4th Australasian Conference on Child Death Inquiries and Reviews
6-7 November 2014

Introductory Address by the Ombudsman

Thank you for that introduction Deborah. Can I commence by acknowledging the Whadjuk-Noongar people, the traditional owners of the land on which we gather today. I pay my respects to their Elders, past and present, and the Elders from other communities who may be with us. It is a privilege to be welcomed to Whadjuk-Noongar country, and I thank Ingrid Cumming for so warmly extending that welcome to all of us here today.

As the Western Australian Ombudsman, it gives me great pleasure to welcome you to the 4th Australasian Conference on Child Death Inquiries and Reviews.

I express my sincere appreciation to the Honourable Helen Morton MLC, Minister for Mental Health, Disability Services and Child Protection for officially opening the conference.

I thank Emma White, Director General, Department for Child Protection and Family Support and members of her Executive Team for their productive collaboration with my office in hosting this conference.

Can I also thank my staff team for their very significant work and commitment in co-hosting this conference.

I express my final thanks to our international and interstate delegates and speakers who have travelled long distances to attend this conference. For those of you who are visiting for the first time, I warmly welcome you to our wonderful State, for those of you returning, welcome back.

The institution of the Ombudsman, now over 200 years old internationally, is an officer of the Parliament that works to ensure that Parliament's laws are administered in a way that is lawful, effective and fair. In doing so it has all the powers of a standing Royal Commission and a critical place in promoting and protecting the rule of law and democracy. Despite the significant number and diversity of roles my office undertakes, I can say with certainty that there is no more important function undertaken by my office than the review of child deaths and family and domestic violence fatalities.

My office commenced responsibility for reviewing the deaths of certain Western Australian children on 30 June 2009. In this role, we review the circumstances in which and why child deaths occur, identify patterns and trends in relation to child deaths and, where appropriate, make recommendations to departments and public

authorities about ways to prevent or reduce child deaths.

Since commencing our child death review responsibility, in addition to reviewing individual child deaths, my office has undertaken three major own motion investigations examining sleep-related infant deaths, the care planning provisions of the *Children and Community Services Act 2004* and suicide by young people.

The report of each investigation was tabled in Parliament. Collectively the reports make 68 recommendations about ways in which child deaths can be prevented, all of which have been accepted by government.

Importantly, all recommendations arising from individual child death reviews and own-motion investigations are actively monitored to ensure they are achieving their intended purpose. To this end, my office has commenced an own-motion investigation examining the implementation of the 46 recommendations contained in the first two of our own-motion investigations arising from our child death review responsibility. The report of this investigation will be tabled in Parliament in 2015.

We have also commenced a major own motion investigation examining the drowning deaths of children. Again, the report of this investigation will be tabled in Parliament next year.

My office also undertakes significant public reporting of our child death review responsibility, indeed, it is by some margin the largest section of my Annual Report, reflecting the importance that my office places on this responsibility and our commitment to inform Parliament, interested stakeholders and the public about the performance of our role and the information we have gathered on child deaths in undertaking the role.

Since 1 July 2012, my office has also undertaken the review of family and domestic violence fatalities. In undertaking this responsibility, we are informed by Western Australia Police of all suspected family and domestic violence fatalities. Our review process then identifies the circumstances in which, and why, family and domestic violence fatalities have occurred and patterns and trends that arise from these reviews. Ultimately, and critically, our review process is directed to identifying ways that family and domestic violence fatalities can be prevented or reduced.

Through the review of family and domestic violence fatalities, my office has identified a pattern of cases in which Violence Restraining Orders were in place. For this reason, I decided to commence 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. I expect it to be the first of a series of major investigations we will undertake as part of our responsibility to review family and domestic violence fatalities.

In attending this conference you will be able to share your skills, abilities, knowledge and experience in reviewing child deaths and family and domestic violence fatalities, successfully responding to children at risk of harm, providing children with the most loving, safe and successful environments in which to thrive and ending the violence that so wrongly takes lives in our community. As individuals, as communities and as agencies of the state, we have a shared responsibility, built on a shared understanding, to collectively and cooperatively work to reduce and prevent child deaths and family and domestic violence fatalities. This conference represents a unique opportunity to develop this shared understanding.

The theme of this years' conference, "Achieving Outcomes that Make a Difference", is broad and ambitious, and purposefully so. Over the next two days, the Conference will, in a positive way, challenge us collectively to consider a range of topics critical to the success of child death inquiries and reviews. These topics include:

- Opportunities for multi-agency and cross-border collaboration;
- Emerging themes and challenges in child protection and the prevention of family and domestic violence and the role of reviews in identifying and addressing these themes and challenges; and
- Leading, and learning, in child protection agencies following a child death.

In addition to our highly qualified presenters and panellists, I am very pleased that we have secured two outstanding keynote speakers, Professor Donna Chung, Head of the Department of Social Work at Curtin University, and Victoria Hovane, Independent Director of Australia's National Research Organisation for Women's Safety, who will give addresses to us on the challenges and opportunities for enhancing child death reviews and Family violence in Aboriginal communities and implications for fatality reviews respectively.

More generally, it is my hope that the conference will provide both theoretical and practical opportunities to reflect, discuss and exchange ideas about:

- The purpose and methodology of inquiries and reviews;
- The response to the findings of reviews;
- Ensuring effective recommendations for improvement that arise from the findings of reviews and that those recommendations are also practical, proportionate and cost-beneficial;
- Monitoring the implementation of recommendations; and
- Measuring and assessing the effectiveness of recommendations.

Constructive and considered oversight and accountability of child protection agencies, our health care providers, the police and other relevant bodies is an essential feature of the modern state. I hope that this Conference provides an opportunity to consider how thoughtful reflection and review of child deaths and family and domestic violence fatalities can strengthen our child protection systems and our responses to family and domestic violence.

Although there is no single legislative, organisational or practice model for the undertaking of inquiries and reviews into child deaths or family and domestic violence fatalities, I can say that there is a singular and shared purpose – the prevention of these child deaths and fatalities.

Moreover, the gathering today of such a diverse range of legal, health, coronial, child protection and other professionals provides an obvious reminder that protecting children and preventing family and domestic violence is undertaken as both a multi-disciplinary and multi-agency endeavour. It is a shared responsibility that is made stronger by our shared understanding and enriched by collaboration and cooperation.

The immeasurable loss caused by the death of a child or a fatality arising from family and domestic violence, demands of us the best that we can be, in all that we do. Our work and our shared purpose is that the tragedies of the past may be prevented in the future. In your exploration of this shared purpose over the next two days, I wish you the greatest success.