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 certain 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.

Own Motion Investigations in 2020-21

In 2020-21, significant work was undertaken on:

- The Office's major own motion investigation *Preventing suicide by children and young people 2020*, which was tabled in Parliament in September 2020;
- A report on giving effect to the recommendations arising from *Preventing suicide by children and young people 2020*, to be tabled in Parliament in 2021-22;
- An investigation into family and domestic violence and suicide, to be tabled in Parliament in 2021-22; and
- An investigation into services provided to children and young people with disordered eating, to be tabled in Parliament in 2022.

Preventing suicide by children and young people 2020

As part of the Ombudsman's responsibility to review the deaths of Western Australian children, on 24 September 2020, *Preventing suicide by children and young people 2020* was tabled in Parliament. The report is comprised of three volumes:

- Volume 1: an executive summary;
- Volume 2: an examination of the steps taken to give effect to the recommendations arising from the report of the Ombudsman's 2014 major own motion investigation, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (**the 2014 Investigation**); and
- Volume 3: the report of the Ombudsman's 2020 major own motion investigation, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people* (**the 2020 Investigation**).

The 2014 Investigation examined the deaths of 36 young people aged 14 to 17 years. Arising from his findings, the Ombudsman made 22 recommendations to four agencies, namely, the Mental Health Commission, Department of Health, Department of Education and the (then) Department for Child Protection and Family Support, all of which were accepted by these agencies. The Ombudsman was very pleased to report to Parliament that he found that steps have been taken or are proposed to be taken (or both) for each of the 22 recommendations of the 2014 Investigation as set out in Volume 2 of the report.

The 2020 Investigation examined a further 79 deaths by suicide that occurred following the 2014 Investigation, as set out in Volume 3. The 2020 Investigation examined what is known about suicide and self-harm by Western Australian children and young people, the research literature, current strategic frameworks, and data obtained during our investigation. Significantly, it also collates State-wide suicide and self-harm data relating to Western Australian children and young people over the 9 years from 1 July 2009 to 30 June 2018 for the first time, including:

- deaths by suicide; and
- hospital admissions and emergency department attendances for self-harming and suicidal behaviour.

Arising from the findings of the 2020 Investigation, the Ombudsman made seven recommendations to four government agencies about preventing suicide by children and young people, including the development of a suicide prevention plan for children and young people to focus and coordinate collaborative and cooperative State government efforts. The Ombudsman is very pleased that each agency has agreed to these recommendations.

The full report, *Preventing suicide by children and young people 2020* is available at: www.ombudsman.wa.gov.au/suicidebychildrenandyoungpeoplereport2020.

The Office is monitoring the steps taken to give effect to the recommendations of *Preventing suicide by children and young people 2020* and in accordance with the Ombudsman's commitment to Parliament, will report on the results of our monitoring in 2021.

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.

Giving effect to the recommendations arising from the Ombudsman's *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.

On 23 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* (**the Investigation**).

As a result of the investigation, the Office made 25 recommendations about ways to prevent or reduce deaths of children by drowning. The Department of Mines, Industry Regulation and Safety and the Building Commissioner agreed to these recommendations.

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

Importantly, the Ombudsman indicated that the Office would actively monitor the implementation of these recommendations and report to Parliament on the results of the monitoring within 12 months of the tabling of the investigation.

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

The Ombudsman found that the Department of Mines, Industry Regulation and Safety (**the Department**) through the Building Commissioner and its Consumer Protection division (now within the Department's Industry Regulation and Consumer Protection division) had either taken steps, or proposed 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. The full report *A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce child deaths by drowning* is available at: www.ombudsman.wa.gov.au/Improving_Admin/AI_Reports.htm#Drownings-follow-up-report-2018.

On 20 May 2021, the Department published a decision paper entitled, *Swimming Pool and Safety Barrier Control* (**the Decision Paper**) (available at www.commerce.wa.gov.au/publications/decision-paper-swimming-pool-and-safety-barrier-control).

The Decision Paper addresses 23 of the Ombudsman's 25 recommendations – 20 of which were made to the Building Commissioner and three directed to the Building Commissioner in collaboration with the Department's Consumer Protection division. The remaining two recommendations (Recommendations 1 and 2) are being

addressed through other work within the Department and were not considered by the Decision Paper.

The Decision Paper includes 16 decisions and states that:

> These decisions are based on the principles of best practice regulation and take full account of the Ombudsman's recommendations and the extensive feedback received in Stages 1 and 2 of the review process.

The approach taken by the Department continues to represent a best practice response to an Ombudsman's investigation. This is particularly noteworthy considering that the issue is about preventing child deaths and the large number of stakeholders that required consultation and coordination.

The Office is pleased to note the continued implementation of the recommendations arising from, *Investigation into ways to prevent or reduce deaths of children by drowning* and this Decision Paper is strongly welcomed.

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

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 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.