Ombudsman Western Australia

Preventing harm

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Trauma Warning/Reader Advisory

This report contains descriptions and discussions of child abuse and family and domestic violence, including sexual abuse, neglect and institutional harm. These accounts may be distressing or triggering for some readers, particularly those with lived experience of trauma.

We acknowledge the courage of victim survivors and the profound impact of abuse. If you feel overwhelmed or need support at any point, please consider reaching out to a trusted support service or mental health professional.

If you need support, you can contact one of the following services:

- Lifeline: 13 11 14
- 1800RESPECT (24/7 national sexual assault, domestic and family violence counselling service): 1800 737 732
- Blue Knot Foundation (support for adult survivors of childhood trauma): 1300 657 380
- Beyond Blue: 1300 22 4636
- Kids Helpline (for 5 to 25 year-olds): 1800 55 1800
- 13YARN (for Aboriginal and Torres Strait Islander people): 13 92 76

Child safeguarding - Statement of Commitment

The Ombudsman is committed to promoting and protecting the safety, wellbeing and rights of all children and young people, their families and carers, and all victim survivors of family and domestic violence.

In exercising our functions, we place the safety, rights and best interests of children and families **at the heart of our work**. Our work is conducted with deep respect for the experiences of all children, young people and victim survivors of family and domestic violence. We work in a child-centred, trauma-informed way and seek to strengthen safeguarding practices, improve accountability and drive better outcomes that protect children and families from harm.

We see the children and victim survivors in our work. We see their families, carers, child protection workers, teachers, early childhood professionals, and the many other dedicated professionals who work to ensure they are safe and cared for.

We are equally committed to protecting the privacy and confidentiality of the children and families who may be connected to our work. Consistent with the confidentiality obligations of the *Parliamentary Commissioner Act 1971* (WA), section 28(2), we have taken all reasonable steps to ensure that information in this report does not identify, or enable the identification of, a child or victim survivor.

Child and Family Safety Team

In January 2026, the Child and Family Safety Team (CFST) was formed, combining the following functions:

- Child death reviews
- Family and domestic violence fatality reviews
- Reportable conduct scheme

The team's unique combination of functions enables it to identify patterns, emerging risks and opportunities for system improvement across the child safeguarding landscape.

By examining both individual instances of harm and broader systemic issues, the team contributes to evidence-based reform aimed at preventing future harm and strengthening safeguards for children and families.

Establishment of the Child and Family Safety Team reflects the growing scale and complexity of our child safeguarding functions. The integration of child death reviews, family and domestic violence fatality reviews, reportable conduct scheme and Child Safe Standards implementation has created opportunities for stronger oversight, while also increasing demand for specialist staff and corporate support.

Our team
The CFST come from many sectors of the human services landscape, sharing significant expertise in child safeguarding, policing, community law, reportable conduct oversight, regulatory compliance, administrative investigations and systemic reviews.

Our goals

- **Protect children and young people from harm** by promoting effective administrative practices across Western Australia.
- **Strengthen accountability** by providing independent oversight of organisations and public authorities responsible for the safety, wellbeing and protection of children, young people and victim-survivors of family and domestic violence.
- **Identify and address systemic issues** through child death reviews, family and domestic violence fatality reviews, thematic inquiries and cross-agency analysis.
- **Drive organisational improvement** by promoting sound administrative practice, procedural fairness, effective investigations and child-safe cultures and effective responses to family and domestic violence.
- **Support prevention and early intervention** through education, guidance, stakeholder engagement and capability building.
- **Influence system reform** by providing independent insights and recommendations that improve services. Strengthen system responses to family and domestic violence and reduce the risk of future harm.
- **Promote a connected child safeguarding system** in which families, communities, organisations, government agencies and regulators work together to keep children and families safe.

Reportable Conduct Scheme

Playing our part in Keeping Kids Safe

Our objective is to promote the safety of children, prevent child abuse and ensure organisations respond appropriately to allegations of child abuse. We are responsible for administering the Reportable Conduct Scheme (**Scheme**) in Western Australia. The Scheme covers over 4,000 organisations across the state, including in regional and remote areas. The complex nature of the Scheme means that the capacity of organisations to implement relevant policy and procedures varies enormously.

The Scheme

We provide external oversight of organisations who notify us of 'reportable conduct' (allegations of harm against children and young people by their employees).

The protection of children is the paramount consideration and informs all aspects of our oversight role.

Our approach to oversight

Our oversight role is designed to support and reinforce the implementation of good practices in organisations. Whilst our role includes ensuring organisations meet their legislative requirements, we take a skills-based approach and play an active role in education and outreach for organisations.

Risk-based lens

Our approach to administering the Scheme is grounded in risk-based principles that prioritise proportionality, responsiveness and efficient use of our finite resources. This risk-based lens guides all discretionary decision making within the oversight of the Scheme. This method enables us to target our resources effectively – supporting systemic and cultural change, safeguarding vulnerable children and upholding robust standards of administrative practice.

In administering the Scheme, we

- Assess for compliance and risk in the initial notifications, including by providing guidance on the risk-management responses of an organisation
- Monitor, oversee and review an organisation's investigation into a reportable conduct allegations and where appropriate make recommendations to improve processes and responses
- Notify the Director General of the Department of Communities (Working With Children Screening Unit) of a substantiated finding of reportable conduct.

CASE STUDY

Continuing a reportable conduct investigation when the subject employee is stood down or leaves the organisation

This case study is de-identified and is intended for learning and practice guidance.

Purpose

This case study highlights why an entity should continue a reportable conduct investigation to completion even when immediate workplace risk has been managed by standing down the subject employee, or where the employee later leaves the organisation. The child safety risk may not remain within the original employing organisation. A subject employee may seek child-related work elsewhere, and other organisations may hold information that is relevant to assessing and responding to that risk.

Background

A government organisation received information about a probationary employee in a regulated child-related setting. The concerns included professional boundaries, inappropriate physical contact, non-compliance with a workplace direction, and inappropriate communication and conduct around young people.

The subject employee was directed away from the workplace while the matter was investigated. Further review identified additional concerning conduct. Another government organisation later became aware that the same person had sought child-related work with a provider in the community.

The child the person later sought to provide services to was aware of the person's conduct in the original workplace and voiced concerns about it. Those concerns were treated as relevant risk information and shared to support risk management and the reportable conduct investigation.

The case shows that standing down or ending employment may manage immediate workplace risk, but not broader risk to children. Completing the investigation enabled the conduct, evidence and findings to be considered and shared where appropriate.

Timeline of key events

When	What happened and why it mattered
December 2024	Initial boundary concerns were identified after staff observed physical contact between the subject employee and young people. The subject employee was reminded of expected professional standards.
January 2025	The organisation issued a direction about the use of personal electronic devices and unauthorised items in the workplace.
February 2025	Available footage later reviewed by the organisation captured further inappropriate communication and conduct during interactions with young people.
March 2025	Further concerns were reported after the subject employee allegedly used a personal device and engaged in inappropriate interactions with young people. Available footage and staff reports became key evidence.
April to May 2025	The matter was referred internally for investigation. Ombudsman WA was notified, and the subject employee was formally directed away from the workplace while the investigation progressed.
May to September 2025	The organisation reviewed evidence and provided procedural fairness to the subject employee, including in relation to additional concerns identified from available footage.
July 2025	A separate government organisation became aware the person had sought child-related work in the community involving a child known to the person through another child-related role. The child voiced concerns about the person's conduct, which were treated as relevant risk information.
November 2025	The subject employee's employment with the original organisation ended.
February 2026	The investigation report found the conduct met the threshold for reportable conduct, including sexual misconduct, and that the person was unsuitable to continue in the child-related role. Relevant information was shared with the Working with Children Screening Unit.

Outcome

The investigation did not stop when immediate workplace risk was controlled. The entity continued to assess evidence, consider additional information, provide procedural fairness and determine whether the conduct met the reportable conduct threshold.

That work mattered because the risk was not limited to the original workplace. The person had sought child-related work elsewhere, and completing the investigation helped relevant organisations identify and respond to the broader risk to children, including by sharing relevant information to support child safety decision-making.

Why this matters

Immediate workplace action	Completed investigation	System-wide child safety
Standing the employee down may reduce immediate risk in the original workplace, but it does not resolve the allegation or determine whether reportable conduct occurred.	A completed investigation creates a clear evidence base, supports procedural fairness, and enables defensible findings, actions and information sharing where appropriate.	Appropriate information sharing helps relevant organisations understand and manage risk where a person seeks child-related work elsewhere, including where a child has voiced relevant concerns.

Key learning points

1. Continue the investigation to completion

Do not close or downscale a reportable conduct investigation only because the subject employee has been stood down, resigned, been dismissed, or otherwise left the organisation. The investigation should still determine what occurred, whether the conduct is reportable conduct, and what action is reasonably required.

2. Think beyond your own organisation

Risk to children can continue outside the original workplace. A person who is stood down or leaves may seek child-related work with another organisation.

3. Record and assess all relevant information

Initial boundary concerns, later incidents, available footage, staff reports and disclosures from young people may need to be considered together. Earlier concerns should not be viewed in isolation when later information suggests a pattern of boundary breaches or escalating conduct.

4. Share information where appropriate

Information sharing between government organisations can be critical where it supports child safety and risk management. A child's concerns should be given appropriate weight where they indicate possible risk.

Information sharing provisions under the Act

The Act includes provisions that support relevant information sharing where appropriate. For example, section 30AA, Protection from liability for giving information: reportable conduct scheme, applies where a person acts in good faith and gives a report, notification or information to the Ombudsman, the head of a relevant entity, or an investigator for the purposes of the Reportable Conduct Scheme.

In practice, this supports entities and government organisations to share relevant information for child safety and risk management, while still considering whether the information sharing is appropriate, necessary and connected to the reportable conduct process.

5. Maintain procedural fairness

Continuing the investigation also protects fairness. The subject employee should be given a meaningful opportunity to respond to the relevant allegations and proposed findings before final decisions are made.

6. Make the outcome useful for future risk management

A completed investigation provides a clear record of the evidence, findings and rationale. This can assist future decision-making by the entity and, where appropriate, other organisations responsible for child safety, including the Working with Children Screening Unit.

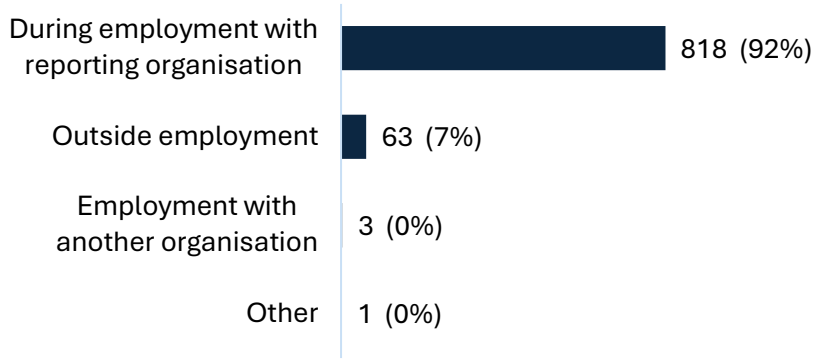
Practical message

The end of employment is not necessarily the end of risk. A reportable conduct investigation should continue to a clear and defensible outcome so child safety risks can be understood, recorded and shared where appropriate.

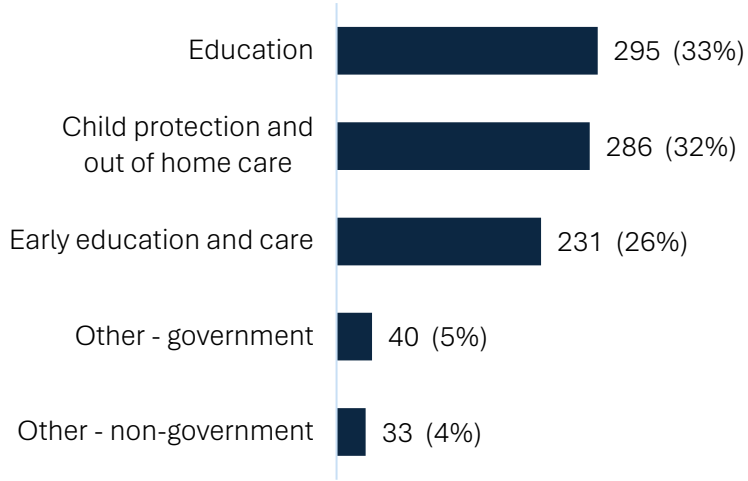
Notification data

The following data relates to the 885 notifications that were received in 2025-26 and considered within our jurisdiction.

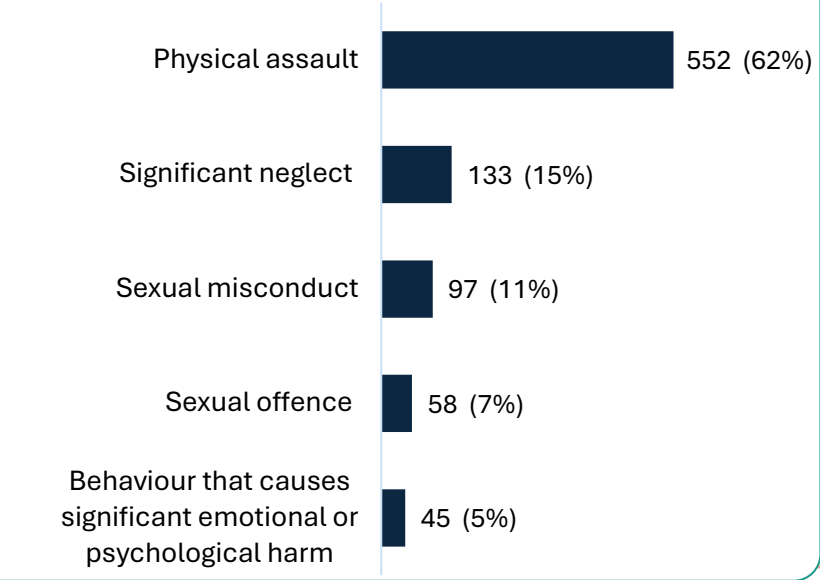
Place of conduct



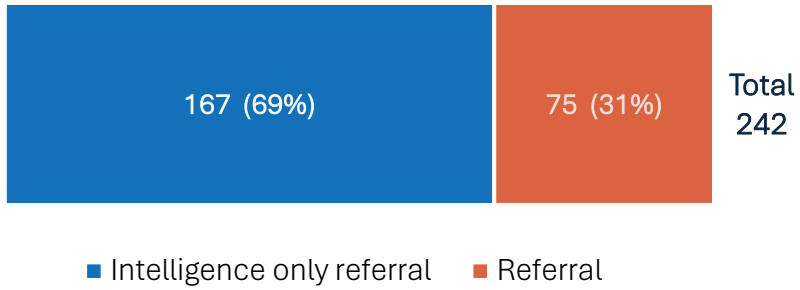
Sector



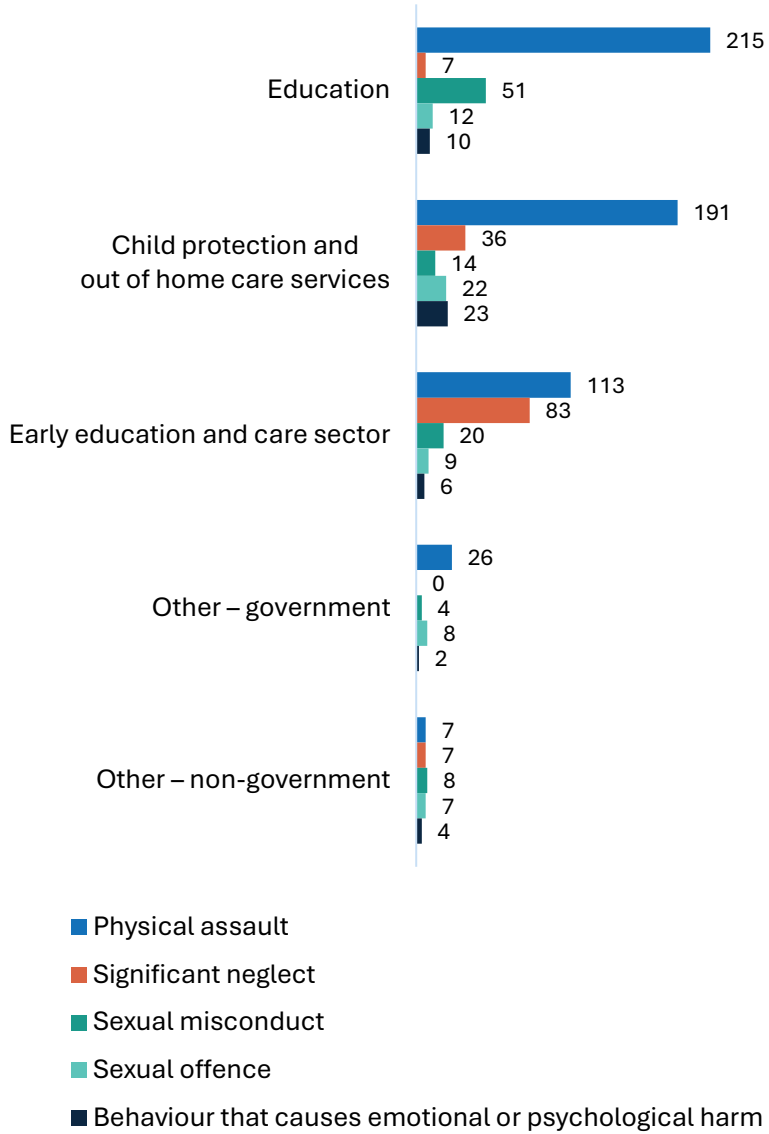
Conduct types



Working with Children Check Screening Unit Referrals

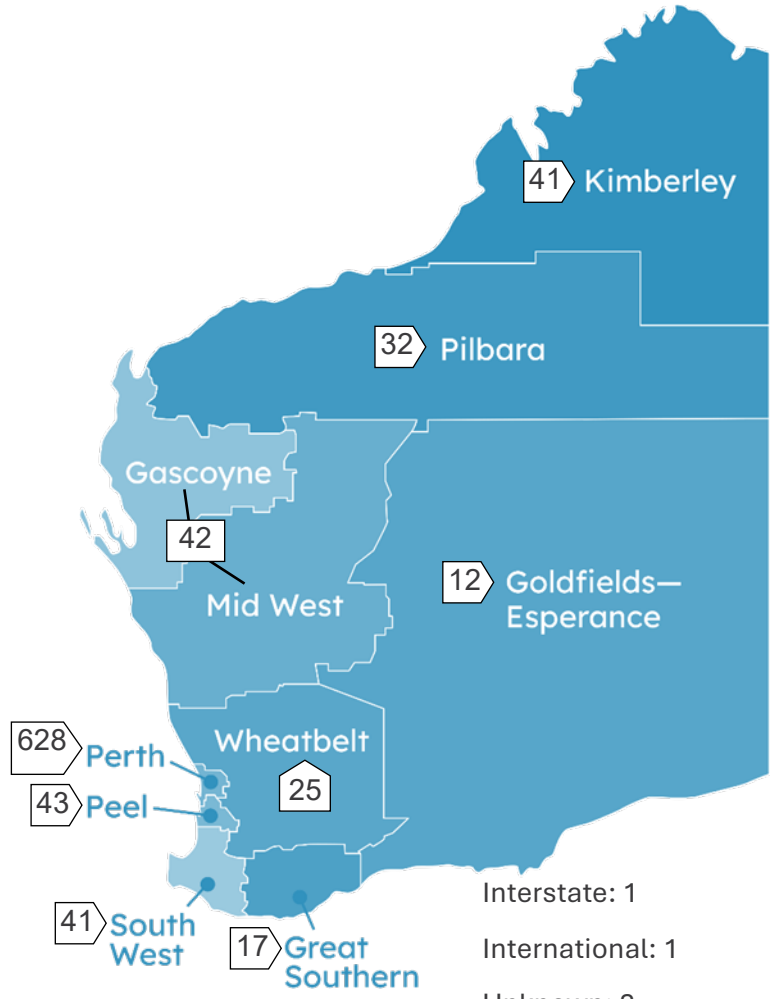


Sector and Conduct Types



Region of conduct

Number of notifications received by region.



Interstate: 1

International: 1

Unknown: 2

Education and outreach snapshot

We play a role in educating and providing advice to organisations, including by supporting them to make continuous improvement in the identification and prevention of reportable conduct.

We also play a part in guiding organisation as they build robust internal reporting mechanisms and policies that support a culture of child safety.

Over 4,000 organisations fall within the jurisdiction of the Scheme, and many of these organisations operate in remote and regional areas. Our education and outreach program has extended across the State, reaching communities from Kununurra and Warmun in the East Kimberley to Bunbury and Margaret River in the South West.

In 2025-26, our outreach events and engagements have been a combination of face-to-face workshops, online webinars, direct organisation contacts via phone or in person and information sessions for a sector or individual organisation. We have been listening to feedback from outreach event participants, and from organisations in regional areas. In the 2026-27 year we look forward to expanding and improving our outreach efforts by engaging further with sector peak bodies, regional communities and Aboriginal Community Controlled Organisations, as well as reviewing the types and accessibility of our online resources.

Image: We presented a ‘Strengthening Child Safety within Organisations’ Lunch & Learn event in Bunbury in November 2025, along with the WA Council of Social Services’ Child Safe Project.

Systems wide changes

We not only assess the responses of organisations to individual allegations of reportable conduct but also examine the broader systems and policies of an organisation for reporting, responding and preventing child abuse. The review of these systems may result in administrative improvements, which we then record and monitor. This is a powerful part of the Reportable Conduct Scheme as it enshrines cultural change within organisations, and ensures robust policies and reporting, which provides the best possible environment for child safety.

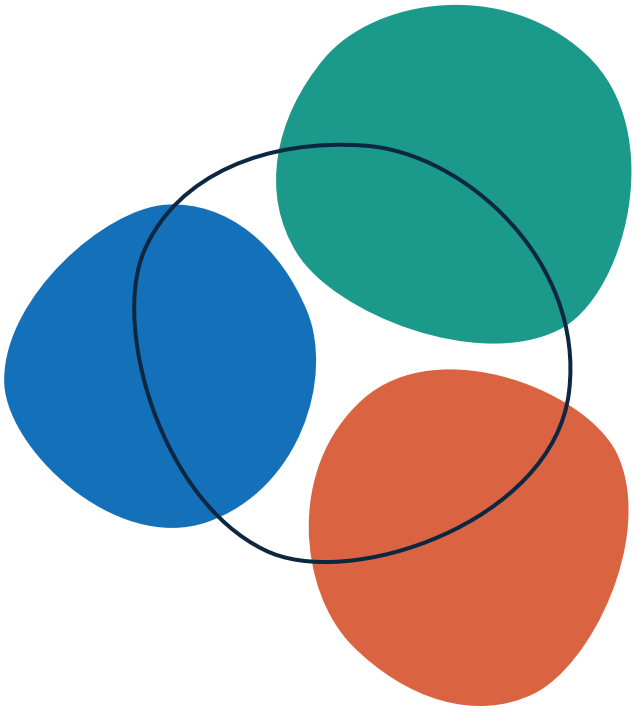
In 2025-26, there were 158 improvement actions made by organisations as a result of our involvement.

Tailored Training

On 4 December 2025, we delivered reportable conduct training to Youth Justice Officers undertaking foundation training at the Department of Justice's Corrective Services Academy. The workshop provided participants with practical guidance on recognising reportable conduct, understanding their reporting obligations, and responding appropriately to concerns involving children and young people.

Through interactive discussions and scenario-based activities tailored to youth justice settings, participants explored how the Scheme supports accountability, transparency and child safety. The training strengthened awareness of the Reportable Conduct Scheme amongst emerging youth justice officers and supported capability building across the sector.

The workshop formed part of our ongoing education and outreach activities aimed at promoting child safe organisational cultures and effective responses to concerns involving children and young people.



CASE STUDY

Responding to sexual misconduct, boundary testing and misuse of trust

Purpose

This case study highlights how a reportable conduct investigation can strengthen child safeguarding outcomes when allegations are thoroughly investigated, findings are evidence-based, and relevant information is shared with child safety agencies. It demonstrates the importance of maintaining professional boundaries, assessing conduct in context, and ensuring risk information is available to support child safety decisions beyond the original organisation.

Background

A regulated child-related organisation delivering youth development and outdoor leadership programs received allegations concerning a contractor paramedic engaged to support young people during an overseas leadership trek. Concerns were raised about the contractor's interactions with a 16-year-old participant, including being alone with the child while applying cream to an intimate area, physical contact during the trek, inappropriate boundary issues, conversations involving sexual matters and drugs, and the administration of prescription medication. Following notification, the matter was reported to the Ombudsman and an independent investigation was commenced.

Timeline of key events

When	What happened and why it mattered
During the trek	Concerns arose regarding the contractor's interactions with a 16-year-old participant, including physical contact, treatment provided in a private setting and other boundary-related behaviours.
Following the trek	Information was provided by staff and the child's parent raising concerns about grooming, inappropriate conduct, sexualised behaviour and the administration of prescription medication. Incident and safeguarding reports were submitted.
April 2025	The organisation assessed the concerns and notified the Ombudsman under the Reportable Conduct Scheme.
May 2025	An independent workplace investigation was commissioned.
June to July 2025	Witnesses were interviewed, documents were reviewed and procedural fairness was provided to the contractor. Police and other relevant parties were consulted.
October 2025	The investigation concluded. Three allegations of sexual misconduct were substantiated and two allegations were not substantiated.

Following the findings	The findings were reported to the Ombudsman. Information was then shared with Working with Children screening authorities to support child safety decision-making.

Outcome

The investigation found that three allegations of sexual misconduct were substantiated on the balance of probabilities. The substantiated conduct involved entering a tent alone with a 16-year-old participant and applying cream to an intimate area; walking alongside the child during the trek with an arm around the child's waist; and allowing an overly familiar physical interaction with the child while sitting together at a river location during the trek.

The investigator concluded that the contractor had crossed professional boundaries and engaged in conduct that was overly intimate and inconsistent with child safe expectations. The conduct was found to constitute reportable conduct relating to sexual misconduct.

Although the conduct occurred overseas, the matter was captured by Western Australia's Reportable Conduct Scheme because it involved a person engaged by a relevant child-related organisation. Following the substantiated findings, a referral was made to the Working with Children Screening Unit. A Working with Children Check authority in another jurisdiction later sought information to assist in reassessing the person's continued suitability to hold a Working with Children Check clearance. This enabled appropriate information sharing with relevant child safe bodies in Australia and allowed risk information to be considered beyond the original organisation.

Why this matters

Oversight role	Investigation quality	System-wide safeguarding
Ombudsman oversight supported a thorough assessment of the allegations and ensured the matter was investigated under the requirements of the Reportable Conduct Scheme.	The investigation assessed witness evidence, organisational policies, safeguarding standards and procedural fairness requirements before findings were made.	The completed investigation enabled information sharing with screening authorities, supporting broader child safety risk assessment and future decision-making about child-related work.

Key learning points

1. Professional boundaries must be maintained

Employees, volunteers and contractors who work with children must maintain clear professional boundaries. Conduct may constitute reportable conduct where interactions become overly intimate, inappropriate or inconsistent with child safe expectations, even where criminal conduct is not established.

2. Avoid situations where adults are alone with children

Organisational safeguarding standards commonly require adults to avoid being alone with children where interactions cannot be observed by others. Transparent practices help protect children and reduce safeguarding risks.

3. Assess conduct in context

A single incident should not always be viewed in isolation. The child's age, vulnerability, the adult's position of authority and the nature of the relationship are relevant when assessing whether conduct crosses professional boundaries.

4. Procedural fairness remains essential

Procedural fairness means giving a person a fair opportunity to know and respond to allegations before findings are made. In this matter, the contractor was informed of the allegations, interviewed and given an opportunity to respond to proposed adverse findings.

5. Information sharing supports child safety

The Scheme can capture relevant conduct even where it occurs outside Western Australia, where the required connection to a regulated child-related organisation exists. This enables appropriate information sharing with relevant child safe bodies in Australia to support broader child safety decision-making.

6. Investigations can drive system improvement

The organisation identified opportunities to strengthen safeguarding practices, including enhanced staff training, clearer contractor obligations, and improved supervision and oversight arrangements for future youth programs.

Practical message

Sexual misconduct may be preceded or accompanied by grooming-type behaviours, including boundary testing, overly familiar contact, secrecy, private interactions, or conduct that isolates a child from safeguards. These behaviours may also be tested in public or in the presence of other adults.

Adults may use a position of trust, professional role or access to a child to normalise inappropriate or exploitative conduct. Clear expectations, active supervision, timely escalation and evidence-based investigations help protect children and strengthen safeguarding practice.

Reviews of certain deaths

The following section discusses our work in reviewing the deaths of children, and deaths that occur in the context of family and domestic violence.

We honour all lives lost and recognise the profound impact of these deaths on families, friends and communities. Their experiences continue to inform and guide our work.

What our death reviews are about

We review certain deaths in Western Australia to identify opportunities to improve the systems and services that support vulnerable children and families.

Through our reviews, the Ombudsman may make recommendations to public authorities to strengthen policies, practices and service delivery. We monitor the implementation of these recommendations, and whether they lead to meaningful improvements.

Our aim is to support earlier, more effective responses that help keep children and families safe, so that preventable deaths can be avoided.

How we work

When we receive a notification of a death, we gather and assess information about the circumstances of the death, the person's interactions with public authorities, and any broader factors that may have contributed to the events leading up to their death. We also collect demographic and contextual information to support analysis, identify trends and inform future review work.

We assess each notification to determine whether a review is warranted and whether there are opportunities to identify lessons that could strengthen services, improve practice or support better outcomes. We consider factors such as:

- the circumstances of the death and the potential system learning
- whether the person who died, or their family, had existing vulnerabilities and contact with public authorities
- whether the death is being reviewed through other review processes (e.g. Courts or medical review), and what that review could cover
- whether the death may have been preventable, and whether there are opportunities to learn from the death and support system change.

Where we undertake a review, we examine the events leading up to the death to understand how public authorities responded and whether there were opportunities to strengthen practice and prevent future harm. We consider the effectiveness of service responses, coordination between agencies, and whether systems operated as intended.

We also analyse patterns across reviews to identify recurring themes, systemic issues and emerging risks that may inform broader investigations or thematic work.

We work closely with agencies throughout the review process to test and verify our findings. Our focus is on learning and system improvement, not individual blame. We take great care to protect confidentiality and report publicly on de-identified findings, themes and recommendations.

Notification of WA child deaths

We receive notification of all deaths of children and young people, up to 18 years of age, in Western Australia. In 2025-26, we were notified of the deaths of 127 children and young people in Western Australia.

We identify if there have been concerns for the safety and wellbeing of the child who died, or a child relative, reported to the Department of Communities in the two years before the death occurred. Or, whether they had been in the care of the Department of Communities.

81 child death reviews were completed in 2025-26

In 2025-26, 45 children (or their child relative) had contact with the Department of Communities for child protection reasons in the two years prior to the death.

Year	Contact	No contact	Total
2021-22	47	115	162
2022-23	63	101	164
2023-24	47	106	153
2024-25	56	105	161
2025-26	45	82	127

Table 1. Number of child deaths notified in the last five years

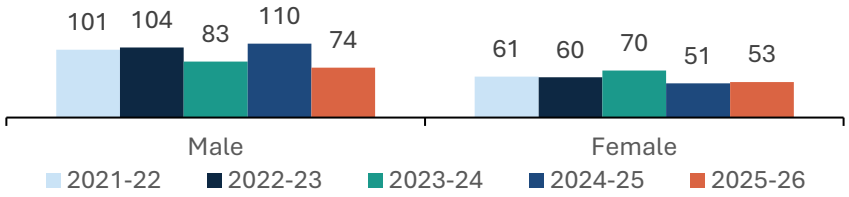
The second column indicates the number of cases where the child or family had contact with the Department of Communities within 2 years of the death

The third column indicates the number of cases where the child or family had no contact with the Department of Communities within 2 years of the death

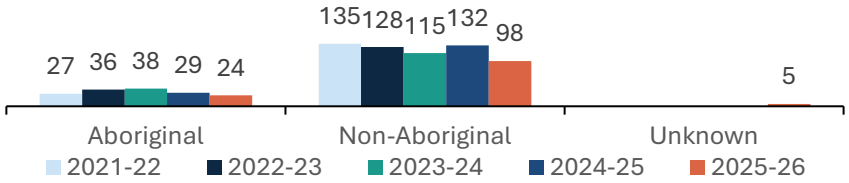
Characteristics of children who died

The charts on this page show the characteristics of the child deaths notified to us in 2025-26. This information is based on the date notified to us, not the date of death. Data may change in future reports as more information becomes available.

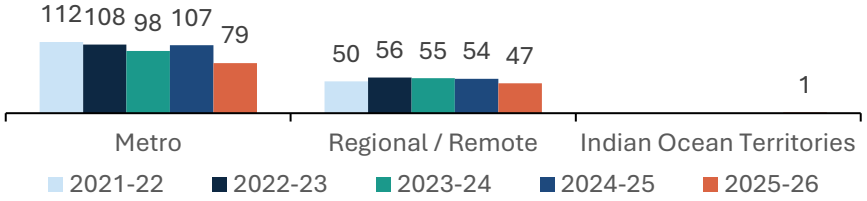
Death notification by sex



Child death notifications by Aboriginal[1] status

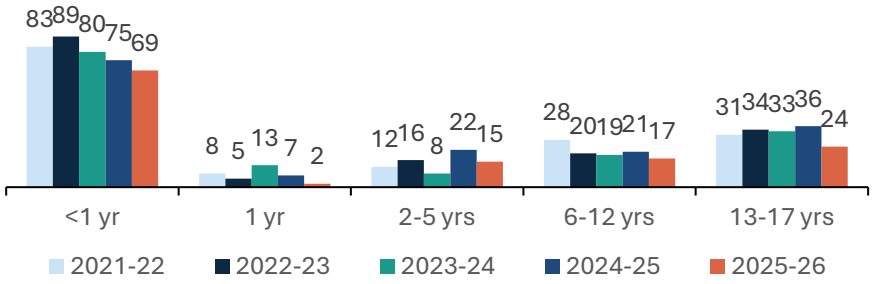


Child death notifications by location



[1] The use of 'Aboriginal' in this chart includes children who are Torres Strait Islander and children who are both Aboriginal and Torres Strait Islander.

Child death notifications by age



	2021-22	2022-23	2023-24	2024-25	2025-26
Illness or medical condition	116	103	98	97	75
Sudden, unexpected death of an infant	7	22	16	20	17
Motor vehicle accident	15	8	13	16	13
Suicide	9	13	11	14	7
Accident other than motor vehicle	5	7	5	3	0
Drowning	5	4	6	4	6
Alleged homicide	5	6	2	0	5
Other	0	1	2	7	4
Total	**162**	**164**	**153**	**161**	**127**

Table 2. Circumstances of child deaths in the last five years

Notification of family and domestic violence fatalities

We receive notifications of all suspected family and domestic violence homicides in Western Australia. This may include:

- where a person is killed by a current or former intimate partner
- where a person is killed by another family member (including Aboriginal kinship relationships) or someone with which they reside
- where there is no intimate or familial relationship, but the death occurs in the context of family and domestic violence, such as where a bystander is killed intervening in a family and domestic violence incident.

Our family and domestic violence fatality reviews include all people who died aged 18 years or older. If a child dies in the context of family and domestic violence, the death is considered through our child death review process.

In 2025-26, we were notified of 12 suspected family and domestic violence homicides. Seven involved suspected intimate partner homicide and five involved a familial relationship.

We completed 30 family and domestic violence fatality reviews.

Year	Suspected intimate partner homicide	Suspected non-intimate familial homicide	In FDV context	Total notified deaths
2021-22	4	2	-	6
2022-23	10	2	1	14
2023-24	11	10	2	23
2024-25	9	5	-	14
2025-26	8	4	-	12

Table 3. Number of FDV deaths notified in the last 5 years

Major themes and learnings

Across both child death and family and domestic violence fatality reviews, common themes and learnings include:

- Barriers to compliance with agency policy and practice requirements, including workforce pressures, gaps in supervision and oversight, and missed opportunities for earlier intervention.
- The need for improved risk assessment and safety planning for vulnerable people.
- The need to strengthen child-centred practice by recognising children as victims in their own right and responding to their safety and wellbeing needs.
- Missed opportunities for information sharing, and coordination responses between agencies.
- The overrepresentation of Aboriginal people in deaths and the need for improvement in culturally responsive and safe interventions.
- The role of alcohol and other drug use and mental health issues in preventable deaths, and the need for specialist expertise and integrated service pathways.
- The overrepresentation of deaths in regional WA, and the need for improved equity in service delivery across the State.

Our reviews highlight the value of strong frontline services, supported by clear policies and effective oversight mechanisms.

Our achievements

In 2025-26 we made three recommendations to agencies to improve how they support vulnerable children and to prevent or reduce the risk of future deaths in similar circumstances.

Investigation Report

On 19 March 2026 we tabled ‘A Review of Family and Domestic Violence in Western Australia’ capturing our family and domestic violence death review work alongside a thorough point-in-time investigation of the performance of Family and Domestic Violence Response Teams (FDVRT).

We made nine recommendations to the Department of Communities and the Western Australia Police Force focused on:

- strengthening governance and oversight of the FDVRT
- improving risk assessment and data systems
- removing barriers to escalation of high risk cases
- improving support for vulnerable groups, including children
- strengthening accountability for people who use violence.

The Department of Communities and the Western Australia Police Force will report to the Ombudsman on the outcomes of this work by 1 October 2026. Both agencies have also committed to a future resample of the FDVRT data to compare results, monitor progress and support continued improvements in practice. The timing of the resample is yet to be confirmed.

National engagement

We are a member of the Australian Domestic and Family Violence Death Review Network, which brings together all state and territory family and domestic violence death review jurisdictions. The Network meets regularly to discuss common themes and to develop national datasets.

In partnership with Australia's National Research Organisation for Women's Safety (ANROWS), the following publications have been released:

- 'Australian Domestic and Family Violence Death Review Network data report: Intimate partner violence homicides 2010-2018' which was released in March 2022.
- 'Australian Domestic and Family Violence Death Review Network data report: Filicides in a domestic and family violence context 2010-2018' which was released in July 2024.

The reports present national insights into family and domestic violence fatalities, and potential intervention points. They are available at www.anrows.org.au

We are also a member of the Australian and New Zealand Child Death Review and Prevention Group, and in partnership with the Australian Institute of Health and Wellbeing, we have collaborated on work to progress national data reporting.

Child Safe Standards Scheme

Independent oversight of Child Safe Organisations

In October 2025, the Government announced its intention for the Ombudsman to be the independent oversight body for organisations engaged in child-related work.

The Scheme will help organisations create places where children are safe. Places where children are respected and protected from abuse, neglect, grooming and harm. It will provide a practical framework to keep child safety at the centre of organisational culture, leadership and everyday decisions.

The Child Safe Standards adds to our work in the Reportable Conduct Scheme and Child Death and Family and Domestic Violence Reviews. Together, these allow us a holistic view.

In helping design the Scheme, we have been:

- Working with government to develop legislation. The legislation will embed the existing National Principles for Child Safe Organisations. These were endorsed nationally in 2019.
- Undertaking research, interjurisdictional reviews, sector specific consultation and engagement.
- Working on our own readiness.

The Scheme is being developed as part of the State's broader child safeguarding system.

We maintain a key focus on child safety being a shared responsibility.

Our aim is to develop a practical, workable Scheme for WA.

In the 2026-27 year, we will take WA organisations, parents and carers, families, and community along with us as we continue to develop the Scheme.

Our Commitment:

- **Strong Organisations**
- **Safer Childhoods**
- **Better Futures**