Own Motion Investigations, Inspections and Monitoring

This section outlines the work of the Office in relation to:

- 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;
- Reviews of the steps taken by government agencies to give effect to our own motion investigation recommendations to improve public administration; and
- Inspection and monitoring functions.

Own Motion Investigations

One of the ways 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 the opportunity to comment on draft conclusions and any recommendations.

Own Motion Investigations in 2023-24

In 2023-24, significant work was undertaken on:

- A report on giving effect to the recommendations arising from the *Investigation into family and domestic violence and suicide*, which was tabled in Parliament in November 2023.
- A project examining the systems of organisations covered by the Reportable Conduct Scheme.
- An investigation into the management of tenant liabilities in public housing.

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 are actively monitored by the Office to ensure its implementation and effectiveness in relation to the observations made in the investigation.

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

About the report

During 2023-24, the departments of Health, Education, Communities and the Mental Health Commission met on a regular basis to discuss and agree on approaches to address joint recommendations arising from *Preventing suicide by children and young people 2020.*

As the need for improved collaboration between public authorities is a key theme of the report, this joint initiative is commendable, as is the identification of future opportunities for further work on giving effect to the recommendations.

Of note is the work undertaken by the departments of Health and Communities to give effect to Recommendation 5 of the report, which related to the collection of gender data in a non-binary form.

A report on giving effect to the recommendations arising from the *Investigation into family and domestic violence and suicide*

About the report

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

The Report included a comprehensive set of state-wide data relating to 68 women and child victims of family and domestic violence who died by suicide in 2017 and their prior interactions with State Government departments and authorities.

The Ombudsman gave a commitment to Parliament that, following the tabling of each major own motion investigation, 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 12 months after the tabling of the major own motion investigation.

Accordingly, in November 2023, the Ombudsman tabled in Parliament *A report on giving effect to the recommendations arising from the Investigation into family and domestic violence and suicide*.

Objectives

The Report made nine recommendations to five State Government departments about ways to prevent or reduce family and domestic violence related deaths by suicide.

The objectives of the Report were to consider, in accordance with sections 25(4) and (5) of the Act:

- 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;
- If no such steps have been, or are proposed to be taken, the reasons therefore; and
- If relevant, whether it appeared to the Ombudsman that no steps that seem to him to be appropriate have been taken within a reasonable time of his making of the Report and recommendations.

Methodology

On 28 June 2023, the Ombudsman wrote to the Mental Health Commissioner, the Director General of the Department of Communities, the Director General of the Department of Health, the Director General of the Department of Justice and the Commissioner of the WA Police Force 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 in order to clarify or validate information provided in their reports to the Ombudsman;
- Developed a preliminary view and provided it to relevant State Government departments 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

Overall, the Office found that steps have been taken, or are proposed to be taken, to give effect to each of the recommendations.

The steps taken to give effect to Recommendations 5 and 8 were considered in *A report on giving effect to the recommendations arising from the Investigation into family and domestic violence and suicide* and were further assessed in 2023-24 as outlined below.

Steps taken to give effect to Recommendations 5 and 8 of the *Investigation into family and domestic violence and suicide*

Recommendation 5: The Department of Communities, in order to better inform practice and policy, conducts a review and examines current data on:

- **the presence of family and domestic violence in duty interactions concerning older children and adolescents;**
- **intake rates related to duty interactions concerning older children and adolescents, particularly where family and domestic violence is identified;**
- **policy, practice, and culture in relation to how the Department of Communities responds to older children and adolescents; and**

provides the resulting review report to this Office within 12 months of the tabling in the Western Australian Parliament of the report of this Investigation.

Steps taken to give effect to the recommendation

The Ombudsman's report on giving effect to the recommendations arising from the *Investigation into family and domestic violence and suicide* further stated that:

> The Office requested that the Department of Communities inform the Office of the steps taken to give effect to the recommendation. In response, the Department of Communities provided the following information:
>
> > A report responding to recommendation five, is due to your office in October 2023.
> >
> > The review has commenced and is examining actions taken by Communities since 2017 to improve outcomes for children and young people impacted by family and domestic violence, including legislative and policy reforms or updates to practice guidance, staff training and service delivery models.
> >
> > The review includes analysis of relevant data including emerging themes and practice trends relating to family and domestic violence responses for older children and adolescents.
>
> **Having carefully considered the information provided by the Department of Communities, I am of the view that steps are proposed to be taken to give effect to Recommendation 5. Further, the Office will carefully consider the report from the Department of Communities as set out in the recommendation upon receipt and**

publish an update on the steps taken to give effect to Recommendation 5 in the Ombudsman's 2023-24 Annual Report.

The Department of Communities provided the review report as outlined by Recommendation 5 as required.

A summary of the review report is outlined below.

Communities' response to recommendation five, adopted two main strategies:

1. Analysis of Communities (Child Protection) administrative data concerning notification and intake for family and domestic violence, broken down by child age; and
2. A review of Communities (Child Protection) policy and casework practice guidance relating to the age of the child and / or the presence of family and domestic violence, a thematic review of oversight agency findings and qualitative review of a defined cohort of child protection decision making.

Part 1 Interactions of children, older children and adolescents

To achieve this, data from the period 1 July 2017 and 31 December 2022 was extracted from Communities' Client Management System (Assist) and analysed, with specific attention to duty interactions and associated decision making about next steps.

Key findings included:

- A significant increase in the proportion of interactions recorded in Assist that include children, which can be attributed to changes in recording practices.
- A gradual increase in the proportion of interactions that include children, that also include either an older child or adolescent.
- An increase in the proportion of interactions involving children where family and domestic violence is recorded. This increase is noted to be greater for children less than 10 years of age, than it has been for older children and adolescents.

In relation to Communities statutory child protection responses, the following key themes were identified, specifically relating to older children and adolescents:

- Family and domestic violence is more likely to be recorded in duty interactions regarding children under the age of 10 years.
- While the presence of family and domestic violence in duty interactions influences decision making for children 14 years and under, Intake rates for adolescents are comparatively lower.
- Identification of family and domestic violence in duty interactions for adolescents is not increasing at the same rates as Interaction recordings concerning all children, inclusive of older children.

- Children in the adolescent age cohort are less likely to be subject to further action being taken by Communities to promote or safeguard the wellbeing of the child pursuant to S.31 of *Children and Community Services Act 2004*.

The findings have informed the identification of opportunities to improve policies and practices regarding Communities' legislative role and responsibilities in circumstances where a child or young person is referred to Child Protection due to concerns about family and domestic violence. These findings will be considered as part of the implementation of the One Communities Family and Domestic Violence Informed Practice Approach, a five-year enhancement project that was endorsed by Communities Leadership Team in March 2023.

Review of the data related to decision making in duty Interactions for adolescents, notes there is an observable difference in decisions for No Further Action, Intake and Intake to Child Safety Investigation in this age cohort, compared to outcomes for 'all children' and 'older children'. With adolescents less likely to be intake for child safety investigation, although the general trend over the reporting periods considered is that adolescents are more likely to be intaked now, compared to 2017 data (9.2 per cent in 2017 compared to 11 per cent in 2022).

Some of the range of practice considerations for Communities work with older children and adolescents, includes:

- That Communities responsibilities set out in the *Children and Community Services Act 2004* are not stratified by age. Communities has the same responsibilities to safeguard the wellbeing of all children (0-17 years);
- Identifying abuse and neglect can include recognition of trauma response behaviours including substance abuse, self-harm or attempted suicide, disengagement from education and antisocial (including criminal) behaviour;
- The agency and autonomy of young people can create unique strengths and challenges to case work. Young people are capable of influencing family dynamics, degree of service engagement and adherence with safety plans (as an example); and
- The age of consent and the mature minor ('gillick') principle. The age of consent in Western Australia is 16 years.

Part 2. Policy, Practice and Culture

Recommendation 5 of the Own Motion Investigation requested that Communities review and examine current data on:

- Policy, practice and culture in relation to how the Department of Communities responds to older children and adolescents.

To inform this aspect of the report, the following steps have been undertaken:

- Review of Communities policies relating to family and domestic violence, and at-risk youth (inclusive of the former Department for Child Protection and Family Support);

- Review of Child Protection Casework Practice Manual, and any practice changes that occurred within the data period;
- Thematic review of oversight agency findings in relation to older children and adolescents within the data period; and
- Qualitative analysis of a small number of case files (n = 7).

Part 3. Considering the findings of this data

Several significant reform projects have been undertaken by Communities since the conclusion of the investigative period considered by the Ombudsman. Communities' policies and practice guidance related to family and domestic violence are currently subject to review, as per the redevelopment of the Child Protection Casework Practice Manual platform, enhancements of the Family and Domestic Violence Response Teams and development of a single agency policy setting aligned with the One Communities Family and Domestic Violence Informed Practice Approach.

In August 2024, the Department of Communities provided additional information relevant to recommendation 5 in relation to family and domestic violence policy and practice, specifically that:

- On 29 July 2024, the Child Protection Casework Practice Manual transitioned to a new software platform (The Guide), increasing functionality that enables more streamlined access to existing content and practice guidance. The second phase of The Guide will launch in early 2025 and will include updated guidance to support Child Protection officers in identifying and responding to family and domestic violence, including working with adolescents. The mapping of content development is underway and will be informed by the findings of the data report and the principles and critical components of the Safe and Together Model.
- The findings have also been considered through development of the One Communities Family and Domestic Violence Informed Practice Approach, noting the final draft for Communities whole of agency policy makes specific statements with respect to children and young people as victim-survivors of family and domestic violence.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 8: The Mental Health Commission, in collaboration with relevant State Government departments and authorities and stakeholders, develop and disseminate a common understanding of what constitutes a trauma-informed approach for Western Australian State Government departments and authorities. Including, but not limited to:

- **A definition and key principles of a trauma-informed approach;**
- **Domains of implementation (including, but not limited to, an organisation's strategic leadership, policy, training for staff, and evaluation);**
- **Consideration of vicarious trauma in the service delivery context;**
- **This approach being intersectional, and elevates the voices and experiences of Aboriginal and/or Torres Strait Islander people; and**
- **A timeline for undertaking this work.**

Steps taken to give effect to the recommendation

The report on giving effect to the recommendations arising from the *Investigation into family and domestic violence and suicide* also stated:

> While it is noted that the Mental Health Commission has commenced work to give effect to Recommendation 8, this work commenced more than eight months after the tabling of the report of the Investigation in Parliament.
>
> Given the exceptionally serious, and extraordinarily egregious nature, of men's violence to women, including the very welcome public attention being in relation to this violence, the fact that an eight-month period elapsed prior to commencing this work is of concern.
>
> For this reason, the Office informed the Mental Health Commission that the Office will review this matter again on 31 December 2023, and it is expected that this work will be significantly advanced, and have a clear timeline for completion, in accordance with, and giving effect to, Recommendation 8. The Mental Health Commission has, pleasingly, now prioritised work to address this recommendation and has committed to providing the Office an update on their progress, including a clear timeline for completion, by 31 December 2023.

The Mental Health Commission provided an update on the steps taken to give effect to Recommendation 8. This included the Terms of Reference for the working group to develop a Trauma-Informed Approach and a timeline for completion of the Trauma-Informed Approach. A summary of the Terms of Reference and timeline for completion supplied by the Mental Health Commission is outlined below:

Introduction

The State Government Working Group for the Development of a Trauma-Informed Approach (**Working Group**) is being established for the purpose of supporting the development of a trauma-informed approach for State Government departments and authorities, as required by Recommendation 8 made by the Western Australian Ombudsman in his major own motion investigation into family and

domestic violence (**FDV**) and suicide report (**the Report**): Investigation into family and domestic violence and suicide report.

Background

On 20 October 2022, the Western Australian Ombudsman tabled in Parliament the Report of his major own motion investigation into FDV and suicide. The Report provided extensive data relating to 68 women and children who were identified as victims of FDV and had died by suicide, and their prior contact with State Government departments and authorities.

As of result of the investigation, the Report identified a range of opportunities across all stages of service engagement to improve the identification of, and responses to FDV in Western Australia. This included an identified need for State Government departments and authorities to use trauma-informed approaches to better meet the needs of individuals who have experienced multiple circumstances of vulnerability, including but not limited to, when responding to FDV and suicidality.

Arising from the findings of the report, the Ombudsman assigned nine recommendations to five State Government departments.

Related to Recommendation 8, Recommendation 9 from the Report was allocated to the WA Police Force, Department of Justice, Department of Health, and Department of Communities. The recommendation directs the named departments to take into account the outcomes of Recommendation 8 by considering: 'how a trauma-informed approach may be incorporated into their operations; and work to improve their organisation's understanding of trauma.'

The close relationship between the two recommendations necessitates that a collaborative cross-agency approach is taken to the work required to meet Recommendation 8. The Mental Health Commission will lead the development of an overarching trauma-informed approach for State Government departments and authorities, in collaboration with other Mental Health Commission directorates, a range of government agencies, Aboriginal people and people with lived experience, families and carers.

Purpose/objectives

Chaired by the Mental Health Commission, the purpose of the Working Group is to provide cross-agency advice and guidance on the development of a trauma-informed approach for State Government, in line with the components outlined in Recommendation 8.

The Working Group's primary objectives are to:

- Ensure across agency contribution into the development of a trauma-informed approach for Western Australian State Government departments and authorities;
- Provide strategic oversight, advice, and input on the components of a trauma-informed approach, as outlined in Recommendation 8.
- Contribute to and provide feedback on the development of a guide to a trauma-informed approach, for dissemination to State Government departments and authorities;

- Identify relevant stakeholders and networks to engage for targeted consultation on the draft guide; and
- Be informed by community, lived experience and outcomes of recent reviews, latest evidence and best practice.

Membership

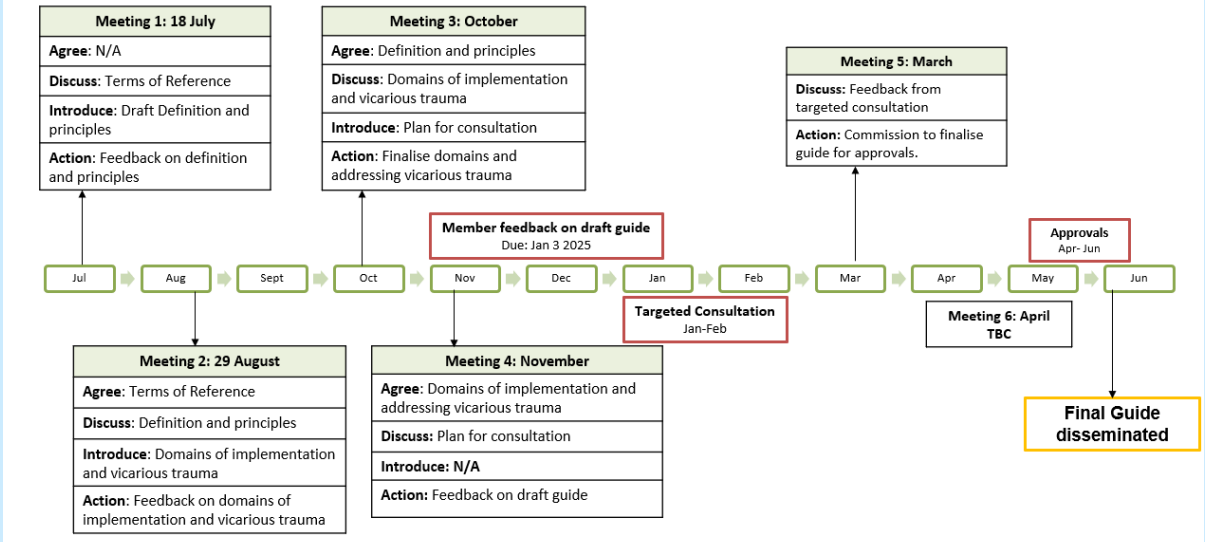
The Working Group consists of representatives from:

- Mental Health Commission
- Department of Education
- Department of Communities
- Department of Health
- Department of Justice
- WA Police Force
- Aboriginal Health Council of Western Australia
- Lived experience representatives

Agencies are responsible for nominating representatives from their agencies with the relevant skills and expertise to deliver on the purpose, objectives, and priorities of the Working Group.

Other agency representatives or observers may be invited to attend meetings and participate as required and agreed by the Chair.

Timeline



Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

The Office will continue to monitor the steps taken to give effect to Recommendation 8 and will publish an update in the Office's 2024-25 Annual Report.

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 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 the WA Police Force in order to ascertain the extent of the WA Police Force's compliance with Parts 2 and 3 of the Act.

Part 4 also provides that the Commissioner of Police must keep a register (**the register**) of certain information related to the exercise of powers conferred under the Act. The information in the register must be provided 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 first annual report, *Report of the monitoring activities of the Parliamentary Commissioner for Administrative Investigations under Part 4 of the Criminal Law (Unlawful Consorting and Prohibited Insignia) Act 2021* for the period ending 23 December 2023, was tabled in Parliament on 13 March 2024.

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.