Own Motion Investigations, Monitoring and 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;
- Undertaking inspection and monitoring functions;
- Providing guidance to public authorities on good decision making and practices and complaint handling through continuous liaison, publications, presentations and workshops; and
- Working collaboratively with other integrity and accountability agencies to encourage best practice and leadership in public authorities.

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 2021-22

In 2021-22, significant work was undertaken on:

- *An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley*, which was tabled in Parliament in July 2021;
- A report on giving effect to the recommendations arising from *Preventing suicide by children and young people 2020*, which was tabled in Parliament in September 2021;
- An investigation into family and domestic violence and suicide, to be tabled in Parliament in 2022; and
- An investigation into services provided to children and young people with disordered eating, to be tabled in Parliament in 2022-23.

An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley

On 2 March 2021, the Honourable John Quigley MLA, Attorney General, wrote to the Ombudsman requesting an investigation into the Office of the Public Advocate's (**OPA**) role in notifying the family of Mrs Joyce Savage of the death of Mrs Savage. The Attorney General also requested that the investigation include the circumstances of OPA's notification to the families of Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mr Ayling and Mr Hartley.

On the same day, in accordance with section 16(1) of the *Parliamentary Commissioner Act 1971*, the Ombudsman initiated an investigation into OPA's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley (**the Investigation**).

Mrs Savage's daughter, Ms Kaye Davis, Mr Ayling's son, (also named) Mr Robert Ayling and Mr Hartley's brother, Mr Phillip Hartley, were contacted as part of the Investigation and each made themselves available during the Investigation to talk about their experiences and views. These experiences and views informed this report of the Investigation (**the Report**). The Ombudsman expressed his hope that the Report would, in turn, provide information to Ms Davis, Mr Ayling and Mr Hartley that is of assistance to them and he expressed his sincerest condolences to the families on the passing of Mrs Savage, Mr Ayling and Mr Hartley.

A person for whom OPA has been appointed as their guardian is a 'represented person'. This was the case for Mrs Savage, Mr Ayling and Mr Hartley. Each was a represented person. But Mrs Savage, Mr Ayling and Mr Hartley were more than represented people. Each led a long life, was a family member and a contributor to their communities. Any delay in notifying a family of the death of a family member will, of course, be upsetting for a family. Further, the delay does not give the dignity to the person's passing that they should, and must, be afforded.

As a result of the Investigation, the Ombudsman formed a number of opinions regarding OPA's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

Arising from these opinions, the Ombudsman made seven recommendations to OPA.

The Ombudsman is very pleased that OPA agreed to all seven recommendations. The Ombudsman will actively monitor the steps taken by OPA to give effect to the recommendations.

In the Ombudsman's view, these seven recommendations, when implemented, will be responsive to the families of Mrs Savage, Mr Ayling and Mr Hartley, but also ensure that in the future OPA does, without delay, notify family upon the death of a loved one.

The Report is available at:
https://www.ombudsman.wa.gov.au/Improving_Admin/AI_Reports.htm#OPA-Report-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.

A report on giving effect to the recommendations arising from *Preventing suicide by children and young people 2020*

About the report

Arising from the Ombudsman's responsibility to review child deaths, the Office undertook a major own motion investigation, *Preventing suicide by children and young people 2020* (**the Investigation**), tabled in Parliament on 24 September 2020.

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 these 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 2020 Investigation examines a further 79 deaths by suicide that occurred following the 2014 Investigation, as set out in Volume 3. The 2020 Investigation examines 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 in the Investigation, the Ombudsman made seven recommendations about ways to prevent or reduce deaths of children and young people by suicide. The Mental Health Commission, Department of Health, Department of Communities and Department of Education each agreed to these recommendations.

The report is available at:
https://www.ombudsman.wa.gov.au/suicidebychildrenandyoungpeoplereport2020.

In 2016-17, the Ombudsman gave a commitment to Parliament that, following the tabling of each major own motion investigation, that the Office would undertake a comprehensive review of the steps taken by government agencies to give effect to the

Ombudsman's recommendations and then table the results of this review in Parliament twelve months after the tabling of the major own motion investigation.

Accordingly, the Ombudsman tabled in Parliament *A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020 (***the Report***)* in September 2021.

The report is available at: https://www.ombudsman.wa.gov.au/Improving_Admin/AI_Reports.htm#Youth-Suicide-Implementation-2021.

Objectives

The objectives of the Report were to consider (in accordance with the *Parliamentary Commissioner Act 1971*):

- The steps that have been taken to give effect to the recommendations;
- The steps that are proposed to be taken to give effect to the recommendations; or
- If no such steps have been, or are proposed to be taken, the reasons therefor.

This Report also considered whether the steps taken, proposed to be taken or reasons for taking no steps:

- Seem to be appropriate; and
- Have been taken within a reasonable time of the making of the recommendations.

Methodology

On 21 May 2021, the Ombudsman wrote to the Mental Health Commissioner, the Director General of the Department of Communities, the Director General of the Department of Health, and the Director General of the Department of Education requesting a report on the steps that have been taken, or were proposed to be taken, to give effect to the recommendations of the Report.

Additionally, the Office:

- Obtained further information from the relevant State Government departments and authorities, in order to clarify or validate information provided in their reports to the Ombudsman;
- Collected additional information relevant to suicide by young people in Western Australia to inform the consideration of whether the steps taken by relevant State Government departments and authorities seem appropriate;
- Reviewed relevant current national and international literature regarding suicide by children and young people and the associated risk factors;
- Developed a preliminary view and provided it to relevant State Government departments and authorities for their consideration and response; and
- Developed a final report on whether steps have been taken to give effect to the recommendations.

Summary of Findings

The Office is very pleased that in relation to all the recommendations, the Mental Health Commission, the Department of Communities, the Department of Health, and the Department of Education we have found that steps have been taken, and are

proposed to be taken, to give effect to the recommendations. In no instance have we found that no steps have been taken to give effect to the recommendations.

In undertaking the review of the steps taken by the agencies to give effect to the recommendations, it is very evident that there is a particularly positive and very pleasing emphasis on strong cooperation and collaboration between the agencies. This is vitally important as the tragedy of suicide by children and young people cannot be prevented by a single program, service or agency working in isolation.

The work of the Office in ensuring that the recommendations of the Investigation are given effect does not end with the tabling of this report. The Office will continue to monitor and report on the steps taken to give effect to the recommendations arising from the Investigation. As such, provided below is a progress update on the steps taken to give effect to Recommendation 6 of the Investigation by the Department of Communities.

Progress update

On 22 October 2021, the Director General of the Department of Communities provided the Office with a progress update on Recommendation 6 of *Preventing suicide by children and young people 2020*, which stated that:

> Communities has recently established the Reviews and Recommendations Oversight Group (the Oversight Group), to align and streamline activity across the agency. The Oversight Group is scoped to endorse themed work packages and oversight the implementation of internal and external recommendations delivered to Communities.
>
> Oversight Group members, who represent relevant divisions across Communities and hold decision-making authority, are responsible for developing an environment of continuous service improvement through the identification of:
> - opportunities to inform and drive reforms through regular review of risk themes and practice trends; and
> - interdependencies and opportunities to work across business areas to deliver holistic, effective results.
>
> The Oversight Group is overseeing the implementation of [Recommendation] … 6 from the Ombudsman's Own Motion Investigation, *Preventing suicide by children and young people 2020* …
>
> In September 2021, the Oversight Group endorsed the project scope which will address Recommendation 6. The Cumulative Harm Project will improve policy frameworks, practice guidance, service delivery to support sustainable, holistic responses for children and young people who:
> - experience cumulative harm through multiple repeat presentations, which considered in isolation, do not reach the intake threshold.
> - experience acute distress as a result of cumulative harm and are at risk of suicide and/or suicide behaviours (including suicide attempt, suicidal ideation, self-harm and reckless risk-taking).
>
> The Cumulative Harm Project proposes to achieve these objectives by:
> - Reviewing and assessing policies, practice guidance, processes and tools that are used to address identifying, responding and intervening in:
>   - children, young people and families with history with Communities who are the subject of multiple interactions and are at risk of, or currently experiencing, cumulative harm; and

  - children and young people with history with Communities who are at risk of harm as a result of suicide behaviours, including those of a parent, carer or guardian.
- Develop improvement opportunities for service delivery, including communications, training, and development for frontline staff.

The Cumulative Harm Project will include data collection and research to assess and develop findings, which will be tested with key stakeholders. From this, recommendations relating to practice guidance, staff engagement opportunities and a corresponding implementation plan will be developed. It is anticipated that this Project will be finalised by June 2022.

Communities has updated the *Casework Practice Manual* (CPM) which provides guidance for Child Protection Workers, as authorised officers of the CEO, in carrying out the functions and powers of *Children and Community Services Act 2004* (the Act). On 30 August 2021, the CPM entry '*Alcohol and other drug use - at risk young people'* was introduced. This entry includes guidance on responding to young people, both in the CEO's care and otherwise, who are assessed as at immediate high risk due to their alcohol or other drug use, inclusive of medical and/or mental health crisis.

As you might be aware the *Children and Community Services Amendment Bill 2021* passed in WA Parliament on 14 October 2021. Amendments were made regarding young people once they leave the care of the CEO's care. These changes included:

- a leaving care plan must be prepared once a child reaches 15 years of age;
- leaving care plans should include the social services proposed to be provided for the child post-care;
- children leaving care must be provided with social services the CEO considers appropriate having regard to the child's needs, regardless of whether those needs are identified in the child's last care plan; and
- children leaving care are to receive written information on their entitlements post-care.

Public authorities named in regulations must prioritise CEO requests for assistance to a child in care, a child under an SGO or a care leaver who qualifies for assistance until they reach 25, provided it would be consistent with and not unduly prejudice the performance of the public authority's functions to do so.

As you might be aware Communities, in partnership with Anglicare WA, have piloted Home Stretch WA. The State Government in its 2021-22 State Budget committed $37.2 million to expand the Home Stretch pilot into a permanent state-wide program to enhances access to supports and services for young people aged 18 to 21 years who are leaving, or have left, out-of-home care.

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.

Monitoring of the *Criminal Law (Unlawful Consorting and Prohibited Insignia) Act 2021*

On 24 December 2021, the *Criminal Law (Unlawful Consorting and Prohibited Insignia) Act 2021* (**the Act**) was promulgated. This is an Act to:

- Make consorting unlawful between certain offenders;
- Provide for the identification of organisations for the purposes of the Act;
- Prohibit the display in public places of insignia of identified organisations;
- Provide for the issue of dispersal notices to members of identified organisations and make any consorting contrary to those notices unlawful;
- Provide for police powers relating to unlawful consorting and insignia of identified organisations; and
- Make consequential and other amendments to the *Community Protection (Offender Reporting) Act 2004* and *The Criminal Code*.

Parts 2 and 3 of the Act provide for unlawful consorting notices, insignia removal notices, display of prohibited insignia, dispersal notices and the use of police powers and criminal charges relating to these parts.

Part 4 of the Act provides that the Ombudsman must keep the exercise of powers conferred under the Act under scrutiny. Further, the Ombudsman must inspect the records of WA Police Force in order to ascertain the extent of WA Police Force's compliance with Parts 2 and 3 of the Act.

The Commissioner of Police must keep a register (**the register**) of the issue and service of all notices under the Act, the revocation or variation of any notice issued and served under the Act, any prosecution for an offence under the Act, the use of any police powers whilst operationalising the Act and any certificate of service given under the Act. The Commissioner of Police must provide the register to the Ombudsman.

Further, under Part 4 of the Act, the Ombudsman must report annually on the monitoring activities undertaken as soon as practicable after each anniversary of the day on which Part 4 came into operation. The Ombudsman must provide a copy of the annual report to the responsible Minister and the Commissioner of Police.

The annual report may include any observations that the Ombudsman considers appropriate to make about the operation of the Act and must include any recommendations made by the Ombudsman and details of any actions taken by the Commissioner of Police in respect of any recommendations. The annual report must include any information contained in the register. The annual report must also include a review of the impact of the operation of the Act on a particular group in the community if such an impact came to the attention of the Ombudsman.

The Minister must cause the annual report to be tabled in Parliament within 12 sitting days after the Minister receives a copy of the report.

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.