# Own Motion Investigations and Administrative Improvement

A key function of the Office is to improve the standard of public administration. The Office achieves positive outcomes in this area in a number of ways including:

- Improvements to public administration as a result of:
  - The investigation of complaints;
  - Reviews of child deaths and family and domestic violence fatalities; and
  - Undertaking own motion investigations that are based on the patterns, trends and themes that arise from the investigation of complaints, and the review of certain child deaths and family and domestic violence fatalities;
- Providing guidance to public authorities on good decision making and practices and complaint handling through continuous liaison, publications, presentations and workshops;
- Working collaboratively with other integrity and accountability agencies to encourage best practice and leadership in public authorities; and
- Undertaking inspection and monitoring functions.

## Improvements from Complaints and Reviews

In addition to outcomes which result in some form of assistance for the complainant, the Ombudsman also achieves outcomes which are aimed at improving public administration. Among other things, this reduces the likelihood of the same or similar issues which gave rise to the complaint occurring again in the future. Further details of the improvements arising from complaint resolution are shown in the Complaint Resolution section.

Child death and family and domestic violence fatality reviews also result in improvements to public administration as a result of the review of individual child deaths and family and domestic violence fatalities. Further details of the improvements arising from reviews are shown in the Child Death Review section and the Family and Domestic Violence Fatality Review section.

## Own Motion Investigations

One of the ways that the Office endeavours to improve public administration is to undertake investigations of systemic and thematic patterns and trends arising from complaints made to the Ombudsman and from child death and family and domestic violence fatality reviews. These investigations are referred to as own motion investigations.

Own motion investigations are intended to result in improvements to public administration that are evidence-based, proportionate, practical and where the benefits of the improvements outweigh the costs of their implementation.

Own motion investigations that arise out of child death and family and domestic violence fatality reviews focus on the practices of agencies that interact with children and families and aim to improve the administration of these services to prevent or reduce child deaths and family and domestic violence fatalities.

## Selecting topics for own motion investigations

Topics for own motion investigations are selected based on a number of criteria that include:

- The number and nature of complaints, child death and family and domestic violence fatality reviews, and other issues brought to the attention of the Ombudsman;
- The likely public interest in the identified issue of concern;
- The number of people likely to be affected;
- Whether reviews of the issue have been done recently or are in progress by the Office or other organisations;
- The potential for the Ombudsman's investigation to improve administration across public authorities; and
- Whether investigation of the chosen topic is the best and most efficient use of the Office's resources.

Having identified a topic, extensive preliminary research is carried out to assist in planning the scope and objectives of the investigation. A public authority selected to be part of an own motion investigation is informed when the project commences and Ombudsman staff consult regularly with staff at all levels to ensure that the facts and understanding of the issues are correct and findings are evidence-based. The public authority is given regular progress reports on findings together with the opportunity to comment on draft conclusions and any recommendations.

## Monitoring the implementation of recommendations

Recommendations for administrative improvements are based closely on evidence gathered during investigations and are designed to be a proportionate response to the number and type of administrative issues identified. Each of the recommendations arising from own motion investigations is actively monitored by the Office to ensure its implementation and effectiveness in relation to the observations made in the investigation.

In addition, significant work was undertaken during the year on two reports in relation to the steps taken to giving effect to the recommendations arising from own motion investigations.

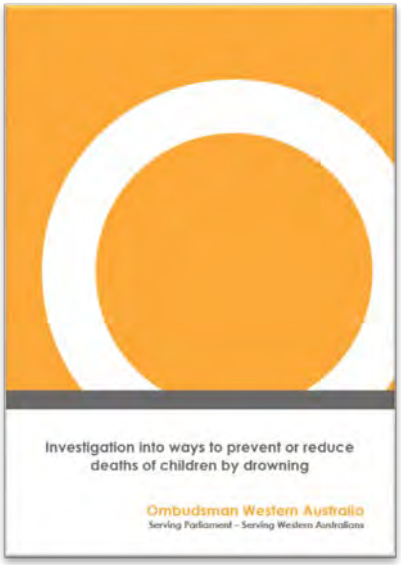
## Own Motion Investigations in 2017-18

In 2017-18, significant work was undertaken on:

- *Investigation into ways to prevent or reduce child deaths by drowning*, tabled in Parliament on 23 November 2017;
- *A report on giving effect to the recommendations arising from the Investigation into ways to prevent or reduce child deaths by drowning* to be tabled in Parliament in 2018;
- *A report on giving effect to the recommendations arising from the Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, to be tabled in Parliament in 2018-19;
- An investigation into deaths of children who drowned in a dam or river; and
- A report on giving effect to Recommendation 54 of the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*.

### *Investigation into ways to prevent or reduce deaths of children by drowning*

In November 2017, the Office tabled in Parliament the report of a major own motion investigation, *Investigation into ways to prevent or reduce deaths of children by drowning.*




Through the review of the circumstances in which, and why, child deaths occurred, the Ombudsman identified a pattern of cases in which children appeared to have died by drowning. The Ombudsman decided to undertake an investigation into these deaths with a view to determining whether it may be appropriate to make recommendations to any local government or State Government department or authority about ways to prevent or reduce deaths of children by drowning.

To undertake the investigation, the Office conducted an extensive literature review, comprehensively considered 34 deaths of children by drowning notified to the Office over a six year investigation period, surveyed all local governments in Western Australia (to which the Office received a 99 per cent response rate), selected five local governments for further investigation, collected and analysed comprehensive information regarding the number of private swimming pools in local government districts and the quality of the swimming pool barrier inspection process, engaged with the Department of Commerce, the Building Commissioner, the Department of Health, the Department of Local Government and Communities and relevant non-government and not-for-profit organisations.

The Office also collected and analysed de-identified information regarding the number of children admitted to a hospital or who attended an emergency department at a hospital following a non-fatal drowning incident. The Office found that 258

children were admitted to a hospital and 2,310 children attended an emergency department at a hospital following a non-fatal drowning incident.

The Ombudsman found that a range of work has been undertaken by the Department of Commerce and the Building Commissioner to administer their respective responsibilities in relation to swimming pool safety.

The Ombudsman also found that there is important further work that should be done. This work is detailed in the findings of this report. It will be critical that this work is undertaken with strong cooperation between the Department of Mines, Industry Regulation and Safety, the Building Commissioner, local governments and other key stakeholders, including intra-agency, inter-agency and cross sectoral arrangements – this is the most efficient and effective way to achieve positive change.

Arising from the findings, the Ombudsman made 25 recommendations about ways to prevent or reduce deaths of children by drowning. The Ombudsman is very pleased that the Department of Commerce and the Building Commissioner have agreed to these recommendations.

In keeping with the Ombudsman's commitment to Parliament to ensure Parliament is informed about the implementation of investigations, the Office will actively examine the steps taken to give effect to the recommendations and report the results of this examination to Parliament in 2018.

The full report, *Investigation into ways to prevent or reduce deaths of children by drowning* is available at www.ombudsman.wa.gov.au/drowningsreport.

## *A report on giving effect to the recommendations arising from the Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*

Through the review of the circumstances in which and why child deaths occurred, the Ombudsman identified a pattern of cases in which young people appeared to have died by suicide. Of the child death notifications received by the Office since the child death review function commenced, nearly a third related to children aged 13 to 17 years old. Of these children, suicide was the most common circumstance of death, accounting for nearly forty per cent of deaths. Furthermore, and of serious concern, Aboriginal children were very significantly over-represented in the number of young people who died by suicide. For these reasons, the Ombudsman 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 report of the findings and recommendations arising from that investigation, titled *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, was tabled in Parliament on 9 April 2014. The report made 22 recommendations to four government agencies about ways to prevent or reduce suicide by young people. Each agency agreed to these recommendations.

During 2017-18, significant work was undertaken on a report by the Office on the steps taken to give effect to the 22 recommendations arising from the findings of this report. The report will be tabled in Parliament in 2018-19.

## Continuous Administrative Improvement

The Office maintains regular contact with staff from public authorities to inform them of trends and issues identified in individual complaints and the Ombudsman's own motion investigations with a view to assisting them to improve their administrative practices. This contact seeks to encourage thinking around the foundations of good administration and to identify opportunities for administrative improvements.

Where relevant, these discussions concern internal investigations and complaint processes that authorities have conducted themselves. The information gathered demonstrates to the Ombudsman whether these internal investigations have been conducted appropriately and in a manner that is consistent with the standards and practices of the Ombudsman's own investigations.



## Guidance for Public Authorities

The Office provides publications, workshops, assistance and advice to public authorities regarding their decision making and administrative practices and their complaint handling systems. This educative function assists with building the capacity of public authorities and subsequently improving the standard of administration.

### Publications

The Ombudsman has a range of guidelines available for public authorities in the areas of effective complaint handling, conducting administrative investigations and administrative decision making. These guidelines aim to assist public authorities in strengthening their administrative and decision making practices. For a full listing of the Office's publications, see Appendix 3.

### Workshops for public authorities

During the year, the Office continued to proactively engage with public authorities through presentations and workshops.

Workshops are targeted at people responsible for making decisions or handling complaints as well as customer service staff. The workshops are also relevant for supervisors, managers, senior decision and policy makers as well as integrity and governance officers who are responsible for implementing and maintaining complaint handling systems or making key decisions within a public authority.

The workshops are tailored to the organisation or sector by using case studies and practical exercises. Details of workshops conducted during the year are provided in the Collaboration and Access to Services section.

### Working collaboratively

The Office works collaboratively with other integrity and accountability agencies to encourage best practice and leadership in public authorities. Improvements to public administration are supported by the collaborative development of products and forums to promote integrity in decision making, practices and conduct. Details are provided in the Collaboration and Access to Services section.

# Inspection and Monitoring Functions

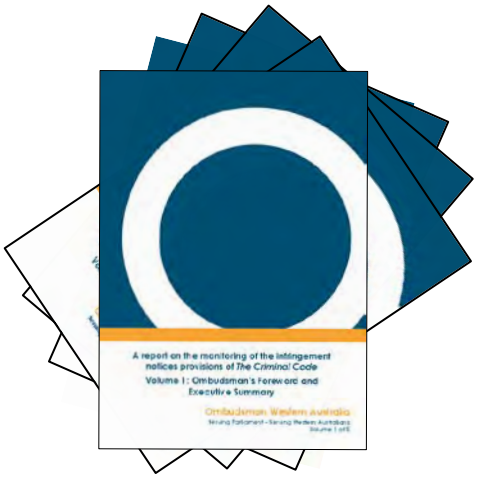
## Telecommunications interception records

The *Telecommunications (Interception and Access) Western Australia Act 1996*, the *Telecommunications (Interception and Access) Western Australia Regulations 1996* and the *Telecommunications (Interception and Access) Act 1979* (Commonwealth) permit designated 'eligible authorities' to carry out telecommunications interceptions. The Western Australia Police (**WAPOL**) and the Corruption and Crime Commission are eligible authorities in Western Australia. The Ombudsman is appointed as the Principal Inspector to inspect and report on the extent of compliance with the legislation.

In 2017-18, significant work was undertaken on *A report on the monitoring of the infringement notices provisions of The Criminal Code*, tabled in Parliament on 30 November 2017 by the Minister for Police as required by section 723 (6) of the *Criminal Code Amendment (Infringement Notices) Act 2011*.

## *A report on the monitoring of the infringement notices provisions of The Criminal Code*

In 2017-18, the Office provided *A report on the monitoring of the infringement notices provisions of The Criminal Code* to the Minister for Police and the Commissioner of Police and the report was tabled in Parliament by the Minister for Police on 30 November 2017.




In accordance with the relevant provisions of *The Criminal Code*, Parliament gave the Ombudsman an important function to keep under scrutiny the operation of the infringement notices provisions of *The Criminal Code*, relevant regulations made under *The Criminal Code* and the relevant provisions of the *Criminal Investigation (Identifying People) Act 2002* in relation to infringement notices (**Criminal Code infringement notices**). Importantly, this scrutiny included review of the impact of the operation of the provisions on Aboriginal and Torres Strait Islander communities.

The infringement notices provisions of *The Criminal Code* and the relevant regulations allow authorised officers to issue Criminal Code infringement notices for two prescribed offences, with a modified penalty of $500.

The report found that considerable positive work has been undertaken by WAPOL to implement Criminal Code infringement notices effectively and identified opportunities for further work to be undertaken by WAPOL.

The report also found that the key economic objectives arising from the introduction of Criminal Code infringement notices have been achieved, including anticipated outcomes relating to reducing administrative demands on police officers and avoided court appearances for alleged offenders.

The report identified a range of impacts of the introduction of Criminal Code infringement notices on Aboriginal and Torres Strait Islander communities (and in doing so also identified impacts for other people and communities experiencing vulnerability). The report identifies a range of measures to address these impacts (and concomitantly makes recommendations about these measures).

While certain of these recommended measures are specific to Criminal Code infringement notices, mostly these recommended measures are applicable to the impact of the broader criminal justice system on Aboriginal and Torres Strait Islander people (particularly the overrepresentation of Aboriginal and Torres Strait Islander people in the criminal justice system, including as recipients of Criminal Code infringement notices).

The report makes 34 recommendations relating to proposed amendments to the relevant regulations made under *The Criminal Code* as well as the proposed introduction of, or amendments to, other legislation, schemes, policies, procedures and other measures. The Ombudsman is very pleased that WAPOL has accepted each of the recommendations directed to them.

The full report, *A report on the monitoring of the infringement notices provisions of The Criminal Code*, is available at www.ombudsman.wa.gov.au/infringementnoticesreport.

## Criminal organisations control

Under the *Criminal Organisations Control Act 2012*, the Ombudsman scrutinises and reports on the exercise of certain powers by WAPOL, for a five year period commencing in November 2013.

In accordance with the *Criminal Organisations Control Act 2012*, a report was prepared by the Ombudsman for the monitoring period ending 1 November 2017. A copy of this report was provided to the Minister for Police and the Commissioner of Police in accordance with the *Criminal Organisations Control Act 2012.*