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 2018-19

In 2018-19, significant work was undertaken on:

- *A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce deaths of children by drowning,* tabled in Parliament on 8 November 2018;
- An investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people, to be tabled in Parliament in 2019; and
- An investigation into family and domestic violence and suicide, to be tabled in Parliament in 2020.

A report on giving effect to the recommendations arising from 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 Office identified that 34 deaths of children by drowning were notified to the Office over a six year investigation period. For this reason, 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.

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 report of the findings and recommendations arising from that investigation, titled *Investigation into ways to prevent or reduce deaths of children by drowning*, was tabled in Parliament on 23 November 2017. The report made 25 recommendations to two government agencies about ways to prevent or deaths of children by drowning. Each agency agreed to these recommendations.

Importantly, the Ombudsman also indicated that the Office would actively monitor the implementation of these recommendations and report to Parliament on the results of the monitoring.

Accordingly, on 8 November 2018 the Ombudsman tabled in Parliament *A report on giving effect to the recommendations arising from the Investigation into ways to prevent or reduce deaths of children by drowning'*.

The Office found that in relation to all of the recommendations, the Department of Mines, Industry Regulation and Safety and the Building Commissioner have either taken steps, or propose to take steps (or both) to give effect to the recommendations. In no instances did the Office find that no steps had been taken to give effect to the recommendations.

Following the report, the Department of Mines, Industry Regulation and Safety, the Building Commissioner and local governments have made particularly positive progress in the areas of improving consistency and quality of swimming pool inspections and the training and professional development of swimming pool inspectors. The very evident level of national collaboration in relation to portable swimming pools, and Western Australian leadership in relation to this, is also very pleasing.

The death of a child by drowning is a tragedy – for the child's life lost and for the parents, families and communities who have been personally affected by the tragic death. It is the Ombudsman's sincerest hope that the recommendations of the Report, and the positive steps that have been taken to give effect to the recommendations, will contribute to preventing and reducing these tragic deaths in the future.

The Office will continue to monitor, and report on, the steps being taken to give effect to these recommendations.

The full report, *A report on giving effect to the recommendations arising from 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 2018-19, 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 2019.

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.

Good Practice Guidance for the collection of overdue rates for people in situations of vulnerability

The office has, over a period of time, received complaints regarding the collection of overdue rates for people in situations of vulnerability. Following an investigation by the Office, including considering relevant legislative and regulatory requirements, a review of relevant literature, analysis of good practice and consultation with local governments, the Office has developed Good Practice Guidance for local governments regarding their role in collecting overdue rates owed by people in situations of vulnerability.

The Office has identified four principles reflecting contemporary good practice in the collection of overdue rates for people in situations of vulnerability. These principles are:

1. Good culture;
2. Good decisions;
3. Good support; and
4. Good service.

For each principle, further underpinning guidance is presented. Where helpful, specific initiatives are suggested that reflect potential approaches to implement the guidance.

The Good Practice Guidance is designed to assist local governments to:

- Consider their own policies and practices for the collection of rates and overdue rates in respect to people in situations of vulnerability; and
- Identify any aspects of these policies and practices that may present opportunities for improvement to ensure that the process is efficient and effective for local governments and is fair and equitable for all ratepayers.

All ratepayers have a responsibility to pay overdue rates. The guidance in no way overrides, detracts from, or diminishes, the responsibility of ratepayers to pay overdue rates, consistent with the *Local Government Act 1995*. Nonetheless, a large body of research demonstrates that a fair, reasonable and flexible approach leads to better repayment outcomes and fewer resources expended in the collection of payments.

Implementation of the Good Practice Guidance can, and should, be done in a way that does not impose any unreasonable or inappropriate regulatory costs on local governments (which, of course, are paid for by ratepayers).

It is absolutely appropriate for local governments to consider the relevance, costs and benefits of implementing the four Good Practice Principles and tailor areas of the Good Practice Guidance to their specific circumstances. In particular:

1. Local governments may have already implemented good practice frameworks in relation to assisting people in situations of vulnerability, including in the collection of overdue rates. Where this is the case, the Good Practice Guidance can be used to ensure these existing frameworks adequately address the issues contained in the Good Practice Guidance, rather than the need to write new guidance;
2. Local governments may have either more or less ratepayers in situations of vulnerability and therefore the extent of adoption of guidance underpinning principles may appropriately vary; and
3. It is completely appropriate and reasonable for smaller local governments to consider the practicalities and resources required to tailor the guidance to their specific circumstances.

Read more about the *Local government collection of overdue rates for people in situations of vulnerability: Good Practice Guidance* on the Office's website.

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 Force (**WA Police Force**) 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.

Criminal organisations control

Under the *Criminal Organisations Control Act 2012*, the Ombudsman scrutinises and reports on the exercise of certain powers by the WA Police Force, 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 whole monitoring period ending 1 November 2018. A copy of this report was provided to the Attorney General and the Commissioner of Police in accordance with the *Criminal Organisations Control Act 2012.*