Own Motion Investigations and Administrative Improvement

A key function of the Office is to improve the standard of administration in public authorities. The Office achieves positive outcomes in this area in a number of ways including:

- Making recommendations and suggestions to improve public administration as a result of:
  - The investigation of complaints; and
  - Reviews of child deaths.
- Undertaking own motion investigations that are based on the patterns, trends and themes that arise from the resolution of individual complaints and child death reviews, referred to as own motion investigations;
- Providing guidance to public authorities on decision making 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 a public authority's administrative practices. 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 reviews also result in improvements to administrative practices as a result of the review of individual child deaths. Further details of the improvements arising from complaint resolution are shown in the Child Death 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 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 outweigh the costs.

Own motion investigations that arise out of child death reviews focus on the practices of agencies that provide services to children and their families and aim to improve the administration of these services so as to prevent or reduce child deaths.

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 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 the public sector; 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 advised when the project commences and Ombudsman staff consult regularly with staff at all levels to ensure that the facts and understanding of the issues are correct and findings are evidence-based. The public authority is given regular progress reports on findings together with the opportunity to comment on draft conclusions and any recommendations.

Monitoring the implementation of recommendations

Recommendations for administrative improvements are based closely on evidence gathered during investigations and are designed to be a proportionate response to the number and type of administrative issues identified. Each of the recommendations arising from own motion investigations is actively monitored by the Ombudsman's office to ensure its implementation and effectiveness in relation to the observations made in the investigation.

Own Motion Investigations in 2011-12

In 2011-12, two major own motion investigations were conducted relating to:

- Planning for children in care; and
- Sleep-related deaths of infants.

Planning For Children in Care Report

In November 2011, the Planning for Children in Care report was tabled in Parliament. The full report, entitled *Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004*, is available on the Ombudsman's website.

Reasons for the investigation

For the majority of Western Australian children, their parents and family network provide for their protection and care. However, at the commencement of this investigation there were 3,356 children in the care of the Chief Executive Officer (**CEO**) of the Department for Child Protection (**DCP**). For these children (referred to as 'children in care'), the State provides protection and care. The way in which the State is to perform this role is set out in the *Children and Community Services Act 2004* (**CCS Act**), the objects of which include 'to provide for the protection and care of children in circumstances where their parents have not given, or are unlikely to give that protection and care…' (s.6(d)).

As part of providing for the protection and care of children in care, the CCS Act contains a number of provisions requiring care planning for children in care. These include requirements for the preparation, timing, content and review of care plans, as well as provisions specific to participation by the child, their family and carers in care planning, and to Aboriginal and Torres Strait Islander children in care. There are also further instruments that have the effect of regulating the administration of care planning responsibilities in Western Australia, in particular the policies and procedures established by DCP.

Cooperation between DCP, the Department of Health and the Department of Education is a critical aspect of the care planning system and is promoted by the CCS Act.

This cooperation is consistent with the recommendations of the Department for Community Development: Review Report, presented by the independent reviewer Ms Prudence Ford (**the Ford Review**). The Ford Review report recommendations were endorsed by the (then) Western Australian Government in 2007. Recommendation 63, in particular, recommended that 'the Departments of Health and Education and Training (now the Department of Education and the Department of Training and Workforce Development) respectively be required to develop a Health Plan (covering physical, mental and dental health) and an Educational Plan respectively for each child or young person in care.'

Objectives of the investigation

The objective of the investigation was to examine how State Government agencies have administered the requirements of the CCS Act regarding care planning for children in care, in particular whether:

- DCP has established policies and procedures for care planning that are consistent with the requirements of the CCS Act;
- DCP is appropriately complying with the requirements for the preparation, timing and review of provisional care plans and care plans, set out in the CCS Act and its own policies and procedures;
- Care plans address the areas that the CCS Act and DCP's policies and procedures identify as necessary to ensure a child's wellbeing; and

- Health care planning and education planning are undertaken in accordance with the agreements that DCP has established with the Department of Health and the Department of Education, and in accordance with the related policies and procedures of the three agencies.

The investigation examined the administration of care planning for those children in care who were of primary school age at the commencement of the investigation, had been taken into care after 1 July 2008, and were still in care when the investigation commenced. This cohort numbered 443 children in total.

Key messages from the investigation

Significant and pleasing progress on improved planning for children in care has been achieved, however, there is still work to be done, particularly in relation to the timeliness of preparing care plans and ensuring that care plans fully incorporate health and education needs, other wellbeing issues, the wishes and views of children in care and are regularly reviewed.

There has been significant and pleasing progress on improved planning for children in care but there is still work to be done.

The key messages arising from the investigation, and set out in the report are:

- In the five years since the proclamation of the CCS Act, the three State Government agencies that are primarily responsible for planning for children in care have cooperated to operationalise the requirements of the CCS Act. This work has resulted in the agencies redesigning the system for care planning, as follows:
    - DCP has developed a series of policies and procedures for care planning that are consistent with the CCS Act;
    - DCP and the Department of Health have agreed and developed a comprehensive strategy for health care planning that addresses the Ford Review recommendations regarding health care planning for children in care; and
    - DCP and the Department of Education have taken initial steps to address the Ford Review recommendations regarding education planning for children in care.
- DCP had prepared provisional care plans and/or care plans for nearly all children included in the investigation, as required by the CCS Act, however:
    - In most instances examined, DCP did not achieve the timeframes for care planning as required by the CCS Act and its own policies and procedures, although timeliness varied widely across DCP districts; and
    - In many instances examined, DCP had not conducted reviews of care plans, as required by the CCS Act.

- Many of the children in care included in the investigation had not received appropriate health care and education planning. More particularly:
    - Although DCP and the Department of Health have commenced a comprehensive strategy for health care planning, only one third of children included in the investigation had received health assessments and/or medical examinations, as agreed in the strategy; and
    - Although DCP and the Department of Education have taken initial steps to establish a strategy for education planning, they have not yet implemented the education component of care planning and therefore few *Documented Education Plans* had been prepared for children included in the investigation.
- Many care plans did not record or otherwise demonstrate that the children in care included in the investigation were given the opportunity to express their wishes and views about their own care planning, as required by the CCS Act.
- Only half of the care plans we examined in detail covered all of the areas of child wellbeing identified in the CCS Act and DCP's policies and procedures.

All 23 recommendations for administrative improvement arising from the planning for children in care report were accepted by the agencies involved.

The report also identified 23 recommendations for improvement in care planning for children in care. Agencies have agreed to these recommendations and monitoring of their implementation and effectiveness is discussed further below.

Monitoring the implementation and effectiveness of report recommendations

Each of the recommendations arising from own motion investigations is being monitored by the Office to ensure its implementation and effectiveness in relation to the observations made in the investigation.

Relevant agencies have provided reports on their progress to date in implementing the recommendations arising from the report on planning for children in care. These reports indicate that, to date, satisfactory progress has been made in implementing the recommendations. The Ombudsman will undertake further work in 2012-13 to confirm the implementation of the recommendations and the extent to which this action by agencies has resulted in the intended administrative improvements.

The Ombudsman monitors recommendations to ensure their implementation and effectiveness.

The Ombudsman also monitors improvements in care planning through the review of individual child deaths. These reviews identified good practice by DCP and other public authorities, as well as good interagency communication and cooperation, in relation to care planning.

Investigation into ways to prevent or reduce sleep-related infant deaths

Investigation rationale and objectives

Own motion investigations are informed by patterns and trends arising from child death notifications to the Ombudsman. The Ombudsman identified a high proportion of cases in which infants (defined as children under the age of 12 months) died during their sleep. For this reason, the Ombudsman decided to undertake an investigation of these sleep-related infant deaths with a view to determining whether it was appropriate to make recommendations to any department or agency about ways to prevent or reduce such deaths.

The objectives of the investigation are to:

- Analyse all sleep-related infant deaths notified to the Ombudsman between 1 July 2009 and 31 December 2011;
- Undertake research, including a comprehensive literature and practice review, in relation to sleep-related infant deaths;
- Undertake consultation with key stakeholders;
- Identify patterns and trends specifically in relation to sleep-related infant deaths; and
- From this analysis, pattern and trend identification, research and consultation, identify opportunities for State government agencies to prevent or reduce sleep-related infant deaths and make recommendations to these agencies accordingly.

A full report of the investigation will be tabled in Parliament in November 2012 and, once tabled, will be available from the Ombudsman's website.

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 them improving 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 if 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.

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. Workshops and presentations conducted during the year include:

- Various presentations on the role of the Ombudsman to:
    - Local government governance specialists at the Western Australian Local Government Association 2011 State Conference;
    - Local government managers at the Local Government Managers Australia Customer Service Forum;
    - Aged care and disability service providers and relevant government agencies at a Seniors Forum coordinated by Centrelink;
    - Department for Child Protection staff at their complaint forum;
    - New public sector officers at the Public Sector Commission's Ethics and Integrity Induction Program; and
    - Prison Officers, as part of the Department of Corrective Services induction program.
- *Good Administrative Decision Making* to Department of Housing staff; and
- *Managing Unreasonable Complainant Conduct* to members of the State Administrative Tribunal.

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 section on Collaboration and Access to Services.

Inspection and Monitoring Functions

Telecommunications Interception Inspections

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. Western Australia Police and the Corruption and Crime Commission are eligible authorities in Western Australia. The Ombudsman is appointed as the Principal Inspector to inspect relevant records of both agencies to ascertain the extent of their compliance with the legislation. The Ombudsman must inspect the telecommunications interception records at least twice during each financial year and must report to the responsible Ministers about the results of those inspections within three months of the end of the financial year.

Monitoring of Criminal Penalty Infringement Notices

The *Criminal Code Amendment (Infringement Notices) Act 2011* (**the Act**) amends the *Criminal Code* and introduces a new scheme into Western Australia for the issue of Criminal Penalty Infringement Notices by Western Australia Police for certain *Criminal Code* offences.

The Act will require the Ombudsman to keep under scrutiny the operation of relevant parts of the *Criminal Code* and regulations and relevant parts of the *Criminal Investigation (Identifying People) Act 2002* for a period of 12 months. The scrutiny is to include the impact on Aboriginal and Torres Strait Islander communities. The Ombudsman will have to report to the Minister for Police and the Commissioner of Police as soon as practicable after this time and the Minister is to table the report in both Houses of Parliament as soon as practicable after receiving the report.