Asia Pacific Coroners Society (APCS) Annual Conference

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Speech by Chris Field, Western Australian Ombudsman

Introduction

Can I thank Judge Sara Hinchey for that kind introduction. Can I also thank the State Coroner for inviting me to address you today. My office enjoys an excellent working relationship with the office of the Western Australian Coroner – a relationship not just based on our complementary roles, but one, from our perspective, that reflects the vital work that coroners undertake.

Before I commence, I acknowledge the traditional owners of this land, the Wadjuk Noongar people. As we join here today near the banks of the Swan River, a place of great cultural significance to Wadjuk Noongar people, I pay my respects to elders past, present and future.

During my term as Ombudsman, I have had the great privilege of holding the office of the President of the Australasian and Pacific Ombudsman Region of the International Ombudsman Institute and, more recently, an Executive Member of the World Board of the Institute. In both roles, I have worked closely with colleagues throughout the Asia Pacific region. On behalf of the office of the Western Australian Ombudsman, I warmly welcome conference delegates from the Asia Pacific. The proximity of Australia and its Asian Pacific neighbours is not simply geographic – our cultural, governance and trading bonds are deep and strong, and may I say with admitted parochialism, those bonds have a particular depth and strength for Western Australians.

In my presentation today, I will discuss the role of the office of the Ombudsman in relation to child death reviews and family and domestic violence fatality reviews.

To do so, I will first outline the background to these roles, before moving to provide an overview of these roles. Next, I will examine certain demographic characteristics that can be identified by the undertaking of reviews. I will then consider, arising from reviews, findings that we make regarding the administration of the legislative responsibilities of state government agencies, before exploring the recommendations that we make arising from these findings. I will then consider our role in undertaking major own-motion investigations, prior to considering the relationship of our work with other critical stakeholders, before offering some concluding observations.

Background

Let me commence by providing some background to our review roles. In relation to our role to review child deaths, in November 2001, prompted by the coronial inquest into the death of a 15 year old Aboriginal girl at the Swan Valley Noongar

Community, the (then) Government announced a special inquiry into the response by Government agencies.

The resultant 2002 report recommended that a Child Death Review Team be formed to review the deaths of children in Western Australia.

Responding to the report the (then) Government established the Child Death Review Committee, or 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 Department. Ms Prudence Ford was appointed the independent reviewer and presented her report to the (then) Premier in January 2007.

In considering the need for an independent, inter-agency child death review model, the Ford Review recommended that: "The CDRC together with its current resources be relocated to the Ombudsman" 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".

Subsequently, the Ombudsman's legislation, the *Parliamentary Commissioner Act*, was amended to enable the Ombudsman to undertake child death reviews, and on 30 June 2009, the child death review function in my office commenced operation.

In relation to our role to review family and domestic violence fatalities, the associated *Annual Action Plan* to 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*, identified a range of strategies including a 'capacity to systematically review family and domestic violence deaths and improve the response system as a result'. The *Annual Action Plan* set out 10 key actions to progress the development and implementation of an integrated response, including the need to '[r]esearch models of operation for family and domestic violence fatality review committees to determine an appropriate model for Western Australia'.

Following a 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, my office commenced its family and domestic violence fatality review function.

Overview of Roles

I now want to provide an overview of how these roles work. Put simply, our role is to review the circumstances in which and why child deaths and family and domestic

violence fatalities occur, to identify patterns and trends arising from reviews and to make recommendations about ways to prevent or reduce deaths and fatalities.

To do this in relation to child death reviews, the Department for Child Protection and Family Support receives information from the Coroner on reportable deaths of children and notifies my office of these deaths. The notification provides my office with a copy of the information provided to the Department by the Coroner about the circumstances of the child's death together with a summary outlining the past involvement of the Department with the child.

My office assesses all child death notifications received to determine if the death is, or is not, an investigable death. An investigable death is defined in our legislation, and largely relates to the fact that a child, or a relative of the child, was known to the Department. If the death is an investigable death, it must be reviewed. If the death is a non-investigable death, it can be reviewed (using my powers to investigate any matter of my own motion).

In relation to family and domestic violence fatalities, Western Australia Police informs my office of all family and domestic violence fatalities and provides information about the circumstances of the death together with any relevant information of prior police 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*.
The extent of reviews depends on a number of factors, including the circumstances surrounding the death or fatality and the level of involvement of state government departments and other public authorities.

Ultimately, review processes are intended to identify key learnings that will positively contribute to ways to prevent or reduce deaths and fatalities. Extensive reporting of de-identified information arising from reviews is undertaken by my office, indeed, the reviews chapters are by far the largest sections of our Annual Report.

Reviews do not set out to establish the cause of a death or fatality – this, of course, is the role of the Coroner. Nor do reviews of family and domestic violence fatalities seek to determine whether a suspected perpetrator has committed a criminal offence; this, of course, is only a role for a relevant court. Confidentiality of all parties involved with a review is strictly observed and any document that is sent to, or by, my office in the course of, or for the purposes of, an investigation under the *Parliamentary Commissioner Act* and was prepared specifically for the purposes of the investigation is privileged and is not admissible in evidence in any proceedings (with the exception of proceedings for perjury or any offence under the *Royal Commissions Act)* – effectively akin to a public interest immunity.

Our review methodology includes reviewing individual deaths and fatalities referred to the office, as well as undertaking major investigations of our own-motion, the latter of which, I will return to in detail later. The undertaking of reviews is done as if they are investigations under the *Parliamentary Commissioner Act.* This means that in undertaking reviews we have all the powers of a Standing Royal Commission and the particular powers provided under the Act.

The office operates on the basis of a 'no surprises' approach in all its work, including in its reviews and investigations, affording the opportunities for individual and agency engagement and response otherwise provided for in the *Parliamentary Commissioner Act,* and the rules of procedural fairness more generally.

The office places a strong emphasis on timely reviews. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths and fatalities. In 2015-16, nearly three quarters of all reviews were completed within six months and 80% of family and domestic violence fatality reviews were completed within 12 months.

During 2015-16, there were 41 child deaths subject to review and 22 reviewable family and domestic violence fatalities.

Demographics

Through the undertaking of reviews, demographic information is obtained on a range of characteristics including gender, Aboriginal status, age groups and residence in the metropolitan or regional areas. As I mentioned earlier, this information, properly de-identified, is extensively reported in our Annual Reports. Today, I propose to provide a brief summary of this information.

First, I will discuss information arising from child death reviews. Considering all seven years of data arising from child death reviews undertaken by my office, male children are over-represented compared to the population for all age groups, but particularly for children under the age of one and children aged between six and 12 years. Aboriginal children are also over-represented compared to the population and are more likely than non-Aboriginal children to be under the age of one and living in regional and remote locations.

Children in regional locations are over-represented compared to the child population as a whole, and more so for investigable deaths. Further analysis of the data shows that 83% of Aboriginal children who died were living in regional or remote locations when they died.

The child death notification received by my office 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, as you know, can only be determined by the Coroner. The two main circumstances of death for the 621 child death notifications received in the seven years from 30 June 2009 to 30 June 2016 are: sudden, unexpected deaths of infants, representing 33% of the total child death notifications received and motor vehicle accidents representing 19% of total child death notifications.

Reviews also highlight the impact of certain social or environmental 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 and may be allegations as opposed to proven matters. 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 a public authority. These factors include family and domestic violence identified in 55% of reviews, alcohol use in 37% of reviews, drug or substance use in 33% of reviews, homelessness in 21% of reviews and parental mental health issues in 20% of reviews.

One of the features of deaths reviewed is the co-existence of a number of these social and environmental factors. The following observations can be made: where family and domestic violence was present, alcohol use was a co-existing factor in over half of the cases; drug or substance use was a co-existing factor in nearly half of the cases; homelessness was a co-existing factor in nearly a third of the cases; and parental mental health issues were a co-existing factor in over a quarter of the cases.

Where alcohol use was present: family and domestic violence was a co-existing factor in over three quarters of the cases; drug or substance use was a co-existing factor in over half of the cases; and homelessness was a co-existing factor in over a third of the cases.

In examining the child death notifications by 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.

Of the 621 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2016, there were 228 related to deaths of infants, 125 related to children aged from 1 to 5 years, 69 related to children aged from 6 to 12 years, and 199 related to children aged from 13 to 17 years. Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for males, Aboriginal children and children living in regional or remote locations.

An examination of the patterns and trends of the circumstances of infant deaths showed that of the 228 infant deaths, 204 were categorised as sudden, unexpected deaths of an infant and the majority of these appear to have occurred while the infant had been placed for sleep. For children aged 1 to 5, illness or medical condition is the most common circumstance of death, followed by motor vehicle accidents and drowning. For children in the age group 6 to 12, motor vehicle accidents are the most common circumstance of death, followed by illness or medical condition and drowning.

Suicide is the most common circumstance of death for the age group 13 to 17, followed by motor vehicle accidents and illness or medical condition.

Second, I will discuss information arising from family and domestic violence fatality reviews. In relation to the characteristics of the persons who died for the 73 family and domestic violence fatalities notifications received by the office from 1 July 2012 to 30 June 2016, a number of observations can be made. Compared to the Western Australian population, women who died were over-represented, and in relation to the

41 women who died, 39 involved a male suspected perpetrator. Of the 32 men who died, six were apparent suicides, 15 involved a female suspected perpetrator, nine involved a male suspected perpetrator and two involved multiple suspected perpetrators of both genders.

In its work, the office is quite properly 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.

Of the 73 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2016, coronial and criminal proceedings were finalised in 28 cases. Information is obtained on a range of characteristics of the perpetrator including gender, age group and Aboriginal status.

Compared to the Western Australian population, male perpetrators of fatalities were over-represented, with nine males convicted of manslaughter and 12 males convicted of murder. Compared to the Western Australian population, perpetrators of fatalities in the age groups 30-39 and 40-49 were over-represented, and perpetrators of fatalities that occurred in regional or remote locations were over-represented.

Information provided to the office by police 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, of course, can only be determined by the Coroner. The principal circumstances of death in 2015-16 were alleged homicide by stabbing and physical assault.

The office finalised 58 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2016. For 40 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 other intimate personal relationship. For the remaining 18 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).

Issues and Recommendations

In undertaking reviews, a range of issues with the administration of state government agencies' responsibilities are identified. It is important to note that issues are not identified in every review, and when an issue has been identified, it does not necessarily mean that the issue is related to, or could have prevented, the death of a child or a family and domestic violence fatality. Examples of issues identified include not undertaking sufficient intra and inter-agency communication and collaboration, not adequately meeting policies and procedures, missed opportunities to promote positive interventions, not meeting recordkeeping requirements, not identifying family and domestic violence fatality incidents, not adequately informing staff of practice and policy requirements, not adequately implementing policies and procedures, and not adequately progressing departmental investigations in a timely manner.

In response to the issues identified, my office makes recommendations to prevent or reduce child deaths and family and domestic violence fatalities. In 2015-16, the office made 19 recommendations to prevent or reduce child deaths and eight recommendations to prevent or reduce family and domestic violence fatalities. Additionally, during reviews, public authorities may, and do, voluntarily undertake to make improvements to public administration.

My office actively monitors what steps have been taken to give effect to these recommendations. The results of this monitoring are reported in our annual reports.

Own-motion investigations

As many delegates will be aware, a fundamental role of the Ombudsman is to receive, investigate and resolve complaints. This is largely a reactive role. This is not to say, however, that this role is in any way unimportant. My colleague former Commonwealth Ombudsman, and now Acting New South Wales Ombudsman, Professor John McMillan, has observed that "the right to complain, when securely embedded in a legal system, is surely one of the most significant human rights achievements that we can strive for".

Complaint investigation and resolution also reveals patterns and trends in public administration – systemic issues that may, and do, require further consideration.

And so it is too with the work of reviews. By undertaking reviews we are able to consider whether there is a need to undertake investigations of our volition – often referred to as own-motion investigations. These proactive investigations are undertaken with all of the powers of a Standing Royal Commission and the particular powers of the *Parliamentary Commissioner Act*. The reports produced from these major investigations are tabled in Parliament and include extensive reporting of the reasons why investigations were undertaken, the methodology used in the investigation, a review of the literature considered in undertaking the investigation, the evidence we have gathered, our analysis of the evidence, our findings and our recommendations.

The office has identified a need to undertake four major own-motion investigations since commencing its child death review role.

First, the Ombudsman's examination of reviews of deaths of children aged six to 12 years has identified the critical nature of certain core health and education needs. Where these children are in the CEO's care, inter-agency cooperation between the Department for Child Protection and Family Support, 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.

Accordingly, the office identified a need to undertake an investigation of planning for children in the care of the Chief Executive Officer of the Department – a particularly vulnerable group of children in our community.

This investigation involved the Department for Child Protection and Family Support, the Department of Health and the Department of Education and considered, among

other things, the relevant provisions of the *Children and Community Services Act*, the internal policies of each of these departments along with the recommendations arising from the Ford Review.

The investigation found that in the five years following the introduction of the *Children and Community Services Act*, these three agencies have 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 made 23 recommendations designed to assist with this work to be done, all of which were agreed by the departments.

Second, given the prevalence of sleep related deaths for children under one year of age, the office identified a need to investigate the number of deaths that had occurred after infants had been placed to sleep.

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 to 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 made 23 recommendations about ways to prevent or reduce sleep-related infant deaths, all of which were accepted by the agencies involved.

Third, given that, for children aged 13 to 17 years old, suicide was the most common circumstance of death, accounting for over forty per cent of deaths, and furthermore, Aboriginal children were very significantly over-represented in the number of young people who died by suicide, my 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 investigation found that State government departments and authorities had already undertaken a significant amount of work that aims to prevent and reduce suicide by young people in Western Australia, however, there was more work to be done. The office found that this work includes practical opportunities for individual agencies to enhance their provision of services to young people. Critically, as the reasons for suicide by young people are multi-factorial and cross a range of government agencies, the office found that this work includes the development of a collaborative, inter-agency approach to preventing suicide by young people.

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

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

Suicide by young people is a tragedy. Government agencies, through collaborative policy development and service provision, have a vital role to play in preventing youth suicide. Ultimately, this investigation, and report, is intended to enhance and improve the way that government agencies undertake this vital work.

Fourth, given 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 a major own-motion investigation into ways to prevent or reduce child deaths by drowning. In 2015-16, the office undertook significant work on this major own-motion investigation and the report of the investigation will be tabled in Parliament in 2017.

Arising from my role to review family and domestic violence fatalities, my office identified the need to undertake a major own-motion investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities.

To undertake the investigation, in addition to an extensive literature review and stakeholder engagement, my office collected and analysed a comprehensive set of de-identified state-wide data relevant to family and domestic violence and examined 30 family and domestic violence fatalities notified to my office.

My office found that a range of work had been undertaken by state government departments and authorities to administer their relevant legislative responsibilities, including their responsibilities arising from the *Restraining Orders Act*. My office found, however, that there is important further work that should be done. This work, detailed in the findings of the report, includes a range of important opportunities for improvement for state government departments and authorities, working individually and collectively, across all stages of the VRO process. My office also found that Aboriginal Western Australians are significantly overrepresented as victims of family violence, yet underrepresented in the use of VROs. Following from this, my office identified that a separate strategy, specifically tailored to preventing and reducing Aboriginal family violence, should be developed. This strategy should actively invite and encourage the full involvement of Aboriginal people in its development and be comprehensively informed by Aboriginal culture.

Furthermore, this investigation identified nine key principles for state government departments and authorities to apply when responding to family and domestic violence and in administering the *Restraining Orders Act*. Applying these principles will enable state government departments and authorities to have the greatest impact on preventing and reducing family and domestic violence and related fatalities.

Arising from the findings, the office made 54 recommendations to four government agencies about ways to prevent or reduce family and domestic violence fatalities, all of which were agreed by the agencies.

In all of our work, we do consider the potential for our recommendations to create inappropriate regulatory burden – a burden that is ultimately borne by the taxpayer. In his speech, ‘Law – Complexity and Moral Clarity’, His Honour Chief Justice French described a ‘galloping growth in regulation’ including a ‘growth of less visible soft law’ in the form of administrative guidelines.

It cannot be overstated that, insofar as any oversight agency was to believe that public administration could necessarily be improved in every instance, without regard to cost, opportunity cost or unintended consequence, would be mistaken.

Simply put, designing public administration with perfectly good intentions is easier than implementing those intentions perfectly, as a range of public policies from American prohibition onwards bears testament.
Ombudsman must not just have good intentions when seeking to improve the work of public administrators. They must have a clear series of principles and mechanisms in place that seek to ensure that the investigations they choose, how the investigations are undertaken and the recommendations for improvements that the investigations make, are needed, evidence-based and ensure that the cost of implementing and undertaking the improvement is outweighed by its benefit. These

principles should equally apply to the sort of "soft-law" that can be created by Ombudsman recommendations.

As a matter of some comfort, it has been my experience that Ombudsman offices are very mindful of these issues and have a range of principled and practical mechanisms in place to ensure that their work is needed, procedurally fair, evidence-based, proportionate, cost beneficial and does not suffer from overreach.

It is perhaps in part for these reasons that 100% of the recommendations made by my office have been accepted by agencies over the past decade.

And if a recommendation is worth making, then it must be worth ensuring that it is implemented and its function in achieving improvements monitored and reported. The *Parliamentary Commissioner Act* provides that I may request agencies report to me on the steps that have been taken to give effect to my recommendations; the steps that are proposed to be taken to give effect to the recommendations; or if no such steps have been, or are proposed to be taken, the reasons therefor.

In doing so, we are not only able to assure Parliament that steps have been taken to give effect to recommendations we make, but that we can, through the receiving of reports, meeting with agencies and the undertaking of fieldwork, identify where improvements have been made.

To this end, this month, I will table in Parliament a report on giving effect to the recommendations arising from the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, which will set out the results of my monitoring activities in relation to our major own motion investigation into ways to prevent or reduce family and domestic violence fatalities that was tabled in Parliament 12 months ago.

More generally, and as I have already noted, the monitoring of all recommendations made by my office is taken very seriously and reported on in my annual reports.

Advisory Panel and Consultation

When the office commenced its child death review role, a decision was made to establish a panel of expert advisors to ensure that work of the office could be as informed, evidence-based and contemporary as possible. The Panel was later expanded to include members with expertise in relation to family and domestic violence.

The Panel provides independent advice to the office on issues and trends that fall within the scope of its review roles; contemporary professional practice; and issues that impact on the capacity of public authorities to ensure the safety and wellbeing of children, victims and families. For example, in 2015-16, the Panel provided advice to the Ombudsman regarding our major own-motion investigation in relation to family and domestic violence fatalities.

Panel members are principally drawn from academia and non-government organisations, and a range of government agencies are offered observer status on

the Panel. Last year, observers from Western Australia Police, the Department for Child Protection and Family Support, the Department of Health, the Department of Education, the Department of Corrective Services, the Department of the Attorney General, the Mental Health Commission and the Department of Aboriginal Affairs attended meetings.

The Panel, which met four times in 2015-6, is chaired by my Assistant Ombudsman, Reviews, Natarlie De Cinque, who, along with a number of senior members of my staff, is attending this conference.

In addition to the valued and important work of the Panel, the work of the office in undertaking reviews is informed by extensive liaison and, where appropriate within the Ombudsman's legislation, information sharing with the office of the Coroner, a wide range of relevant state government agencies, accountability and similar agencies such as the office of the Auditor General and Commissioner for Children and Young People; non-government organisations such as the Women's Council for Domestic and Family Violence Services and research institutions, including universities.

Given the over-representation of Aboriginal Western Australians in deaths and fatalities, it is particularly critical that our work is informed by listening to, and working with, Aboriginal people and communities. In that regard, in 2016, my office appointed a Principal Aboriginal Liaison Officer, Alison Gibson and will shortly appoint an Aboriginal Liaison Officer that will report to Alison. The Principal Aboriginal Liaison Officer provides high level advice, assistance and support to the office's Corporate Executive and to staff conducting reviews and investigations of the deaths of children and family and domestic violence fatalities in Western Australia, complaint investigation and resolution involving Aboriginal people as well as own-motion investigations. The position also assists to raise awareness of, and accessibility to, my office for Aboriginal communities and support cross cultural communication between my staff and Aboriginal people. This work builds on the regional awareness and accessibility program that my office commenced in 2007, visiting every region of our vast state, including rural and remote Aboriginal communities, over the last decade.

Conclusion

Since its beginnings in Sweden over 200 years ago, the institution of the Ombudsman has undertaken a significant evolution. Ombudsmen are now woven into the governance fabric of nearly one hundred countries around the world, helping to protect and promote human rights, democracy and the rule of law. Moreover, the Ombudsman is a significant pathway to access to justice. For example, in Australia, Ombudsmen deal with a similar number of complaints to courts and tribunals, and do so in a timely and cost-effective way.

At the same time that the Ombudsman has spread throughout the world, the expansion of the Ombudsman institution has not been one of just scale, but also scope. Ombudsmen now undertake a much wider range of activities than was the case traditionally. To use my office as an example, in addition to the "classical" Ombudsman functions, we undertake inspections of telecommunications intercepts,

investigation of public interest disclosures (more popularly referred to as 'whistleblowers' complaints), investigation of complaints from overseas students, monitoring of the control of criminal organisations, monitoring of criminal code infringement notices and the role of Energy and Water Ombudsman. This expansion of functions can be observed in Ombudsman offices around the world.

But there can be no role more important that Ombudsmen have been asked to undertake than the review of child deaths and family and domestic violence fatalities – it is a role to be undertaken with the utmost of humility and respect and a singular commitment to evidence-based change.

In undertaking our role, I acknowledge the employees of state government departments and authorities, including police officers and child protection workers, as well as non-government organisations, who, on a day to day basis undertake the most challenging of work, to protect children, to strengthen families, to keep victims safe and hold perpetrators accountable.

I also acknowledge, and express my deepest sympathy to, the families and communities who have been affected by child deaths and family and domestic violence fatalities in Western Australia.

The reality for all of us in the room is simple - one death is too many. From my experience, I am completely confident that coroners, ombudsmen and death and fatality review teams are acutely aware of the responsibility they have to examine deaths in our society, and learning from such examinations, make recommendations to prevent and reduce deaths in the future.

To that end, I warmly congratulate our Coroner for organising this conference and providing such a valuable opportunity for us to meet, share our experiences and, ultimately, improve the way that we undertake the important responsibilities that have been given to us.

Thank you.