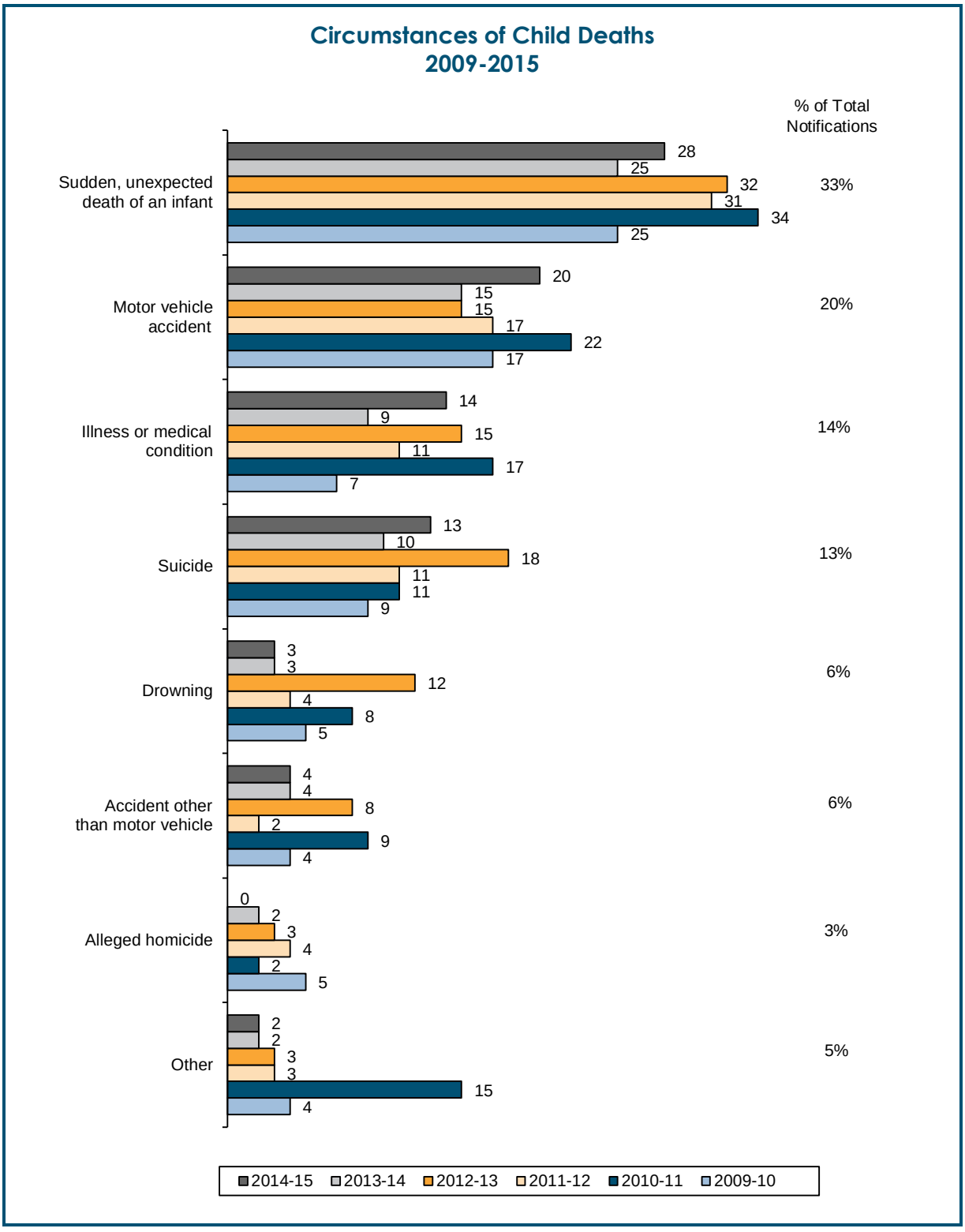
Circumstances of child deaths

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 six years.



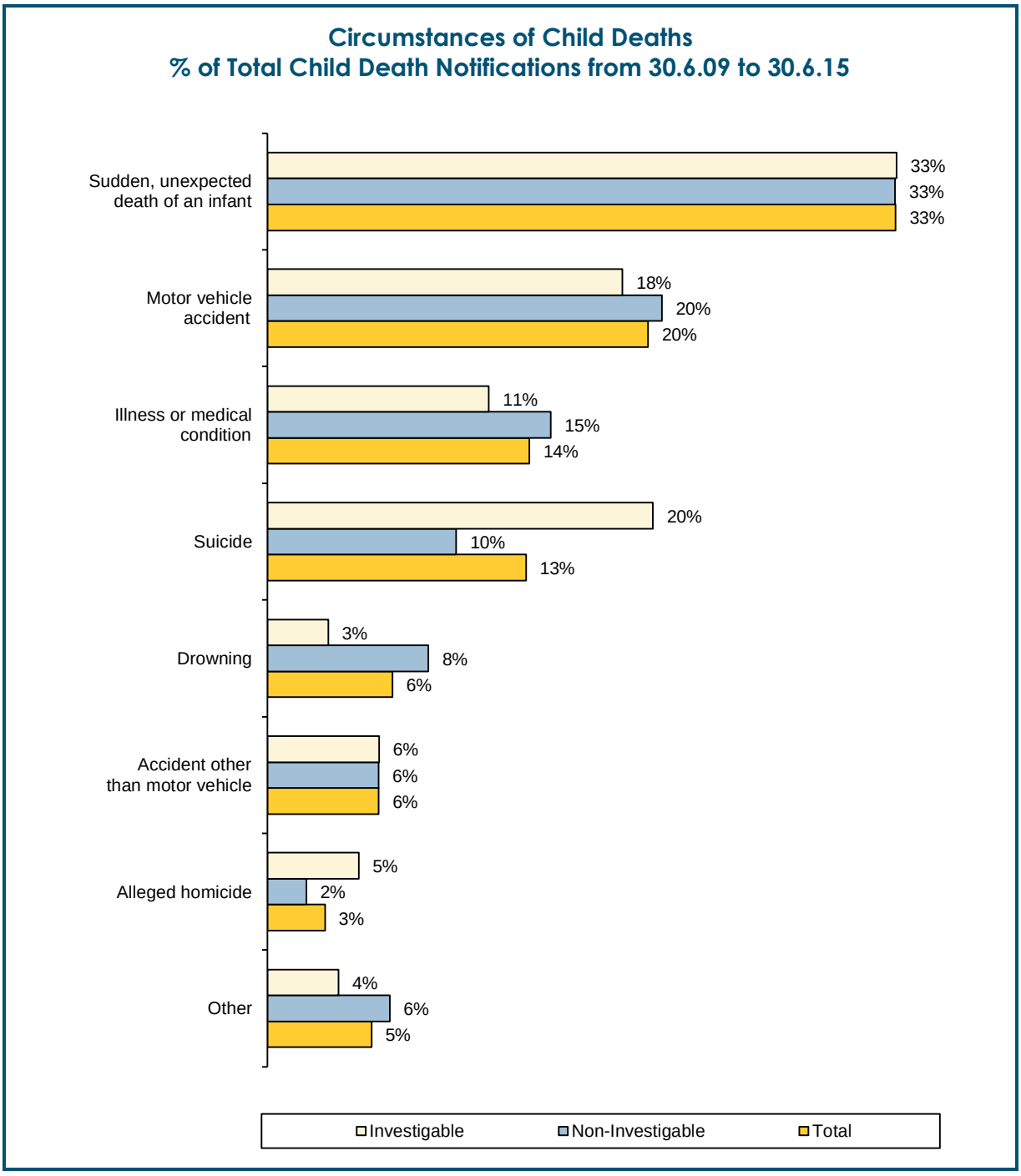
Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

Note 2: 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 537 child death notifications received in the six years from 30 June 2009 to 30 June 2015 are:

- Sudden, unexpected deaths of infants, representing 33% of the total child death notifications from 30 June 2009 to 30 June 2015 (33% of the child death notifications received in 2009-10, 29% in 2010-11, 37% in 2011-12, 30% in 2012-13, 36% in 2013-14, and 33% in 2014-15); and
- Motor vehicle accidents, representing 20% of the total child death notifications from 30 June 2009 to 30 June 2015 (22% of the child death notifications received in 2009-10, 19% in 2010-11, 20% in 2011-12, 14% in 2012-13, 21% in 2013-14, and 24% in 2014-15).

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



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

- Suicide; 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 DCPFS. 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
2014-15	4	20	14			3	28	13	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;
- Parenting;
- 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 DCPFS or another public authority.

Social or Environmental Factor	% of Finalised Reviews from 30.6.09 to 30.6.15
Family and domestic violence	58%
Parenting	58%
Alcohol use	37%
Drug or substance use	35%
Homelessness	25%
Parental mental health issues	19%

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:
  - Parenting was a co-existing factor in nearly three quarters of the cases;
  - Drug or substance use was a co-existing factor in over half of the cases;
  - Alcohol use was a co-existing factor in over half of the cases;
  - Homelessness was a co-existing factor in over a third of the cases; and
  - Parental mental health issues were a co-existing factor in almost a quarter of the cases.
- Where alcohol use was present:
  - Parenting was a co-existing factor in over three quarters of the cases;
  - 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 half of the cases; and
  - Homelessness was a co-existing factor in over a third of the cases.

Reasons for contact with DCPFS

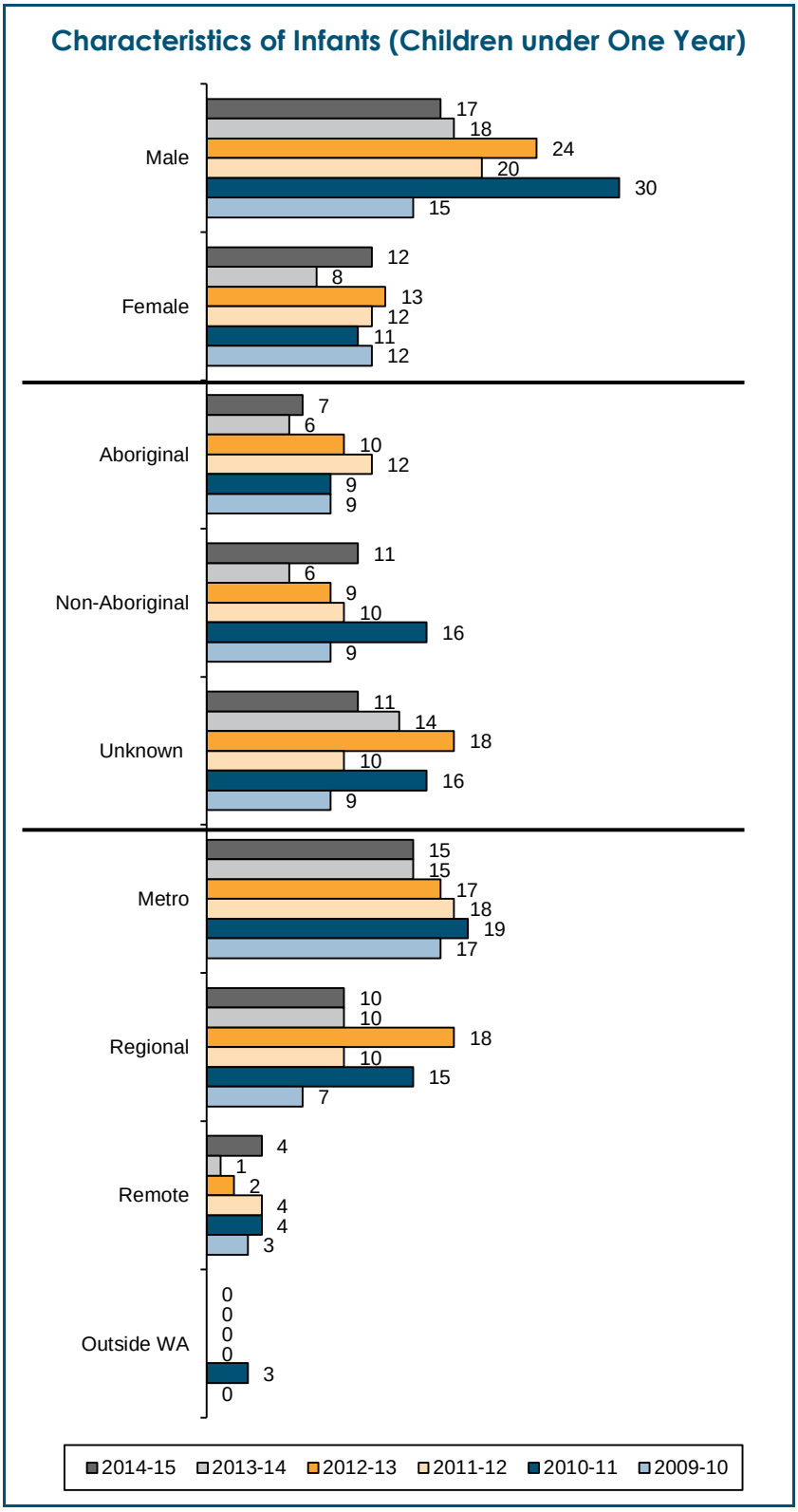
In 2014-15, the majority of children who were known to DCPFS were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, access, fostering or adoption enquiries and homelessness.

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 537 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2015, there were 192 (36%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.

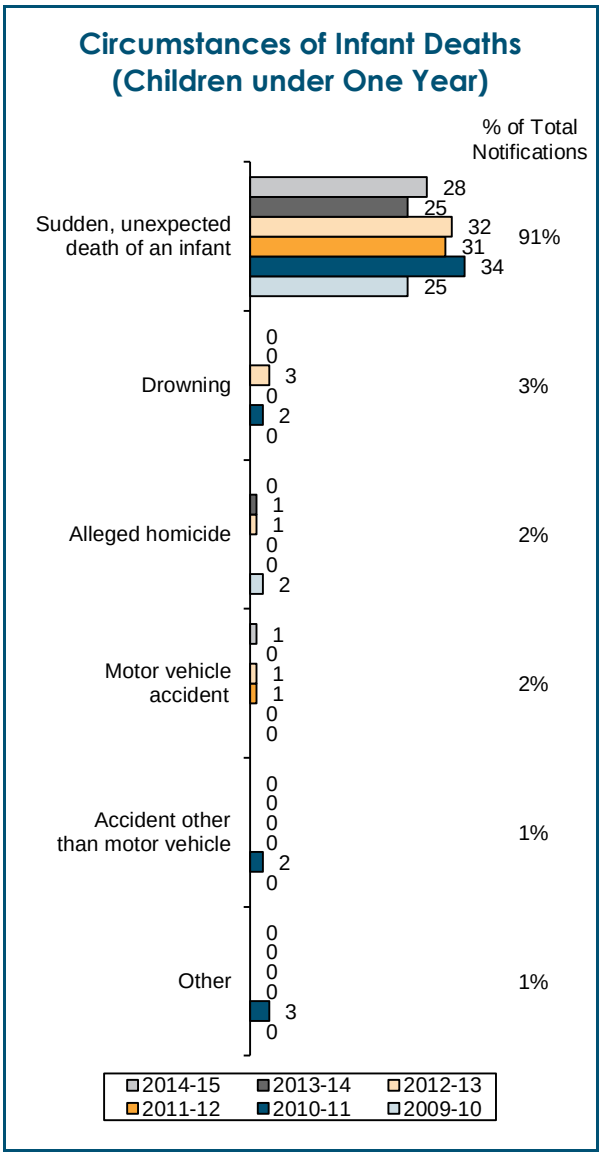


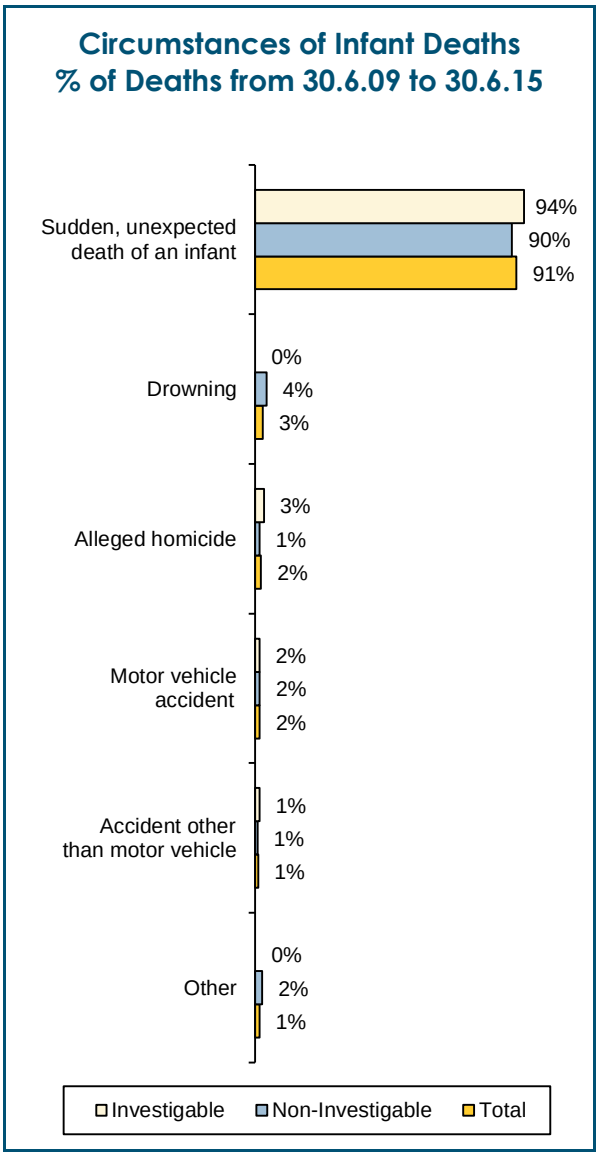
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 74% of investigable infant deaths and 59% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 65% of investigable deaths and 33% 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 43% 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 192 infant deaths, 175 (91%) were categorised as sudden, unexpected deaths of an infant and the majority of these (115) 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.





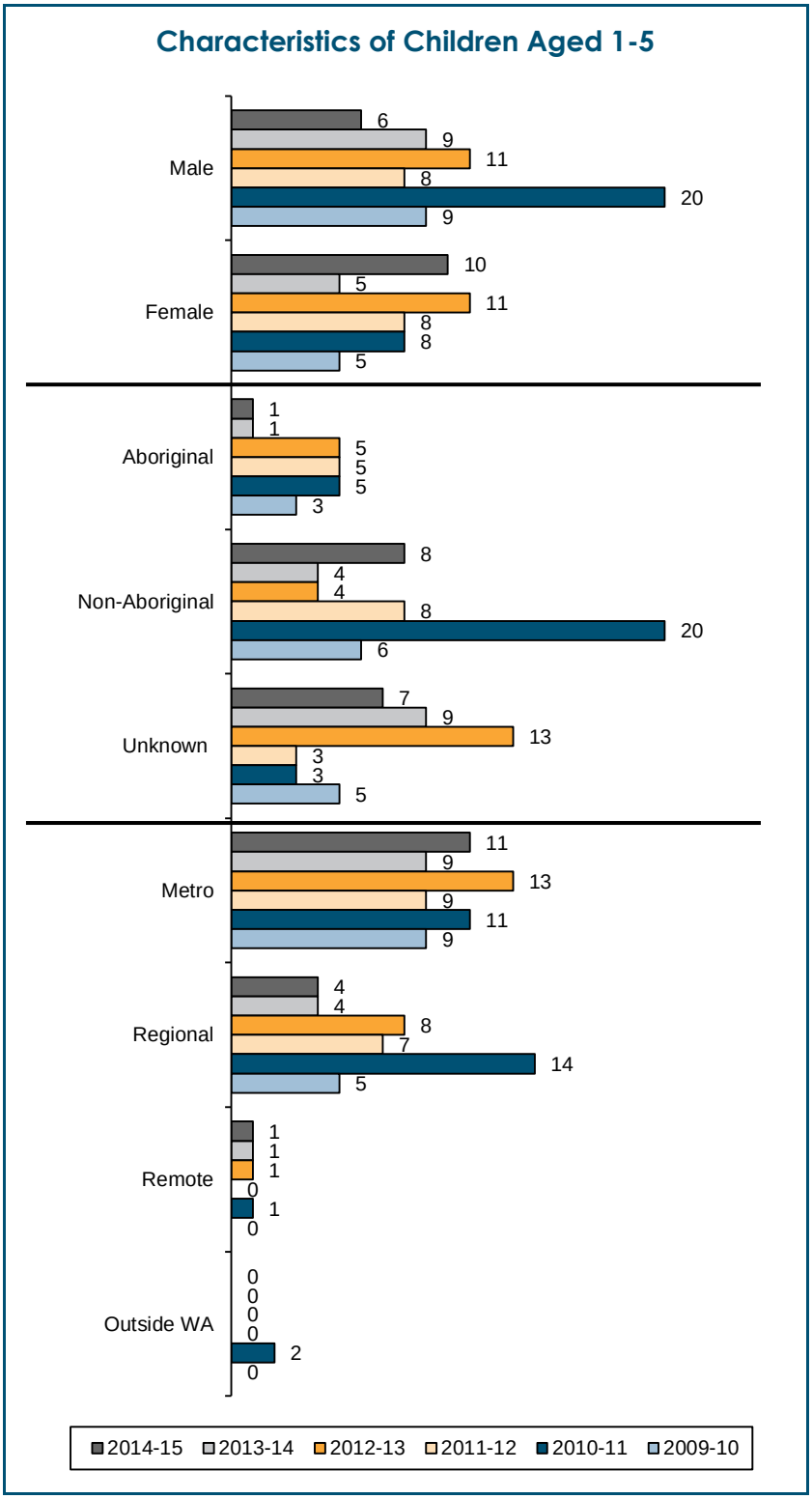
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Sixty six deaths of infants were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 537 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2015, there were 110 (20%) related to children aged from 1 to 5 years.

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

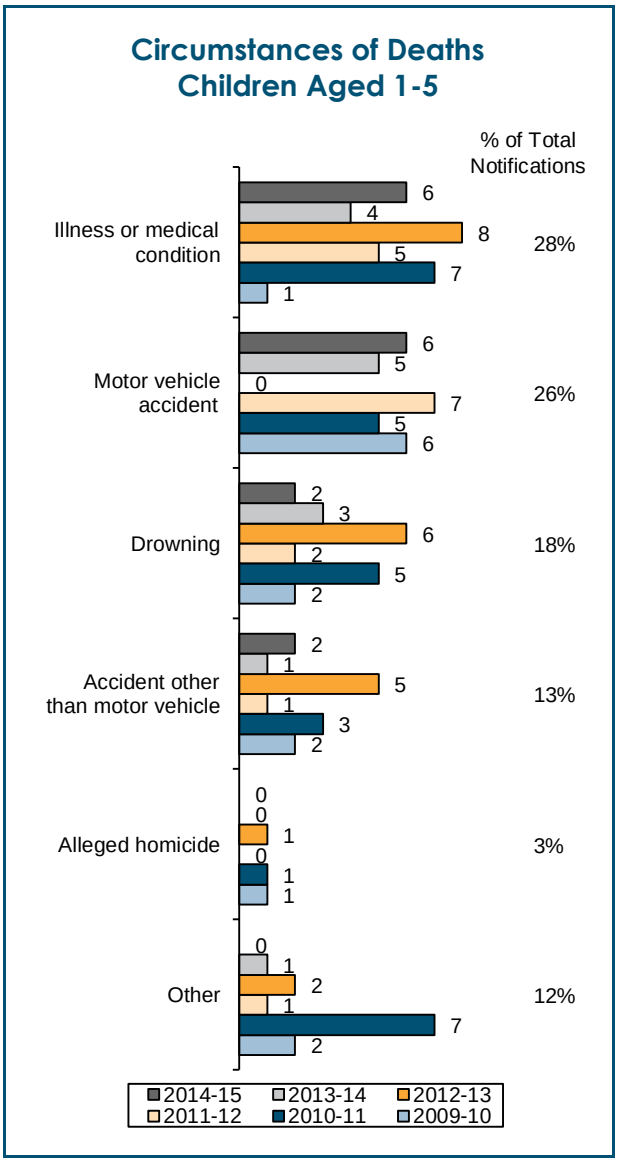


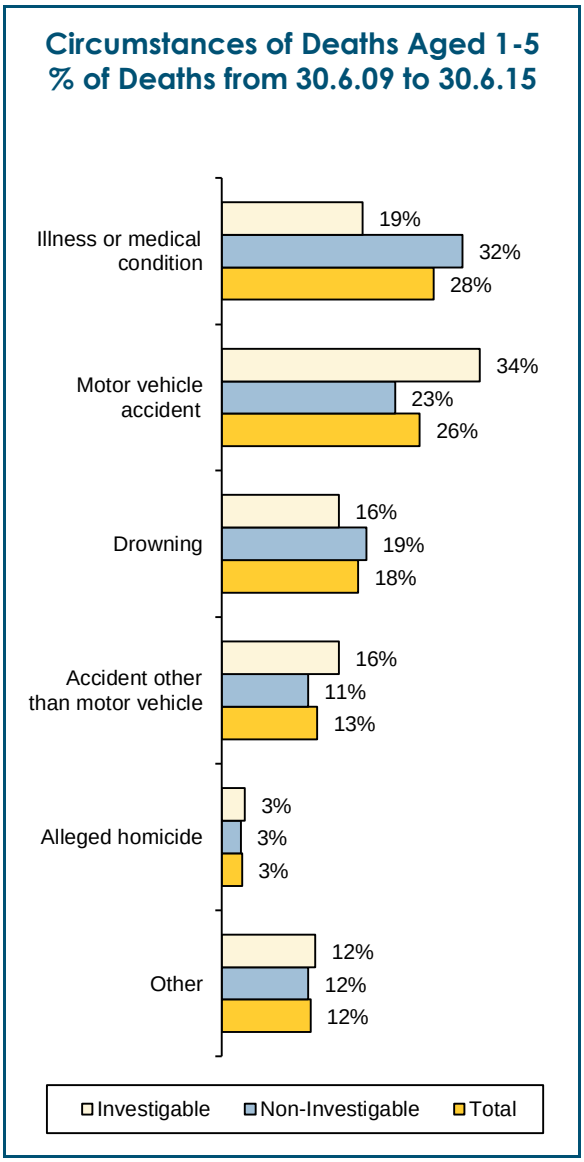
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 63% of investigable deaths and 55% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Aboriginal children – 52% 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 – 47% of investigable deaths and 41% 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 (28%), followed by motor vehicle accidents (26%) and drowning (18%).





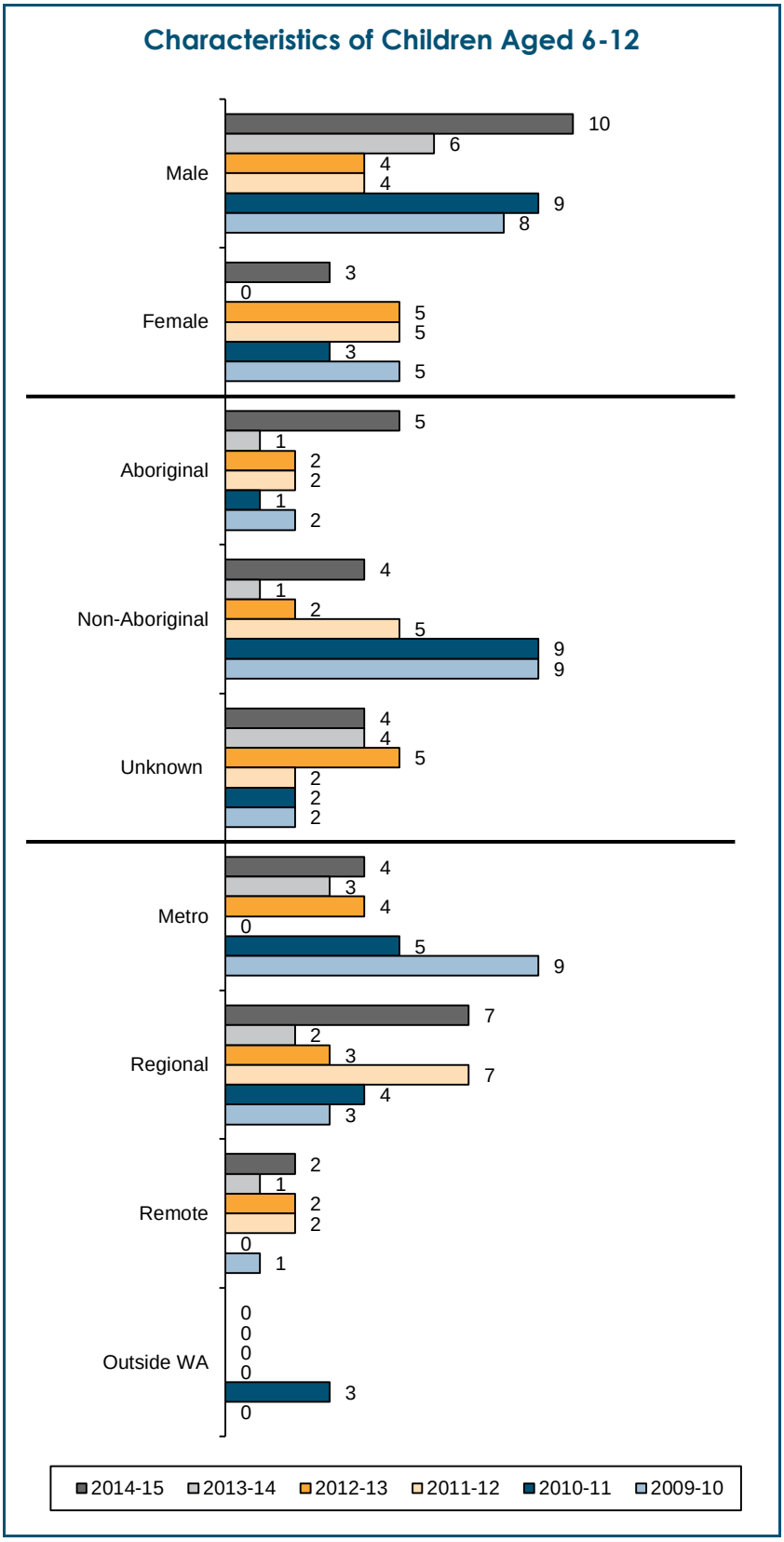
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

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

Deaths of children aged 6 to 12 years

Of the 537 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2015, there were 62 (12%) related to children aged from 6 to 12 years.

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

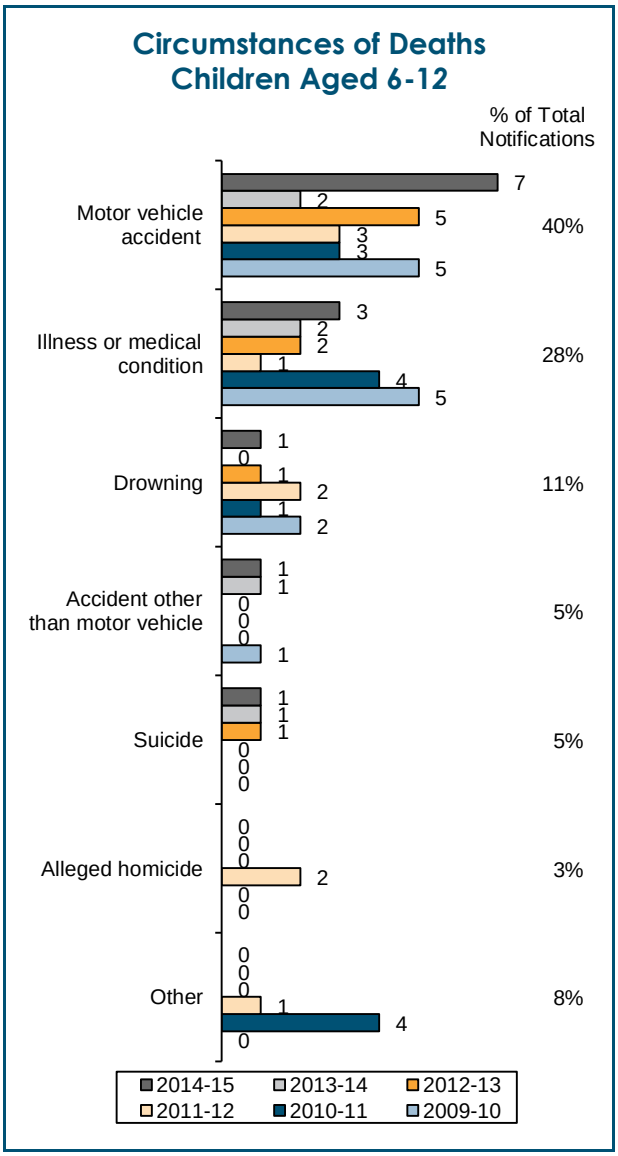


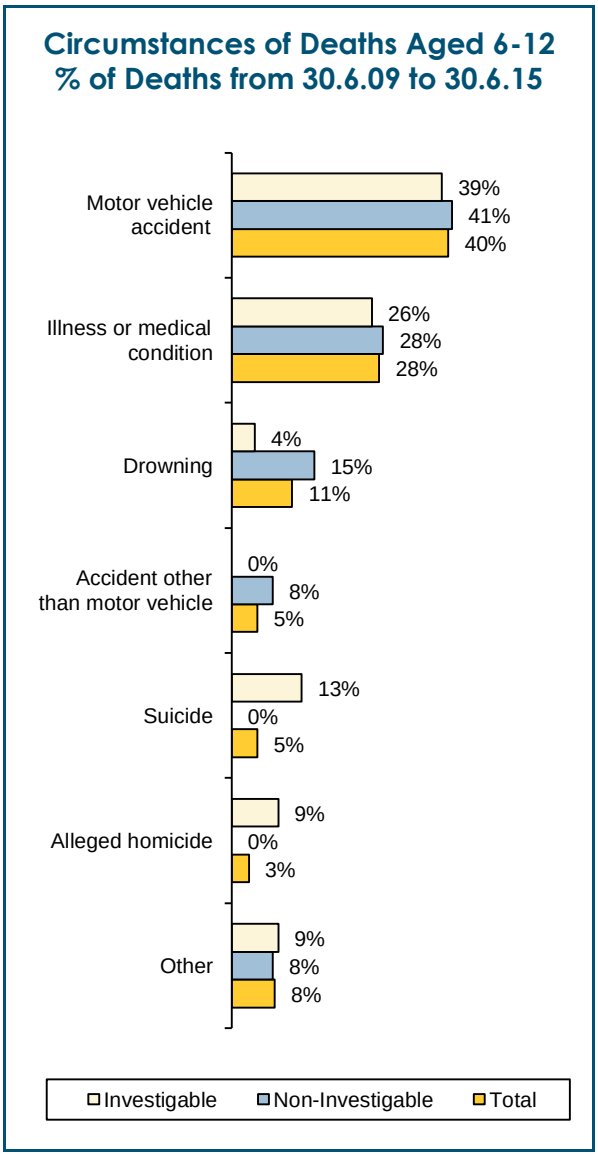
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 57% of investigable deaths and 72% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population;
- Aboriginal children – 48% of investigable deaths and 14% of non-investigable deaths of children aged 6 to 12 were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 70% of investigable deaths and 50% 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 (40%), followed by illness or medical condition (28%) and drowning (11%).





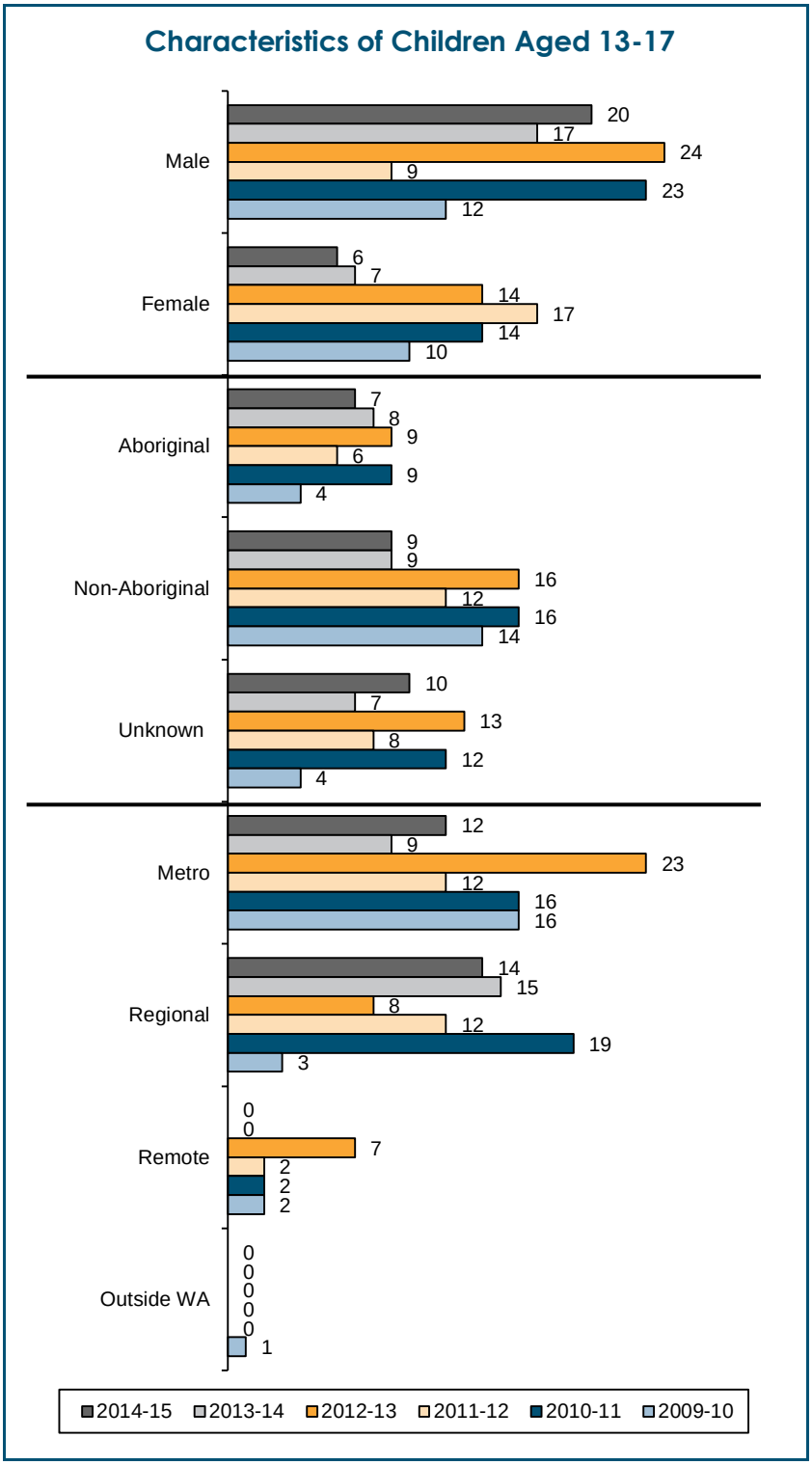
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

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

Deaths of children aged 13 – 17 years

Of the 537 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2015, there were 173 (32%) related to children aged from 13 to 17 years.

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

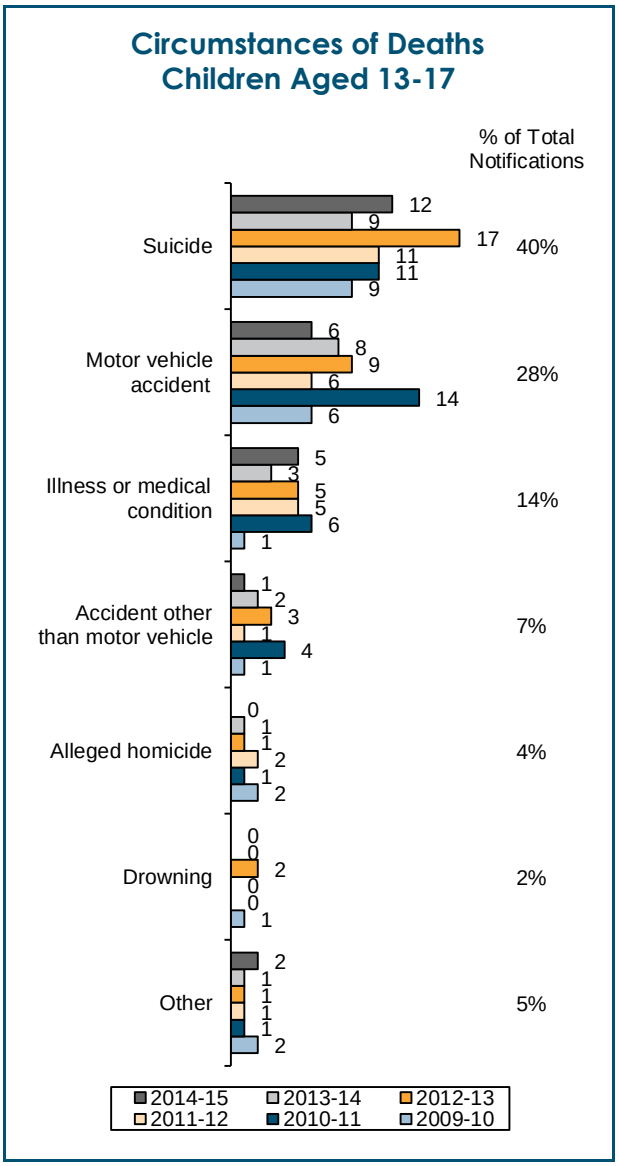


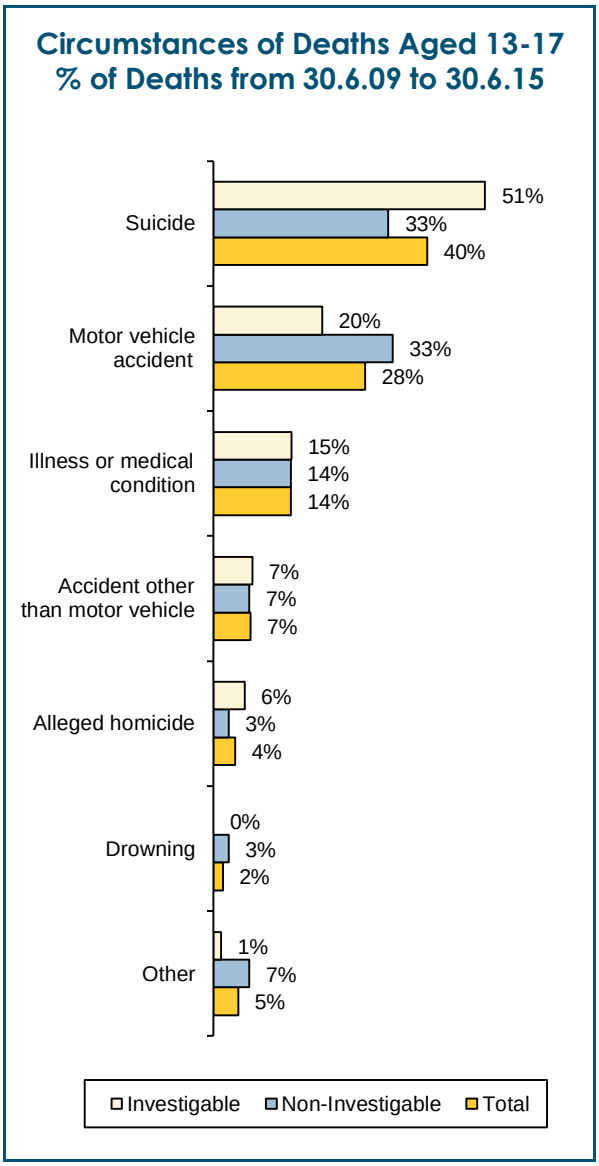
Note: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

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

- Males – 55% of investigable deaths and 64% of non-investigable deaths of children aged 13 to 17 were male compared to 51% in the child population;
- Aboriginal children – 55% of investigable deaths and 16% 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 – 61% of investigable deaths and 41% of non-investigable deaths of children aged 13 to 17, living in Western Australia, were living in regional or remote locations compared to 27% in the child population.

As shown in the following chart, suicide is the most common circumstance of death for this age group (40%), particularly for investigable deaths, followed by motor vehicle accidents (28%) 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.

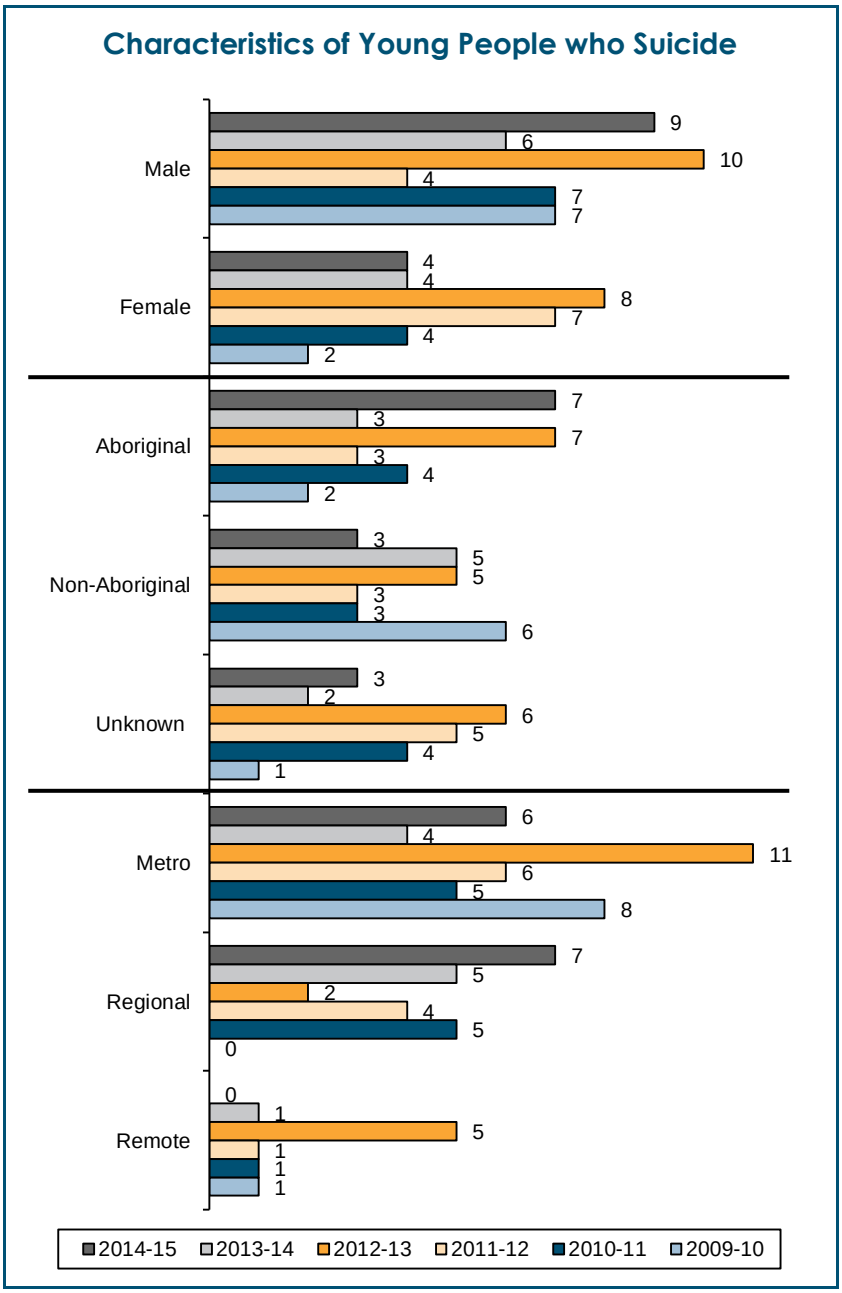
Sixty nine deaths of children aged 13 to 17 years were determined to be investigable deaths.

Suicide by young people

Of the 72 young people who apparently took their own lives from 30 June 2009 to 30 June 2015:

- Three were under 13 years old;
- Four were 13 years old;
- Eight were 14 years old;
- Seventeen were 15 years old;
- Sixteen were 16 years old; and
- Twenty four 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 shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 55% of investigable deaths and 65% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 51 apparent suicides by young people where information on the Aboriginal status of the young person was available, 66% of the investigable deaths and 19% 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 61% of investigable youth suicides and 26% of non-investigable youth suicides were young people who were living in regional or remote locations compared to 27% in the child population.

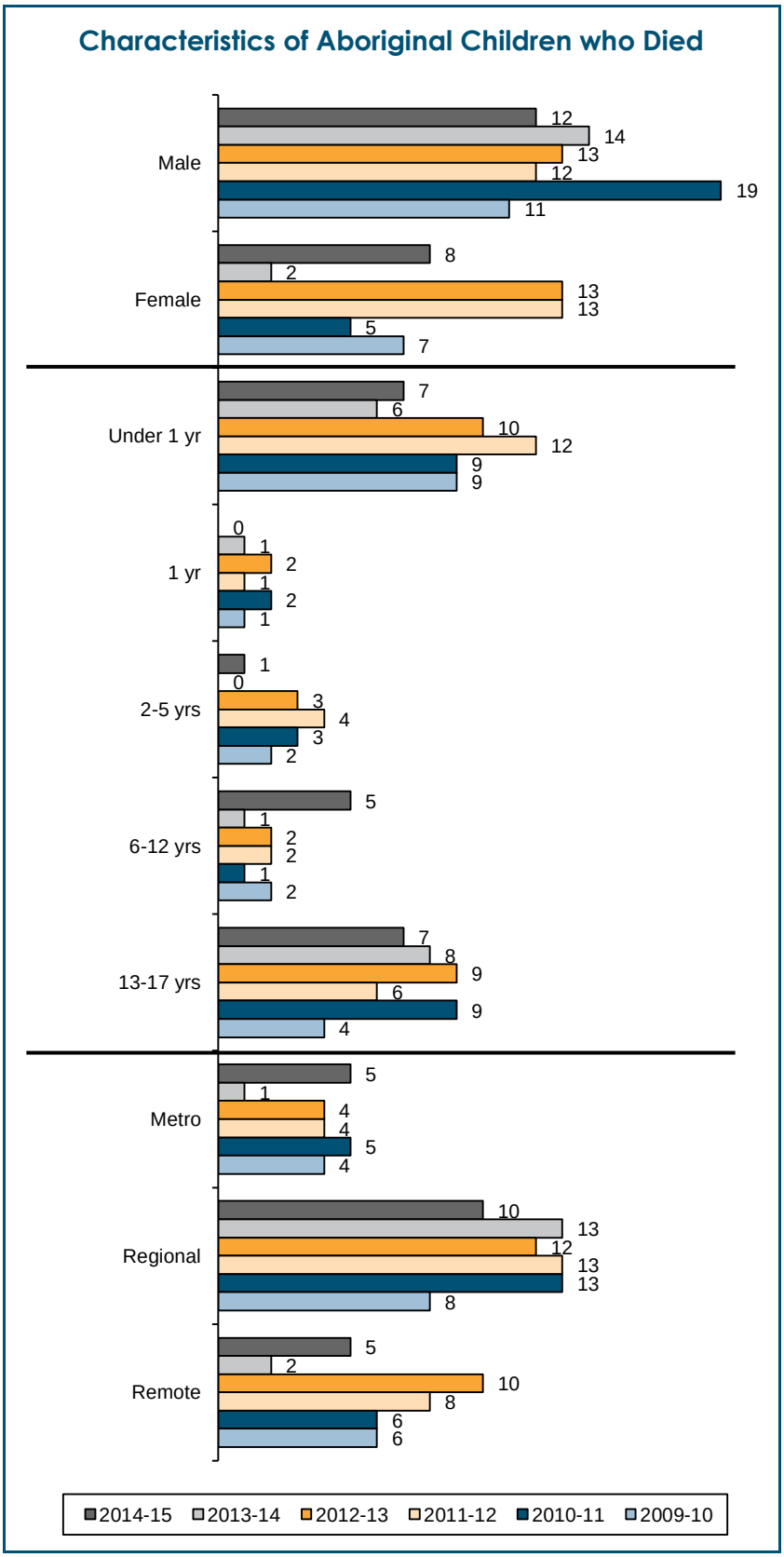
Deaths of Aboriginal children

Of the 346 child death notifications received from 30 June 2009 to 30 June 2015, where the Aboriginal status of the child was known, 129 (37%) of the children were identified as Aboriginal.

For the notifications received, the following chart demonstrates:

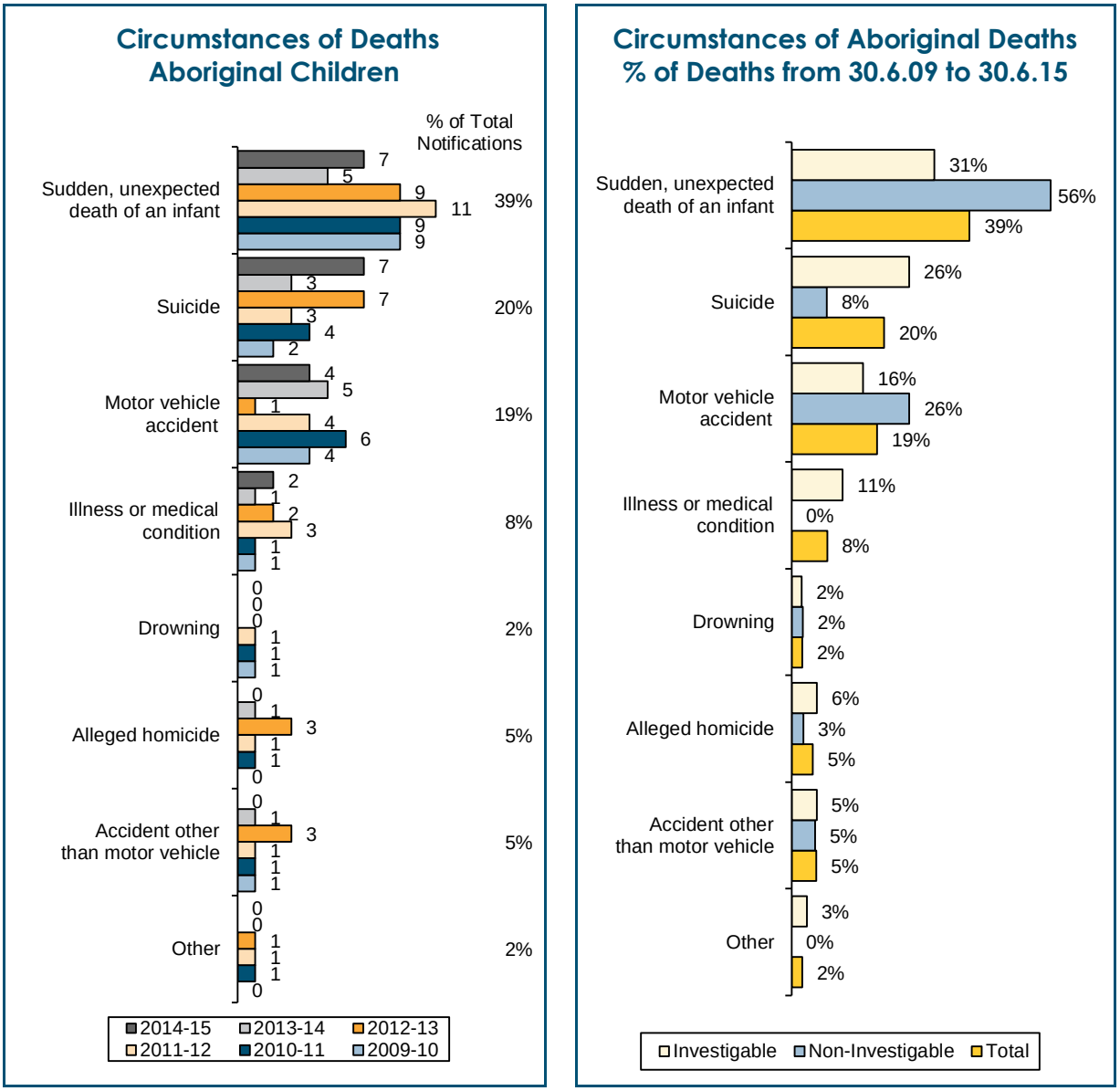
- Over the six year period from 30 June 2009 to 30 June 2015, the majority of Aboriginal children who died were male (63%). For 2014-15, 60% of Aboriginal children who died were male;
- Most of the Aboriginal children who died were under the age of one or aged 13-17; and
- The deaths of Aboriginal children living in regional communities far outnumber the deaths of Aboriginal children living in the metropolitan area. Over the six year period, 82% 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 deaths of infants (39%), suicide (20%), and motor vehicle accidents (19%) are the largest circumstance of death categories for the 129 Aboriginal child death notifications received in the six years from 30 June 2009 to 30 June 2015.



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 undertaking sufficient intra-agency communication to enable effective case management and collaborative responses.
- Not undertaking sufficient inter-agency communication to enable effective case management and collaborative responses.
- Not adequately meeting policies and procedures relating to management and timeliness of case allocation.
- Not adequately meeting policies and procedures relating to decision making for case closure where child protection concerns are not resolved.
- Not adequately meeting policies and procedures relating to Safety and Wellbeing Assessments.
- Not adequately meeting policies and procedures relating to the Signs of Safety Framework.
- Not conducting Safety and Wellbeing Assessments in a sufficiently timely manner.
- Not adequately meeting policies and procedures in relation to pre-birth planning.
- Not providing sufficient case management supervision to ensure timely action in regard to pre-birth planning.

- Not adequately meeting policies and procedures relating to post-birth safety planning.
- Missed opportunities to promote infant safe sleeping by providing appropriate information, including risks of co-sleeping associated with parental alcohol use and/or drug use.
- Not adequately meeting policies and procedures in relation to family and domestic violence.
- Actions in relation to non-compliant pool security.
- 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.

- Revising policies for effective intra-agency communication and collaboration when working with children and their families who reside in more than one district.
- Improving inter-agency communication to promote effective decision making and collaborative inter-agency responses.
- Improving compliance with policies and procedures relating to:
  - Management of case allocations;
  - Case closure where child protection concerns have not been resolved;
  - Signs of Safety Framework;
  - Safety and Wellbeing Assessments;
  - Pre-birth planning;
  - Family and domestic violence; and
  - Inter-agency collaboration.
- Using the findings from the Ombudsman's child death reviews for learning and practice guidance in relation to family and domestic violence.
- Improved pre-birth parenting support.
- Revising policies to improve guidance to staff in undertaking pre-birth planning.
- Improving the provision of infant safe sleeping information and education.
- Improving appropriate and timely assessments in relation to Safety and Wellbeing Assessments.
- Reviewing non-compliant 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

Through the undertaking of child death reviews, the Office identified a need to undertake an investigation into the number of deaths that had occurred after infants had been placed to sleep, referred to as 'sleep-related infant deaths'.

The investigation principally involved the Department of Health but also involved the (then) Department for Child Protection and the (then) Department for Communities. The objectives of the investigation were to analyse all sleep-related infant deaths notified to the Office, consider the results of our analysis in conjunction with the relevant research and practice literature, undertake consultation with key stakeholders and, from this analysis, research and consultation, recommend ways the departments could prevent or reduce sleep-related infant deaths.

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

The investigation also found that a range of risk factors were prominent in sleep-related infant deaths reported to the Office. Most of these risk factors are potentially modifiable and therefore present opportunities for the departments to assist parents, grandparents and carers to modify these risk factors and reduce or prevent sleep-related infant deaths.

The report of the investigation titled *Investigation into ways that State Government departments and authorities can prevent or reduce sleep-related infant deaths* was tabled in Parliament in November 2012. 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.

More particularly, significant work was undertaken during the year on a report in relation to the implementation of the Ombudsman's recommendations arising from the *Investigation into ways that State Government departments and authorities can prevent or reduce sleep-related infant deaths*.

Case Study

Infant A

Infant A died at the age of two months in the circumstances of co-sleeping. Following Infant A's birth, concerns were reported to DCPFS that the family was homeless, the parental relationship had broken down and Infant A's mother was suffering from post-natal depression. DCPFS located the family, sighted both children, discussed co-sleeping risks and provided information regarding accommodation options. Additionally, DCPFS records indicated previously reported concerns regarding the family and Infant A's sibling due to alleged parental drug use.

The Ombudsman's review identified that while, importantly, the risks of co-sleeping were discussed (although not documented) with the family, an opportunity was missed to discuss specifically the increased risk of infant death when co-sleeping with parents who may be affected by drugs.

In response to this review DCPFS agreed to take action to enable and support compliance with policies and procedures relating to safe infant sleeping.

Deaths of children aged 1 to 5 years

Deaths from drowning

The *Royal Life Saving Society – Australia: National Drowning Report 2014* (available at http://www.royallifesaving.com.au/) states (at page 8) that:

> *Children under five continue to account for a large proportion of drowning deaths in swimming pools, particularly home swimming pools. It is important to ensure that home pools are fenced with a correctly installed compliant pool fence with a self-closing and self-latching gate.*

Through the undertaking of child death reviews, including the prevalence of drowning as a circumstance of death for children under one year of age and children between one and five years of age, the Office identified a need to commence, in 2014-15, a major own motion investigation into ways to prevent or reduce child deaths by drowning. The report of this major own motion investigation will be tabled in Parliament in 2016.

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 DCPFS, 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

Through the undertaking of child death reviews, the Office identified a need to undertake an investigation of planning for children in the care of the Chief Executive Officer of the (then) Department for Child Protection – a particularly vulnerable group of children in our community.

This investigation involved the (then) Department for Child Protection, the Department of Health and the Department of Education and considered, among other things, the relevant provisions of the *Children and Community Services Act 2004*, the internal policies of each of these departments along with the recommendations arising from the Review of the Department for Community Development undertaken by Ms Prudence Ford.

The investigation found that in the five years since the introduction of the *Children and Community Services Act 2004*, these three agencies had worked cooperatively to operationalise the requirements of the Act. In short, significant and pleasing progress on improved planning for children in care had been achieved, however, there was still work to be done, particularly in relation to the timeliness of preparing care plans and ensuring that care plans fully incorporate health and education needs, other wellbeing issues, the wishes and views of children in care and are regularly reviewed.

The report, titled *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 report made 23 recommendations that were designed to assist with the work to be done, all of which were agreed by the relevant Departments.

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.

More particularly, significant work was undertaken during the year on a report in relation to the implementation of Ombudsman recommendations arising from 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*.

Deaths of primary-school aged children from motor vehicle accidents

In 2014-15, the Ombudsman received seven notifications of the deaths of children aged six to 12 years in the circumstances of motor vehicle accidents. In five cases the child who died was a passenger travelling in a car.

The Office of Road Safety's Fact Sheet *Restraints* (available at http://www.ors.wa.gov.au/) states at page one:

> *Drivers and passengers travelling unrestrained in a car are at least 10 times more likely to be killed in a road crash than those wearing a seat belt. Wearing a seat belt may reduce the chance of being killed in a road accident by up to 50%.*
>
> *In Rural areas 14% of those killed or seriously injured were unrestrained, compared to 5% of those killed or seriously injured in the Metropolitan area.*

The Ombudsman's reviews of these cases identified that of the five children travelling in cars only one notification identified that the child was wearing a seat belt at the time of the accident and four of the five accidents occurred in rural and remote areas.

Deaths of children aged 13 to 17 years

Suicide by young people

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, the Office decided to undertake a major own motion investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people.

The objectives of the investigation were to analyse, in detail, deaths of young people who died by suicide notified to the Office, comprehensively consider the results of this analysis in conjunction with the relevant research and practice literature, undertake consultation with government and non-government stakeholders and, if required, recommend ways that agencies can prevent or reduce suicide by young people.

The Office found that State Government departments and authorities had already undertaken a significant amount of work that aimed to prevent and reduce suicide by young people in Western Australia, however, there was still more work to be done. The Office found that this work included 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, the Office also found that this work included the development of a collaborative, inter-agency approach to preventing suicide by young people. In addition to the Office's findings and recommendations, the comprehensive level of data and analysis contained in the report of the investigation was intended be a valuable new resource for government departments and authorities to inform their planning and work with young people. In particular, the Office's analysis suggested this planning and work target four groups of young people that the Office identified.

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.

Arising from the investigation findings, the Ombudsman made 22 recommendations to four government agencies about ways to prevent or reduce suicide by young people, all agreed to by the agencies.

Identification of good practice

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

Case Study

Child B

Child B was born with complex health care needs. In early childhood, Child B entered into the care of the Chief Executive Officer of DCPFS, and was placed with a foster carer.

DCPFS coordinated care planning meetings for Child B, involving health and education service providers, the foster carers and relevant non-government disability services. The Care Plans developed from these meetings detailed Child B's health, educational and emotional care needs and how these would be managed.

Child B subsequently died due to an illness.

The Ombudsman's review of this case identified good practice related to inter-agency collaboration and care planning for Child B.

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 commenced an own motion investigation into ways that State Government departments and authorities can prevent or reduce child deaths by drowning.

The Office monitors the implementation of recommendations from 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
- *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.

In particular, in 2014-15 the Office undertook significant work on a report on the implementation of recommendations arising from the following two reports:

- *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 Office 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 Ombudsman's 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 DCPFS to support the child death review process and objectives. Regular liaison occurs between the Ombudsman and the Director General of DCPFS, 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 DCPFS'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 2014-15 and during the year, the following members provided a range of expertise:

- Professor Steve Allsop (Director, National Drug Research Institute of Curtin University);
- Ms Jocelyn Jones (Health Sciences, Curtin University);
- 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 DCPFS, 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.

4th Australasian Conference on Child Death Inquiries and Reviews

The Office, together with DCPFS, hosted the 4th Australasian Conference on Child Death Inquiries and Reviews on 6 and 7 November 2014. This year the conference also considered inquiries and reviews of family and domestic violence fatalities.

The conference was officially opened by the Honourable Helen Morton MLC, Minister for Child Protection, and featured opening and closing addresses from the Ombudsman and Emma White, Director General of DCPFS.

This important biennial conference, hosted for the first time in Western Australia, provided a program of national and international leaders in reviews of child deaths, serious injuries to children, and family and domestic violence fatalities.

The conference's theme, 'Achieving Outcomes that Make a Difference', provided delegates with the opportunity to consider a range of topics critical to the success of child death and family and domestic violence fatality reviews. These topics included:

- Challenges and opportunities for enhancing child death review functions;
- Child death review: achieving outcomes that make a difference;

- Leading for learning following a child fatality;
- Creating a culture of learning in safeguarding following a crisis;
- Prevention of youth suicide;
- Child death: the impact of family and domestic violence on Aboriginal women, children and families; and
- Issues and challenges for family and domestic violence fatality review jurisdictions and child protection agencies.

Attendees had the opportunity to participate in discussions about innovations, challenges and future opportunities to strengthen child protection services and child death and family and domestic violence fatality review practices by achieving outcomes that make a difference.

During his opening address, the Ombudsman highlighted the importance of working collaboratively across professional and jurisdictional boundaries to develop expertise in conducting child death reviews and reviews of family and domestic violence fatalities in Australia and New Zealand.

The conference, which received very positive feedback, featured keynote addresses from Professor Donna Chung, Head of the Department of Social Work at Curtin University, and Victoria Hovane, Managing Director of Tjallara Consulting. Former Director General of DCPFS, Terry Murphy, and Jayne Forsdike, from Newcastle Children's Social Care, also gave presentations to delegates. Copies of all presentation slides are available on the Ombudsman's website.

Other key stakeholder relationships

There are a number of public authorities and other bodies 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 organisations; 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 organisations 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, Office staff liaise with Aboriginal community leaders, Aboriginal Health Services, local governments, regional offices of Western Australia Police, DCPFS and community advocates.

Family and Domestic Violence Fatality Review

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

This section sets out the work of the Office in 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 in family and domestic violence fatalities;
- Improvements to public administration to address issues;
- 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 and supported by the *First Action Plan: Building a Strong Foundation 2010-2013* (available at https://www.dss.gov.au/), which established the 'groundwork for the National Plan', and the *Second Action Plan: Moving Ahead 2013-2016* (available at https://www.dss.gov.au/), which builds upon this work.

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 report of the investigation will be tabled in Parliament in 2015 and publically available immediately upon tabling. Additionally, the report of the investigation will be reported upon comprehensively in the Ombudsman Western Australia Annual Report 2015-16.

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; or

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

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

(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;

or

(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

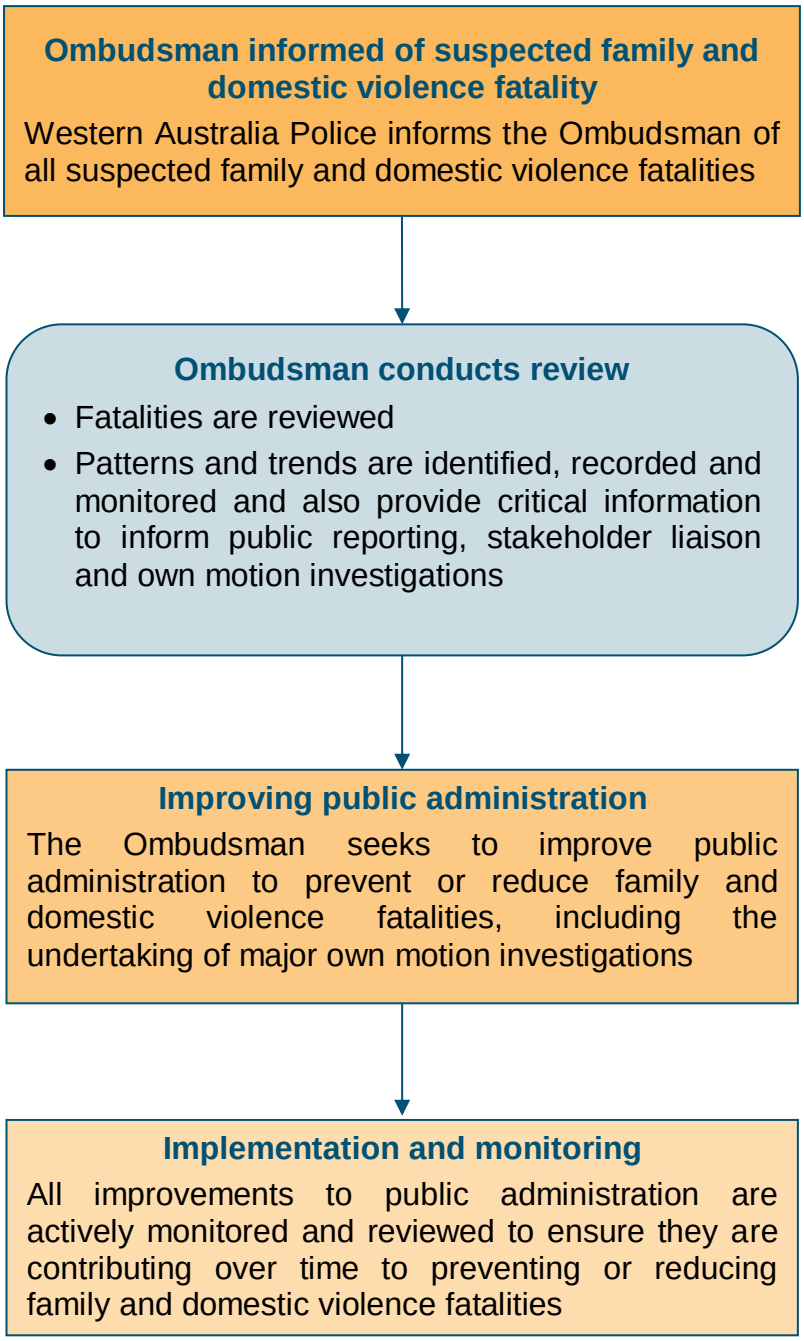
(ii) De facto partner or former de facto partner.

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 2014-15, the number of reviewable family and domestic violence fatalities received was 16, compared to 15 in 2013-14 and 20 in 2012-13.

Patterns and Trends Identified from Family and Domestic Violence Fatality Reviews

Information on interpretation of data

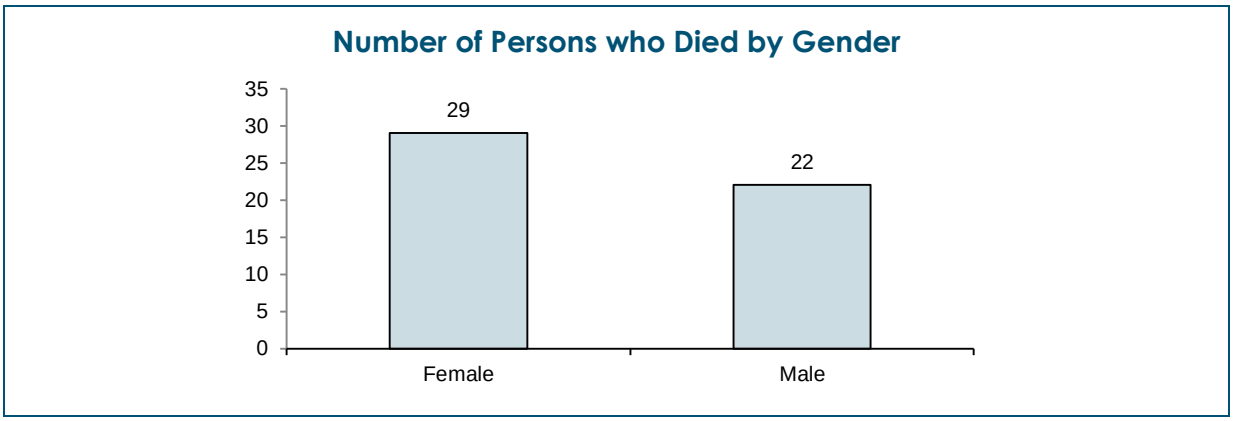
Information in this section is derived from the 51 reviewable family and domestic violence fatalities received from 2012-13 to 2014-15. As the information in the following charts is based on three years of data only, very significant care should be undertaken in interpreting the data. In subsequent reporting years, information will be presented across multiple years and include analysis of underlying patterns and trends.

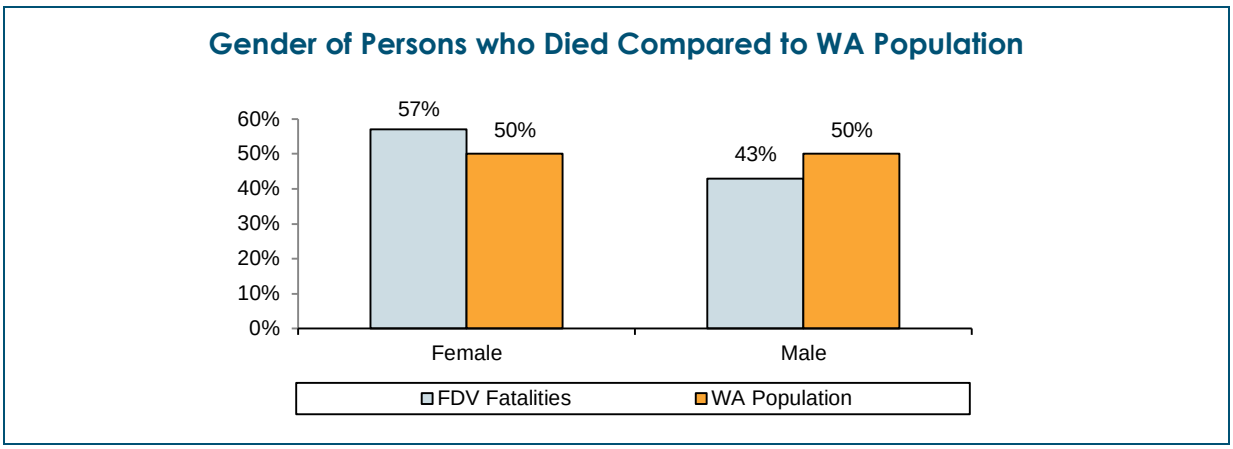
By examining family and domestic violence fatalities, the Ombudsman is able to capture data relating to demographics, risk factors and social and environmental characteristics and identify patterns and trends in relation to these deaths. When family and domestic violence fatality reviews are finalised, 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. They also 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.

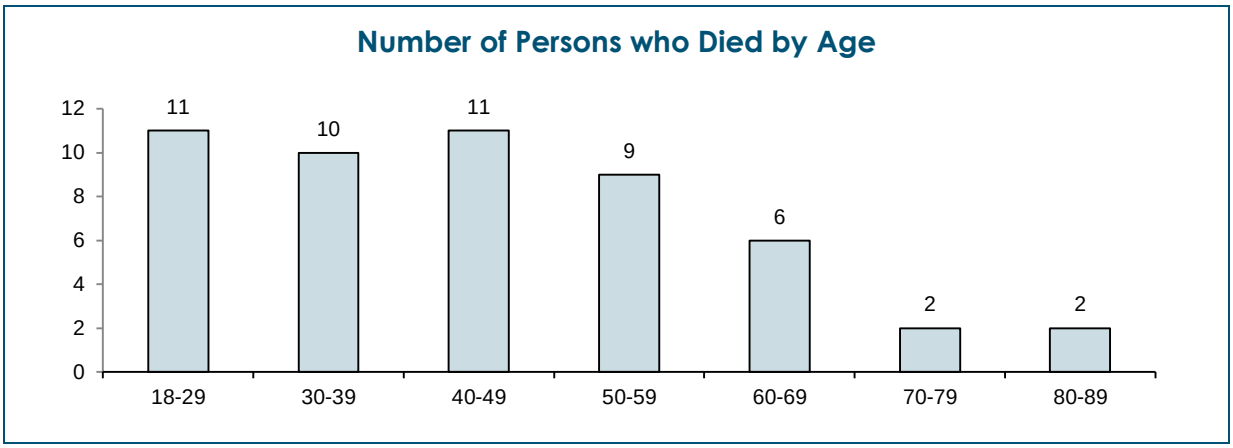
The following charts show characteristics of the persons who died for the 51 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2015. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

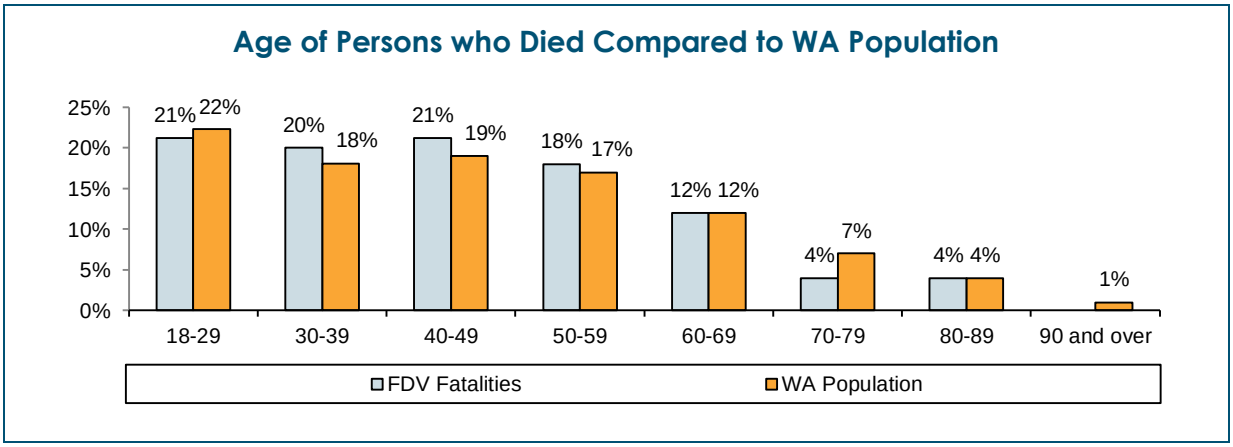


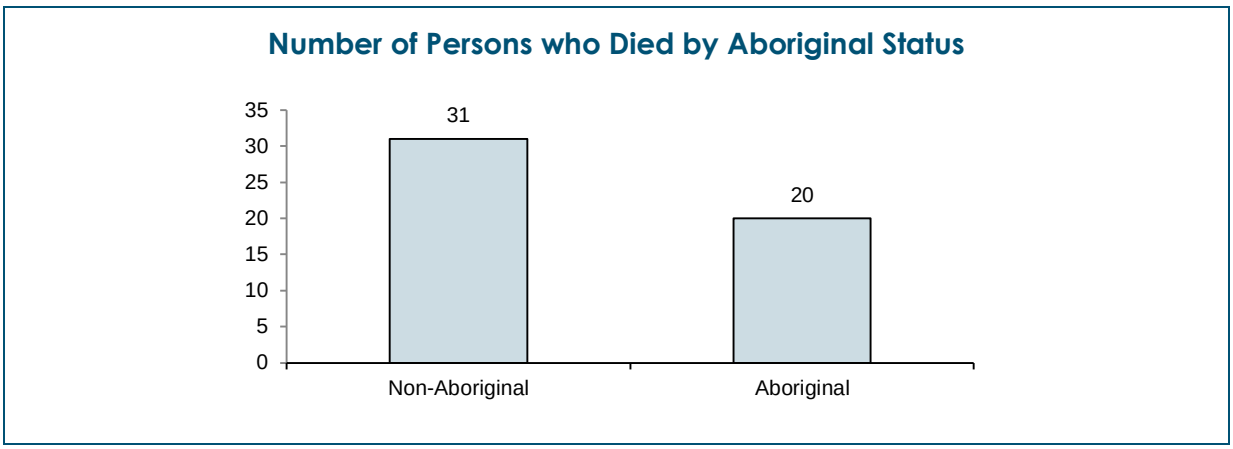


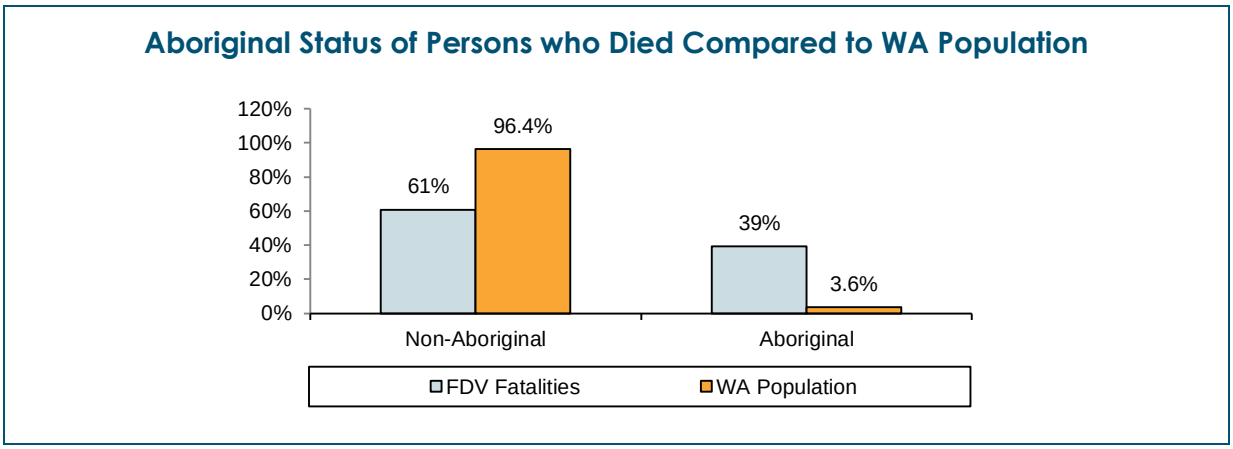
Compared to the Western Australian population, females who died in the three years from 1 July 2012 to 30 June 2015, were over-represented, with 57% of persons who died being female compared to 50% in the population.

In relation to all 29 females who died, the suspected perpetrator is a male. Of the 22 men who died, four were apparent suicides, 11 involved a female suspected perpetrator, and seven involved a male suspected perpetrator.

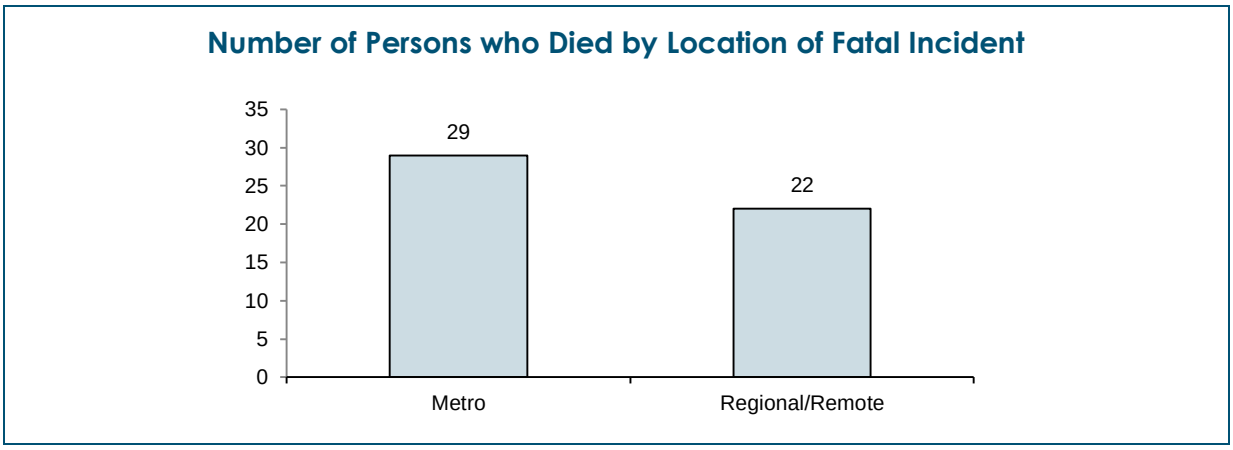


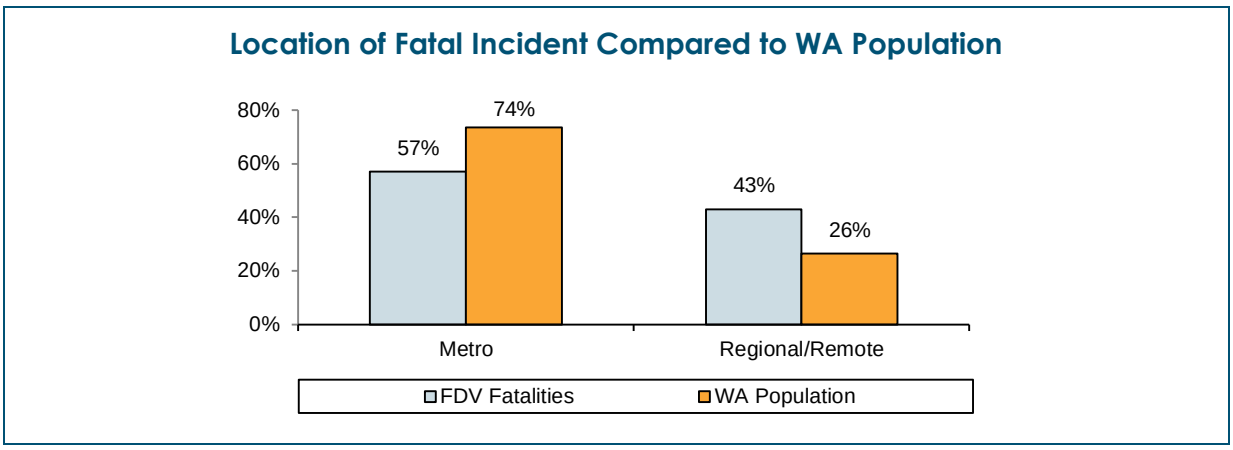






Compared to the Western Australian population, Aboriginal people who died were over-represented, with 39% of people who died in the three years from 1 July 2012 to 30 June 2015 being Aboriginal compared to 3.6% in the population. Of the 20 Aboriginal people who died, 11 were female and 9 were male.





Compared to the Western Australian population, incidents in regional or remote locations were over-represented, with 43% of fatal incidents in the three years from 1 July 2012 to 30 June 2015 occurring in regional or remote locations, compared to 26% 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.*

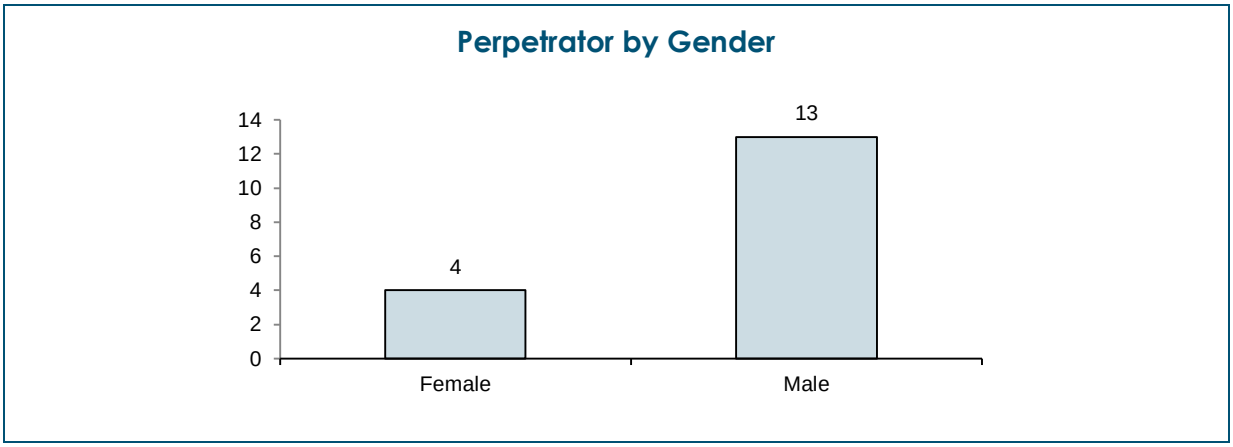
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

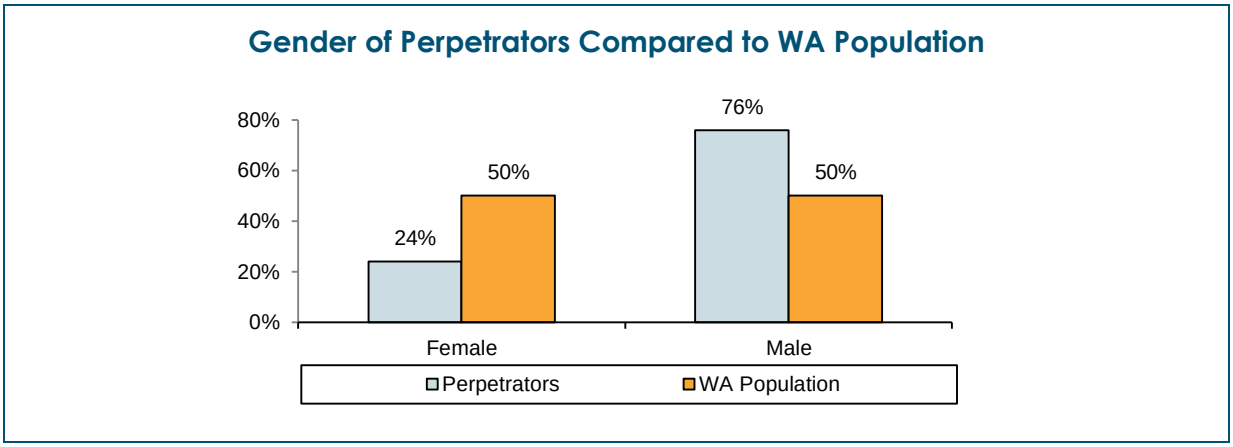
Characteristics of the perpetrators

Information in this section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2015 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2015.

Of the 51 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2015, coronial and criminal proceedings were finalised in 17 cases.

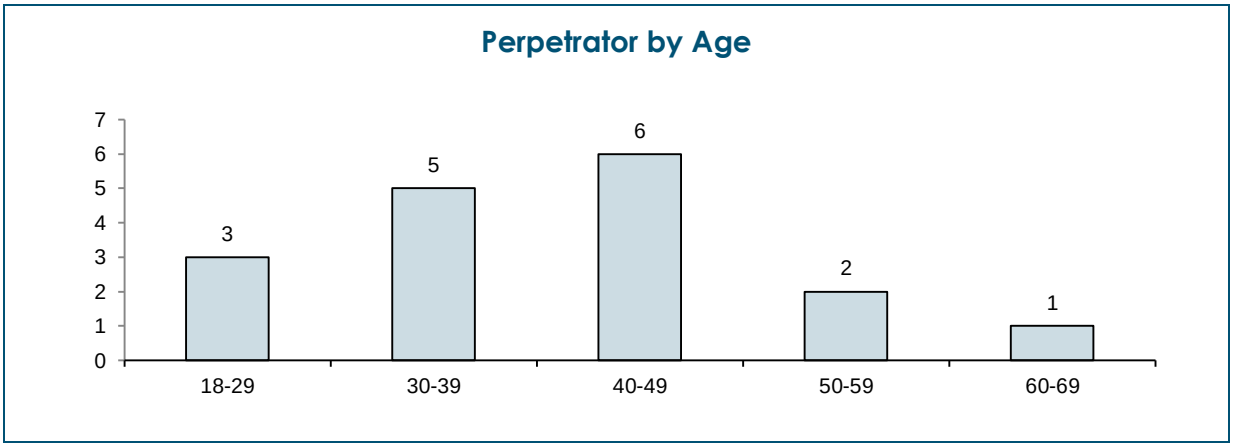
Information is obtained on a range of characteristics of the perpetrator including gender, age group and Aboriginal status. The following charts show characteristics for the 17 perpetrators where both the criminal proceedings and the coronial process have been finalised.

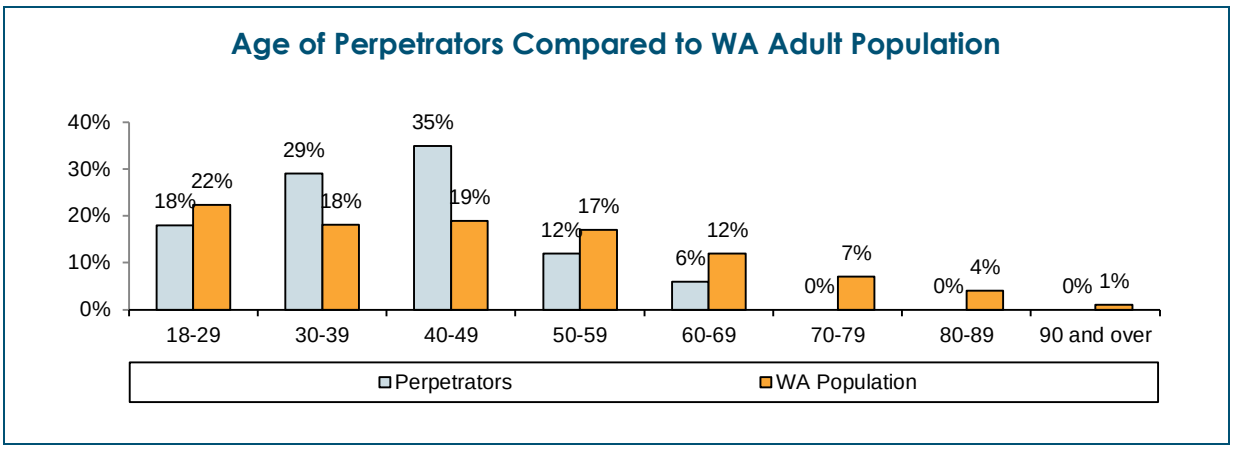




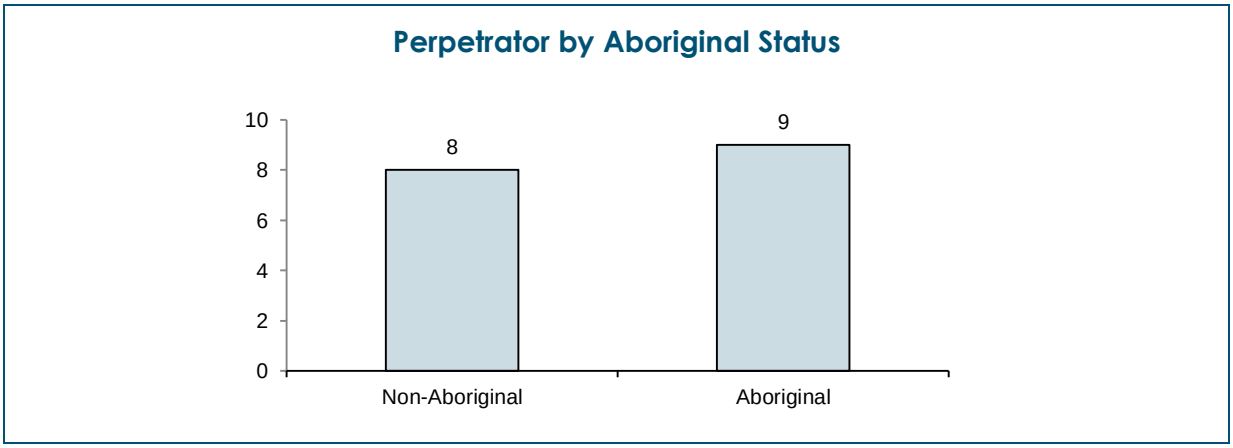
Compared to the Western Australian population, male perpetrators of fatalities in the years from 1 July 2012 to 30 June 2015 were over-represented, with 76% of perpetrators being male compared to 50% in the population.

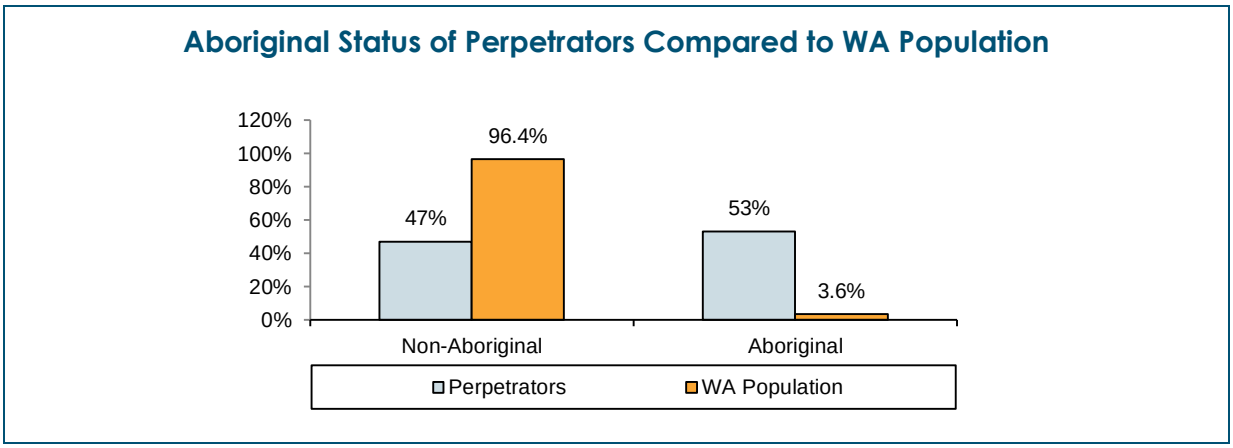
Six males were convicted of manslaughter and seven males were convicted of murder. Three females were convicted of manslaughter and one female was convicted of murder.





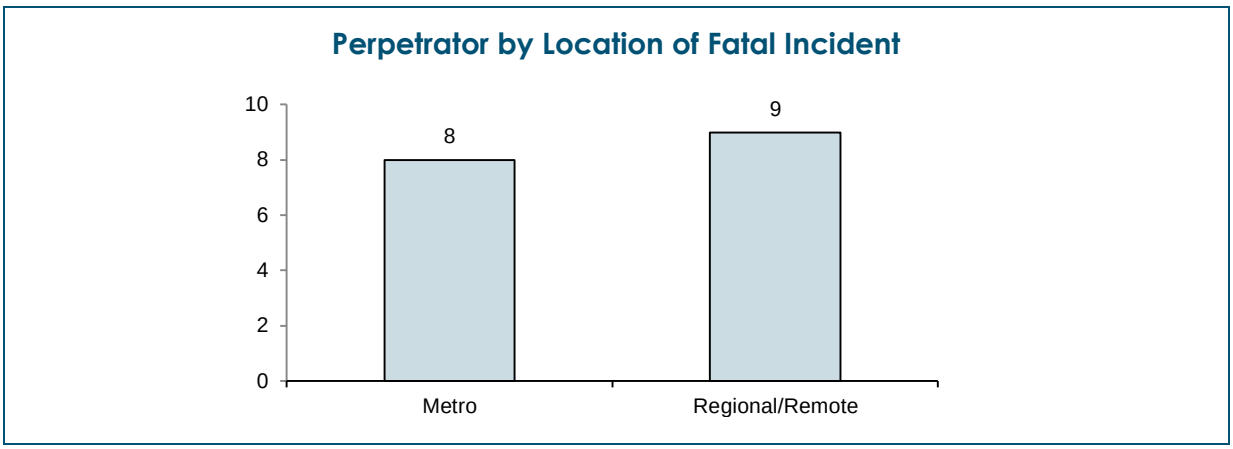
Compared to the Western Australian adult population, perpetrators of fatalities in the three years from 1 July 2012 to 30 June 2015 in the age groups 30-39 and 40-49 were over-represented, with 29% of perpetrators being in the 30-39 age group compared to 18% in the population, and 35% of perpetrators being in the 40-49 age group compared to 19% in the population.

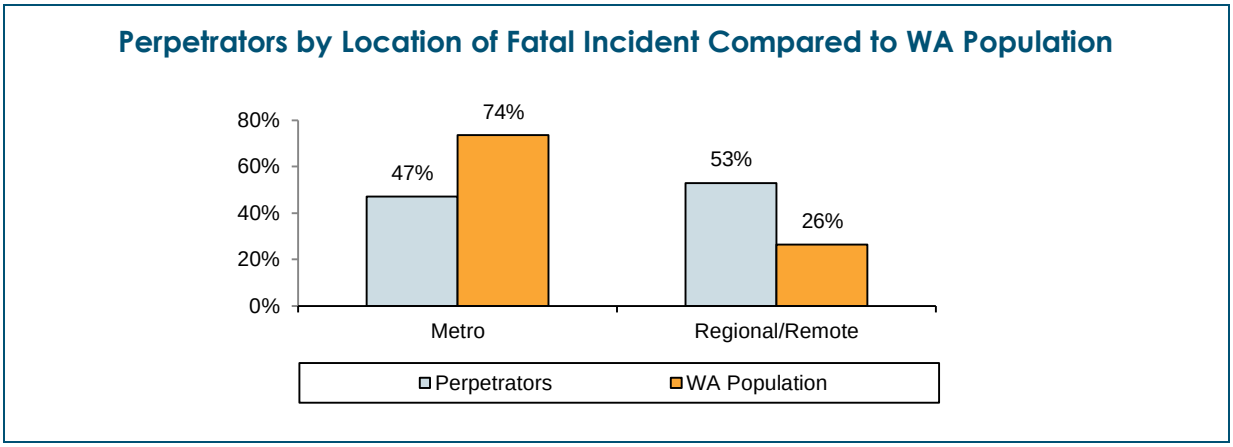




Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the three years from 1 July 2012 to 30 June 2015 were over-represented with 53% of perpetrators being Aboriginal compared to 3.6% in the population.

In eight of the nine cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.





The majority of fatal incidents occured in regional or remote areas.

Compared to the Western Australian population, perpetrators of fatalities that occurred in regional or remote locations in the three years from 1 July 2012 to 30 June 2015 were over-represented, with 53% of perpetrators in regional or remote locations compared to 26% of the population living in those locations.

Circumstances of family and domestic violence fatalities

Information provided to the Office by WAPOL about family and domestic violence fatalities includes 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:

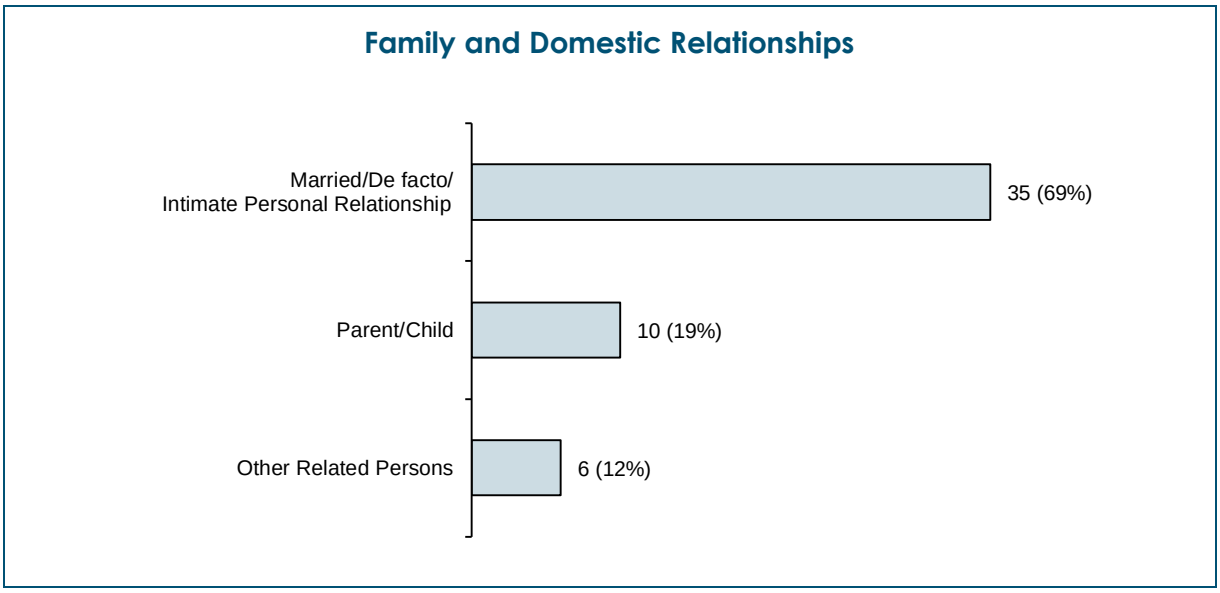
- Alleged homicide, including:
  - Stabbing;
  - Physical assault;
  - Gunshot wound;
  - Asphyxiation/suffocation;
  - Drowning; and
  - Other.

- Apparent suicide, including:
  - Gunshot wound;
  - Overdose of prescription or other drugs;
  - Stabbing;
  - Motor vehicle accident;
  - Hanging;
  - Drowning; and
  - Other.
- 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 2014-15 were alleged homicide by stabbing and physical assault.

Family and domestic relationships

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



Of the 51 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2015:

- 35 fatalities (69%) involved a married, de facto or intimate personal relationship, of which there were 31 alleged homicides and 4 apparent suicides. The 35 fatalities included 8 deaths that occurred in 4 cases of alleged homicide/suicide and, in all 4 cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. Of the remaining 27 alleged homicides, 19 (70%) of the people who died were female and 8 (30%) were male;
- There were 10 people who died (19%) who were either the parent or adult child of the suspected perpetrator. Of these, 4 (40%) were female and 6 (60%) were male. In 6 cases (60%) the person who died was the parent or step-parent and in 4 cases (40%) the person who died was the adult child or step-child; and

- There were 6 people who died (12%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, 2 (33%) were female and 4 (67%) 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 related to family and domestic violence.
- Not adequately informing staff of family and domestic violence policies and procedures.
- Not adequately implementing family and domestic violence policies and procedures.
- Not adequately progressing family and domestic violence investigations in a timely manner.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities for internal communication to enable the location of a victim of family and domestic violence.
- Inaccurate recordkeeping.

Improvements to Public Administration to Address Issues

To address the types of issues identified during the Ombudsman's reviews, the public authorities involved agreed to carry out a range of actions. The following are the types of improvements arising from family and domestic violence fatality reviews.

- Improving awareness of the requirements of family and domestic violence policies and procedures.
- Improving compliance with the requirements of family and domestic violence policies and procedures.
- Improving intra-agency communication to achieve compliance with family and domestic violence policies and procedures.
- Improving recordkeeping practices.

In addition to improvements arising from the review of family and domestic violence fatalities, the Office undertakes major own motion investigations from identified patterns and trends arising from the undertaking of reviews. These major own motion investigations also lead to improvements to public administration to address the issues identified in these major own motion investigations (principally through the making of recommendations to public authorities about ways to prevent or reduce family and domestic violence fatalities).

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 undertaken significant work on 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.

Emerging Themes from Family and Domestic Violence Fatality Reviews

Information on interpretation of emerging themes

Information in this section is derived from the 43 reviewable family and domestic violence fatalities finalised from 2012-13 to 2014-15. As the information in the following section is based on three years of data, care should be undertaken in interpreting the emerging themes.

Type of relationships

The Ombudsman finalised 43 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2015.

For 30 (70%) of the finalised reviews of family and domestic violence fatalities, the fatality 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. For the remaining 13 (30%) of the finalised family and domestic violence fatality reviews, the fatality 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'.

For the 43 finalised reviews, the circumstances of the fatality were as follows:

- For the 30 intimate partner fatalities, 27 were alleged homicide and 3 were apparent suicide; and
- For the 13 non-intimate partner fatalities, all were alleged homicide.

Intimate partner relationships

Of the 27 intimate partner relationship fatalities involving alleged homicide:

- There were 20 fatalities where the person who died was female and the suspected perpetrator was male, and 7 where the person who died was male and the suspected perpetrator was female;
- There were 12 intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In 7 of these fatalities the person who died was female and in 5 the person who died was male;
- There were 15 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 4 at the residence of the person who died or the residence of the suspected perpetrator, 4 at the residence of a family or friends, and 4 at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 14 fatalities that occurred in regional and remote areas, and in 11 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 13 non-intimate partner fatalities, there were eight fatalities involving a parent and adult child and five fatalities where the parties were otherwise related.

Of the 13 non-intimate partner fatalities, all of which involved alleged homicide:

- In the 4 fatalities where the person who died was female, the suspected perpetrator was a male. In the 9 fatalities where the person who died was male, 6 of the suspected perpetrators were male and 3 were female;
- There were 5 non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 4 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 6 at the residence of the person who died or the residence of the suspected perpetrator, and 3 at the residence of family or friends or in a public place; and
- There were 4 fatalities that occurred in regional and remote areas.

Prior reports of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reports of alleged family and domestic violence between the parties. In 18 (67%) of the 27 intimate partner fatalities involving alleged homicide, alleged family and domestic violence 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 (23%) of the 13 non-intimate partner fatalities, alleged family and domestic violence between the parties had been reported to WAPOL or other public authorities.

Cases with no previous reports of family and domestic violence

In nine (33%) of the 27 intimate partner fatalities involving alleged homicide, the fatal incident was the only family and domestic violence between the parties that had been 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.*

Family and domestic violence involving Aboriginal people

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

Of the 43 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2015, Aboriginal Western Australians were over-represented, with 17 persons who died being Aboriginal. In each case, the suspected perpetrator was also Aboriginal. There were 14 of these fatalities that occurred in a regional or remote area of Western Australia, of which 11 were intimate partner fatalities.

Of the 43 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2015, eight (19%) occurred in the Kimberley region compared to 1.6% of people in the Western Australian population living in the region. All of these fatalities involved Aboriginal people as both the person who died and the suspected perpetrator. The over-representation of family and domestic violence fatalities involving Aboriginal people in the Kimberley region, is consistent with the over-representation of family and domestic violence in the Kimberley region reported in the *Second Action Plan: Moving Ahead 2013-2016* (available at https://www.dss.gov.au/). This plan indicates (at page 24) that in regional areas of Western Australia, 'particularly the Kimberley, the rate of reported family and domestic violence per head of population is significantly higher than the metropolitan area'.

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.

Factors co-occurring with family and domestic violence

On the information available, relating to the 40 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2015, the Ombudsman's reviews identify where alcohol use and/or drug use are factors associated with the fatality, and where there may be a history of alcohol use and/or drug use.

	ALCOHOL USE		DRUG USE	
	Associated with fatal event	Prior history	Associated with fatal event	Prior history
Person who died only	1	0	1	4
Suspected perpetrator only	2	8	4	6
Both person who died and suspected perpetrator	14	15	3	5
Total	**17**	**23**	**8**	**15**

The Ombudsman's reviews will continue to identify patterns and trends and consider improvements associated with co-occurring factors in relation to family and domestic violence.

Major own motion investigations

In addition to investigations of individual family and domestic violence fatalities, the Office identifies patterns and trends arising out of reviews to inform major own motion investigations that examine the practice of public authorities that provide services to children, their families and their communities. In 2014-15, the Office undertook significant work on a major own motion investigation into issues associated with Violence Restraining Orders and their relationship with family and domestic violence fatalities.

Other mechanisms to prevent or reduce family and domestic violence fatalities

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

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

fatality review bodies in other States to facilitate consistent approaches and shared learning;

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

Stakeholder Liaison

Efficient and effective liaison has been established with WAPOL to develop and support the implementation of the 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 is an advisory body established 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 2014-15 and during the year the following members provided a range of expertise:

- Professor Steve Allsop (Director, National Drug Research Institute, Curtin University);
- Ms Jocelyn Jones (Health Sciences, Curtin University);
- 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 2014-15, 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.

4th Australasian Conference on Child Death Inquiries and Reviews

The Office, together with DCPFS, hosted the 4th Australasian Conference on Child Death Inquiries and Reviews on 6 and 7 November 2014. This year the conference also considered inquiries and reviews of family and domestic violence fatalities.

The conference was officially opened by the Honourable Helen Morton MLC, Minister for Child Protection, and featured opening and closing addresses from the Ombudsman and Emma White, Director General of DCPFS.

This important biennial conference, hosted for the first time in Western Australia, provided a program of national and international leaders in reviews of child deaths, serious injuries to children, and family and domestic violence fatalities.

The conference's theme, 'Achieving Outcomes that Make a Difference', provided delegates with the opportunity to consider a range of topics critical to the success of child death and family and domestic violence fatality reviews. These topics included:

- Challenges and opportunities for enhancing child death review functions;
- Child death review: achieving outcomes that make a difference;
- Leading for learning following a child fatality;
- Creating a culture of learning in safeguarding following a crisis;
- Prevention of youth suicide;
- Child death: the impact of family and domestic violence on Aboriginal women, children and families; and
- Issues and challenges for family and domestic violence fatality review jurisdictions and child protection agencies.

Attendees had the opportunity to participate in discussions about innovations, challenges and future opportunities to strengthen child protection services and child death and family and domestic violence fatality review practices by achieving outcomes that make a difference.

During his opening address, the Ombudsman highlighted the importance of working collaboratively across professional and jurisdictional boundaries to develop expertise in conducting child death reviews and reviews of family and domestic violence fatalities in Australia and New Zealand.

The conference, which received very positive feedback, featured keynote addresses from Professor Donna Chung, Head of the Department of Social Work at Curtin University, and Victoria Hovane, Managing Director of Tjallara Consulting. Former Director General of DCPFS, Terry Murphy, and Jayne Forsdike, from Newcastle Children's Social Care, also gave presentations to delegates. Copies of all presentation slides are available on the Ombudsman's website.

Other key stakeholder relationships

There are a number of public authorities and other bodies 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, significant work was undertaken during the year on a report in relation to the implementation of Ombudsman recommendations arising from own motion investigations.

Own Motion Investigations in 2014-15

In 2014-15, significant work was undertaken on an own motion investigation, regarding issues associated with Violence Restraining Orders and their relationship with family and domestic violence fatalities.

In 2014-15, the Ombudsman also commenced work on a major own motion investigation into ways to prevent or reduce child deaths by drowning.

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 records

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 and report on the extent of compliance with the legislation.

Infringement Notices

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

Criminal organisations control

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.

2014-15 initiatives:

The ICG met four times in 2014-15.

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. **2014-15 initiatives:** The Office presented on five 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 2015-16.
International Ombudsman Institute	**Background:** The International Ombudsman Institute (**IOI**), established in 1978, is the only global organisation for the cooperation of more than 170 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. **2014-15 initiatives:** The Ombudsman attended the International Ombudsman Institute Executive Committee meeting on 26 October, followed by the International Ombudsman Institute Board meeting on 27-29 October 2014.
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. **2014-15 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. **2014-15 initiatives:** The Ombudsman participated in the ANZOA Annual General Meeting and Executive Committee meeting in November 2014.
Indonesian/ Australian Ombudsman Linkages and Strengthening Program **Members:** Western Australian Ombudsman Commonwealth Ombudsman New South Wales Ombudsman Ombudsman Republik Indonesia	**Background:** The Indonesian/Australian 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. **2014-15 initiatives:** In December 2014, the Ombudsman hosted two staff from the Ombudsman Republik Indonesia for a one week internship. The interns met with senior Ombudsman staff and received training in the Office's complaint handling processes.

Ombudsman co-hosts the 4th Australasian Conference on Child Death Inquiries and Reviews

In November 2014, the Office co-hosted the 4th Australasian Conference on Child Death Inquiries and Reviews with the Department for Child Protection and Family Support. This important biennial conference, hosted for the first time in Western Australia, brought together a diverse range of professionals responsible for conducting reviews of child deaths, serious child injuries and family and domestic violence fatalities.

Further details about the Conference are in the Child Death Review section, and copies of the Conference presentations are available on the Ombudsman's website.

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 and complaint clinics held during regional visits assist them to make their complaint. Other initiatives in 2014-15 include:

- Regular updating and simplification of the Ombudsman's publications and 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 61% to 65% 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 as well as children and young people;
- The Office attends events to raise community awareness of, and access to, its service, such as the Financial Counsellors' Association conference in October 2014, and Homeless Connect in November 2014; and
- The Office's visits to adult prisons and juvenile custodial facilities provide an opportunity for adults and young 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 2014-15:

- The total number of visits to the website has increased by 11% to 80,445 page visits compared to 72,363 page visits in 2013-14.
- The top two most visited pages (besides the homepage and the Contact Us page) on the site were 'The role of the Ombudsman' and 'How to make a complaint'; 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 2014 and February and May 2015.

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2014-15. Two regional visits were conducted, to Kalgoorlie-Boulder in July 2014 and Northam in May 2015, including such activities as:

- 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;
- Meetings with Aboriginal community members to discuss government service delivery and where the Office may be able to assist;
- Training and workshops for regionally-based public authorities;
- Meetings and liaison with community service organisations, to provide information about the Office's services; and
- Meetings with community youth groups and a Youth Council.

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.

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

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.

Ombudsman's speeches and presentations

- Chaired the closing session of the 2014 Australian Institute of Administrative Law National Administrative Law Conference *Innovations in Administrative Law and Decision-Making* in July 2014;
- *The Role of the Ombudsman* to University of Western Australia Administrative Law Students in October 2014;
- Introductory address of the 4th Australasian Conference on Child Death Inquiries and Reviews in November 2014;
- *The Role of the Ombudsman* to Edith Cowan University Administrative Law Students in March 2015;
- *The Role of the Ombudsman in Good Decision Making* to the Legalwise Decision Making Principles and Good Practice Seminar in March 2015; and
- *The Role and Function of the Ombudsman* to the Department of Corrective Services Senior Leadership Team in March 2015.

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

Speeches and presentations by other staff

- Presentations on the Ombudsman's report, *Investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people* to a range of government agencies and non-government organisations – for further details see the Own Motion Investigations and Administrative Improvement section;
- *The Role of the Ombudsman* to the Public Sector Management Program in July 2014;
- *The Role of the Ombudsman* to Curtin University staff in October 2014;
- *Reforming Complaint Resolution – Achieving Improved Timeliness and Effectiveness* to the National Investigation Symposium in Sydney in November 2014;
- *The Role of the Ombudsman* to Prison Superintendents at the Adult Justice Services Senior Managers Meeting in March 2015;
- *Good Decision Making* and *Effective Complaint Handling* to State Government departments and local governments in the Wheatbelt Region in April 2015;
- *The Role and Functions of the Ombudsman* to senior staff at the Department of Education in June 2015; and
- *The Role and Functions of the Ombudsman* to staff at Acacia Prison in June 2015.

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

The Office liaised with a range of other public authorities in 2014-15, including:

- The Department of Corrective Services;
- The Office of the Inspector of Custodial Services;
- The Corruption and Crime Commission;
- The Department of Housing;
- The Department of Transport;
- The Department of Education;
- The Department for Child Protection and Family Support;
- Western Australia Police;
- Various universities; and
- Various local governments.

Liaison relating to reviews and own motion investigations

The Office undertook a range of liaison activities in relation to its reviews of child deaths and family and domestic violence fatalities and 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*, issued in July 2014, is a key publication used by the Office to communicate information to its stakeholders about the Office's performance, achievements, events and resources.

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.


Ombudsman Western Australia

news

Ombudsman tables report in Parliament on investigation into ways that State government departments and authorities can prevent or reduce suicide by young people

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.