

STATEMENT

Child Death Review - the Hawke Children

This statement includes the names of people who have died.

Background

We review the deaths of children where there have been concerns for the safety and wellbeing of the child reported to the Department of Communities in the two years before the death occurred.

During our review, we look for opportunities that agencies may have had to intervene to reduce the chances of the death occurring and prevent future deaths in similar circumstances. Patterns and trends are examined, and we make and follow up on recommendations to improve practices.

These reviews are statutorily different to coronial inquests. We do not apportion blame; we can compel information and there is a legal presumption of confidentiality that aids full and frank cooperation.

Why issue this statement

Legal confidentiality provisions mean we do not publish information about individual deaths. Limited aggregated information is reported in our Annual Report each year.

However, extensive media reporting about the Hawke Children has referred to the Ombudsman's role in reviewing child deaths. The Ombudsman considers it important for public confidence to report on the work undertaken in relation to these tragic deaths.

The Hawke Children

We conducted a review into the deaths of Jamela Jabari, Anand Jabari and Kelvin Oliver Jr.

Our review examined the circumstances leading up to the deaths, the actions and decisions of agencies involved with the children, and opportunities to strengthen systems and responses for vulnerable children and families, particularly in regional areas. The review was completed in November 2025.

The review involved analysis of agency records, video evidence and correspondence, as well as engagement with five government agencies, undertaken by staff with experience in child welfare and policing. It included:

1,730+ pages of key agency records reviewed

4h 20 min of body worn camera footage examined

250+ pages of investigation analysis and reporting

95+ pieces of correspondence exchanged with agencies

5 agencies directly engaged

In more detail

This review involved substantial work to understand the experiences of Jamela Jabari, Anand Jabari and Kelvin Oliver Jr, establish what occurred before their deaths, and identify any opportunities for intervention. The review did not consult the family despite a request to so.

The team reviewed 35 body worn camera recordings, representing four hours and 20 minutes of video evidence, and more than 1,600 pages of Department of Communities records, including case files, family and domestic violence reports, interaction reports, housing documents, a 33-page internal review report and a Child Safety Investigation outcome report.

The investigation also examined more than 130 pages of WA Police Force records, including six Family Violence Incident Reports, 17 Computer Aided Dispatch reports, five running sheet entries, bail information, court outcomes and criminal histories.

To clarify and test findings, the team held multiple meetings with the WA Police Force and the Department of Communities, supported by substantial written correspondence. This included at least 33 pieces of correspondence with the WA Police Force and 49 with the Department of Communities. The team also engaged with the WA Country Health Service, the Department of Education and the Coroners Court.

Recommendations

Our investigation made three practical recommendations aimed at strengthening child-centred family violence responses, improving child protection assessment and supervision, and strengthening organisational responses when workforce shortages affect frontline child protection services. They were:

Department of Communities

The Department of Communities develops a supervision framework and implementation plan that includes the monitoring and evaluation of case practice supervision for frontline child safety practitioners.

Department of Communities

The Department of Communities takes steps to strengthen the effectiveness of current strategies for frontline child protection service delivery when the number of child safety practitioners in a District falls below critical staffing levels.

Western Australia Police Force

That in February or March 2026, the Western Australia Police Force Family Violence Health Checks focus on child victims of family violence to determine the level of compliance with child centred family violence practice standards and identify if any improvement actions are required.

Monitoring

Our monitoring may include:

- **Early progress checks:** requesting an update within the first few months to confirm that implementation has commenced.
- **Follow-up through subsequent reviews:** assessing how earlier recommendations have been put into practice and whether they are contributing to improved outcomes.
- **Annual reporting:** formally requesting an update each year on action taken to implement recommendations made two years earlier and reporting to Parliament.

Status

WA Police Force and the Department of Communities have provided written assurances that appropriate action has been taken. We will test those assurances through subsequent monitoring, considering the current independent assurance arrangements commissioned by Minister Stojkovski.

We have also reviewed our own practices and are trialling processes to include family members in death review processes.

An opportunity for reflection

Children affected by family violence may be the first to recognise escalating risk. Their concerns must be heard, believed and acted upon.

Effective responses require agencies to recognise children as victims in their own right, identify cumulative harm, share information and act together before safety concerns escalate.

We extend our deepest respects to the family, loved ones, workers and community who sought to care for Jamela, Anand and Kelvin Jr.