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 to improve public administration as a result of:
  - The investigation of complaints; and
  - Reviews of child deaths and family and domestic violence fatalities.
- Undertaking own motion investigations that are based on the patterns, trends and themes that arise from the resolution of individual complaints, child deaths and family and domestic violence fatalities;
- Providing guidance to public authorities on good decision making and practices and complaint handling through continuous liaison, publications, presentations and workshops;
- Working collaboratively with other integrity and accountability agencies to encourage best practice and leadership in public authorities; and
- Undertaking inspection and monitoring functions.

Improvements from Complaints and Reviews

In addition to outcomes which result in some form of assistance for the complainant, the Ombudsman also achieves outcomes which are aimed at improving 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 and family and domestic violence fatality reviews also result in improvements to administrative practices 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 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 Office to ensure its implementation and effectiveness in relation to the observations made in the investigation.

Own Motion Investigations in 2012-13

In 2012-13, a major own motion investigation relating to the sleep-related deaths of infants was conducted and two further own motion investigations were commenced relating to:

- Suicide by young people; and
- Local government collection of outstanding rates.

Sleep-related Infant Deaths Report

In November 2012, the Ombudsman tabled in Parliament a report of an own motion investigation entitled *Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths.* The report is available on the Ombudsman's website.

Reasons for the investigation

Infant deaths formed a significant proportion of the child deaths notified to the Ombudsman as part of the Ombudsman's child death review function. Over the period 1 July 2009 to 31 December 2011, the Chief Executive Officer of the Department for Child Protection and Family Support notified the Ombudsman of 242 child deaths. Ninety one (38%) of these deaths concerned infants (children under the age of 12 months).

Through the review of the circumstances in which and why child deaths occurred, the Ombudsman identified a pattern of cases in which infants appeared to die suddenly and unexpectedly during their sleep. This occurred in 54 (59%) of the 91 cases of infant death notified to the Ombudsman.

For this reason, the Ombudsman decided to undertake an investigation of these sleep-related infant deaths (**the Ombudsman's cases**) with a view to determining whether it was appropriate to make recommendations to any State Government department about ways to prevent or reduce such deaths.

Objectives of the investigation

The objectives of the investigation were 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 departments to prevent or reduce sleep-related infant deaths, and make recommendations to these departments accordingly.

Key findings and messages from the investigation

The Department of Health has undertaken work to contribute to safe sleeping practices but there is still important work to be done.

In summary, the investigation found that the Department of Health has undertaken a range of work to contribute to safe sleeping practices in Western Australia, however, there is still important work to be done. This work includes, in particular, establishing a comprehensive statement on safe sleeping that will form the basis for safe sleeping advice to parents, including advice on modifiable risk factors, that is sensitive and appropriate to both Aboriginal and culturally and linguistically diverse communities and is consistently applied state-wide by health care professionals and non-government organisations at the ante-natal, hospital-care and post-hospital stages. This statement and concomitant policies and practices should also be adopted, as relevant, by the Department for Child Protection (as it then was) and the Department of Communities (as it then was).

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

- The most frequent cause of sleep-related infant deaths is likely to be Sudden Infant Death Syndrome (commonly referred to as SIDS). SIDS is a classification of the cause of death used by medical practitioners and coroners. A definition of SIDS that is widely accepted in Australia is:

  > The sudden and unexpected death of an infant, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history.

- The research literature identifies that certain factors increase the risk of SIDS, and refers to these as 'risk factors' for SIDS. Some of the identified risk factors concern infant characteristics (**infant risk factors**). It is important to note that these risk factors are correlative, not necessarily causal. The infant risk factors are:
  - Infant is aged older than one month and less than four months;
  - Infant is male;
  - Infant was born prematurely;
  - Infant had low birth weight; and
  - Infant's mother smoked during pregnancy.

  These infant risk factors for SIDS have also been found to be relevant to other types of sleep-related infant deaths. Our analysis found that these infant risk factors were also prominent among the Ombudsman's cases.

- Other identified risk factors for SIDS concern characteristics of the infant's sleeping environment (**environmental risk factors**). These environmental risk factors are:

- Prone sleeping position;
- Unsafe sleeping surface;
- Unsafe bedding; and
- Environmental tobacco smoke (within the infant's sleeping environment).

These environmental risk factors for SIDS have been found to be relevant to other types of sleep-related infant deaths. Our analysis found that these environmental risk factors were also prominent among the Ombudsman's cases.

- Forty eight (89%) of the Ombudsman's cases involved risk factors that are potentially modifiable. This indicates that, by assisting parents and carers in relation to the possible modification of these risk factors, there are potential opportunities for State Government departments and authorities to prevent or reduce the number of sleep-related infant deaths beyond that action which is currently undertaken.
- Thirty (56%) of the Ombudsman's cases involved one or more of the environmental risk factors that safe sleeping advice has traditionally and still commonly recommends should be avoided. These findings point to the continued relevance of the four key messages common to safe sleeping advice and the importance of continuing to assist parents and carers to follow this advice when placing their infants to sleep. The four key messages about how to avoid the environmental risk factors were:
  - Place an infant on its back to sleep;
  - Use a safe sleeping surface;
  - Use safe bedding, keep infant's head uncovered, and avoid soft toys and other items in the infant's sleeping environment; and
  - Avoid environmental tobacco smoke.
- In eight (15%) of the Ombudsman's cases, the infants were placed to sleep in a cot or bed somewhere other than their usual sleep location. Recent research has suggested that the risk of SIDS is higher when the infant sleeps in a different location than their usual place of sleep, particularly if at a friend or relative's house.
- Twenty nine (54%) of the Ombudsman's cases reportedly involved co-sleeping, and in all of these cases infant and/or environmental risk factors were also involved. Infant risk factors were involved in 28 (97%) of the 29 cases, and environmental risk factors were involved in 16 (55%) of the 29 cases. In 15 (52%) of the 29 Ombudsman's cases in which the infant was reportedly co-sleeping at the time of death, both infant and environmental risk factors featured in the circumstances of the infant's death.
- Twenty eight (52%) of the Ombudsman's cases involved infants whose mothers reported smoking during pregnancy. The Department of Health already has in place a range of policies and strategies designed to inform pregnant women of the dangers of smoking and to assist them to give up smoking where they choose to do so. Our analysis points to the continued importance of these policies and strategies, as well as to the importance of linking strategies to deliver safe

sleeping advice with the range of existing programs designed to assist people to give up smoking.

- Nineteen (35%) of the Ombudsman's cases involved Aboriginal infants, even though Aboriginal infants comprise only 6% of WA infants. This finding reflects the research literature, which has identified that Aboriginal infants are over-represented among infants whose death is diagnosed as SIDS, and that the decline in the rate of SIDS has not been as significant in the Aboriginal population as it has been in the non- Aboriginal population.
- At least three (6%) of the Ombudsman's cases involved infants from culturally and linguistically diverse backgrounds, and all of these cases involved modifiable risk factors. All three cases involved modifiable risk factors (apart from maternal smoking during pregnancy), and all three deaths occurred in circumstances that safe sleeping advice commonly recommends should be avoided.
- Twenty (37%) of the Ombudsman's cases involved infants from families whose children had already been the subject of concerns raised with the (then) Department for Child Protection. In 15 of these 20 cases, the Department for Child Protection had determined that some action should be taken in regard to the child or a child relative of the child, and that action was taken. These concerns and actions were not necessarily related to modifiable risk factors associated with sleep-related infant deaths.
- In 14 (26%) of the Ombudsman's cases, fathers or grandparents were immediately present at the time of the infant's death. In two of these 14 cases, the infant was in the primary care of the father, and in another two cases, the infant was in the primary care of a grandparent. The research literature and our consultations with stakeholders also identify that as well as playing the role of direct carer, fathers and grandparents may influence how mothers place infants to sleep.

The report identified 23 recommendations about ways to prevent or reduce sleep-related infant deaths and set out opportunities for the Departments involved to put the recommendations into practice. The Departments have agreed to the recommendations and were highly co-operative and positively engaged with the investigation.

All 23 recommendations for administrative improvement arising from the sleep-related infant deaths report were accepted by the Departments.

Monitoring the implementation and effectiveness of report recommendations

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 including, through:

- Whether child death reviews undertaken by the Office show evidence of improved practice in relation to the areas subject to own motion investigations (for further details see the Child Death Review section); and
- Reports by the relevant agencies on progress to date in the implementation of the recommendations made by the Ombudsman.

Further monitoring by the Office will be undertaken through an own motion investigation, commencing in 2013-14, to review the implementation and effectiveness of recommendations made by the Ombudsman.

Own Motion Investigations in 2013-14

During 2012-13, the Ombudsman undertook two own motion investigations:

- Ways that State Government departments and authorities can prevent or reduce suicide by young people; and
- Local Government collection of outstanding rates.

Reports of each investigation will be tabled in Parliament in 2013-14.

In 2013-14, the Ombudsman will commence own motion investigations relating to:

- Family and domestic violence fatality reviews; and
- Implementation and effectiveness of recommendations made by the Ombudsman as a result of own motion investigations, and complaints and reviews.

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.

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:
    - New public sector officers at the Public Sector Commission's Ethics and Integrity Induction Program;
    - Members of the Bunbury Youth Advisory Council; and
    - Officers of the Health Complaints Advisory Group.
- The *Role of the Ombudsman* and *Ensuring your complaint handling system is accessible to children and young people* at the Commissioner for Children and Young People's *Making Complaints Processes Child-Friendly* Seminars;
- *The Ombudsman and Local Government - Resolving Complaints and Promoting Good Administrative Practice* at the Local Government Managers Australia Finance Conference; and
- *The Role of the Ombudsman* and training on *Good Decision Making* and *Effective Complaint Handling* for public authorities during the Office's Pilbara and Bunbury Regional Awareness and Accessibility Programs (see further details in the Collaboration and Access to Services section).

Working Collaboratively

The Office works collaboratively with other integrity and accountability agencies to encourage best practice and leadership in public authorities. Improvements to public administration are supported by the collaborative development of products and forums to promote integrity in decision making, practices and conduct. Details are provided in the Collaboration and Access to Services section.

Inspection and Monitoring Functions

Telecommunications Interception 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. The 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.