The Year in Brief for 2012-13

Resolving Complaints

Complaints and Enquiries

There were 11,710 contacts with the Office, including 9,445 enquiries and 2,265 complaints.

Timely Complaint Handling

Timely complaint handling in 2012-13 meant that:

- 83% of allegations were finalised within 3 months; and
- There has been a reduction of 67% in the average age of complaints on hand.

Following the introduction of the Office's complaint handling improvement program in 2007-08, very significant improvements have been achieved in timely complaint handling, including:

- The average age of complaints decreased from 173 days at 30 June 2007 to 33 days at 30 June 2013; and
- Complaints on hand older than 12 months have decreased by 90%.

Efficient Complaint Handling

- The average cost of finalising allegations has reduced this year to $1,821.
- As a result of the Office's complaint handling improvement program, commencing in 2007-08, the average cost of finalising allegations has now reduced for five consecutive years by a total of 38% (from $2,941 per finalised allegation in 2007-08 to $1,821 per finalised allegation in 2012-13).

Child Death Reviews

- There were 37 investigable child deaths.
- Timely review processes have resulted in 68% of reviews completed within 3 months.
- Important patterns and trends in relation to child deaths have been identified.
- As a result of child death reviews, improvements to public administration, designed to prevent or reduce child deaths, have been achieved.

Family and Domestic Violence Fatality Reviews

An important new function to review family and domestic violence fatalities commenced on 1 July 2012. In the first year of operation:

- Significant work has been undertaken to develop structures and processes to ensure that the function is undertaken effectively and efficiently;
- There were 20 reviewable family and domestic violence fatalities from a total of 22 notifications; and
- Issues, patterns and trends arising from family and domestic violence fatality reviews have been identified and are set out in the Annual Report.

Own Motion Investigations and Administrative Improvements

- Complaints to the Ombudsman resulted in improvements to administrative decision making and practices.
- A report of a major own motion investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths was tabled in Parliament in November 2012. 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 work to be done, particularly in relation to establishing a comprehensive statement on safe sleeping that will form the basis for safe sleeping advice to parents. The report made 23 recommendations, all of which were accepted by the agencies involved.
- Significant work has been undertaken on own motion investigations into ways that State Government departments and authorities can prevent or reduce suicide by young people and local government collection of outstanding rates.

Collaboration and Access to Services

- Liaison and collaboration with other Ombudsmen and Western Australian accountability agencies has been undertaken.
- Access for regional Western Australians, in particular Aboriginal Western Australians, continued to be a focus through the Office's Regional Access and Awareness Program.