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 2022-23

In 2022-23, significant work was undertaken on:

- A report on giving effect to the recommendations arising from the *Investigation into the handling of complaints by the Legal Services and Complaints Committee*, which was tabled in Parliament in September 2022;
- A report on giving effect to the recommendations arising from *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 October 2022;
- Investigation into family and domestic violence and suicide, which was tabled in Parliament in October 2022; and
- A report on giving effect to the recommendations arising from the *Investigation into family and domestic violence and suicide*, to be tabled in Parliament in 2023.

Investigation into family and domestic violence and suicide

On 20 October 2022, the Ombudsman tabled in Parliament the report of his major own motion investigation titled *Investigation into family and domestic violence and suicide*.

The investigation commenced following the Ombudsman's identification of the need to undertake a major own motion investigation into family and domestic violence and suicide while undertaking his important responsibilities of reviewing family and domestic violence fatalities and child deaths.

To undertake this investigation, in addition to an extensive literature review and stakeholder engagement, the Office collected and analysed a comprehensive set of state-wide data relating to those who died by suicide in circumstances where family and domestic violence had previously been identified by one or more State government departments or authorities. This included an examination of 68 women and child victims of family and domestic violence who died by suicide in 2017.

The Ombudsman found that a range of work has been undertaken by State government departments and authorities to administer their relevant legislative responsibilities to support the safety of women and children experiencing family and domestic violence. The Ombudsman found, however, that there is important further work that should be done, including a range of important opportunities for improvement for State government departments and authorities, working individually and collectively, across all stages of the service spectrum to improve the identification of, and responses to, family and domestic violence in Western Australia.

In addition, this investigation identified the need for State government departments and authorities to use a trauma informed approach when working with people who have experienced multiple circumstances of vulnerability, including in responding to family and domestic violence and suicidality.

Arising from the findings of the investigation, the Ombudsman made nine recommendations to four government agencies about ways to prevent or reduce family and domestic violence related deaths by suicide. The Ombudsman is very pleased that each agency has agreed to these recommendations.

The full report, *Investigation into family and domestic violence and suicide*, is available at: www.ombudsman.wa.gov.au/Publications/Reports/FDV-Suicide-2022-Volumes-1-to-4.pdf

The Office is monitoring the steps taken to give effect to the recommendations of *Investigation into family and domestic violence and suicide* and in accordance with the Ombudsman's commitment to Parliament, will report on the results of our monitoring in 2023.

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 the *Investigation into the handling of complaints by the Legal Services and Complaints Committee*

About the report

On 21 September 2022, the Ombudsman released his report on giving effect to the recommendations arising from the *Investigation into the handling of complaints by the Legal Services and Complaints Committee.*

Following a request to the Ombudsman by the Honourable John Quigley MLA, Attorney General, to consider the handling of complaints by the Legal Profession Complaints Committee (**the LPCC**), the Ombudsman completed an investigation into the handling of complaints by the LPCC on 11 December 2020.

In the report of the investigation, the Ombudsman set out a series of opinions regarding the handling of complaints by the LPCC. Arising from these opinions, the Ombudsman made thirteen recommendations to the LPCC. This report sets out the steps taken by the now Legal Services and Complaints Committee (**LSCC**) to give effect to the Ombudsman's recommendations.

The report is available at:

www.ombudsman.wa.gov.au/Publications/Reports/Legal-Services-and-Complaints-Committee-Report-September-2022.pdf

Objectives

The objectives of this 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 23 July 2021, the Office wrote to the LSCC, 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:

- Reviewed and considered the information provided by the LSCC and the information, clarification or validation provided to the Office;

- Obtained further information from the LSCC, in order to clarify or validate information provided in the LSCC's report to the Office;
- Developed a preliminary view and provided it to the LSCC for its consideration and response; and
- Having fully considered the responses of the LSCC, developed a final report.

Summary of Findings

In the report of the investigation, the Ombudsman identified serious problems with the timeliness of the LSCC's handling of complaints as well as its lack of key performance indicators, inadequate public reporting and lack of a modern electronic system for complaints management. Accordingly, it is pleasing that the response to the report by the LSCC has been timely and effective.

Following over a decade of indications that the LSCC would institute an electronic complaints management system, in the report the Ombudsman recommended (Recommendation 13) that the LSCC implement an electronic complaints management system by no later than the end of the financial year 2021-22 and should aim to do so by December 2021. The LSCC has given effect to the Ombudsman's recommendation and implemented an electronic complaints management system, slightly ahead of the time the Ombudsman recommended, ending over a decade of delay. In the report, the Ombudsman further recommended (Recommendation 2) that the LSCC achieved the closure of very aged complaints. Again, the LSCC has done so, and again ahead of the time that the Ombudsman recommended.

Overall, the LSCC has either given effect, taken steps to give effect, or steps have been proposed to give effect, to all thirteen recommendations in the report.

A report on giving effect to the recommendations arising from *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*

About the report

On 18 October 2022, the Ombudsman released his report on giving effect to the recommendations arising from *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 Ombudsman include in his investigation, 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.

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. This report sets out the steps taken by OPA to give effect to the Ombudsman's recommendations.

The report is available at:

www.ombudsman.wa.gov.au/Improving_Admin/Publications/Reports/Office-of-the-Public-Advocate-Report-October-2022.pdf

Objectives

The objectives of this 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 16 March 2022, the Ombudsman wrote to the Public Advocate, 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 OPA, in order to clarify or validate information provided in OPA's report to the Office;
- Reviewed and considered the information provided by OPA and the information, clarification or validation provided to the Office;
- Developed a preliminary view and provided it to OPA for its consideration and response; and
- Developed a final report.

Summary of Findings

Having very carefully considered the information provided by OPA regarding their implementation of the seven recommendations, the Ombudsman is pleased to report that OPA has taken steps to give effect to each of the seven recommendations. In no instance did the Ombudsman find that no steps have been taken to give effect to a recommendation. This is an important and pleasing outcome.

The Ombudsman is also pleased to report that the Public Advocate and her staff have been highly cooperative, open and timely during the undertaking of the investigation and this report. A preparedness to accept oversight and accountability and take positive steps to improve the provision of their essential services to some of Western Australia's most vulnerable citizens reflects very well on OPA.

Inspection and Monitoring Functions

Inspection of 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.

Monitoring of Protected Entertainment Precincts

The *Liquor Control Act 1988* (**the Liquor Control Act**) was amended through the *Liquor Control Amendment (Protected Entertainment Precincts) Act 2022 (***the Amendment Act***)* to provide for the establishment of Protected Entertainment Precincts and for the exclusion of people from a precinct who behave in an unlawful, anti-social, violent, disorderly, offensive, indecent or threatening way, or are convicted of specified serious offences, which occurred in the precinct. The Amendment Act received Royal Assent on 1 December 2022 with Part 5AA of the Act (containing the protected entertainment precincts provisions) commencing on 24 December 2022.

Under the Liquor Control Act, the Ombudsman must keep under scrutiny the operation of, and the exercise of powers under the provisions of Part 5AA of the Liquor Control Act, any regulations made for the purposes of Part 5AA and any regulations made to prescribe an area of the State to be a Protected Entertainment Precinct.

As soon as practicable after the third anniversary of the day on which Part 5AA of the Liquor Control Act comes into operation, the Ombudsman must prepare a report on the Ombudsman's monitoring work and activities and give a copy of the report to the Minister and to the Commissioner of Police.

The report must, if the Ombudsman has identified any group in the community that is particularly affected by the operation of, or the exercise of powers under the provisions of this new law, include a review of the impact of the operation of, and the exercise of powers under, those provisions on that group. The report may also include recommendations about amendments that might appropriately be made to the Liquor Control Act.

The Ombudsman may at any other time considered appropriate, prepare a report on the Ombudsman's work and activities and give a copy of the report to the Minister and the Commissioner of Police.

The Minister must cause a report to be tabled in Parliament as soon as practicable after the Minister received 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.

A workshop for public authorities was held in Karratha in May 2023. 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.