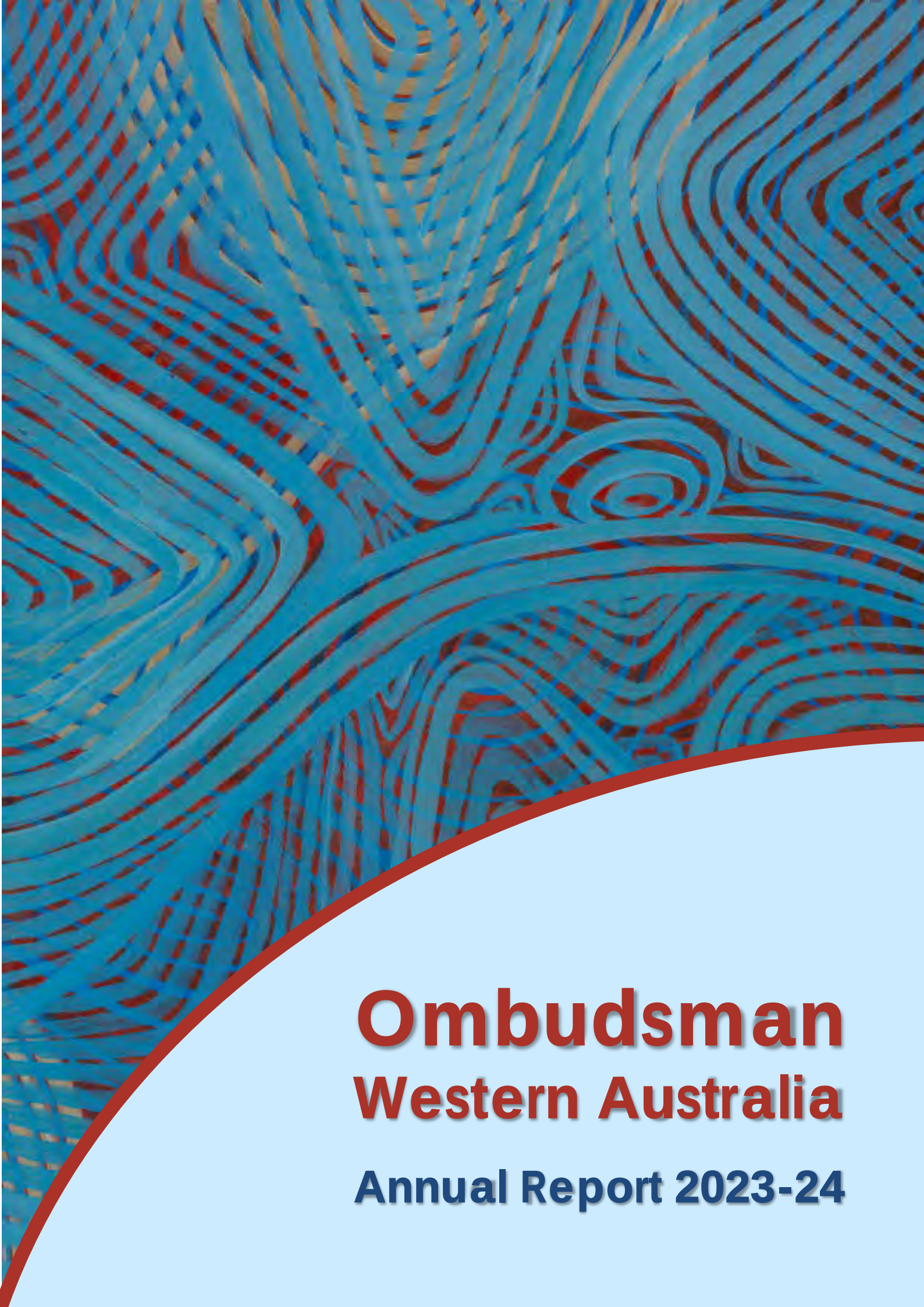


Ombudsman
Western Australia

Annual Report 2023-24

The President of the Legislative Council

The Speaker of the Legislative Assembly

Annual Report of the Parliamentary Commissioner for Administrative Investigations (Ombudsman) for the year ended 30 June 2024

In accordance with section 64(1) of the *Financial Management Act 2006* (as modified by section 5(2) and Schedule 2), I am pleased to submit to Parliament the Annual Report of the Parliamentary Commissioner for Administrative Investigations (Ombudsman) for the financial year ended 30 June 2024.

The report has been prepared in accordance with the *Financial Management Act 2006* and section 27 of the *Parliamentary Commissioner Act 1971.*

David Robinson
Deputy Ombudsman

19 September 2024

Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander people of Australia as the traditional custodians of this land. We recognise and respect the long history and ongoing cultural connection Aboriginal and Torres Strait Islander people have to Australia, recognise the strength, resilience and capacity of Aboriginal and Torres Strait Islander people and pay respect to Elders past and present, and emerging leaders.

About this report

This report describes the functions and operations of the Ombudsman Western Australia for the year ending 30 June 2024.

First published by Ombudsman Western Australia in September 2024. This report was written, designed, printed and converted for electronic viewing in-house. It can also be made available in alternative formats to meet the needs of people with disability. Requests should be directed to the publications team at (08) 9220 7555 or mail@ombudsman.wa.gov.au.

ISSN 1832-245X (Print)
ISSN 2205-815X (Online)

Contents

This page has been intentionally left blank.

Overview

This section provides an executive summary of the Office's performance, general information about the Office and the Office's Performance Management Framework.

Deputy Ombudsman's Overview

The Ombudsman's primary role is to investigate and resolve complaints. In 2023-24, we received 14,516 contacts from Western Australians, comprising 12,079 enquiries and 2,437 complaints.

Complaints must be resolved effectively and efficiently. In the last year, 95% of complaints were resolved within three months. The average age of complaints on 30 June 2024 was 41 days. The average cost of resolving complaints in 2023-24 was $1,314.

The Ombudsman also reviews certain child deaths and family and domestic violence fatalities.

At the completion of investigations and reviews, the Ombudsman has the power to make recommendations. In 2023-24, we made eight recommendations about ways to prevent or reduce child deaths and family and domestic violence fatalities. This year, all our recommendations were accepted.

2023-24 was the first full year of the Reportable Conduct Scheme (**the Scheme**). The Scheme aims to make Western Australian children safer. The Scheme requires heads of organisations that exercise care, supervision or authority over children to notify allegations of, or convictions for, child abuse by their employees to the office of the Ombudsman and then investigate these allegations. We monitor, oversee and review these investigations.

The Scheme implements key recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse and provides that child abuse in organisations will be notified to an impartial and independent body; investigated and dealt with to ensure children are protected from abuse within institutions.

We also continued work on two other relatively new functions; scrutinising the exercise of powers under the Protected Entertainment Precincts provisions of the *Liquor Control Act 1988* and, as the Western Australian Charitable Trusts Commission, receiving and investigating complaints about charitable trusts.

The Ombudsman serves all Western Australians. To increase awareness of, and accessibility to, our services by those living in the regions, we visited the Gascoyne region in August 2023, the Esperance region in December 2023 and the Mid West region in May 2024. The office also conducted a range of other engagement and collaboration initiatives in the metropolitan area and as part of the regional outreach program. Members of the Ombudsman's Aboriginal Engagement and Collaboration team played an important role in this work ensuring that the office was accessible to Aboriginal people in the areas we visited.

I would like to thank all staff for their professionalism and commitment to the work of the office over the last 12 months. This annual report shows only a small part of the hard work they do every day in the service of all Western Australians.

David Robinson
DEPUTY OMBUDSMAN

Year in Brief 2023-24

- We received 2,437 complaints and 12,079 enquiries.
- We finalised 95% of complaints within 3 months.
- All our recommendations were accepted.
- In relation to our review of child deaths and family domestic violence fatalities, we:
  - Received 139 notifications of child deaths of which 49 went to investigation;
  - Received 29 reviewable family and domestic violence fatalities; and
  - Made eight recommendations about ways to prevent or reduce these deaths and fatalities.

- The Reportable Conduct Scheme expanded on 1 January 2024 to cover additional categories of conduct and additional sectors. The Scheme provides independent oversight of how organisations that exercise care, supervision or authority over children handle allegations of, and convictions for, child abuse by their employees. In 2023-24, we received 696 notifications of reportable conduct and, arising from the Ombudsman's involvement, organisations took 97 actions to prevent reportable conduct.
- We tabled a report in Parliament: *A report on giving effect to the recommendations arising from the Investigation into family and domestic violence and suicide*.
- We completed *A 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 2022*, which was tabled in Parliament by the Attorney General.
- We enhanced regional awareness and access to the Office, including visits to:
    - Carnarvon in the Gascoyne Region;
    - Esperance in the Goldfields-Esperance Region; and
    - Geraldton and Mullewa in the Mid-West Region.

Operational Structure

The Role of the Ombudsman

The Parliamentary Commissioner for Administrative Investigations – more commonly known as the Ombudsman – is an independent and impartial officer of the Western Australian Parliament. The Ombudsman is responsible to the Parliament rather than to the government of the day. This allows the Office of the Ombudsman to be independent in exercising its functions.

Functions of the Ombudsman

The Office has five principal functions derived from its governing legislation, the *Parliamentary Commissioner Act 1971*, and other legislation, codes or service delivery arrangements.

Principal Functions

Investigating and resolving complaints	Receiving, investigating and resolving complaints about State Government agencies, local governments and universities.
Reviewing certain deaths	Reviewing child deaths and family and domestic violence fatalities.
Undertaking own motion investigations	Improving public administration for the benefit of all Western Australians through own motion investigations.
Reportable Conduct Scheme	Monitoring, overseeing and reviewing investigations undertaken by organisations into allegations of, and convictions for, abuse of children involving any of the organisation's employees.
Other functions	Undertaking a range of additional functions, including statutory inspection and monitoring functions.

Other Functions of the Ombudsman

Complaints and appeals by overseas students	Under the relevant national code, the Ombudsman can receive complaints or appeals by overseas students.
Charitable Trusts	The Western Australian Charitable Trusts Commission, constituted by the Ombudsman, can receive and investigate complaints about charitable trusts.
Public Interest Disclosures	The Ombudsman can receive disclosures of public interest information relating to matters of administration, and public officers.
Complaints from residents of the Indian Ocean Territories	Under a service delivery arrangement between the Ombudsman and the Australian Government, the Ombudsman can investigate complaints about public authorities in the Ombudsman's jurisdiction that provide services in the Indian Ocean Territories (Christmas and Cocos (Keeling) Islands).
Complaints from persons detained under terrorism legislation	Persons detained under relevant terrorism legislation can make a complaint to the Ombudsman.
Inspection of Telecommunications Interception records	The Ombudsman inspects the records of the Western Australia Police Force (**WA Police Force**) and the Corruption and Crime Commission to ascertain the extent of compliance with relevant telecommunications interception legislation.
Scrutiny of police powers in relation to unlawful consorting and prohibited insignia	The Ombudsman keeps under scrutiny the exercise of powers by the WA Police Force to ascertain the extent of their compliance with unlawful consorting and prohibited insignia legislation.
Scrutiny of powers in relation to Protected Entertainment Precincts	The Ombudsman keeps under scrutiny the operation of, and exercise of powers under, the Protected Entertainment Precincts provisions of the relevant liquor control legislation.
Energy and Water Ombudsman	The Energy and Water Ombudsman Western Australia resolves complaints about electricity, gas and water providers. The Ombudsman undertakes the role of the Energy and Water Ombudsman. The costs of the Energy and Water Ombudsman are met by industry members.

A full list of legislation governing these functions can be found in the Appendices Section in Appendix 2.

Our Vision, Mission and Values

Our Vision

Lawful, reasonable, fair and accountable decision making and practices by public authorities.

Our Mission

To serve Parliament and Western Australians by:

- Receiving, investigating and resolving complaints about State Government agencies, local governments, universities and charitable trusts;
- Reviewing child deaths and family and domestic violence fatalities;
- Overseeing and monitoring that relevant organisations are accountable for, and are, preventing, notifying and dealing with reportable conduct;
- Improving public administration for the benefit of all Western Australians through own motion investigations and education and liaison programs with public authorities; and
- Undertaking a range of additional functions, including statutory inspection and monitoring functions.

Our Values

- **Fair**: We observe the requirements of our legislation at all times, use a 'no surprises' approach in all of our work and provide our services equitably to all Western Australians.
- **Independent and impartial**: The Ombudsman is an officer of the Parliament, independent of the government of the day and impartial in all of our work.
- **Accountable**: We should be, and are, accountable for our performance and proper expenditure of taxpayers' money. Being accountable means being:
  - **Rigorous**: We undertake work that is important to the community and our decisions are supported by appropriate evidence.
  - **Responsible**: All recommendations for change to public administration are practical and proportionate to the problem identified and have a net public benefit.
  - **Efficient**: We undertake our work in a timely way at least cost. We value working with other agencies that further good public administration but we never duplicate their work.

Our Strategic Focus

- Complaint resolution that is high quality, independent, fair and timely, with an emphasis on early resolution, practical remedies for members of the public and improvements to public administration.

- Improved public administration through own motion investigations, making practical recommendations for improvement and monitoring their implementation.

- Review of child deaths and family and domestic violence fatalities, identifying patterns and trends and making recommendations to public authorities about ways to prevent or reduce these deaths.

- Protect children from harm by ensuring that organisations are preventing abuse of children involving any of the organisation's employees, and notifying the Ombudsman and taking appropriate action in response to allegations.

- Keep under scrutiny the operation of, and the exercise of powers of relevant agencies under, specific legislation, and inspect the records of the WA Police Force and the Corruption and Crime Commission in relation to telecommunication interceptions to ensure statutory compliance.

- Collaboration with other Ombudsman and accountability agencies, raising community awareness, making our services accessible and promoting good decision making practices and complaint handling in public authorities.

- Strong and effective governance and attracting, developing and retaining a skilled and valued workforce with a culture that supports high quality, responsive and efficient service.

Management

Management of the Office is undertaken by the Ombudsman and the Office's Corporate Executive which includes the leaders of the teams in the Office.

The role of the Corporate Executive is to:

- To ensure that operational activities and priorities align with the strategic direction of the Office.
- To facilitate informed decision making on policy, resource allocation, and operational effectiveness and efficiency.
- To assess the Office's performance against key performance indicators, identifying areas of success and opportunities for improvement.
- To identify, assess, and mitigate risks and challenges that may impact the achievement of organisational objectives, ensuring resilience and continuity of operations.
- To develop strategies for stakeholder relations, fostering appropriate and constructive relationships with all external stakeholders.
- To ensure the application of the principles of good governance, integrity, and compliance with legal and regulatory requirements, safeguarding the agency's reputation and public trust.
- To promote a culture of innovation, service excellent and continuous improvement.

For more information, see the Disclosures and Legal Compliance section.

Chris Field PSM

Ombudsman

Chris Field PSM is the Western Australian Ombudsman. He concurrently holds the roles of Energy and Water Ombudsman and Charitable Trusts Commissioner. He is an Adjunct Professor in the School of Law at the University of Western Australia.

Chris was awarded a Public Service Medal in the 2023 Australia Day Honours List for 'outstanding public service as Ombudsman and President of the International Ombudsman Institute.' Also in 2023, in a formal ceremony in Taipei, he was awarded the highest honour of the Control Yuan, the First Grade Medal. The Medal was granted in honour of 'His extraordinary contribution to the promotion of international ombudsman and human rights work.' He was the 2022 recipient of the *Justitia Regnorum Fundamentum* Award granted by the Commissioner for Fundamental Rights of Hungary for 'those who have achieved extraordinary, exemplary results in the field of protecting fundamental rights.'

Chris is currently Australia's longest serving ombudsman, having been appointed in 2007 at age 39 by a Labor Government, reappointed twice by a Liberal Government and then reappointed by a Labor Government. From May 2021 to March 2024, Chris served as IOI President. The IOI is the global organisation for the cooperation of 205 independent Ombudsman institutions from more than 100 countries, organised in six regional chapters - Africa, Asia, Australasian and Pacific, Europe, the Caribbean and Latin America and North America.

He is the author of journal articles on the ombudsman and teaches an advanced administrative law unit at the University of Western Australia. He commenced his career as a lawyer at one of Australia's leading law firms, Arthur Robinson and Hedderwicks (now Allens Linklaters). Chris holds Arts and Law (Honours) degrees from La Trobe University, graduating in 1996.

Chris has been on extended leave since April 2024.

David Robinson

Deputy Ombudsman

David was appointed in February 2024. David has previously served as the Acting Deputy Director General, People, Culture and Standards in the Department of Justice and prior to that spent 20 years at the Corruption and Crime Commission, including eight years as Director Operations and18 months as acting as Chief Executive.

Belinda West

Principal Assistant Ombudsman
Own Motion Investigations and Monitoring

Belinda joined the Office in 2008 and commenced in her current role in March 2020. Prior to this, Belinda was an Assistant Ombudsman from 2014. She has more than 30 years of experience working in the public sector in financial and performance auditing and leadership roles in both line and accountability agencies.

Natarlie De Cinque

Principal Assistant Ombudsman
Reviews

Natarlie joined the Office in 2009 and commenced in her current role in July 2019. Prior to this, Natarlie was an Assistant Ombudsman from 2016. She has worked in the State public sector for over 25 years, and has extensive experience working with the issues of child safety and wellbeing, and family and domestic violence.

Alison Cameron

Principal Assistant Ombudsman
Reportable Conduct

Alison joined the Office in 2017 and commenced acting in her current role in November 2023. Prior to this, Alison has been an Assistant Ombudsman, Director and a number of roles in Complaint Resolution. She was admitted to legal practice in 2009 and has extensive experience working in the public sector, both within Australia and Canada.

Marcus Claridge

Principal Assistant Ombudsman
Energy and Water

Marcus joined the Office in 2011 and commenced in his current role in April 2018. Prior to this, Marcus was Director, Energy and Water Ombudsman and has worked in other investigatory roles. Marcus has over 35 years of regulatory and investigations experience, both within Australia and Asia.

Christina Anthony

Senior Assistant Ombudsman
Complaint Resolution

Christina joined the Office in 2008 and commenced acting in her current role in July 2022. Prior to this, she worked in a number of roles in Complaint Resolution and Executive Services including as a Director from 2015. She has more than 15 years of public sector experience in investigations and complaint handling.

Rebecca Poole

Senior Assistant Ombudsman
Strategic Policy and Projects

Rebecca joined the Office in 2006 and commenced in her current role in April 2022. Prior to this, she was an Assistant Ombudsman from 2018 and a Director from 2010. She has extensive experience managing strategic research, policy and projects and intergovernmental and international engagement on issues of good governance.

Laurence Riley

Assistant Ombudsman
Aboriginal Engagement and Collaboration

Laurence joined the Office in August 2022 as the Office's first Assistant Ombudsman for Aboriginal engagement and collaboration. Laurence is from the Wilmen, Menang, Kenang and Ballardong Clan groups of the Noongar nation, and Nanda Clan of the Yamatji nation. Laurence has 24 years of experience in government and non-government sectors in the areas of education, health, social and emotional wellbeing, mental health, justice, housing, employment services and corrective services.

Kyle Heritage

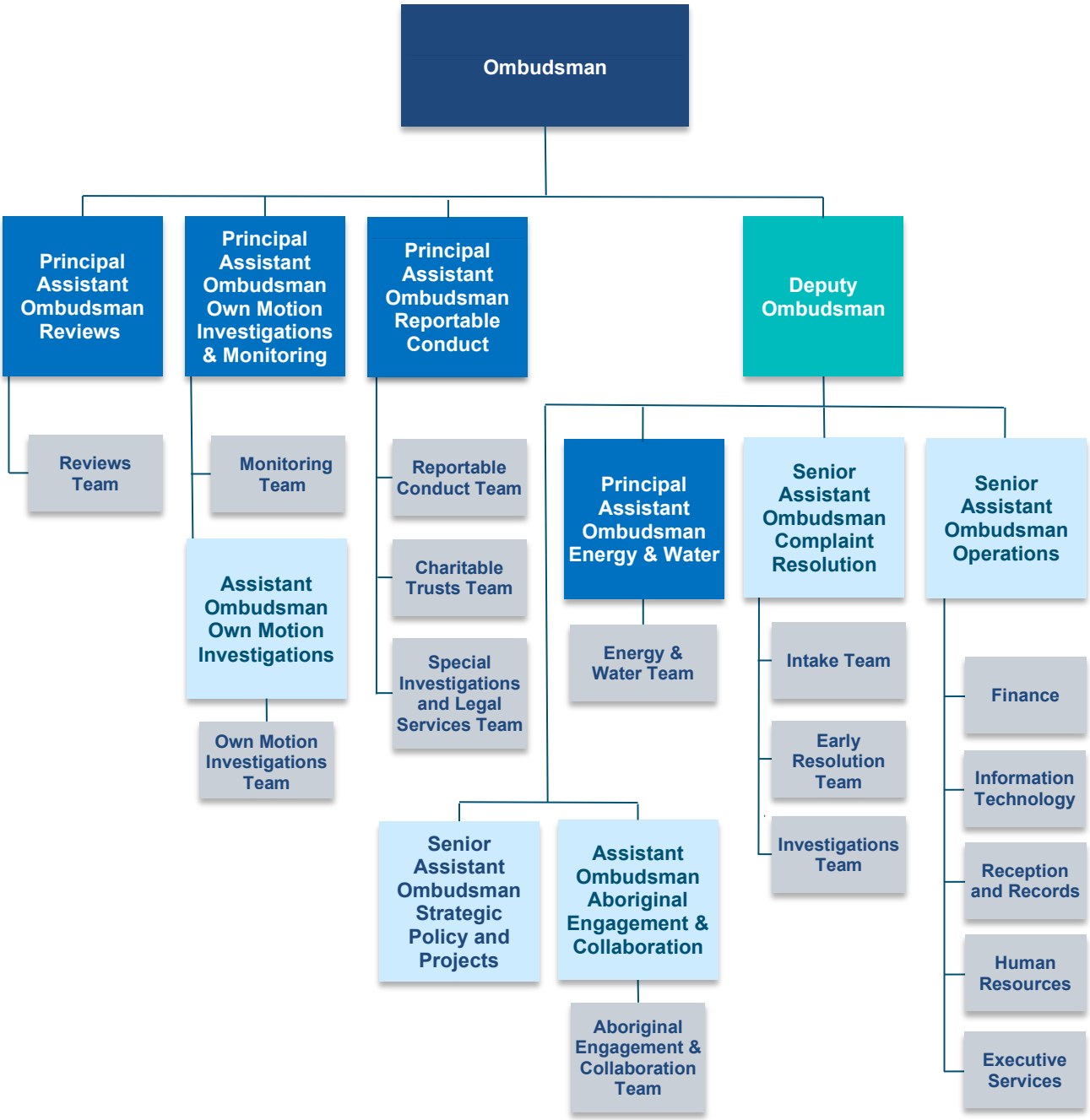
Assistant Ombudsman
Own Motion Investigations

Kyle joined the Office in 2016 and commenced acting in his current role in May 2023. Prior to this, he worked in a number of senior project management, research and international relations roles. He has over 10 years of experience in the public sector in both accountability and central agencies.

The position Senior Assistant Ombudsman Operations was vacant at 30 June 2024.

Our Structure and Teams

Organisational Structure as at 30 June 2024



Team Responsibilities

- The **Intake Team** has responsibility for handling enquiries, receiving and assessing complaints and undertaking the early resolution of complaints, where appropriate.
- The **Early Resolution Team** undertakes the early resolution of complaints through informal investigations.
- The **Investigations Team** handles the investigation of complaints that are lengthy or complex.
- The **Reviews Team** reviews child deaths and family and domestic violence fatalities, identifies patterns and trends arising from these reviews and makes recommendations to relevant public authorities to prevent or reduce these deaths.
- The **Own Motion Investigations Team** undertakes own motion investigations and other strategies aimed at improving public administration.
- The **Monitoring Team** undertakes the inspecting, monitoring, and reporting functions as outlined in specific legislation. This includes:
  - the inspection of records relating to telecommunication interceptions;
  - monitoring the exercise of police powers as outlined in legislation relating to unlawful consorting notices, prohibited insignia, and consorting contrary to dispersal notices; and
  - keeping under scrutiny the operation of, and the exercise of, powers as required by legislation relating to protected entertainment precincts.
- The **Aboriginal Engagement and Collaboration Team** provides expert advice and support to each of the Ombudsman's functions, including continuing to promote high levels of awareness and accessibility for Aboriginal Western Australians to the Office.
- The **Reportable Conduct Team** monitors, oversees and reviews investigations undertaken by organisations into allegations of, and convictions for, abuse of children involving any of the organisation's employees, and provides education and advice to organisations about identifying and preventing reportable conduct.
- The **Charitable Trusts Team** receives complaints about charitable trusts and undertakes investigations as required.
- The **Energy and Water Ombudsman Team** has responsibility for handling enquiries and receiving, investigating and resolving complaints about electricity, gas and water services providers.
- The **Operations Teams** are responsible for Finance, Information Technology, Records and Reception, Human Resources and Executive Services. These teams support the Office in providing governance, business services, ensuring integrity and compliance of corporate services and are responsible for communications, community outreach and engagement programs and publications.

Performance Management Framework

The Ombudsman's performance management framework is consistent with the Government goal of *Safe, Strong and Fair Communities: Supporting our local and regional communities to thrive.*

Desired Outcomes of the Ombudsman's Office

The public sector of Western Australia is accountable for, and is improving the standard of, administrative decision making and practices, and relevant entities are accountable for, and are, preventing, notifying and dealing with reportable conduct.

Key Effectiveness Indicators

- Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies.
- Number of improvements to practices or procedures as a result of Ombudsman action.
- Where the Ombudsman made recommendations regarding reportable conduct, the percentage of recommendations accepted by relevant entities.
- Number of actions taken by relevant entities to prevent reportable conduct.

Service Provided by the Ombudsman's Office

Resolving complaints about the decision making of public authorities, improving the standard of public administration, and to oversee and monitor that relevant entities are accountable for, and are, preventing, notifying and dealing with Reportable Conduct.

Key Efficiency Indicators

- Percentage of allegations finalised within three months.
- Percentage of allegations finalised within 12 months.
- Percentage of allegations on hand at 30 June less than three months old.
- Percentage of allegations on hand at 30 June less than 12 months old.
- Average cost per finalised allegation.
- Average cost per finalised notification of death.
- Average cost per notification of reportable conduct.
- Cost of monitoring and inspection functions.

This page has been intentionally left blank.

Our Performance in 2023-24

This section of the report compares results with targets for both financial and non-financial indicators and explains significant variations. It also provides information on achievements during the year, major initiatives and projects, and explains why this work was undertaken.

Summary of Performance

Key Performance Indicators

Key Effectiveness Indicators

The Ombudsman aims to improve decision making and administrative practices in public authorities. The Office does this by investigating and resolving complaints, reviews of certain child deaths and family and domestic violence fatalities, and own motion investigations. Improvements may occur through actions identified and implemented by agencies as a result of the Ombudsman's investigations and reviews, or as a result of the Ombudsman making specific recommendations and suggestions.

Key Effectiveness Indicators are the percentage of these recommendations and suggestions accepted by public authorities and the number of improvements that occur as a result of Ombudsman action.

Key Effectiveness Indicators	2022-23	2023-24 Target	2023-24 Actual	Variance from Target
Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies (a)	100%	100%	**100%**	-
Number of improvements to practices or procedures as a result of Ombudsman action (b)	75	100	**40**	(60)
Where the Ombudsman made recommendations regarding reportable conduct, the percentage of recommendations accepted by relevant entities (c)	Not applicable	100%	**Not applicable**	Not applicable
Number of actions taken by relevant entities to prevent reportable conduct (d)	26	51	**97**	46

Another important role of the Ombudsman is to enable remedies to be provided to people who make complaints to the Office where service delivery by a public authority may have been inadequate. The remedies may include reconsideration of decisions, more timely decisions or action, financial remedies, better explanations and apologies.

In 2023-24, there were 209 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman.

Key Efficiency Indicators

Key Efficiency Indicators	2022-23	2023-24 Target	2023-24 Actual	Variance from Target
Percentage of allegations finalised within three months	96%	95%	**95%**	-
Percentage of allegations finalised within 12 months	100%	100%	**100%**	-
Percentage of allegations on hand at 30 June less than three months old	93%	90%	**88%**	(2%)
Percentage of allegations on hand at 30 June less than 12 months old	100%	100%	**100%**	-
Average cost per finalised allegation (a)	$1,547	$1,890	**$1,314**	(576)
Average cost per finalised notification of death (b)	$8,415	$14,655	**$11,571**	(3,084)
Average cost per notification of reportable conduct (c)	$6,027	$6,000	**$3,687**	(2,313)
Cost of monitoring and inspection functions (d)	$735,183	$1,168,000	**$1,000,679**	(167,321)

For further details, see the Key Performance Indicator section.

Summary of Financial Performance

	2022-23 Actual ('000s)	2023-24 Target ('000s)	2023-24 Actual ('000s)	Variance from Target ('000s)
Total cost of services	$12,611	15,620	14,205	(1,415)
Income other than income from State Government	$2,685	2,745	2,711	(34)
Net cost of services	$9,926	12,875	11,494	(1,381)
Net increase/(decrease) in cash and cash equivalents	$1,229	20	2,008	1,988
Total equity	$1,524	808	3,062	2,254

The variation mainly relates to an underspend in expenditure. Further explanations are contained in Note 9 'Explanatory Statement' to the Financial Statements.

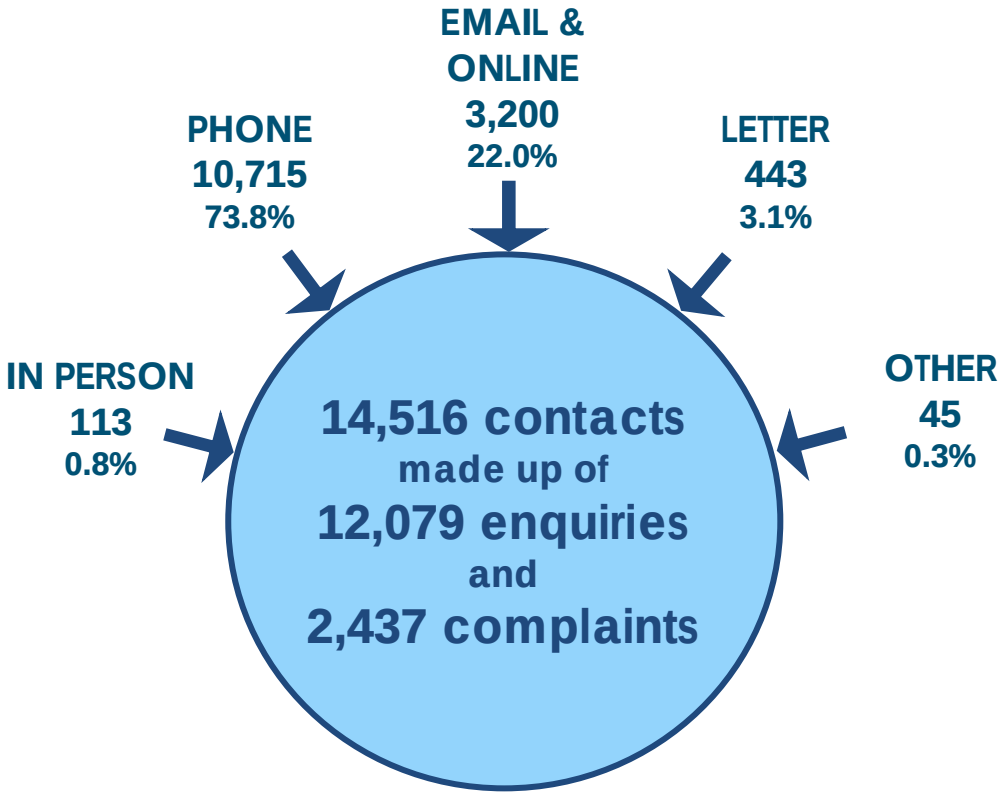
Complaint Resolution

A core function of the Ombudsman is to resolve complaints received from the public about the decision making and practices of State Government agencies, local governments and universities (commonly referred to as public authorities). This section of the report provides information about how the Office assists the public by providing independent and timely complaint resolution and investigation services or, where appropriate, referring them to a more appropriate body to handle the issues they have raised.

Contacts

In 2023-24, the Office received 14,516 contacts from members of the public consisting of:

- 12,079 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 2,437 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

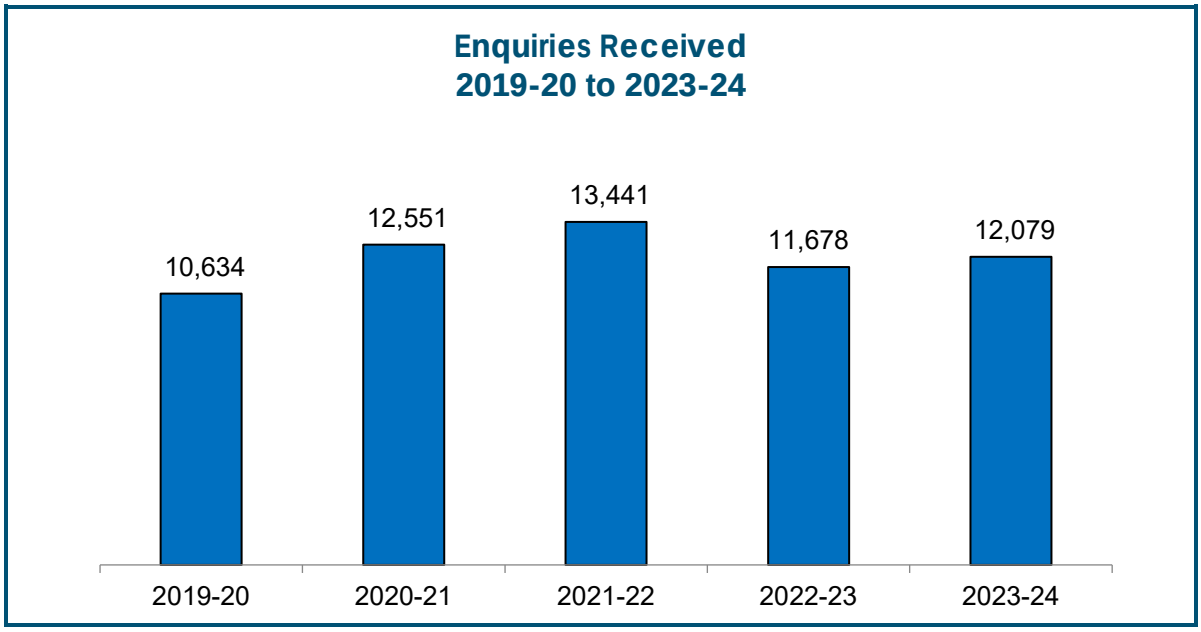


Enquiries Received

There were 12,079 enquiries received during the year.

For enquiries about matters that are within the Ombudsman's jurisdiction, staff provide information about the role of the Office and how to make a complaint. For approximately half of these enquiries, the enquirer is referred back to the public authority in the first instance to give it the opportunity to hear about and deal with the issue. This is often the quickest and most effective way to deal with the issue. Enquirers are advised that if their issues are not resolved by the public authority, they can make a complaint to the Ombudsman.

For enquiries that are outside the jurisdiction of the Ombudsman, staff assist members of the public by providing information about the appropriate body to handle the issues they have raised.

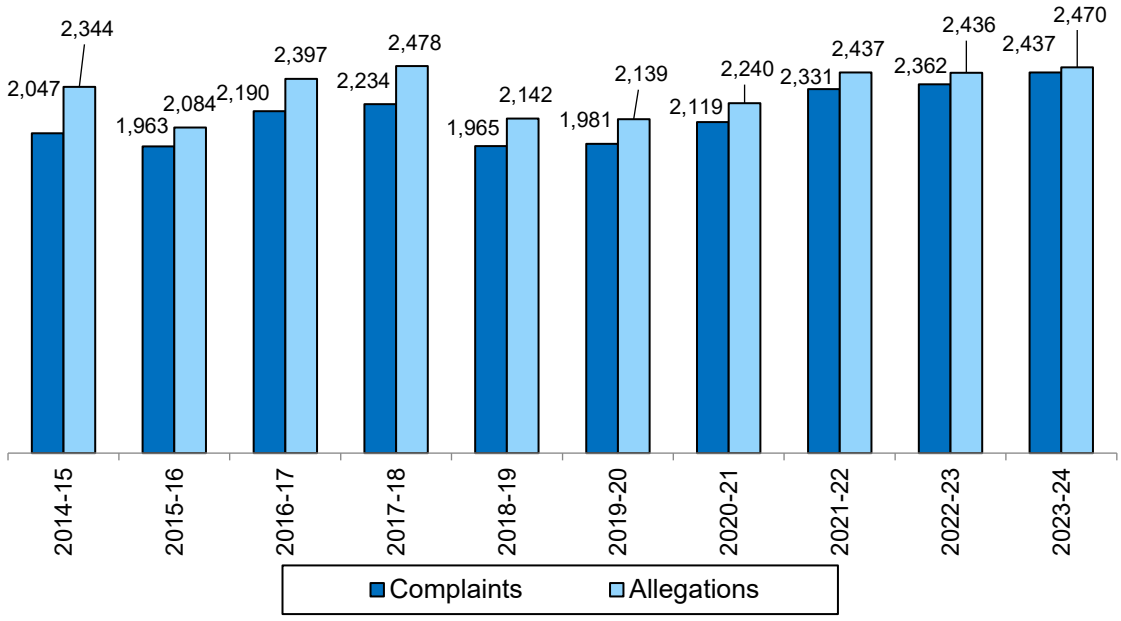


Enquirers are generally encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

Complaints Received

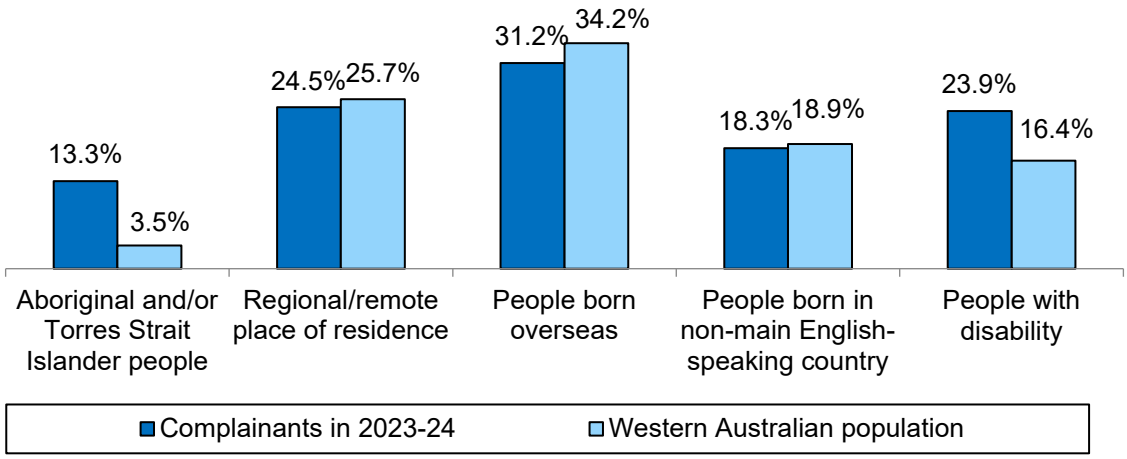
In 2023-24, the Office received 2,437 complaints, with 2,470 separate allegations, and finalised 2,417 complaints. There are more allegations than complaints because one complaint may cover more than one issue.

Total Number of Complaints and Allegations Received 2014-15 to 2023-24



Note: The number of complaints and allegations shown for a year may vary in this and other charts by a small amount from the number shown in previous annual reports. This occurs because, during the course of an investigation, it can become apparent that a complaint is about more than one public authority, or there are additional allegations with a start date in a previous reporting year.

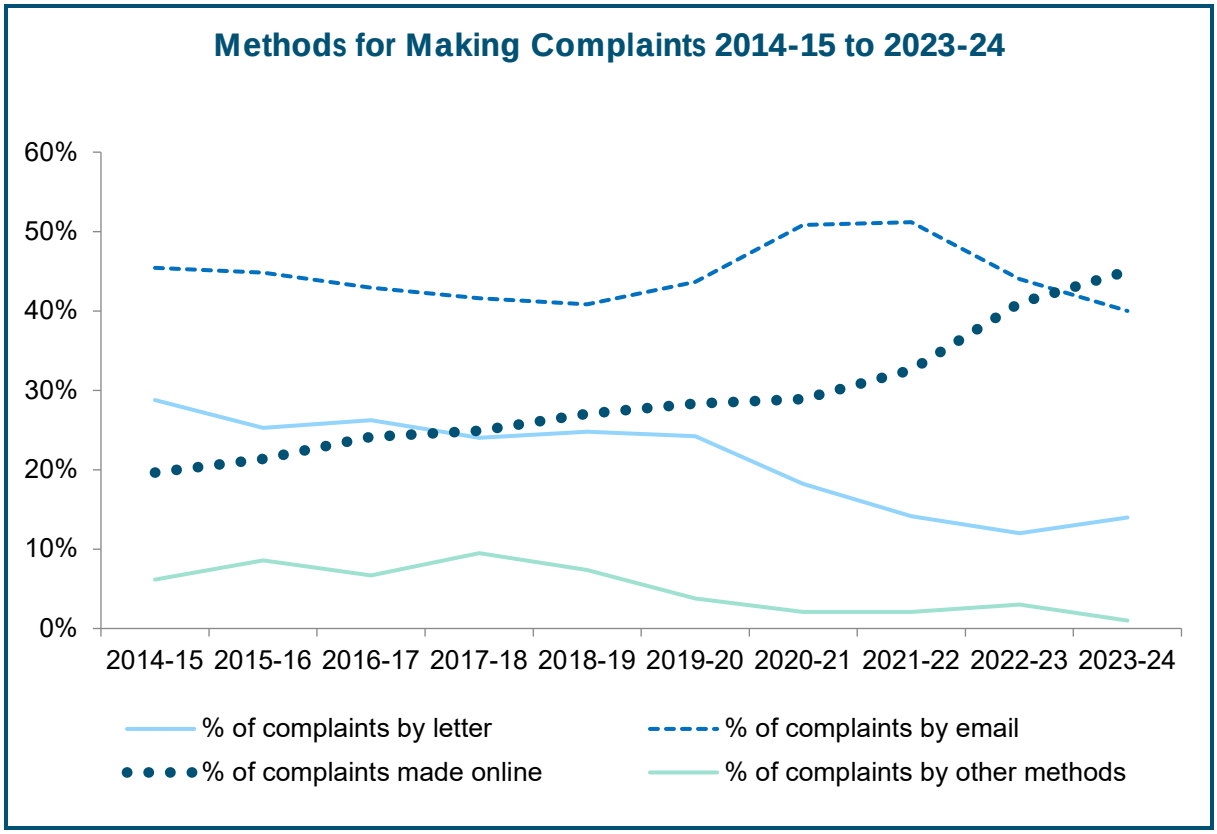
Characteristics of Complainants in 2023-24



Note: Non-main English-speaking countries as defined by the Australian Bureau of Statistics are countries other than Australia, the United Kingdom, the Republic of Ireland, New Zealand, Canada, South Africa and the United States of America. Being from a non-main English-speaking country does not imply a lack of proficiency in English.

How Complaints Were Made

In 2023-24, 45% of complaints were lodged through the Office's online complaint form, overtaking email (40%) for the first time as the preferred method to lodge complaints. There were also 14% of complaints lodged by letter and one per cent by other methods including during regional visits and in person.



Resolving Complaints

Early resolution involves facilitating a timely response and resolution of a complaint.

Where it is possible and appropriate, staff use an early resolution approach to investigate and resolve complaints. This approach is highly efficient and effective and results in timely resolution of complaints. It gives public authorities the opportunity to provide a quick response to the issues raised and to undertake timely action to resolve the matter for the complainant and prevent similar complaints arising again. The outcomes of complaints may result in a remedy for the complainant or improvements to a public authority's administrative practices, or a combination of both. Complaint resolution staff also track recurring trends and issues in complaints and this information is used to inform broader administrative improvement in public authorities and investigations initiated by the Ombudsman (known as own motion investigations).

Time Taken to Resolve Complaints

Timely complaint handling is important. The early resolution of issues can result in more effective remedies and prompt action by public authorities to prevent similar problems occurring again. The Office's continued focus on timely complaint resolution has resulted in sustained improvements in the time taken to handle complaints.

In 2023-24:

- The percentage of allegations finalised within 3 months was 95%; and
- The percentage of allegations on hand at 30 June less than 3 months old was 88%.

95% of allegations were finalised within 3 months.

Complaints Finalised in 2023-24

There were 2,417 complaints finalised during the year and, of these, 1,593 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 1,040 were finalised at initial assessment, 513 were finalised after an Ombudsman investigation and 40 were withdrawn.

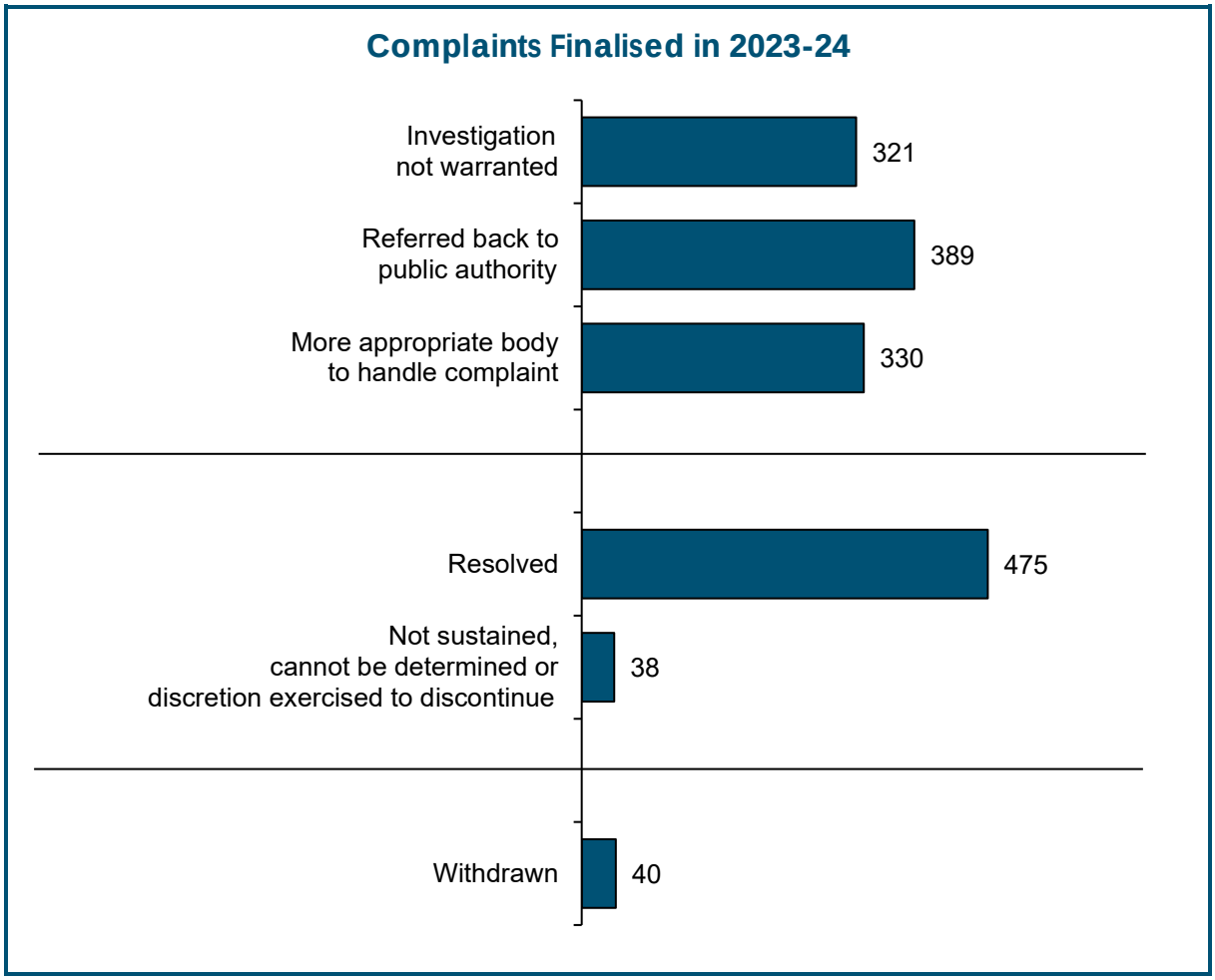
Complaints finalised at initial assessment

Over a third (37%) of the 1,040 complaints finalised at initial assessment were referred back to the public authority to provide it with an opportunity to resolve the matter before investigation by the Ombudsman. This is a common and timely approach and often results in resolution of the matter. The person making the complaint is asked to contact the Office again if their complaint remains unresolved. In a further 330 (32%) of the complaints finalised at initial assessment, it was determined that there was a more appropriate body to handle the complaint. In these cases, complainants are provided with contact details of the relevant body to assist them.

Complaints finalised after investigation

Of the 513 complaints finalised after investigation, 90% were resolved through the Office's early resolution approach. This involves Ombudsman staff contacting the public authority to progress a timely resolution of complaints that appear to be able to be resolved quickly and easily. Public authorities have shown a strong willingness to resolve complaints using this approach and frequently offer practical and timely remedies to resolve matters in dispute, together with information about administrative improvements to be put in place to avoid similar complaints in the future.

The following chart shows how complaints about public authorities in the Ombudsman's jurisdiction were finalised.

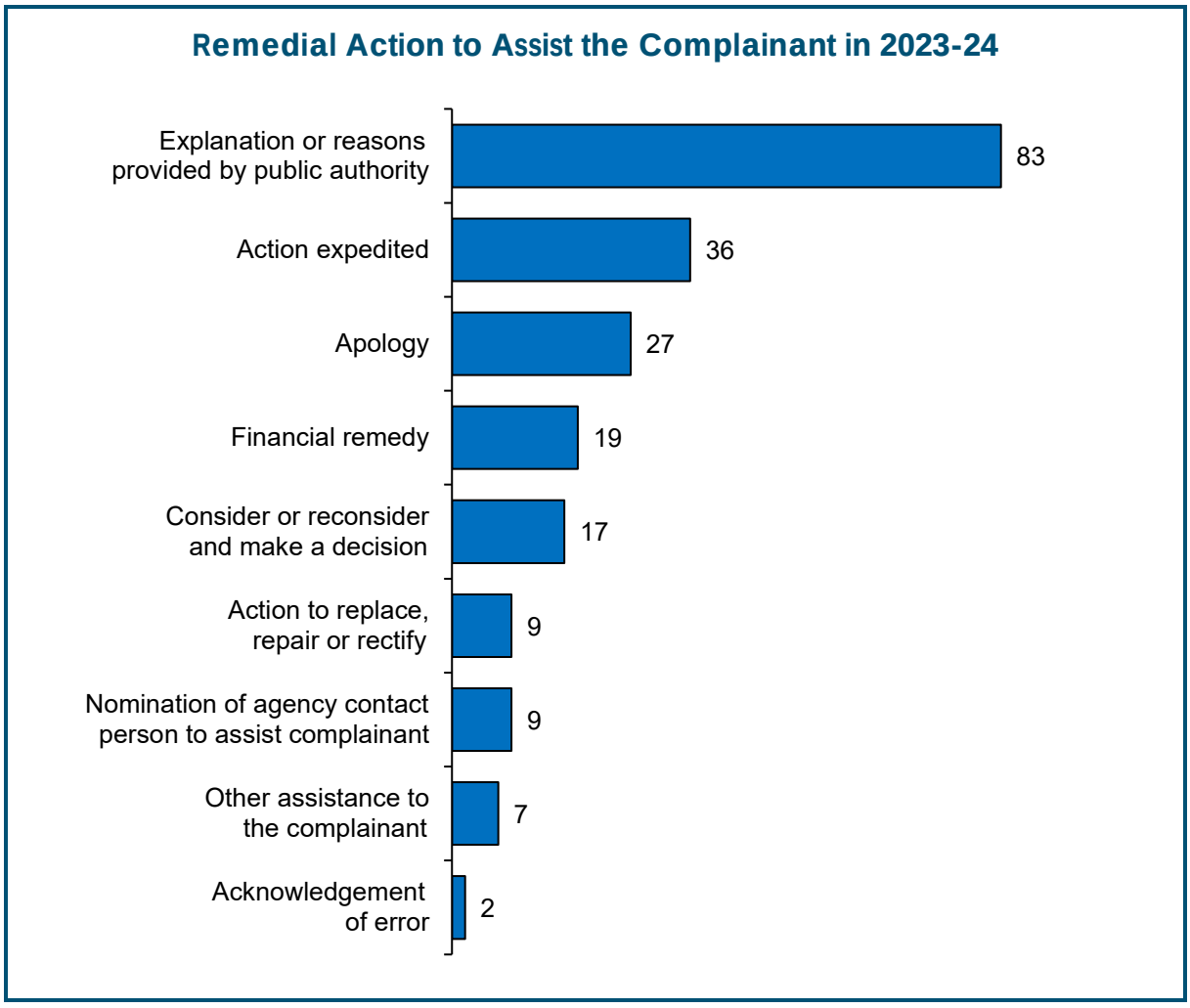


Note: Investigation not warranted includes complaints where the matter is not in the Ombudsman's jurisdiction.

Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2023-24, there were 209 remedies provided by public authorities to assist complainants. In some cases, there is more than one action to resolve a complaint. For example, the public authority may apologise and reverse their original decision. In a further 92 instances, the Office referred the complaint to the public authority following its agreement to expedite examination of the issues and to deal directly with the person to resolve their complaint. In these cases, the Office follows up with the public authority to confirm the outcome and any further action the public authority has taken to assist the individual or to improve their administrative practices.

The following chart shows the types of remedies provided to complainants.



Outcomes to improve public administration

In addition to providing individual remedies, complaint resolution can also result in improved public administration. This occurs when the public authority takes action to improve its decision making and practices in order to address systemic issues and prevent similar complaints in the future. Administrative improvements include changes to policy and procedures, changes to business systems or practices and staff development and training. In 2023-24, public authorities made 32 improvements to improve their administration following the Ombudsman's investigations.

Case Study

Decision reversed and rebate granted following Ombudsman involvement

A person installed a security system and applied to a public authority for a rebate that the public authority was offering. The public authority declined the application on the basis that the installer was not appropriately licenced. The person had the installation inspected by another installer with the appropriate licence and reapplied for the rebate. The public authority again declined the application. The person complained to the Ombudsman.

The Ombudsman contacted the public authority to commence an investigation into the decision to decline the rebate application. The public authority reviewed the matter and decided that the original decision was correct under the rebate rules. However, the public authority considered that the decision to decline the application went against the spirit of the rebate scheme considering that the installer's incorrect licence was out of the person's control and the person had acted in good faith. Therefore, the public authority changed its decision, approved the rebate application and apologised for any frustration or anxiety the original decision may have caused.

Case Study

Public authority's email spam filter altered

A person complained to the Ombudsman about a significant delay in receiving any response from a public authority that was providing support to the person.

The Ombudsman contacted the public authority, which provided information about the support the person had received and acknowledged that there had been a delay in processing a payment for the person's support. The public authority progressed the payment but said it could not locate relevant emails from the person.

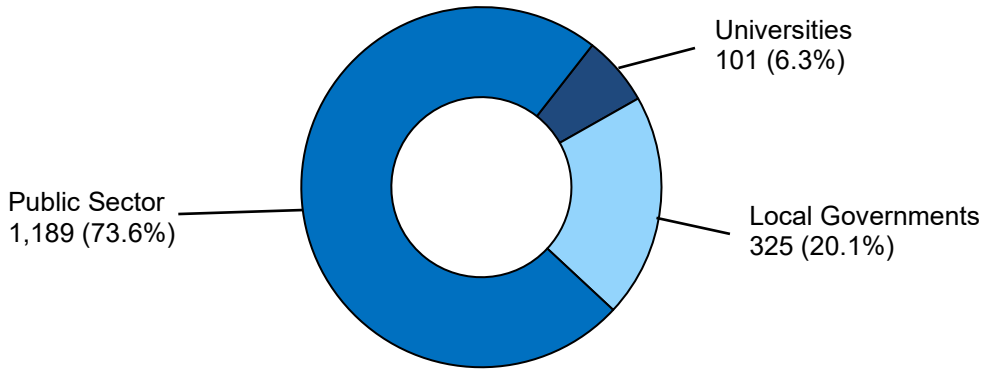
The public authority identified that the emails had been marked as spam and not received by the intended recipient. The Ombudsman asked the public authority to consider how to prevent the issue occurring again in the future. The public authority subsequently informed the Ombudsman that its email security system had been amended to provide a more proactive, risk-based approach to monitoring emails.

About the Complaints

Of the 2,437 complaints received, 1,615 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 822 complaints were about bodies outside the Ombudsman's jurisdiction. In these cases, Ombudsman staff provided assistance to enable the people making the complaint to take the complaint to a more appropriate body.

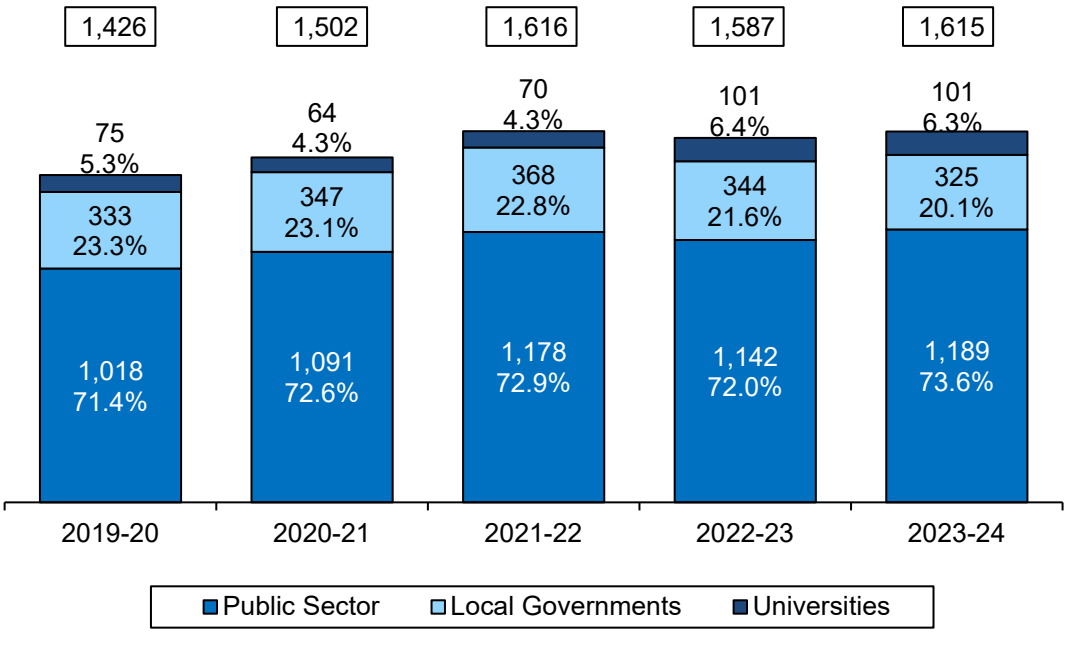
Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (1,189 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (325 complaints); and the university sector (101 complaints).

Complaints Received about Public Authorities within the Ombudsman's Jurisdiction in 2023-24



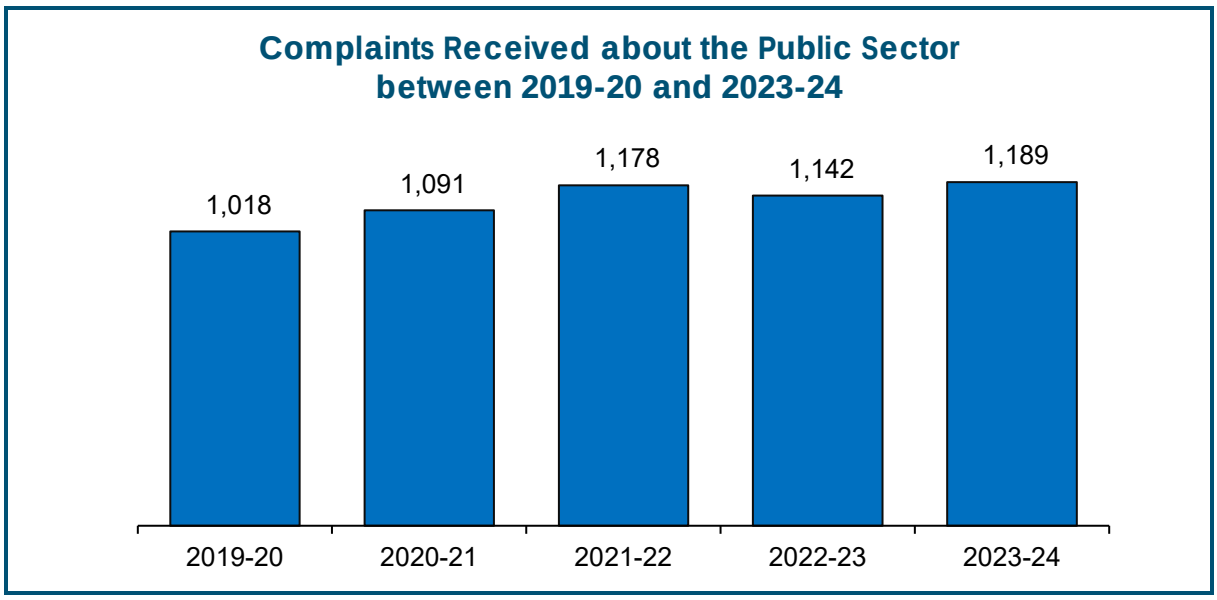
The proportion of complaints about each sector in the last five years is shown in the following chart.

Complaints Received about Public Authorities within the Ombudsman's Jurisdiction between 2019-20 and 2023-24

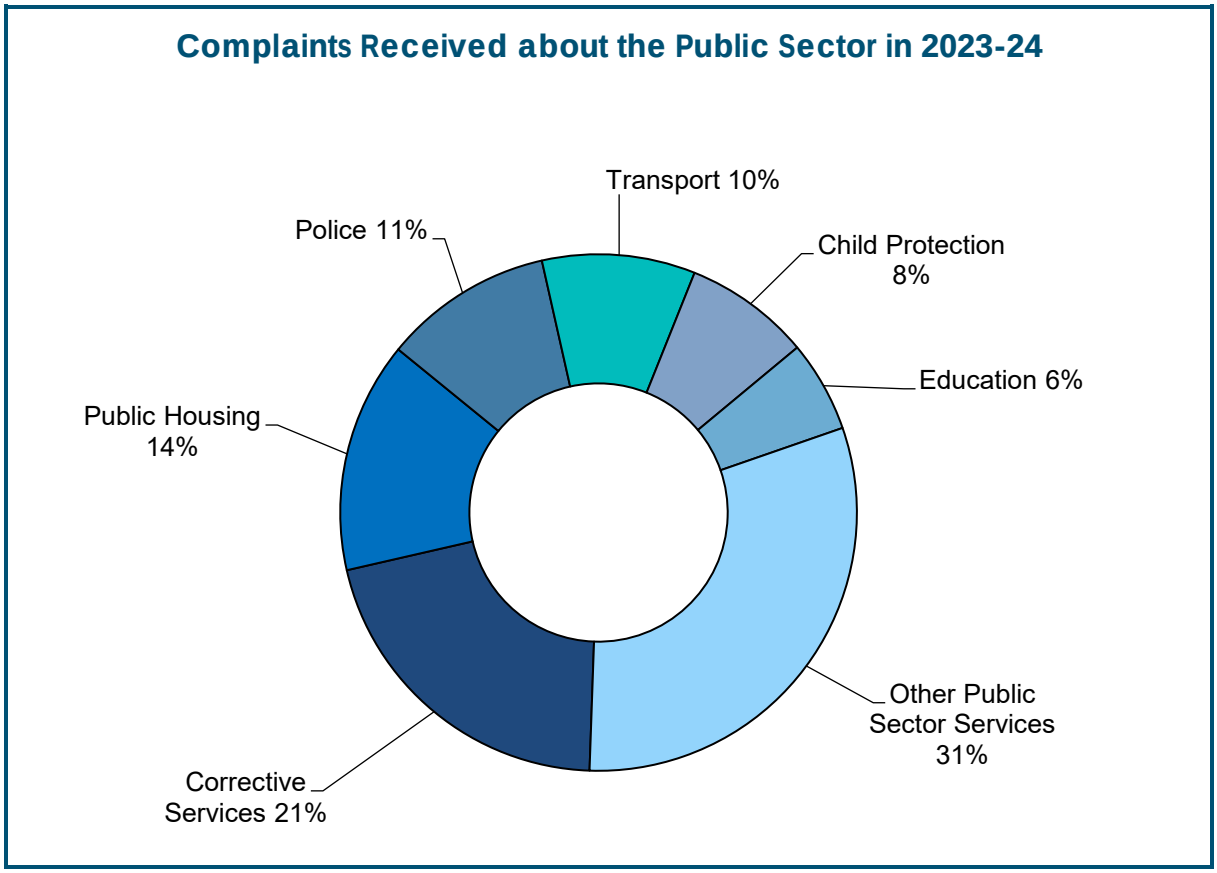


The Public Sector

In 2023-24, there were 1,189 complaints received about the public sector and 1,161 complaints were finalised. The number of complaints about the public sector as a whole since 2019-20 is shown in the chart below.



Public sector agencies deliver a very diverse range of services to the Western Australian community. In 2023-24, complaints were received about key services as shown in the following chart.



Note: Percentages may not add to 100% due to rounding.

Of the 1,189 complaints received about the public sector in 2023-24, 69% were about six key service areas covering:

- Corrective services, in particular prisons (248 or 21%)
- Public housing (172 or 14%)
- Police (126 or 11%)
- Transport, including roads, public transport and licensing (114 or 10%)
- Child protection (94 or 8%)
- Education, including public schools and TAFE colleges (68 or 6%). Information about universities is shown separately under the university sector.

The remaining 31% of complaints were about 72 other public authorities, of which 89% had 10 or fewer complaints in 2023-24. For further details about the number of complaints received and finalised about individual public sector agencies and authorities, see Appendix 1.

Outcomes of complaints about the public sector

In 2023-24, there were 189 actions taken by public sector bodies as a result of Ombudsman action following a complaint. These resulted in 167 remedies being provided to complainants and 22 improvements to public sector practices.

The following case study illustrates the outcomes arising from complaints about the public sector. Further information about the issues raised in complaints and the outcomes of complaints is shown on the following pages for each of the six key service areas and for the other public sector services as a group.

Case Study

Hospital reimburses lost property after Ombudsman involvement

A person complained to a hospital about a vulnerable family member losing property at the hospital. They said the family member was not in a position to keep track of their belongings when they were transferred to the ward. The hospital investigated the complaint and did not find any evidence of staff carelessness or mishandling of property and therefore declined to replace the property. The person complained to the Ombudsman.

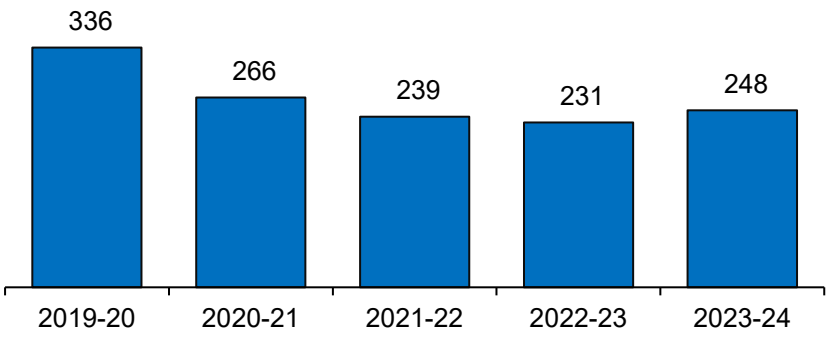
The Ombudsman contacted the health service responsible for the hospital to determine the status of the hospital's investigation into the matter. As a result of the Ombudsman's enquiry, the health service completed a further assessment and determined that the hospital's policy on personal property will be reviewed. The health service also decided to reimburse the person for the lost property.

The Ombudsman later followed up with the health service to confirm that the reimbursement had been processed and the hospital's policy had been updated to address the handling of valuable personal property.

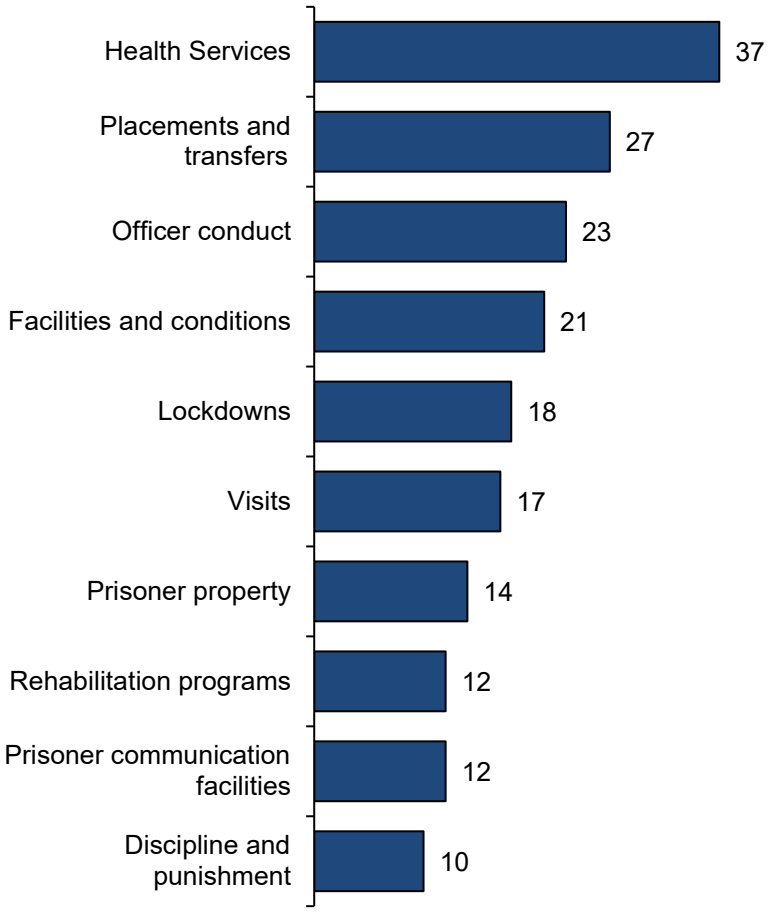
Public sector complaint issues and outcomes

Corrective Services

Complaints received



Most common allegations

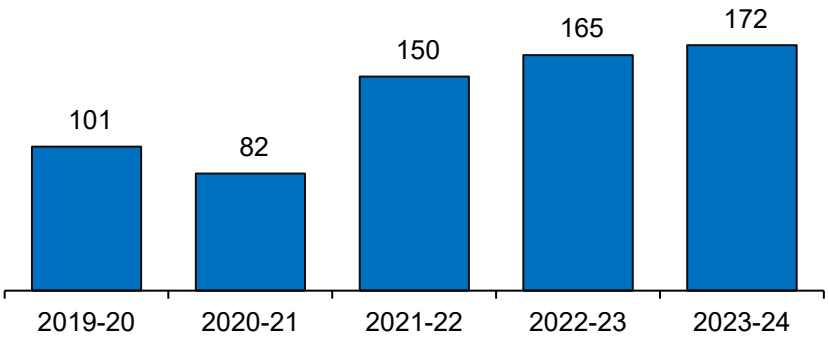


Outcomes achieved

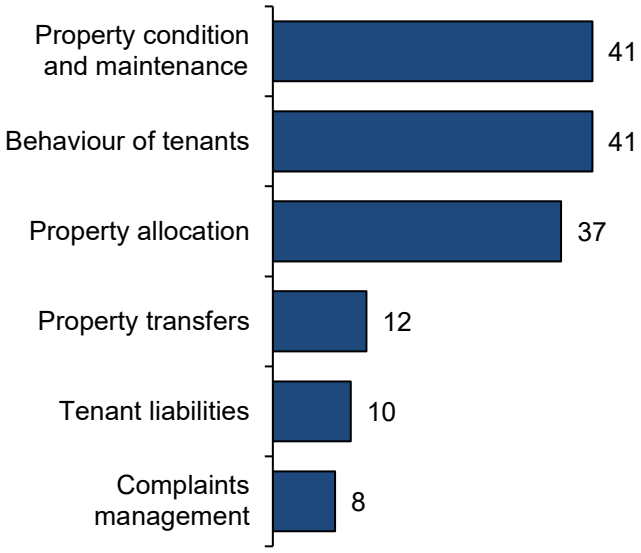
- Financial payment or ‘act of grace’ payment
- Action to replace, repair or rectify a matter
- Consider or reconsider a matter and make a decision
- Action expedited
- Explanation given or reasons provided
- Staff training and discipline.

Public Housing

Complaints received



Most common allegations

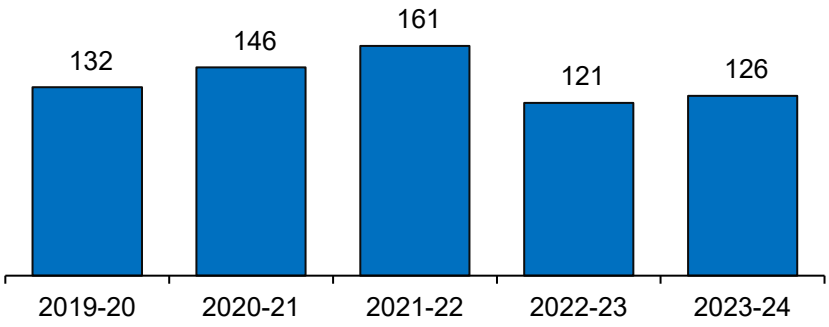


Outcomes achieved

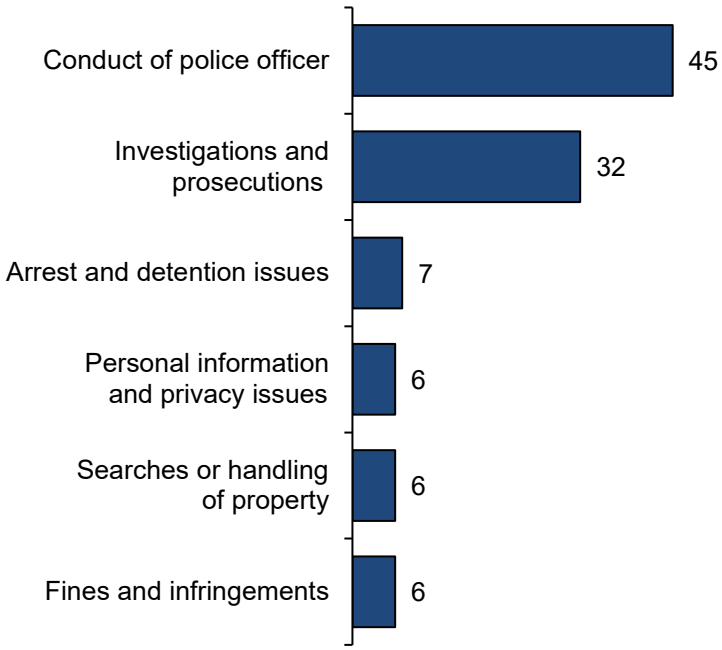
- Monetary charge reduced, withdrawn or refunded
- Action to replace, repair or rectify a matter
- Consider or reconsider a matter and make a decision
- Apology given
- Acknowledgement of error
- Action expedited
- Explanation given or reasons provided
- Senior officer nominated to handle the matter
- Change to business systems or practices
- Staff training.

Police

Complaints received



Most common allegations

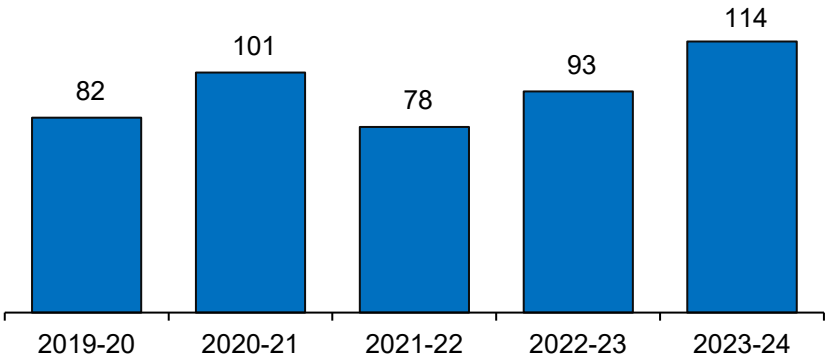


Outcomes achieved

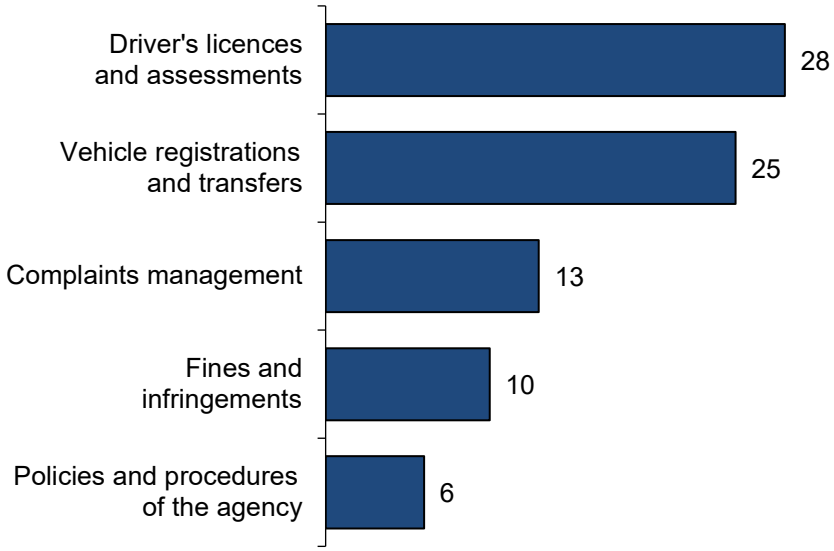
- Apology given
- Action expedited
- Explanation given or reasons provided.

Transport

Complaints received



Most common allegations

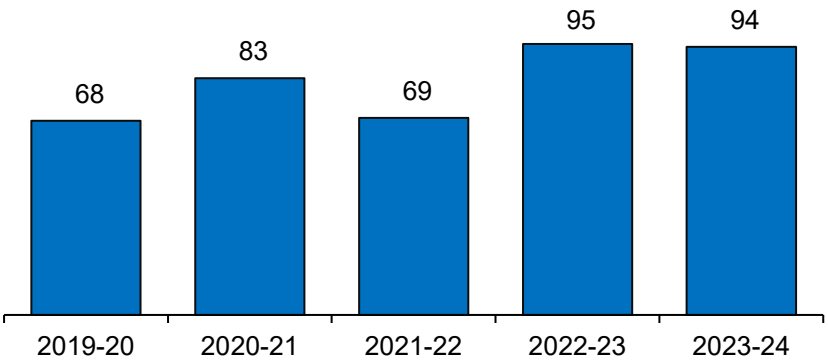


Outcomes achieved

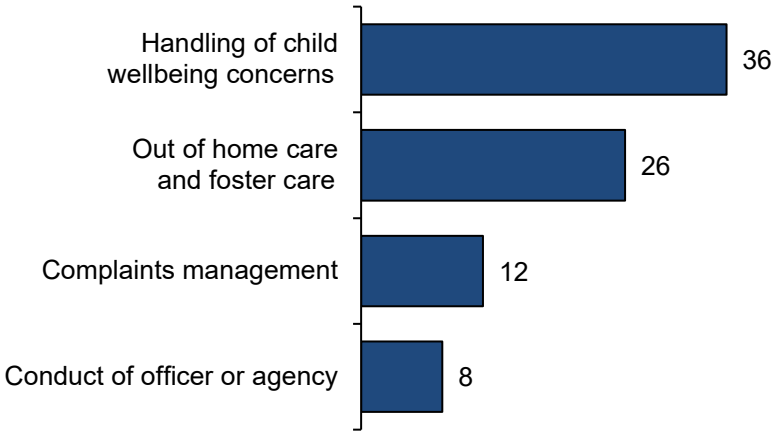
- Monetary charge reduced, withdrawn or refunded
- Apology given
- Acknowledgement of error
- Action expedited
- Explanation given or reasons provided
- Senior officer nominated to handle the matter
- Change to business systems or practices
- Update to publications and websites
- Staff training.

Child Protection

Complaints received



Most common allegations

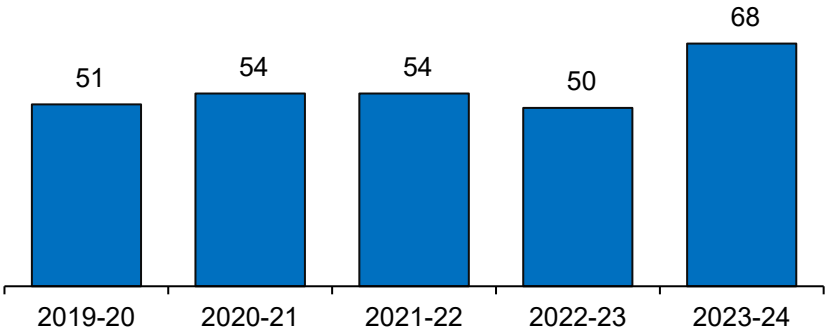


Outcomes achieved

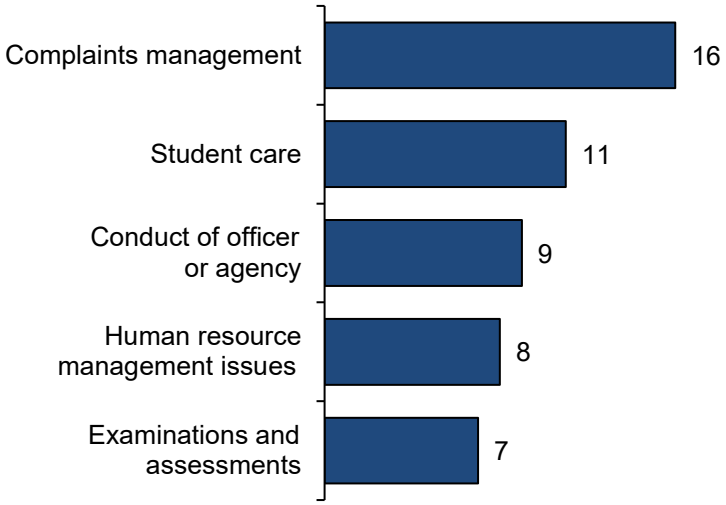
- Consider or reconsider a matter and make a decision
- Apology given
- Acknowledgement of error
- Action expedited
- Explanation given or reasons provided
- Senior officer nominated to handle the matter
- Change to policy or procedure
- Staff training.

Education

Complaints received



Most common allegations



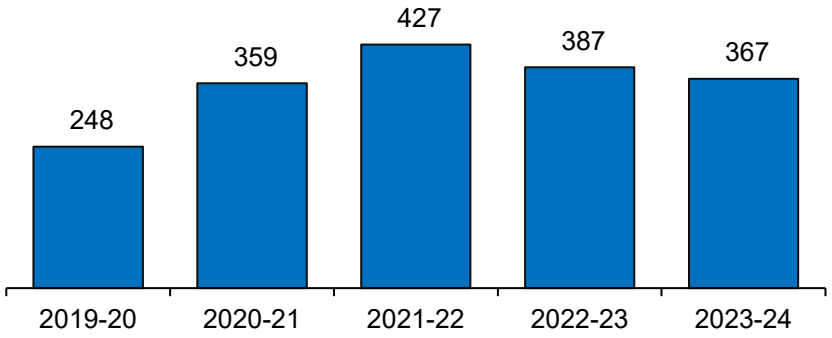
These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2018* relating to TAFE colleges and other public education agencies. Further details on these appeals are included later in this section.

Outcomes achieved

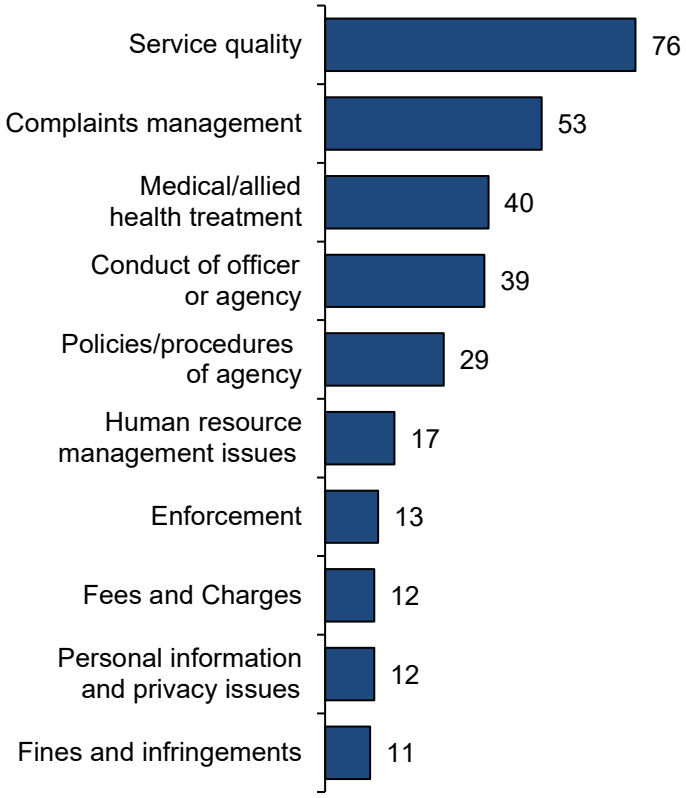
- Action to replace, repair or rectify a matter
- Consider or reconsider a matter and make a decision
- Apology given
- Action expedited
- Explanation given or reasons provided.

Other Public Sector Services

Complaints received



Most common allegations



Outcomes achieved

- Monetary charge reduced, withdrawn or refunded
- Action to replace, repair or rectify a matter
- Consider or reconsider a matter and make a decision
- Apology given
- Action expedited
- Explanation given or reasons provided
- Senior officer nominated to handle the matter
- Change to policy, procedure, business systems or practices
- Conduct audit or review
- Staff training.

The following case study provides an example of action taken by a public sector agency as a result of the involvement of the Ombudsman.

Case Study

Ombudsman involvement leads to overdue maintenance being completed

A public housing tenant complained to the public authority about maintenance work that had not been completed at their property. The public authority had visited the property to identify the work required and raised work orders with their maintenance contractor, but 12 months later the maintenance issues were still not resolved. The tenant complained to the Ombudsman.

The Ombudsman contacted the public authority about the maintenance delay and requested information about the status of the public authority's work orders. The public authority acknowledged that the maintenance issues had not been resolved in a timely manner and explained it had followed up with the maintenance contractor and visited the property to identify more extensive work to remedy the issues at the property. The Ombudsman requested that the public authority consider further remedies for the tenant in light of the maintenance problems that were not resolved.

The public authority wrote to the tenant to acknowledge that the problems were not resolved in a timely manner, explain the timeframe for completing the outstanding works, and offer a rent credit to acknowledge the inconvenience the tenant experienced.

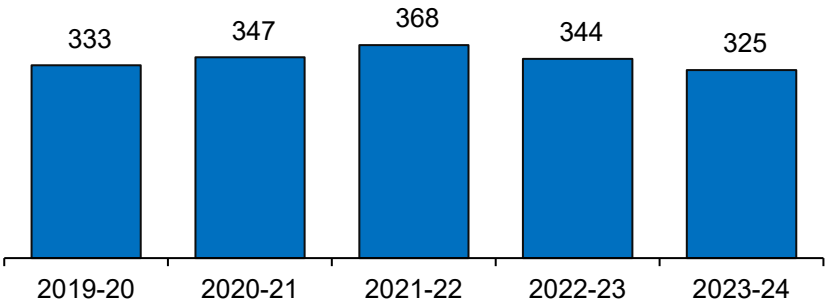
The Ombudsman later followed up with the public authority to confirm that the rent credit had been applied and the maintenance works completed.

The local government sector

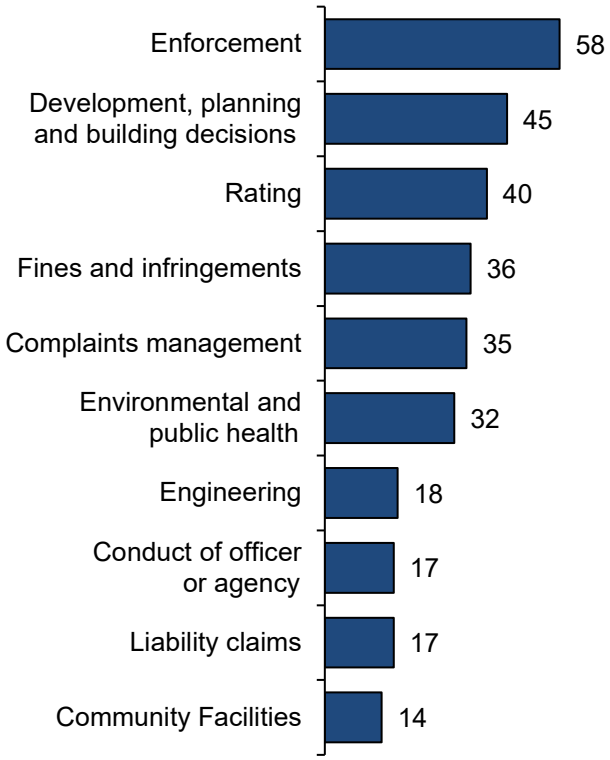
The following section provides further details about the issues and outcomes of complaints for the local government sector.

Local Government

Complaints received



Most common allegations



Outcomes achieved

- Financial payment or monetary charge withdrawn
- Action to replace, repair or rectify a matter
- Consider or reconsider a matter and make a decision
- Apology given
- Action expedited
- Explanation given or reasons provided
- Change to business systems or practices
- Update to publications or websites
- Conduct audit or review
- Improved record keeping
- Staff training.

Case Study

Local government apologises and improves process for development consultation

A resident contacted their local government about a neighbouring development. The resident complained that the local government had not responded to their concerns about the development, which they raised as part of the local government's community consultation. The resident also complained that the development was encroaching on their property and the local government was not taking adequate enforcement action. The local government did not provide a response that was satisfactory to the resident, so the resident complained to the Ombudsman.

The Ombudsman contacted the local government, which said it was still investigating the resident's concerns. The Ombudsman referred the complaint to the local government for it to respond directly to the resident and inform the Ombudsman what actions it takes in response to the complaint.

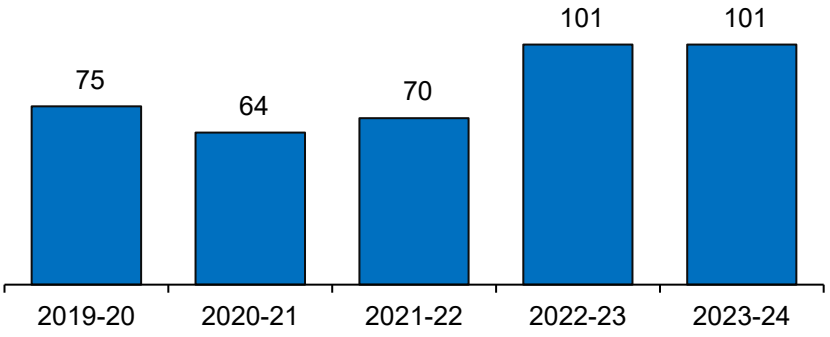
The local government wrote to the resident to explain that the concerns the resident raised during community consultation on the development were considered and some adjustments were made by the developer. The local government acknowledged that it did not provide the resident with notice of the outcome of the consultation and apologised for the oversight. The local government also amended its systems to ensure that people who make submissions are notified of the outcome as part of the development assessment process. The local government continued to work with the builder in relation to the encroachment on the resident's property.

The university sector

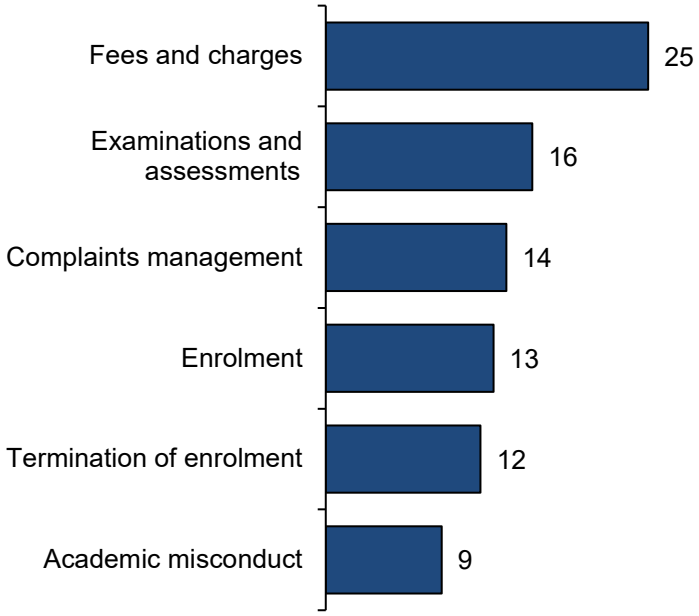
The following section provides further details about the issues and outcomes of complaints for the university sector.

Universities

Complaints received



Most common allegations



These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2018.* Further details on these appeals are included later in this section.

Outcomes Achieved

- Monetary charge reduced, withdrawn or refunded
- Action to replace, repair or rectify a matter
- Consider or reconsider a matter and make a decision
- Action expedited
- Change to policy or procedure
- Conduct audit or review
- Improved record keeping
- Staff training.

Case Study

Fees waived after university incorrectly awarded advanced standing

A student completed units of a degree at one university and then transferred to another university. The second university awarded the student advanced standing, which is recognition for prior learning, and the student completed their degree. The student subsequently applied for registration with the professional practice governing body, however their registration was rejected on the basis that the units completed at the first university did not provide full coverage of the subjects. The student contacted the second university about the advanced standing being incorrect resulting in a degree that did not meet the requirements for registration.

The university worked with the student to enrol them in two units to cover the relevant subjects. The student requested a fee waiver for the units, which the university granted. The university also clarified the registration requirements with the professional practice governing body and implemented new administrative processes to ensure future awards of advanced standing meet the requirements for registration.

The student commenced the final unit required to meet registration requirements and again applied for the fees to be waived. The university declined the request. The student complained to the university, which upheld its decision. The student then complained to the Ombudsman.

The Ombudsman commenced an investigation and requested a report from the university along with evidence to support its position. The Ombudsman considered whether the university's decision to decline a fee waiver for the final unit was reasonable, considering that the university acknowledged it had awarded advanced standing incorrectly and granted a fee waiver the other affected units. The university subsequently decided to waive the fees for the unit as a goodwill gesture to settle the matter.

Other Complaint Related Functions

Reviewing appeals by overseas students

The *National Code of Practice for Providers of Education and Training to Overseas Students 2018* (**the National Code**) sets out standards required of registered providers that deliver education and training to overseas students studying in Australian universities, TAFE colleges and other education agencies. It provides overseas students with rights of appeal to external, independent bodies if the student is not satisfied with the result or conduct of the internal complaint handling and appeals process.

Overseas students studying with both public and private education providers have access to an Ombudsman who:

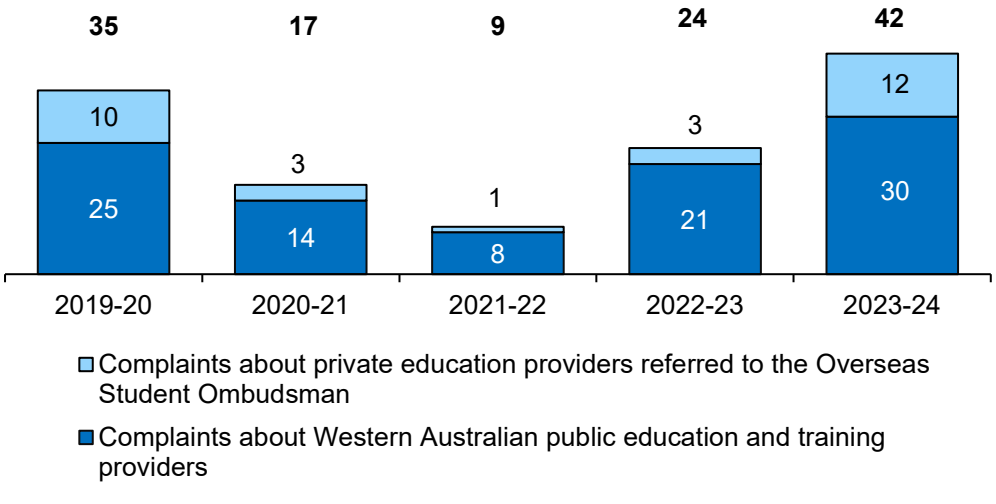
- Provides a free complaint resolution service;
- Is independent and impartial and does not represent either the overseas students or education and training providers; and
- Can make recommendations arising out of investigations.

In Western Australia, the Ombudsman is the external appeals body for overseas students studying in Western Australian public education and training organisations. The Overseas Students Ombudsman is the external appeals body for overseas students studying in private education and training organisations.

Complaints lodged with the Office under the National Code

Education and training providers are required to comply with 11 standards under the National Code. In dealing with these complaints, the Ombudsman considers whether the decisions or actions of the agency complained about comply with the requirements of the National Code and if they are fair and reasonable in the circumstances.

Complaints Received from Overseas Students under the National Code between 2019-20 and 2023-24



During 2023-24, the Office received 42 complaints from overseas students, including 30 complaints about public education and training providers. All of the 30 complaints about public education providers within the Ombudsman's jurisdiction were about universities. The Office also received 12 complaints that, after initial assessment, were found to be about a private education provider. The Office referred these complainants to the Overseas Students Ombudsman.

The 30 complaints by overseas students about public education and training providers involved 30 separate allegations, relating to:

- Fees and charges (13);
- Termination of enrolment (8);
- Enrolment issues (4)
- Handling of academic misconduct allegations (2);
- Examinations and assessments (2); and
- Other issues (1).

During the year, the Office finalised 30 complaints by overseas students about public education and training providers.

Case Study

University provides refund to overseas student following Ombudsman involvement

An international student was enrolled in units of study with a university but did not complete all assessments and received a grade of zero for the units. The student requested a refund of their tuition fees as their medical circumstances made it difficult for them to complete the units.

The university considered the request but rejected it on the basis that the medical circumstances were pre-existing and known to the student before the census date, which is the cut-off date to be able to withdraw from units and obtain a refund. The university said that it had already made adjustments to accommodate the student's medical circumstances and help them complete the units. The university said that there was no evidence that the student's ability to complete the units had changed after the census date.

The student appealed the university's decision and provided more information about difficulties accessing support services and a further medical certificate with more information about the student's circumstances. The university confirmed its original decision. The student then complained to the Ombudsman.

The Ombudsman commenced an investigation and requested a report and evidence from the university. The university further reviewed the case, and considering all the evidence and the student's circumstances, changed its position and agreed that the student had been impacted by their medical circumstances after the census date. Accordingly, the university provided a refund to the student.

Charitable Trusts

On 21 November 2022, the Ombudsman commenced an important new function as the Western Australian Charitable Trusts Commission (**WACTC**) following the commencement of the *Charitable Trusts Act 2022* (**CT Act**).

Complaints may be made directly to the Ombudsman as the WACTC or matters may be referred to the Ombudsman by the Attorney General for investigation.

Charitable trusts play a significant role in the Western Australian Aboriginal community as they are utilised to hold mining royalties and native title settlement funds.

Role of the Ombudsman as the Western Australian Charitable Trusts Commission

The role of the Ombudsman, as WACTC, is set out in Section 30 of the CT Act, and is to:

(a) conduct investigations, including audits of the accounts of charitable trusts under investigation;
(b) make an investigator's report on each investigation; and
(c) make recommendations to the trustees of charitable trusts in respect of matters arising out of investigations.

The Ombudsman is afforded specific powers under the CT Act as well as being able to rely on existing powers under the *Parliamentary Commissioner Act 1971* which includes the powers, rights and privileges of a Royal Commission.

The CT Act also provides the Ombudsman with specific investigative powers, including the power to issue a notice requiring a person to provide a document or information relating to a charitable trust or concerning any person involved in the administration of a charitable trust.

The Ombudsman must prepare a report on an investigation and that report must be provided to the Attorney General. The report may be accompanied by a notice for a trustee to take reasonably necessary action(s) in a specified timeframe. Failure to comply with a notice and take those actions is grounds for the removal of the trustee.

Complaints and enquiries received

From 1 July 2023 to 30 June 2024, the Office received:

- Three enquiries about Charitable Trusts; and
- Two complaints about Charitable Trusts.

Of the two complaints received, one was resolved by the Office during 2023-24. Two charitable trusts investigations remained ongoing.

If a complaint is outside the Ombudsman's jurisdiction, where possible, the Office provides the complainant with contact details for other State and Commonwealth regulators who may be able to assist with their complaint.

Public Interest Disclosures

Section 5(3) of the *Public Interest Disclosure Act 2003* allows any person to make a disclosure to the Ombudsman about particular types of 'public interest information'. The information provided must relate to matters that can be investigated by the Ombudsman, such as the administrative actions and practices of public authorities; or relate to the conduct of public officers.

Key members of staff have been authorised to deal with disclosures made to the Ombudsman and have received appropriate training. They assess the information provided to determine whether the matter requires investigation, having regard to the *Public Interest Disclosure Act 2003*, the *Parliamentary Commissioner Act 1971* and relevant guidelines. If a decision is made to investigate, subject to certain additional requirements regarding confidentiality, the process for investigation of a disclosure is the same as that applied to the investigation of complaints received under the *Parliamentary Commissioner Act 1971*.

There were no public interest disclosures received during the year.

Indian Ocean Territories

Under a service delivery arrangement between the Ombudsman and the Australian Government, the Ombudsman handles complaints about State Government departments and authorities delivering services in the Indian Ocean Territories and about local governments in the Indian Ocean Territories. There were six complaints received during the year.

Terrorism

The Ombudsman can receive complaints from a person detained under the *Terrorism (Preventative Detention) Act 2006* about administrative matters connected with their detention. There were no complaints received during the year.

Requests for Review

Occasionally, the Ombudsman is asked to review or re-open a complaint that was investigated by the Office. The Ombudsman is committed to providing complainants with a service that reflects best practice administration and, therefore, offers complainants who are dissatisfied with a decision made by the Office an opportunity to request a review of that decision.

In 2023-24, three reviews were undertaken, representing 0.1 per cent of the total number of complaints finalised by the Office. In all cases, the original decision was upheld.

Stakeholder Liaison

The Office liaised with a range of agencies in relation to complaint resolution in 2023-24, including:

- Department of Communities;
- Department of Education; and
- Various prisons.

Child Death Review

Overview

This section sets out the work of the Office in relation to its child death review function. Information on this work has been set out as follows:

- The role of the Ombudsman in relation to child death reviews;
- The child death review process;
- Analysis of child death reviews;
- Issues identified in child death reviews;
- Recommendations;
- Timely handling of notifications and reviews;
- Major own motion investigations arising from child death reviews;
- Other mechanisms to prevent or reduce child deaths; and
- Stakeholder liaison.

The Role of the Ombudsman in Relation to Child Death Reviews

The Ombudsman is notified of all child deaths in Western Australia. The Office undertakes reviews of certain child deaths to identify learnings, and analyses data on child deaths to identify patterns and trends, which enables the Ombudsman to make recommendations for system improvements that may prevent or reduce the risk of future child deaths.

The child death review function enables the Ombudsman to review investigable deaths. Investigable deaths are defined in the Ombudsman's legislation, the *Parliamentary Commissioner Act 1971* (see Section 19A(3)), and occur when a child dies in any of the following circumstances:

- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children and Community Services Act 2004*, the CEO had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child; and

- Any of the actions listed in section 32(1) of the *Children and Community Services Act 2004* was done in respect of the child or a child relative of the child.

- The child or a child relative of the child is in the CEO's care or protection proceedings are pending in respect of the child or a child relative of the child.

In addition to determining if a child death is an investigable death, since 1 July 2020, the Ombudsman also identifies whether the child death will be reviewed by the Coroner (reportable deaths) or an existing medical review mechanism (including *Perinatal and Infant Mortality Review Committee* and a health service provider's *Mortality Review Committee*). The Ombudsman will review all investigable deaths as well as those child deaths that are not reviewed by one of these existing death review mechanisms.

The Ombudsman can also review other notified child deaths. Under Section 16 of the *Parliamentary Commissioner Act 1971*, the Ombudsman may determine to undertake a child death review under his own motion, where a child death may not be defined as an investigable death in accordance with Section 19A(3).

In undertaking a child death review, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths. The Ombudsman may also undertake major own motion investigations arising from child death reviews (discussed later in this section).

In reviewing child deaths the Ombudsman has wide powers of investigation, including powers to obtain information relevant to the death of a child and powers to recommend improvements to public administration about ways to prevent or reduce child deaths across all agencies within the Ombudsman's jurisdiction. The Ombudsman also has powers to monitor the steps that have been taken, are proposed to be taken, or have not been taken, to give effect to the recommendations.

The Child Death Review Process

The Ombudsman is notified of all child deaths that occur in WA

Births, Deaths and Marriages notifies the Ombudsman of all registered child deaths

The Department of Health notifies the Ombudsman of all child deaths known to Health Service Providers

Communities notifies the Ombudsman of all child deaths notified to it by the Coroner (those deaths that are reportable to the Coroner)

The Ombudsman reconciles the data from the three notification sources to identify the individual child deaths. Each child death notification is assessed to determine:

- whether the death is an investigable death or a non-investigable death; and
- whether a review will be conducted by an existing medical death review mechanism (including the *Perinatal and Infant Mortality Review Committee* and health service provider's *Mortality Review Committee*).

Ombudsman conducts review

- All investigable deaths are reviewed
- All deaths that are not reported to the Coroner, and not reviewed by an existing medical death review mechanism are reviewed
- Other deaths can be reviewed

Identifying patterns and trends

- Data on all child deaths is obtained, and reconciled
- Patterns and trends are identified, analysed and reported and also provide critical information to inform the selection and undertaking of major own motion investigations

Improving public administration

The Ombudsman seeks to improve public administration to prevent or reduce child deaths, including making recommendations to prevent or reduce child deaths arising from reviews and major own motion investigations

Implementation of recommendations and monitoring improvements

The Ombudsman actively monitors the implementation of recommendations as well as ensuring those improvements to public administration are contributing over time to preventing or reducing child deaths

Analysis of Child Death Reviews

By reviewing child deaths, the Ombudsman is able to identify, record and report on a range of information and analysis, including:

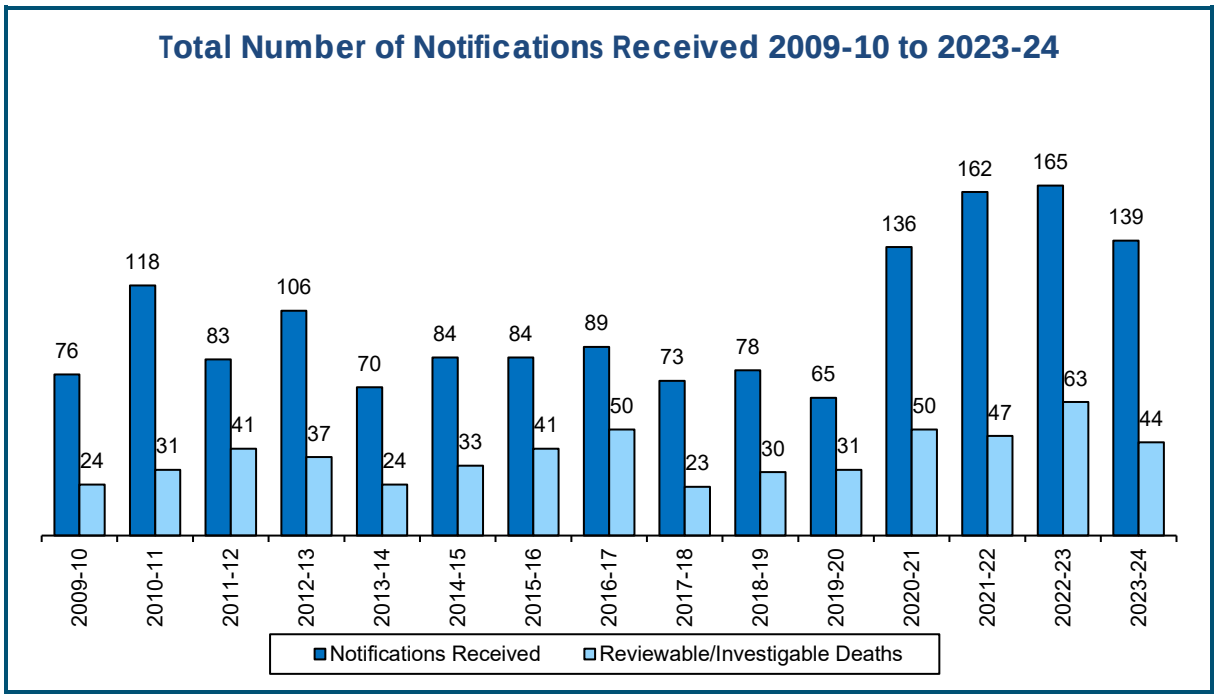
- The number of child death notifications and reviews;
- The comparison of investigable deaths over time;
- Demographic information identified from child death notifications;
- Circumstances in which child deaths have occurred;
- Social and environmental factors associated with investigable child deaths;
- Analysis of children in particular age groups; and
- Patterns, trends and case studies relating to child death reviews.

Number of child death notifications and reviews

Expanded data on child deaths

From 1 July 2020, the Ombudsman has received notifications of all child deaths in Western Australia. The data for the year 2020-21 onwards relates to all child deaths, while data from earlier years relates to child deaths reported to the Coroner and notified from Communities.

During 2023-24, there were 44 child deaths that were investigable and subject to review from a total of 139 child death notifications received.



Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Due to a lag in death registration and notification of relevant death data, number of death notifications will increase for the last reported year. In the 2022-23 Annual Report, complete data on 143 deaths (57 Investigable Deaths) had been provided to the Ombudsman. As additional data was provided in 2023-24, this has been revised to 165 deaths (63 Investigable deaths) notified to the Ombudsman in 2022-23.

Demographic information identified from child death reviews

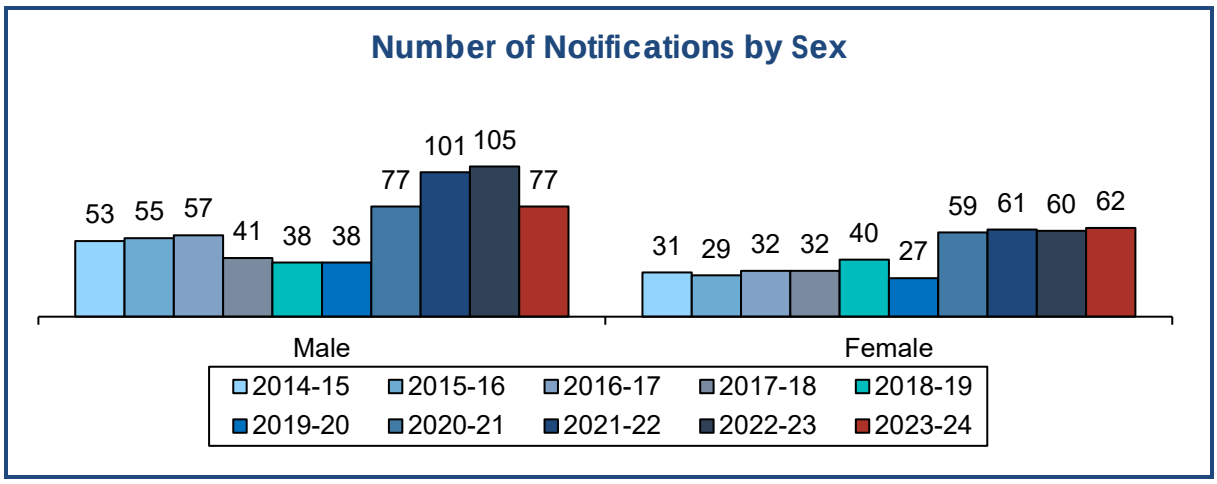
Information is obtained on a range of characteristics of the children who have died including sex, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected by Communities in order to prevent or reduce deaths.

The following charts show:

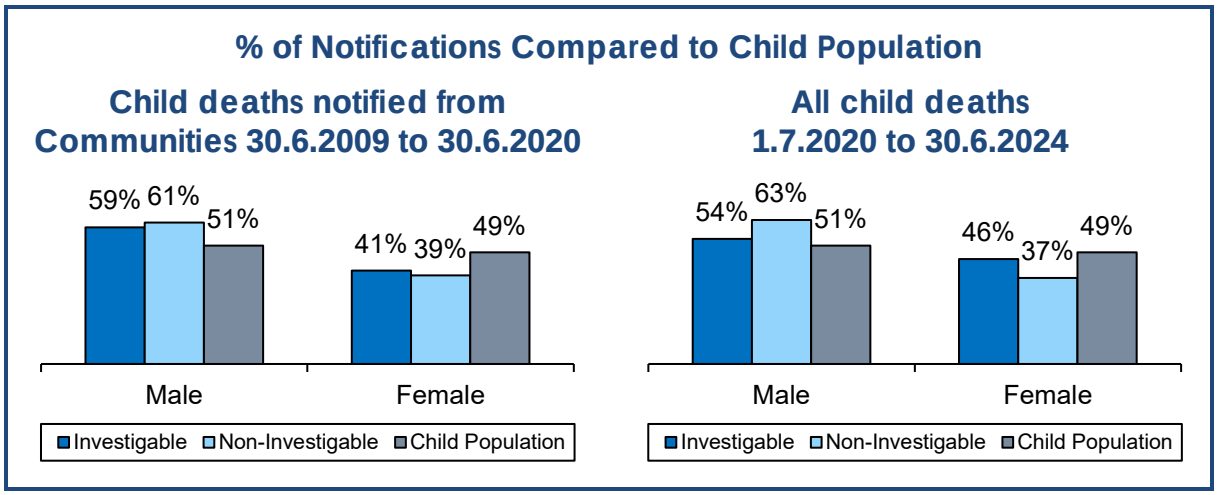
- The number of children in each group for each year for the last 10 years.
- The percentage of children in each group for both investigable deaths and non-investigable deaths, compared to the child population in Western Australia,
    - for the period from 30 June 2009 to 30 June 2020, when the Ombudsman received notifications from Communities of deaths reported to the Coroner; and
    - for the period from 1 July 2020 to 30 June 2024 relating to all child deaths.

Males and females

Information is collated on a child's sex (male or female) as identified in agency documentation provided to this Office. As shown in the following charts, male children are over-represented compared to the population for both investigable and non-investigable deaths.



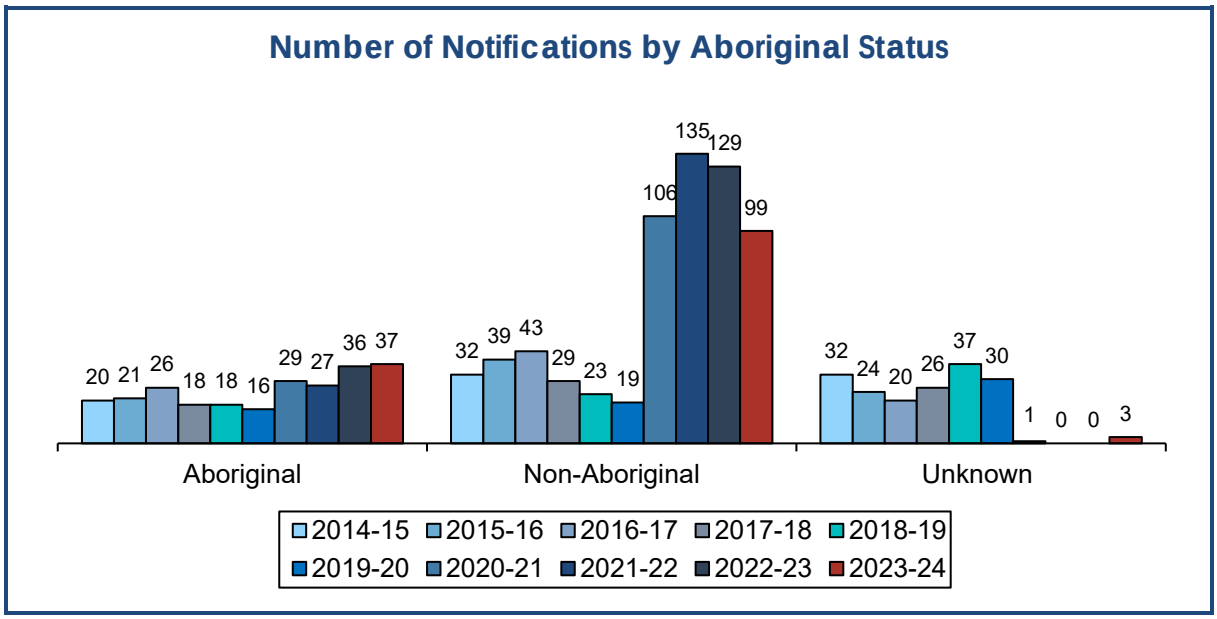
Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



Further analysis of the data shows that, considering all 15 years of the Ombudsman's child death review function, male children are over-represented for all age groups, but particularly for children aged over six years.

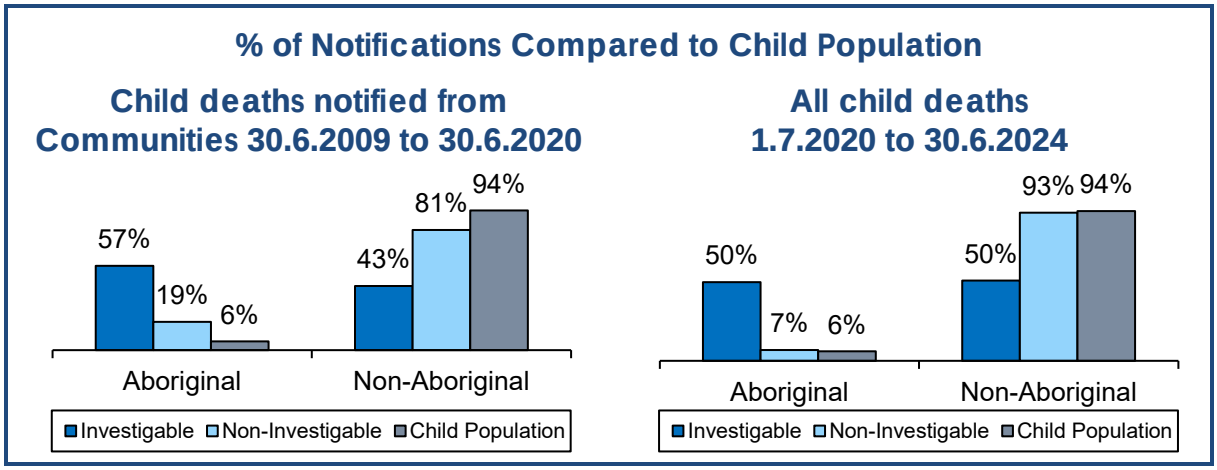
Aboriginal status

Information on Aboriginal status is collated where a child, or one/both of their parents, identify as Aboriginal to agencies they have contact with, and this is recorded in the documentation provided to this Office. As shown in the following charts, Aboriginal children are over-represented compared to the population in all deaths and more so for investigable deaths.



Note 1: The 'Aboriginal' category in the charts includes children who are Torres Strait Islander and children who are both Aboriginal and Torres Strait Islander. Use of the term 'Aboriginal' reflects the dominant heritage of First Nations people in Western Australia.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

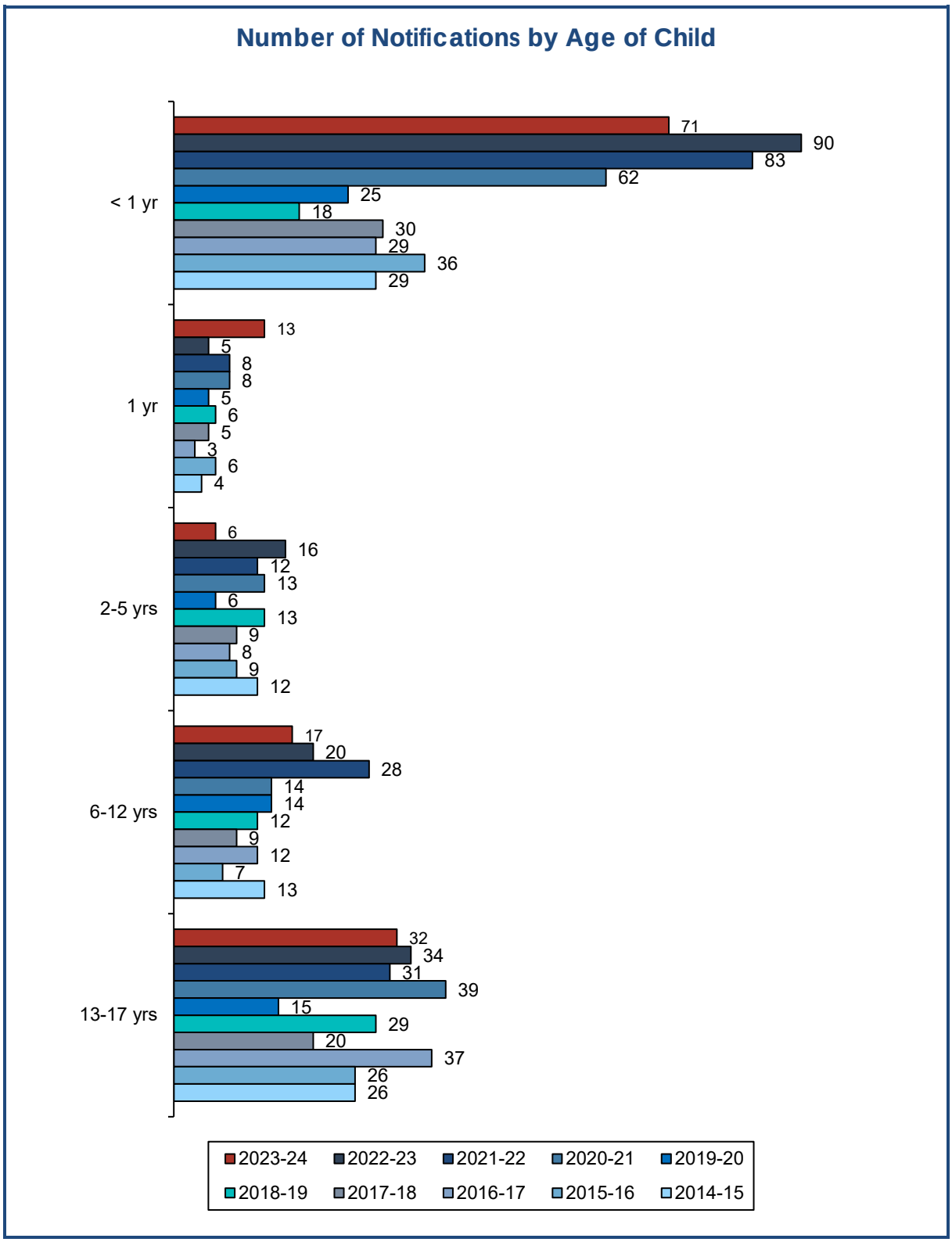


Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported because further information may become available on the Aboriginal status of the child during the course of a review.

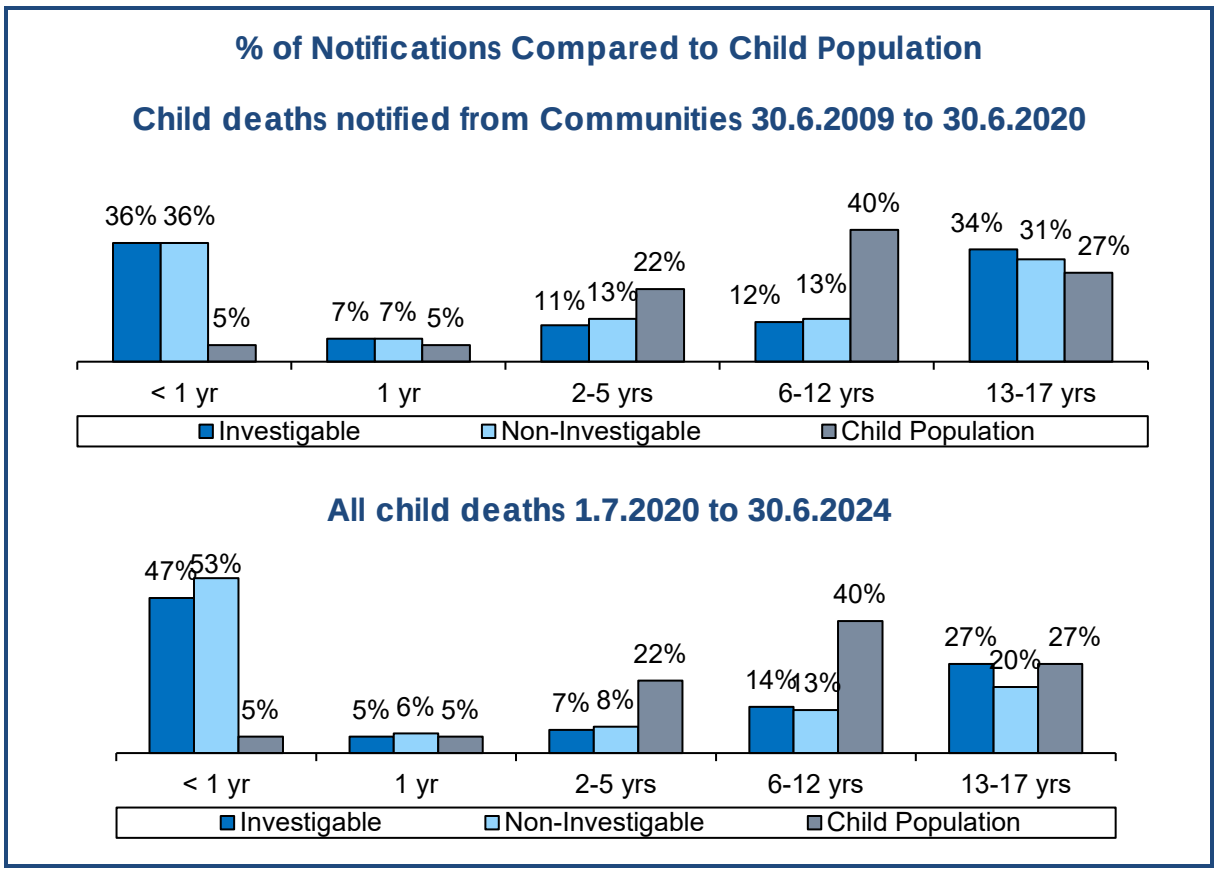
Further analysis of the data shows that Aboriginal children are more likely than non-Aboriginal children to be under the age of one and living in regional and remote locations.

Age groups

As shown in the following charts, children under one year, children aged one year, and children aged between 13 and 17 are over-represented compared to the child population as a whole for both investigable and non-investigable deaths.



Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

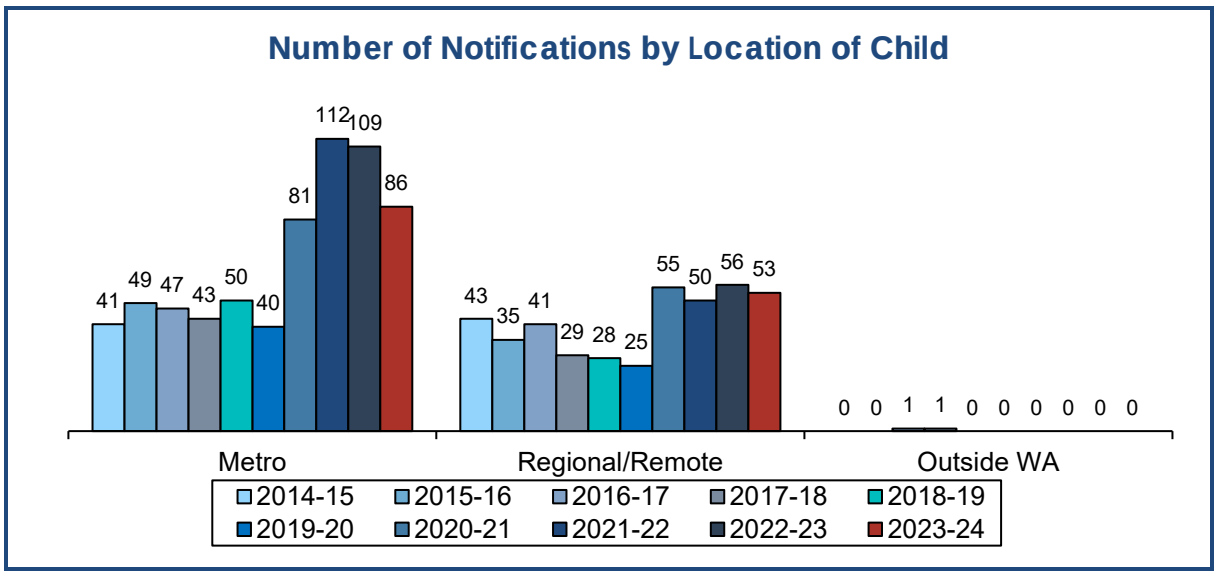


Note: Percentages may not add to 100 per cent due to rounding.

A more detailed analysis by age group is provided later in this section.

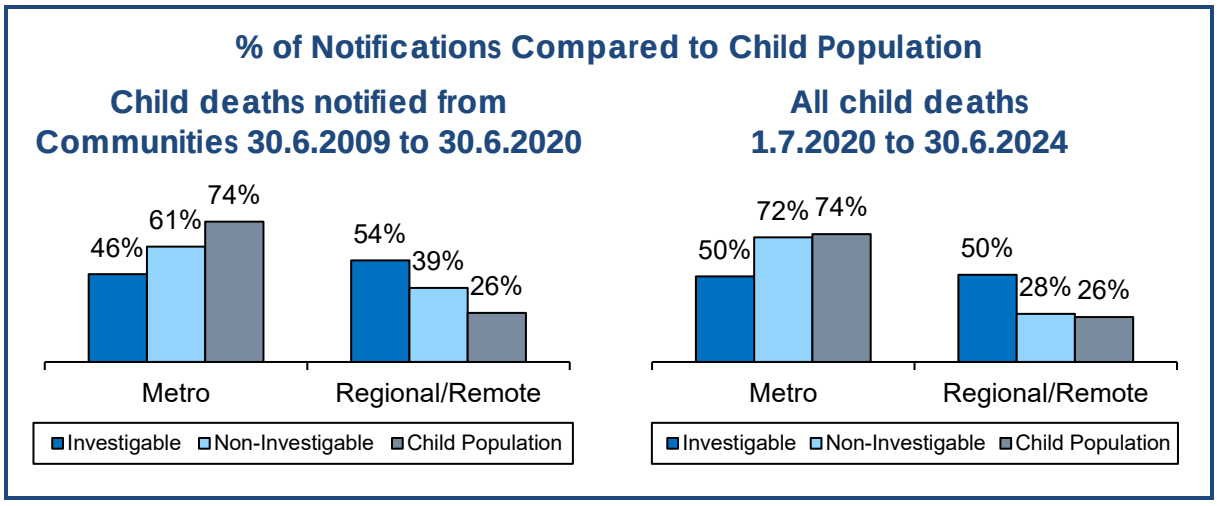
Location of residence

As shown in the following charts, children in regional locations are over-represented compared to the child population as a whole, and more so for investigable deaths.



Note 1: Outside WA includes children whose residence is not in Western Australia, but the child died in Western Australia. Numbers may vary slightly from those previously reported because further information may become available on the place of residence of the child during the course of a review.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



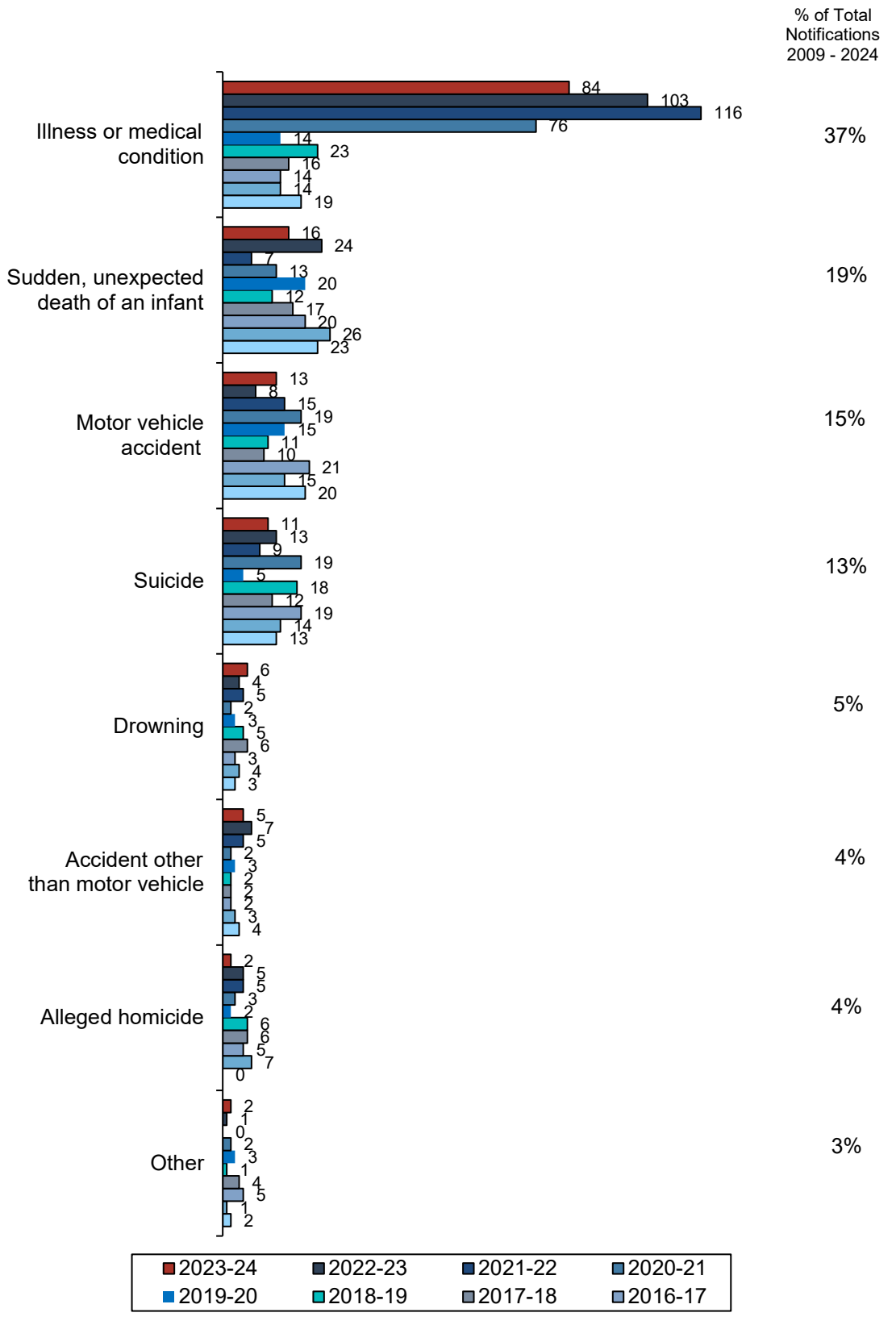
Further analysis of the data shows that 72% of Aboriginal children who died were living in regional or remote locations when they died. Most non-Aboriginal children who died lived in the metropolitan area but the proportion of non-Aboriginal children who died in regional areas (30%) is higher than would be expected based on the child population.

Circumstances in which child deaths have occurred

The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner.

The following chart shows the circumstances of notified child deaths for the last 10 years.

Circumstances of Child Deaths



Note 1: Numbers may vary slightly from those previously reported because further information may become available on the circumstances in which the child died during the course of a review.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.

The main circumstances of death for the 1,528 child death notifications received in the 15 years from 30 June 2009 to 30 June 2024 are illness or medical condition (37%), sudden, unexpected deaths of infants (19%) and motor vehicle accidents (15%).

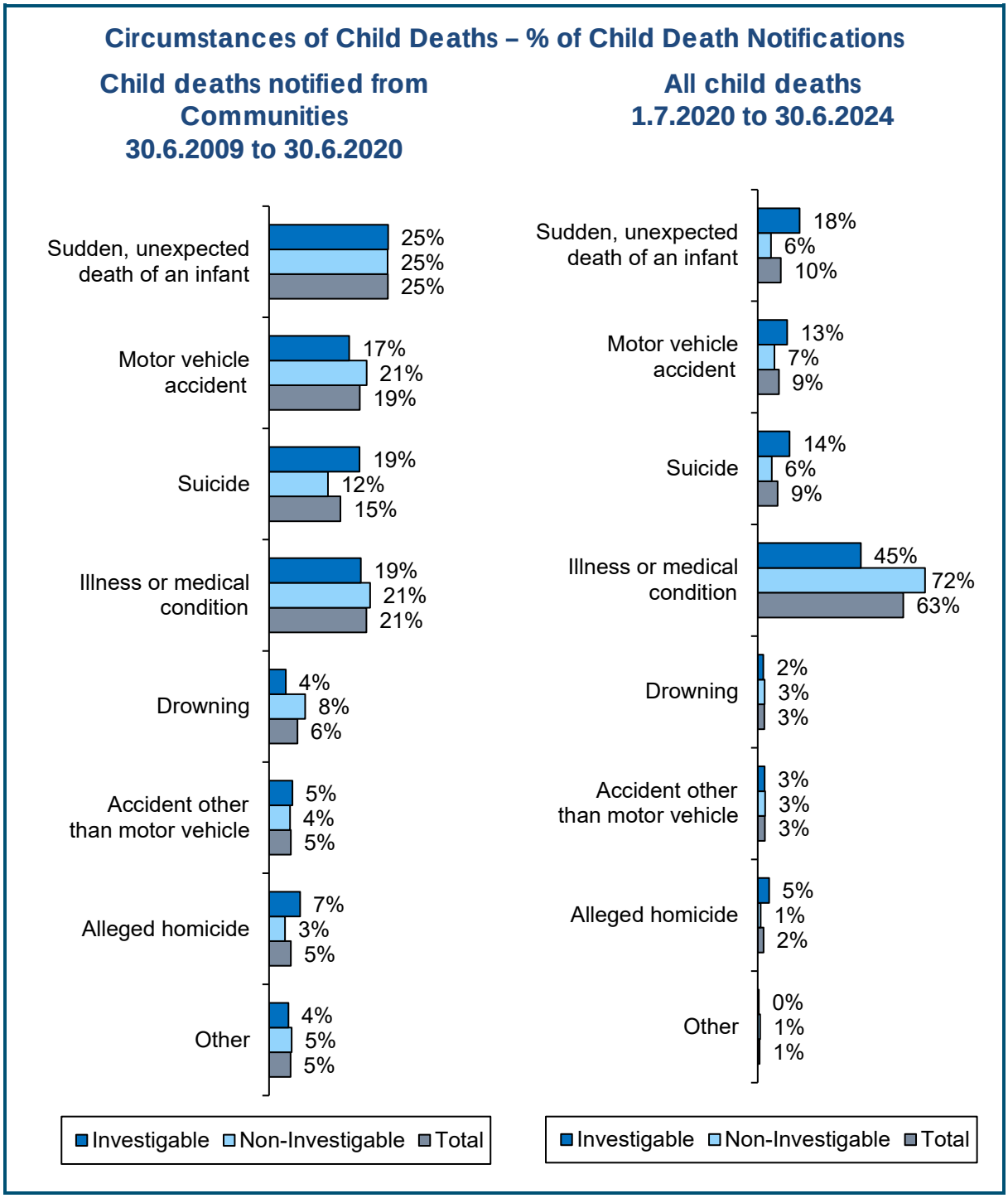
For the period 30 June 2009 to 30 June 2020, when the Ombudsman received notifications from Communities about child deaths reported to the Coroner, the main circumstances of death were:

- Sudden, unexpected deaths of infants, representing 25% of the total child death notifications over this period (17% of the child death notifications received in 2009-10, 23% in 2010-11, 33% in 2011-12, 25% in 2012-13, 30% in 2013-14, 27% in 2014-15, 31% in 2015-16, 22% in 2016-17, 23% in 2017-18, 15% in 2018-19, and 31% in 2019-20); and
- Motor vehicle accidents, representing 19% of the total child death notifications over this period (22% of the child death notifications received in 2009-10, 19% in 2010-11, 20% in 2011-12, 14% in 2012-13, 21% in 2013-14, 24% in 2014-15, 18% in 2015-16, 24% in 2016-17, 14% in 2017-18, 14% in 2018-19, and 23% in 2019-20.

For the period 1 July 2020 to 30 June 2024, when the Ombudsman received notifications of all child deaths in Western Australia, the main circumstances of death were:

- Illness or medical condition, representing 63% of the total child death notifications over this period (56% of child death notifications received in 2020-21, 72% in 2021-22, 62% in 2022-23 and 60% in 2023-24); and
- Sudden, unexpected deaths of infants, representing 10% of the total child death notifications over this period (10% of child death notifications received in 2020-21, 4% in 2021-22, 15% in 2022-23 and 12% in 2023-24).

The following chart provides a breakdown of the circumstances of death for child death notifications for investigable and non-investigable deaths.



Note: Percentages may not add to 100 per cent due to rounding.

Considering all 15 years of the Ombudsman's child death review function, there are three areas where the circumstance of death shows a higher proportion for investigable deaths than for deaths that are not investigable. These are:

- Suicide;
- Alleged homicide; and
- Sudden, unexpected death of an infant.

Social and environmental factors associated with investigable child deaths

A number of social and environmental factors affecting the child or their family may impact on the wellbeing of the child, such as:

- Family and domestic violence;
- Drug or substance use;
- Alcohol use;
- Parenting;
- Homelessness; and
- Parental mental health issues.

Reviews of investigable deaths often highlight the impact of these factors on the circumstances leading up to the child's death and, where this occurs, these factors are recorded to enable an analysis of patterns and trends to assist in considering ways to prevent or reduce future deaths.

It is important to note that the existence of these factors is associative. They do not necessarily mean that the removal of this factor would have prevented the death of a child or that the existence of the factor necessarily represents a failure by Communities or another public authority.

The following table shows the percentage of investigable child death reviews associated with particular social and environmental factors for the period 30 June 2009 to 30 June 2024.

Social or Environmental Factor	% of Finalised Reviews of investigable deaths from 30.6.2009 to 30.6.2024
Family and domestic violence	73%
Parenting	62%
Drug or substance use	48%
Alcohol use	43%
Parental mental health issues	30%
Homelessness	21%

One of the features of the investigable deaths reviewed is the co-existence of a number of these social and environmental factors. The following observations can be made:

- Where family and domestic violence was present:
  - Parenting was a co-existing factor in 67% of the cases;
  - Drug or substance use was a co-existing factor in 57% of the cases;
  - Alcohol use was a co-existing factor in 52% of the cases;
  - Parental mental health issues were a co-existing factor in 35% of the cases; and

- Homelessness was a co-existing factor in 25% of the cases.

- Where alcohol use was present:
  - Parenting was a co-existing factor in 77% of the cases;
  - Family and domestic violence was a co-existing factor in 87% of the cases;
  - Drug or substance use was a co-existing factor in 69% of the cases;
  - Parental mental health issues were a co-existing factor in 32% of the cases; and
  - Homelessness was a co-existing factor in 32% of the cases.

Reasons for contact with Communities

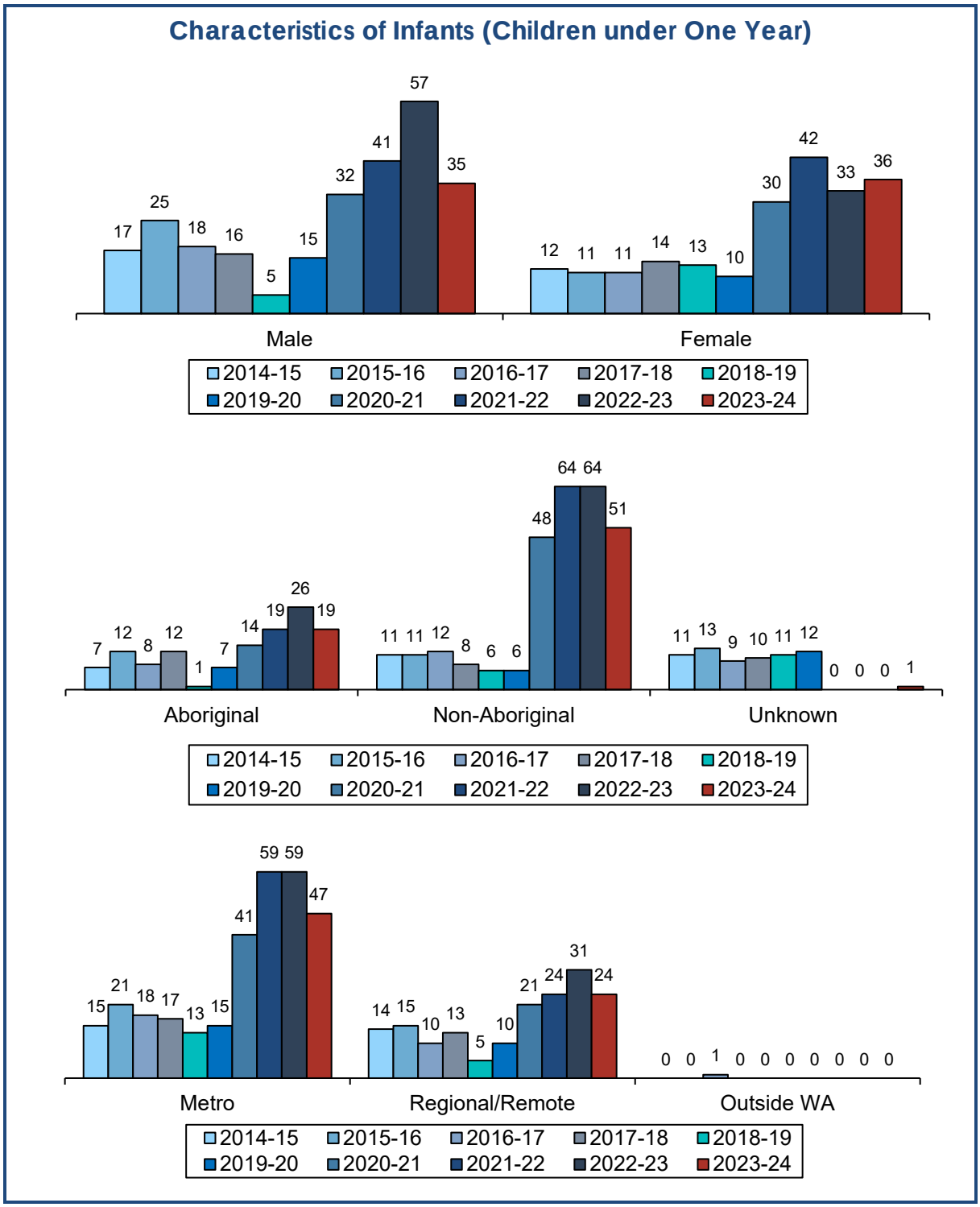
In child deaths notified to the Ombudsman in 2023-24, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

Analysis of children in particular age groups

In examining the child death notifications by their age groups, the Office is able to identify patterns that appear to be linked to childhood developmental phases and associated care needs. This age-related focus has enabled the Office to identify particular characteristics and circumstances of death that have a high incidence in each age group and refine the reviews to examine areas where improvements to public administration may prevent or reduce these child deaths. The following section identifies four groupings of children: under one year (**infants**); children aged 1 to 5; children aged 6 to 12; and children aged 13 to 17 and demonstrates the learning and outcomes from this age-related focus.

Deaths of infants

Of the 1,528 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2024, there were 636 (42%) related to deaths of infants. The characteristics of infants who died in the last 10 years are shown in the following charts.



Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

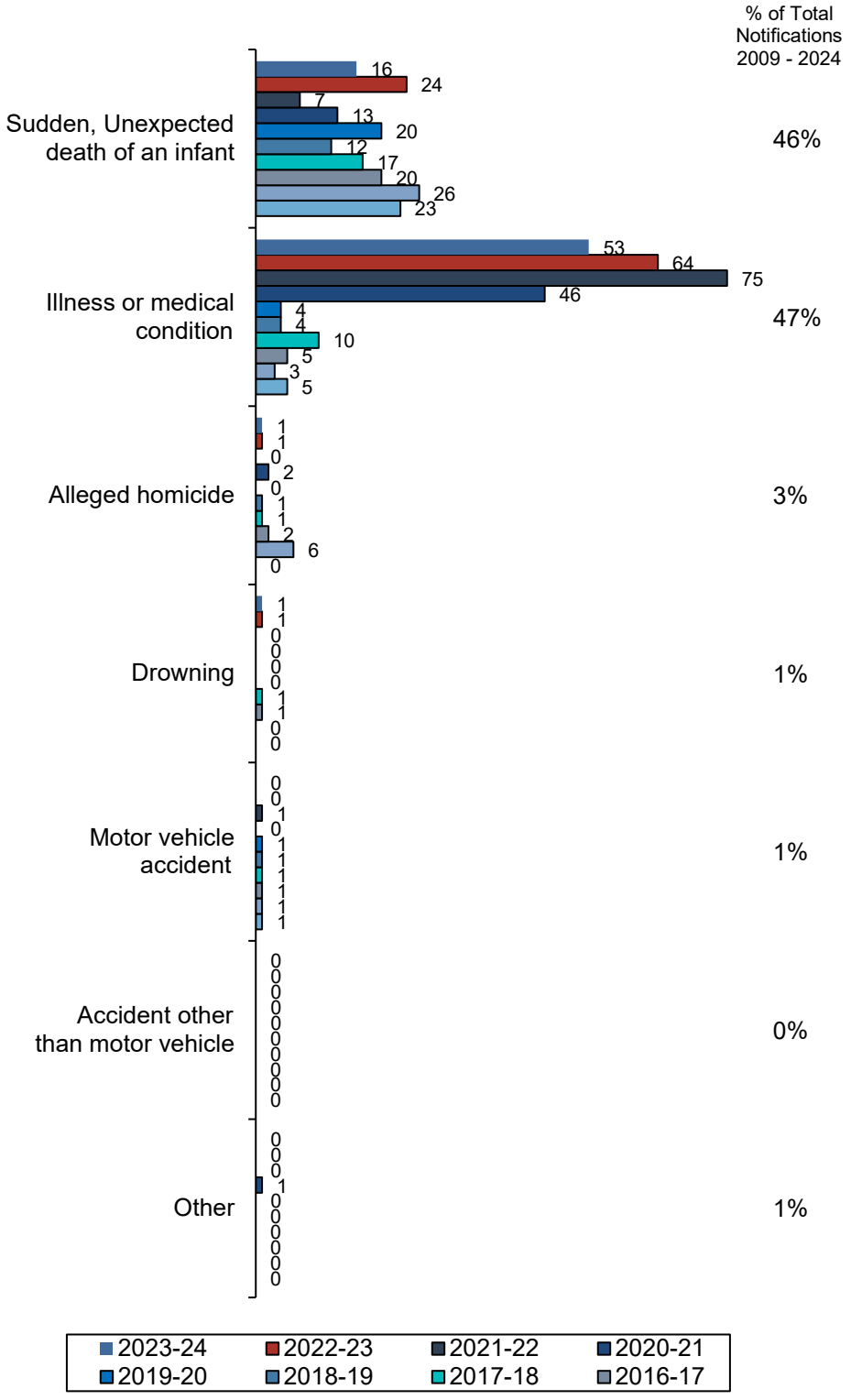
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these infant deaths, there was an over-representation compared to the child population for:

- Males – 58% of investigable infant deaths and 58% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 65% of investigable deaths and 15% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 53% of investigable infant deaths and 30% of non-investigable deaths of infants, living in Western Australia, were children living in regional or remote locations compared to 26% in the child population.

An examination of the patterns and trends of the circumstances of infant deaths showed that of the 636 infant deaths, 293 (46%) were categorised as sudden, unexpected deaths of an infant and 81% of these (238) appear to have occurred while the infant had been placed for sleep. There were also 47% of infant deaths (300) in circumstances of illness or medical condition, however the majority of these (238) were notified to the Ombudsman under the expanded jurisdiction from 1 July 2020. There were a small number of other deaths as shown in the following charts.

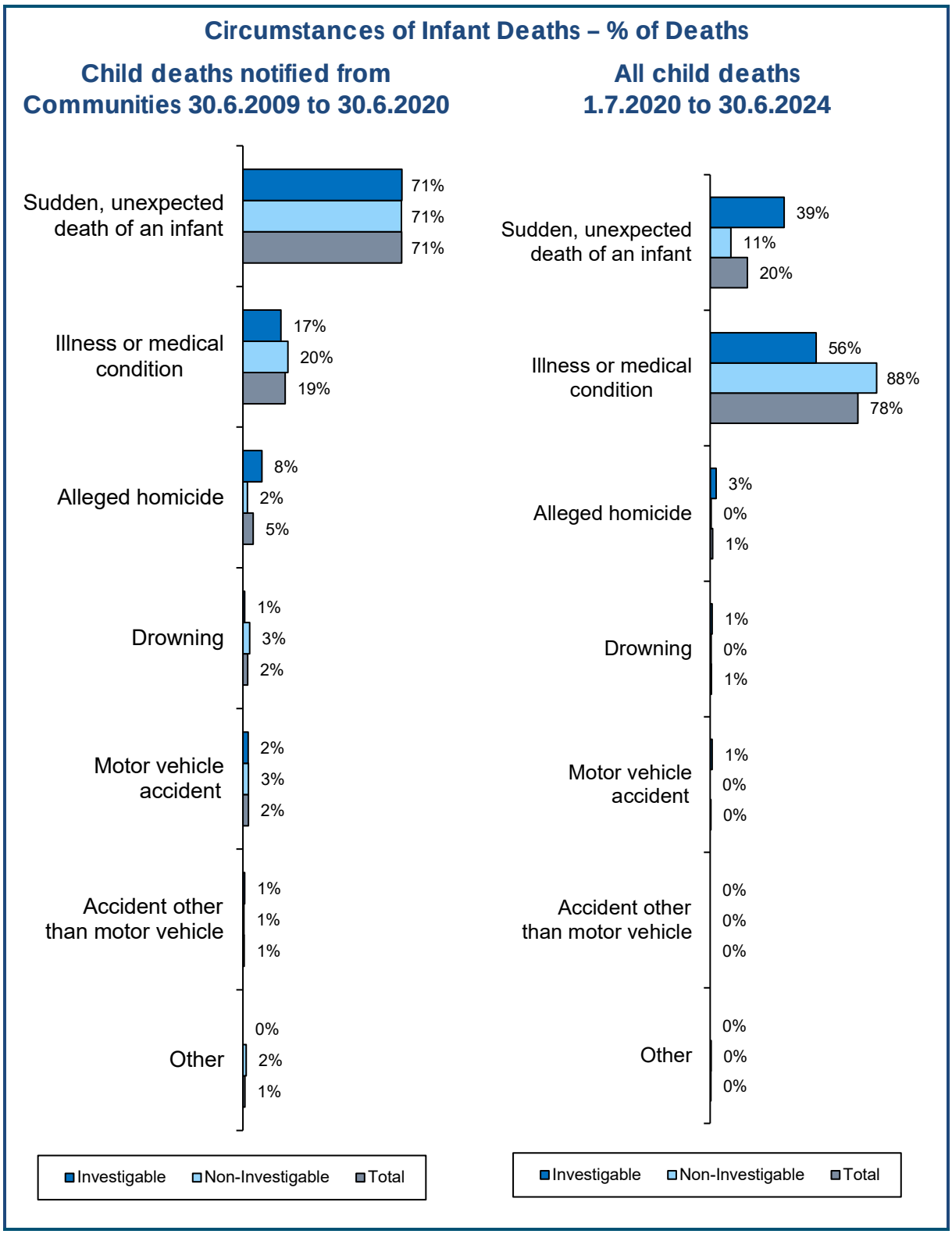
Circumstances of Infant Deaths (Children under One Year)



Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.



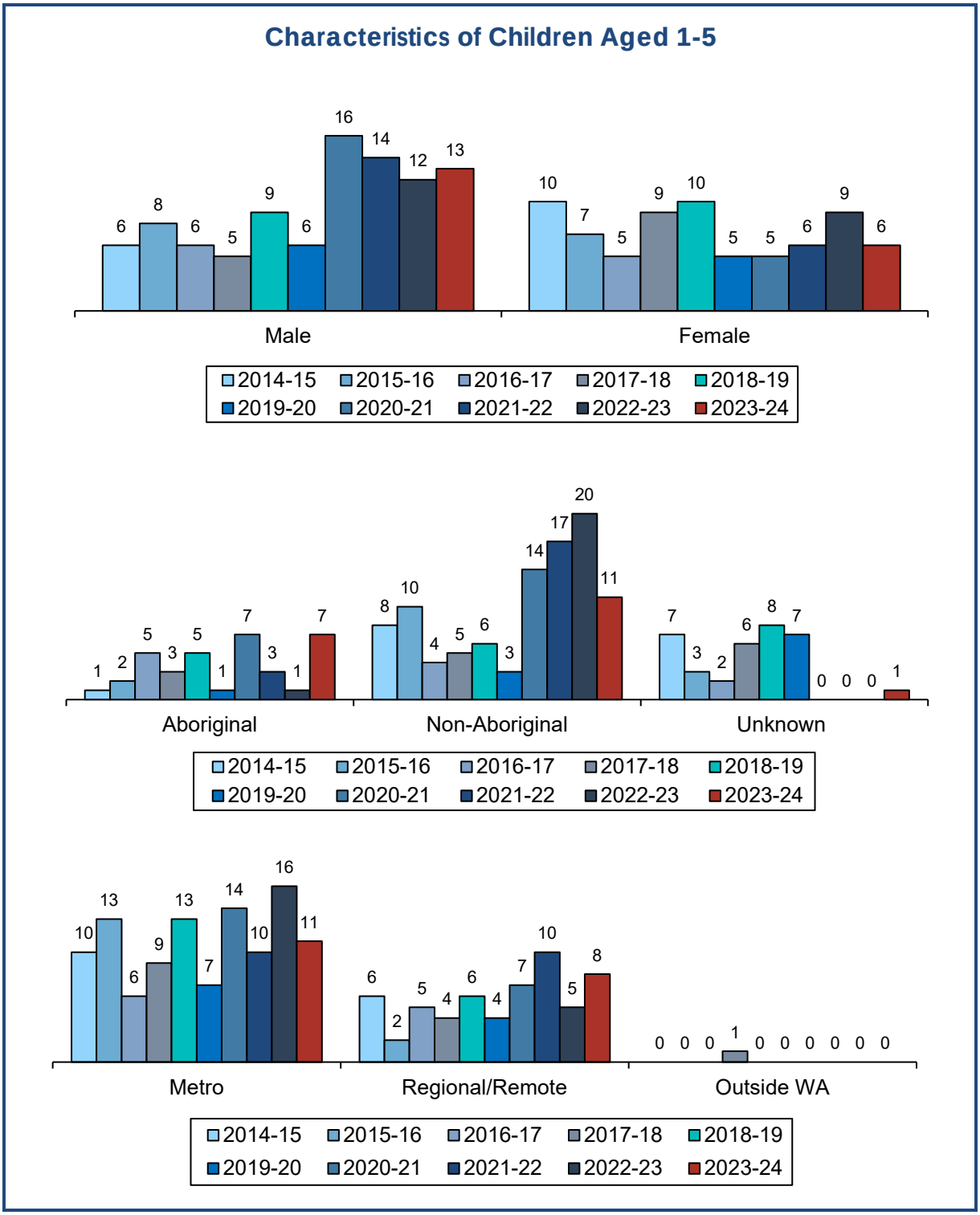
Note: Percentages may not add to 100 per cent due to rounding.

Two hundred and twenty-five deaths of infants were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 1,528 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2024, there were 261 (17%) related to children aged from 1 to 5 years.

The characteristics of children who died in the last 10 years aged 1 to 5 are shown in the following charts.



Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

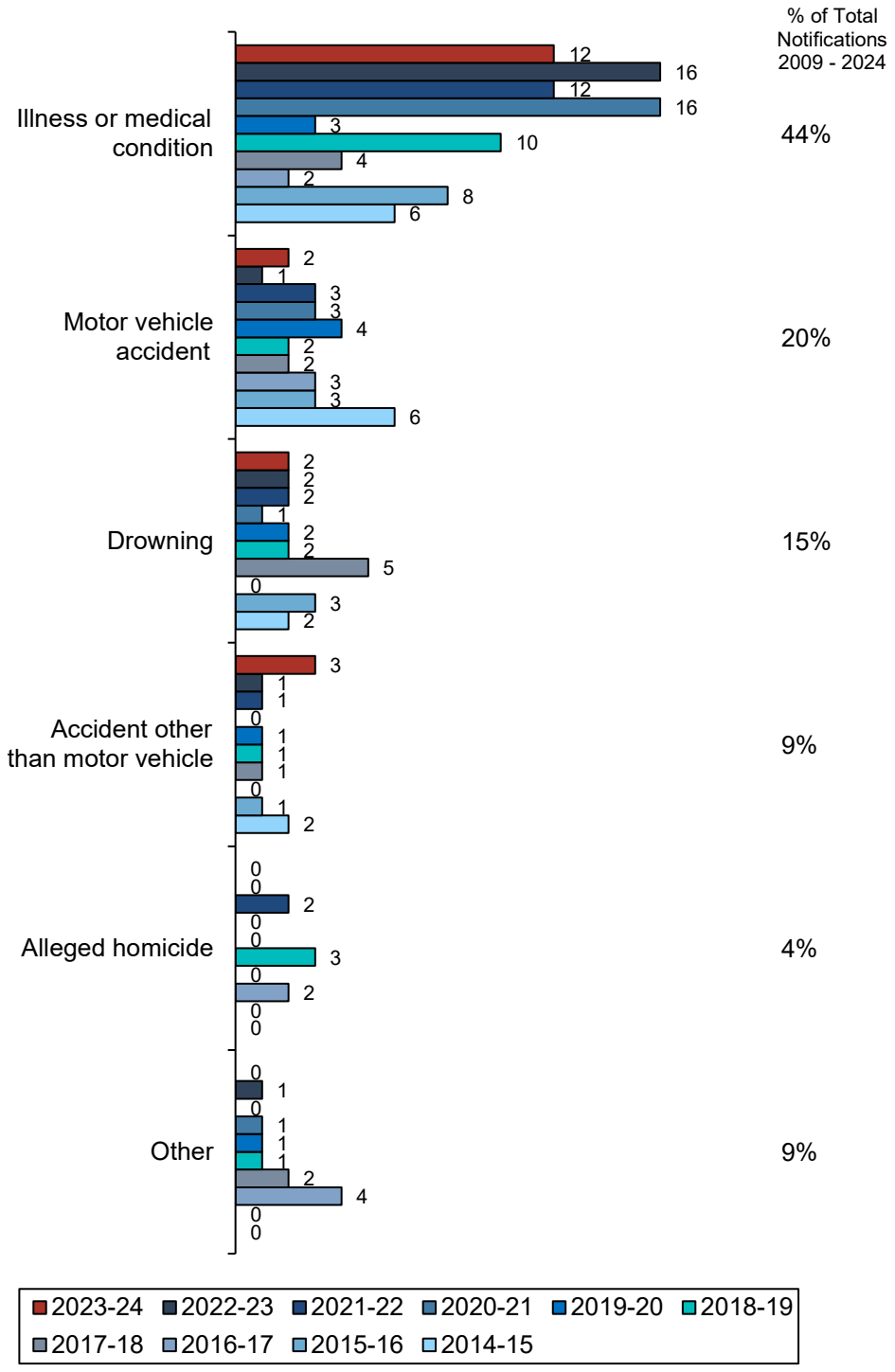
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 54% of investigable deaths and 60% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Aboriginal children – 51% of investigable deaths and 12% of non-investigable deaths of children aged 1 to 5 were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 47% of investigable deaths and 33% of non-investigable deaths of children aged 1 to 5, living in Western Australia, were children living in regional or remote locations compared to 26% in the child population.

As shown in the following chart, illness or medical condition is the most common circumstance of death for this age group (44%), followed by motor vehicle accidents (20%) and drowning (15%).

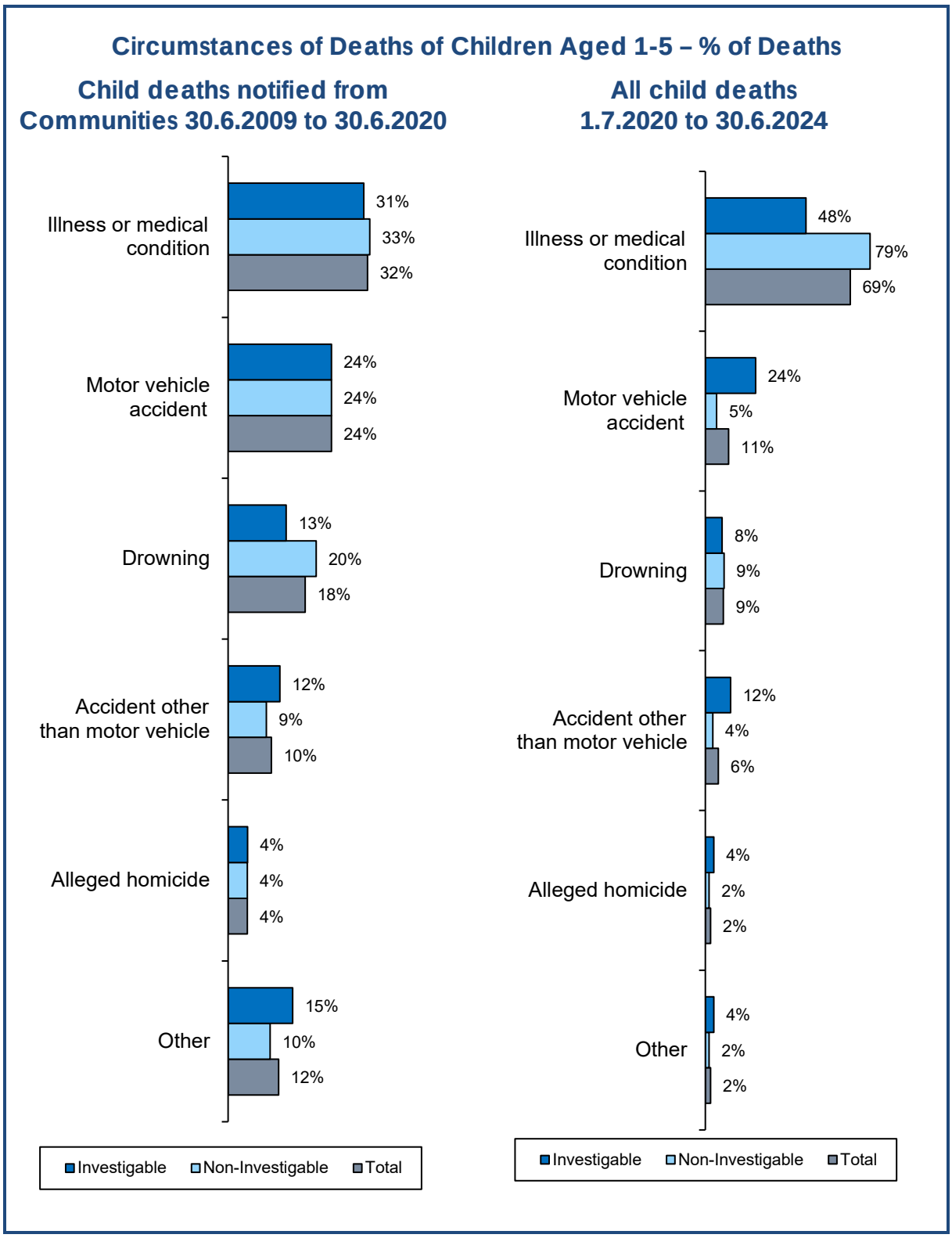
Circumstances of Deaths of Children Aged 1-5



Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.



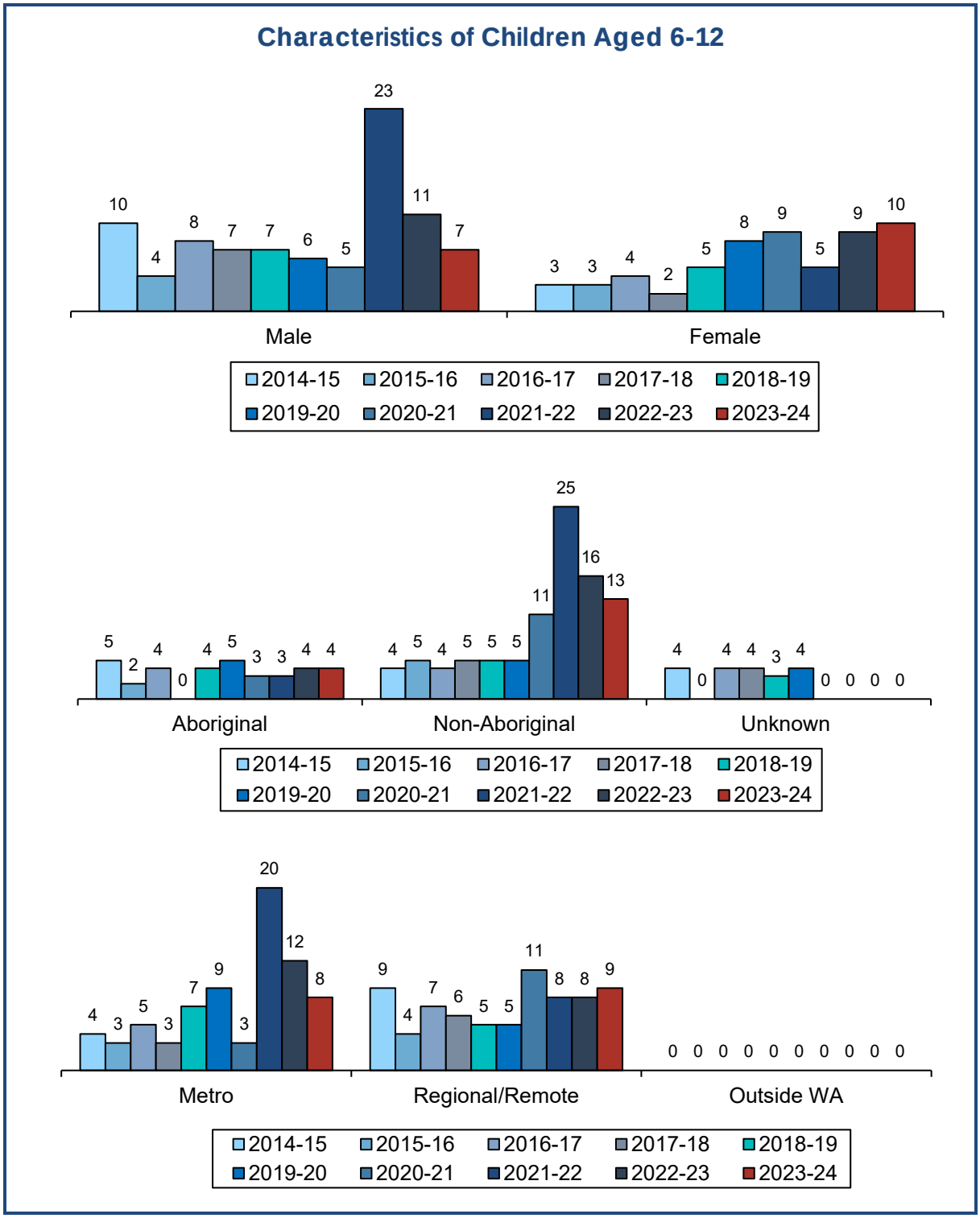
Note: Percentages may not add to 100 per cent due to rounding.

Ninety-two deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of children aged 6 to 12 years

Of the 1,528 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2023, there were 195 (13%) related to children aged from 6 to 12 years.

The characteristics of children who died in the last 10 years aged 6 to 12 are shown in the following charts.



Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

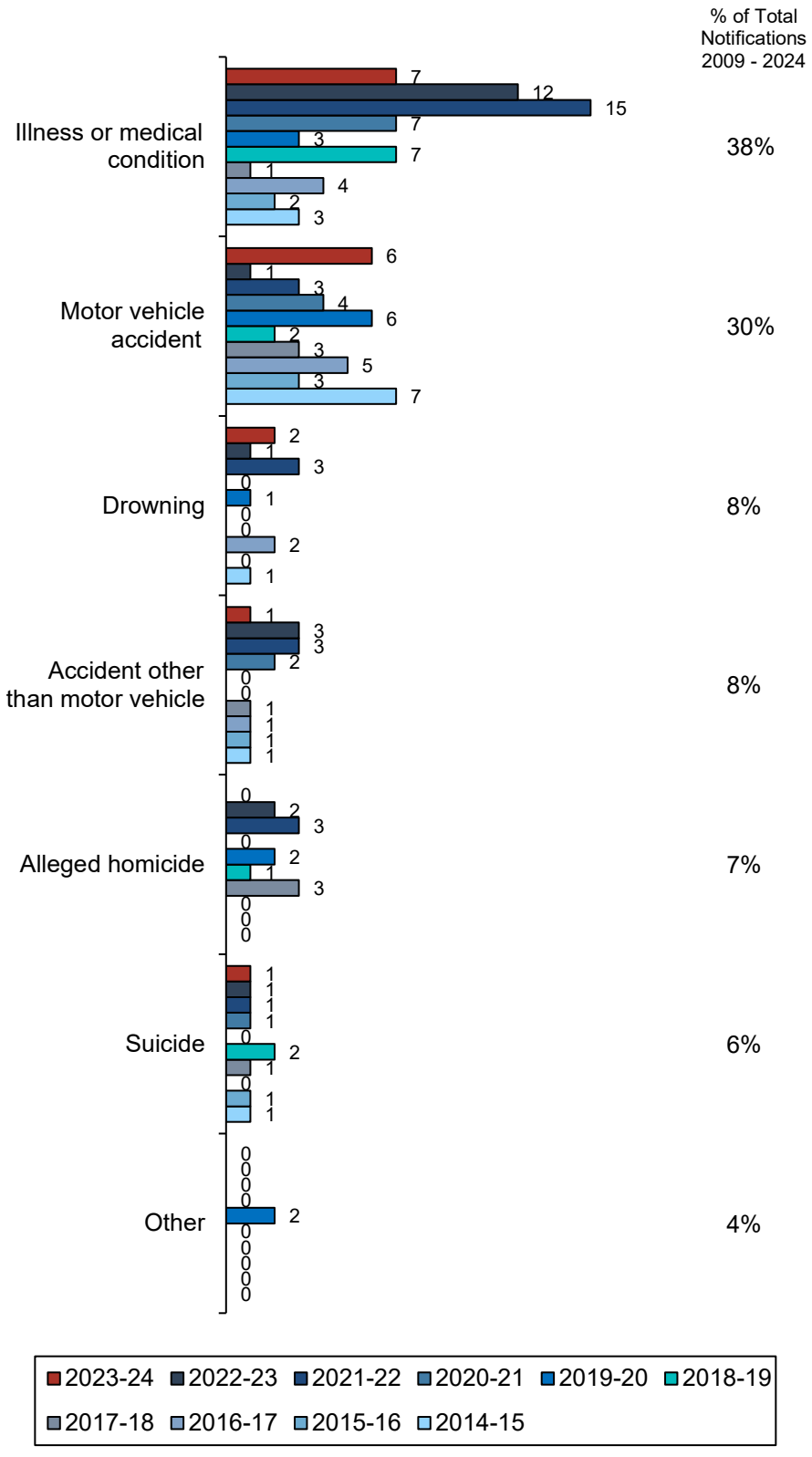
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 54% of investigable deaths and 65% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population;
- Aboriginal children – 49% of investigable deaths and 10% of non-investigable deaths of children aged 6 to 12 were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 58% of investigable deaths and 46% of non-investigable deaths of children aged 6 to 12, living in Western Australia, were children living in regional or remote locations compared to 26% in the child population.

As shown in the following chart, illness or medical conditions are the most common circumstance of death for this age group (38%), followed by motor vehicle accidents (30%).

Circumstances of Deaths of Children Aged 6-12

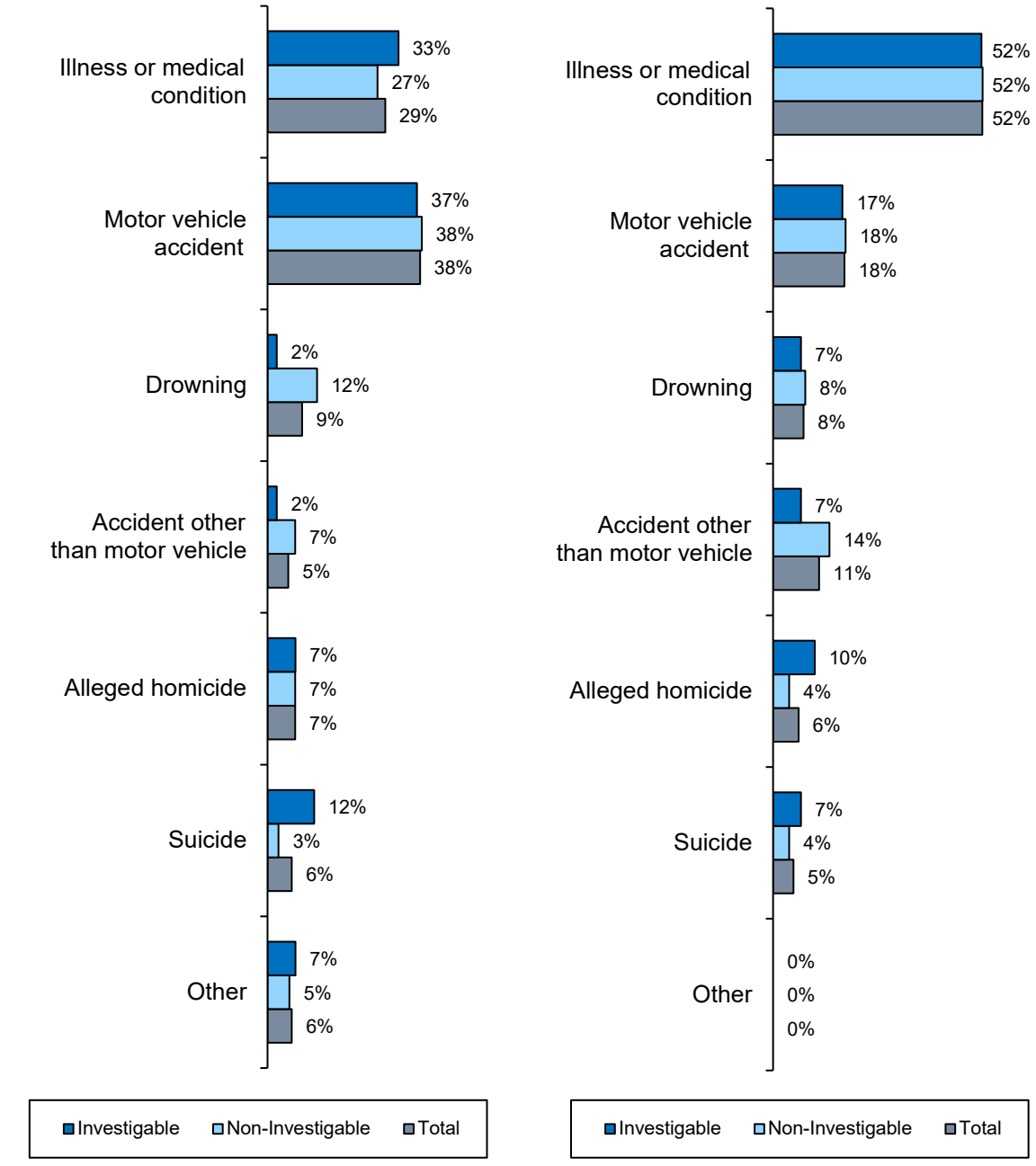


Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.

Circumstances of Deaths of Children Aged 6-12 – % of Deaths



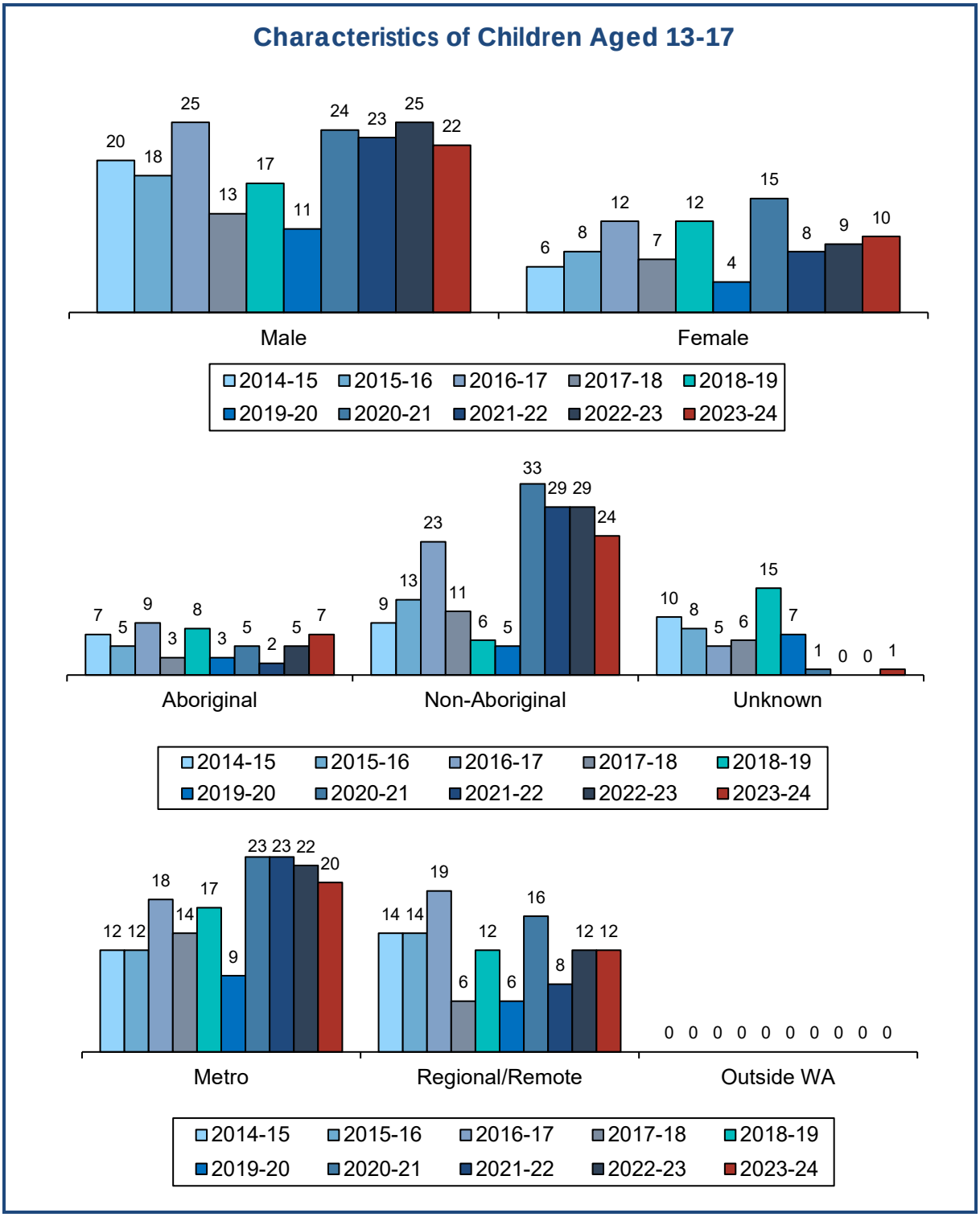
Note: Percentages may not add to 100 per cent due to rounding.

Seventy two deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of children aged 13 – 17 years

Of the 1,528 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2024, there were 436 (29%) related to children aged from 13 to 17 years.

The characteristics of children who died in the last 10 years aged 13 to 17 are shown in the following charts.



Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

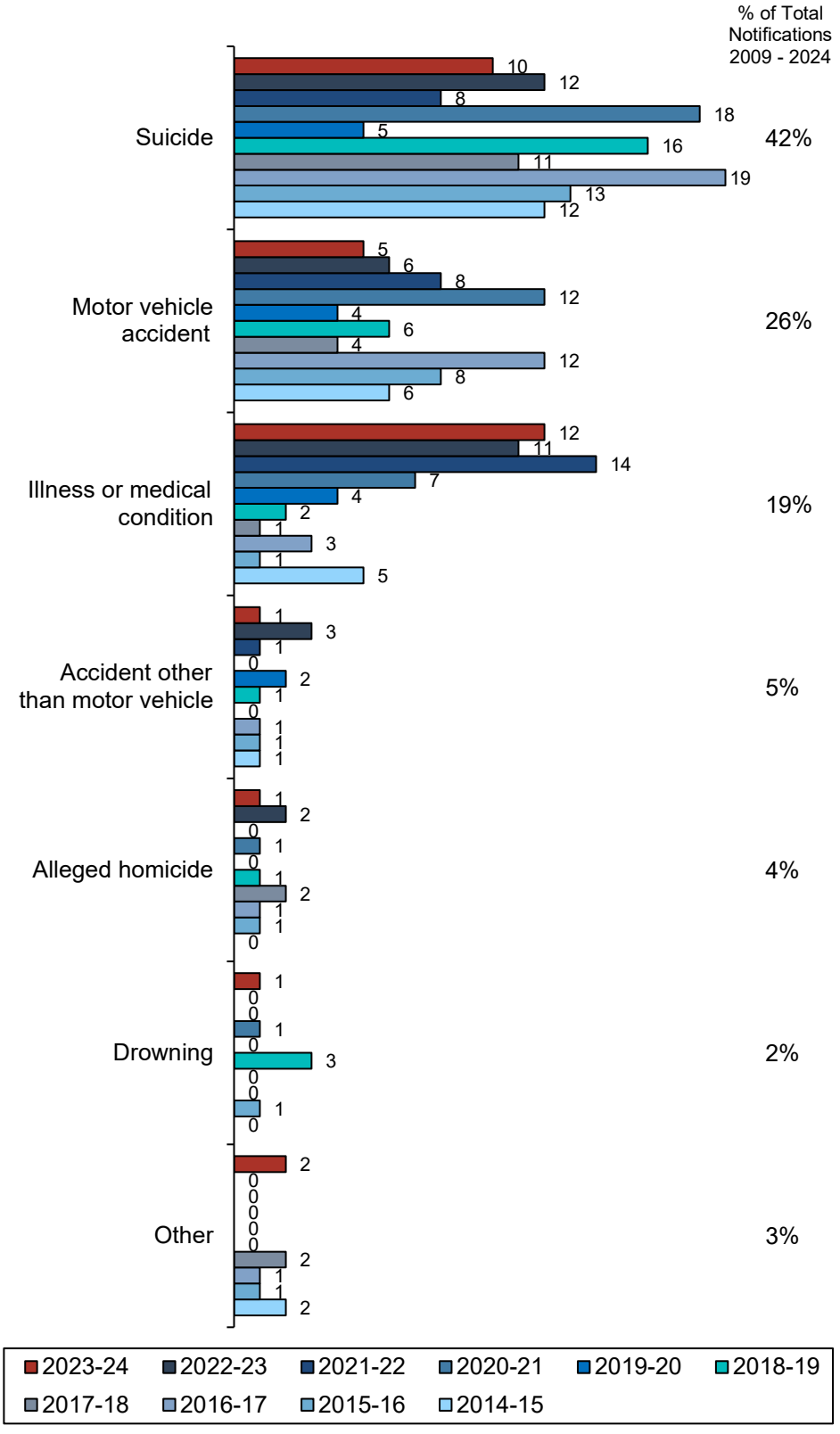
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 60% of investigable deaths and 68% of non-investigable deaths of children aged 13 to 17 were male compared to 51% in the child population;
- Aboriginal children – 45% of investigable deaths and 9% of non-investigable deaths of children aged 13 to 17 were Aboriginal compared to 6% in the child population; and
- Children living in regional or remote locations – 52% of investigable deaths and 37% of non-investigable deaths of children aged 13 to 17, living in Western Australia, were living in regional or remote locations compared to 26% in the child population.

As shown in the following chart, suicide is the most common circumstance of death for this age group (43%), particularly for investigable deaths, followed by motor vehicle accidents (27%) and illness or medical condition (17%).

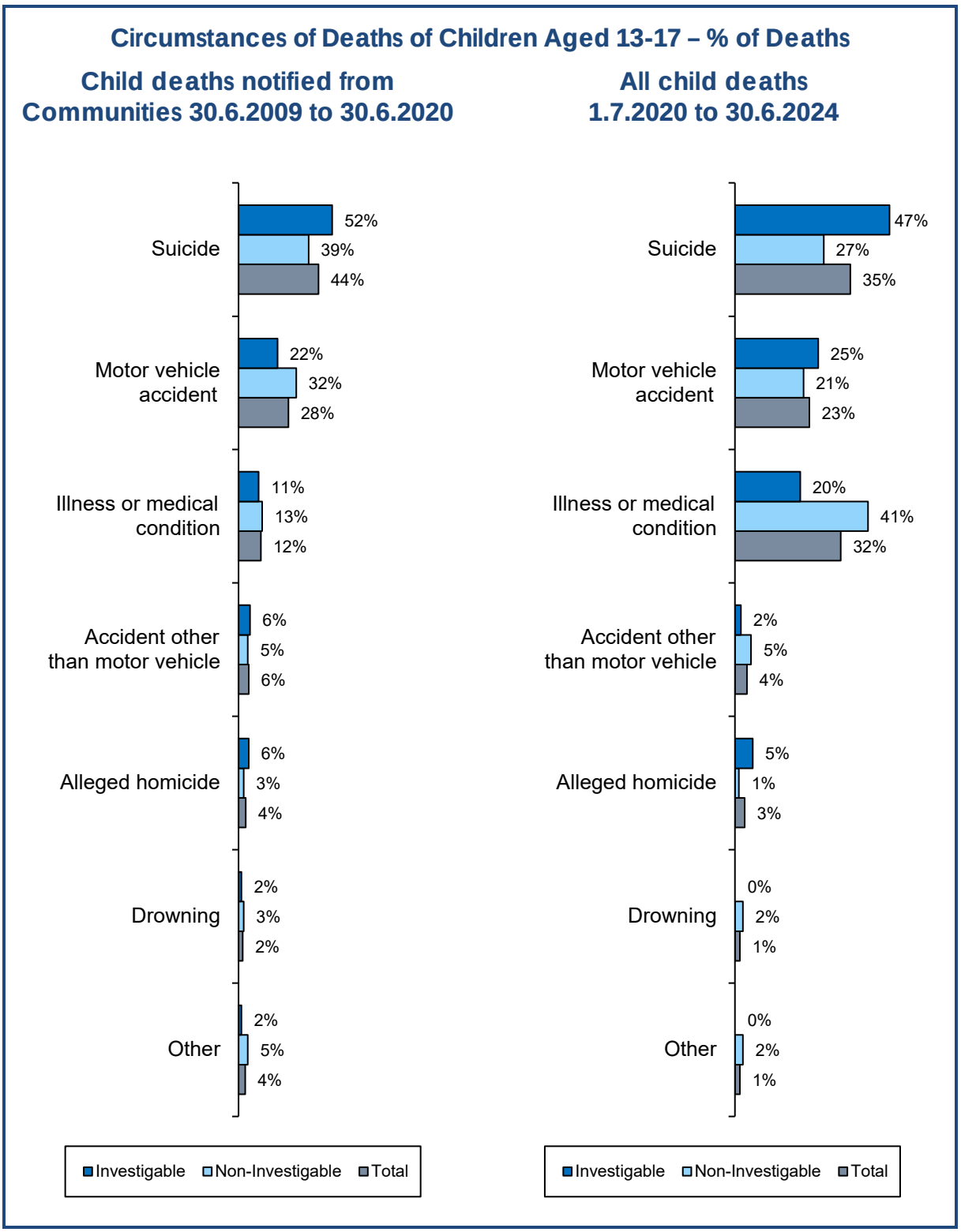
Circumstances of Deaths of Children Aged 13-17



Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.



Note: Percentages may not add to 100 per cent due to rounding.

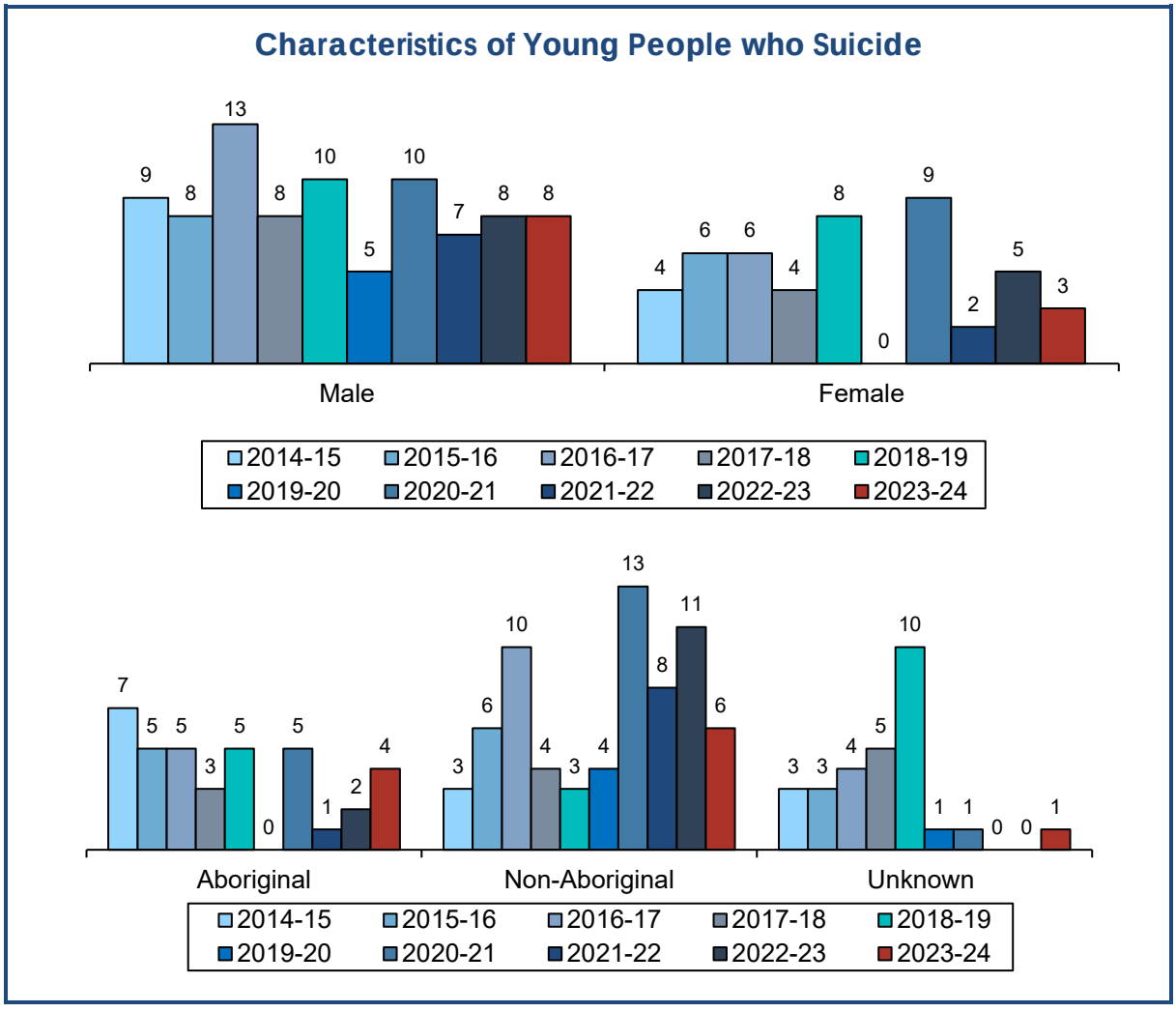
One hundred and eighty deaths of children aged 13 to 17 years were determined to be investigable deaths.

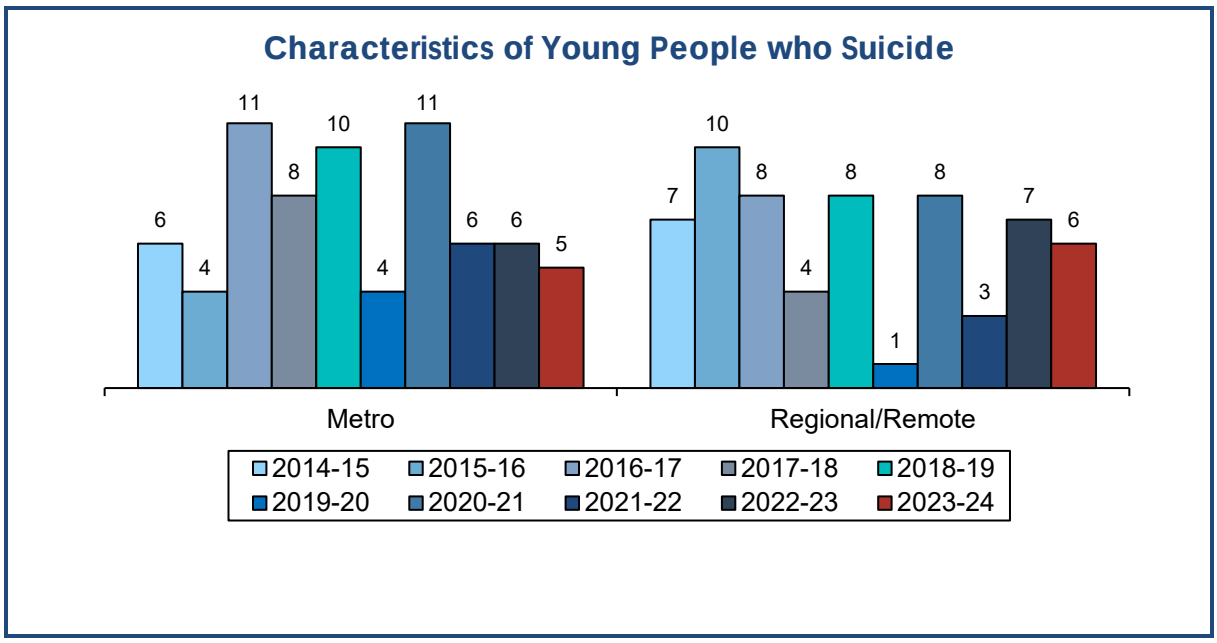
Suicide by young people

Of the 192 young people who apparently took their own lives from 30 June 2009 to 30 June 2024:

- Eleven were under 13 years old;
- Twelve were 13 years old;
- Twenty were 14 years old;
- Thirty nine were 15 years old;
- Fifty were 16 years old; and
- Sixty were 17 years old.

The characteristics of the young people who apparently took their own lives are shown in the following chart.





Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

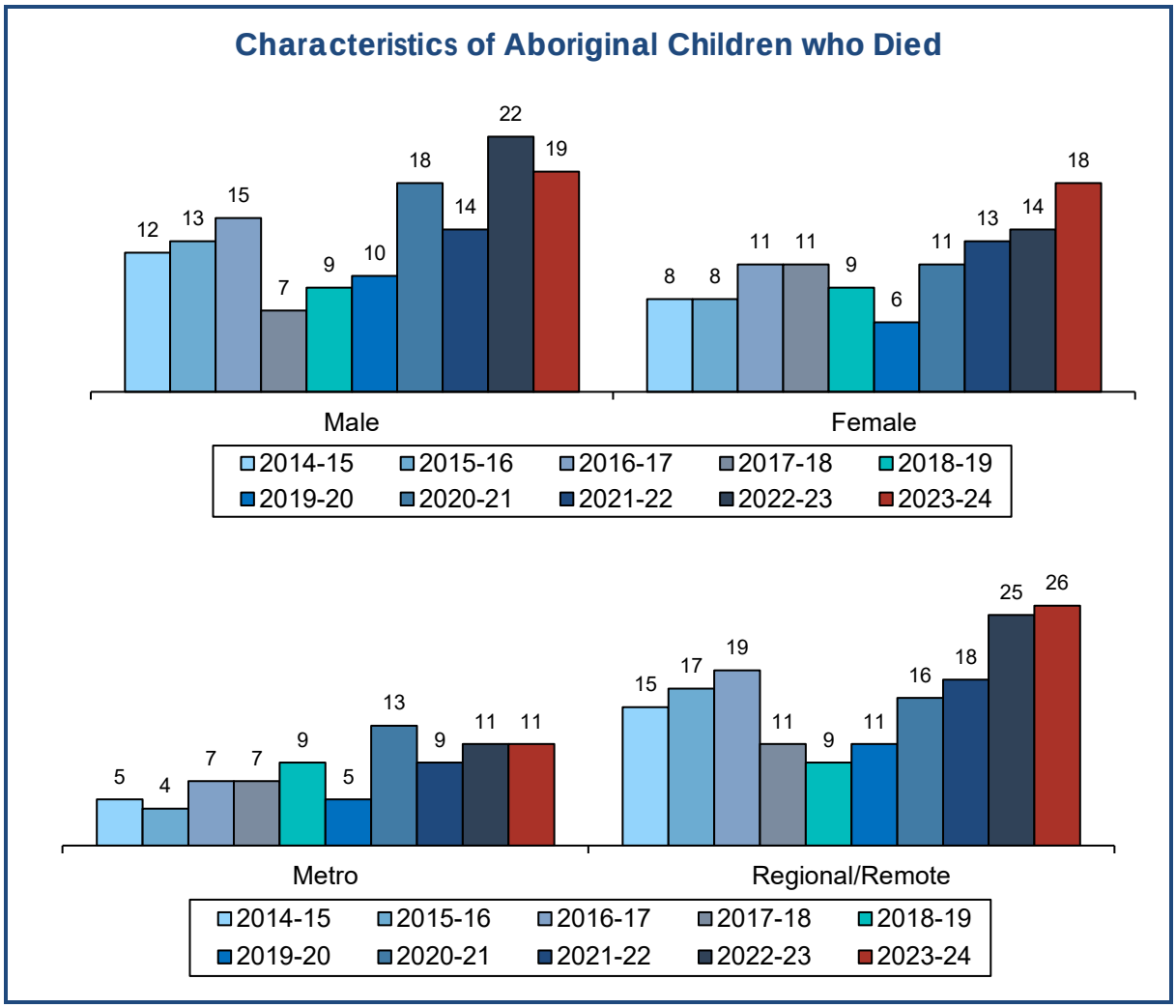
- Males – 54% of investigable deaths and 71% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 146 apparent suicides by young people where information on the Aboriginal status of the young person was available, 56% of the investigable deaths and 12% of non-investigable deaths were Aboriginal young people compared to 6% in the child population; and
- Young people living in regional and remote locations – the majority of apparent suicides by young people occurred in the metropolitan area, but 56% of investigable suicides by young people and 34% of non-investigable suicides by young people were young people who were living in regional or remote locations compared to 26% in the child population.

Deaths of Aboriginal children

Of the 1,196 child death notifications received from 30 June 2009 to 30 June 2024, where the Aboriginal status of the child, or their parent/s, was recorded by agencies they had contact with in documentation provided to this Office, 357 (30%) of the children were identified as Aboriginal.[1]

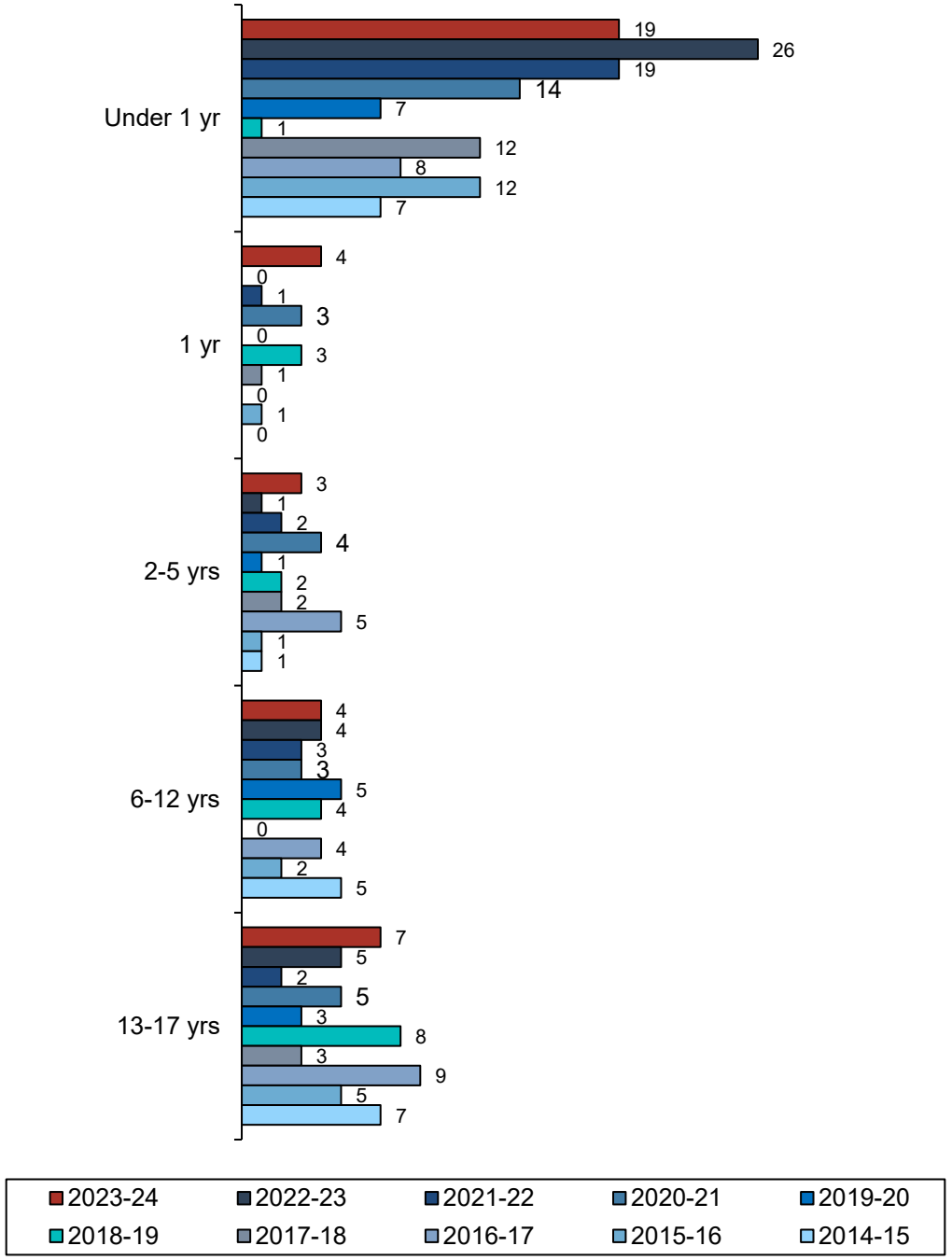
For the notifications received:

- Over the 15 year period from 30 June 2009 to 30 June 2024, the majority of Aboriginal children who died were male (58%). For 2023-24, 51% of Aboriginal children who died were male;
- Most of the Aboriginal children who died were under the age of one or aged 13-17; and
- The deaths of Aboriginal children living in regional communities far outnumber the deaths of Aboriginal children living in the metropolitan area. Over the 15 year period, 72% of Aboriginal children who died lived in regional or remote communities.



[1] 'Aboriginal' includes children who are Torres Strait Islander and children who are both Aboriginal and Torres Strait Islander. Use of the term 'Aboriginal' reflects the fact that the principal heritage of the first Western Australians are Aboriginal Western Australians and is in no way intended to exclude Torres Strait Islander people.

Characteristics of Aboriginal Children who Died

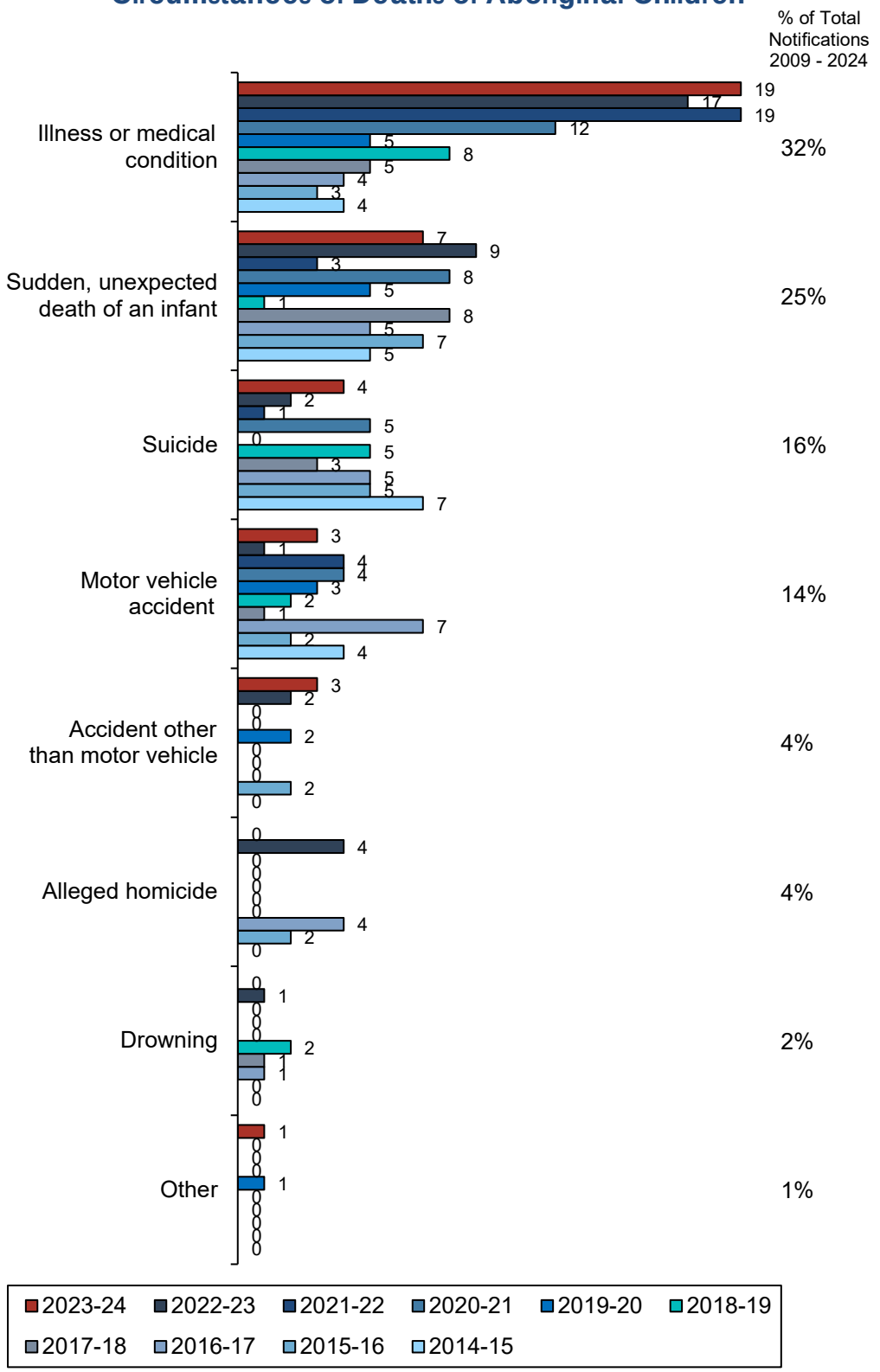


Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

As shown in the following chart, illness or medical condition (32%), sudden, unexpected deaths of infants (25%), suicide (16%), and motor vehicle accidents (16%) are the largest circumstance of death categories for the 357 Aboriginal child death notifications received in the 15 years from 30 June 2009 to 30 June 2024. However, 67 (59%) of reported deaths in circumstances of illness or medical condition are in the four years since 1 July 2020 when the jurisdiction expanded to all child deaths.

Circumstances of Deaths of Aboriginal Children

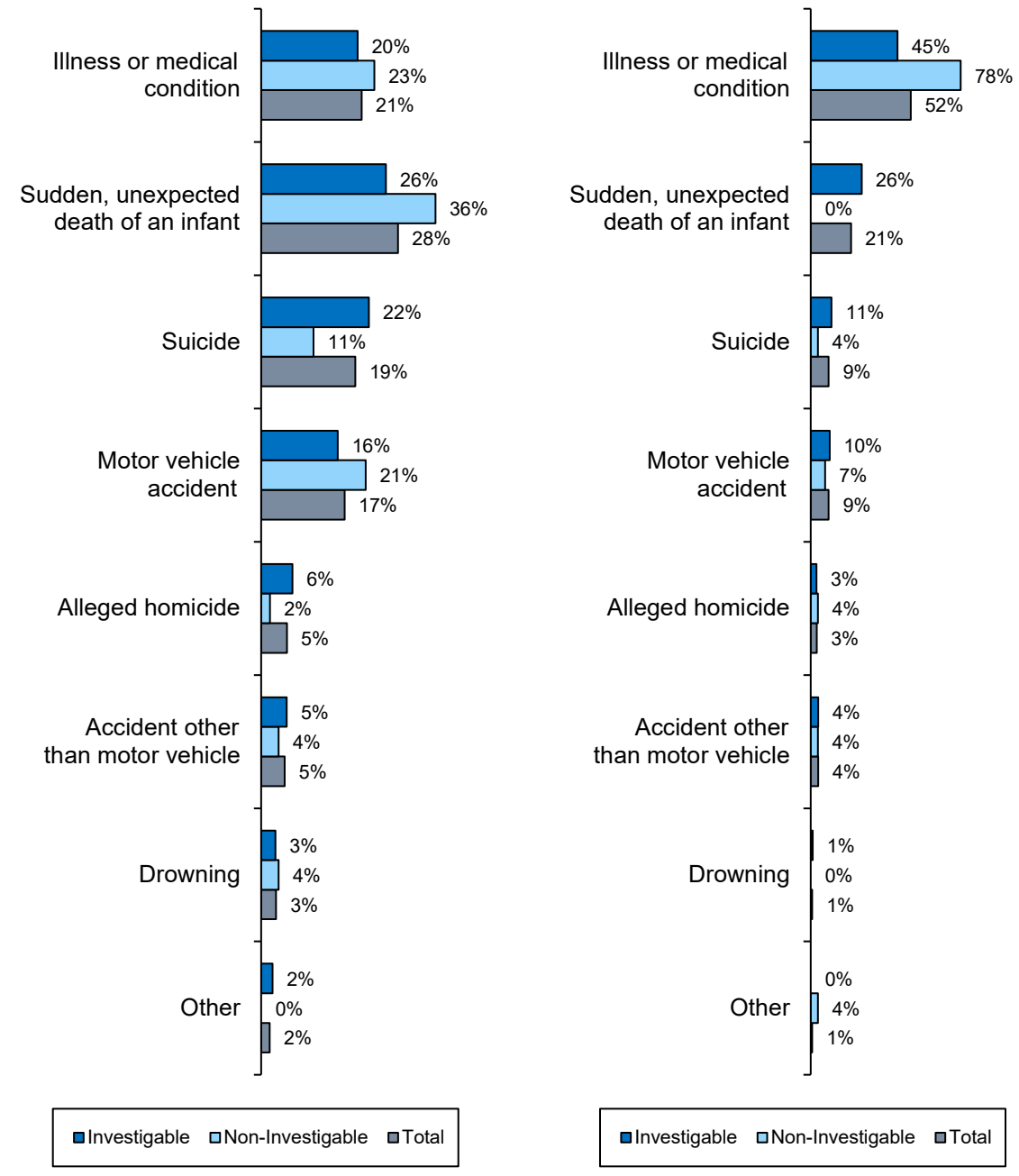


Note 1: Numbers may vary slightly from those previously reported because further information may become available during the course of a review.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 3: Percentages relate to all 15 years of the Ombudsman's child death review function. Percentages may not add to 100 per cent due to rounding.

Circumstances of Aboriginal Child Deaths – % of Deaths



Note: Percentages may not add to 100 per cent due to rounding.

Issues Identified in Child Death Reviews

Having undertaken reviews of child deaths since 30 June 2009, this Office has identified learnings for system improvements in how key stakeholder agencies work to promote the safety and wellbeing of children. The following issues reflect some of the common and current identified patterns and trends in these reviews:

- Key stakeholder agencies (including education, child protection, health and justice) operationalise their legislative responsibilities through policy and procedures for working with children and families, to promote child wellbeing and safety. Child Death Reviews often identify issues of compliance in implementing these policy and practice requirements. Where this may indicate systemic compliance issues, this Office will examine how agencies facilitate compliance (training, supervision of staff, delegations for critical decision making, workload management etc), how agencies monitor policy implementation (real time tracking, data analysis and reporting, oversight frameworks etc) and how agencies measure outcomes and effectiveness.
- Pro-active and timely interagency communication and collaboration is important where a child has contact with multiple government agencies and community service providers. Where Child Death Reviews identify issues with information sharing and joint assessment and safety planning, this Office will examine associated barriers to identify where improvements can be affected.
- Working with families in a culturally safe and responsive manner is critical to promoting child safety and wellbeing. Common across Child Death Reviews is the need for increased use of interpreters, improved mapping of cultural background and connections, an integrated trauma informed approach, and accessing expert consultation for assessment and safety planning that incorporates culturally aligned strategies.
- For investigable deaths, the home environment may include exposure to child protection risk factors including family and domestic violence, parental drug/alcohol use and associated neglect. Infants and children living with disability are particularly vulnerable in these living circumstances. Our reviews examine how agencies work with these family circumstances to identify pathways for supporting change to improve a child's life trajectory.

Often, agencies are working to address the issues identified in our reviews, and this Office will monitor the progression of this work and outcomes. The Ombudsman will also make recommendations to facilitate improvement in these areas and will track agency implementation of these recommendations and their impact in preventing or reducing the risk of future child deaths in similar circumstances.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce child deaths. The following six recommendations were made by the Ombudsman in 2023-24 arising from child death reviews (certain recommendations may be de-identified to ensure confidentiality).

1. That Communities provides the Ombudsman with a copy of the Child Safety Investigation Review report, once completed, in relation to the assessment of alleged child sexual abuse of Miss A.
2. In addition to providing a practice clinic on the appropriate application of the Gillick Principle, Communities reviews the Casework Practice Manualand determines whether amendments to the relevant entries and/or any further action is required to ensure that all child protection staff responsible for decision making regarding alleged child sexual abuse of children under 16 years of age have the appropriate induction; ongoing guidance and training; and supervision in relation to the *Children and Community Services Act 2004*, the *Criminal Code Act Compilation Act 1913*; consent, and the appropriate application of the Gillick Principle, and reports back to the Ombudsman within 12 weeks of the finalisation of this review.
3. Communities consider the findings of this review and provides the Ombudsman within four months of the finalisation of this review, with a report outlining how Communities evaluates the implementation and effectiveness of the High-risk Infant Casework Practice Manual entry and related resources in promoting child safety. In particular, the report should address whether governance processes are effective in ensuring child protection practices associated with assessment and safety planning for high-risk infants are promoting child safety and that practice is consistent with the principles, powers and duties outlined in the *Children and Community Services Act 2004*.
4. WA Police considers the findings of this review and provides a report to the Ombudsman within three months of the finalisation of this review that outlines the:
    - WA Police's current initiatives associated with improving responses to child protection and care (including copies of any new policies and/or procedures); and
    - results of the WA Police's considerations of options associated with the administration of arrest warrants in the circumstances where the arrested person is a parent with caregiving responsibilities for infants/children and/or may be breastfeeding.
5. Communities undertakes an internal review to ascertain how the issues identified in this child death review occurred and provides a report to the Ombudsman within six months of the finalisation of this child death review, outlining the internal review findings and whether any further action is required to facilitate the Communities' provision of parental responsibility for children in CEO Care including:
    - to promote compliance with legislative and practice requirements that 'must' be undertaken; and
    - provide a collaborative, trauma-informed response to children at-risk of suicide.

6. The Communities considers the findings of this review and determines whether any immediate actions are required to promote disability informed child protection responses, including but not limited to consideration of:
    - options within the Communities current client management (including the alert function) to facilitate storage and retrieval of information of a child's disability;
    - the adequateness of current practice guidance for disability informed assessment and safety planning, including location of this information in the Casework Practice Manual chapter that relates to children in the CEO's care, Interaction Tool completion guidance, and alignment of Child Safety Investigation priority guidance with Question 16 of the Interaction Tool; and
    - whether clarification is required on how to access specialist disability consultation, including how to gain the views of children with disabilities, and when such consultation is required.

The Ombudsman's *Annual Report 2024-25* will report on the steps taken to give effect to the four recommendations made about ways to prevent or reduce child deaths in 2022-23. The Ombudsman's *Annual Report 2025-26* will report on the steps taken to give effect to the six recommendations made about ways to prevent or reduce child deaths in 2023-24.

Steps taken to give effect to the recommendations arising from child death reviews in 2021-22

The Ombudsman made eight recommendations about ways to prevent or reduce child deaths in 2021-22. The Office has requested that the relevant public authorities notify the Ombudsman regarding:

- 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 therefore.

Recommendation 1: That Communities considers strengthening the governance framework for the implementation of IFS, including the delivery of contracted services, and provides a report to this Office by 31 December 2021.

Steps taken to give effect to the recommendation

Under ntified, to diverthe *Earlier Intervention and Family Support Strategy*, Intensive Family Support (**IFS**) is Communities' key initiative to work with families where child protection risk has been idet children from entering the Chief Executive Officer's care. IFS assists families to develop safety for their children.

Through the Ombudsman's child death reviews, we identified that there was not a governance mechanism to monitor operational compliance with practice requirements (such as safety planning, the development of Multidisciplinary Case Consultation and

timely referral to contracted IFS Service Providers) and effectiveness in service delivery. This Office identified the need for Communities to strengthen the governance framework, to promote IFS implementation and optimise outcomes for children and families.

Communities provided this Office with a letter dated 29 December 2021, in which Communities relevantly informed this Office that:

> The recently established Reviews and Recommendations Oversight Group (the Oversight Group) has oversight of the implementation of all recommendations delivered to Communities. The Oversight Group has allocated the recommendation to the Service and Operational Improvement division which has commenced work on implementation as follows:
>
> **Support to Intensive Family Support Service providers**
> Between 9 March and 30 July 2021, the Earlier Intervention and Family Support Strategy (EIFS) Team undertook statewide support visits to Intensive Family Support (IFS) providers and Communities' districts, which included visits within the Regional District on 28 and 29 June 2021. During these visits, resources and support was provided to promote collaborative relationships and processes between providers and Districts.
>
> **Meeting with IFSS Providers**
> On 22 November 2021, Communities facilitated a two-hour workshop with all IFSS providers via Microsoft Teams, to:
>
> - discuss the recommendation and its implication for IFSS providers;
> - explore a governance structure and processes which could be applied to future contracts; and
> - discuss the development of a Related Resource for Child Protection Workers and staff, which details each individual provider's meeting and correspondence requirements as outlined in IFSS provider contracts and agreed place based processes between Districts and providers.
>
> Outcomes of the meeting included:
> - discussion on the need to promote consistencies in service provision across IFSS providers, Communities' provision of IFS and in collaborative processes between service providers and Communities;
> - discussion on the need to improve mechanisms for information sharing between IFSS providers,
> - agreement to further explore a future governance framework via a planned IFSS Providers Forum (see below); and
> - agreement to develop a Related Resource for Child Protection Workers and staff as stated above.
>
> **IFSS Providers Forum**
> An IFSS Providers Forum (the Forum) was … to be held on 21 February 2022 and will include an agenda item for further discussion on options for a future governance framework.
>
> **Casework Practice Manual Updates**
> New practice guidance for Child Protection Workers regarding considerations when working with Earlier Intervention and Family Support (EIFS) contracted services is in the final stages of development. The new guidance includes considerations when making referrals and working with high-risk cases. It is anticipated the guidance will be uploaded to the Casework Practice Manual (CPM) in 2022.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to this recommendation. In response, Communities provided information in a letter to this Office dated 25 March 2024, containing a report prepared by Communities.

In its report, Communities relevantly informed this Office that:

New Casework Practice Manual Entry

- A new entry, EIFS and Related Resources has been added to the CPM to provide more focused guidance for staff in relation to how they can work collaboratively with external IFS services. The new guidance outlines the following:
  - How each IFS service works to support families according to their individual need.
  - Referral pathways for each IFS service.
  - Understanding the different roles and responsibilities for IFS service providers and how this interacts with Communities' case management responsibilities.
  - How to work collaboratively with IFS service providers to meet child safety goals, while promoting a culturally and trauma informed response.
  - A Regional Service Model (RSM) which was developed in place of the existing IFSS model delivered in East Kimberley, Pilbara and Southwest regions.

Regional Service Model

- In 2022, Communities engaged an external Aboriginal consultant to develop the RSM, which was appropriate for local needs and allowed for future expansion to other regions across the State.
- The RSM provides a trauma-informed culturally responsive service where outcomes are delivered through collaboration and collective effort.
- A new Related Resource, *Referral Pathways – EIFS Regional Service Model*, has been developed and is included in the new CPM entry.

IFSS Communication and Governance

- A new Related Resource, *IFSS Communication and Governance Summary*, provides guidance to Communities' District staff in working with IFS services in their region as well as outside their districts.
- The resource was developed by IFS service providers to outline their internal processes when working with Communities Districts, referral processes, and sets out service expectations.
- The Related Resource is included in the new CPM entry.

Next Steps

In 2024, Communities will undertake a review of EIFS functions with a focus on internal and external services working in collaboration to deliver safe and effective services to families.

While Communities' report indicates steps have been taken to support IFS implementation, two years after this recommendation was made by the Ombudsman, it is unclear that there is sufficient governance to monitor IFS operational compliance. This Office will continue to examine the implementation and effectiveness of IFS in future child death reviews. It is also noted that the Office of the Auditor General released the report *Implementation of the Earlier Intervention and Family Support Strategy* on 27 June 2024, which examines IFS and makes associated recommendations.

Following careful consideration of the information provided, Communities has considered strengthening the governance framework of IFS and provided this Office with a report, however, it is not clear that adequate steps have been taken to give effect to the intent of this recommendation.

Recommendation 2: Department of Education (DOE) considers if action is required to strengthen the operation and effectiveness of Participation Teams including with respect to the collection of data, minimum practice standards, governance strategies and evaluation processes (including evaluating unsuccessful referrals), and provides the Ombudsman with a report, within four months of the finalisation of this review, that outlines the results of the DOE's consideration.

Steps taken to give effect to the recommendation

Where 15- to 17-year-olds may have disengaged from education, Participation Teams provide support to the young person to move from schooling to further education, training or employment. Through the Ombudsman's reviews, the need to improve the operation and effectiveness of these teams was identified.

DOE provided this Office with a letter received 22 July 2022, in which DOE relevantly informed this Office that:

> DOE has initiated an internal assessment of the Operation of Participation Coordination…
>
> A working group has been formed to deliver a proposal, for consideration by Corporate Executive, to improve DOE's approach to participation….
>
> The internal assessment has identified the 5 following system-wide improvement opportunities to strengthen Department participation strategies and processes:
>
> **Improvement Opportunity 1 (IO1):** Assess data collection and management processes to provide recommendations that enable improvements to the tracking, monitoring, supporting, and reporting on students disengaging from school and/or transitioning in and out of alternatives to full-time school.
>
> **Improvement Opportunity 2 (IO2):** Develop System-supported engagement approaches for at-risk year 9 and 10 students, with the aim of retaining them in schooling in years 11 and 12.
>
> **Improvement Opportunity 3 (IO3):** Review planning, provision and delivery of Education and Training Participation Plans (ETPPs) to enhance quality, relevance and equity of access.
>
> **Improvement Opportunity 4 (IO4):** Build the cultural responsiveness of participation and engagement services for Aboriginal students, with a focus on connection and contribution to culture and community.
>
> **Improvement Opportunity 5 (IO5):** Review the functions and responsibilities of Engagement and Transition managers and Participation Coordinators, to ensure the focus of their efforts aligns with system strategy and directions, and that their expertise has the greatest impact.

This Office requested that DOE inform the Office of any further information on the steps taken to give effect to this recommendation. In response DOE provided information in a letter to this Office dated 11 March 2024 containing a report prepared by DOE.

In DOE's report, DOE relevantly informed this Office that:

> DOE has given the recommended consideration to whether action is required to strengthen the operation and effectiveness of the participation function and that a process had commenced to progress the further work.
>
> The outcome of consideration through the body of work [outlined above] was corporate executive providing in-principle support for improvements in the following areas identified in the recommendation.
>
> **Data Collection**

DOE has developed a new online Notice of Arrangements (NOA) for more accurate and timely NOA data collection.

DOE has mapped and scoped data management practices that can better support Participation teams and assist with more effective monitoring and reporting. The preferred solution identified as part of this work is progressing.

Minimum Practice Standards
DOE is developing a code of practice for Participation teams and consistent approaches for key priority areas of Participation service delivery including:

- inter/intra-regional transfer of students requiring Participation support.
- supporting students who are pregnant or parenting.
- students refusing to engage.

Engagement and Transition Managers from the 8 regions meet and have workshops to improve system wide communication and support.

Governance strategies
DOE is progressing work and oversight of improvement activities with two new positions for the current financial year – Executive Consultant, Participation Operational Priorities and Principal Consultant, Operational Initiatives.

Activity and progress is reported to the People and Services Committee, a subcommittee of the Corporate Executive.

Quarterly assurance process on progress of work is undertaken by DOE.

Evaluation Processes
In further developing data collection and reporting, the scoping of the new Participation Management Database includes the need to be able to draw information and data to support ongoing evaluation of the efficiency and effectiveness of the Participation function.

By improving the efficiency and effectiveness of the Participation function, the Request for Assistance (RFA) process is currently being considered. Supported by a working group, this is considering the current process for requesting assistance for a student and working towards an approved education, training or employment outcome for them. This work includes consideration of when a referral (RFA) is not successful (not approved) and to improve the process to ensure continuity of support and no gaps in service to students.

It is noted that, having informed the Ombudsman of five improvement opportunities in July 2022, DOE continues to take associated actions.

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

Recommendation 3: Communities provides the Ombudsman with a report by 30 June 2022 setting out:

a. Communities' minimum practice standard for the provision and documentation of culturally responsive practice when conducting a Child Safety Investigation (CSI) with Aboriginal families;
b. a governance process to ensure CSIs are not approved if they do not meet this standard; and
c. how Communtiies will monitor and evaluate the implementation and effectiveness of this minimum practice standard.

Steps taken to give effect to the recommendation

While Communities is undertaking work to effect improvement in culturally safe and responsive practice with Aboriginal children, families and communities (including the development of the Aboriginal Cultural Framework to outline Communities' Aboriginal

cultural reform for the next five years), the timeframe for this organisational change is long term. Through child death reviews, this Office identified there was a need for some immediate action, to ensure child protection workers were meeting the minimum practice standard in working with Aboriginal families.

Communities provided this Office with a letter dated 4 July 2022, which included a copy of a project plan titled *Strengthening Culturally Responsive Practice in Child Safety Investigations*.

Communities further informed this Office, by email dated 19 September 2022 that:

> Communities shares the Ombudsman's view that there are opportunities to strengthen Communities' culturally responsive practice, and in particular in relation to Child Safety Investigations (CSIs) for Aboriginal children. On 4 July 2022 Communities provided your office with the Project Plan *Strengthening Culturally Responsive Practice in Child Safety Investigations* (the Project Plan). Following on from this, your office provided feedback in relation to the Project Plan which outlined a view that the Project Plan may not address the Ombudsman's findings and associated recommendation…
>
> As a result of consultations, the Specialist Child Protection Unit is progressing elements of the Project Plan, including the jurisdictional scan, and reviewing the Aboriginal Practice Leader consultations form. It is anticipated that the work of Aboriginal Outcomes division in the Aboriginal Cultural Capability Reform Program (ACCRP) and the Aboriginal Competency Framework may inform future activities of the working group. The Specialist Child Protection group is also liaising with Learning and Development who are engaging with team leaders in selected districts to inform a review of the CSI Reviewer training…

Following provision of this information, this Office informed Communities that the Project Plan did not appear to give effect to the recommendation.

This Office subsequently requested that Communities inform the Office of any further information on the steps taken to give effect to this recommendation. In response, Communities provided information in a letter to this Office dated 25 March 2024, containing a report prepared by Communities.

While Communities' report indicates steps have been taken towards improving culturally safe and responsive practice, it is the view of this Office that sufficient action has not been taken to give effect to this recommendation. The Office met with Communities to discuss this matter, and Communities subsequently provided this Office with a letter dated 26 July 2024, which provided further information on actions relevant to this recommendation:

> Communities' initial response to this recommendation was the Strengthening Culturally Responsive Practice in CSIs Project. This project was finalised in 2023 and improved the quality of Aboriginal Practice Leader (APL) consultations and revised the CSI Reviewer Training module. In addition, a revised Capability Matrix for Leading Culturally Responsive Practice in CSIs was developed and implemented.
>
> <u>Communities' Case Practice Manual (CPM)</u>
>
> Over the past two years there has been considerable investment of time and funding to transition the CPM to a new platform. Communities' workforce identified the functionality of the CPM as a significant issue impacting upon their practice. Through a commissioning process, LivePro has been adopted and existing CPM information has been uploaded over the preceding months. The new platform, known as the Guide, will be launched on Monday 29 July 2024, a significant milestone in this project.
>
> Over the next six months, work will be undertaken on the qualitative content for the new Guide. Whilst some amendments have been made to the CPM entry on CSIs, to clarify expected actions for culturally responsive practice, it is recognised that further work is needed to strengthen practice guidance on culturally responsive practice in CSIs…

Signs of Safety Child Protection Practice Framework

Western Australia implemented the Signs of Safety Practice Child Protection Framework in 2008. Despite this length of time, there is a continual need to focus on Signs of Safety implementation and building practice breadth and depth, in particular in the context of staff turnover. Elia is an international organisation that describes itself as "the home of Signs of Safety". Over the past two years, Elia have been engaged by Communities to deliver safety planning training to every district, noting safety planning is a core component of CSIs. Elia's most recent visit in June 2024 included a strategic planning session with District Directors. As a result, District Directors have decided to focus on the first twelve months of a worker's journey into child protection, to build confident practitioners. Every District is finalising a Signs of Safety plan, to enable visibility and accountability of efforts. When Elia return in September, they will be visiting the Pilbara and Kimberley regions, where turnover and lower numbers of qualified staff impact the quality of child protection practice. Elia will focus on building expertise in child protection practice in the context of CSIs, with a focus on culturally responsive practice.

Communities is on a journey of building culturally responsive practice, with more work underway. Communities is committed to this work and respectfully requests your consideration to a further 12 months to enable our agency to take further steps to give effect to this recommendation.

I would also like to take this opportunity to note Communities' broader programs of work to increase culturally safe and responsive practice across Communities eleven portfolios. These include:

- Aboriginal Community Controlled Organisation (ACCO) Strategy 2022-2032
- Aboriginal Engagement Framework (AEF)
- Aboriginal Cultural Capability Reform Program (ACCRP)
- Aboriginal Workforce Support Program
- Aboriginal Cultural Framework
- Reconciliation Action Plan

It is noted that Communities has indicated that further steps will be taken in the next 12 months to give effect to this recommendation.

Following careful consideration of the information provided, it is determined that adequate steps have not at this time been taken to give effect to this recommendation. Communities have proposed to give effect to this recommendation in 2024-25.

Recommendation 4: In implementing Recommendation 3, Communities includes information on the minimum practice standard for assessing the need for, and facilitating the use of, accredited interpreters when conducting a CSI with Aboriginal families.

Steps taken to give effect to the recommendation

Where English is not a person's first language, there may be a need for an interpreter to be engaged when discussing child protection assessment and safety planning. This Office has identified through child death reviews that there is a need for Communities to take action to ensure interpreter use when appropriate.

Communities provided this Office with a letter dated 4 July 2022 and an email dated 19 September 2022, as detailed in Recommendation 3.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to this recommendation. In response, Communities

provided information in a letter to this Office dated 25 March 2024, containing a report prepared by Communities.

In its report, Communities relevantly informed this Office that:

> On 1 May 2022, Recommendation 46 of the 2017 Statutory Review of the Children and Community Services Act 2004 (the Act) came into effect. This sets out the principles in section 9 of the Act to include reference to the use of interpreters when working with children, parents and families where they may have difficulty understanding or communicating in English. Implementation of this recommendation included strengthening policy and practice guidance and improvements to Communities' client database, Assist.
>
> In 2023, Communities strengthened the APL Consult process. To reflect these changes, updates were made to the consultation form providing additional information to inform and frame the consultation with an APL, including:
> - Language/tribal group,
> - Whether an interpreter is required, and
> - Any relevant family/kinships connections to support identification of important relationships that may not have otherwise been captured.
>
> These changes were actioned following consultation with Aboriginal Practice Leaders across the state.

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

Recommendation 5: Due to issues in the recruitment and retention of suitable experienced staff to the Regional District, Communities will explore immediate options to support the district to meet demand and work more intensively with IFS cases, including undertaking regular case reviews.

Steps taken to give effect to the recommendation

Following on from Recommendation 1, this Office identified that a Regional District's IFS was experiencing particular issues meeting operational requirements for providing IFS to families. Recommendations 5-8 intended to require the Department to take action to ensure IFS operation in that Regional District was supported to function adequately.

This Office requested that Communities inform the Office of the steps taken to give effect to this recommendation. In response, Communities provided information in a letter to this Office dated 25 March 2024, containing a report prepared by Communities.

In its report, Communities relevantly informed this Office that:

> In 2022, the Regional District took steps to overcome challenges in the recruitment and retention of staff. Communities also allocated new funding for the provision of an additional IFS Team within the Regional District, to be based in a second town within the Regional District.

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

Recommendation 6: In 2022, Communities will review IFS practice guidance to ensure that IFS case practice requirements include mechanisms to review cases, including the circumstances of individual children within family groups, and involve external stakeholders in ways which are achievable for districts.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 8 August 2022 in which Communities relevantly informed this Office that:

> The Specialist Child Protection Unit has undertaken broad internal stakeholder consultation to gather information on Communities' service delivery experience in relation to Multidisciplinary Case Consultations (MCCs).

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to this recommendation. In response, Communities provided information in a letter to this Office dated 25 March 2024, containing a report prepared by Communities.

In its report, Communities relevantly informed this Office that:

> Following receipt of this recommendation, Communities' Specialist Child Protection Unit undertook broad internal stakeholder consultations to gather information on Communities' service delivery experience in relation to Multidisciplinary Case Consultations (MCCs)…
>
> Internal stakeholder feedback has been collated and has informed:
> - amendments to the *Intensive Family Support CPM* entry, and
> - a planned broader review of EIFS, inclusive of Intensive Family Support, which will include a focus on MCCs.
>
> In January 2024, Communities provided the Ombudsman's with details of a Project Charter that is being finalised outlining the parameters for review of EIFS functions. The review of EIFS functions will focus on the synergy and gaps of internal and external services working in collaboration to deliver safe and effective services to families. The project will provide a comprehensive review of critical functions and case practice guidance of internal IFS teams.
>
> In scope of the project will be critical functions within the Child Protection IFS teams including service provisions, case practice guidance and functions, previous evaluations and MCCs. This will include current policies, procedures, and practices as well as structural composition of the IFS teams. Recommendations from the Ombudsman in the context of internal IFS team practices, processes, and roles and responsibilities will also be considered. This work is underway and anticipated completion is August 2024.
>
> <u>Current Status</u>
> The CPM entry Intensive Family Support has been updated to provide more focused guidance for staff. The new guidance includes the following:
>
> - Guidance for MCC meetings has been moved under the heading 'tools and culturally secure practice' to reinforce the message that MCCs are part of a suite of tools in the IFS tool kit for Child Protection Workers.
> - Support for the use of professional judgement and supervision over prescriptive practice.
> - A focus on the importance of reviewing safety plans and using MCCs and other IFS tools as and when is appropriate for the circumstances of the case. This focus better aligns practice guidance to feedback received from consultations about when the use of MCCs in practice has been a helpful tool.
>
> On 5 March 2024, these changes were communicated to the Child Protection Workforce via broadcast email.

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

Recommendation 7: Communities will undertake a desktop audit of all IFS cases open to the Regional District on 1 April 2022, identify cases where activities to consult internal and external stakeholders have not been sufficient, and take action to ensure that these cases are subject to a review and/or Multidisciplinary Case Consultation (MCC).

Steps taken to give effect to the recommendation

At the time of this child death review, it was a Communities' practice requirement that when a family was transferred to IFS, a Multidisciplinary Case Consultation (MCC) would be convened and recorded. The MCC was a consultation held between specialist staff that focused on the best interests of the child and developed an IFS plan to engage the family in improving the child's safety and wellbeing. This Office identified that the Regional District needed to take action to ensure all IFS cases had a current MCC recorded and reviewed as required.

Communities provided this Office with a letter dated 8 August 2022 in which Communities relevantly informed this Office that:

> On 1 April 2022, the IFS cases open to the Regional District totalled 32 Family Groups and included 79 individual children. Of those 32 family groups:
>
> - 25 had MCC's completed,
> - 2 had no recent MCC, however did have a Signs of Safety Mapping meeting, and
> - 5 had no MCC or recent review.
>
> Four of the cases that had not been subject to a MCC or review were closed to IFS after 1 April 2022.

This Office notes that the practice requirement to undertake a MCC at the commencement of IFS has now been removed from Communities' Casework Practice Manual as a 'must' action, but still remains as part of the process. This Office will continue to monitor that IFS provision has a clear plan, which has been developed in the child's best interests.

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

Recommendation 8: Communities will provide a report to the Ombudsman within six months of the finalisation of this review, which:

a. details actions taken to review IFS practice guidance;
b. details actions taken to address barriers to provision of IFS by the Regional District in accordance with Communities' legislative and practice requirements in all the circumstances;
c. identifies all cases open to IFS in the Regional District as of 1 April 2022;
d. indicates the dates that MCC/case reviews occurred; and
e. provides a copy of the most recent MCC/case review.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 8 August 2022 in which Communities relevantly informed this Office of steps taken to address the recommendation actions.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to this recommendation. In response Communities provided information in a letter dated 25 March 2024.

In regard to *a. actions taken to review IFS practice guidance,* see Recommendation 6.

In regard to *b. actions taken to address barriers to provision of IFS by the Regional District in accordance with Communities' legislative and practice requirements in all the circumstances,* see Recommendation 5 and 6.

In regard to *c.* identifies all cases open to IFS in the Regional District as of 1 April 2022, see Recommendation 7.

In regard to *d. indicates the dates that MCC/case reviews occurred; and e. provides a copy of the most recent MCC/case review*, dated copies of the most recent MCC/case reviews for cases open to IFS in the Regional District as of 1 April 2022 were provided by Communities to the Office, in August 2022.

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

The Office will continue to monitor, and report on, the steps being taken to give effect to the recommendations including through the undertaking of reviews of child deaths, and family and domestic violence fatalities, and in the undertaking of major own motion investigations.

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of child deaths. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2023-24, timely review processes have resulted in 69% of all reviews being completed within six months.

Major Own Motion Investigations Arising from Child Death Reviews

In addition to taking action on individual child deaths, the Office identifies patterns and trends arising out of child death reviews to inform major own motion investigations that examine the practices of public authorities that provide services to children and their families.

The Office also actively monitors the steps taken to give effect to recommendations arising from own motion investigations.

Details of the Office's own motion investigations and monitoring of the steps taken to give effect to recommendations are provided in the Own Motion Investigations, Inspections and Monitoring section.

Other Mechanisms to Prevent or Reduce Child Deaths

In addition to reviews of individual child deaths and major own motion investigations, the Office uses a range of other mechanisms to improve public administration with a view to preventing or reducing child deaths. These include:

- Assisting public authorities by providing information about issues that have arisen from child death reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of a child or a child's siblings;
- Through working with public authorities and communities where children may be at risk to consider child safety issues and potential areas for improvement, and highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information with other accountability and oversight agencies, including Ombudsmen in other States to facilitate consistent approaches and shared learning;
- Engaging with other child death review bodies in Australia and New Zealand through interaction with the Australian and New Zealand Child Death Review and Prevention Group;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of child deaths; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

The Department of Communities

Efficient and effective liaison has been established with Communities to support the child death review process and objectives. Regular liaison occurs at senior executive

level, to discuss issues raised in child death reviews and how positive change can be achieved.

Key stakeholder relationships

There are a number of public authorities and other bodies that interact with, or deliver services to, children and their families. Important stakeholders with which the Office liaised in 2023-24 as part of the child death review jurisdiction include:

- The Coroner;
- Public authorities that have involvement with children and their families including:
  - Department of Communities
  - Department of Health
  - Various health service providers
  - Department of Education
  - Department of Justice
  - The Mental Health Commission
  - WA Police Force
  - Other accountability and similar agencies, including the Commissioner for Children and Young People and the Office of the Chief Psychiatrist;
- Non-government organisations; and
- Research institutions, including universities.

A Memorandum of Understanding has been established by the Ombudsman with the Commissioner for Children and Young People and a letter of understanding has been established with the Coroner.

Family and Domestic Violence Fatality Review

Overview

This section sets out the work of the Office in relation to this function. Information on this work has been set out as follows:

- The role of the Ombudsman in relation to family and domestic violence fatality reviews;
- The family and domestic violence fatality review process;
- Analysis of family and domestic violence fatality reviews;
- Issues identified in family and domestic violence fatality reviews;
- Recommendations;
- Timely handling of notifications and reviews;
- Major own motion investigations arising from family and domestic violence fatality reviews;
- Other mechanisms to prevent or reduce family and domestic violence fatalities; and
- Stakeholder liaison.

Learnings from the review of family and domestic violence related fatalities provides opportunity to influence policy development and service provision, to prevent or reduce the risk of future family and domestic violence related deaths. At the request of the State Government, the Ombudsman Western Australia commenced the responsibility for reviewing family and domestic violence fatalities on 1 July 2012.

The Role of the Ombudsman in Relation to Family and Domestic Violence Fatality Reviews

Information regarding the use of terms

Information in relation to those fatalities that are suspected by WA Police Force to have occurred in circumstances of family and domestic violence are described in this report as family and domestic violence fatalities. For the purposes of this report the person who has died due to suspected family and domestic violence will be referred to as 'the person who died' and the person whose actions are suspected of causing the death will be referred to as the 'suspected perpetrator' or, if the person has been convicted of causing the death, 'the perpetrator'.

Additionally, following Coronial and criminal proceedings, it may be necessary to adjust relevant previously reported information if the outcome of such proceedings is that the death did not occur in the context of a family and domestic relationship.

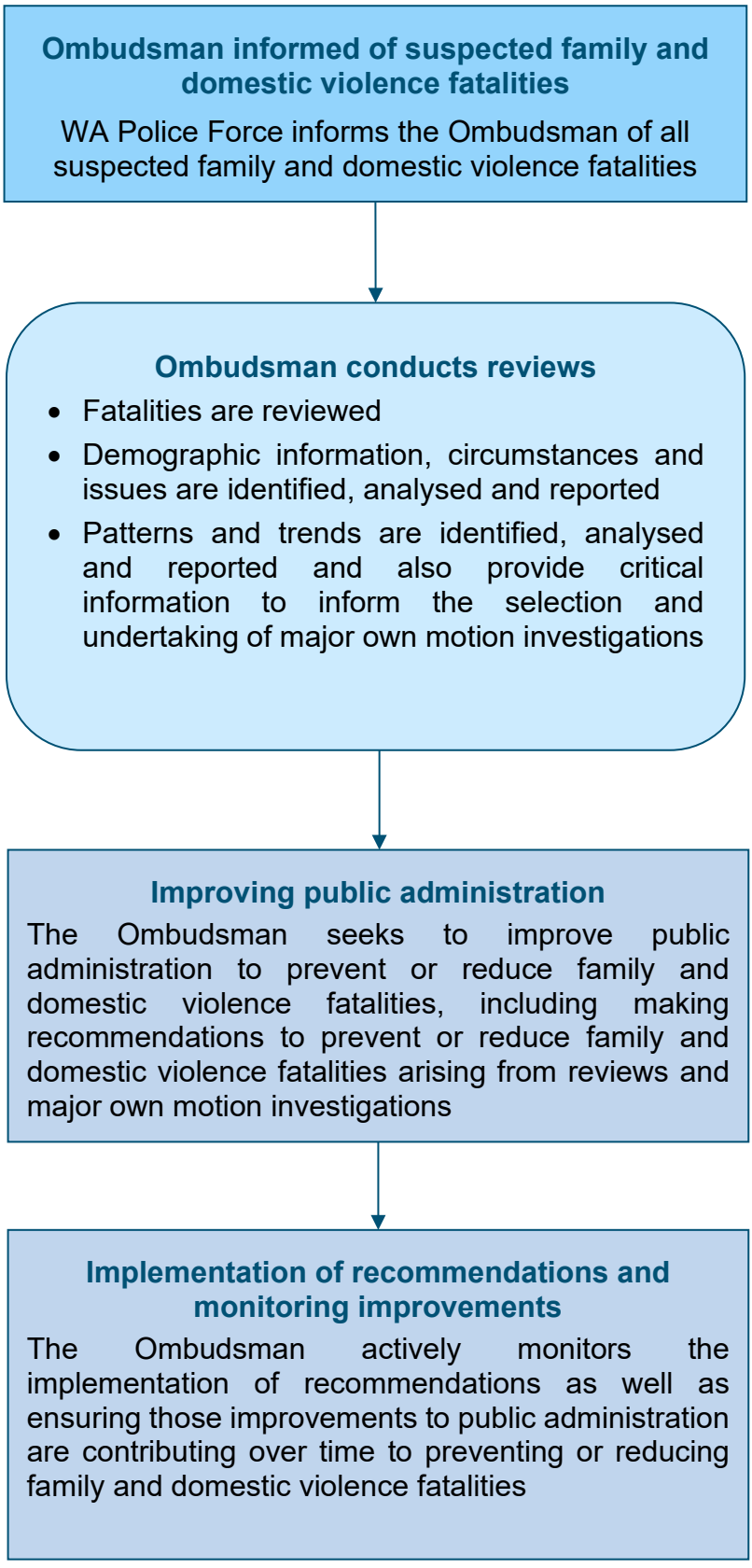
WA Police Force informs the Office of all family and domestic violence fatalities and provides information about the circumstances of the death together with any relevant information of prior WA Police Force contact with the person who died and the suspected perpetrator. A family and domestic violence fatality involves persons apparently in a 'family relationship' as defined by section 4 of the *Restraining Orders Act 1997*.

If the relationship meets this definition, a review is undertaken. A review may also be undertaken where a fatality occurs in the circumstances of family and domestic violence.

The extent of a review depends on a number of factors, including the circumstances surrounding the death and the level of involvement of relevant public authorities in the life of the person who died or other relevant people in a family and domestic relationship with the person who died, including the suspected perpetrator. Confidentiality of all parties involved with the case is strictly observed.

The family and domestic violence fatality review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce family and domestic violence fatalities. The review does not set out to establish the cause of death of the person who died; this is properly the role of the Coroner. Nor does the review seek to determine whether a suspected perpetrator has committed a criminal offence; this is only a role for a relevant court.

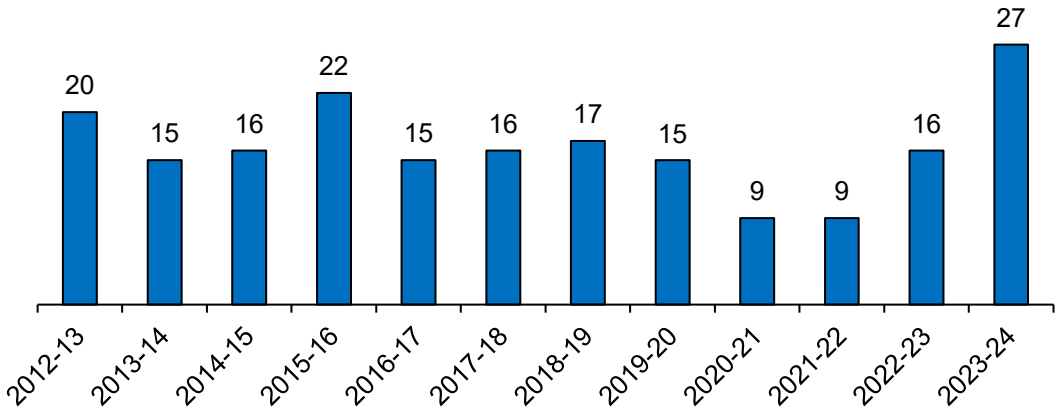
The Family and Domestic Violence Fatality Review Process



Analysis of Family and Domestic Violence Fatality Reviews

Number of family and domestic violence fatality reviews

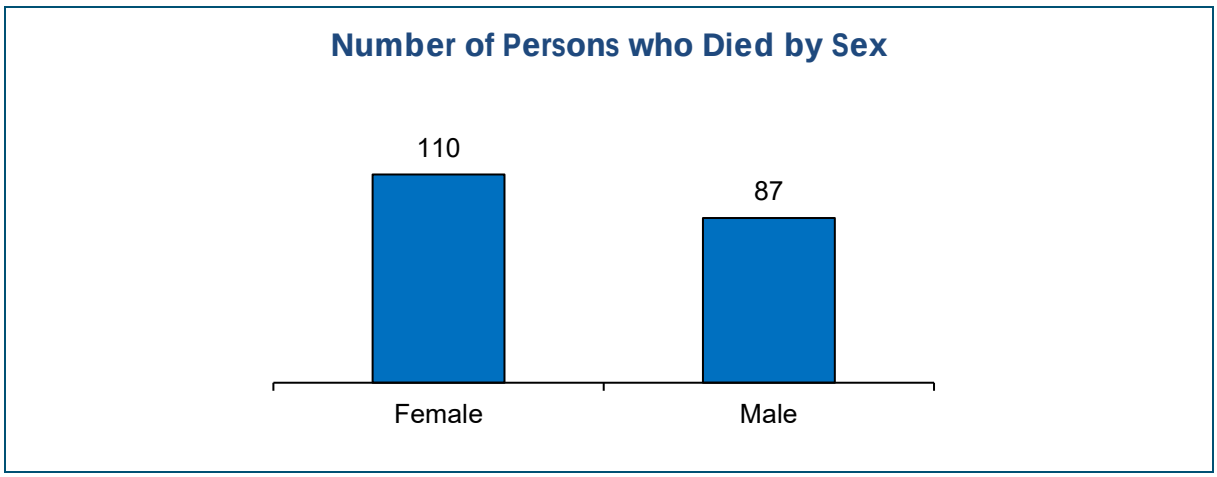
The chart below identifies the number of reviewable family and domestic violence fatalities notified to the Ombudsman. This chart reflects data of notification, not date of death.

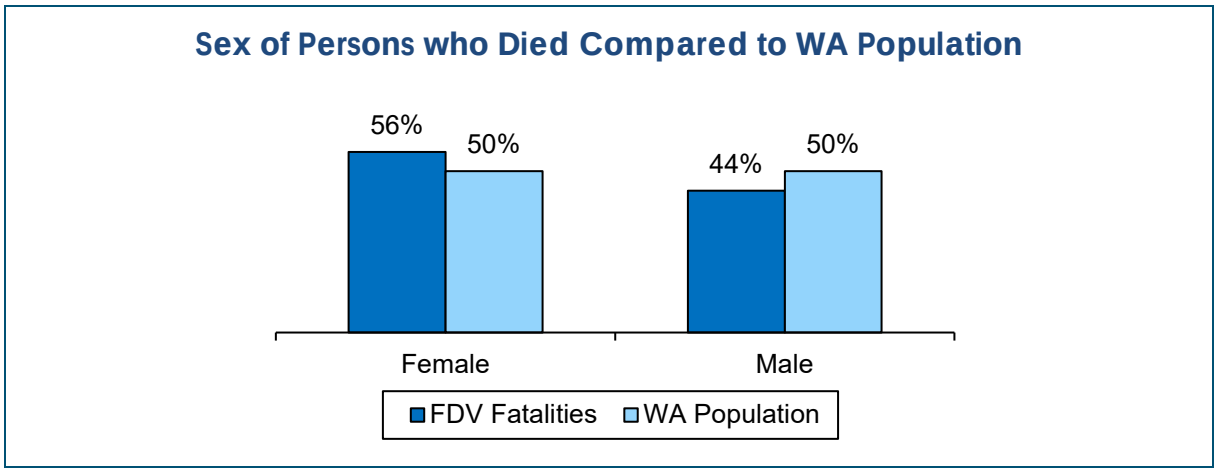


Demographic information identified from family and domestic violence fatality reviews

Information is obtained on a range of characteristics of the person who died, including sex, age group, Aboriginal status, and location of the incident in the metropolitan or regional areas.

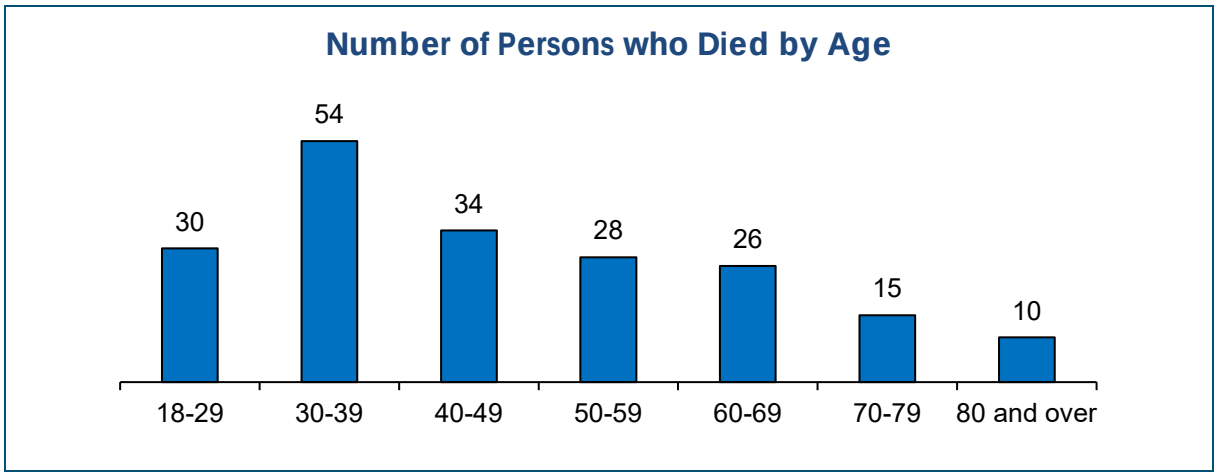
The following charts show characteristics of the persons who died for the 197 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2024. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

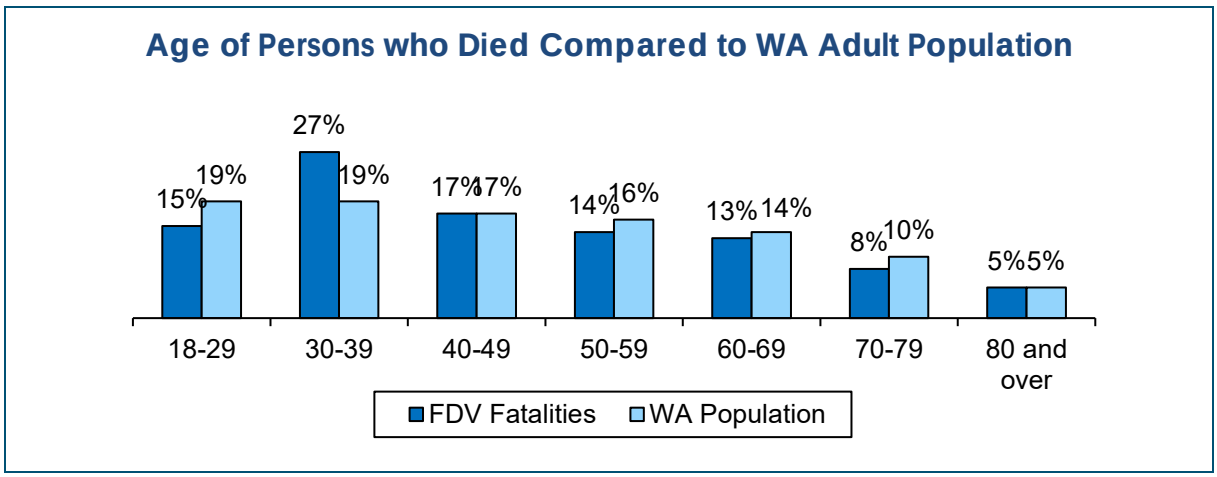




Information is collated on the sex of the deceased, and the suspected perpetrator, as identified in agency documentation provided to this Office. Compared to the Western Australian population, females who died in the 12 years from 1 July 2012 to 30 June 2024 were over-represented, with 56% of persons who died being female compared to 50% in the population.

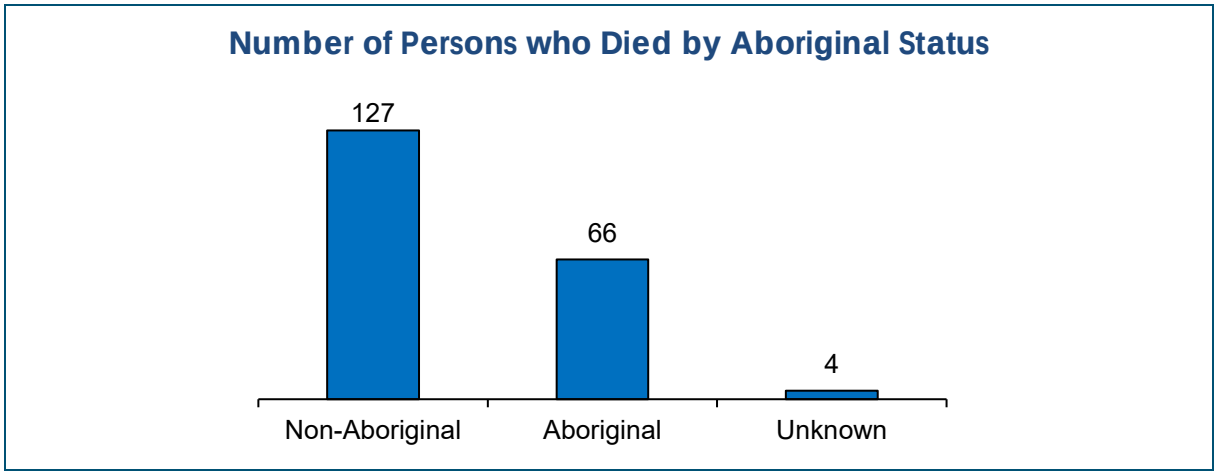
In relation to the 110 females who died, 98 involved a male suspected perpetrator, eight involved a female suspected perpetrator, one involved multiple suspected perpetrators of both sexes and three were apparent suicides. Of the 87 men who died, 30 involved a female suspected perpetrator, 33 involved a male suspected perpetrator, four involved multiple suspected perpetrators of both sexes and 20 were apparent suicides.

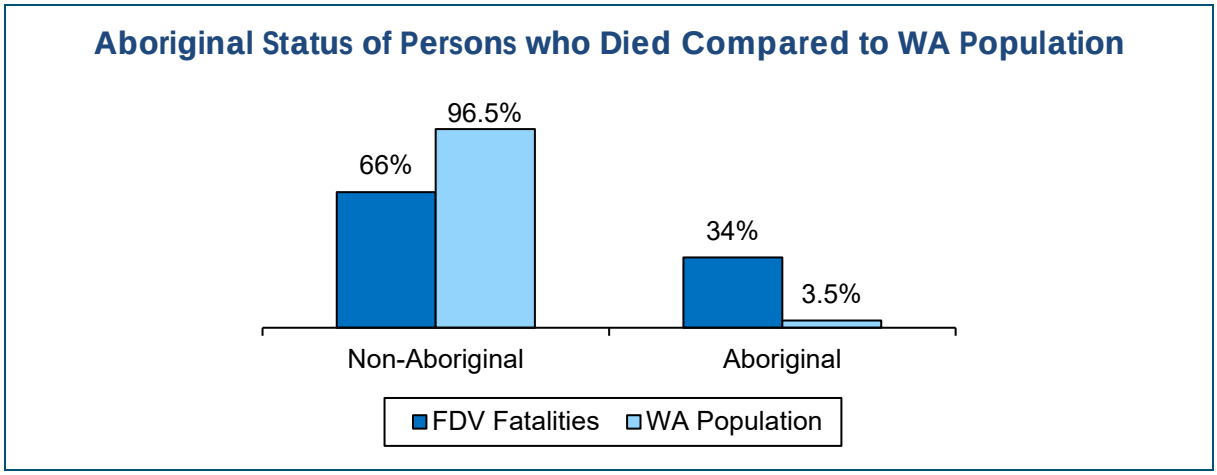




Note: Percentages may not add to 100% due to rounding.

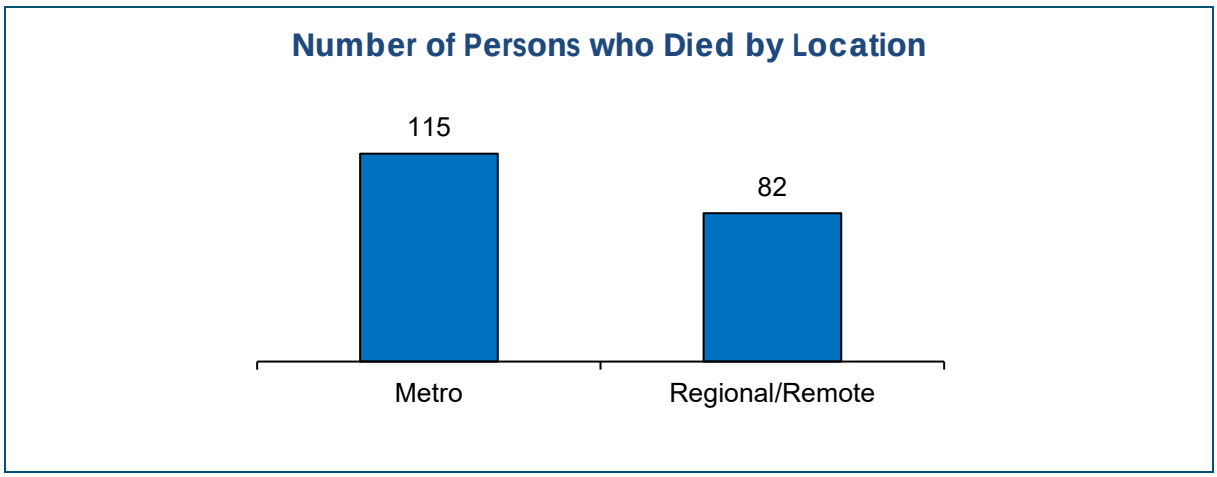
Compared to the Western Australian adult population, the age group 30-39 is over-represented, with 27% of persons who died being in the 30-39 age group compared to 19% of the adult population.

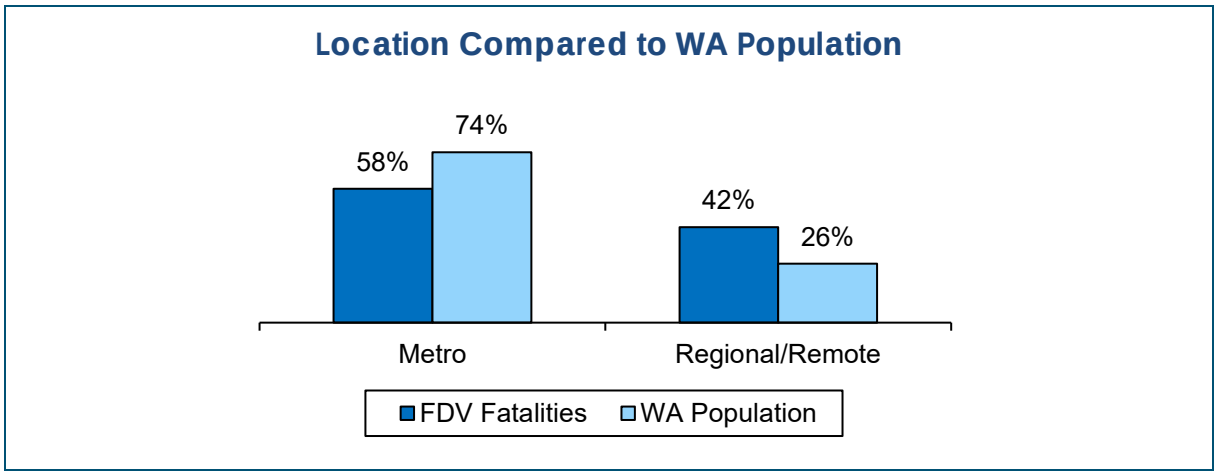




Note: In the above chart, percentages are based on those where Aboriginal status is known.

Information on Aboriginal status is collated where the deceased, and suspected perpetrator, identify as Aboriginal to agencies they have contact with, and this is recorded in the documentation provided to this Office. Compared to the Western Australian population, Aboriginal people who died were over-represented, with 34% of people who died in the 12 years from 1 July 2012 to 30 June 2024 being Aboriginal compared to 3.5% in the population. Of the 66 Aboriginal people who died, 40 were female and 26 were male.





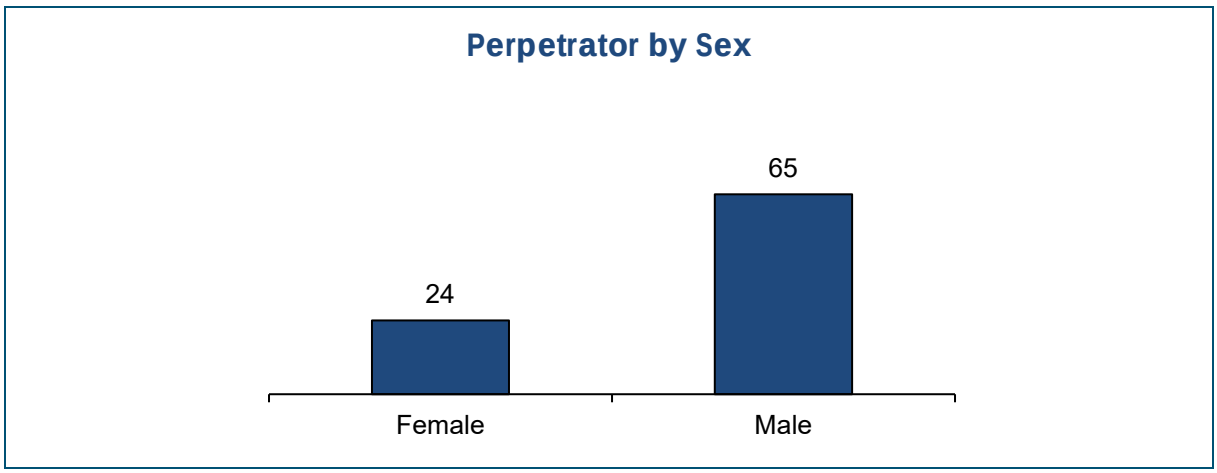
Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 42% of the people who died in the 12 years from 1 July 2012 to 30 June 2024 living in regional or remote locations, compared to 26% of the population living in those locations.

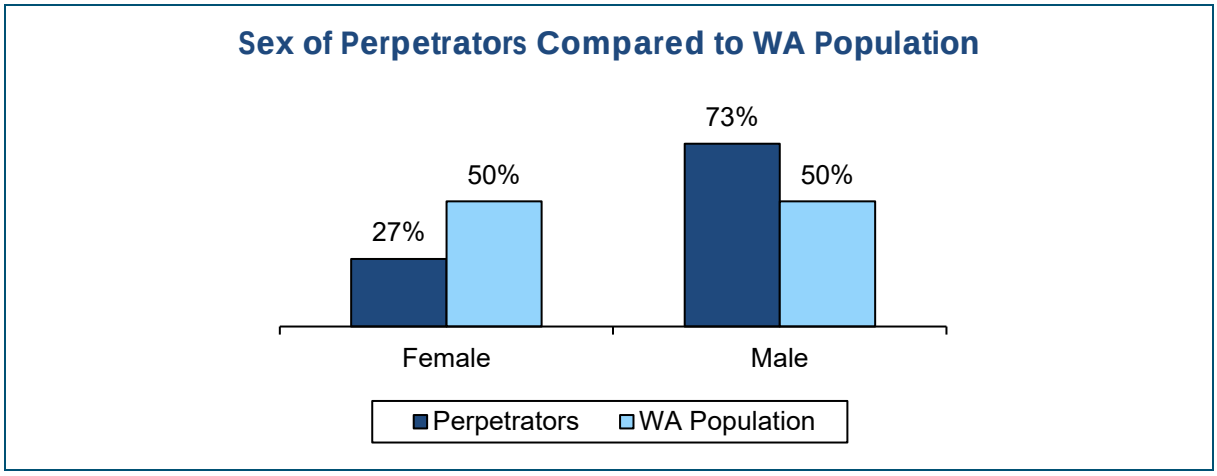
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2024 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2024.

Of the 197 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2024, coronial and criminal proceedings were finalised in relation to 89 perpetrators.

Information is obtained on a range of characteristics of the perpetrator including sex, age group and Aboriginal status. The following charts show characteristics for the 89 perpetrators where both the coronial process and the criminal proceedings have been finalised.



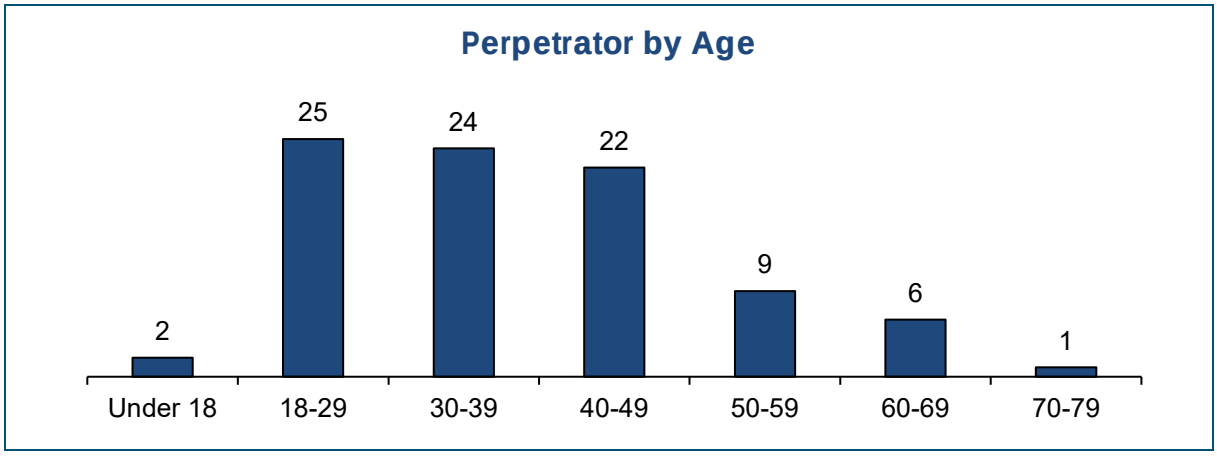


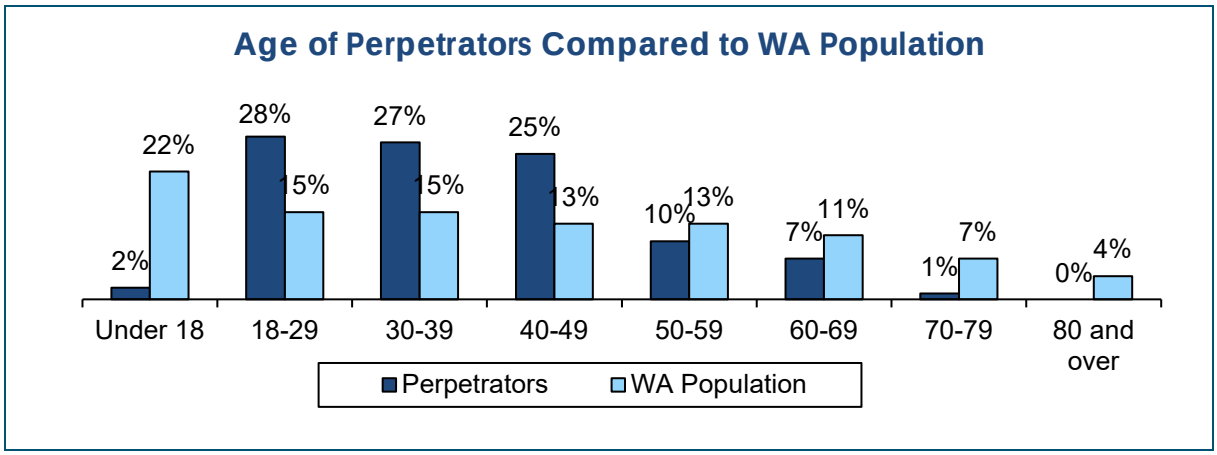
Compared to the Western Australian population, male perpetrators of fatalities in the 12 years from 1 July 2012 to 30 June 2024 were over-represented, with 73% of perpetrators being male compared to 50% in the population.

Twenty-one males were convicted of manslaughter, 43 males were convicted of murder and one male was convicted of unlawful assault occasioning death. Eleven females were convicted of manslaughter, 12 females were convicted of murder, and one female was convicted of unlawful assault occasioning death.

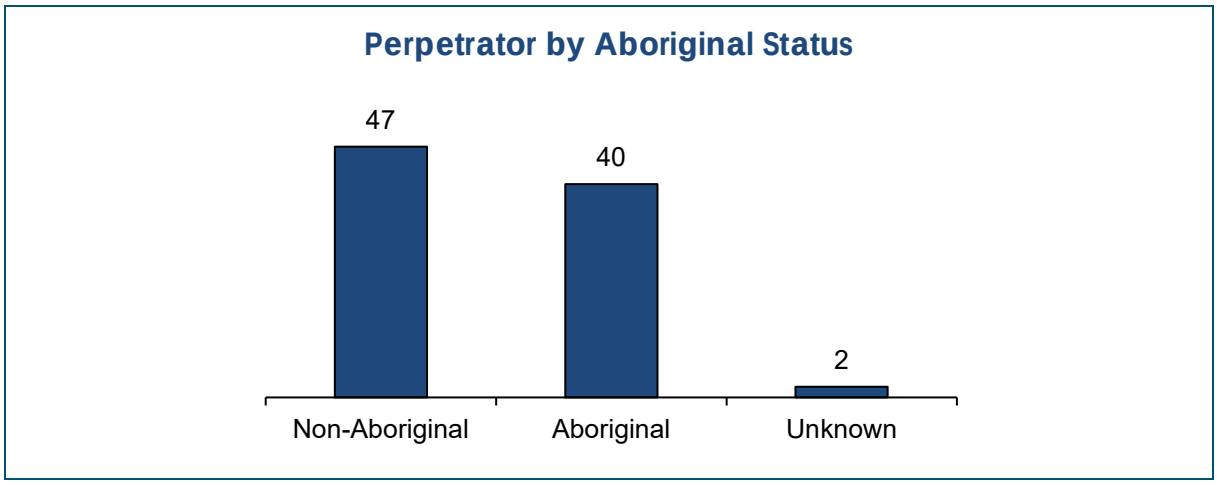
Of the 23 fatalities by the 24 female perpetrators, in 22 fatalities the person who died was male, and in one fatality the person who died was female. Of the 66 fatalities by

the 65 male perpetrators, in 49 fatalities the person who died was female, and in 17 fatalities the person who died was male.

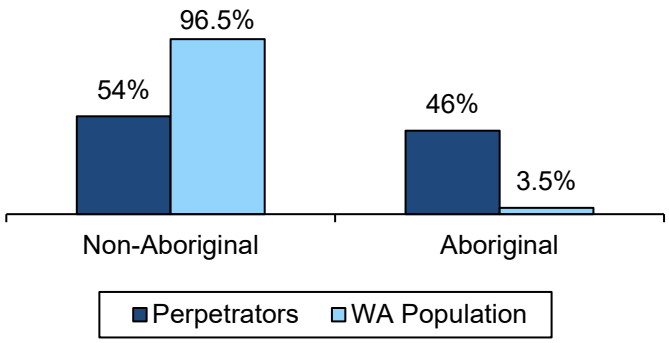




Compared to the Western Australian population, perpetrators of fatalities in the 12 years from 1 July 2012 to 30 June 2024 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 28% of perpetrators being in the 18-29 age group compared to 15% in the population, 27% of perpetrators being in the 30-39 age group compared to 15% in the population, and 25% of perpetrators being in the 40-49 age group compared to 13% in the population.



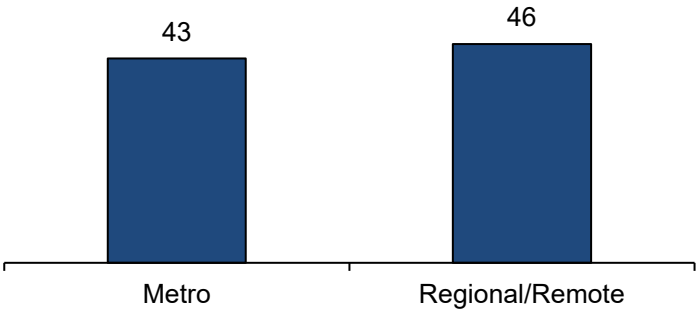
Aboriginal Status of Perpetrators Compared to WA Population



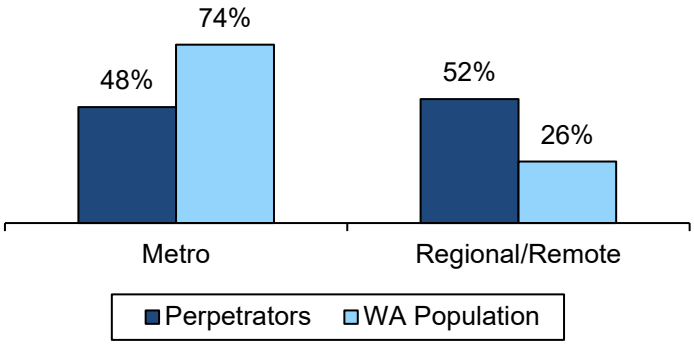
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the 12 years from 1 July 2012 to 30 June 2024 were over-represented with 46% of perpetrators (where Aboriginal status was recorded in information provided to this Office) being Aboriginal compared to 3.5% in the population.

In 38 of the 40 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location



Perpetrators by Location Compared to WA Population

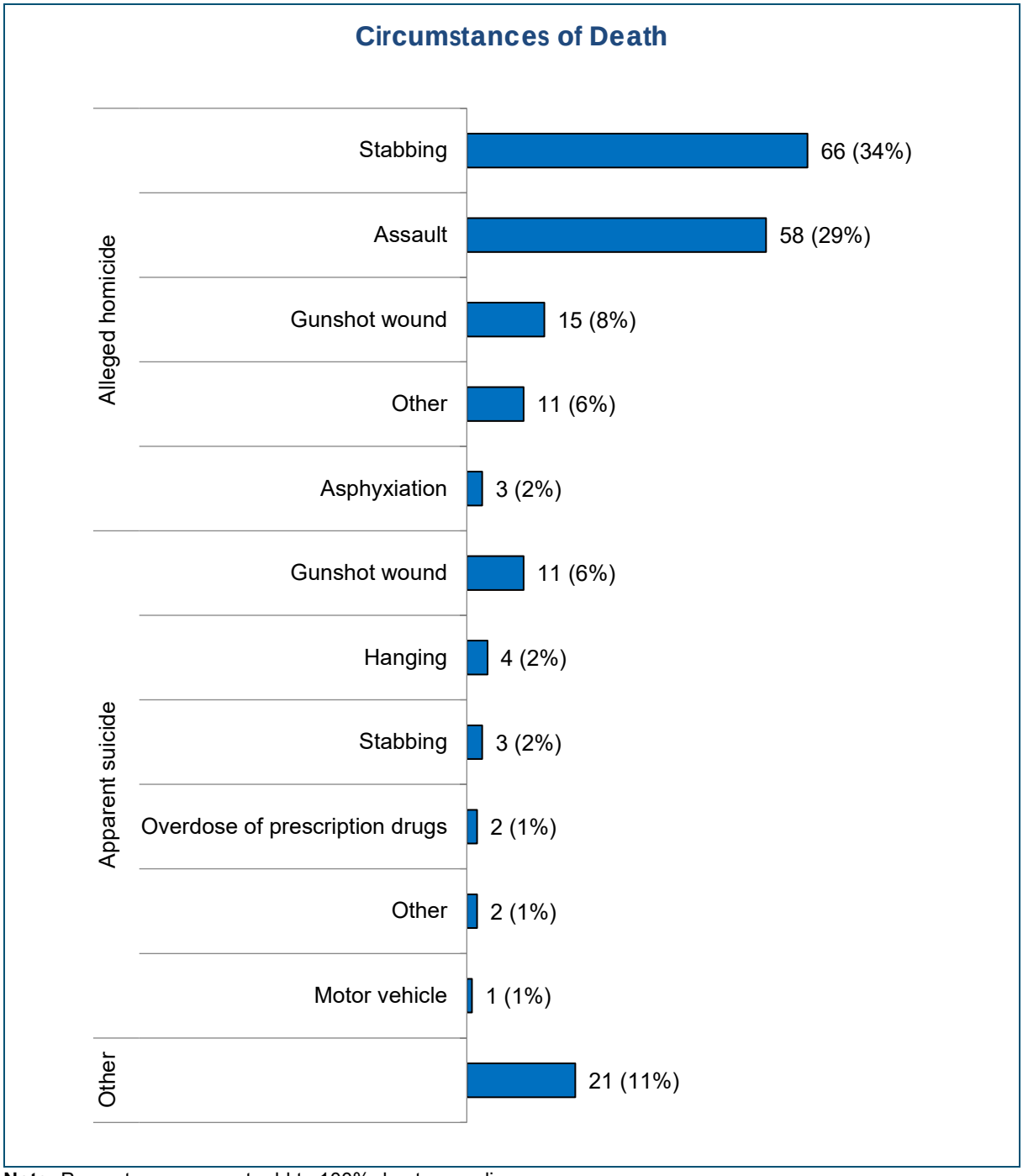


Compared to the Western Australian population, of the 89 fatalities from 1 July 2012 to 30 June 2024 for which coronial and criminal proceedings were finalised, regional or remote locations were over-represented, with 52% of the fatal incidents occurring in regional or remote locations compared to 26% of the population living in those locations.

Circumstances in which family and domestic violence fatalities have occurred

Information provided to the Office by WA Police Force about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

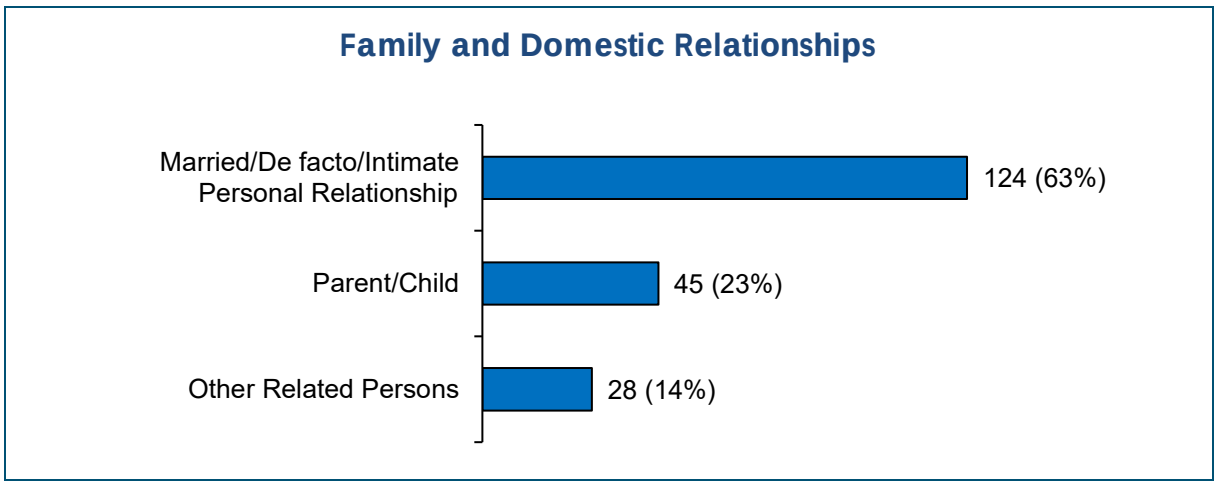
The following chart shows the circumstance of death as categorised by the Ombudsman for the 197 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2024.



Note: Percentages may not add to 100% due to rounding.

Family and domestic relationships

As shown in the following chart, married, de facto, or intimate personal relationship are the most common relationships involved in family and domestic violence fatalities.



Note: Percentages may not add to 100% due to rounding.

Of the 197 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2024:

- 124 fatalities (63%) involved a married, de facto or intimate personal relationship, of which there were 100 alleged homicides, 17 apparent suicides and seven in other circumstances. The 124 fatalities included 24 deaths that occurred in 12 cases of alleged homicide/suicide and, in all 12 cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. Of the other five apparent suicides, four involved males and one involved a female. Of the remaining 88 alleged homicides, 63 (72%) of the people who died were female and 25 (28%) were male;
- 45 fatalities (23%) involved a relationship between a parent and adult child, of which there were 27 alleged homicides, six apparent suicides and 12 in other circumstances. Of the 27 alleged homicides, 12 (44%) of the people who died were female and 15 (66%) were male. Of these 27 fatalities, in 20 cases (74%) the person who died was the parent or step-parent and in seven cases (26%) the person who died was the adult child or step-child; and
- There were 28 people who died (14%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, 10 (36%) were female and 18 (64%) were male.

Issues Identified in Family and Domestic Violence Fatality Reviews

Having undertaken reviews of family and domestic violence fatalities since 1 July 2012, this Office has identified learnings for system improvements in how key stakeholder agencies work to promote the safety and wellbeing of women and children. The following issues reflect some of the common and current identified patterns and trends in these reviews:

- Beyond the limited legislated responsibilities relating specifically to family and domestic violence (ie the *Restraining Orders Act 1997* and *Criminal Code*) agencies develop policy and procedures in accordance with their commitment to National and State family and domestic violence strategies. While the intent is to promote perpetrator accountability and behaviour change, and victim safety, there is opportunity for improvement in agency implementation and facilitation of these policies. This Office has identified that competing demands across agencies can impact on policy compliance.
- Many key stakeholder agencies and community services are involved in the lives of the perpetrator and victim in the months leading up to the fatality. Reviews by this Office have identified a need for increased, timely information sharing and collaborative safety planning.
- Working with families in a culturally safe and responsive manner is critical. Common findings across reviews undertaken by this Office are the need for increased use of interpreters, improved mapping of cultural background and connections, an integrated trauma informed approach, and accessing expert consultation for assessment and safety planning that incorporates culturally aligned strategies.
- The nexus between family and domestic violence, drug and alcohol use, and/or mental health issues is prevalent in the fatalities reviewed by this Office. Findings indicate a need for improved understanding by agencies in working with these coexisting challenges, and increased pathways for effective treatment programs.

Often, agencies are working to address the issues identified in our reviews, and this Office will monitor the progression of this work and outcomes. The Ombudsman will also make recommendations to facilitate improvement in these areas and will track agency implementation of these recommendations and their impact in preventing or reducing the risk of future child deaths in similar circumstances.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following two recommendations were made by the Ombudsman in 2023-24 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. The WA Police Force provides a copy of the Family Violence Division's Regional District Health Check to this Office along with setting out any further actions that are required to ensure District compliance with family and domestic violence (**FDV**) practice requirements.

2. That the WA Police Force provides the Ombudsman with a copy of the Internal Investigation report, once completed, in relation to its response to protect Ms A's safety from 9 October 2021 to 24 October 2021.

The Ombudsman's *Annual Report 2024-25* will report on the steps taken to give effect to the six recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2022-23. The Ombudsman's *Annual Report 2025-2*6 will report on the steps taken to give effect to the two recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2023-24.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2021-22

The Ombudsman made one recommendation about ways to prevent or reduce family and domestic violence fatalities in 2021-22. The Office has requested that the relevant public authorities notify the Ombudsman regarding:

- The steps that have been taken to give effect to the recommendation;
- The steps that are proposed to be taken to give effect to the recommendation; or
- If no such steps have been, or are proposed to be taken, the reasons therefore.

Recommendation 1: The WA Police Force provides a report to the Ombudsman by 1 October 2022 on the progress of discussions with the DOJ regarding information exchange when WA Police Force have contact with an individual subject to a community order, and the creation of a protocol to facilitate information sharing.

Steps taken to give effect to the recommendation

Through the Ombudsman's FDV fatality reviews, we have identified that when perpetrators of violence are being supervised on community-based orders, the Department of Justice is not always aware of contact the perpetrator may have with WA Police Force. This Office is of the view that improved information sharing would provide the Department of Justice with the timely opportunity to address perpetrator accountability through supervision of persons on community orders.

The WA Police Force provided this Office with a letter dated 21 September 2022, in which WA Police Force relevantly informed this Office that:

> The WA Police Force Family Violence Division has opened discussion with the Department of Justice (Adult Community Corrections) to create a working group whereby the type of information to be shared will be determined, any legal preclusions identified, and identified and technical solutions proposed to enable efficient and timely exchange.
>
> …
>
> On the 14 July 2022, an executive meeting was conducted and an agreement was reached to progress a working group to explore opportunities for improved information sharing for family violence interactions…
>
> Three subgroups are now being formed which include Business, Legal and Technical Advisory Groups to provide recommendations enabling the working group to reach agreement and resolve any identified issues that may hinder the realisation of an effective information sharing process.

This Office requested that WA Police Force inform the Office of any further information on the steps taken to give effect to the recommendation. In response, WA Police Force provided a letter to this Office dated 12 March 2024, in which the WA Police Force relevantly informed this Office that:

> The WA Police Force has established an information sharing working group with the DOJ to identify and resolve issues impacting information sharing access.
>
> An outcome from the group has led to the establishment of an expansion of DOJ's access to WA Police Force Systems with 70 additional Adult Community Correction (ACC) employees provided access to the WA Police Force Incident Management System (IMS) to proactively access pertinent data on Family Violence Incident Reports (FVIR).
>
> The WA Police Force provides DOJ with a daily report pertaining to family violence incidents that may be cross referenced by DOJ to identify any individuals subject to a DOJ order.

This Office is monitoring the effectiveness of this action, and the capacity of DOJ to use this IMS access to identify WA Police Force contact when supervising family and domestic violence perpetrators in the community, in current family and domestic violence fatality reviews.

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

The Office will continue to monitor, and report on, the steps being taken to give effect to the recommendations including through the undertaking of reviews of family and domestic violence fatalities and in the undertaking of major own motion investigations.

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of family and domestic violence fatalities. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2023-24, timely review processes have resulted in 62% of all reviews being completed within six months and 69% of reviews completed within 12 months.

Major Own Motion Investigations Arising from Family and Domestic Violence Fatality Reviews

In addition to investigations of individual family and domestic violence fatalities, the Office identifies patterns and trends arising out of reviews to inform major own motion investigations that examine the practice of public authorities that provide services to children, their families and their communities.

The Office actively monitors the steps taken to give effect to recommendations arising from own motion investigations.

Details of the Office's own motion investigations and monitoring of the steps taken to give effect to recommendations arising from own motion investigations are provided in the Own Motion Investigations, Inspections and Monitoring section.

Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

In addition to reviews of individual family and domestic violence fatalities and major own motion investigations, the Office uses a range of other mechanisms to improve public administration with a view to preventing or reducing family and domestic violence fatalities. These include:

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through working with public authorities and communities where individuals may be at risk of family and domestic violence to consider safety issues and potential areas for improvement, and to highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information, where appropriate, with other accountability and oversight agencies including Ombudsmen and family and domestic violence fatality review bodies in other States to facilitate consistent approaches and shared learning;
- Engaging with other family and domestic violence fatality review bodies in Australia through membership of the Australian Domestic and Family Violence Death Review Network (**the Network**). The Network worked in partnership with the Australia's National Research Organisation for Women's Safety (**ANROWS**) to publish the report Filicides in a domestic violence and family context 2010-2018 (First Edition 2024);
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

Efficient and effective liaison has been established with WA Police Force to develop and support the implementation of the process to inform the Office of family and domestic violence fatalities. Regular liaison occurs at senior officer level between the Office and WA Police Force.

Key stakeholder relationships

There are a number of public authorities and other bodies that interact with, or deliver services to, those who are at risk of family and domestic violence or who have experienced family and domestic violence. Important stakeholders, with which the Office liaised as part of the family and domestic violence fatality review function in 2023-24, included:

- The Coroner;
- Relevant public authorities including:
  - WA Police Force
  - Health Service Providers
  - The Department of Justice
  - The Department of Communities;
- The Centre for Women's Safety and Wellbeing and relevant non-government organisations; and
- Research institutions including universities.

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

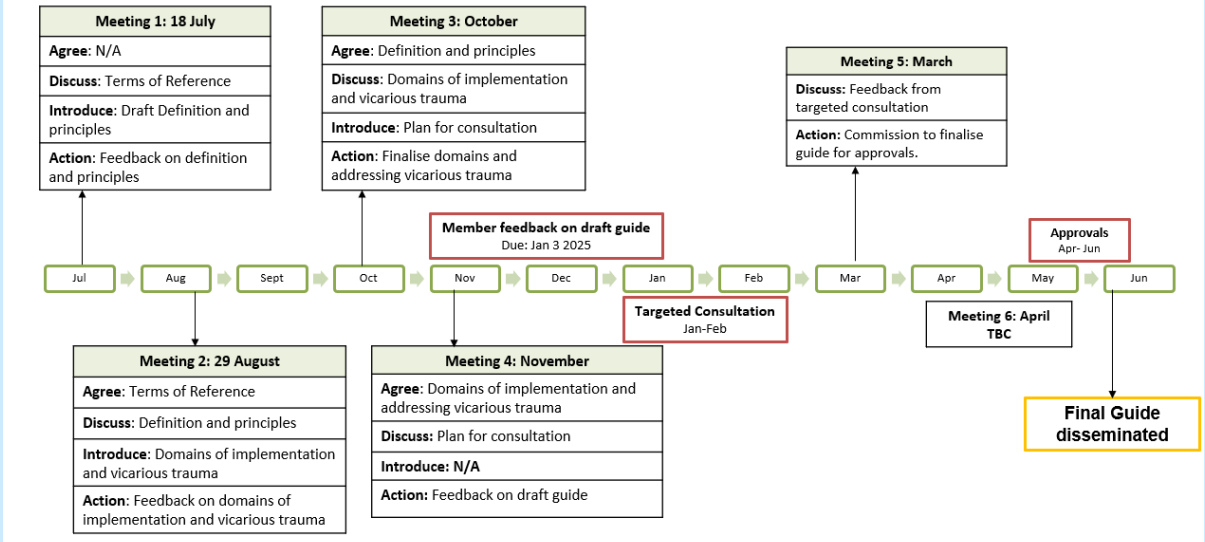
The Working Group consists of representatives from:

- 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.

Reportable Conduct Scheme

Background

The *Royal Commission into Institutional Responses to Child Sexual Abuse* (**the Royal Commission**) highlighted the numerous times and ways in which children reported abuse and were not believed, or no action was taken. The Royal Commission recommended that States and Territories establish Reportable Conduct Schemes to prevent harm to children by holding organisations accountable for the conduct of their staff.

Western Australia's Reportable Conduct Scheme (**Scheme**) commenced on 1 January 2023, following amendments to the *Parliamentary Commissioner Act 1971* (**Act**). The Scheme expanded significantly on 1 January 2024 to include additional agencies, as well as additional types of reportable conduct.

What is the Reportable Conduct Scheme?

The Scheme compels heads of organisations that exercise care, supervision or authority over children to notify allegations of, or convictions for, child abuse by their employees to the Ombudsman and then investigate these allegations. The Ombudsman will monitor, oversee and review these investigations.

Expansion of the Scheme

The jurisdiction of the Scheme expanded on 1 January 2024 to include additional organisations as well as new types of reportable conduct.

From 1 January 2024, the Scheme included the following additional organisations:

- Accommodation and residential services;
- Religious institutions; and
- Disability services.

At full operation the Scheme now requires over 4,000 organisations across Western Australia to report to the Ombudsman.

The additional types of conduct added from 1 January 2024 are as follows:

- Significant neglect of a child; and
- Any behaviour that causes significant emotional or psychological harm to a child.

The role of the Ombudsman under the Reportable Conduct Scheme

The role of the Ombudsman under the Scheme is comprised of the following functions, set out in section 19M(1) of the Act:

(a) to oversee and monitor the reportable conduct scheme;

(b) to educate and provide advice to relevant entities in order to assist them to identify and prevent reportable conduct and to notify and investigate reportable allegations and reportable convictions;

(c) to support relevant entities to make continuous improvement in the identification and prevention of reportable conduct and the reporting, notification and investigation of reportable allegations and reportable convictions;

(d) to monitor the investigation of reportable allegations and reportable convictions by relevant entities;

(e) if the Commissioner considers it to be in the public interest to do so – to investigate reportable allegations and reportable convictions;

(f) if the Commissioner considers it to be in the public interest to do so – to investigate whether reportable allegations or reportable convictions have been appropriately handled or investigated or responded to by the head of a relevant entity;

(g) to make recommendations to relevant entities in relation to the findings of the investigations referred to in paragraph (e) or (f);

(h) to monitor the compliance of relevant entities with the reportable conduct scheme and whether appropriate and timely action is taken by a relevant entity;

(i) to monitor a relevant entity's systems for preventing, notifying and dealing with reportable conduct;

(j) to report to Parliament on the reportable conduct scheme;

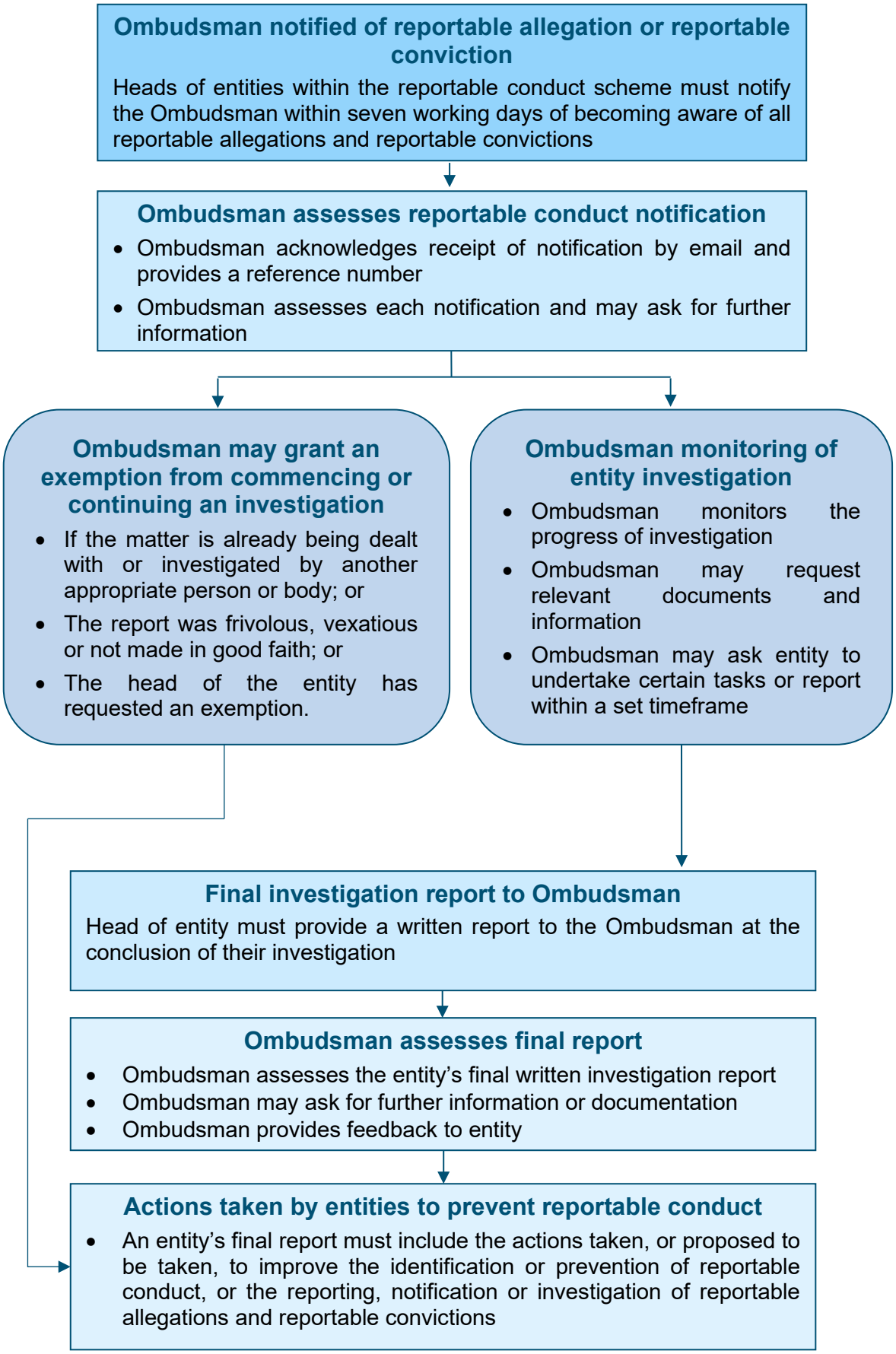
(k) to perform any other function conferred on the Commissioner under this Division.

In undertaking his role under the Scheme, the Ombudsman is required to regard the best interests of children as the paramount consideration, under section 19K of the Act:

19K. Paramount consideration

The Commissioner [Ombudsman] and any other person performing functions under this Division must regard the best interest of children as the paramount consideration.

The Reportable Conduct Process



Reportable allegations and convictions

Organisations within the scope of the Scheme are required to notify the Ombudsman within seven working days of becoming aware of:

- a **reportable allegation** (namely, matters that include 'any information that leads a person to form the belief on reasonable grounds that an employee of a relevant entity has engaged in reportable conduct or conduct that may involve reportable conduct'); and
- a **reportable conviction** (that are matters involving 'a conviction, whether before, on or after commencement day, for an offence under a law of this State, another State, a Territory or the Commonwealth that is an offence referred to in section 19G(1)(a) [a sexual offence] or (d) [an offence prescribed by the regulations for the purposes of this paragraph].'

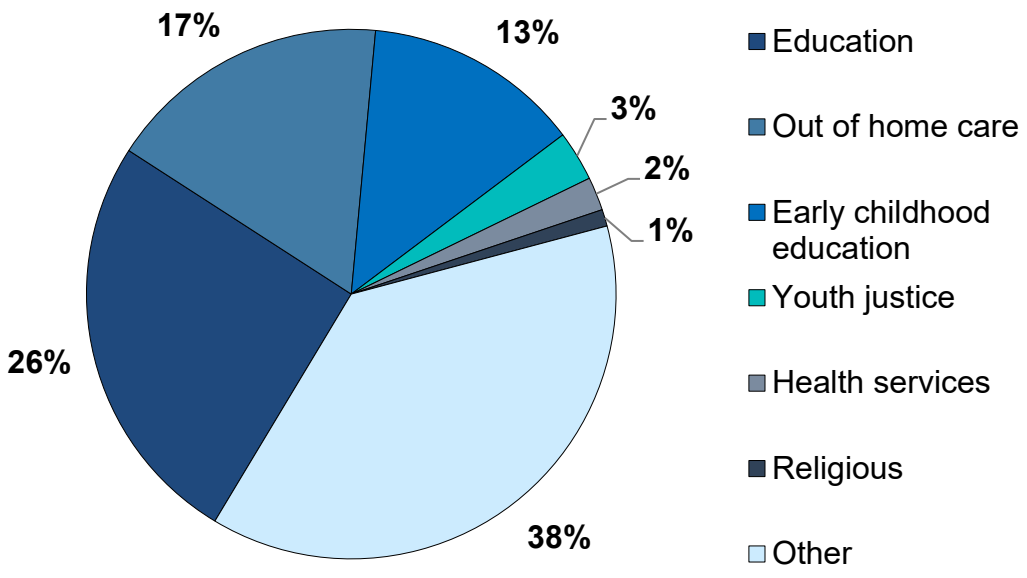
Notifications of reportable allegations

During 2023-24, the Office received 696 notifications of reportable allegations under the Scheme. The Office has not received any notifications of reportable convictions since 1 January 2023.

Notifications by sector

In 2023-24, the education, out of home care, and early childhood education sectors reported most frequently to the Office (26 per cent, 17 per cent and 13 per cent, respectively), as shown in the chart below:

Percentage of notifications of reportable allegations, by sector



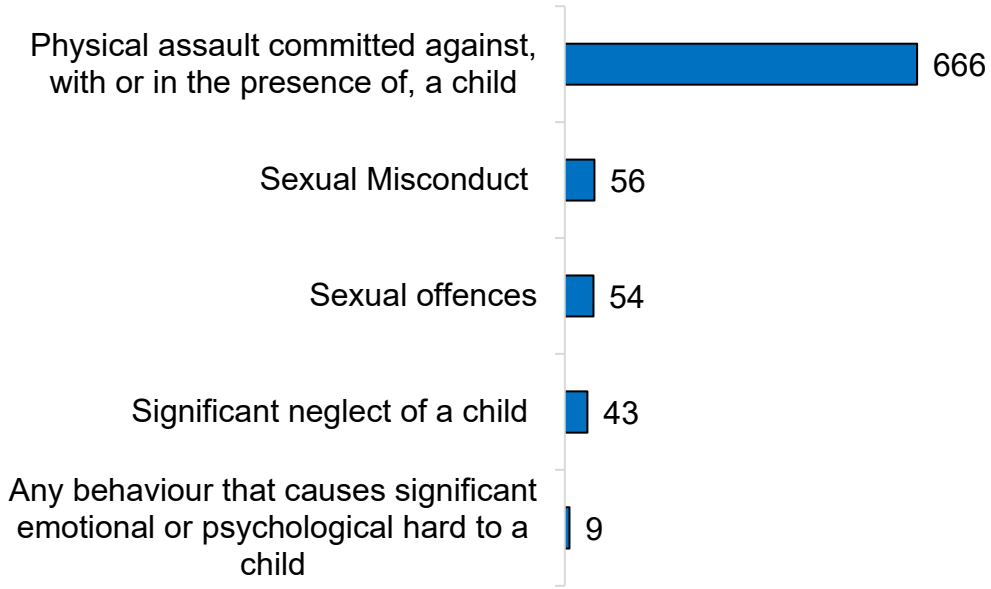
Reportable conduct notifications by reportable allegation type

Under the Act, there are six types of allegations of reportable conduct that must be reported to the Ombudsman:

- Sexual offences (against, with or in the presence of, a child);
- Sexual misconduct (against, with or in the presence of, a child);
- Physical assault (against, with or in the presence of, a child);
- Significant neglect of a child;
- Any behaviour that causes significant emotional or psychological harm to a child; and
- An offence prescribed by the regulations (none at present).

The majority of notifications received in 2023-24 involved allegations of physical assault (80 per cent), as shown in the chart below:

Number of reportable conduct notifications by type of reportable conduct



Enquiries

The Office has a dedicated reportable conduct enquiries line and email address as an important part of its function to provide information and education about the Scheme. During 2023-24, the Office received 290 enquiries.

Findings and outcomes of entity investigations of reportable conduct

Section 19Z of the Act requires organisations to provide the Office with a written report of the outcomes of all reportable conduct investigations, including the actions taken.

The Office assesses each investigation report against the requirements of the Act and may seek further information regarding an entity's response to a reportable allegation. A relevant entity may also be provided with advice or education to assist it in improving its systems for preventing, identifying and responding to reportable conduct.

Of the investigations undertaken by organisations, and monitored by the Office, in 2023-24, 98% were found to be compliant with the requirements of the Act. In 2023-24, the Office received 144 investigation reports.

Exempt investigations

The Ombudsman may exempt the head of a relevant entity from commencing or continuing an investigation in certain circumstances, including when:

- the matter is already being dealt with or investigated by another appropriate person or body; or
- the head of the relevant entity has made a request for the exemption in a notice under section 19Y of the Act.

During 2023-24, the Office received 89 requests from a relevant entity requesting an exemption from continuing an investigation:

- 5 requests were later withdrawn by the relevant entity;
- 70 exemptions were granted; and
- 14 requests for an exemption were under consideration on 30 June 2024.

Exempt organisations

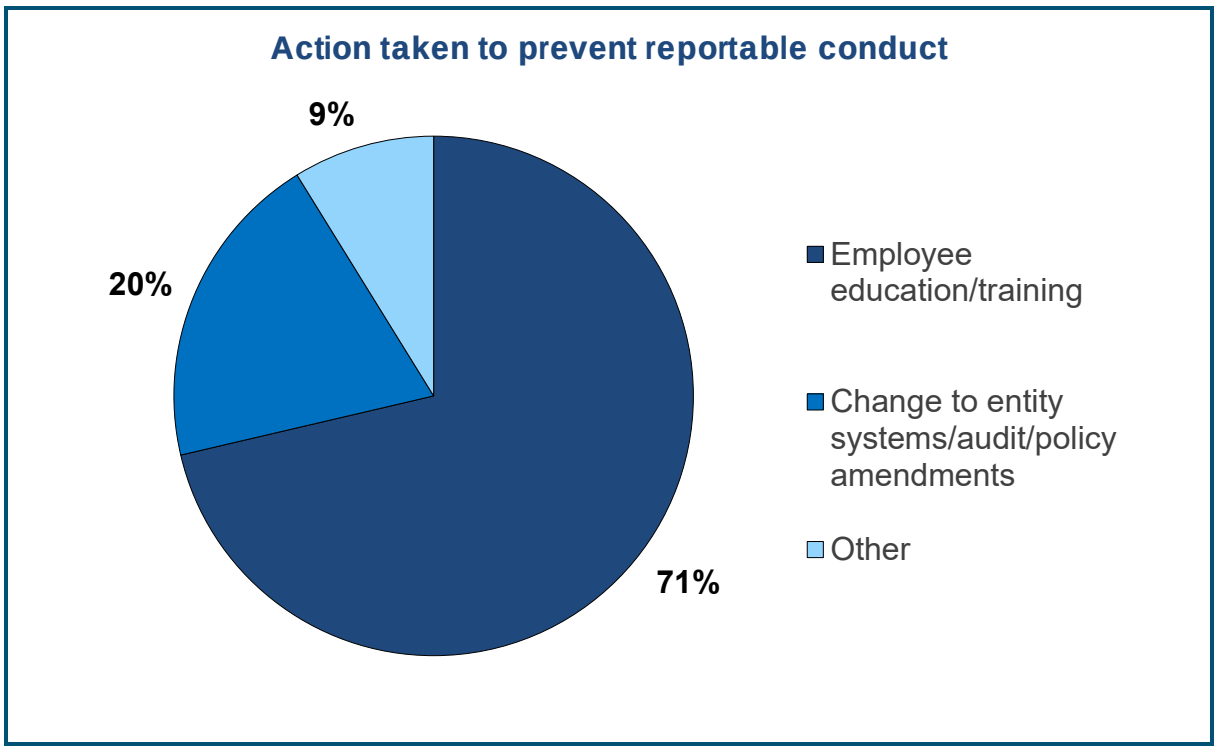
The Ombudsman may also exempt an organisation from the Scheme, by written notice given pursuant to section 19O of the Act.

During 2023-24, no organisations were exempted from the Scheme.

Action taken to prevent reportable conduct

During 2023-24, a total of 477 actions were taken by organisations to prevent reportable conduct at the conclusion of a reportable conduct investigation.

The chart below provides a summary of the types of actions taken to improve reportable conduct systems within organisations:



The Office collects a range of additional information about the improvement actions undertaken by organisations at all stages of the reportable conduct process, including actions taken prior to Ombudsman involvement and actions taken during the identification and notification of a reportable conduct matter regarding the safety of children.

The types of organisations covered by the Reportable Conduct Scheme

The Scheme only applies to organisations that exercise care, supervision or authority over children. The types of organisations covered by the Scheme include:

- Western Australian government departments and authorities, and local governments;
- Child protection and out-of-home-care services:
  - Providers of approved foster carers and kinships carers;
  - Providers of residential care and family group homes;
- Early childhood education and care services:
  - Providers of approved education and care services and child care services;
  - Providers of an approved family day care service;
- Education services:
  - Government and non-government schools;
  - TAFE colleges;
  - Registered training organisations;
  - Universities;
- Health services:
  - Public health service providers;
  - Licensed private hospital service providers;
  - Mental health service providers that have inpatient beds for children;
  - Drug and alcohol treatment service providers that have inpatient beds for children;
  - Ambulance services;
- Justice and detention services:
  - A provider of a juvenile detention centre; and
  - A provider of community justice services funded by the Department of Justice.
- Accommodation and residential services:
  - Providers of a homelessness service that provides overnight beds specifically for children as part of its primary activities and is funded by the Department of Communities;
  - Providers of boarding facilities for students who are children;
  - Organisations that provide overnight camps for children as part of its primary activity;
  - A provider of any other accommodation or respite services for children;
- Religious bodies; and
- Disability service providers.

Education and guidance

The Office undertakes its function of providing education and guidance through:

- Our dedicated enquiries line and reportable conduct email address;
- Providing information to organisations during reportable conduct investigations;
- Delivering in-person and online presentations to organisations; and
- Publishing a range of online guidance and support materials on our website.

During 2023-24, the Office worked closely and cooperatively with stakeholders in key sectors and organisations included in the Scheme to provide education and guidance to assist in building their capacity to meet their reporting obligations and comply with the Scheme. This included:

- Attending meetings with organisations and delivering workshops on the Scheme;
- Developing tailored guidance and support materials and education programs for each sector, in collaboration with peak bodies for the sector; and
- Providing information to organisations to assist them in their handling of individual investigations.

During 2023-24, the Office held a range of information sessions and workshops for organisations covered by the Scheme and other stakeholders. The Office provided 17 workshops with early education providers, five religious organisations, and 12 other in-scheme organisations; as well as regional outreach in Geraldton. An inter-agency forum was held in June 2024 to coordinate communication and engagement between agencies.

In addition, the Office regularly liaised with a range of bodies in relation to the Scheme, including:

- The Department of Communities
- The Department of Education
- The Department of Health
- The Department of Justice
- WA Police Force.

Collaboration and Access to Services

Engagement with key stakeholders is essential to the Office's achievement of the most efficient and effective outcomes. The Office does this through:

- Working collaboratively with other integrity and accountability bodies to encourage best practice, efficiency and leadership;
- Ensuring ongoing accountability to Parliament as well as accessibility to its services for public authorities and the community; and
- Developing, maintaining and supporting relationships with public authorities and community groups.

Working Collaboratively

The Office works with integrity and accountability bodies to promote best practice, efficiency and leadership. Working with these bodies also provides an opportunity for the Office to benchmark its performance and stakeholder communication activities against other similar agencies, and to identify areas for improvement through the experiences of others.

Information sharing with Ombudsmen from other jurisdictions

Background:

Where appropriate, the Office shares information and insights about its work with Ombudsmen from other jurisdictions, as well as with other accountability and integrity bodies.

The Office's involvement:

The Office exchanged information with other Parliamentary Ombudsmen and industry-based Ombudsmen during the year.

Australia and New Zealand Ombudsman Association

Members: Parliamentary and industry-based Ombudsmen from Australia and New Zealand.

Background:

The Australia and New Zealand Ombudsman Association (**ANZOA**) is the peak body for Parliamentary and industry-based Ombudsmen from Australia and New Zealand.

Our involvement:

The Ombudsman is a member of ANZOA. The Office periodically provides general updates on its activities and has nominated representatives who participate in interest groups in the areas of Indigenous engagement, systemic issues and policy influence, people and development, data and analytics, and public relations and communications.

Providing Access to the Community

Communicating with complainants

The Office provides a range of information and services to assist specific groups, and the public more generally, to understand the role of the Ombudsman and the complaint process. Many people find the Office's enquiry service and drop-in sessions held during regional visits assist them to make their complaint. Other initiatives in 2023-24 include:

- Regular updating of the Ombudsman's publications and website to provide easy access to information for people wishing to make a complaint and those undertaking the complaint process;
- Ongoing promotion of the role of the Office and the type of complaints the Office handles through presentations and participating in events in the community; and
- The Office's Youth Awareness and Accessibility Program and Prison Program.

Access to the Ombudsman's services

The Office continues to implement a number of strategies to ensure its complaint services are accessible to all Western Australians. These include access through online facilities as well as more traditional approaches by letter and through visits to the Office. The Office also holds drop-in sessions and engages with community groups, particularly through the Regional Awareness and Accessibility Program. Initiatives to make services accessible include:

- Access to the Office through a Freecall number, which is free from landline phones;
- Access to the Office online. The importance of providing an accessible online service is demonstrated by the online complaint form overtaking email as the preferred method to lodge complaints for the first time. This year 45% of all complaints received were lodged through the online complaint form compared to 40% by email and the remaining 15% by post and other methods;
- Information on how to make a complaint to the Ombudsman is available in 17 languages in addition to English and features on the homepage of the

Ombudsman's website. People may also contact the Office with the assistance of an interpreter by using the Translating and Interpreting Service;

- The Office's accommodation, building and facilities provide access for people with disability. People with hearing and speech impairments can contact the Office using the National Relay Service;
- The Office's Regional Awareness and Accessibility Program targets awareness and accessibility for regional and Aboriginal Western Australians;
- The Office attends events to raise community awareness of, and access to, its services, such as information stands at:
    - The City of Armadale NAIDOC Festival in July 2023;
    - The Financial Counsellors' Association of WA Conference marketplace in October 2023;
    - Seniors Recreation Council of WA 'Have a Go Day' in November 2023;
    - The Wagin Woolorama Agricultural Show in March 2024; and
    - The Financial Counselling Australia Conference in May 2024.
- The Office's visits to adult prisons and the juvenile detention centre provide an opportunity for adult prisoners and juvenile detainees to meet with representatives of the Office and lodge complaints in person.

Staff from Ombudsman Western Australia (also representing the Energy and Water Ombudsman Western Australia) with staff from the Telecommunications Industry Ombudsman and Consumer Protection at the Wagin Woolorama Agricultural Show, March 2024.

Ombudsman website

The Ombudsman's website provides a wide range of information and resources for:

- Members of the public on the complaint handling services provided by the Office as well as links to other complaint bodies for issues outside the Ombudsman's jurisdiction;
- Public authorities on decision making, complaint handling and conducting investigations;
- Organisations that work with children on the Reportable Conduct Scheme;
- Children and young people as well as information for non-government organisations and government agencies that assist children and young people, including downloadable print material tailored for children and young people. The youth pages can be accessed at www.ombudsman.wa.gov.au/youth;
- People from diverse backgrounds, including information in a wide range of community languages;
- Access to the Ombudsman's reports such as *A report on giving effect to the recommendations arising from the Investigation into family and domestic violence and suicide*;
- The latest news about events and collaborative initiatives such as the Regional Awareness and Accessibility Program; and
- Links to other key functions undertaken by the Office such as the Energy and Water Ombudsman website and other related bodies including other Ombudsmen and other Western Australian accountability agencies.

The website continues to be a valuable resource for the community and public sector as shown by the increased use of the website this year. In 2023-24:

- The total number of visits to the website was 198,430; nearly double the year before;
- The top five most visited pages (besides the homepage and the Contact Us page) on the site were *How to make a complaint*, *What you can complain about*, *Making your complaint*, *Reportable Conduct*, and *Complaints by Overseas Students*; and
- The *Effective Handling of Complaints Made to Your Organisation Guidelines* and *Procedural Fairness Guidelines* were the two most viewed documents.

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2023-24. Regional visits were conducted to:

- Carnarvon in the Gascoyne Region in September 2023;
- Esperance in the Esperance-Goldfields Region in December 2023; and
- Geraldton and Mullewa in the Mid-West Region in May 2024.

The visits include activities such as:

- Drop-in sessions, which provided an opportunity for members of the local community to raise their concerns face-to-face with the staff of the Office;
- Information sessions for the Aboriginal community, Elders and service providers, which provided an opportunity for Aboriginal communities to discuss government service delivery and where the Office may be able to assist;
- Liaison with community, advocacy and consumer organisations to provide information about our role;
- Liaison with public authorities, including a workshop on *Effective Complaint Handling* in Geraldton in May 2024; and
- Liaison with organisations that work with children to provide information about the Reportable Conduct Scheme, including an *Introduction to the Reportable Conduct Scheme* information session in Geraldton in May 2024.

The Program is an important way for the Office to raise awareness of its services and provide access to its services for regional and Aboriginal Western Australians. In 2023-24, the visits were coordinated with the Western Australian Energy and Water Ombudsman, the Health and Disability Services Complaints Office, the Equal Opportunity Commission, the Commonwealth Ombudsman, the Telecommunications Industry Ombudsman, the Australian Financial Complaints Authority, the Department of Energy, Mines, Industry Regulation and Safety – Consumer Protection, and the Aboriginal Legal Service. This collaborative approach provides additional benefits to people in the regions as it helps provide a 'one-stop-shop' model for complaints.

The Office also held an information stall at the Wagin Woolorama Agricultural Show in March 2024, in collaboration with the Energy and Water Ombudsman and Telecommunications Industry Ombudsman.

The Program enables the Office to:

- Deliver key services directly to regional communities, particularly through drop-in sessions and information sessions;
- Increase awareness and accessibility among regional and Aboriginal Western Australians (who were historically under-represented in complaints to the Office); and
- Deliver key messages about the Office's work and services.

The Program also provides a valuable opportunity for staff to strengthen their understanding of the issues affecting people in regional and Aboriginal communities.

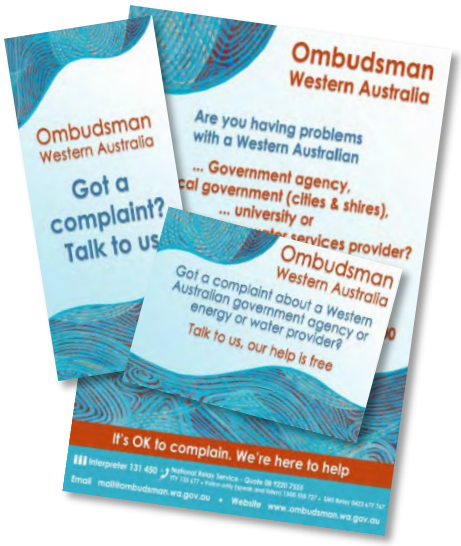
Staff from the Equal Opportunity Commission, Ombudsman Western Australia, Telecommunications Industry Ombudsman, Health and Disability Services Complaints Office, and the Australian Financial Complaints Authority at the drop-in session in Carnarvon, September 2023.

Staff from the Equal Opportunity Commission, Commonwealth Ombudsman, Aboriginal Legal Service, Ombudsman Western Australia, Telecommunications Industry Ombudsman, and Health and Disability Services Complaints Office in Esperance, December 2023.

Aboriginal engagement

In 2018, the Office established the Aboriginal Engagement and Collaboration Branch led by an Assistant Ombudsman, the first time an executive-level position was created for the Office's work with Aboriginal people.

The Office also engaged an Aboriginal artist in 2018 to produce an artwork for the Office. The artwork is featured on the cover of this report and has been used as a theme for new publications.



The Aboriginal Engagement and Collaboration Branch members:

- Attended events and meetings with government and non-government service providers;
- Engaged with Aboriginal organisations to provide an opportunity to raise issues affecting the Aboriginal community and to raise awareness of the Office's role; and
- Participated in Aboriginal community information sessions in the regions as part of its Regional Awareness and Accessibility Program.

The Aboriginal staff also coordinated cultural awareness information and events for staff of the Office throughout the year, including training on *Aboriginal Cultural Awareness*, and provided information to staff about culturally important dates and events being held in the community.

Prison Program

The Office continued the Prison Program during 2023-24. Three visits were made to prisons and the juvenile detention centre to raise awareness of the role of the Ombudsman and enhance accessibility to the Office for adult prisoners and juvenile detainees in Western Australia.

Speeches, Presentations and Training

The Ombudsman and staff delivered speeches, presentations and training throughout the year:

- Address by the Ombudsman and (then) IOI President on the occasion of the Australia and New Zealand Ombudsman Association annual *Meeting of the Minds* Conference in July 2023;
- *The Role of the Ombudsman* by the Manager Community Engagement and Business Intelligence to the Aboriginal Legal Service in July 2023;
- *Role of the Child Death Reviews and Family and Domestic Violence Fatality Reviews by the Ombudsman* by the Senior Assistant Ombudsman Reviews to the Youth Justice Services Team Leaders Conference in August 2023;
- An information session and roundtable meeting with staff from state government agencies and local governments as part of the regional visit to Carnarvon in September 2023;
- The Senior Assistant Ombudsman Energy and Water participated in the *Ask an Ombudsman* panel at the Financial Counsellors Association of WA Conference in October 2023;
- An information session and roundtable meeting with staff from state government agencies and local governments as part of the regional visit to Esperance in December 2023;
- *The Ombudsman and Energy and Water Ombudsman* by the Manager Community Engagement and Business Intelligence to financial counsellors hosted by the Financial Counselling Association of WA in March 2024;
- *Effective Complaint Handling* workshop by the Senior Assistant Ombudsman Energy and Water for staff from state government agencies and local governments as part of the regional visit to Geraldton in May 2024;
- *Introduction to the Reportable Conduct Scheme* presentation by the Oversight and Investigations Officer to government and non-government organisations that work with children as part of the regional visit to Geraldton in May 2024; and
- The Senior Assistant Ombudsman Energy and Water and the Principal Consultant Aboriginal Engagement and Collaboration participated in the *First Nations Yarning Circle* at the Financial Counselling Australia National Conference in May 2024.

Speeches by the Ombudsman are available on the Speeches by the Ombudsman page of the website.

Staff from the Reportable Conduct Team also held 32 information sessions, in person and online, about the Reportable Conduct Scheme to various government and non-government organisations. More information is provided in the Reportable Conduct Scheme section of this report.

Liaison with Public Authorities

The Office undertook a range of meetings and liaison activities in relation to its functions.

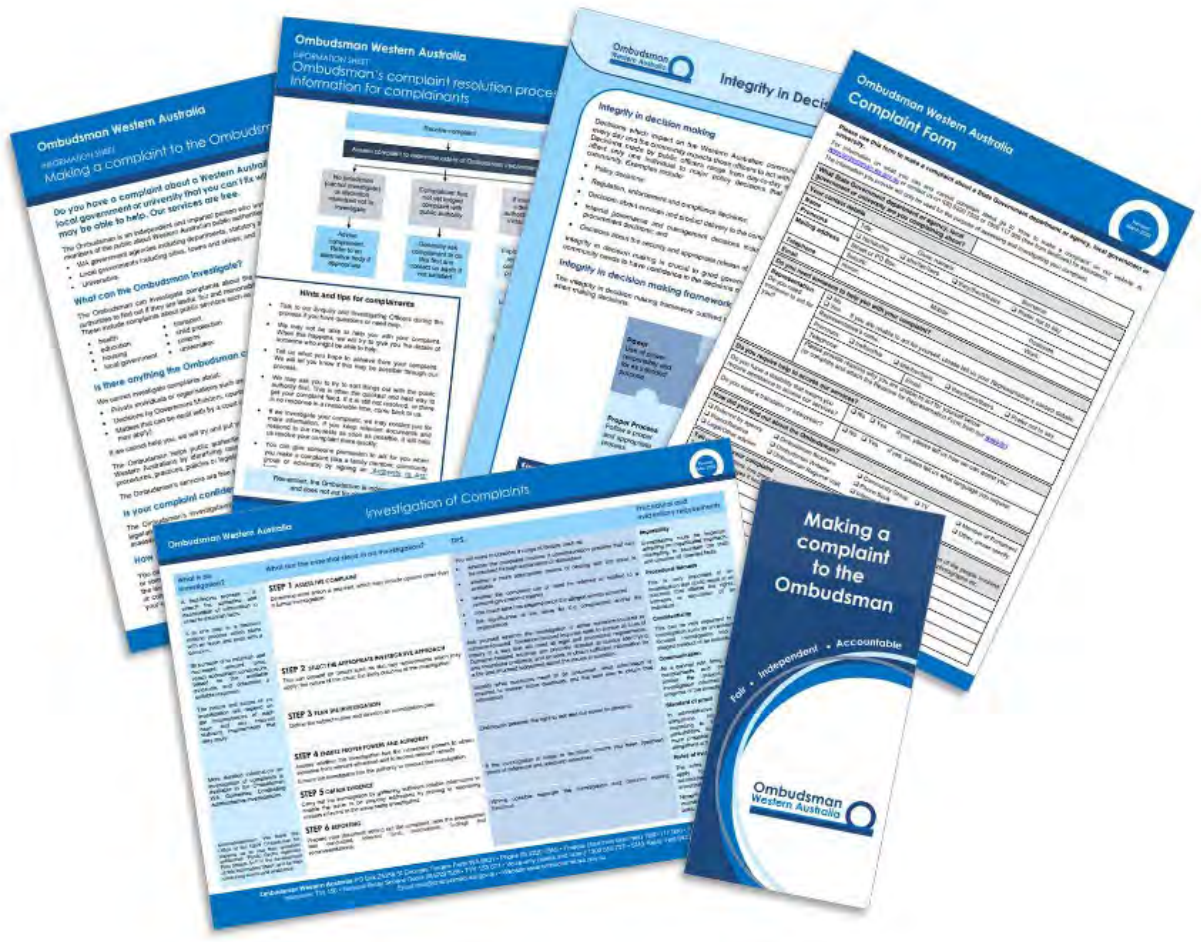
See further details in the following sections:

- Complaint Resolution section
- Child Death Review section
- Family and Domestic Violence Fatality Review section
- Reportable Conduct Scheme section
- Own Motion Investigations, Inspections and Monitoring section.

Publications

The Office has a comprehensive range of publications about the role of the Ombudsman, which are available on the Ombudsman's website.

A range of new publications were developed during 2023-24, particularly for the Reportable Conduct Scheme.



Disclosures and Legal Compliance

This section provides details of the Office's audited financial statements and key performance indicators, along with information on other mandatory disclosures and legal compliance.

Independent Audit Opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

2024

Parliamentary Commissioner for Administrative Investigations

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

I have audited the financial statements of the Parliamentary Commissioner for Administrative Investigations (Parliamentary Commissioner) which comprise:

- the statement of financial position as at 30 June 2024, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended
- notes comprising a summary of material accounting policies and other explanatory information.

In my opinion, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Parliamentary Commissioner for Administrative Investigations for the year ended 30 June 2024 and the financial position as at the end of that period
- in accordance with Australian Accounting Standards (applicable to Tier 2 Entities), the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for opinion

I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my report.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the Parliamentary Commissioner for the financial statements

The Parliamentary Commissioner is responsible for:

- keeping proper accounts
- preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards (applicable to Tier 2 Entities), the *Financial Management Act 2006* and the Treasurer's Instructions
- such internal control as it determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

7th Floor Albert Facey House 469 Wellington Street Perth MAIL TO: Perth BC PO Box 8489 Perth WA 6849 TEL: 08 6557 7500

In preparing the financial statements, the Parliamentary Commissioner is responsible for:

- assessing the entity's ability to continue as a going concern
- disclosing, as applicable, matters related to going concern
- using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Parliamentary Commissioner.

Auditor's responsibilities for the audit of the financial statements

As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control.

A further description of my responsibilities for the audit of the financial statements is located on the Auditing and Assurance Standards Board website. This description forms part of my auditor's report and can be found at https://www.auasb.gov.au/auditors_responsibilities/ar4.pdf

Report on the audit of controls

Opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Parliamentary Commissioner for Administrative Investigations. The controls exercised by the Parliamentary Commissioner for Administrative Investigations are those policies and procedures established to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with the State's financial reporting framework (the overall control objectives).

In my opinion, in all material respects, the controls exercised by the Parliamentary Commissioner for Administrative Investigations are sufficiently adequate to provide reasonable assurance that the controls within the system were suitably designed to achieve the overall control objectives identified as at 30 June 2024, and the controls were implemented as designed as at 30 June 2024.

The Parliamentary Commissioner's responsibilities

The Parliamentary Commissioner is responsible for designing, implementing and maintaining controls to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities are in accordance with the *Financial Management Act 2006*, the Treasurer's Instructions and other relevant written law.

Auditor General's responsibilities

As required by the *Auditor General Act 2006,* my responsibility as an assurance practitioner is to express an opinion on the suitability of the design of the controls to achieve the overall control objectives and the implementation of the controls as designed. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3150 Assurance Engagements on Controls issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements and plan and perform my procedures to obtain reasonable assurance about whether, in all material respects, the controls are suitably designed to achieve the overall control objectives and were implemented as designed.

An assurance engagement involves performing procedures to obtain evidence about the suitability of the controls design to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including an assessment of the risks that controls are not suitably designed or implemented as designed. My procedures included testing the implementation of those controls that I consider necessary to achieve the overall control objectives.

I believe that the evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Limitations of controls

Because of the inherent limitations of any internal control structure, it is possible that, even if the controls are suitably designed and implemented as designed, once in operation, the overall control objectives may not be achieved so that fraud, error or non-compliance with laws and regulations may occur and not be detected. Any projection of the outcome of the evaluation of the suitability of the design of controls to future periods is subject to the risk that the controls may become unsuitable because of changes in conditions.

Report on the audit of the key performance indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the Parliamentary Commissioner for Administrative Investigations for the year ended 30 June 2024 reported in accordance with *Financial Management Act 2006* and the Treasurer's Instructions (legislative requirements). The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators report of the Parliamentary Commissioner for Administrative Investigations for the year ended 30 June 2024 is in accordance with the legislative requirements, and the key performance indicators are relevant and appropriate to assist users to assess the Parliamentary Commissioner's performance and fairly represent indicated performance for the year ended 30 June 2024.

The Parliamentary Commissioner's responsibilities for the key performance indicators

The Parliamentary Commissioner is responsible for the preparation and fair presentation of the key performance indicators in accordance with the *Financial Management Act 2006* and the Treasurer's Instructions and for such internal controls as the Parliamentary Commissioner determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

In preparing the key performance indicators, the Parliamentary Commissioner is responsible for identifying key performance indicators that are relevant and appropriate, having regard to their purpose in accordance with Treasurer's Instruction 904 Key Performance Indicators.

Auditor General's responsibilities

As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the key performance indicators. The objectives of my engagement are to obtain reasonable assurance about whether the key performance indicators are relevant and appropriate to assist users to assess the entity's performance and whether the key performance indicators are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3000 Assurance Engagements Other than Audits or Reviews of Historical Financial Information issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements relating to assurance engagements.

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 904 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments, I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

I believe that the evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

My independence and quality management relating to the report on financial statements, controls and key performance indicators

I have complied with the independence requirements of the *Auditor General Act 2006* and the relevant ethical requirements relating to assurance engagements. In accordance with ASQM 1 Quality Management for Firms that Perform Audits or Reviews of Financial Reports and Other Financial Information, or Other Assurance or Related Services Engagements, the Office of the Auditor General maintains a comprehensive system of quality management including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Other information

The Ombudsman is responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2024, but not the financial statements, key performance indicators and my auditor's report.

My opinions on the financial statements, controls and key performance indicators does not cover the other information and accordingly I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, controls and key performance indicators my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements and key performance indicators or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I did not receive the other information prior to the date of this auditor's report. When I do receive it, I will read it and if I conclude that there is a material misstatement in this information, I am required to communicate the matter to those charged with governance and request them to correct the misstated information. If the misstated information is not corrected, I may need to retract this auditor's report and re-issue an amended report.

Matters relating to the electronic publication of the audited financial statements and key performance indicators

This auditor's report relates to the financial statements and key performance indicators of the Parliamentary Commissioner for Administrative Investigations for the year ended 30 June 2024 included in the annual report on the Parliamentary Commissioner's website. The Parliamentary Commissioner's management is responsible for the integrity of the Parliamentary Commissioner's website. This audit does not provide assurance on the integrity of the Parliamentary Commissioner's website. The auditor's report refers only to the financial statements, controls and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from the annual report. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to contact the entity to confirm the information contained in the website version.

Jordan Langford-Smith
Senior Director Financial Audit
Delegate of the Auditor General for Western Australia
Perth, Western Australia
9 August 2024

Financial Statements

This page has been intentionally left blank.

30 June 2024

Financial Statements

Certification of Financial Statements

For the financial year ended 30 June 2024

The accompanying financial statements of the Parliamentary Commissioner for Administrative Investigations have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the financial year ended 30 June 2024 and the financial position as at 30 June 2024.

At the date of signing, we are not aware of any circumstances which would render the particulars included in the financial statements misleading or inaccurate.

Leyla Nowbakht
Chief Finance Officer

09 August 2024

David Robinson
Deputy Ombudsman
Acting as the Ombudsman under section 6A of the *Parliamentary Commissioner Act 1971*

09 August 2024

Parliamentary Commissioner for Administrative Investigations
Statement of Comprehensive Income

For the year ended 30 June 2024

	Notes	2024 $	2023 $
COST OF SERVICES			
Expenses			
Employee benefits expense	2.1(a)	11,186,618	9,743,632
Supplies and services	2.2	1,160,877	1,243,895
Depreciation and amortisation expense	4.1, 4.2, 4.3	243,299	257,348
Accommodation expenses	2.2	1,319,548	1,223,173
Finance costs	6.2	3,741	1,100
Other expenses	2.2	291,254	141,372
Total cost of services		**14,205,337**	**12,610,521**
Income			
Other Income	3.2	2,711,108	2,684,988
Total Income		**2,711,108**	**2,684,988**
NET COST OF SERVICES		**11,494,229**	**9,925,533**
Income from State Government			
Service appropriation	3.1	12,481,000	10,944,000
Resources received	3.1	135,481	116,416
Total income from State Government		**12,616,481**	**11,060,416**
SURPLUS/(DEFICIT) FOR THE PERIOD		**1,122,252**	**1,134,883**
OTHER COMPREHENSIVE INCOME		**-**	**-**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**1,122,252**	**1,134,883**

The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

Parliamentary Commissioner for Administrative Investigations
Statement of Financial Position

As at 30 June 2024

	Notes	2024 $	2023 $
ASSETS			
Current Assets			
Cash and cash equivalents	6.3	3,378,333	1,440,156
Restricted cash and cash equivalents	6.3	-	7,653
Receivables	5.1	29,594	6,330
Amounts receivable for services	5.2	208,000	208,000
Total Current Assets		**3,615,927**	**1,662,139**
Non-Current Assets			
Restricted cash and cash equivalents	6.3	-	272,507
Receivables	5.1	349,510	-
Amounts receivable for services	5.2	2,176,000	2,065,000
Plant and equipment	4.1	76,420	122,816
Intangible assets	4.2	150,965	284,471
Right-of-use assets	4.3	47,020	49,347
Total Non-Current Assets		**2,799,915**	**2,794,141**
TOTAL ASSETS		**6,415,842**	**4,456,280**
LIABILITIES			
Current Liabilities			
Payables	5.3	395,657	312,040
Employee related provisions	2.1(b)	2,459,199	2,033,334
Lease liabilities	6.1	3,973	6,391
Contract liabilities	5.4	58,422	77,066
Total Current Liabilities		**2,917,251**	**2,428,831**
Non-Current Liabilities			
Employee related provisions	2.1(b)	403,086	410,868
Lease liabilities	6.1	33,468	34,424
Contract liabilities	5.4	-	58,422
Total Non-Current Liabilities		**436,554**	**503,714**
TOTAL LIABILITIES		**3,353,805**	**2,932,545**
NET ASSETS		**3,062,037**	**1,523,735**
EQUITY			
Contributed equity		1,704,000	1,288,000
Accumulated surplus/(deficit)		1,358,037	235,735
TOTAL EQUITY		**3,062,037**	**1,523,735**

The Statement of Financial Position should be read in conjunction with the accompanying notes.

Parliamentary Commissioner for Administrative Investigations
Statement of Changes in Equity

For the year ended 30 June 2024

	Contributed equity $	Accumulated surplus/(deficit) $	Total equity $
Balance at 1 July 2022	**1,267,000**	**(899,148)**	**367,852**
Surplus/(Deficit)	-	1,134,883	1,134,883
Total comprehensive income for the period	-	1,134,883	1,134,883
Transactions with owners in their capacity as owners:			
Capital appropriations	21,000	-	21,000
Total	21,000	-	21,000
Balance at 30 June 2023	**1,288,000**	**235,735**	**1,523,735**
Balance at 1 July 2023	**1,288,000**	**235,735**	**1,523,735**
Changes in accounting policy or correction of prior period error [(a)]	-	50	50
Restated Balance at 1 July 2023	**1,288,000**	**235,785**	**1,523,785**
Surplus/(Deficit)	-	1,122,252	1,122,252
Total comprehensive income for the period		1,122,252	1,122,252
Transactions with owners in their capacity as owners:			
Capital appropriations	416,000	-	416,000
Total	416,000	-	416,000
Balance at 30 June 2024	**1,704,000**	**1,358,037**	**3,062,037**

(a) This relates to a minor adjustment to June 2023 Business Activity Statement in October 2023.

The Statement of Changes in Equity should be read in conjunction with the accompanying notes.

Parliamentary Commissioner for Administrative Investigations
Statement of Cash Flows

For the year ended 30 June 2024

	Notes	2024 $	2023 $
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		12,162,000	10,707,000
Holding account drawdown		208,000	208,000
Capital appropriations		416,000	21,000
Net cash provided by State Government		**12,786,000**	**10,936,000**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(11,067,040)	(9,647,710)
Supplies and services		(1,109,817)	(1,183,777)
Finance costs		(3,741)	(1,100)
Accommodation		(1,304,579)	(1,210,029)
GST payments on purchases		(275,592)	(248,857)
GST payments to taxation authority		(26,288)	(99,175)
Other payments		(166,814)	(70,173)
Receipts			
GST receipts on sales		279,573	272,630
GST receipts from taxation authority		-	56,934
Other receipts		3,036,875	2,684,988
Net cash provided by (used in) operating activities		**(10,637,423)**	**(9,446,269)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(125,144)	(238,645)
Net cash provided by (used in) investing activities		**(125,144)**	**(238,645)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Principal elements of lease payments		(15,905)	(21,772)
Net cash provided by (used in) financing activities		**(15,905)**	**(21,772)**
Net increase/(decrease) in cash and cash equivalents		2,007,527	1,229,314
Cash and cash equivalents at the beginning of the period		1,720,316	491,002
Adjustment for the reclassification of accrued salaries account		(349,510)	
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	6.3	**3,378,333**	**1,720,316**

The Statement of Cash Flows should be read in conjunction with the accompanying notes.

Parliamentary Commissioner for Administrative Investigations
Notes to the Financial Statements
for the year ended 30 June 2023

1. Basis of preparation

The Office is a WA Government not-for-profit entity controlled by the State of Western Australia, which is the ultimate parent.

A description of the nature of its operations and its principal activities have been included in the 'Overview' which does not form part of these financial statements.

These annual financial statements were authorised for issue by the Accountable Authority of the Office on 09 August 2024.

Statement of compliance

The financial statements constitute general purpose financial statements that have been prepared in accordance with Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by Treasurer's instructions. Several of these are modified by Treasurer's instructions to vary application, disclosure, format and wording.

The Act and Treasurer's instructions are legislative provisions governing the preparation of financial statements and take precedence over Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board. Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

Basis of preparation

These financial statements are presented in Australian dollars applying the accrual basis of accounting and using the historical cost convention. Certain balances will apply a different measurement basis (such as the fair value basis). Where this is the case the different measurement basis is disclosed in the associated note.

Accounting for Goods and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of goods and services tax (GST), except that the:

(a) amount of GST incurred by the Office as a purchaser that is not recoverable from the Australian Taxation Office (**ATO**) is recognised as part of an asset's cost of acquisition or as part of an item of expense; and

(b) receivables and payables are stated with the amount of GST included.

Cash flows are included in the Statement of cash flows on a gross basis. However, the GST components of cash flows arising from investing and financing activities which are recoverable from, or payable to, the ATO are classified as operating cash flows.

Contributed equity

Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated as contributions by owners (at the time of, or prior to, transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by TI 955 *Contributions by Owners made to Wholly Owned Public Sector Entities* and have been credited directly to Contributed Equity.

Comparative information

Except when an Australian Accounting Standard permits or requires otherwise, comparative information is presented in respect of the previous period for all amounts reported in the financial statements. AASB 1060 provides relief from presenting comparatives for:

- Property, Plant and Equipment reconciliations;
- Intangible Asset reconciliations; and
- Right of Use Asset reconciliations.

Judgements and estimates

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements and estimates made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements and/or estimates are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances.

2. Use of our funding

Expenses incurred in the delivery of services

This section provides additional information about how the Office's funding is applied and the accounting policies that are relevant for an understanding of the items recognised in the financial statements. The primary expenses incurred by the Office in achieving its objectives and the relevant notes are:

	Notes
Employee benefits expenses	2.1(a)
Employee related provisions	2.1(b)
Other expenditure	2.2

2.1(a) Employee benefits expense

	2024 $	2023 $
Employee benefits	9,954,176	8,602,091
Superannuation - defined contribution plans	1,097,893	918,491
Other related expenses	134,549	223,050
Employee benefits expenses	**11,186,618**	**9,743,632**
Add: AASB 16 Non-monetary benefits	19,059	14,380
Employee Contributions (per Note 3.2 Other Income).	(16,400)	(14,545)
Total employee benefits provided	**11,189,277**	**9,743,467**

Employee benefits: Include wages, salaries and social contributions, accrued and paid leave entitlements and paid sick leave; and non-monetary benefits recognised under accounting standards other than AASB 16 (such as medical care, housing, cars and free or subsidised goods or services) for employees.

Termination benefits: Payable when employment is terminated before normal retirement date, or when an employee accepts an offer of benefits in exchange for the termination of employment. Termination benefits are recognised when the Office is demonstrably committed to terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

Superannuation: is the amount recognised in profit or loss of the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, the GESB schemes, or other superannuation funds.

AASB 16 Non-monetary benefits: are non-monetary employee benefits, predominantly relating to the provision of vehicle benefits that are recognised under AASB 16 and are excluded from the employee benefits expense.

Employee Contributions: are contributions made to the Office by employees towards employee benefits that have been provided by the Office. This includes both AASB 16 and non-AASB 16 employee contributions.

Note 2.1(b) Employee related provisions

	2024 $	2023 $
Current		
Employee benefits provisions		
Annual leave	967,104	750,953
Long service leave	1,476,495	1,254,693
Purchased leave scheme	4,886	18,591
	2,448,485	**2,024,237**
Other provisions		
Employment on-costs	10,714	9,097
	10,714	**9,097**
Total current employee related provisions	**2,459,199**	**2,033,334**

	2024 $	2023 $
Non-current		
Employee benefits provisions		
Long service leave	401,251	409,030
	401,251	**409,030**
Other provisions		
Employment on-costs	1,835	1,838
	1,835	**1,838**
Total non-current employee related provisions	**403,086**	**410,868**
Total employee related provisions	**2,862,285**	**2,444,202**

Provision is made for benefits accruing to employees in respect of annual leave and long service leave for services rendered up to the reporting date and recorded as an expense during the period the services are delivered.

Annual leave liabilities are classified as current as there is no right at the end of the reporting period to defer settlement for at least 12 months after the end of the reporting period.

The provision for annual leave is calculated at the present value of expected payments to be made in relation to services provided by employee up to the reporting date.

Long service leave liabilities are unconditional long service leave provisions and are classified as current liabilities as the Office does not have the right at the end of the reporting period to defer settlement of the liability for at least 12 months after the reporting period.

Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Office has the right to defer the settlement of the liability until the employee has completed the requisite years of service.

The provision for long service leave is calculated at present value as the Office does not expect to wholly settle the amounts within 12 months. The present value is measured taking into account the present value of expected future payments to be made in relation to services provided by employees up to the reporting date. These payments are estimated using the remuneration rate expected to apply at the time of settlement, and discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Purchase leave liabilities are classified as current as they must be cleared or paid out within 12 months.

Employment on-costs involve settlements of annual and long service leave liabilities which gives rise to the payment of employment on-costs including workers' compensation insurance. The provision is the present value of expected future payments.

Employment on-costs, including workers' compensation insurance premiums, are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of 'Other expenditure', Note 2.2 (apart from the unwinding of the discount (finance cost)), and are not included as part of the Office's 'employee benefits expense'. The related liability is included in 'Employment on-costs provision'.

	2024 $
Employment on-cost provision	
Carrying amount at start of period	10,935
Additional provisions recognised	1,614
Carrying amount at end of period	**12,549**

Key sources of estimation uncertainty – long service leave

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Several estimates and assumptions are used in calculating the Office's long service leave provision. These include:

- Expected future salary rates;
- Discount rates;
- Employee retention rates; and
- Expected future payments.

Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision. Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

2.2 Other expenditure

	2024 $	2023 $
Supplies and services		
Communications	57,765	61,748
Consumables	59,521	69,731
Services and contracts	561,212	510,197
Services received free of charge	122,152	103,271
Insurance	40,075	22,513
Travel	63,550	266,670
Other	256,602	209,766
Total supplies and services expenses	**1,160,877**	**1,243,895**
Accommodation expenses		
Office Rental and outgoings	1,276,301	1,190,001
Repairs and maintenance	29,919	20,028
Services received free of charge	13,328	13,145
Total accommodation expenses	**1,319,548**	**1,223,173**
Other		
Employment on-costs	1,613	248
Audit fee	118,077	70,199
Bad debts	7,352	544
Loss on disposal on non-current assets	(210)	-
Other	164,422	70,381
Total other	**291,254**	**141,372**
Total other expenditure	**2,771,679**	**2,608,441**

Supplies and services expenses are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any materials held for distribution are expensed when the materials are distributed.

Office rental is expensed as incurred as Memorandum of Understanding Agreements between the Office and the Department of Finance for the leasing of office accommodation contain significant substitution rights.

Repairs, maintenance and cleaning costs are recognised as expenses as incurred.

Other operating expenses generally represent the day-to-day running costs incurred in normal operations.

3. Our funding sources

How we obtain our funding

This section provides additional information about how the Office obtains its funding and the relevant accounting policy notes that govern the recognition and measurement of this funding. The primary income received by the Office and the relevant notes are:

	Notes
Income from State Government	3.1
Other income	3.2

3.1 Income from State Government

	Notes	2024 $	2023 $
Appropriation received during the period:			
- Service appropriation		11,744,000	10,258,000
- Special Acts		737,000	686,000
Total service appropriation		**12,481,000**	**10,944,000**
Resources received from other public sector entities during the period:			
State Solicitor's Office	2.2	17,409	2,095
Department of the Premier and Cabinet	2.2	104,744	101,176
Department of Finance	2.2	13,328	13,145
Total resources received		**135,481**	**116,416**
Total income from State Government		**12,616,481**	**11,060,416**

Service Appropriations are recognised as income at the fair value of consideration received in the period in which the Office gains control of the appropriated funds. The Office gains control of appropriated funds at the time those funds are deposited in the bank account or credited to the holding account held at Treasury.

Resources received from other public sector entities is recognised as income equivalent to the fair value of assets received, or the fair value of services received that can be reliably determined and which would have been purchased if not donated.

Summary of consolidated account appropriations

For the year ended 30 June 2024

	2024 Budget $	2024 Additional Funding* $	2024 Revised Budget $	2024 Actual $	2024 Variance $
Delivery Services					
Item 4 Net amount appropriated to deliver services	11,744,000			11,744,000	-
- Parliamentary Commissioner Act 1971	691,000	46,000		737,000	-
Total appropriations provided to deliver services	**12,435,000**	**46,000**	**-**	**12,481,000**	**-**
Capital					
Item 94 Capital appropriations	420,000		(4,000)	416,000	-
Total Consolidated account appropriations	**12,855,000**	**46,000**	**(4,000)**	**12,897,000**	**-**

*Additional funding includes supplementary funding and new funding authorised under section 27 of the Act and amendments to standing appropriations.

3.2 Other income

	2024 $	2023 $
Employee contributions[(a)]	16,400	14,545
Other revenue - general	68,553	46,202
Other recoup[(b)]	2,626,155	2,624,241
Total other income	**2,711,108**	**2,684,988**

(a) Contributions made to the Office by employees towards employee benefits that have been provided by the Office under the Senior Officer Vehicle Scheme.

(b) Includes recoup for the costs of the functions of the Energy and Water Ombudsman Western Australia and services of the Office in relation to complaints involving the Indian Ocean Territories (see Note 8.7).

Revenue is recognised and measured at the fair value of consideration received or receivable.

4. Key assets

This section includes information regarding the key assets the Office utilises to gain economic benefits or provide service potential. The section sets out both the key accounting policies and financial information about the performance of these assets:

	Notes
Plant and equipment	4.1
Intangibles	4.2
Right-of-use assets	4.3

4.1 Plant and equipment

Year ended 30 June 2024	Furniture and Fittings $	Computer Hardware $	Office Equipment $	Communications $	Total $
1 July 2023					
Gross carrying amount	6,814	449,390	40,007	-	496,211
Accumulated depreciation	(6,814)	(345,240)	(21,342)	-	(373,396)
Carrying amount at start of period	**-**	**104,150**	**18,665**	**-**	**122,816**
Additions	-	-	23,805	-	23,805
Depreciation	-	(61,192)	(9,009)	-	(70,201)
Carrying amount at end of period	**-**	**42,958**	**33,461**	**-**	**76,420**
Gross carrying amount	6,814	449,390	63,812	-	520,016
Accumulated depreciation	(6,814)	(406,432)	(30,350)	-	(443,596)

Initial recognition

Items of plant and equipment, costing $5,000 or more are measured initially at cost. Where an asset is acquired for no cost or significantly less than fair value, the cost is valued at its fair value at the date of acquisition. Items of plant and equipment costing less than $5,000 are immediately expensed direct to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

Subsequent measurement

Plant and equipment is stated at historical cost less accumulated depreciation and accumulated impairment losses.

Useful lives

All plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits.

Depreciation is generally calculated on a straight-line-basis, at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life. Typical estimated useful lives for the different asset classes for current and prior years are included in the table below:

Asset	Useful life: years
Furniture and fittings	10 years
Plant and machinery	10 years
Computer hardware	3 years
Office equipment	5 years
Motor vehicles	3 - 5 years
Software[(a)]	3 years

(a) Software that is integral to the operation of related hardware.

Impairment

Non-financial assets, including items of plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised.

Where an asset measured at cost and is written down to its recoverable amount, an impairment loss is recognised through profit or loss.

Where a previously revalued asset is written down to its recoverable amount, the loss is recognised as a revaluation decrement through other comprehensive income to the extent that the impairment loss does not exceed the amount in the revaluation surplus for the class of asset.

As the Office is a not-for-profit agency, the recoverable amount of regularly revalued specialised assets is anticipated to be materially the same as fair value.

If there is an indication that there has been a reversal in impairment, the carrying amount shall be increased to its recoverable amount. However this reversal should not increase the asset's carrying amount above what would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised in prior years.

4.2 Intangible assets

Year ended 30 June 2024	Computer Software $	Total $
1 July 2023		
Gross carrying amount	2,483,405	2,483,405
Accumulated amortisation	(2,198,934)	(2,198,934)
Carrying amount at start of period	**284,471**	**284,471**
Additions	24,273	24,273
Amortisation	(157,780)	(157,780)
Carrying amount at 30 June 2024	**150,965**	**150,965**

Initial recognition

Intangible assets are initially recognised at cost. For assets acquired at significantly less than fair value, the cost is their fair value at the date of acquisition.

Acquired and internally generated intangible assets costing $5,000 or more that comply with the recognition criteria of AASB 138 *Intangible Assets* (as noted above), are capitalised.

Costs incurred below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

An internally generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

(a) the technical feasibility of completing the intangible asset so that it will be available for use or sale;

(b) an intention to complete the intangible asset, and use or sell it;

(c) the ability to use or sell the intangible asset;

(d) the intangible asset will generate probable future economic benefit;

(e) the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and

(f) the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Costs incurred in the research phase of a project are immediately expensed.

Subsequent measurement

The cost model is applied for subsequent measurement of intangible assets, requiring the asset to be carried at cost less any accumulated amortisation and accumulated impairment losses.

4.2.1 Amortisation and impairment

Charge for the period

	2024 $	2023 $
Computer software	157,780	163,532
Total amortisation for the period	**157,780**	**163,532**

As at 30 June 2024 there were no indications of impairment to intangible assets.

The Office held no goodwill or intangible assets with an indefinite useful life during the reporting period. At the end of the reporting period there were no intangible assets not yet available for use.

Useful lives

Amortisation of finite life intangible assets is calculated on a straight line basis at rates that allocate the asset's value over its estimated useful life. All intangible assets controlled by the Office have a finite useful life and zero residual value. Estimated useful lives are reviewed annually.

The estimated useful lives for each class of intangible asset are:

Asset	Useful life: years
Computer software[(a)]	3 years

(a) Software that is not integral to the operation of any related hardware.

Impairment of intangible assets

Intangible assets with indefinite useful lives are tested for impairment annually or when an indication of impairment is identified. As at 30 June 2024 there were no indications of impairment to intangible assets.

The policy in connection with testing for impairment is outlined in note 4.1.

4.3 Right of use assets

Charge for the period

Year ended 30 June 2024	Vehicles $	Total $
Carry amount at beginning of period	49,347	49,347
Additions	12,991	12,991
Depreciation	(15,318)	(15,318)
Net carrying amount as at end of period	**47,020**	**47,020**

The Office has leases for vehicles. The lease contracts are typically made for fixed periods of 5 years.

The Office has also entered into a Memorandum of Understanding Agreements with the Department of Finance for the leasing of office accommodation. These are not recognised under AASB 16 because of substitution rights held by the Department of Finance and are accounted for as an expense as incurred.

Initial recognition

At the commencement date of the lease, the Office recognises right-of-use assets and a corresponding lease liability for most leases. The right-of-use assets are measured at cost comprising of:

- the amount of the initial measurement of lease liability;
- any lease payments made at or before the commencement date less any lease incentives received;
- any initial direct costs; and
- restoration costs, including dismantling and removing the underlying asset.

The corresponding lease liabilities in relation to these right-of-use assets have been disclosed in note 6.1 Lease liabilities.

The Office has elected not to recognise right-of-use assets and lease liabilities for short-term leases (with a lease term of 12 months or less) and low value leases (with an underlying value of $5,000 or less). Lease payments associated with these leases are expensed over a straight-line basis over the lease term.

Subsequent measurement

The cost model is applied for subsequent measurement of right-of-use assets, requiring the asset to be carried at cost less any accumulated depreciation and accumulated impairment losses and adjusted for any re-measurement of lease liability.

Depreciation and impairment of right-of-use assets

Right-of-use assets are depreciated on a straight-line basis over the shorter of the lease term and the estimated useful lives of the underlying assets.

If ownership of the leased asset transfers to the Office at the end of the lease term or the cost reflects the exercise of a purchase option, depreciation is calculated using the estimated useful life of the asset.

Right-of-use assets are tested for impairment when an indication of impairment is identified.

The policy in connection with testing for impairment is outlined in note 4.1.

5. Other assets and liabilities

This section sets out those assets and liabilities that arose from the Office's controlled operations

	Notes
Receivables	5.1
Amounts receivable for services	5.2
Payables	5.3
Contract liabilities	5.4

5.1 Receivables

	2024 $	2023 $
Current		
Receivables	584	700
GST receivable	22,414	-
Purchased leave receivable	6,596	5,630
Total current	**29,594**	**6,330**
Non-current		
Accrued salaries account[(a)]	349,510	
Total non - current	**349,510**	**-**
Total receivable at end of the period	**379,104**	**6,330**

(a) Funds transferred to Treasury for the purpose of meeting the 27th pay in a reporting period that generally occurs every 11 year. This account is classified as non-current except for the year before the 27th pay year.

Receivables are recognised at original invoice amount less any allowances for uncollectible amounts (i.e. impairment). The carrying amount of net receivables is equivalent to fair value as it is due for settlement within 30 days.

Accrued salaries account contains amounts paid annually into the Treasurer's special purpose account. It is restricted for meeting the additional cash outflow for employee salary payments in reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

The account has been reclassified from 'Cash and cash equivalents' to 'Receivables' as it is considered that funds in the accounts are not cash but a right to receive the cash in future. Comparative amounts have also been reclassified.

5.2 Amounts receivable for services (Holding Account)

	2024 $	2023 $
Current	208,000	208,000
Non-current	2,176,000	2,065,000
Total Amounts receivable for services at end of period	**2,384,000**	**2,273,000**

Amounts receivable for services represent the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.

The amounts receivable for services are a financial assets at amortised costs, and are considered not impaired (i.e. there is no expected credit loss of the holding accounts).

5.3 Payables

	2024 $	2023 $
Current		
Trade payables	35,403	-
Accrued expenses	102,423	78,106
Accrued salaries	232,049	209,045
Accrued superannuation	25,782	22,522
GST payable	-	2,367
Total payables at end of period	**395,657**	**312,040**

Payables are recognised at the amounts payable when the Office becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value, as settlement is generally within 15 - 20 days.

Accrued salaries represent the amount due to staff but unpaid at the end of the reporting period. Accrued salaries are settled within a fortnight after the reporting period. The Office considers the carrying amount of accrued salaries to be equivalent to its fair value.

5.4 Contract liabilities

	2024 $	2023 $
Current		
Software contracts[(a)]	58,422	77,066
Total current	**58,422**	**77,066**
Non-current		
Software contracts[(a)]	-	58,422
Total non-current	**-**	**58,422**
Balance at end of period	**58,422**	**135,487**

(a) Software contracts for finance, records management, case management and email system that are over a period of 2 or more years.

6. Financing

This section sets out the material balances and disclosures associated with the financing and cashflows of the Office.

	Notes
Lease liabilities	6.1
Finance costs	6.2
Cash and cash equivalents	6.3
Capital commitments	6.4

6.1 Lease liabilities

	Notes	2024 $	2023 $
Lease liabilities			
Not later than one year		3,973	6,391
Later that one year and not later than five years		33,468	34,424
Later than 5 years		-	-
		37,441	**40,815**
Current		3,973	6,391
Non-current		33,468	34,424
		37,441	**40,815**

At the commencement date of the lease, the Office recognises lease liabilities measured at the present value of lease payments to be made over the lease term. The lease payments are discounted using the interest rate implicit in the lease. If that rate cannot be readily determined, the Office uses the incremental borrowing rate provided by Western Australia Treasury Corporation.

Lease payments included by the Office as part of the present value calculation of lease liability include:

- fixed payments (including in-substance fixed payments), less any lease incentives receivable;
- variable lease payments that depend on an index or rate initially measured using the index or rate at the commencement date;
- amounts expected to be payable by the lessee under residual value guarantees;
- the exercise price of purchase options (where these are reasonably certain to be exercised);
- payments for penalties for terminating a lease, where the lease term reflects the agency exercising an option to terminate the lease; and
- periods covered by extension or termination options are only included in the lease term by the Office if the lease is reasonably certain to be extended (or not terminated).

The interest on the lease liability is recognised in profit or loss over the lease term so as to produce a constant periodic rate of interest on the remaining balance of the liability for each period. Lease liabilities do not include any future changes in variable lease payments (that depend on an index or rate) until they take effect, in which case the lease liability is reassessed and adjusted against the right-of-use asset.

Variable lease payments, not included in the measurement of lease liability, that are dependent on sales an index or a rate, are recognised by the Office in profit and loss in the period in which the condition that triggers those payments occurs.

Subsequent measurement

Lease liabilities are measured by increasing the carrying amount to reflect interest on the lease liabilities; reducing the carrying amount to reflect the lease payments made; and remeasuring the carrying amount at amortised cost, subject to adjustments to reflect any reassessment or lease modifications.

This section should be read in conjunction with note 4.3.

	2024 $	2023 $
Lease expenses recognised in the Statement of comprehensive income		
Lease interest expense	3,741	1,100

6.2 Finance costs

	2024 $	2023 $
Finance costs		
Interest expense on Lease Liabilities	3,741	1,100
Total finance costs	**3,741**	**1,100**

Finance cost includes the interest component of lease liability repayments, and the increase in financial liabilities and non-employment provisions due to the unwinding of discounts to reflect the passage of time.

6.3 Cash and cash equivalents

	Notes	2024 $	2023 $
Current			
Cash and cash equivalents		3,378,333	1,440,156
Restricted cash and cash equivalents			
– Indian Ocean Territories	8.7	(2,620)	7,653
– Contribution from appropriation[(b)]		2,620	
Non-current			
– Accrued salaries suspense account[(a)]		-	272,507
Balance at end of period		**3,378,333**	**1,720,316**

(a) Funds held in the suspense account for the purpose of meeting the 27th pay in a reporting period that occurs every 11th year. This account is classified as non-current for 10 out of 11 years.

(b) The actual number of complaints received were higher than budget. The contribution from the Office's appropriation will be adjusted by Commonwealth funding in 2024-25.

For the purpose of the Statement of cash flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand and are subject to insignificant risk of changes in value.

6.4. Commitments

All commitments are presented inclusive of GST.

6.4 Capital commitments

	2024 $	2023 $
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements, are payable as follows:		
Within 1 year[(a)]	-	14,928
Later than 1 year and not later than 5 years	-	-
Later than 5 years	-	-
	-	**14,928**

(a) Due to the timing of the replacement of Office assets, some assets were committed, but not paid in 2022-23.

7. Financial instruments and Contingencies

This note sets out the key risk management policies and measurement techniques of the Office.

	Note
Financial instruments	7.1
Contingent assets and liabilities	7.2

7.1 Financial instruments

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

	2024 $	2023 $
Financial Assets		
Cash and cash equivalents	3,378,333	1,720,316
Financial assets at amortised cost[(a)]	2,740,690	2,279,330
Total financial assets	**6,119,023**	**3,999,646**
Financial Liabilities		
Financial liabilities at amortised cost[(b)]	433,098	215,000
Total financial Liabilities	**433,098**	**215,000**

(a) The amount of Financial assets at amortised costs excludes GST recoverable from the ATO (statutory receivable).

(b) The amount of Financial liabilities at amortised costs excludes GST payable to the ATO (statutory payable).

7.2 Contingent assets and liabilities

Contingent assets and contingent liabilities are not recognised in the statement of financial position but are disclosed and, if quantifiable, are measured at the best estimate.

The Office entered into an agreement with the Organisation for Economic Co-operation and Development (OECD) in September 2023.
The agreement is currently on hold due to the Corruption and Crime Commission into the circumstances in which the Ombudsman entered into the agreement.
Whilst this is acknowledged as a contingent liability of the Office, it has yet to be determined whether the Office will ultimately proceed with the agreement.
The maximum potential contingent liability for the OECD agreement at 30 June 2024 was $208,455 (EUR 129,960.00).

8. Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

	Note
Events occurring after the end of the reporting period	8.1
Changes in accounting policy	8.2
Key management personnel	8.3
Related party transactions	8.4
Remuneration of auditors	8.5
Supplementary financial information	8.6
Indian Ocean Territories	8.7

8.1 Events occurring after the end of the reporting period

The Office is not aware of any event after the end of the reporting period that may have an impact on the financial statements.

8.2 Changes in accounting policy

The Office has adopted the following new Australian Accounting Standards in accordance with transitional provisions applicable to each standard:

AASB 2021-2 - Amendments to Australian Accounting Standards – Disclosure of Accounting Policies and Definition of Accounting Estimates

AASB 2021-5 - Amendments to Australian Accounting Standards – Deferred Tax related to Assets and Liabilities arising from a Single Transaction

AASB 2021-6 - Amendments to Australian Accounting Standards – Disclosure of Accounting Policies: Tier 2 and Other Australian Accounting Standards

AASB 2021-7b - Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections

AASB 2022-1 - Amendments to Australian Accounting Standards – Initial Application of AASB 17 and AASB 9 – Comparative Information

AASB 2022-7 - Editorial Corrections to Australian Accounting Standards and Repeal of Superseded and Redundant Standards

AASB 2022-8 - Amendments to Australian Accounting Standards – Insurance Contracts: Consequential Amendments

AASB 2023-2 – Amendments to Australian Accounting Standards – International Tax Reform – Pillar Two Model Rules

AASB 2023-4 - Amendments to Australian Accounting Standards – International Tax Reform – Pillar Two Model Rules: Tier 2 Disclosures

The Office considers these standards do not have a material impact on the Office.

8.3 Key management personnel

The Office has determined key management personnel to include cabinet ministers and senior officers of the Office. The Office does not incur expenditures to compensate Ministers and those disclosures may be found in the *Annual Report on State Finances* .

The total fees, salaries, superannuation, non-monetary benefits and other benefits for senior officers of the Office for the reporting period are presented within the following bands:

Compensation band ($)	2024	2023
450,001 - 500,000	1	1
400,001 - 450,000	-	-
350,001 - 400,000	-	-
300,001 - 350,000	-	-
250,001 - 300,000	-	-
200,001 - 250,000	4	6
150,001 - 200,000	2	3
100,001 - 150,000	3	2
50,001 - 100,000	1	1
0 - 50,000	1	-

	2024 $	2023 $
Total compensation of senior officers	**2,181,696**	**2,670,247**

8.4 Related party transactions

The Office is a wholly owned public sector entity that is controlled by the State of Western Australia.

Related parties of the Office include:

- all cabinet ministers and their close family members, and their controlled or jointly controlled entities;
- all senior officers and their close family members, and their controlled or jointly controlled entities;
- other agencies and statutory authorities, including related bodies, that are included in the whole of government consolidated financial statements (i.e. wholly-owned public sector entities);
- associates and joint ventures of a wholly-owned public sector entity; and
- the Government Employees Superannuation Board (GESB).

Material transactions with other related parties

Other than superannuation payments to GESB (Note 2.1 (a)) there were no other related party transactions that involved key management personnel and/or their close family members and/or their controlled (or jointly controlled) entities.

8.5 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit for the current financial year is as follows:

	2024 $	2023 $
Auditing the accounts, financial statements, controls, and key performance indicators	61,600	56,000
	61,600	**56,000**

8.6 Supplementary financial information

(a) Write-offs

During the financial year, $7,352 (2023: $544) was written off under the authority of:

	2024 $	2023 $
The Accountable Authority	7,352	544
	7,352	**544**

(b) Losses through theft, defaults and other causes

There were no losses of public money and public and other property during the period.

(c) Forgiveness of debts

There were no debts waived during the period.

(d) Gifts of public property

There were no gifts of public property provided by the Office during the period.

8.7 Indian Ocean Territories

The Indian Ocean Territories Reimbursement Fund (**the Fund**) was established in March 1996 and became operational in July 1996. The purpose of the Fund is to meet the cost of the services of the Office in relation to complaints involving the Indian Ocean Territories. Any balance of the Fund at the end of the financial year is included in the Office's Operating Account. Any under or over expenditure at the end of the reporting period, for example, due to fluctuations in complaint numbers, is refunded or recouped from the Commonwealth Department of Infrastructure, Transport, Regional Development, Communications and the Arts (**DITRDCA**) in the subsequent reporting period. Where, by agreement with DITRDCA, any funds are retained for expenditure in the next year, this is treated as restricted cash. The figures presented below for the fund have been prepared on a cash basis.

	2024 $	2023 $
Opening Balance	7,653	4,630
Receipts	23,817	29,976
Payments	(34,090)	(26,953)
Closing Balance [(a)]	**(2,620)**	**7,653**

(a) The actual number of complaints received were higher than budget. The contribution from the Office's appropriation will be adjusted by Commonwealth funding in 2024-25.

9. Explanatory statements

This section explains variations in the financial performance of the Office.

	Note
Explanatory statement for controlled operations	9.1

9.1 Explanatory statement for controlled operations

This explanatory section explains variations in the financial performance of the Office undertaking transactions under its own control, as represented by the primary financial statements.

All variances between annual estimates (original budget) and actual results for 2024 and between the actual results for 2024 and 2023 are shown below. Narratives are provided for key major variances which vary more than 10% from their comparative and which are more than 1% of the:

1. Estimate and actual results for the current year:

- Total Cost of Services of the annual estimates for the Statement of comprehensive income and Statement of cash flows (i.e. 1% of $15,620,000), and
- Total Assets of the annual estimates for the Statement of financial position (i.e. 1% of $4,123,000).

2. Actual results between the current year and the previous year:

- Total Cost of Services pf the previous year for the Statements of comprehensive income and Statement of cash flows (i.e. 1% of $12,610,521); and
- Total Assets of the previous year for the Statement of financial position (i.e. 1% of $4,456,280).

9.1.1 Statement of Comprehensive Income Variances

	Variance Note	Estimate 2024 $	Actual 2024 $	Actual 2023 $	Variance between estimate and actual $	Variance between actual results for 2024 and 2023 $
Statement of Comprehensive Income						
Employee benefits expense	A	11,272,000	11,186,618	9,743,632	(85,382)	1,442,986
Supplies and services	1	2,710,000	1,160,877	1,243,895	(1,549,123)	(83,018)
Depreciation and amortisation expense		319,000	243,299	257,348	(75,701)	(14,049)
Accommodation expenses	2	913,000	1,319,548	1,223,173	406,548	96,375
Finance costs		5,000	3,741	1,100	(1,259)	2,641
Other expenses	B	401,000	291,254	141,372	(109,746)	149,882
Total cost of services		**15,620,000**	**14,205,337**	**12,610,521**	**(1,414,663)**	**1,594,816**
Income						
Other Income		2,745,000	2,711,108	2,684,988	(33,892)	26,120
Total Income		**2,745,000**	**2,711,108**	**2,684,988**	**(33,892)**	**26,120**
NET COST OF SERVICES		**12,875,000**	**11,494,229**	**9,925,533**	**(1,380,771)**	**1,568,696**
Income from State Government						
Service appropriation	C	12,435,000	12,481,000	10,944,000	46,000	1,537,000
Resources received	3	440,000	135,481	116,416	(304,519)	19,065
Total income from State Government		**12,875,000**	**12,616,481**	**11,060,416**	**(258,519)**	**1,556,065**
SURPLUS/(DEFICIT) FOR THE PERIOD		**-**	**1,122,252**	**1,134,883**	**1,122,252**	**(12,631)**
OTHER COMPREHENSIVE INCOME		**-**	**-**	**-**	**-**	**-**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**-**	**1,122,252**	**1,134,883**	**1,122,252**	**(12,631)**

Major estimate and actual (2024) variance narratives

1) The variance in supplies and services expense is primarily due to expenses included in accommodation expenses in actual to reflect the nature of expenses more accurately.

2) The variance in accommodation expenses is primarily due to a portion of expenses included in supplies and services in estimate and lower cost of resources received free of charge than estimate.

3) The variance in resources received free of charge is primarily due to lower cost of resources received free of charge than estimate

Major actual (2024) and comparative (2023) variance narratives

A) The variance in employee benefit expenses is primarily due to an increase in salary cost in line with approved additional funding for the various functions delivered by the Office.

B) The variance in other expenses is primarily due to purchase of computer equipment due to the increase in the number of full time equivalent and increase in the audit costs.

C) The variance in service appropriation is primarily due to fund being received for Reportable Conduct Scheme for Western Australia, Oversight by the Parliamentary Commissioner under Part 5AA (Protected Entertainment Precincts) of the Liquor Control Act 1988 and Investigations by the Parliamentary Commissioner under the Charitable Trust Act 2022.

9.1.2 Statement of Financial Position Variances

	Variance Note	Estimate 2024 $	Actual 2024 $	Actual 2023 $	Variance between estimate and actual $	Variance between actual results for 2024 and 2023 $
Statement of Financial Position						
ASSETS						
Current Assets						
Cash and cash equivalents		247,000	3,378,333	1,440,156	3,131,333	1,938,177
Restricted cash and cash equivalents		5,000	-	7,653	(5,000)	(7,653)
Other current assets		16,000	-	-	(16,000)	-
Receivables		460,000	29,594	6,330	(430,406)	23,264
Amounts receivable for services		208,000	208,000	208,000	-	-
Total Current Assets		**936,000**	**3,615,927**	**1,662,139**	**2,679,927**	**1,953,788**
Non-Current Assets						
Restricted cash and cash equivalents		232,000	-	272,507	(232,000)	(272,507)
Receivables		-	349,510	-	349,510	349,510
Amounts receivable for services		2,176,000	2,176,000	2,065,000	-	111,000
Plant and equipment	4	232,000	76,420	122,816	(155,580)	(46,396)
Intangible assets	4	473,000	150,965	284,471	(322,035)	(133,506)
Right-of-use assets		74,000	47,020	49,347	(26,980)	(2,327)
Total Non-Current Assets		**3,187,000**	**2,799,915**	**2,794,141**	**(387,085)**	**5,774**
TOTAL ASSETS		**4,123,000**	**6,415,842**	**4,456,280**	**2,292,842**	**1,959,562**
LIABILITIES						
Current Liabilities						
Payables		449,000	395,657	312,040	(53,343)	83,617
Employee related provisions	5,D	2,104,000	2,459,199	2,033,334	355,199	425,865
Lease liabilities		24,000	3,973	6,391	(20,027)	(2,418)
Contract liabilities	6	144,000	58,422	77,066	(85,578)	(18,644)
Total Current Liabilities		**2,721,000**	**2,917,251**	**2,428,831**	**196,251**	**488,420**
Non-Current Liabilities						
Employee related provisions	5	541,000	403,086	410,868	(137,914)	(7,782)
Lease liabilities		53,000	33,468	34,424	(19,532)	(956)
Contract liabilities	E	-	-	58,422	-	(58,422)
Total Non-Current Liabilities		**594,000**	**436,554**	**503,714**	**(157,446)**	**(67,160)**
TOTAL LIABILITIES		**3,315,000**	**3,353,805**	**2,932,545**	**38,805**	**421,260**
NET ASSETS		**808,000**	**3,062,037**	**1,523,735**	**2,254,037**	**1,538,302**
EQUITY						
Contributed equity		1,706,000	1,704,000	1,288,000	(2,000)	416,000
Accumulated surplus/(deficit)		(898,000)	1,358,037	235,735	2,256,037	1,122,302
TOTAL EQUITY		**808,000**	**3,062,037**	**1,523,735**	**2,254,037**	**1,538,302**

Major estimate and actual (2024) variance narratives

4) The variance in plant and equipment and intangible assets is primarily due to the timing of asset replacement which fluctuates year by year.

5) The variance in employee related provisions is primarily due to the transfer of leave provision of additional employees arising from the new functions for the Office and some staff long service leave liability becoming due during the financial year.

6) The variance in contract liabilities is primarily due to the timing of asset replacement of intangible assets.

Major actual (2024) and comparative (2023) variance narratives

D) The variance in employee related provisions is primarily due to the transfer of leave provision of additional employees arising from the new functions for the Office.

E) The variance in contract liabilities is primarily due to the Office not having a software contract which is longer than two years.

9.1.3 Statement of Cash Flows Variances

	Variance Note	Estimate 2024 $	Actual 2024 $	Actual 2023 $	Variance between estimate and actual $	Variance between actual results for 2024 and 2023 $
Statement of Cash Flows						
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation	F	12,116,000	12,162,000	10,707,000	46,000	1,455,000
Holding account drawdown		208,000	208,000	208,000	-	-
Capital appropriations	G	420,000	416,000	21,000	(4,000)	395,000
Net cash provided by State Government		**12,744,000**	**12,786,000**	**10,936,000**	**42,000**	**1,850,000**
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	H	(11,252,000)	(11,067,040)	(9,647,710)	184,960	(1,419,330)
Supplies and services	7	(1,956,000)	(1,109,817)	(1,183,777)	846,183	73,960
Finance costs		(5,000)	(3,741)	(1,100)	1,259	(2,641)
Accommodation	8	(913,000)	(1,304,579)	(1,210,029)	(391,579)	(94,550)
GST payments on purchases		(271,000)	(275,592)	(248,857)	(4,592)	(26,735)
GST payments to taxation authority		-	(26,288)	(99,175)	(26,288)	72,887
Other payments	9,I	(715,000)	(166,814)	(70,173)	548,186	(96,641)
Receipts						
GST receipts on sales		271,000	279,573	272,630	8,573	6,943
GST receipts from taxation authority		-	-	56,934	-	(56,934)
Other receipts	10,J	2,745,000	3,036,875	2,684,988	291,875	351,887
Net cash provided by (used in) operating activities		**(12,096,000)**	**(10,637,423)**	**(9,446,269)**	**1,458,577**	**(1,191,154)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets	11	(608,000)	(125,144)	(238,645)	482,856	113,501
Net cash provided by (used in) investing activities		**(608,000)**	**(125,144)**	**(238,645)**	**482,856**	**113,501**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Principal elements of lease payments		(20,000)	(15,905)	(21,772)	4,095	5,867
Net cash provided by (used in) financing activities		**(20,000)**	**(15,905)**	**(21,772)**	**4,095**	**5,867**
Net increase/(decrease) in cash and cash equivalents		20,000	2,007,527	1,229,314	1,987,527	778,213
Cash and cash equivalents at the beginning of the period		464,000	1,720,316	491,002	1,256,316	1,229,314
Adjustment for the reclassification of accrued salaries account		-	(349,510)	-	(349,510)	(349,510)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**484,000**	**3,378,333**	**1,720,316**	**2,894,333**	**1,658,017**

Major estimate and actual (2024) variance narratives

7) The variance in supplies and services expense is primarily due to expenses included in accommodation expenses in actual to reflect the nature of expenses more accurately.

8) The variance in accommodation expenses is primarily due to a portion of expenses included in supplies and services in estimate.

9) The variance in other payments is primarily due to a portion of expenses included in other payments for the estimate, being included in accommodation for the actual.

10) The variance in other receipts is primarily due to the recoup of cost from prior year and employee leave transfer.

11) The variance in purchase of non-current assets relates in deferring the implementation of case management system.

Major actual (2024) and comparative (2023) variance narratives

F) The variance in service appropriation is primarily due to fund being received for Reportable Conduct Scheme for Western Australia, Oversight by the Parliamentary Commissioner under Part 5AA (Protected Entertainment Precincts) of the Liquor Control Act 1988 and Investigations by the Parliamentary Commissioner under the Charitable Trust Act 2022.

G) The variance in capital appropriation is primarily due to fund received for case management system.

H) The variance in employee benefit expenses is primarily due to an increase in salary cost in line with approved additional funding for the various functions delivered by the Office.

I) The variance in other payments is primarily due to purchase of computer equipment due to the increase in the number of full time equivalent.

J) The variance in other receipts is primarily due to the recoup of cost from prior year and employee leave transfer

30 June 2024

Key Performance Indicators

Certification of Key Performance Indicators

For year ended 30 June 2024

I hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the Parliamentary Commissioner for Administrative Investigations' performance, and fairly represent the performance of the Parliamentary Commissioner for Administrative Investigations for the financial year ended 30 June 2024.

David Robinson

DEPUTY OMBUDSMAN

Acting as the Ombudsman under section 6A of the *Parliamentary Commissioner Act 1971*

09 August 2024

Key Performance Indicators

Key Effectiveness Indicators

The desired outcome for the Parliamentary Commissioner for Administrative Investigations (**the Ombudsman**) is:

> *The public sector of Western Australia is accountable for, and is, improving the standard of administrative decision making and practices, and relevant entities are accountable for, and are, preventing, notifying and dealing with reportable conduct.*

Key Effectiveness Indicators	2019-20	2020-21	2021-22	2022-23	2023-24 Target	2023-24 Actual
Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies (a)	100%	100%	100%	100%	**100%**	**100%**
Number of improvements to practices or procedures as a result of Ombudsman action (b)	72	109	57	75	**100**	**40**
Where the Ombudsman made recommendations regarding reportable conduct, the percentage of recommendations accepted by relevant entities (c)	Not applicable - the new Reportable Conduct function commenced on 1 January 2023			Not applicable	**100%**	Not applicable
Number of actions taken by relevant entities to prevent reportable conduct (d)	Not applicable - the new Reportable Conduct function commenced on 1 January 2023			26	**51**	**97**

a) For public authority responses each year, the percentage of recommendations and suggestions relating to improved practices and procedures that were accepted by the public authority.

b) For public authority responses each year, the number of recommendations and suggestions relating to improved practices and procedures that were accepted by the public authority.

c) For relevant entity responses each year, the percentage of recommendations regarding reportable conduct that were accepted by the relevant entity.

d) For relevant entity responses each year, the number of actions to prevent reportable conduct taken by relevant entities as a result of the Ombudsman's involvement.

Comparison of Actual Results and Budget Targets

Public authorities have accepted every recommendation made by the Ombudsman, matching the actual results of the past four years and meeting the 2023-24 target.

The 2023-24 actual number of improvements to practices and procedures of public authorities as a result of Ombudsman action (40) is less than the 2023-24 target (100) and the 2022-23 actual (75) as there are fluctuations in improvements from year to year, related to the number, nature and outcomes of investigations finalised by the Office in any given year.

The Reportable Conduct Scheme (the Scheme) for Western Australia commenced on 1 January 2023. There were no recommendations made regarding reportable conduct

in 2023-24, the first full year of the operation of the Reportable Conduct Scheme. The Office's role has been primarily educative, with focus on engaging with agencies to inform them of their reporting and investigation obligations under the Scheme and guide them on drafting and implementing appropriate administrative policies and procedures, prior to undertaking a compliance phase of making recommendations for administrative improvements to already existing systems.

The 2023-24 actual number of actions taken by relevant entities to prevent reportable conduct (97) is more than the 2023-24 target (51) and the 2022-23 actual (26) as this 2023-24 was first full year of the operation of the Reportable Conduct Scheme.

Key Efficiency Indicators

The Ombudsman's Key Efficiency Indicators relate to the following service:

> *Resolving complaints about the decision making of public authorities, improving the standard of public administration, and to oversee and monitor that relevant entities are accountable for, and are, preventing, notifying and dealing with Reportable Conduct.*

Key Efficiency Indicators	2019-20	2020-21	2021-22	2022-23	2023-24 Target	2023-24 Actual
Percentage of allegations finalised within three months	95%	96%	97%	96%	**95%**	**95%**
Percentage of allegations finalised within 12 months	100%	100%	100%	100%	**100%**	**100%**
Percentage of allegations on hand at 30 June less than three months old	92%	87%	96%	93%	**90%**	**88%**
Percentage of allegations on hand at 30 June less than 12 months old	99%	100%	100%	100%	**100%**	**100%**
Average cost per finalised allegation (a)	$1,858	$1,885	$1,749	$1,547	**$1,890**	**$1,314**
Average cost per finalised notification of death (b)	$17,926	$17,565	$17,097	$8,415	**$14,655**	**$11,571**
Average cost per notification of reportable conduct (c)	Not applicable - the new Reportable Conduct function commenced on 1 January 2023			$6,027	**$6,000**	**$3,687**
Cost of monitoring and inspection functions (d)	$408,008	$407,486	$516,576	$735,183	**$1,168,000**	**$1,000,679**

a) This is the cost of complaint resolution services divided by the number of allegations finalised.
b) This is the cost of undertaking the death review function divided by the number of notifications finalised.
c) This is the cost of reportable conduct services divided by the number of notifications received.
d) This is the cost of monitoring and inspection functions under relevant legislation.

Comparison of Actual Results and Budget Targets

The 2023-24 actual results for timeliness Key Efficiency Indicators met or were close to the 2023-24 target.

The 2023-24 actual average cost per finalised allegation ($1,314) is lower than the 2023-24 target ($1,890) and 2022-23 actual ($1,547) due to increased efficiencies driven by staff vacancies.

The 2023-24 actual average cost per finalised notification of death ($11,571) is lower than the 2023-24 target ($14,655) but higher than the 2022-23 actual ($8,415) as a result of the Ombudsman concluding a program to finalise a number of notifications received since the commencement of a new jurisdiction to review all child deaths that occur in Western Australia. This resulted in an increase in the number of notifications finalised in 2022-23, and a subsequent reduction in the average cost per notification, which, as predicted by the 2023-24 target, increased to a level expected for the volume of notifications going forward.

The 2023-24 actual cost per notification of reportable conduct ($3,687) is less than the 2023-24 target ($6,000) and the 2022-23 actual ($6,027) as a result of higher number of notifications received in 2023-24, the full year of the Scheme's operation.

The 2023-24 actual cost of monitoring and inspection functions ($1,000,679) is less than the 2023-24 target ($1,168,000) and higher than 2022-23 actual ($735,183) as a result of the commencement of, and funding for, a new function for the Ombudsman under amendments to the *Liquor Control Act 1988* which commenced part-way through 2022-23.

Other Disclosures and Legal Compliance

Ministerial Directives

The Ombudsman reports directly to the Western Australian Parliament rather than to the government of the day, or a particular Minister, and Ministers cannot issue directives to the Ombudsman.

Other Financial Disclosures

Pricing policies of services provided

The Office currently receives revenue for the following functions:

- Costs for the Energy and Water Ombudsman functions are recouped from the Energy and Water Ombudsman (Western Australia) Limited on a full cost recovery basis. These costs are determined by the actual staffing costs involved in delivering the service plus an allowance for overheads and costs of particular operational expenses; and
- Under an arrangement with the Australian Government, the Office handles enquiries and complaints from the Indian Ocean Territories about local governments and Western Australian public authorities delivering services to the Indian Ocean Territories. Each year the Office recoups costs from the Australian Government for any complaints received from the Indian Ocean Territories. Cost recovery is based on the average cost per complaint in the last two years as published in the Office's annual reports. Administrative costs and the costs of any travel to the Indian Ocean Territories by the Ombudsman or staff and any promotional materials are also recouped in full.

Capital works

There were no major capital projects undertaken during 2023-24.

Employment of staff

As at 30 June 2024, there were 92 people (81.9 full-time equivalent positions (**FTEs**)) directly employed by the Office, including 64 full-time employees and 28 part-time employees. This includes people on unpaid leave, contract staff providing short term expertise and backfilling staff during extended leave periods and people seconded out of the Office.

All employees are public sector employees operating in executive, policy, enquiry, investigation and administrative roles. The following table provides a breakdown of the categories of employment for staff directly employed by the Office as at 30 June in 2022-23 and 2023-24.

Employee Category	2022-23	2023-24
Full-time permanent	51	57
Full-time contract	7	7
Part-time permanent	24 (14.7 FTEs)	26 (16.9 FTEs)
Part-time contract	2 (1.5 FTEs)	2 (1.0 FTE)
TOTAL	**84 (74.2 FTEs)**	**92 (81.9 FTEs)**

Human resources strategies and staff development

In 2023-24, the Office continued implementation of the Office's *Aboriginal Action Plan*, which includes a range of strategies to enhance the Office's services for, and engagement with, Aboriginal Western Australians. Employment was recognised as a key area of focus, and actions in the *Aboriginal Action Plan* relating to employment include recruitment, retention and professional development for Aboriginal staff. The Office also continued to implement the workforce strategies in its *Disability Access and Inclusion Plan 2020-2025* and committed to further diversity strategies through its *Workforce and Diversity Plan 2021-2026* and *Multicultural Plan 2021-2025*.

In accordance with Commissioner's Instruction 40: Ethical Foundations, the Office implemented an Integrity Framework, which included a review of all integrity related policies and procedures and all staff were required to familiarise themselves with the updated Code of Conduct policy.

- *Accounting for individual performance*

  The Office's performance management system was reviewed and updated and includes identifying expectations as well as performance-based recognition. Managers and staff annually formalise a performance agreement that provides a framework to:

  - Identify and acknowledge the contribution employees make in the achievement of the Office's operational and strategic goals; and
  - Develop and retain skilled employees and assist employees to achieve their professional and personal career aspirations.

- *Continual learning*

  The Office implemented a new online learning and development platform, which is available to all staff.

  The Learning and Development platform provides staff with high-quality professional and personal development and training opportunities that are relevant

and accessible at any time. The online learning platform includes a comprehensive induction training module as well as mandatory training modules for staff. The Staff Support Program continued to be delivered to all staff during 2023-24. Sessions included EEO Law and Workplace Culture, Health and Wellbeing, Countering Foreign Intelligence and Disability Awareness. In addition to in-house development, staff are encouraged to attend external training, conferences and seminars to improve their skills and knowledge in areas relevant to their work. These opportunities are facilitated through development plans as part of staff annual performance reviews, and the continual learning assists with positioning the Office as an employer of choice.

- *A safe and healthy workplace*

  The Work Health and Safety management system, plan, policy and procedures were reviewed and updated to align with the *Work Health and Safety Act 2020*. More information is in the Work health, safety and injury management section.

During the year, the Proactive Wellbeing Strategy was rolled out to all divisions in the Office. The Strategy is a proactive and preventative approach to supporting individual wellbeing by considering the unique challenges faced in the working environment and job roles, and how personal life intersects with this. All staff were offered an initial 90-minute Preventative Wellbeing Coaching session.

The Office continued delivering on key focus areas of the *Workforce and Diversity Plan 2021-2026* (**the Workforce Plan**). with:

- Reviewing the Recruitment Policy and Procedures to recruit high-quality staff, in particular for new functions;
- Attracting and retaining high-quality staff, including enabling flexible working arrangements and through offering internships and seasonal clerkship programs;
- Providing staff development through quality induction, performance management, our Staff Support Program, internal and external training, and study assistance;
- Promoting diversity in the workforce for people from diverse cultural backgrounds, people from Aboriginal and Torres Strait Islander backgrounds, and for people with disability;
- Implementing the strategies in the Office's *Disability Access and Inclusion Plan 2020-2025*, *Aboriginal Action Plan* and *Multicultural Plan 2021-2025*;
- Reviewing and updating the suite of human resource policies in line with the Office's strategies and with guidance provided by the relevant external agencies and staff feedback processes; and
- Providing Corporate Executive with workforce reporting to support evaluation and ongoing review of the strategies in the *Workforce and Diversity Plan*.

Unauthorised use of credit cards

Staff of the Office hold corporate credit cards where their functions warrant the use of this facility.

The Office has robust policies and procedures regulating credit card use, and the use of a credit card for personal purposes is prohibited.

Despite each cardholder being reminded of their obligations annually under the Office's credit card policy, in 2023-24 three employees inadvertently use the corporate credit card for personal expenses. The matter was not referred to disciplinary action as the Chief Finance Officer noted prompt advice and settlement of the personal use amount and that the nature of the expenditures was immaterial and characteristic of an honest mistake.

Personal Use of Credit Cards	2023-24
Number of instances the Western Australian Government Purchasing Cards have been used for personal purposes	3
Aggregate amount of personal use expenditure.	$383
Aggregate amount of personal use expenditure settled by the due date (within 5 working days).	$383
Aggregate amount of personal use expenditure settled after the due date (after 5 working days).	Nil
Aggregate amount of personal use expenditure outstanding at 30 June 2023.	Nil
Number of referrals for disciplinary action instigated by the notifiable authority during the reporting period.	Nil

Other Legal Requirements

Expenditure on advertising, market research, polling and direct mail

In accordance with the *Electoral Act 1907* section 175ZE, the Office is required to report on expenditure incurred in relation to advertising agencies, market research, polling (surveys), direct mail and media advertising organisations. The expenditure incurred in relation to those matters in 2023-24 was $17,729 (Excluding GST) for recruitment advertising and promoting regional visits.

Category of expenditure	Company	Total
Advertising	Initiative Media Australia Pty Ltd	$ 17,330
	Meta	$ 399
Media advertising		Nil
Market research		Nil
Polling		Nil
Direct mail		Nil
Total		**$ 17,729**

Disability Access and Inclusion Plan outcomes

The Office is committed to providing optimum access and service to people with disability, their families and carers. In 2023-24, the Office continued to implement the strategies under its *Disability Access and Inclusion Plan 2020-2025* (**DAIP**). Current initiatives to address desired DAIP outcomes are shown below.

Outcome 1: People with disability have the same opportunities as other people to access the services of, and any events organised by, the Office.

People can access the complaint handling services provided by the Office by lodging a complaint in various ways including by post, email, online and in person. The online option is available through the Office's website, which meets the website accessibility requirements set out in the *Accessibility and Inclusivity Standard* under the *Western Australia Whole of Government Digital Services Policy*.

Staff ask and record where a person making a complaint to the Office is experiencing disability and, if so, record whether the person with disability requires any assistance to access the Office's services.

The Office is accessible for people with disability who attend in person, and enquiries can be made by telephone using the National Relay Service for people with voice or hearing impairments. Venues for events and meetings are assessed for suitable access for people with disability and dietary requirements are appropriately catered. Organisations that provide information and support to people with disability are specifically informed about the Office's activities as part of its Regional Awareness and Accessibility Program.

In 2023-24, approximately 23.9% of people accessing the Office's complaint handling service were people with disability, compared to 16.4% in the population.

Outcome 2: People with disability have the same opportunities as other people to access the buildings and other facilities of the Office.

The Office's accommodation, building and facilities provide access for people with disability, including lifts that accommodate wheelchairs and feature braille on the access buttons. Accessible and ambulant toilets are located on all floors used by the Office (the Ground Floor, Level 2 and Level 3), and a low reception desk on Level 2 accommodates wheelchair access. The building also includes electronic doors at the entrance and through to the lifts, a ramp at the front of the building, and a disabled parking bay beneath the building.

Outcome 3: People with disability receive information from the Office in a format that will enable them to access the information as readily as other people are able to access it.

All Office documents are in plain English and publications are available in alternative formats on request. The Office's website meets the website accessibility requirements set out in the *Accessibility and Inclusivity Standard* under the *Western Australia Whole of Government Digital Services Policy*. Online documents are published in PDF format, and correspondence can be sent by email and is scanned with Optical Character Recognition to PDF format, compatible with screen reader technology. In 2023-24, the Office commenced the development of an Easy Read booklet and issued a new brochure and poster for the Energy and Water Ombudsman which were checked to ensure they met a lower reading level.

Phone access is available through the National Relay Service for people with voice or hearing impairments calling the Office, and signs are provided in the reception area to assist visitors who have a hearing impairment.

The Office's Energy and Water Ombudsman website also features Browsealoud, a text-to-speech tool that assists people with low literacy or vision impairments to access the information on the website.

Outcome 4: People with disability receive the same level and quality of service from the staff of the Office as other people receive from the staff of the Office.

The services provided by the Office have been adapted to reduce access barriers for people with disability and information is available in various formats on request. The Office has an internal guideline for staff on *Assisting complainants with vision, hearing or speech impairments*. The document is part of the internal Complaint Handling Toolkit and provides useful information, contacts and procedures for all staff when dealing with a complainant with disability.

In 2023-24, staff received training in *Communication Disability*, which included a presentation by a person with lived experience with disability who uses an alternative and augmentative communication (AAC) device. All new staff are asked to complete the *Disability Awareness* online training module produced by the Australian Government as part of their induction, along with information about the Office's DAIP and a video on providing services to people with disability, *You Can Make A Difference* produced by the (then) Disability Services Commission.

Outcome 5: People with disability have the same opportunities as other people to make complaints to the Office.

A key role of the Office is to handle complaints about public authorities and anyone with disability has an equal opportunity to make a complaint. Where necessary, the complaint process is modified to meet the needs of a person with disability. This includes meeting people outside the Office and modifying communication strategies; for example, by using an interpreter (such as the National Relay Service or Auslan interpreter) where required.

Information on reviews of decisions in relation to complaints to the Ombudsman and making a complaint about the Ombudsman's other services is accessible from the website and is available in alternative formats.

Outcome 6: People with disability have the same opportunities as other people to participate in any public consultation by the Office.

Staff and members of the public with disability have an equal opportunity to participate in any consultation process of the Office. Any public consultation conducted by the Office and promoted on the website meets disability access requirements. Documents released for public consultation can also be made available in alternative formats to meet the needs of people with disability.

In 2023-24, the Office commenced a project that included a survey of disability organisations in Western Australia regarding their systems for handling reportable conduct. The outcome of this project will increase awareness of the Reportable Conduct Scheme and promote the safety of children and young people with disability.

Outcome 7: People with disability have the same opportunities as other people to obtain and maintain employment with the Office.

The Office's accommodation, building and facilities provide access for people with disability, including lifts and walkways that accommodate wheelchairs and feature braille on the access buttons. Accessible and ambulant toilets are located on all floors used by the Office. The Office also provides suitable equipment to enable employees with vision impairments to access electronic information.

People with disability are encouraged to apply for positions in the Office and recruitment processes are modified as required to enable people with disability to have the same opportunity as other people to compete on merit for advertised positions. The Office monitors the proportion of applicants with disability to ensure its recruitment processes are accessible. A report on the proportion of applicants and proportion of staff reporting disability is provided to the Office's Corporate Executive.

Appropriate modifications are made to the duties undertaken, hours of work and/or equipment required to enable employees with disability, or who acquire disability, to maintain productive employment with the Office.

Compliance with Public Sector Standards and Ethical Codes

In the administration of the Office, the Ombudsman has complied with the *Public Sector Standards in Human Resource Management*, the *Code of Ethics* and the Office's *Code of Conduct*.

Procedures designed to ensure such compliance have been put in place and appropriate internal assessments are conducted to satisfy the Ombudsman that the above statement is correct.

The following table identifies action taken to monitor and ensure compliance with public sector standards and ethical codes.

Significant action to monitor and ensure compliance with Western Australian Public Sector Standards
Managers and staff are aware of, and are required to comply with, the *Public Sector Standards in Human Resource Management* (**the Standards**). This is supported by policies and procedures relating to the Standards, regular professional development for managers and staff about the Standards and related policies, and the inclusion of the policies in the induction process. Monitoring provisions include: • For recruitment, selection and appointment, an individual review of each process is undertaken prior to the final decision to ensure compliance with the *Employment Standard*; • A review process to ensure that, for acting opportunities and secondments, a merit-based process is used and there are no inadvertent extensions that result in long-term opportunities without expressions of interest or a full merit selection process; • A monitoring process to ensure there are current performance management processes in place for all employees; and • The continuous development of policies and procedures in accordance with the Standards to ensure compliance and relevancy. **Compliance issues:** Internal reviews have shown compliance with the Standards is achieved before any final decision is made. There have been no breaches found of the Standards.

Significant action to monitor and ensure compliance with the *Code of Ethics* and the Office's *Code of Conduct*

The *Code of Ethics* and the Office's *Code of Conduct* (**Ethical Codes**) are available on the Office's intranet and are part of the Online Induction for new staff. *Guidelines for Ethical and Accountable Decision Making* were reviewed and are a ready reference for staff when dealing with situations related to the Ethical Codes. An Accountable and Ethical Decision Making (**AEDM**) online training module was created and all existing staff were enrolled to refresh their training. All new staff are required to complete the AEDM as part of their Induction program.

The Office's *Code of Conduct* supports the Commissioner's Instruction No. 40: Ethical Foundations and links the Office's corporate values with expected standards of personal conduct. All staff, contractors and consultants who carry out work for, or on behalf of, the Office are required to comply with the spirit of the *Code of Conduct.* On appointment, all staff sign the *Code of Conduct* to confirm their understanding of its application in the workplace and swear an oath or make an affirmation about maintaining appropriate confidentiality. Seventy-nine per cent of staff have acknowledged the updated Code of Conduct issued in September 2023.

Ethics and conduct related policies and procedures are in place for declaring and managing conflicts of interest and gifts, benefits and hospitality. The Ethical Codes and related policies are included in the induction process and there is regular professional development for managers and staff about the Ethical Codes. and the Performance Management and Development process references conduct matters as an expectation of all Ombudsman staff.

The Office has procedures in place for reporting unethical behaviour and misconduct. The Office also has a policy and internal procedures relating to *Public Interest Disclosures* and strongly supports disclosures being made by staff.

Monitoring provisions for Ethical Codes include:

- High level review, and Ombudsman, Deputy Ombudsman or Principal Assistant Ombudsman sign-off, for management of conflicts of interest and gifts, benefits and hospitality, as well as reviews each year by the Deputy Ombudsman of the registers of conflicts of interest and gifts, benefits and hospitality to determine if there are any patterns or trends that need action by the Office;
- High level consideration and sign-off of requests for review of the Office's handling of a complaint and any complaints about the conduct of staff; and
- Seeking opportunities to improve current practices through internal audits and reviewing policies and procedures to ensure compliance and relevancy. Internal audits conducted each year are referred to the Office's Internal Audit Committee and Risk Management Committee.

Compliance issues: There has been no evidence of non-compliance with the Ethical Codes.

Recordkeeping Plans

The Office is committed to maintaining a strong records management framework and aims for best practice recordkeeping practices. The Office is continuously improving recordkeeping practices to ensure they are consistent with the requirements of the *State Records Act 2000* and meet the needs of the Office for high quality recordkeeping. The Office's framework includes:

- A *Recordkeeping Plan*, a *Retention and Disposal Schedule*, a *Records Management Policy*, a *Records File Classification Plan and Security Framework* and a *Records Disaster Recovery Plan*;
- Content Manager, the Office's electronic document records management system (**EDRMS**)
- RESOLVE the Office's electronic case management system for managing complaints in the Ombudsman and Energy and Water Ombudsman jurisdictions; and
- A series of guidelines and a user manual, together with an online training module, are made available to staff.

Work commenced on an upgrade to Version 10.1 of Content Manager to further integrate Recordkeeping functionality into workflows present within the Office.

Evaluation and review of efficiency and effectiveness of systems and training

The Office's Retention and Disposal Schedule for Functional Records was approved by the State Records Commission on 13 May 2022, and subsequently implemented in the EDRMS.

The efficiency and effectiveness of the recordkeeping training program is reviewed regularly through monitoring staff use of the EDRMS to ensure that staff are following the recordkeeping requirements of the Office. As part of a program of regular reviews of the effectiveness of the Office's recordkeeping systems, the results of staff recordkeeping surveys are used to develop targeted training and other programs to address common themes across the Office.

Induction and training

All records-related plans, policies, guidelines and manuals are available on the Office's intranet to assist staff to comply with their recordkeeping requirements and include user friendly guides for training staff.

The Office's Online Induction within the Learning Management platform includes a recordkeeping training module. This is part of the induction process for new staff and is also available as a resource for existing staff members. The induction process also includes individual training sessions with new staff members conducted by the Records and Customer Service Manager. Recordkeeping roles and responsibilities are also included in *Accountable and Ethical Decision Making* training and the Office's *Code of Conduct*, which is signed by all staff on appointment.

Government Policy Requirements

WA Multicultural Policy Framework

In 2020-21, the Office developed its *Multicultural Plan 2021-2025* (**Multicultural Plan**). The strategies in the Multicultural Plan are aligned with the Government's Western Australian Multicultural Policy Framework for the Western Australian public sector. The Multicultural Plan is a four-year plan and will act as a key strategic document to guide the Office's service responsiveness, employment opportunities and community outputs for people of CaLD backgrounds.

Below is a summary of the Office's key achievements under its Multicultural Plan in 2023-24.

Policy priority 1: Harmonious and inclusive communities
To increase the cultural competency skills of staff, the *Diverse WA* online module produced by the Office of Multicultural Interests and the Public Sector Commission's Aboriginal and Torres Strait Islander cultural awareness online training are part of the induction of all new staff. As at 30 June 2024, 75% of all staff have completed both online training modules. The Office supports an inclusive workplace. In 2023-24, the Office's Equity, Diversity and Inclusion (**EDI**) Council developed a calendar of events that are important to CaLD communities. Key events were promoted to staff. In October 2023, the Office's EDI Council held an interactive staff development session which promoted diversity and inclusion.
Policy priority 2: Culturally responsive policies, programs and services
The Office captures cultural and linguistic data about its staff and about people who access the Office's services to monitor representation of diversity groups, including people from CaLD backgrounds. In 2023-24, the Office continued to collect country of birth information from staff and report the results to the Corporate Executive. Staff ask for, and record, information about country of birth and language so that the Office can continually assess accessibility to its services for people from CaLD backgrounds. The Office is developing and enhancing its recruitment strategies to improve representation of employees from CaLD backgrounds. In 2023-24, job advertisements and recruitment documents were amended to emphasise the Office's commitment to diversity and to encourage job applications from people of CaLD backgrounds. The Office is increasing its engagement with, and access for, CaLD communities. In 2023-24, the Office sent information about its regional visits to organisations that work with CaLD communities.

Policy priority 3: Economic, social, cultural, civic and political participation
The Office is developing initiatives that support people from CaLD backgrounds to enter leadership positions. In 2023-24, the Office monitored representation of people from CaLD backgrounds across employment levels.

Work health, safety and injury management

Commitment to work health and safety and injury management

The Office is committed to ensuring a safe and healthy workplace. The goal is for a workplace that is free from work-related injuries and diseases by developing and implementing safe systems of work and by continuing to identify hazards and control risks as far as practicable.

The Office maintains a Work Health and Safety (**WHS**) framework that includes:

- Safe work practices;
- Managing and reporting workplace hazards, incidents and injuries;
- Injury management, including a Return to Work Program that extends to non-work related injuries;
- Emergency procedures;
- Trained first aid officers and regular checks of first aid supplies; and
- General employee health and wellbeing, including an Employee Assistance Program.

All employees are made aware of their WHS responsibilities through mandatory online training. The Office's WHS policies and guidelines are also accessible to employees through the Office's intranet.

There is a strong executive commitment to the health, safety and wellbeing of staff. Hazards and other issues relating to health, safety and wellbeing can be raised with elected WHS representatives or directly with a member of the Corporate Executive, and key issues are brought to the attention of the Ombudsman, who is committed to their prompt and effective resolution.

Consultation

The Office promotes a consultative environment in which management, staff and other stakeholders work together to continually improve WHS practices. Formal mechanisms for consultation with employees and others on WHS matters include:

- The Office has WHS responsibilities within its tenancy and also works closely with the building management at Albert Facey House to ensure a safe working environment is maintained;
- The Office has an elected WHS Representative who acts as an important link between management and staff, so that they can work together and arrive at solutions to make the workplace safe;
- The Staff Consultative Committee has WHS responsibilities and the Office's WHS Representative is a standing member of the Committee. WHS matters are a

standing item on the agenda to allow Committee members to refer matters raised by staff to the Committee for resolution and inform their team of issues and safe working practices raised at Committee meetings;

- The Management Consultative Committee has WHS as a standing item on its agenda and managers receive training in their WHS responsibilities;
- There is dissemination of WHS information and discussion at team meetings; and
- There is training on WHS matters for both management and staff.

Statement of compliance

The Office complies with the injury management requirements of the *Workers' Compensation and Injury Management Act 1981* and is committed to providing injury management support to all workers who sustain a work related injury or illness with a focus on a safe and early return to their pre-injury/illness position. Rehabilitation support is also provided to employees with non-work related injuries or when recovering from a protracted illness.

As part of this approach, the Office encourages early intervention in injury management, and ensures there is early and accurate medical assessment and management of each injury, work related or not.

Assessment of WHS systems

The Office has implemented a *WHS Management Plan* in accordance with the *Work Health and Safety Act 2020*, which includes guidelines detailing WHS roles and responsibilities within the Office and outlining the approach to identify, assess and control hazards and the associated risks. The Office's WHS systems are included in the Internal Audit Program.

Internal evaluation of the accommodation at Albert Facey House is ongoing and workplace inspections are undertaken regularly by the Office's elected WHS Representatives. Any WHS changes identified are promptly addressed.

There is ongoing review of the Office's emergency procedures, including for dealing with unreasonable conduct by visitors to the Office, and there are regular trial evacuations of Albert Facey House, where fire alarms are activated and all staff within the building are evacuated for drill purposes.

Annual performance

During 2023-24, no workers' compensation claims were recorded. The Office's WHS and injury management statistics for 2023-24 are shown below.

	Actual Results			Results Against Target	
Measure	**2021-22 Actual**	**2022-23 Actual**	**2023-24 Actual**	**2023-24 Target**	**Comment on Result**
Number of fatalities	0	0	0	0	Target achieved
Lost time injury/disease (LTI/D) incidence rate	0	0	0	0	Target achieved
Lost time injury/disease severity rate	0	0	0	0	Target achieved
Percentage of injured workers returned to work within (i) 13 weeks; and (ii) 26 weeks.	NA	NA	NA	Greater than or equal to 80% return to work within 26 weeks	NA
Percentage of managers and supervisors trained in work health and safety and injury management responsibilities.	100%	100%	73%	>80%	Target not achieved

Appendices

This page has been intentionally left blank.

Appendix 1 – Complaints Received and Finalised

		Complaints finalised at assessment				Complaints finalised at investigation				
	Total Complaints Received in 2023-24	Issue not in jurisdiction	More appropriate body to handle complaint	Referred back to the public authority	Investigation not warranted	Resolved	Sustained	Not sustained, cannot be determined, or discontinued	Withdrawn	**Total Complaints Finalised in 2023-24**
PUBLIC SECTOR										
Biodiversity, Conservation and Attractions, Department of	10	2	1	2	2	3				10
Central Regional TAFE	1		2							2
Child and Adolescent Health Service	6		5	1						6
Communities, Department of	275	15	20	66	29	136		3	5	274
Construction Training Fund	1					1				1
Department of Energy, Mines, Industry Regulation and Safety	26	2	9	5	3	6			2	27
DevelopmentWA	1									
East Metropolitan Health Service	17	2	13	1					1	17
Economic Regulation Authority			1							1
Education, Department of	52	2	11	6	7	15				41
Finance, Department of	17		3		1	7			3	14
Fire and Emergency Services, Department of	2			1				1	1	3
Fremantle Port Authority	2	1								1
Gold Corporation	3	1		1		1				3
Government Employees Superannuation Board (GESB)	1		1							1
Health and Disability Services Complaints Office	12	2		5	2	2				11
Health, Department of	8	2	5			4				11
Horizon Power	1					1				1
Insurance Commission of Western Australia	7		4	1	1	3				9
Jobs, Tourism, Science and Innovation, Department of	5	2	1	2						5
Justice, Department of	247	13	50	69	34	63		1	6	236
Landgate	7	1	1	2	3	2			1	10
Legal Aid WA	6			3	2	1				6
Legal Practice Board	12			3	3	2		1		9
Legal Services and Complaints Committee	3	1		1		2				4
Local Government, Sport and Cultural Industries, Department of	3		1	1						2

		Complaints finalised at assessment				Complaints finalised at investigation				
	Total Complaints Received in 2023-24	Issue not in jurisdiction	More appropriate body to handle complaint	Referred back to the public authority	Investigation not warranted	Resolved	Sustained	Not sustained, cannot be determined, or discontinued	Withdrawn	Total Complaints Finalised in 2023-24
Lotteries Commission	2		1							1
Main Roads Western Australia	13	3	5	1	2	2				13
Mental Health Commission	1			1						1
Mental Health Tribunal	1									
Metropolitan Cemeteries Board	5	1	1			1		1		4
North Metropolitan Health Service	14		8	1	3	3				15
North Metropolitan TAFE	5			2	2	1		1		6
Planning, Lands and Heritage, Department of	15	3	3	3	3	2		1		15
Primary Industries and Regional Development, Department of	6	1	3	1	3			1		9
Prisoners Review Board	1		1							1
Public Advocate	24	1	1	11	4	3				20
Public Transport Authority	20		4	2	1	12				19
Public Trustee	56	5	5	18	12	10			2	52
Radiological Council	1					1				1
SERCO - Acacia Prison	29	4	5	11	4	6				30
Small Business Development Corporation	10	1		1	1	12				15
South Metropolitan Health Service	12	1	9		1					11
South Metropolitan TAFE	6		1	4					1	6
South Regional TAFE	2		1							1
Teacher Registration Board	1				1					1
Training Accreditation Council			1							1
Training and Workforce Development, Department of	2			1	1					2
Transport, Department of	81	4	8	19	10	34			5	80
Veterinary Practice Board of Western Australia	2		1			1				2
WA Country Health Service	8		6	1	1	1				9
Water and Environmental Regulation, Department of	14	2	1	5	3	1			1	13
Western Australia Police Force	126	9	40	52	9	11				121
Western Australian Electoral Commission	2	1			1					2
Western Power Corporation	1			1						1
Workcover	4		1	1	1				1	4
TOTAL PUBLIC SECTOR COMPLAINTS	**1,189**	**82**	**234**	**306**	**150**	**350**	**0**	**10**	**29**	**1,161**

		Complaints finalised at assessment				Complaints finalised at investigation				
	Total Complaints Received in 2023-24	Issue not in jurisdiction	More appropriate body to handle complaint	Referred back to the public authority	Investigation not warranted	Resolved	Sustained	Not sustained, cannot be determined, or discontinued	Withdrawn	Total Complaints Finalised in 2023-24
LOCAL GOVERNMENT										
Albany, City of	2			1						1
Armadale, City of	9			4	2	3				9
Ashburton, Shire of	1									
Augusta / Margaret River, Shire of	6	1	1	1	1			1		5
Bassendean, Town of	3			1		2				3
Bayswater, City of	12		4	1	2	3				10
Belmont, City of	10		1	4		4			1	10
Beverley, Shire of	1			1						1
Bridgetown / Greenbushes, Shire of						1				1
Broome, Shire of	1			1						1
Bruce Rock, Shire of	1			1						1
Bunbury, City of	3		1	1		1				3
Busselton, City of	8		2	2		2				6
Cambridge, Town of	3					4				4
Canning, City of	4			2		1				3
Carnarvon, Shire of	1					1				1
Chittering, Shire of	2			1	1	1				3
Claremont, Town of	1	1								1
Cockburn, City of	11	3	2	1		3		2		11
Cocos (Keeling) Islands, Shire of	6	1		2		3				6
Coolgardie, Shire of	2					1				1
Corrigin, Shire of			1							1
Cottesloe, Town of	4	1	1		1	2				5
Dandaragan, Shire of	2				1			1		2
Dardanup, Shire of	1								1	1
Denmark, Shire of	2		1							1
Donnybrook / Balingup, Shire of	1									
East Fremantle, Town of	1	1								1
East Pilbara, Shire of	2		2							2
Esperance, Shire of	1		1							1
Exmouth, Shire of						1				1
Fremantle, City of	11		6	2	1	4				13
Gingin, Shire of	2	1		1						2
Gosnells, City of	8			3	1	5				9
Greater Geraldton, City of	5		2			2				4
Harvey, Shire of	1									
Joondalup, City of	10	2	1	2	1	8		1		15
Kalamunda, City of	11	1	2	1	3					7
Kalgoorlie / Boulder, City of	3		1	2						3
Karratha, City of						1				1
Kondinin, Shire of	1				1					1
Kwinana, City of	5		1	1	2					4
Mandurah, City of	10		6	2	1	2				11
Meekatharra, Shire of	2			1		1				2
Melville, City of	8		4			3				7
Mosman Park, Town of						1				1

		Complaints finalised at assessment				Complaints finalised at investigation				
	Total Complaints Received in 2023-24	Issue not in jurisdiction	More appropriate body to handle complaint	Referred back to the public authority	Investigation not warranted	Resolved	Sustained	Not sustained, cannot be determined, or discontinued	Withdrawn	Total Complaints Finalised in 2023-24
Mt. Marshall, Shire of	1					1				1
Mundaring, Shire of	5			1		4			1	6
Murray, Shire of	2	1			1					2
Narrogin, Shire of						1				1
Nedlands, City of	3	1	2			2				5
Northam, Shire of	4	1		2		1				4
Northampton, Shire of	1		1							1
Perth, City of	20		16	2	2					20
Plantagenet, Shire of	1			1		1				2
Port Hedland, Town of	1			1		1				2
Ravensthorpe, Shire of			1							1
Rockingham, City of	7	1	3	1	3	2			1	11
Serpentine / Jarrahdale, Shire of	3		2		1					3
Shark Bay, Shire of	2		1							1
South Perth, City of	8	1	2			4				7
Stirling, City of	32	1	6	3	3	13			1	27
Subiaco, City of	1		1			1				2
Swan, City of	26	1	5	4	3	9		2		24
Three Springs, Shire of	1			1						1
Toodyay, Shire of	2		1	1	2					4
Victoria Park, Town of	10	1	1	1	4	5				12
Vincent, City of	5		3	1	1					5
Wanneroo, City of	11		3		2	6				11
York, Shire of	1	1								1
TOTAL LOCAL GOVERNMENT COMPLAINTS	**325**	**21**	**88**	**58**	**40**	**111**	**0**	**7**	**5**	**330**

	Total Complaints Received in 2023-24	Complaints finalised at assessment				Complaints finalised at investigation				Total Complaints Finalised in 2023-24
		Issue not in jurisdiction	More appropriate body to handle complaint	Referred back to the public authority	Investigation not warranted	Resolved	Sustained	Not sustained, cannot be determined, or discontinued	Withdrawn	
UNIVERSITIES										
Curtin University	37	4	2	8	5	5		7	2	33
Edith Cowan University	31	1	2	9	8	3		8	1	32
Murdoch University	11		1	2	4	3				10
University of Notre Dame	2	2								2
University of Western Australia	20		3	6	4	3		6	3	25
TOTAL UNIVERSITIES	**101**	**7**	**8**	**25**	**21**	**14**	**0**	**21**	**6**	**102**
AGENCIES OUT OF JURISDICTION										
Organisation not identified	2				3					3
Agencies out of jurisdiction	820	98	723							821
TOTAL AGENCIES OUT OF JURISDICTION	**822**	**98**	**723**		**3**					**824**
TOTAL COMPLAINTS										
Total complaints about agencies in jurisdiction	1,615	110	330	389	211	475		38	40	1593
Total complaints about agencies out of jurisdiction	822	98	723		3					824
GRAND TOTAL	**2,437**	**208**	**1,053**	**389**	**214**	**475**	**0**	**38**	**40**	**2417**

Appendix 2 – Legislation

Principal Legislation

- *Parliamentary Commissioner Act 1971*

Legislation and Other Instruments Governing Other Functions

Charitable Trusts	• *Charitable Trusts Act 2022*
Complaints and appeals by overseas students	• *National Code of Practice for Providers of Education and Training to Overseas Students 2018*
Public Interest Disclosures	• *Public Interest Disclosure Act 2003*
Complaints from residents of the Indian Ocean Territories	• *Indian Ocean Territories (Administration of Laws) Act 1992* • *Christmas Island Act 1958* (Commonwealth) • *Cocos (Keeling) Islands Act 1955* (Commonwealth)
Complaints from persons detained under terrorism legislation	• *Terrorism (Preventative Detention) Act 2006*
Inspection of Telecommunications Interception records	• *Telecommunications (Interception and Access) Act 1979* (Commonwealth) • *Telecommunications (Interception and Access) Western Australia Act 1996* • *Telecommunications (Interception and Access) Western Australia Regulations 1996*
Scrutiny of police powers in relation to unlawful consorting and prohibited insignia	• *Criminal Law (Unlawful Consorting and Prohibited Insignia) Act 2021*
Scrutiny of powers in relation to Protected Entertainment Precincts	• *Liquor Control Act 1988*

Energy and Water Ombudsman	• *Electricity Industry Act 2004* • *Energy Coordination Act 1994* • *Water Services Act 2012* • *Constitution of the Energy and Water Ombudsman (Western Australia) Limited* • *Charter of the Energy and Water Ombudsman (Western Australia) Limited*

Other Key Legislation Impacting on the Office's Activities

- *Auditor General Act 2006;*
- *Children and Community Services Act 2004;*
- *Corruption, Crime and Misconduct Act 2003;*
- *Disability Services Act 1993;*
- *Economic Regulation Authority Act 2003;*
- *Equal Opportunity Act 1984;*
- *Financial Management Act 2006;*
- *Industrial Relations Act 1979;*
- *Minimum Conditions of Employment Act 1993*;
- *Procurement Act 2020;*
- *Public Sector Management Act 1994;*
- *Royal Commissions Act 1968;*
- *Salaries and Allowances Act 1975;*
- *State Records Act 2000;* and
- *Work Health and Safety Act 2020.*

The Ombudsman Western Australia and Aboriginal Western Australians

In 2017-18, Ombudsman Western Australia commissioned Aboriginal artist, Barbara Bynder, to create an artwork to be reproduced by the Office in its publications, including this Annual Report.

This initiative is part of the Office's Aboriginal Action Plan, a comprehensive whole-of office plan that has been guided by the Office's Aboriginal staff led by its Principal Aboriginal Liaison Officer.

The Office is committed to working in a collaborative and transparent manner and by respecting Aboriginal people's right to self-determination. The Office is committed to working with, and for, Aboriginal Western Australians to build understanding of the unique vulnerability and disadvantage faced by Aboriginal people due to past wrongs.

By incorporating the artwork into publications and communications with Aboriginal people, the Office aims to further facilitate this understanding, as well as enhance accessibility to, and awareness of, the Office for Aboriginal Western Australians.

Artist's Statement

This painting represents the idea of fairness, mediation and accessible services where just decision making is promoted and founded on unbiased outcomes for all parties as well as promoting development of sustainable relationships with Aboriginal people and their communities.

The Ombudsman Western Australia aims to develop and maintain sustainable relationships with Aboriginal communities and people of Western Australia.

To understand how relationships are developed and maintained in contemporary Aboriginal society, I have researched the topic to develop and create an artwork that represents the idea of relationship building, mediation and fair decision making between the Ombudsman Western Australia, Government Departments and Aboriginal people. During our discussions we came to an agreement that this would be best represented showing three specific elements in the painting thus representing the Ombudsman, agency and Aboriginal people. I have represented these three elements equally, as hills that come to a point where they meet with a river flowing between them representing independence.

In Noongar and other Aboriginal cultures research demonstrates that there is similarity in the way that building and maintaining strong relationships occur. Following the

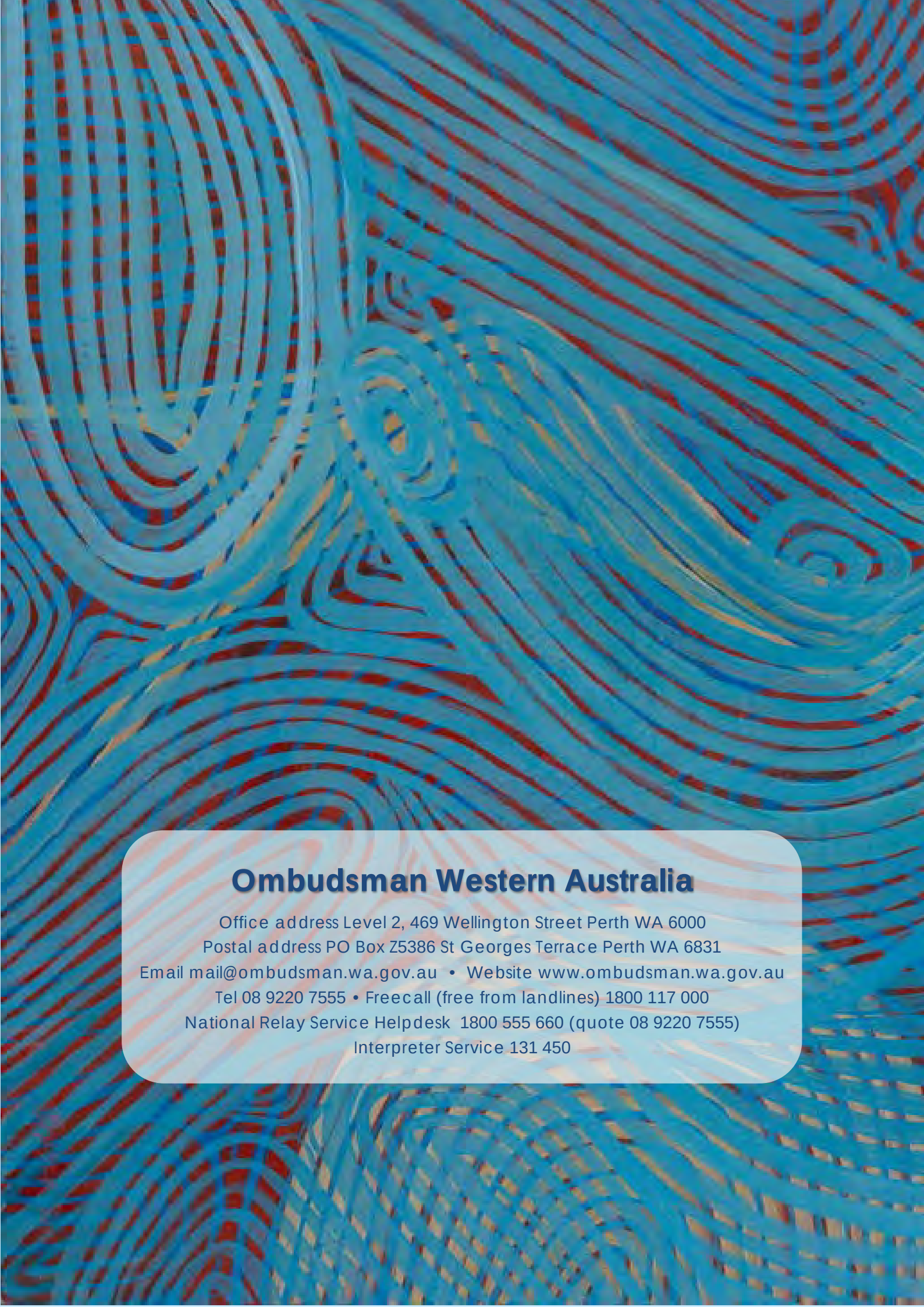
processes of historical cultural practice and relationship building and how this is developed through the idea of kinship law is embedded in the background of this painting. Although this practice has adapted, changed and evolved due to the impact of colonization, relationships remain core elements of contemporary Aboriginal culture and is maintained through understanding of and through the idea of culture. The linear work in the painting is representative of contemporary Aboriginal culture and the idea of songlines that traverse the Australian continent connecting Aboriginal people to each other. Although the songlines appear invisible if you look closely you can see that the linear work beneath the surface is visible. Relationship protocols in Aboriginal cultures today, continue to influence cultural values and protocols of contemporary Aboriginal society.

In more traditional areas of Australia, decision making is applied through senior men and women who come together to discuss conflict and disputes within their communities. Basil Sansom, Anthropologist (*The Camp at Wallaby Cross: Aboriginal fringe dwellers in Darwin*, 1979), studied conflict resolution in the Northern Territory. Sansom observed dispute resolution in three different camps who lived in a neighbourhood that shared the same area of land. Each camp was managed by senior men separately, yet they came together to discuss the rules for sharing the same space and how outsiders would be managed whilst staying or visiting the camps because they wanted to maintain good relationships with fellow country men and women and because they wanted to keep the peace in the camps. Sansom sketched a drawing of his understanding for the mediation of dispute process which has influenced and informed this painting because the protocols that Sansom talks about in his research remains prevalent in today's Aboriginal society.

Research also determines that the best practice for mediation and fair decision making in today's Aboriginal society is driven by 'insider knowledge' therefore being a primary method in resolving conflict and disputes and is found to be the most effective approach to resolving disputes (Turner-Walker, 2010, *Clash of the Paradigms: Night Patrols in remote central Australia*). The results of Turner-Walker's (2010) research concurs with Sansom's (1979) research and highlights the importance of understanding the relationships that exist between Aboriginal people and how this is relational with the idea of culture therefore maintaining cultural values through practicing culture.

To promote the vision of the Ombudsman Western Australia the painting represents the following characteristics; fairness, transparency, acting independently, providing accessible services and promoting fair decision-making processes. The process for implementing this vision of the Ombudsman Western Australia is to develop, maintain and sustain relationships between the Ombudsman, agency and Aboriginal community and people.

Barbara Bynder
Karda Designs



Ombudsman Western Australia

Office address Level 2, 469 Wellington Street Perth WA 6000
Postal address PO Box Z5386 St Georges Terrace Perth WA 6831
Email mail@ombudsman.wa.gov.au • Website www.ombudsman.wa.gov.au
Tel 08 9220 7555 • Freecall (free from landlines) 1800 117 000
National Relay Service Helpdesk 1800 555 660 (quote 08 9220 7555)
Interpreter Service 131 450