



TIPS AND TRAPS FOR REGULATORS

Second edition

October 2009

REPORT OF THE QUEENSLAND OMBUDSMAN

Tips and Traps for Regulators

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October 2009

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FOREWORD

One of my Office's functions under the *Ombudsman Act 2001* is to help agencies to improve the quality of their decision-making and administrative practices.

With this function in mind, I published a report in 2007 to provide guidance to public sector regulators. The report was published with the consent of the then Speaker, the Honourable Mike Reynolds, AM, MP, given under s.54 of the Act.

The report discusses the principles of good regulatory practice from a public sector perspective, and illustrates those principles by using case studies drawn from investigations conducted by my Office. It contains many suggestions about ways public sector agencies can improve their regulatory practices.

The report has now been amended to include new case studies (based on more recent investigations) that demonstrate aspects of good regulatory practice.

Since the report was first published, the Ombudsman Act has been amended to authorise me to publish information to help agencies improve their administrative practices and procedures, provided the information does not identify any person.

This second edition of *Tips and Traps for Regulators* is published under that authority.

I trust public sector regulators and their officers will find the report both informative and useful.



David Bevan
Queensland Ombudsman



TABLE OF CONTENTS

FOREWORD	v
HOW TO USE THIS REPORT	ix
STRUCTURE OF THIS REPORT	x
DICTIONARY AND ABBREVIATIONS	xi
CHAPTER 1: INTRODUCTION	1
1.1 Role of Ombudsman	1
1.2 Publication with approval of Speaker	1
1.3 Sources used in this report.....	2
1.4 Regulatory strategy.....	4
1.5 What this report is about	6
1.6 The nature of policies	7
1.7 Regulatory Reform Review, Regulatory Best Practice Handbook and Procedural Guidelines	9
1.8 Terminology	10
CHAPTER 2: ENSURING KNOWLEDGE, SKILLS AND VALUES	11
2.1 Recruitment practices	12
2.2 Policies and manuals.....	13
2.3 Training.....	14
CHAPTER 3: DISCRETION & THE ROLE OF RISK MANAGEMENT	19
3.1 Discretion.....	19
3.2 Risk management.....	19
3.3 Prioritisation of reactive work.....	20
3.4 Balancing reactive and proactive work.....	23
3.5 Risk management of proactive work.....	24
3.6 Issues relevant to both reactive and proactive wo.....	25
CHAPTER 4: INVESTIGATIVE PRACTICES	29
4.1 Investigative planning.....	29
4.2 Inadequate evidence gathering.....	33
4.3 Use of legal advice	35
4.4 Expert witnesses.....	36
4.5 Establishing material facts.....	37
CHAPTER 5: SYSTEMS FOR EFFECTIVE REGULATION	41
5.1 Bring-up systems	41
5.2 Systems for effective investigation	42
5.3 Facilitating future enforcement action.....	43
5.4 Supervisory systems	45
5.5 Review systems	47
5.6 Approval systems	48
5.7 Delegations.....	49
5.8 Organisational structures.....	50
5.9 Review of policies	51

CHAPTER 6: REGULATORS WORKING TOGETHER	53
6.1 Lead agency and partner agencies.....	53
6.2 Lead agency’s role	54
6.3 Practices to be consistent	55
6.4 Sharing of case records	56
6.5 Referrals.....	57
CHAPTER 7: COMMUNICATING WITH THE PUBLIC	59
7.1 Making policies publicly available.....	59
7.2 Updates to notifier.....	61
7.3 Communication with persons affected.....	64
7.4 Confidentiality of notifier details.....	64
CHAPTER 8: REGULATORY SCHEME	67
8.1 Jurisdiction	67
8.2 Overlapping regulatory schemes	69
8.3 Penalties.....	69
8.4 Clearly defining unlawful activity	70
CHAPTER 9: REGULATORY INDEPENDENCE	75
9.1 Where potential offender is another regulator.....	75
9.2 Conflict of interest and bias.....	76
9.3 Regulatory capture	78
CHAPTER 10: RECORDKEEPING	83
10.1 Meaning of record	84
10.2 Complete records	85
10.3 Contemporaneous and separate records	88
10.4 Reasons for decisions	89
10.5 Records of ‘anonymous’ information	92
10.6 Avoiding unprofessional comments.....	93
10.7 Unattached records.....	94
10.8 Organisation of records.....	95
10.9 Project managed cases.....	96
10.10 Internal self-assessment tools and/or internal audits.....	97
CHAPTER 11: ELECTRONIC DATA CAPTURE	99
11.1 Accuracy of data	99
11.2 Data in form useful for case management	100
11.3 Automatic reporting.....	101
CHAPTER 12: COMPLAINT MANAGEMENT.....	103
CHAPTER 13: AUDITS OF REGULATORS	107
13.1 Performance audits	107
13.2 Audits of regulators.....	107
CHAPTER 14: CONCLUSION.....	109
APPENDIX A: INVESTIGATION PLAN TEMPLATE	111
APPENDIX B: REGULATOR’S AUDIT TOOL.....	113
BIBLIOGRAPHY.....	127

HOW TO USE THIS REPORT

Over the years, the Office of the Queensland Ombudsman has investigated numerous complaints about the actions of public sector agencies in their role as regulators.

Those investigations have highlighted the challenging nature of that role having regard to the high standards public sector regulators are expected to meet in regard to efficiency, effectiveness, consistency and accountability.

Our investigations have also identified areas of regulatory activity in which agencies often fail to meet these standards.

This report explains the principles of good regulatory practice and uses case studies drawn from investigations we have conducted to illustrate common deficiencies in regulatory practice and their causes. It also contains numerous recommendations for improving agencies' practices and procedures.

The report is therefore intended as a guide for agencies that discharge regulatory functions and can be used as a tool for reviewing and identifying improvements to their systems and practices in areas such as:

- case assessment and choosing the best regulatory option
- investigative planning and evidence gathering
- prioritising work
- communicating with notifiers and persons affected by investigations
- exercising the discretion to take prosecution action
- maintaining independence and the perception of independence
- working with other agencies with overlapping or related responsibilities
- recordkeeping
- recruitment and training
- policies and manuals
- audits of regulatory performance.

The report also contains a Regulator's Audit Tool (Appendix B) based on the recommendations in this report, which agencies can use to identify areas for improvement.

It should be noted that the report does not discuss the merits of the various regulatory models or suggest which model regulators should adopt. Regulators' roles and circumstances vary and they must determine for themselves the regulatory model most appropriate for them to adopt.

STRUCTURE OF THIS REPORT

- Chapter 1** **Introduction** explains the role of the Ombudsman and the purpose of this report.
- Chapter 2** **Ensuring knowledge, skills and values** examines how effective recruitment practices and ongoing training affect the skills and values of enforcement officers.
- Chapter 3** **Discretion and the role of risk management** focuses on the regulator's discretion to choose the enforcement action it will take in relation to a potential breach (or class of potential breach) of a regulatory scheme. The chapter also highlights the importance of balancing reactive and proactive work.
- Chapter 4** **Investigative practices** looks at the impact of poor investigative planning and offers advice to improve investigative practices.
- Chapter 5** **Systems for effective regulation** examines systems (including policies and procedures) that can be implemented to support effective regulatory practice.
- Chapter 6** **Regulators working together** discusses issues that arise where regulators' responsibilities overlap and provides advice on how regulators can effectively work together.
- Chapter 7** **Communication with the public** deals with the importance of effectively communicating regulatory policies and practice to improve compliance as well as communicating with notifiers and those with an interest in the outcome of an investigation.
- Chapter 8** **Regulatory scheme** defines the components of a good regulatory scheme.
- Chapter 9** **Regulatory independence** deals with issues of independence where a regulator receives notification that another regulator is a potential offender.
- Chapter 10** **Recordkeeping** talks about the importance of regulators making and keeping appropriate records of all significant operational activity.
- Chapter 11** **Electronic data capture** explains how regulators can ensure electronic data is captured effectively as part of the recordkeeping and case management process.
- Chapter 12** **Complaint management** discusses the importance of regulators having in place effective complaints management systems for dealing with complaints about their actions and the requirements of an effective system.
- Chapter 13** **Audits of regulators** outlines how audits can identify efficiencies and explains how to use the Regulator's Audit Tool found at Appendix B.
- Chapter 14** **Conclusion** encourages regulators to use the report as a resource for reviewing and evaluating the effectiveness of their regulatory systems.

DICTIONARY AND ABBREVIATIONS

Agency	Means a department, local government or public authority that is a regulator, unless the context indicates otherwise
Best Practice Guide	<i>Best Practice Guide to Recordkeeping</i> published by Queensland State Archives (December 2003)
Better Decisions Project report	The report titled <i>Better Decisions Project: A framework for effective administrative decision making systems</i> , a joint project of the then Department of Tourism, Fair Trading and Wine Industry Development and the Queensland Ombudsman (in partnership with the Department of the Premier and Cabinet) (2005)
Bring-up	A reminder or other form of prompt, either manual or electronic
Case	A case based on a notification or on other information that an alleged breach has or may have occurred
CEO	Chief executive officer
Chief executive officer	The Director-General or principal officer of an agency
Complainant	A person who makes a complaint about a regulator
Complaint	A complaint about a regulator
Enforcement action	Any action (including an investigation or court action) taken by a public sector agency to address or prevent non-compliance with a regulatory scheme or to encourage compliance with the scheme
Enforcement officer	An officer of an agency who performs enforcement responsibilities
Enforcement responsibility	A statutory responsibility to take enforcement action
FOI Act	<i>Freedom of Information Act 1992</i> (Qld)
Investigation	An inquiry by an agency into a notification or breach or potential breach of a regulatory scheme, regardless of the complexity of the inquiry
IS40	<i>Information Standard 40 – Recordkeeping</i> , published by Queensland State Archives
Judicial Review Act	<i>Judicial Review Act 1991</i> (Qld)
Lead agency	An agency with primary responsibility for the administration of a regulatory scheme
Licence	A document issued under a regulatory scheme prescribing the conditions under which an activity may be carried on
Notification	A notification of a potential breach, including a self-notification
Notifier	A person who makes a notification
Office	Office of the Queensland Ombudsman
Ombudsman Act	<i>Ombudsman Act 2001</i> (Qld)
Partner agency	Each agency in a regulation group
PIN	An acronym for ‘penalty infringement notice’ and used to notify a person of a fine imposed for a breach of a regulatory scheme
Potential breach	A potential breach of a regulatory scheme
Potential offender	Includes: <ul style="list-style-type: none"> • An individual or entity the subject of the notification or issue of concern to the public sector agency • A licence holder
PS Act	<i>Penalties and Sentences Act 1992</i> (Qld)
Public Records Act	<i>Public Records Act 2002</i> (Qld)
Public sector agency	Means a department, local government or public authority

QORE	Queensland Office of Regulatory Efficiency
Regulation group	A group of agencies with responsibilities for the administration of a regulatory scheme or aspects of the scheme, whether their jurisdiction overlaps or not
Regulator	A public sector agency with responsibilities for the administration of a regulatory scheme or part of a scheme
Regulatory Reform Review	<i>Review of Legislative and Regulatory Reform Initiatives in the Queensland Government Phase 1</i> , published by the Service Delivery and Performance Commission (2006)
Regulatory scheme	A scheme established by legislation for regulating specified activities or categories of activity
RTI Act	<i>Right to Information Act 2009</i> (Qld)
Self-notification	A notification of a potential breach made by the potential offender
WEP	The Workplace Electrocution Project – An investigation into the adequacy of the responses of government agencies to nine fatal electrical incidents; and an analysis of the effectiveness of changes made to Queensland’s electrical safety framework since those incidents occurred
WEP report	<i>Report of the Queensland Ombudsman – The Workplace Electrocution Project – A report on investigations into the adequacy of the responses of government agencies to nine fatal electrical incidents; and an analysis of the effectiveness of changes made to Queensland’s electrical safety framework since those incidents occurred</i> , published by the Queensland Ombudsman (2005)

CHAPTER 1: INTRODUCTION

The role of the regulator is becoming increasingly complex and demanding. As one leading academic in the field explains it:

Regulators, under unprecedented pressure, face a range of demands, often contradictory in nature: be less intrusive - but be more effective; be kinder and gentler - but don't let the bastards get away with anything; focus your efforts - but be consistent; process things quicker - and be more careful next time; deal with important issues - but do not stray outside your statutory authority; be more responsive to the regulated community - but do not get captured by industry.¹

This report discusses the principles of good regulatory practice from a public sector perspective and illustrates those principles by using case studies drawn from investigations conducted by my Office. It then suggests ways public sector agencies can improve their regulatory practices.

1.1 ROLE OF OMBUDSMAN

Section 12(c) of the *Ombudsman Act 2001* (Ombudsman Act) requires me to consider the 'administrative practices and procedures of agencies generally' with a view to making recommendations or providing other help to them to improve their practices and procedures. I am aware, from monitoring the complaints my Office receives, of deficiencies in the systems of some regulators.

1.2 PUBLICATION WITH APPROVAL OF SPEAKER

Section 54 of the Ombudsman Act provides that:

The Speaker may, at the ombudsman's written request, authorise the ombudsman to publish, in the public interest or in the interests of any agency, organisation or person—

- (a) a report relating generally to the performance of the ombudsman's functions; or*
- (b) a report relating to any particular case investigated by the ombudsman;*

whether or not the matters to be dealt with in the report have been the subject of a report tabled in the Assembly under this Act.

In my opinion, publication of this report assists regulators to more effectively carry out their responsibilities. The first edition of this report was published under s.54 of the Ombudsman Act with the authority of the then Speaker of Parliament, the Honourable Mike Reynolds, AM, MP, given on 8 October 2007.

¹ *The Regulatory Craft*, Malcolm Sparrow (2000) cited in External Advisory Committee on Smart Regulation-Canada (2004) *Smart Regulation: A Regulatory Strategy for Canada*, retrieved 22 January 2007 from the world wide web: www.regulatoryreform.com/pdfs/Canada%20Smart%20Regulation%20Report%20Sept%202004.pdf at page 16.

Since that time, the Ombudsman Act has been amended to authorise the Ombudsman to disclose information to an agency for the purpose of improving its administrative practice and procedures.² This edition of the report is authorised under those amended provisions.

1.3 SOURCES USED IN THIS REPORT

In preparing this report, I have drawn upon a range of sources.

1.3.1 Own initiative investigation

In late 2005, I decided to conduct, of my own initiative³, an investigative review of a sample of notifications received by a regulator with a view to assessing whether those notifications had been dealt with appropriately.

My decision stemmed from complaints received by my Office raising the following issues:

- whether officers were acting consistently in responding to notifications, especially in cases where officers decided to take no enforcement action
- whether officers were keeping proper records of their operational decisions about such incidents
- the effectiveness of the regulator's relationship with partner agencies with overlapping responsibilities.

1.3.1.1 Terms of reference and objects

The relevant terms of reference of my investigation were to examine:

- the appropriateness of the regulator's administrative actions⁴ in relation to notifications
- the quality of records (including electronic records) made in respect of those administrative actions
- whether officers' administrative actions were being properly supervised and audited
- the sufficiency of training of enforcement officers and supervisors
- the adequacy of proactive compliance programs and outcomes
- communication and coordination of activities with partner agencies
- interactions with partner agencies in circumstances where those agencies may have been potential offenders
- systems used for making, storing and providing access to records of enforcement action.

The principal objects of the investigation were⁵ to:

² See s.92(1)(v)(A) of the Ombudsman Act.

³ Section 12(a)(iii) of the Ombudsman Act.

⁴ For the purposes of the Ombudsman Act, 'administrative action' includes both an act and an omission.

⁵ In relation to the terms of reference.

CHAPTER 1: INTRODUCTION

- identify relevant practices and procedures
- determine the extent to which officers were complying with the practices and procedures
- determine whether the practices and procedures were adequate
- recommend improvements to the practices and procedures
- if applicable, formulate proposals to amend legislation to enhance regulation.

I gave my final report and recommendations in respect of that investigation to the CEO of the regulator.

A number of the themes in that report are of general interest to regulators and are discussed in this report.

1.3.2 WEP report

On 30 June 2005, my report, called *The Workplace Electrocution Project – A report on investigations into the adequacy of the responses of government agencies to nine fatal electrical incidents; and an analysis of the effectiveness of changes made to Queensland's electrical safety framework since those incidents occurred* (WEP report), was tabled in the Queensland Parliament.

The WEP report summarised my opinions and recommendations, and those of the former Ombudsman, concerning:

- whether the agencies had complied with their legislative responsibilities to investigate the fatal incidents and take appropriate regulatory action
- how the investigation of such incidents and the electrical safety regulation system in Queensland could be improved.

In the WEP report, I expressed opinions and made recommendations about a number of issues of significance to regulators, namely:

- investigative planning
- investigative skills and expertise
- access to experts
- supervision
- the role of regulators
- effective regulatory schemes
- good regulatory strategy
- the dangers of regulatory capture.

These issues are also discussed in this report.

1.3.3 Mine Safety Report

In June 2008, my report, called *The Regulation of Mine Safety in Queensland: A Review of the Queensland Mines Inspectorate* (Mine Safety Report), was tabled in the Queensland Parliament.

The Mine Safety Report contained my opinions and recommendations concerning:

- Queensland Mines Inspectorate's investigative process
- actions taken in relation to breaches of mine safety legislation
- the quality of records made about those actions
- policies and practices in relation to prosecution or other action for breaches of the mine safety legislation
- training of inspectors
- the adequacy of proactive compliance programs and outcomes
- systems used for the collection and storage of, and access to, compliance data
- the availability of compliance data to the public
- allegations that the Inspectorate was too close to mining interests.

The Mine Safety Report contained recommendations about a number of issues of significance to regulators.

1.3.4 Better Decisions Project report

The Better Decisions Project was established in April 2003 by the then Department of Tourism, Racing and Fair Trading, in partnership with the Department of the Premier and Cabinet, and my Office. Officers from the Department of Justice and Attorney-General and the Queensland Building Services Authority also contributed their experience, expertise and guidance to the project as members of a consultative committee.

The report on the project presents an administrative framework, developed in the project, referred to as the 'Better Decisions Framework'. The report examines administrative decision-making at a systems level, focusing particularly on decision-making systems for regulatory functions, such as registration and accreditation programs, occupational and business licensing, and enforcement of legislation.

The Better Decisions Framework is primarily intended to be a guide for officers involved in the design and establishment of new administrative decision-making systems, and officers participating in substantial reviews of existing decision-making systems.

1.3.5 Other case studies

Since the Ombudsman's Office commenced in 1974, it has investigated many complaints about the conduct of public sector agencies as regulators. This report also draws on some of those investigations as case studies.

1.4 REGULATORY STRATEGY

The Council of Australian Governments has agreed that the following broad principles ought to apply to Australian regulatory schemes:

CHAPTER 1: INTRODUCTION

Regulatory measures should contain compliance strategies which ensure the greatest degree of compliance at the lowest cost to all parties.⁶

Measures to encourage compliance may include ... public education and consultation and the choice of alternative regulatory approaches with compliance in mind.⁷

Mandatory regulatory instruments should contain appropriate sanctions to enforce compliance and penalise non-compliance.⁸

As I stated in the WEP report, most regulatory authorities have a variety of enforcement actions available to them, such as:

- persuading potential offenders to comply with their obligations through advice and education
- issuing a warning for minor or first time breaches
- issuing an infringement notice or other statutory notice requiring compliance
- having the potential offender agree to an enforceable undertaking
- taking prosecution action
- revoking an existing licence, grant or privilege/right.

There are a number of theories/models of regulation that postulate the order and/or circumstances in which various enforcement actions should be taken.

⁶ Council of Australian Governments (amended 2004) *Principles and Guidelines for National Standard Setting and Regulatory Action by Ministerial Councils and Standard-Setting Bodies*, retrieved 22 January 2007 from the world wide web: www.coag.gov.au/meetings/250604/coagpg04.pdf at page 7.

⁷ Council of Australian Governments (amended 2004) *Principles and Guidelines for National Standard Setting and Regulatory Action by Ministerial Councils and Standard-Setting Bodies*, retrieved 22 January 2007 from the world wide web: www.coag.gov.au/meetings/250604/coagpg04.pdf at page 7; for further detail about the range of regulatory options available, see Queensland Government, Department of State Development Guidelines on alternatives to prescriptive regulation, retrieved 22 January 2007 from the world wide web: http://www.sd.qld.gov.au/dsdweb/v3/guis/templates/content/gui_cue_doc.cfm?id=5496 at pages 12 and 13; and State of Victoria, Department of Treasury and Finance (2005) *Victorian Guide to Regulation*, Melbourne: State of Victoria at pages 2-5, 2-6 and 2-7.

⁸ Council of Australian Governments (amended 2004) *Principles and Guidelines for National Standard Setting and Regulatory Action by Ministerial Councils and Standard-Setting Bodies*, retrieved 22 January 2007 from the world wide web: www.coag.gov.au/meetings/250604/coagpg04.pdf at page 8.

1.5 WHAT THIS REPORT IS ABOUT

This report does not discuss the merits of the various regulatory models. Nor does it suggest which model regulators should adopt. Regulators' circumstances vary and they are in the best position to determine which regulatory model is appropriate for them.⁹

My concern is that, regardless of the model adopted, a regulator should administer its regulatory scheme in a way that is:

- **Effective** – the regulator achieves the objectives of the regulatory scheme
- **Consistent** – the regulator fairly and equitably enforces the scheme
- **Transparent** – the regulator's policies and procedures/strategies for administering the regulatory scheme are open to scrutiny by decision-makers (including supervisors) and those affected by the scheme
- **Accountable** – the regulator has and adheres to procedures about the way the regulatory scheme is to be administered.¹⁰

It is widely accepted that these aims are desirable.¹¹ They are also consistent with the obligation on chief executive officers under s.51(1)(b) of the *Public Service Act 1996* to manage their agencies 'in a way that promotes the effective, efficient, economical and appropriate management of public resources'.

Our investigations over the years have shown that some regulators have poor administrative practices in various aspects of regulation, from primary aspects (such as prioritisation) through to complementary aspects (such as recordkeeping). Those investigations were the catalyst for this report as they identified standards of good regulatory practice and made recommendations for improving regulatory practice.

⁹ For detailed discussion of various regulatory strategies see Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press, particularly at page 114 ('Many regulatory agencies lack systematic compliance measurement systems'); Ayres, I. and Braithwaite, J. (1992) *Responsive Regulation: Transcending the Deregulation Debate*, New York: Oxford University Press, particularly at chapter 2; Baldwin, R. and Cave, M. (1999) *Understanding Regulation: Theory, Strategy and Practice*, Oxford: Oxford University Press, particularly in chapter 8; Queensland Office of Regulatory Efficiency.

¹⁰ Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press, particularly at page 114 ('Many regulatory agencies lack systematic compliance measurement systems and cannot prove, therefore, that declines in enforcement numbers reflect better compliance rather than softer attitudes').

¹¹ Better Regulation Task Force (April 1999) *Enforcement*, London: Better Regulation Task Force; see also State of Victoria, Department of Treasury and Finance (2005) *Victorian Guide to Regulation*, Melbourne: State of Victoria at pages 3-1, 3-2 and 3-11; see also External Advisory Committee on Smart Regulation-Canada (2004) *Smart Regulation: A Regulatory Strategy for Canada*, retrieved 22 January 2007 from the world wide web: www.regulatoryreform.com/pdfs/Canada%20Smart%20Regulation%20Report%20Sept%202004.pdf at pages 14 and 15; see also chapter 6 'What is "Good" Regulation?' in Baldwin, R. and Cave, M. (1999) *Understanding Regulation: Theory, Strategy and Practice*, Oxford: Oxford University Press at page 76; Queensland Office of Regulatory Efficiency.

CHAPTER 1: INTRODUCTION

In this report, my recommendations are necessarily of a general nature as each regulator is different. I encourage regulators to seek the assistance of my Administrative Improvement Unit in implementing the suggested improvement measures in the way that best suits their own circumstances.

1.6 THE NATURE OF POLICIES

Many of my recommendations involve the development and implementation of policies. By policies, I mean any written practices and procedures of a regulator, regardless of their title (for example, 'operational guidelines' are policies).

Policies are a *guide* to consistency in the exercise of discretion, one of the key elements of good decision-making. As was stated by Brennan J in the Administrative Appeals Tribunal:¹²

Inconsistency is not merely inelegant: it brings the process of deciding into disrepute, suggesting an arbitrariness which is incompatible with commonly accepted notions of justice.

I am aware that many officers are under a misconception that policies must always be adhered to. This is not correct. Policies may be departed from if the application of the policy would, in the circumstances of a particular case, produce a result that is unreasonable. Brennan J also explained this concept in *Re Drake No 2* (a case relating to the exercise of ministerial discretion¹³):

There is a distinction between an unlawful policy which creates a fetter purporting to limit the range of discretion conferred by statute, and a lawful policy which leaves the range of discretion intact while guiding the exercise of the power.¹⁴

The following case study involves a departmental policy that I considered to unlawfully fetter the exercise of discretion.

¹² *Re Drake and Minister for Immigration and Ethnic Affairs (No 2)* (1979) 2ALD 634 at 639.

¹³ For a discussion of the different considerations applying to ministerial policy and departmental policies, see *Control of Government Action, Text Cases and Commentary*, Creyke and McMillan, LexisNexis Butterworths, 2005, at 11.5.9 to 11.5.12.

¹⁴ At 641.

CASE STUDY 1

A regulatory scheme provided that the regulator:

- 'shall consider each application' for a licence to carry out a certain commercial activity in a specific part of Queensland
- grant or refuse the application.

The regulator was in the process of conducting a detailed review of the circumstances in which it should grant these licences. In the meantime, the regulator's policy provided that new applications for licences would only be approved when, following thorough assessment, no further concern existed about the possible impacts of the proposal on the site.

The regulator's officers considered that the circumstances authorised an administrative moratorium on issuing new licences until the review had been finalised.

An applicant for a licence complained to my Office that his application had been rejected on the basis of the moratorium.

In considering the case, I noted the views of Pincus J in *Re: Perder Investments Pty Ltd and Elmer*,¹⁵ namely 'When parliament says that in certain circumstances there is a discretion to grant permission, then no official may replace that law by one to opposite effect – for example by a law requiring that in no circumstance shall permission be granted'.

I formed the opinion that the moratorium was an unlawful policy in that it purported to prevent the exercise of the discretion contained in the regulatory scheme.

¹⁵ *Re: Perder Investments Pty Ltd and Elmer* (1991) 23 ALD 545.

CHAPTER 1: INTRODUCTION

Consistent with this position, the Ombudsman is empowered to conduct an investigation if the administrative action to which the investigation relates was in accordance with 'a practice that is or may be unreasonable, unjust, oppressive, or improperly discriminatory in the particular circumstances'. If the Ombudsman is satisfied that an administrative action meets that description, the Ombudsman may report to the CEO of the relevant regulator and make recommendations that the regulator take action to rectify, mitigate or alter the effects of the administrative action or that any practice in accordance with which the administrative action was taken should be varied.

1.7 REGULATORY REFORM REVIEW, REGULATORY BEST PRACTICE HANDBOOK AND PROCEDURAL GUIDELINES

In July 2006, the Service Delivery and Performance Commission published a report called the *Review of Legislative and Regulatory Reform Initiatives in the Queensland Government Phase 1 (Regulatory Reform Review)*.¹⁶ The report stated:

*The review has observed that ... consideration should be given to ... promotion of innovation and policy education on regulation, enforcement and compliance to State government agencies.*¹⁷

Recommendation 4 of the Regulatory Reform Review provides that:

*It is recommended that the Director-General of DSDTI [the then Department of State Development, Trade and Innovation] identifies and evaluates regulatory best practice in the Queensland Government and elsewhere, and disseminates this information to all Queensland Government agencies on an ongoing basis ...*¹⁸

The DSDTI formed the Queensland Office of Regulatory Efficiency (QORE) in February 2007. The QORE's role includes publishing guidelines on regulatory best practice. The information in such guidelines may complement the information contained in this report. Throughout this report, I identify topics that may also be discussed in any guidelines. The contents of my report have been brought to the attention of the QORE.

¹⁶ Service Delivery and Performance Commission (2006) *Review of Legislative and Regulatory Reform Initiatives in the Queensland Government Phase 1*, Brisbane: Service Delivery and Performance Commission.

¹⁷ Service Delivery and Performance Commission (2006) *Review of Legislative and Regulatory Reform Initiatives in the Queensland Government Phase 1*, Brisbane: Service Delivery and Performance Commission at page 16.

¹⁸ Service Delivery and Performance Commission (2006) *Review of Legislative and Regulatory Reform Initiatives in the Queensland Government Phase 1*, Brisbane: Service Delivery and Performance Commission at page 20.

1.8 TERMINOLOGY

1.8.1 Compliance and enforcement

I have noticed that some regulators tend to refer to 'compliance' as action (including no action or negotiated action) taken by the regulator in respect of a potential offender that does not involve court action and to 'enforcement' as court action taken by the regulator against a potential offender. To avoid confusion, throughout this report, I will refer to any action taken by a regulator to enforce or encourage compliance with a regulatory scheme as 'enforcement action'.

1.8.2 Use of 'we' and 'our'

Throughout the remainder of the report, I have used 'we' and 'our' rather than 'I' and 'my' for consistency and readability. However, it should be noted that, unless otherwise indicated:

- the reports on the investigations referred to in the case studies were my reports
- the recommendations referred to in the case studies were my recommendations.¹⁹

¹⁹ See s.86 Delegation, Ombudsman Act.

CHAPTER 2: ENSURING KNOWLEDGE, SKILLS AND VALUES

For officers of regulators to be able to perform their duties competently and professionally, they must have the appropriate:

- **Knowledge** – being knowledge of the principles of regulatory and investigative practice and also technical knowledge²⁰ relevant to the activity being regulated
- **Skills** – being skills incidental to knowledge²¹
- **Values** – being a commitment to the regulator's goals and to the accepted standards of good regulation.

As stated in the WEP report, enforcement officers in public sector agencies should adhere to certain core values,²² including the following:

- they work in a system demanding internal and external²³ accountability and any decision made or action taken by them may be reviewed or questioned by other individuals and bodies
- their principal duty is to fairly enforce the regulatory scheme
- their primary task is to identify the truth about an alleged breach of the law and not to prejudge the case. In other words, they are required to perform their tasks in an impartial, independent and objective manner and not to identify personally with any party
- they should carry out their duties in a lawful and ethical manner and as expeditiously as possible
- they must declare to their manager any potential personal conflict of interest immediately they become aware of it.

In conducting investigations, enforcement officers must:

- check all apparent facts in dispute, which could be decisive or relevant to the outcome and not accept them at face value
- not act as a mediator, conciliator or advisor – the procedures used in these processes are generally inappropriate to the investigation of a statutory offence
- genuinely listen to both sides and give thorough and rational consideration to what is being said
- not form an opinion until all of the facts have been gathered
- never offer opinions or advice to any person while conducting an investigation
- prepare investigation reports that are stand-alone documents upon which their supervisors are able to make proper and informed decisions.²⁴

²⁰ Also referred to as domain knowledge, for example, knowledge of activities that may affect the environment or knowledge of the particular issues in construction workplaces that impact on health and safety.

²¹ For example, ability to take statements or ability to conduct scientific or technical testing.

²² List compiled from *Investigating Complaints: A Manual for Investigators*, NSW Ombudsman, 2004; and *Facing The Facts*, a Crime and Misconduct Commission Guide for dealing with suspected misconduct in Queensland Public Sector Agencies, 2004.

²³ For example, Crime and Misconduct Commission, Queensland Audit Office, Queensland Ombudsman.

²⁴ The investigation report may need to include attachments.

Regulators can ensure their officers possess the appropriate knowledge, skills and values through effective recruitment practices, policies and training programs.

2.1 RECRUITMENT PRACTICES

In developing the selection criteria for positions having regulatory functions, a regulator needs to ensure that those criteria are appropriate to the scheme being administered and will result in the appointment of persons with the right knowledge, skills and values to carry out those functions.

2.1.1 What we have found

Some regulators place too much weight on technical knowledge in their selection criteria, as the following case study illustrates.

CASE STUDY 2

Our investigation of a regulator indicated that it routinely recruited as enforcement officers persons who held technical or trade qualifications in the fields they were likely to investigate, rather than persons who had more generic investigative experience or skills. Our investigation demonstrated that persons with trade qualifications in the field they were investigating were unlikely to become competent enforcement officers without proper training and development, which the regulator had not provided.

On our recommendation the regulator changed its recruitment practices and enhanced training for its officers.

While we are not suggesting that persons who hold technical or trade qualifications should be considered ineligible for appointment as enforcement officers, as the previous Ombudsman pointed out, 'the conduct of investigations is a field of expertise in itself, and includes the appropriate sourcing, use and management of witnesses, including technical experts, to develop a brief of evidence for prosecution'.²⁵

Other regulators, in recruiting officers as enforcement officers, place undue weight on legal knowledge, under the misapprehension that it equates to investigative knowledge and, therefore, the officer will be able to 'hit the ground running', without undertaking training in investigative methodology.

The circumstances of the regulatory scheme (for example, whether scientific testing is required to establish a breach) will help regulators decide the extent of technical knowledge required of officers. Furthermore, a regulator's concern that its enforcement officers need to also be technical experts can usually be addressed by giving enforcement officers access to such an expert, when necessary.

²⁵ Comments of Mr Fred Albietz, Case 1 of the WEP, cited in Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocutation Project*, Brisbane: Queensland Ombudsman at page 113.

CHAPTER 2: ENSURING KNOWLEDGE, SKILLS AND VALUES

2.1.2 What we recommend

Regulators should develop and implement policies that ensure:

- the selection criteria for enforcement officer positions place appropriate emphasis on investigative knowledge, technical knowledge, skills and values, as relevant to the regulatory scheme
- 'gaps' in the knowledge, skills and values of new recruits are identified and bridging training is arranged promptly.

2.2 POLICIES AND MANUALS

As stated in the WEP report,²⁶ an essential ingredient of a good regulatory framework is a quality set of policies for the guidance of enforcement officers. It is also essential that officers comply with those policies in their decision-making, unless special circumstances require departure from a policy.²⁷

2.2.1 What we have found

A low level compliance by enforcement officers with the regulator's policies can demonstrate a lack of effective supervision as was established in the following investigation.

CASE STUDY 3

A regulator had investigative policies in place but officers often did not comply with those policies. There had been little or no auditing or enforcement of compliance with the policies by management. Officers said that they were generally unaware of any consequences of non-compliance with the policies and that there had been little information, training or promotion of them. This led to inconsistent decision-making in enforcing the regulatory scheme.

Some regulators lack relevant operational policies for their enforcement officers, as the following case study illustrates.

²⁶ Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocution Project*, Brisbane: Queensland Ombudsman at page 107.

²⁷ See our comments about the nature of policies at section 1.6.

CASE STUDY 4

Our investigation of a regulator showed that it did not have policies, such as operational manuals, to guide its enforcement officers on:

- investigative practices, including the significance of different forms of evidence
- legislation and available enforcement action
- regulatory strategy and practices, including proactive compliance practices
- recordkeeping for officers of a regulator
- (for relevant officers) dealing with bereaved, stressed and challenging behaviours.

As a result, the regulator's enforcement activity lacked consistency and was not transparent.

On our recommendation, the regulator developed a comprehensive investigative manual addressing the above issues.

In other investigations we have noted that although the regulators had relevant procedures, they were not collated in a logical, easily accessible way.

2.2.2 What we recommend

Regulators should develop and implement manuals for enforcement officers that cover:

- investigative and other enforcement practices
- legislation and available enforcement action
- regulatory strategy
- recordkeeping.

Manuals should be stored and updated electronically, and be subject to an appropriate version control system so officers can be confident that they are referring to the most recent version.

Regulators should develop and implement policies that ensure officers adhere to the provisions of the manuals; for example, by requiring supervisors to periodically audit a sample of files.²⁸

2.3 TRAINING

As stated in the WEP report, the decision-making framework should make provision for the proper training and development of officers to ensure they have the knowledge, skills and values to perform their functions competently.²⁹

²⁸ For further discussion and recommendations about review systems, see section 5.4.

²⁹ Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocution Project*, Brisbane: Queensland Ombudsman at page 112.

CHAPTER 2: ENSURING KNOWLEDGE, SKILLS AND VALUES

2.3.1 What we have found

Many regulators do not have a coordinated system in place for managing the training they provide. Consequently, the training delivered is haphazard, as the following case studies illustrate.

CASE STUDY 5

Our investigation of a regulator revealed that:

- the investigative practice training provided by it was inadequate
- several enforcement officers told our investigators that they had never received any formal investigative training, despite the fact that they were required to interpret legislation, interview witnesses, prepare briefs of evidence, prepare court documents and give evidence on behalf of their regulator before a court, tribunal or other form of administrative inquiry
- enforcement officers had received varying amounts and types of training, depending on factors such as when they commenced employment with the regulator
- there was no formal system of bridging/refreshers training
- there was no advanced course of training for enforcement officers
- there was no system of updates about legislation and policy changes.

As a result, the standard of the regulator's investigations had been publicly criticised.

Following our recommendation, the regulator implemented an accredited investigations training program for its officers.

CASE STUDY 6

We investigated an allegation that a regulator's investigation into a notification had been poorly handled. We found that both the investigation and the training of enforcement officers were inadequate.

We asked the regulator about its training regime. The regulator advised that it had devoted considerable efforts over the previous three years to the development and implementation of dedicated training and recruitment procedures to enhance the investigative skills of its inspectorate. Its investigations training program extended over a six-week period for new investigators and incorporated mock courts, practical assessment, and training modules directed towards:

- compliance
- registration
- investigative questioning
- legislation
- requirements for notebooks and recordkeeping.

The program addressed the kind of deficiencies we had identified in the regulator's investigation.

However, the regulator also advised that training under the investigations training program was only provided to new inductees.

We recommended the regulator review the level of investigative skills of inspectorate staff. In particular, we recommended that the regulator identify inspectorate staff who had not successfully completed the investigations training program and ensure that the investigative skills of these officers were at least equal to the skills of officers who had completed the program.

Many regulators identify training issues through their performance review and planning process, whereby the performance of an enforcement officer is assessed at least annually by the officer and their supervisor and a plan is made for the officer's development.

The officer's need for development may be addressed through measures such as:

- training, provided by an internal or external trainer
- membership of professional associations
- continuing education provided by professional associations
- participation in formal mentoring schemes.

Officers of a regulator must be trained in its policies. It is the first step to ensure officers administer the regulatory system consistently. In the following case study, an investigation was closed prematurely because a supervisor did not understand the purpose of the regulator's policy.

CHAPTER 2: ENSURING KNOWLEDGE, SKILLS AND VALUES

CASE STUDY 7

The regulator received a notification, which, if substantiated, would have been an offence.

The enforcement officer conducted an initial interview. The interviewee provided 'leads' to other potential witnesses.

The regulator's policy was that if a case was likely to result in court action, then as soon as 'sufficient information' had been gathered, the officer was to prepare a report requesting approval from a committee to investigate the case with a view to court action. The reason for that policy was that the regulator did not want to see significant resources spent on detailed investigations if they were not likely to result in court action.

The officer and their supervisor agreed that certain other witnesses should be interviewed but prepared a report requesting approval to investigate the case for court action on the basis of the initial interview.

Another supervisor discouraged the officer from pursuing the approval for that course of action because the information included in the report was hearsay, although admissible evidence may have been available from the potential witnesses nominated by the original interviewee.

That supervisor did not understand the purpose of the approval process and that it was appropriate, for that purpose, to have regard to hearsay evidence.

The next case study relates to a situation where a lack of training in dealing with grieving relatives prejudiced a potential prosecution.

CASE STUDY 8

The notifier, a close relative of the deceased whose death was the subject of an investigation, held certain information that was relevant to the investigation and possible statutory breach. This information was not obtained from the notifier, because the enforcement officer was reluctant to interview the notifier so soon after the relative's death. By the time the enforcement officer obtained the information from the notifier, the period for commencing prosecution proceedings had expired.

On our recommendation, the regulator developed a policy for dealing with such situations and a booklet for next of kin and provided training to its officers.

Officers taking part in training must be able to see the link between the subject matter of the training and their day-to-day work; otherwise, they are far less likely to retain what they have learnt. Some training does not make that link.

In one case, officers of the regulator told our investigators that the training provided to them was too generalised. Much of the training had been delivered by external providers who were not sufficiently familiar with the work of the enforcement officers.

If training is being provided to enforcement officers by an external consultant, the consultant must be well briefed on the nature and demands of the officers' work; otherwise, the training may be perceived as lacking credibility and relevance.

Another deficiency in the training system of some regulators is that they do not have any formal process for ensuring that officers are advised of changes to legislation and policy.

CASE STUDY 9

During an investigation of a regulator's practices, some of its enforcement officers told our investigators that they were rarely informed of changes to legislation and policy relevant to their work.

Other officers said that where the regulator did send out emails advising of legislation and policy changes, it did not provide any explanation of the changes. On these occasions, officers felt they were left to their own devices to ascertain whether the changes should affect their practices.

2.3.2 What we recommend

A regulator should:

- implement a training program that reflects its policies and encompasses appropriate types of training, whether provided externally or internally, such as standard training, bridging training, refresher training, advanced training, or training to enhance professional or technical skills
- ensure the training program is properly managed and reviewed at regular intervals
- ensure the training program is responsive to the needs of the participants. An effective way to do this is to obtain and analyse feedback sheets from the participants. Further, including examples throughout the training material that are relevant to the work of the participants can significantly enhance interest and retention
- provide training in all areas of regulatory practices, including recordkeeping
- implement a performance review and planning process for the continuing development of competencies in the areas discussed in this report
- consider implementing a formal mentoring program for appropriate officers, which can be an effective way of building general corporate interest and knowledge
- ensure all enforcement officers are promptly advised of changes to legislation and policies as well as the intent and effect of those changes (an effective way of doing this is to send updates to all addresses on a subscription email list).

CHAPTER 3: DISCRETION AND THE ROLE OF RISK MANAGEMENT

3.1 DISCRETION

Regulators are constantly called upon to exercise discretion. According to one leading author in the field of regulatory practice, a regulator may exercise four types of discretion:³⁰

- the right to set the mission (regulatory strategy)
- the right to choose what to work on
- the right to choose how to work on it
- the enforcement discretion.

As stated at section 1.4, the first discretion, namely, the choosing of a regulatory strategy, is not within the scope of this report.

In exercising the other discretions, regulators must ensure that the decisions they make are:

- **Effective** – the regulator achieves the objectives of the regulatory scheme
- **Consistent** – the regulator fairly and equitably interacts with potential offenders
- **Transparent** – the regulator administers the regulatory scheme in a way that is open to external scrutiny
- **Accountable** – the regulator implements and complies with appropriate procedures that govern how the regulatory scheme is administered.

Risk management and prioritisation are examples of strategies regulators can employ to guide the exercise of their discretion.

3.2 RISK MANAGEMENT

As stated in the WEP report,³¹ risk management is an integral part of good regulatory practice³² and can be applied as a means of avoiding or mitigating potential problems. A robust risk management framework will result in greater:

- transparency and accountability
- consistency in decision-making
- effectiveness and efficiency.

³⁰ Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press.

³¹ Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocutation Project*, Brisbane: Queensland Ombudsman at page 150.

³² See also Australian Government (2006) *Rethinking Regulation: Report of the Taskforce on Reducing Regulatory Burdens on Business*, Belconnen: Commonwealth of Australia at page 158.

Risk Management AS/NZS 4360:2004 'provides a generic guide for managing risk'³³ and is applicable to the prioritisation of decisions of regulators. *HB 436 Risk Management Guidelines – Companion to AS/NZS 4360:2004*³⁴ 'contains specific guidance on the implementation of the Standard. The two documents are intended to be used together'.³⁵

3.3 PRIORITISATION OF REACTIVE WORK

There are two ways in which a regulator may carry out its business, namely by:

- reacting to notifications of potential breaches³⁶
- proactively taking steps to identify potential breaches or to encourage compliance with the regulatory scheme.

While some regulators are expressly obliged by their legislative scheme to undertake proactive work, others are not. However, all regulators have a 'reactive' responsibility and, therefore, we discuss this issue first.

3.3.1 Prioritisation systems

A regulator that takes a risk management approach to its reactive work will prioritise all notifications according to a formula, scale or model. A typical model requires various weighted factors to be taken into account before a notification is investigated.³⁷

Prioritisation is an essential component of enforcement work because investigation and prosecution resources are finite and, as a general rule, a regulator needs to consider how it can best devote its resources, firstly, to very serious cases,³⁸ secondly, to less serious cases and thirdly, to those cases where commonsense dictates that a less formal response is appropriate.

A good system for prioritising cases will also assist the regulator to make more effective decisions about resourcing because it will generate quantitative data that may support a claim that more resources are needed. Alternatively, the data may refute the claim, for example, by showing that resources are being used inefficiently.

3.3.2 What we have found

Of course, a regulator that develops a prioritisation system must also ensure that the system is being applied and in a consistent manner.

³³ Standards Australia/Standards New Zealand (2004) *Risk Management – AS/NZS 4360:2004*, Sydney/Wellington: Standards Australia/Standards New Zealand at page 1.

³⁴ Standards Australia/Standards New Zealand (2004) *Risk Management Guidelines – Companion to AS/NZS 4360:2004*, Sydney/Wellington: Standards Australia/Standards New Zealand.

³⁵ Standards Australia/Standards New Zealand (2004) *Risk Management – AS/NZS 4360:2004*, Sydney/Wellington: Standards Australia/Standards New Zealand at page iii.

³⁶ Including self-notifications from the potential offender.

³⁷ See Wills, G., Sullivan, G. and Collings, T. (October 2005) *Prioritisation Systems: Sorting the Wheat from the Chaff* (AELERT Conference paper), Brisbane: Department of Natural Resources (NSW), and Department of Natural Resources and Mines (Qld).

³⁸ For example, fatalities and serious bodily harm.

CHAPTER 3: DISCRETION AND THE ROLE OF RISK MANAGEMENT

CASE STUDY 10

A regulator's policy provided that notifications were to be prioritised according to their potential impact (insignificant, minor, moderate, major, emergency). However, none of the cases we reviewed used this terminology or indicated that either the officer or the supervisor had considered the relative priority of the case.

Therefore, the system was clearly ineffective, perhaps because compliance was not enforced and perhaps because the system did not include meaningful criteria for determining the priority level of the notification.

Examples of effective prioritisation systems are described below.

CASE STUDY 11

Under the respective prioritisation systems of regulators A and B, cases are assessed against a number of criteria and given a rating on a scale of seriousness. Regulator A uses numerical scores while regulator B allocates a rating for each criterion (very high, high, medium, low or very low). Under both systems, the individual ratings are then used to allocate an overall priority rating to the case (very high, high, medium, low or very low).

Officers then complete cases in order of priority.

At regulator A, regional managers record each case's priority electronically, as part of the case management system. Regional managers are able to reprioritise cases if new information comes to light.

Regulator A is also able to use its prioritisation system to assist it in making projections for resourcing purposes.

Regulator A reviews the prioritisation bands every three months.

Another advantage of the prioritisation systems of regulators A and B was that they prioritised notifications and self-notifications evenly across the prioritisation ratings. A system that leads to a disproportionate number of cases falling within one rating category will be of little use to a regulator.

A senior officer of one regulator expressed concern to our investigators that, having regard to the regulator's resourcing limitations, if notifications were prioritised into bands, some notifications would be in a band that would never be investigated. He said that it would be difficult to convince these notifiers that this was an appropriate response.

However, an effective prioritisation system enables regulators to identify cases of lower priority to which it can legitimately apply less resource-intensive responses.

CASE STUDY 12

A regulator implemented the following procedure for responding to notifications assessed as being of low priority:

- initially, the notifier and the potential offender are posted an information kit, which may include fact sheets, and are urged to resolve their differences
- the fact sheet for the potential offender might outline the relevant law, which the potential offender might not be aware of
- where the problem is of a continuing nature, the fact sheet for the notifier might urge them to keep a diary of the details of the problem for 21 days
- if the notifier remains dissatisfied after that period, he/she can ask the regulator to proceed to investigate the notification.

The regulator advised that after using these types of procedures for one year, there had been an 80% reduction in subsequent approaches by notifiers.

3.3.3 What we recommend

Regulators should develop and implement policies that ensure:

- cases are effectively prioritised across priority ratings
- most investigative resources are allocated to cases with higher ratings
- wherever practicable (and subject to the regulator's legislation) cases with the lowest priority ratings are addressed in less formal and more cost effective ways.

3.3.4 Prioritisation of anonymous notifications

Every year, regulators receive a significant amount of anonymous information. Regulators should have well defined policies and practices for how such information will be assessed and, if necessary, actioned. Regulators should not automatically classify all anonymous notifications as being of low priority without regard to the merits of the notification.

3.3.5 What we have found

We have noted that some regulators routinely give a notification a low priority if the identity of the notifier is not known. Officers often tell our investigators that anonymous notifications should be treated differently from other notifications because they are less capable of investigation and are often malicious.

Whether a notification is capable of investigation is a legitimate criterion for a prioritisation system. However, not all anonymous notifications are incapable of investigation (for example, where the notifier has provided ample, credible information that a breach has occurred to enable the matter to be productively investigated).

3.3.6 What we recommend

Regulators should develop and implement policies that ensure anonymous notifications are assessed against the same criteria as other notifications, including whether the notification is capable of investigation, and are not routinely classified as 'low priority'.

CHAPTER 3: DISCRETION AND THE ROLE OF RISK MANAGEMENT

3.4 BALANCING REACTIVE AND PROACTIVE WORK

As we have stated,³⁹ some regulators may have a statutory obligation to undertake proactive work. Others may decide that some proactive work is desirable to supplement their reactive work as it will make their work as a regulator more effective. The challenge is to get the balance right. As stated by one expert in regulatory practice:

Most regulators understand the limitations of reactive strategies. Indeed, most regulatory agencies have already made significant investments in methods designed to avert or minimize the need for detection, reaction, and enforcement. Having diversified their tool kits, those agencies now seek some rational strategic framework to make sense of their broader repertoire and to help staff understand what each tool is good for and how to use tools in combination.

The temptation regulators face now is to switch from a reactive strategy (whose failings we know) to a preventative strategy (whose failings we have only recently begun to discover). Both are limiting, because both emphasize one set of tools at the expense of the other.

The strategic focus that regulators need is risk control (or risk reduction). A control strategy embraces all the tools and considers each stage in the chronology of any harm as a potential intervention point.

Thus a control strategy brings no ideological or a priori preference for preventative or reactive tactics. Rather, per the art of problem solving, a control strategy respects the individual characteristics of each problem; seeks to identify its precursors, vital components, and methods of contagion; and from that analysis, picks the right points and moments to intervene.⁴⁰

The proportions in which a regulator undertakes reactive and proactive work and the way it prioritises that work are decisions for the regulator, having regard to its legislative scheme.⁴¹

3.4.1 What we recommend

Whatever the mix, regulators should develop and implement policies that provide a basis for their regulatory strategies.

³⁹ At section 3.3.

⁴⁰ Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press at page 191.

⁴¹ See chapter 13, 'Strategies Reactive, Preventive, Proactive', in Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press.

3.5 RISK MANAGEMENT OF PROACTIVE WORK

Because proactive work is usually identified and initiated by the regulator, its effectiveness depends on how much thought and detail are put into proactive work policies and whether the proactive work program is robust (that is, the reasons for the program are available to the public, the focuses of the proactive work are fair and soundly based and inspections of the same type of activity are carried out at a consistent level of detail).⁴²

3.5.1 What we have found

It is appropriate for regulators to base their proactive work program on a system of 'risk ranking' potential offenders (for example, by carrying out proactive inspections depending upon the risk rank). However, a regulator's risk ranking system will not be effective if it does not ensure consistency across like activities, as illustrated in the following case study.

CASE STUDY 13

A regulator's policy required 'risk ranks' to be allocated to each potential offender to determine the level of proactive compliance attention they would receive.

The risk rank was generally determined by a supervisor who would allocate a ranking of either 1, 2 or 3 to the potential offender, with 3 being the highest rank.

There did not appear to be any criteria against which to assess and allocate a risk rank, such that the regulator could be confident that a potential offender was ranked consistently with other like potential offenders.

Our officers were advised that to change a risk rank, the supervisor with responsibility for monitoring the potential offender would simply ask the relevant enforcement officer to change the risk rank in the electronic system. Commonly, no record would be made of the reasons for doing so.

In the electronic records, there was a field for recording the risk rank of a potential offender. Our officers received an electronic print-out of case information from the regulator's system, which showed that, in many cases, no risk rank had been recorded.

3.5.2 What we recommend

Regulators intending to undertake proactive work should develop and implement policies that ensure:

⁴² Queensland Office of Regulatory Efficiency.

CHAPTER 3: DISCRETION AND THE ROLE OF RISK MANAGEMENT

- the areas of focus of proactive work are identified
- the reasons for focusing on these areas are recorded
- if risk ranking is to be used to identify and prioritise areas:
 - the indicators for each risk ranking are sufficiently detailed
 - the level of officer authorised to set and/or change the risk ranking is specified
 - the reasons for setting or altering the risk ranking are recorded
- the various levels of proactive work are adequately described
- the circumstances in which each level of work will be undertaken are described
- supervisors monitor the performance of proactive work to check if it is being carried out in accordance with the policies.⁴³

3.5.3 Prior warning

Finally, a proactive work program will not be effective if individuals or businesses are routinely warned of impending inspections or other compliance activities.

3.5.4 What we have found

In one case we investigated, the regulator routinely warned the occupiers of premises that an audit would be performed on a particular day.

3.5.5 What we recommend

Regulators should develop and implement policies that ensure that advance warnings of audits of particular premises on a particular day are not routinely given.

3.6 ISSUES RELEVANT TO BOTH REACTIVE AND PROACTIVE WORK

3.6.1 Duty to assess notification

While a regulator has a discretion as to how it responds to an allegation of a breach of the legislative scheme it administers, it arguably has a responsibility to at least assess each allegation.⁴⁴

3.6.2 What we have found

Our investigations of two regulators revealed that each had adopted the practice of not investigating potential breaches of the regulatory scheme because other regulators also had regulatory responsibilities in relation to those breaches.

⁴³ For further discussion, see chapter 9 of Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press and in particular, page 133.

⁴⁴ *Hussein v Secretary of the Department of Immigration and Multicultural and Indigenous Affairs* [2006] FCA 286; *O'Malley v Keelty, Australian Federal Police Commissioner* [2004] FCA 1688; *Hinchcliffe v Commissioner of Police of the Australian Federal Police* [2001] FCA 1747; *Smiles v Commissioner of Taxation* [1992] 35 FCR 405; *King-Brooks v Roberts* [1991] 5 WAR 500; *R v McAulay Ex parte Fardell* [1979] 2 NTR 22; and *R v Commissioner of Police the Metropolis Ex parte Blackburn* [1968] QB 118.

CASE STUDY 14

In the first case, the regulator had adopted the practice of only providing technical support to other regulators in relation to incidents it also had a responsibility to regulate.

We formed the opinion that the regulator had misinterpreted its enforcement responsibility and recommended that it change its approach to enforcement.

These recommendations were accepted.

CASE STUDY 15

In the second case, the regulator was increasingly being requested to respond to and investigate certain types of notifications which could be investigated by other regulators by way of delegated authority. Not all of these other regulators had sought to be conferred with this delegated power.

The regulator had implemented a policy that it would only investigate if the notification related to a significant breach.

We recommended that where there is no delegation to another regulator, those lower priority cases should be subjected to prioritisation procedures (that is, those recommended at section 3.3.3). In other words, the regulator cannot make a blanket decision not to assess such cases, but can prioritise its assessment of these cases. The regulator accepted our recommendation.

3.6.3 What we recommend

Regulators should develop and implement policies that ensure:

- each case is assessed to the extent that an informed decision can be made as to whether it will be investigated in detail
- blanket policies that a particular type of case will not be assessed are avoided.

3.6.4 Consistency in enforcement

Although the legal authorities referred to in this section relate to the exercise of the discretion to prosecute, we do not see why the courts' reasoning should not also apply to decisions about the discretion to use other enforcement options, such as penalty infringement notices.

In many cases, regulators have a discretion whether to prosecute or take other enforcement action for a particular breach. However, regulators cannot have a blanket policy of taking no prosecution or other enforcement action against potential offenders for a particular class of breach.⁴⁵

⁴⁵ *Hussein v Secretary of the Department of Immigration and Multicultural and Indigenous Affairs* [2006] FCA 286; *O'Malley v Keelty, Australian Federal Police Commissioner* [2004] FCA 1688; *Hinchcliffe v Commissioner of Police of the Australian Federal Police* [2001] FCA 1747; *Smiles v Commissioner of Taxation* [1992] 35 FCR 405; *King-Brooks v Roberts* [1991] 5 WAR 500; *R v McAulay Ex parte Fardell* [1979] 2 NTR 22; and *R v Commissioner of Police the Metropolis Ex parte Blackburn* [1968] QB 118.

CHAPTER 3: DISCRETION AND THE ROLE OF RISK MANAGEMENT

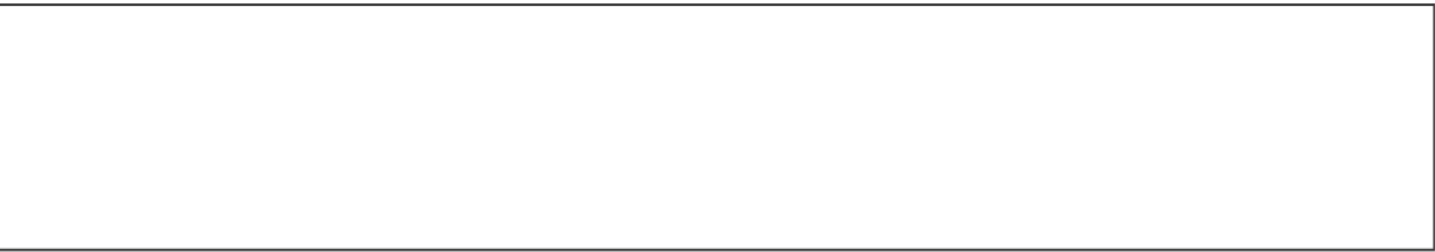
3.6.5 What we have found

In one case we investigated, a regulator had not initiated any prosecutions against certain types of entities for alleged breaches of a regulatory scheme for more than five years despite the fact that many such breaches had been reported to it.

3.6.6 What we recommend

Regulators should develop and implement policies that ensure:

- specified types of activities and entities are not given blanket exemptions from prosecution or other enforcement action
- as far as possible, consistency and transparency in the exercise of prosecutorial discretion and the use of other enforcement options.



CHAPTER 4: INVESTIGATIVE PRACTICES

An investigation should be a thorough and logical gathering of information followed by an objective assessment of that information to reach a valid conclusion.⁴⁶ Investigations that do not meet these criteria are likely to waste resources and be less effective. Furthermore, investigations of similar types of conduct will be less likely to lead to consistent outcomes.

Generally, an enforcement officer is responsible for gathering all relevant information pertaining to a potential breach and, at the conclusion of that information gathering exercise, to report his or her findings and make relevant recommendations.

4.1 INVESTIGATIVE PLANNING

Good investigative practice demands that officers properly plan their investigations to ensure resources are used in the most efficient way. As stated in the WEP report:

*Investigative planning is critical to the success of any investigation.*⁴⁷

The New South Wales Ombudsman has given similar advice:

*More investigations suffer in terms of quality because of poor investigative planning rather than for any other single reason ... A good investigation starts with careful planning and preparation, a clear understanding of the parameters of the investigation, and with proper authority. Care and attention spent in getting it right at the outset will avoid considerable difficulties later on.*⁴⁸

Poorly planned investigations are likely to:

- be ineffective (the issues are often not fully investigated and decisions are based upon incomplete information or no decision is able to be made and the investigation falls into the 'too hard basket')
- lead to decisions that are inconsistent with decisions on other similar notifications
- be inefficient (for example, resources can be wasted pursuing irrelevant avenues of inquiry and delays can result in complaints about the investigation itself, which must be responded to, further drawing resources).

4.1.1 Developing an investigation plan

It is essential that an investigation plan be prepared before commencing an investigation of any complexity.

⁴⁶ Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocution Project*, Brisbane: Queensland Ombudsman at page 112.

⁴⁷ Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocution Project*, Brisbane: Queensland Ombudsman at page 109.

⁴⁸ NSW Ombudsman (2004) *Investigating Complaints: A Manual for Investigators*, Sydney: NSW Ombudsman at page 28.

An investigation plan is essentially a 'road map' for the investigation and should set out its scope or terms of reference. It should also indicate the nature of the issues to be addressed and the investigation's objectives so that there is a clear understanding of when the investigation will be concluded.⁴⁹

The following checklist specifies the basic requirements of a good investigation plan:⁵⁰

- Clarify the key issues to be investigated
- Set out the terms of reference or scope of the investigation and its objectives
- Ensure that the objectives are relevant, achievable and within jurisdiction
- Set out the potential lines of inquiry and the steps the investigation should follow to ensure that it is conducted in a methodical and professional manner
- Identify the resources required to conduct the investigation
- Identify any opportunities for persons to remove, destroy or alter evidence and ways of minimising those opportunities
- Identify any potential problems that may be encountered in making inquiries
- Identify what, if any, redress should be provided for anyone who has suffered detriment as a result of the conduct being investigated
- Set out the timelines to be met during the investigation, thereby facilitating supervision
- Prepare the plan in accordance with a standard format that is flexible enough to be adapted for different types of investigations
- Identify any relevant legislation, code of conduct, standard or benchmark
- Identify the elements of any potential offences or defences
- Identify whether public interest disclosures have been made under whistleblower legislation
- Canvass potential findings.

A good investigation plan helps the case officer to stay focused on the job and to anticipate potential problems.

As mentioned in the above list, the investigation plan should set out the elements of any potential offences to help identify the evidence required to substantiate or disprove those offences.

This process involves examining each word or phrase in a potential offence and determining the particular issues of fact that need to be established to substantiate the commission of the offence.

It is necessary to prove each element of an offence to the appropriate standard.⁵¹ Some elements are common to every offence such as when and where the offence is alleged to have occurred and the identity of the person or entity responsible.

⁴⁹ Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocution Project*, Brisbane: Queensland Ombudsman at page 110.

⁵⁰ NSW Ombudsman (2004) *Investigating Complaints: A Manual for Investigators*, Sydney: NSW Ombudsman at page 28.

⁵¹ To the criminal standard unless legislation provides otherwise, for example, some minor licensing offences.

CHAPTER 4: INVESTIGATIVE PRACTICES

Any possible statutory defences, exemptions or excuses under the relevant legislation should also be identified, considered and broken down into their elements. Officers should turn their mind to the evidence required to negate any defence.

Of course, the extent to which an officer should formally address in the plan each aspect of the checklist will depend on the circumstances and complexity of the investigation.

Officers must be prepared to revisit the investigation plan in light of new evidence obtained during the investigation and, if necessary, recommend to their supervisor that the plan be changed.

A sample investigation plan template is contained in Appendix A.

4.1.2 What we have found

In the absence of an investigation plan, investigations often proceed in a 'knee jerk' fashion. This can lead to:

- allegations and issues being overlooked
- irrelevant issues being pursued
- voluminous documents being generated unnecessarily.

CASE STUDY 16

We conducted several investigations into the way a regulator discharged its regulatory responsibilities. A common finding in our investigations was the absence of investigative planning, as evidenced by the following:

- An enforcement officer stated, when interviewed by our investigators, that strategies were not developed or communicated to them in relation to their investigations. The enforcement officer made the comment that 'You just take a blank pad with you, get the address and you go. That's the way it is, that's how it's always been'. We found that the regulator did not require its officers to undertake investigative planning, which led to inadequate and inefficient investigations.
- An enforcement officer concluded an investigation and advised that insufficient evidence had been gathered to support a breach of the legislation. The enforcement officer did not identify the possible offences (a critical step in investigative planning). As the possible offences were not identified, the evidence that was required to prove or disprove those offences was, likewise, not identified.
- Two persons were injured simultaneously at the same site during a particular incident. However, because of their respective responsibilities, different potential breaches applied to the circumstances in which they suffered their injuries. The regulator's officers investigated the matter as one incident and did not fully appreciate the differences in the potential breaches. They may not have made this error had they prepared an investigation plan.

As a result of the investigation, we recommended that enforcement officers should be trained in how to prepare an investigation plan. The regulator's training manual was amended to include a chapter about investigative planning.

CASE STUDY 17

In the case of one regulator whose operational files were reviewed by our investigators, only three cases out of a total of 188 reviewed contained anything resembling an investigation plan.

In the other 185, there was little or no indication that any of the following key issues had been identified early in the process:

- whether the matters complained about were within jurisdiction
- the relevant legislation or standard
- the elements of any potential offences
- the evidence that might need to be gathered, and in what order, to support potential enforcement action.

CASE STUDY 18

The regulator investigated a notification involving allegations of mistreatment of a person. The notifier was dissatisfied with the regulator's investigation and complained to us.

Our examination of the regulator's file revealed a document that was intended to be an investigation plan and also a document that appeared to be a list of possible witnesses.

However, the investigation plan did not identify critical information such as the regulator's jurisdiction, the scope and purpose of the investigation, possible outcomes to be achieved, and possible sources of evidence such as incident reports or procedures.

We also noted that, according to the regulator's report, the purpose of the investigation was to:

- investigate the truth of the allegations
- investigate whether there was any ongoing risk to the safety of the person.

The report contained very little evidence about the second issue, which we attributed to poor investigative planning, in particular, failure to identify the purpose of the investigation.

We recommended the regulator devote resources to proper investigative planning in future to improve the quality of its investigations.

CHAPTER 4: INVESTIGATIVE PRACTICES

CASE STUDY 19

Under the regulatory scheme, it was an offence if a person failed to comply with any condition in a licence. A notifier claimed that a licence holder had failed to comply with four conditions in the licence.

The enforcement officer advised us that the licence holder had been successfully prosecuted for breaching a condition of the licence. He advised that, because of pressure from the notifier to prosecute the permit holder, he had limited his investigation to the most obvious breach of a licence condition and did not consider whether any other conditions may have been breached.

We considered that this was not a sound response to the notification. In particular, if the prosecution had failed, it would have been extremely difficult to obtain evidence to substantiate the other alleged breaches.

We recommended that where there are allegations of breaches of a number of licence conditions, the enforcement officer should investigate other potential breaches (at least those of equal seriousness) unless there are good reasons for not doing so. Pressure from the notifier for prosecution action is not a good reason.

4.1.3 What we recommend

Regulators should develop and implement policies that ensure:

- officers give investigative planning a high priority
- unless there are good reasons for not doing so, every investigation of any significance is the subject of an appropriate plan
- investigative activity does not commence until the plan has been approved by a supervisor except where there is a risk that evidence will be lost or become difficult to obtain unless immediate action is taken
- investigation plans are reviewed and, if necessary, changed whenever circumstances require.

4.2 INADEQUATE EVIDENCE GATHERING

Regulatory officers must be trained to identify (at the investigative planning stage) the evidence required to establish whether an offence has occurred and then to effectively and efficiently gather that evidence.

4.2.1 What we have found

Our investigations have shown that many enforcement officers do not have the necessary skills to identify and gather relevant evidence, as the examples in the case study illustrate.

4.2.2 What we recommend

Regulators should develop and implement policies that ensure:

- enforcement officers are provided with the requisite training in the laws of evidence and evidence gathering, so that they are able to make informed decisions about the nature of the evidence required to prove the elements of an offence and how to obtain the evidence
- supervisors give a high priority to enforcement officers preparing investigative plans and to reviewing those plans to ensure all relevant lines of inquiry are followed.

CASE STUDY 20

During a broad systems review of a regulator's practices, our officers noted that enforcement officers had frequently failed to obtain relevant evidence that was readily available. For example:

- The regulator investigated whether an employer had complied with its workplace health and safety obligation to employ an officer who was responsible for workplace health and safety at the workplace. The existence of the obligation depended on the number of persons employed at the business. The enforcement officer failed to obtain the employer's records that would have established this fact.
- In another case, no attempt was made to formally interview the directors of a corporation, which was a potential offender, within a reasonable time of the incident.
- An enforcement officer told our officers that when investigating a potential breach, he had been aware that it would have been useful to interview a particular witness but this had not occurred because the witness could not be located. In fact, the enforcement officer had the witness's mobile number and address. The notifier later succeeded in interviewing the witness themselves.
- During another investigation, the examination of certain physical evidence was the only means by which the regulator could decide whether a breach had occurred. The regulator did not examine that physical evidence, and decided that no further action would be taken.
- A defective electrical appliance resulted in a worker's death. The appliance was examined by an expert but the enforcement officer did not take the report into account in considering his recommendation as to whether to prosecute.

As a result of these and other cases, we made recommendations to the CEO about training and investigative planning, with a view to raising the standard of evidence gathering.

CHAPTER 4: INVESTIGATIVE PRACTICES

CASE STUDY 21

This case study relates to the same matter as case study 18. As mentioned in that case study, we thought the regulator had failed to gather sufficient evidence about whether there was any ongoing risk of harm to a person. In particular, the regulator did not appear to have gathered any evidence about:

- whether the potential offender regularly interacted with the person
- the manner in which the potential offender's work colleagues treated the person
- whether there was an appropriate risk management plan and risk management process in place as claimed by the potential offender's employer
- whether any steps were being taken to ensure the person's family was involved in planning for his ongoing care
- whether there were processes in place to ensure that future notifications of mistreatment of the person would be appropriately addressed.

4.3 USE OF LEGAL ADVICE

As stated in the WEP report,⁵² it is incumbent on a regulator to seek legal advice in appropriate cases to ensure its decisions are not contrary to law, for example, to clarify whether the regulator has jurisdiction to investigate a particular notification.

4.3.1 What we have found

The following case study describes situations where a regulator failed to obtain/act upon legal advice when it should have.

CASE STUDY 22

The regulator had:

- failed to obtain legal advice on the interpretation of key terms in legislation, even though the interpretation of those terms determined a significant jurisdictional issue in one case and how the regulator would respond to all future incidents of a particular class
- decided that a person was an independent contractor rather than an employee despite having obtained legal advice that it should conduct further inquiries about the nature of the employment relationship between that person and a corporation that was relevant to the corporation's obligations owed to the person
- failed to act upon legal advice that the regulator should take steps to clarify the entitlements of the holders of various types of licences.

⁵² Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocution Project*, Brisbane: Queensland Ombudsman at page 116.

4.3.2 What we recommend

Regulators should develop and implement policies that ensure:

- legal advice is obtained where there is uncertainty as to the rights, obligations and liabilities of the regulator or the meaning of the legislation it enforces where the issue has a significant bearing on the regulator's operations
- as a general proposition, where legal advice is obtained by a regulator concerning a question of law, the regulator should act in accordance with that advice, unless to do so would be unreasonable
- the reasons for not following relevant legal advice in a particular case or generally are recorded.

4.4 EXPERT WITNESSES

Opinion evidence is not admissible in court proceedings except when it is given by an 'expert'. The court decides whether a witness is qualified (that is, an expert) to give opinion evidence. Witnesses may be examined in a hearing (called a 'voir dire'), as to whether their qualifications make them an expert.

It is good practice for regulators to ensure that the witnesses they hold out as experts are appropriately qualified as inappropriately qualified witnesses may prejudice the regulator's interests in legal proceedings.

4.4.1 What we have found

In some cases, officers have not properly assessed the qualifications of witnesses to be called at hearings to give opinion evidence for the regulator, resulting in the court ruling that the witness was not qualified to give that evidence.

CASE STUDY 23

No effort was made by the regulator to establish whether an officer from another entity that was assisting the regulator's investigation was suitably qualified or experienced to give expert evidence.

As a result, when the officer was called to give evidence at a hearing, he was unable to answer many questions of a technical nature.

In other cases, a regulator may put forward its own enforcement officer to give opinion evidence. If the court does not agree the officer is appropriately qualified to give the evidence or, if the officer does not provide a sound basis for the opinion, the officer's credibility may be undermined to the extent that other evidence the officer gives in his/her capacity as the investigator becomes less credible.

CHAPTER 4: INVESTIGATIVE PRACTICES

4.4.2 What we recommend

Regulators should:

- maintain a central register of all internal and external expert witnesses that includes details of the expert witnesses' qualifications and experience
- wherever possible, ensure that the investigating officer in a case is not put forward by the regulator to give expert evidence in that case.

4.5 ESTABLISHING MATERIAL FACTS

The regulatory scheme and/or the regulator's policies should provide guidance on the material facts that need to be established to support a particular enforcement action. For example, a material question in connection with a particular offence might be 'Was the alleged offender carrying on a business?' Enforcement officers must obtain sufficient evidence of this fact to satisfy the court to the required standard of proof (see below).

Material facts must be established by relevant evidence. They should not be based on guesswork, suspicion, preconceptions, assumptions, generalisations, rumour and/or speculation. On the other hand, evidence is not necessarily proof. It may be accepted or rejected. The applicable standard of proof is usually 'beyond reasonable doubt' for criminal proceedings and 'on the balance of probabilities' for civil proceedings.

In the case of an administrative decision by an enforcement officer (e.g. whether there are sufficient grounds to issue a warning notice), the officer is not limited to considering 'evidence' in the sense in which that term is used in the courts. For example, an enforcement officer making such a decision may have regard to hearsay statements and draw inferences about the most probable version of disputed events.⁵³

However, in making decisions about whether to take particular enforcement action, officers, though not bound by evidentiary principles (except in proceedings in a court), should be guided by them. Examples of evidentiary principles that provide guidance include:

- factual claims that are corroborated can more easily be accepted
- hearsay evidence is not necessarily reliable.⁵⁴

⁵³ Creyke, R. and McMillan, J. (2009) *Control of Government Action – Text, cases and commentary*, 2nd edition, LexisNexis Butterworths, Australia at 12.2.19.

⁵⁴ Creyke, R. and McMillan, J. (2009) *Control of Government Action – Text, cases and commentary*, 2nd edition, LexisNexis Butterworths, Australia at 12.2.20.

At the very least, administrative decisions must be supported by some evidence that bears a logical connection to them. The decision may also need to be supported by factual inferences that are reasonably open and by reasoning that is not logically self-contradictory.⁵⁵ The factual or evidentiary proof that is required to support an administrative decision can vary with the statutory provision that is being acted upon.⁵⁶ For these reasons, in administrative decision-making, it is unhelpful to use the terms 'balance of probabilities' and 'evidence' in the same sense as those terms are used in civil proceedings.⁵⁷

4.5.1 What we have found

The following case studies demonstrate regulators' failures to properly weigh the evidence and establish the material facts.

CASE STUDY 24

A regulator investigated allegations made by a notifier about a person employed in the regulated industry to decide whether disciplinary action should be taken. The notifier was dissatisfied with the outcome and complained to us.

We noted that the information obtained by the enforcement officer consisted, almost entirely, of eyewitness accounts. The officer stated in the investigation report that, as the investigation process was not like a court hearing where witnesses could be called to provide evidence under oath and be cross-examined at length, it was often not possible to form a definite opinion on whether the allegations had been substantiated.

We considered that the officer had applied too strict a test in deciding that disciplinary action should not be initiated. Enforcement officers often have to make decisions on the basis of conflicting information, including conflicting accounts of persons interviewed. Only rarely will the conflicting accounts of two or more witnesses, when evaluated in conjunction with other relevant information, leave an officer in the position of being unable to make a decision on which account is the more or the most credible.

Although enforcement officers do not have the advantage a court has of seeing witnesses examined and cross-examined on oath, they have the advantage of not being bound by the rules of evidence in making a decision or recommendation, and can inform themselves about a matter in any way they consider appropriate. Of course, in doing so, they must comply with the requirements of natural justice and should be guided by evidentiary principles.

We also told the regulator that the information relied on in forming an opinion about credibility should be documented, and adequate reasons recorded for the conclusion reached.

⁵⁵ Creyke, R. and McMillan, J. (2009) *Control of Government Action – Text, cases and commentary*, 2nd edition, LexisNexis Butterworths, Australia at 12.2.24.

⁵⁶ Creyke, R. and McMillan, J. (2009) *Control of Government Action – Text, cases and commentary*, 2nd edition, LexisNexis Butterworths, Australia at 12.2.25.

⁵⁷ *Minister for Immigration and Ethnic Affairs v Wu Shan Liang* (1996) 185 CLR 259 and 282, discussed in Creyke, R. and McMillan, J. (2009) *Control of Government Action – Text, cases and commentary*, 2nd edition, LexisNexis Butterworths, Australia at 12.2.21.

CHAPTER 4: INVESTIGATIVE PRACTICES

CASE STUDY 25

We received a complaint about a regulator's alleged delay in responding to a notification of a potential danger to the notifier's property. The notifier claimed that as a result of the delay his property had suffered damage.

The regulator's file showed that its officer had contacted the potential offender who had told him that the situation was safe.

In view of the conflicting accounts, the enforcement officer contacted another officer who knew both the notifier and the potential offender. That officer advised that the two men were related and that the complaint was a family feud. It appeared that this information was the key factor for the enforcement officer in determining that a further inspection to assess the safety of the site could wait until the following morning.

We told the regulator that, in the absence of other relevant information (such as a history of false complaints by one party against the other), it had given too much weight to the fact that the notifier and the potential offender were related and did not have a good relationship.

4.5.2 What we recommend

When considering whether an offence has been committed, regulators should ensure each piece of evidence is considered in terms of its relevance, reliability and sufficiency (i.e. whether it meets the applicable standard of proof). Each piece of evidence should be weighed against other evidence to establish the material facts.

When making an administrative decision (e.g. whether there are sufficient grounds to issue a warning notice), regulators are not bound by the rules of evidence but should be guided by evidentiary principles. Their administrative decisions must be supported by some evidence that bears a logical connection to them.



CHAPTER 5: SYSTEMS FOR EFFECTIVE REGULATION

This chapter examines some systems (including policies and procedures) that can be implemented to support effective regulatory practice.

5.1 BRING-UP SYSTEMS

Managing a heavy workload in a timely way is an ongoing challenge for most regulators. Regulatory action that is delayed without good reason:

- loses its deterrent effect
- can damage the regulator's reputation.

5.1.1 What we have found

Sometimes, officers do not take necessary regulatory action in a timely manner because of their excessive workload. In other cases, officers simply forget to take the action as the following cases illustrate.

CASE STUDY 26

An officer asked a potential offender to address two issues.

The officer received a satisfactory response from the potential offender about the first issue and closed the case without obtaining any evidence that the second issue had been addressed.

CASE STUDY 27

A brief of evidence was provided to the regulator's legal unit for determination as to whether a prosecution should be brought. The legal unit neglected to promptly perform the task and the statutory time limit for bringing proceedings expired. No system was in place to remind officers when time limits were about to expire.

CASE STUDY 28

A regulator's usual practice where a potential offender advised that it had completed a task the regulator had directed it to undertake was to accept that advice as correct without any independent verification.

5.1.2 What we recommend

Regulators should have electronic case management systems in place that:

- record the dates by which critical operational actions must be completed
- generate reminders/bring-ups prior to the due date for an action
- notify the appropriate supervisor (or, at least, enable the supervisor to discover) when an action has not been completed by the due date.

5.2 SYSTEMS FOR EFFECTIVE INVESTIGATION

Sometimes, a regulator's own policies or practices do not encourage effective regulation. Where this is the case, the deficiencies may become systemic and prejudice the regulator's reputation.

5.2.1 What we have found

In individual cases, the regulator's lack of response may have been justifiable, for example:

- the potential offender's operations may have been in a remote location so that it was impracticable for an enforcement officer to carry out a site inspection to verify the potential offender's claim that they were complying with their licence conditions
- based on the potential offender's history, the officer believed the claim to be reliable.

However, as a general response, the practice was fraught with danger.

These case studies also exemplify instances of effective regulation giving way to expediency.

CASE STUDY 29

Officers of a regulator said that, generally, they were given as much credit for closing a file and conducting a 'timely investigation' as they were for undertaking a detailed investigation of an incident with a view to commencing a prosecution.

In such an environment, there was little motivation for officers to undertake the more complex and time-consuming investigations.

CASE STUDY 30

An enforcement officer relied on an 'internal investigation' by the potential offender, including expert evidence provided by an employee of the potential offender regarding the examination of an item of equipment critical to the investigation.

The enforcement officer did not conduct any independent testing on the item to verify the findings of the expert who clearly could not be perceived as being independent or impartial.

CASE STUDY 31

Regulators A and B were responsible for two distinct pieces of legislation. However, each Act was relevant to the same incident. The notifier complained to regulator A. Regulator B had already conducted an investigation into the incident.

In advising the notifier that it would not take further action, regulator A endorsed the findings of regulator B without looking at the evidence upon which those findings were based to determine whether it established a breach of the legislation regulator A administered.

CHAPTER 5: SYSTEMS FOR EFFECTIVE REGULATION

5.2.2 What we recommend

Regulators should develop and implement policies that ensure:

- unless it is impracticable to do so in the circumstances, independent corroboration is sought for advice from a potential offender that it has taken steps that the regulator has directed it to take or that it has agreed to take
- where a potential offender conducts its own investigation of a potential regulatory breach by its employees and concludes that no breach has occurred, the regulator carefully review the investigation and findings
- where two or more regulators are responsible for administering separate but overlapping regulatory regimes and one regulator conducts an investigation and concludes no breach has occurred of the regime it administers, the other regulator should independently consider whether a breach of the legislation it administers has occurred
- officers' performance is not assessed solely on the basis of the number of cases they close.

5.3 FACILITATING FUTURE ENFORCEMENT ACTION

Regulators should think strategically about what enforcement action is likely to be the most effective in the circumstances. In making that assessment, they need to have regard to, among other things, the seriousness of the inappropriate activity and the resources involved in taking the action. They should also think about how to take the enforcement action in a way that will facilitate future enforcement action in the event that the initial action is unsuccessful in preventing or addressing the inappropriate activity.

For example, an officer intending to send a warning notice should ensure the notice contains sufficient details so that the alleged offender is left in no doubt about what action needs to be taken or what activity must cease.

5.3.1 What we have found

The following case study relates to a situation where the enforcement officer issued a warning notice containing insufficient details of the prohibited activity.

CASE STUDY 32

Our investigation of one regulator uncovered a warning letter to the following effect:

I am writing to warn you that [an officer of the regulator] has detected an alleged offence committed by you. Details of this alleged offence are:

Date
[date]
Location of alleged offence/s
Brisbane
Description /nature of alleged offence/s
Carry on business without a licence
Act / Regulation reference/s
Section X of the YZ Act

Corrective Actions Required: Ensure your actions in regard to your business do not include the sale or arranging the sale of specified products (*the products specified could not be sold without a licence*)

Corrective actions required:

We considered that the warning should have contained the following additional information:

- sufficient details to support the enforcement officer's opinion that the potential offender was carrying on the relevant business without a licence
- the penalty for the alleged offence
- other requirements to assist enforcement for example, a requirement that the potential offender confirm in writing by a specified date that the conduct has ceased
- advice that failure to comply with the notice may result in further enforcement action being taken.

Including this additional information in the notice would have facilitated future enforcement action being taken against the potential offender in the event of non-compliance with the notice.

5.3.2 What we recommend

Regulators should plan their enforcement action (including by carefully drafting any documents prepared for the purpose of taking that action) to ensure that if particular enforcement action fails, the foundations have been laid to enforce compliance with the regulatory scheme by an alternative effective means.

CHAPTER 5: SYSTEMS FOR EFFECTIVE REGULATION

5.4 SUPERVISORY SYSTEMS

Effective supervision is important because it brings greater consistency to, and identifies deficiencies in, regulatory practices. However, supervision will not be effective if the supervisor simply rubber-stamps the subordinate's recommendation. Supervisors must 'value add' by applying their greater knowledge and experience to the circumstances of the case.

5.4.1 What we have found

These case studies illustrate an inadequate level of supervision by regulators.

CASE STUDY 33

We reviewed several cases investigated by a regulator in which there was no evidence that the relevant supervisors had actually endorsed recommendations made by enforcement officers, as required by the regulator's policy.

In one case, a supervisor denied having endorsed an enforcement officer's recommendation despite having written the word 'noted' on a post-it note on the officer's report.

Some officers suggested that their managers had less investigative experience than they had and therefore had to rely on the enforcement officers' opinions because of their technical expertise.

CASE STUDY 34

Our review of a regulator's practices revealed that many closed cases contained the notation that it was satisfied and there should be no further action. There was no record indicating that supervisors had approved the decision or were even aware the case had been closed.

The regulator had no policy requiring enforcement officers to obtain the approval of a supervisor before closing a case.

CASE STUDY 35

A person who complained to us about a regulator's failure to take enforcement action claimed that the enforcement officer's supervisor may have been influenced by a culture of expediency. In other words, the complainant alleged that, based on his observations of the way the regulator's officers had conducted themselves, the modus operandi had been to close his case as soon as possible. He accused the regulator of having adopted a 'blame the victim' approach to his notification and of having unfairly dismissed his allegations.⁵⁸

The records of the decision-making process did not help to dispel the complainant's claims. An enforcement officer had completed his investigation of the incident and prepared a report that included findings. The covering letter to his supervisor said that, although there may have been a breach of the legislation, it was considered unlikely that sufficient evidence to support a successful prosecution could be gathered. Therefore, no further action was recommended.

The supervisor simply forwarded the report and covering letter to a senior officer with the endorsement 'Forwarded – recommendation supported'. The senior officer then endorsed the report 'noted and accepted'.

When interviewed, neither the supervisor nor the senior officer could explain their decisions.

5.4.2 What we recommend

As mentioned, a supervisor should apply their greater experience and knowledge in reviewing a subordinate's recommendation that enforcement action be taken or not be taken. The supervisor should make an appropriate record of why they supported or did not support the recommended course of action.

Finally, regulators' policies need to ensure that decisions to close a case are made by a sufficiently senior officer whose performance is not assessed solely or primarily by the number of cases closed by the officers' subordinates.⁵⁹

⁵⁸ Such a culture can have a negative impact on the functioning of the agency, as Sparrow states, namely 'When frontline officers discover (often to their cost) that senior managers care more about conflict minimisation than mission accomplishment, morale plummets, experienced enforcement officers leave, and an agency's long-term capacity to fulfil its public responsibilities suffers significant damage', in Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press at page 64.

⁵⁹ 'President Clinton's March 4, 1995, memo describing his regulatory reinvention initiative provided heads of regulatory agencies at the federal level unambiguous direction on the subject of performance measurement: *Reward Results, not Red Tape*: I direct you to change the way you measure the performance of both your agency and your frontline regulators so as to focus on results, not process and punishment ... You should identify appropriate performance measures and prepare a draft in clear, understandable terms, of the results you are seeking to achieve through your regulatory program': 'President's Memorandum on Regulatory Reform: Regulatory Reinvention Initiative', March 4, 1995, Public Papers of the Presidents of the United States (1995), page 3, in Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press at pages 109 and 110.

CHAPTER 5: SYSTEMS FOR EFFECTIVE REGULATION

5.5 REVIEW SYSTEMS

A process involving the regular review of a sample of cases is a useful supplementary tool to ensure:

- consistency of decisions
- investigations are being conducted lawfully and effectively.

5.5.1 What we have found

Our investigations have found that some regulators do not have any case review system. Other regulators have inadequate systems, as the following case studies illustrate.

CASE STUDY 36

A regulator's investigations manual provided that a senior officer would select, on a monthly basis, approximately 10% of case reports that had not been recommended for prosecution and determine if the investigation findings were valid and decisions made in accordance with the investigation and prosecution policies.

There were three types of cases. Priority 1 cases involved death or grievous bodily harm. Priority 2 involved bodily harm or dangerous events. Priority 3 were the remaining cases. We concluded that the review system was inadequate because the proportion of cases reviewed was too low and the more serious cases were no more likely to be reviewed than the less serious ones.

CASE STUDY 37

A regulatory scheme prescribed time limits for regulators administering the scheme to issue requests for information to persons making applications under the scheme. We investigated a regulator's administration of the scheme and found that, in almost 25% of files containing such requests, it had:

- issued them late
- failed to notify applicants that it had extended the time for requesting information
- issued a request after an extension had expired.

We recommended that the regulator implement a system whereby a supervisor undertakes a periodic audit of a random sample of information requests and extensions to check their compliance with the regulatory scheme requirements and guidelines.

5.5.2 What we recommend

Regulators should have systems in place that provide for:

- a sample of cases to be reviewed, at regular intervals, with emphasis on cases closed without enforcement action being taken, to identify inconsistent decision-making and inefficient or unauthorised practices
- the sample to be selected in such a way as to be reasonably representative of the total case population and, generally, be weighted in favour of the more serious cases⁶⁰
- the review to be undertaken by an officer or officers of sufficient seniority and experience
- appropriate action to be taken in response to identified instances of inconsistent decision-making and inefficient or unauthorised practices.

5.6 APPROVAL SYSTEMS

Appropriate approval processes are an important component of an effective regulatory system. A best practice model generally employs a multi-tiered approach to decision-making.

5.6.1 What we have found

Inconsistent decision-making can arise from inadequate approval processes or from failure to adhere to the processes, as the following case studies illustrate.

CASE STUDY 38

A regulator had a policy whereby a decision to investigate a case with a view to court action would only be made by a committee of senior officers of the regulator on the recommendation of the senior officer for the relevant region.

However, the senior officer for the region could later decide to discontinue that investigation, without consulting or notifying the committee, thereby encouraging inconsistent approaches to the taking of prosecution action from region to region.

CASE STUDY 39

A regulator's policy in relation to taking prosecution action was to the effect that serious consideration shall be given to the institution of proceedings in relation to significant incidents and all such incidents must be notified to the Prosecutions Section.

Our officers inspected a case file that revealed the enforcement officer had suspected that a serious incident had occurred but had not notified the Prosecutions Section and had not undertaken further investigations to determine whether the incident was significant.

⁶⁰ For further guidance on sampling design, see section 3.3 – Sampling Design, in Moore, David S. and McCabe, George P. (1993) *Introduction to the Practice of Statistics*, 2nd edn, New York: W.H. Freeman and Company; and Neumann, W.L. (1997) *Social Research Methods: Qualitative and Quantitative Approaches*, 3rd edn, Sydney: Allyn and Bacon.

CHAPTER 5: SYSTEMS FOR EFFECTIVE REGULATION

5.6.2 What we recommend

Regulators should:

- develop and implement approval processes that ensure, to the extent possible, consistency in decision-making
- conduct audits at regular intervals to ensure the processes are being complied with.

5.7 DELEGATIONS

The legislation establishing a regulatory scheme often provides that the relevant Minister or the holder of a specified position or public office is authorised to make decisions under the scheme.

Many schemes require the making of numerous decisions and therefore it is common for legislation to allow Ministers and other officials to delegate their powers and functions to others (by name, or as the holder of a specified position or office). Some legislation also allows the sub-delegation of powers and functions.⁶¹

In deciding whether it is appropriate to delegate a decision-making power, the delegator should first of all ensure that the power can be lawfully delegated and also consider whether the proposed delegate has the necessary qualifications, skills and experience.

If a decision-making power is delegated to a senior officer and the number of decisions to be made in exercise of that delegation is high, there is a potential for a 'bottleneck' to develop, hampering the effectiveness of the regulator.

5.7.1 What we have found

The following case studies illustrate the problems that can arise from inappropriate delegations.

CASE STUDY 40

We investigated allegations of unreasonable delay in a council's processing of development applications. Most of the delay occurred at the decision stage and the full council made most of these decisions. We examined the practices of other councils and noted that almost two-thirds of decisions on development applications were made by council officers acting under delegation.

We recommended that the council grant further delegations of decision-making power to a standing committee of the council or to appropriate staff, thus enabling the full council and senior officers to devote greater attention to more complex or controversial applications.

⁶¹ See Tourism, Fair Trading and Wine Industry Development, and Queensland Ombudsman (2006) *Better Decisions Project: A Framework for Effective Administrative Decision Making Systems*, Brisbane: Tourism, Fair Trading and Wine Industry Development, and Queensland Ombudsman at page 34.

CASE STUDY 41

A regulator's policy provided that prosecution proceedings could only be commenced on the approval of a committee comprising senior officers (including some who were legally qualified) and the final approval of the CEO.

We considered that the requirement that the CEO give final approval in relation to all prosecution proceedings had the potential to create a bottleneck. We also questioned whether this is an effective use of a CEO's time.

We recommended that the regulator review its approval process and suggested that a more efficient alternative may be for the CEO to approve such decisions in large or sensitive cases and that, in other cases, the CEO simply be provided with regular reports or minutes of the committee's decisions on cases it considers for court action and intervene if the CEO considered it appropriate.

5.7.2 What we recommend

It is a matter for the CEO of each regulator to determine who should have authority to make various decisions, including decisions to prosecute. If it is considered appropriate that a senior officer make all decisions of a certain type, the situation needs to be monitored to ensure a bottleneck does not develop.

Each regulator should carefully consider what delegations are appropriate to effectively discharge its responsibilities.

5.8 ORGANISATIONAL STRUCTURES

Good organisational structures can enhance the effectiveness of the regulator.

5.8.1 What we have found

The following case study illustrates that poor organisational structures can impede regulatory effectiveness.

CASE STUDY 42

A senior officer claimed regionalisation of the regulator was the major cause of resource problems in relation to investigative activities and caused a lack of coordination that was hampering its attempts to achieve other operational goals.

An enforcement officer in the same regulator based in a regional area told our investigators that one of his cases required both local witnesses and witnesses in Brisbane to be interviewed. He said he had difficulty arranging for an enforcement officer in Brisbane to interview the Brisbane-based witnesses because the salaries of the Brisbane officers formed part of the Brisbane office's separate budget and the Brisbane office was reluctant to make its officers available for work that was not a 'Brisbane' case.

CHAPTER 5: SYSTEMS FOR EFFECTIVE REGULATION

5.8.2 What we recommend

Much has been written about the most effective structures for regulators⁶² and it is not the purpose of this report to promote any particular structure. Each regulator's circumstances are different and it is for the regulator to make its own decisions about which structure best suits its operations and its objectives.

Therefore, our only recommendation on this issue is that a regulator should review its organisational structure at regular intervals to ensure it provides optimal support in achieving its goals and objectives.

5.9 REVIEW OF POLICIES

Often, officers in the field have complained to us that their policy division had developed an inappropriate policy that impacted on their work but had not consulted them.

It is good practice to properly consult with officers in the field when reviewing policy because the officers may be able to alert policy drafters to unusual situations they would not otherwise be aware of, or to unintended consequences a policy may have on the regulator's operations.⁶³

5.9.1 What we have found

The following case study illustrates a lack of effective consultation with operational officers in policy development and review.

CASE STUDY 43

The regulator had hundreds of policies on its electronic policy database. Some supervisors in small district offices said that, as a group, head office from time to time provided them with long lists of policies and asked them to advise which of them was outdated. They said a large number of documents on the regulator's electronic policy database were outdated and the way head office went about approaching the supervisors was unhelpful and an excessive burden on them.

The following case study illustrates a good consultation system.

CASE STUDY 44

The regulator's policies were stored on a database and each policy had a review date. When the review date for a policy was reached, the officer responsible for the review was automatically sent a 'bring-up' to undertake the review, coordinate consultation to assess the policy's currency and make any necessary changes.

⁶² See for example, Chapter 11: The Problem Solving Infrastructure, in Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press.

⁶³ Queensland Office of Regulatory Efficiency.

5.9.2 What we recommend

Regulators should develop and implement policies that ensure:

- officers are allocated responsibility for the review of specified policies
- the officer responsible for the review of a policy is sent a bring-up when it is time to undertake the review
- that officer properly consults with officers in the field who frequently apply that policy (proper consultation means that the officers consulted are directed to the relevant parts of the policy and provided with a summary of relevant issues for their consideration and input).

CHAPTER 6: REGULATORS WORKING TOGETHER

As stated in the WEP report,⁶⁴ it is well established that effective communication with members of the public and other stakeholders enhances the ability of a regulator to achieve its goals. When the regulator's stakeholders include other regulators with overlapping responsibilities, the effectiveness of the regulatory scheme will depend on the level of communication and cooperation.

6.1 LEAD AGENCY AND PARTNER AGENCIES

Where a group of regulators administers a regulatory scheme, one regulator (the 'lead agency') should take the primary responsibility because, without leadership, the coordination of the administration of the scheme may suffer. Consequently, regulators will incur unnecessary costs (for example, through duplication of effort) and their reputations as effective regulators are likely to be prejudiced.

Administrative Arrangements Orders are issued from time to time specifying the responsibilities of each agency of the Queensland Government. The current Administrative Arrangements Order⁶⁵ is available on the Department of the Premier and Cabinet website.⁶⁶ However, sometimes there is confusion over which regulator is the 'lead agency'. It is obviously important that the relevant regulators work together to resolve that confusion.

6.1.1 What we have found

We have found instances where regulators did not work together to determine the lead agency for the regulation of certain cases or types of cases, with the result that no regulator took primary responsibility.

CASE STUDY 45

Under a regulatory regime, where an incident occurred that resulted in a person's death, three regulators had overlapping jurisdiction to investigate.

There was no consultation among these regulators about which one would be the lead agency for investigating any such incident or the responsibilities of each regulator.

This led to duplication of investigative effort and resources and a fragmented approach to the investigation. Two of the regulators regarded each other as the lead agency.

⁶⁴ Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocutation Project*, Brisbane: Queensland Ombudsman at page 147.

⁶⁵ Administrative Arrangements Order (No. 3) 2007.

⁶⁶ <http://www.premiers.qld.gov.au/policy/machinerygovt/>.

CASE STUDY 46

An officer of a regulator sought written advice from a partner agency about an issue in the case, on the mistaken assumption that the partner agency had undertaken its own investigation. The partner agency relied upon the 'internal investigation' of the potential offender in providing specific but incomplete 'advice' to the regulator about the limited prospects of a successful prosecution. It did not disclose that it had not undertaken an independent investigation.

We recommended extensive changes to the regulatory scheme, which, among other things, clarified enforcement responsibilities.

CASE STUDY 47

Regulator A asked regulator B to provide technical assistance by conducting tests on an item of equipment that was the property of the potential offender. Regulator B did not provide that assistance, despite having a statutory power to seize and test the equipment. Officers of regulator B were unable to explain to our investigators why no action had been taken.

6.1.2 What we recommend

Partner agencies have appropriate arrangements in place in accordance with the relevant legislation (supported by a written agreement such as a memorandum of understanding) identifying which regulator is the lead agency for specified categories of cases and the responsibilities of partner agencies.⁶⁷

6.2 LEAD AGENCY'S ROLE

The lead agency should assume responsibility for coordination of regulation by the regulators within the group.

6.2.1 What we have found

The following case study is an example of the type of unsatisfactory situation that may arise where no regulator takes the lead role.

⁶⁷ See also Australian Public Service Commission (2005) *Working Together: Principles and Practices to Guide the Australian Public Service*, retrieved 23 January 2007 from the world wide web: <http://www.apsc.gov.au/mac/workingguide.htm>.

CHAPTER 6: REGULATORS WORKING TOGETHER

CASE STUDY 48

The lead agency had previously had a policy of ensuring that, where partner agencies refused to carry out their regulatory responsibilities, appropriate action was taken. However, the policy was withdrawn and not replaced.

When other regulators in the group refused to carry out their regulatory responsibilities, the lead agency took no action with the result that certain activities were not regulated.

6.2.2 What we recommend

The lead agency for a regulatory scheme should develop and implement a policy to ensure that cases within the jurisdiction of the regulation group continue to be appropriately assessed and actioned where another regulator refuses to carry out its regulatory responsibility. The lead agency may do this by persuading the other regulator (or a third regulator) to take the necessary action, taking the action itself or a combination of those options.

6.3 PRACTICES TO BE CONSISTENT

Where two or more regulators are responsible for administering a regulatory scheme, the public is entitled to expect that the scheme will be enforced consistently across Queensland, regardless of which regulator takes or should take enforcement action.⁶⁸

Therefore, although regulators are generally free to make their own choice of the most effective regulatory model, the practices of a group of regulators regulating a scheme should be consistent, to the extent practicable.

6.3.1 What we have found

The next case study demonstrates an inconsistent approach to regulation by regulators administering a regulatory scheme as well as an attempt to achieve consistency by some of those regulators.

⁶⁸ See Queensland Office of Public Service Merit and Equity (2004) *Seamless Government: Improving Outcomes for Queenslanders, Now ... and in the Future*, retrieved 1 May 2007 from the world wide web: www.opsme.qld.gov.au/seamless/seamless_final.pdf; Better Regulation Task Force (April 1999) *Enforcement*, London: Better Regulation Task Force at page 5; see also External Advisory Committee on Smart Regulation-Canada (2004) *Smart Regulation: A Regulatory Strategy for Canada*, retrieved 22 January 2007 from the world wide web: www.regulatoryreform.com/pdfs/Canada%20Smart%20Regulation%20Report%20Sept%202004.pdf, which endorses the creation of a more seamless regulatory environment.

6.3.2 What we recommend

Lead agencies should:

- ensure that their policies regarding the administration of their regulatory responsibilities can be conveniently accessed by other regulators in the regulation group
- promote the use of consistent enforcement practices and procedures by all regulators in the group.

CASE STUDY 49

We investigated the administration of a regulatory scheme by the lead agency. Numerous other regulators were also required to jointly regulate one part of the scheme. However, the lead agency offered no formal guidance on the appropriate way to enforce that part. Therefore, the other regulators adopted their own enforcement practices, some of which were very different. This led to potential offenders being treated differently, depending on the regulator taking the action.

We recommended that the lead agency take ongoing action to promote consistency in the enforcement practices and procedures by all partner agencies. The lead agency accepted our recommendation. We are awaiting its advice as to how it has decided to implement our recommendation.

However, our investigators noted that a small group of the partner agencies had taken the initiative of attempting to operate under a consistent set of enforcement policies.

6.4 SHARING OF CASE RECORDS

It is important that each regulator in a regulation group has timely access to relevant case information held by another regulator in the group, to ensure consistent enforcement practices and to avoid duplication.

6.4.1 What we have found

In the absence of effective information sharing mechanisms, the potential for inconsistency increases with the number of regulators in the regulation group, as this case study illustrates.

6.4.2 What we recommend

Regulators in a regulation group should have arrangements in place (ideally supported by a memorandum of understanding) that ensure relevant case information is exchanged between them in a timely way, subject to any requirements to maintain confidentiality.

CHAPTER 6: REGULATORS WORKING TOGETHER

CASE STUDY 50

Regulators in a large regulation group of over 150 agencies did not have access to each other's case records. Therefore, officers did not know how partner agencies had responded to cases that were similar to their cases, to facilitate consistent administration of the regulatory scheme. For example, officers were not aware of submissions other regulators had made to courts in similar cases about penalties.

We considered that consistency in the administration of a regulatory scheme was paramount, regardless of whether there was one regulator or many, although we noted the potential for inconsistency increased with the number of regulators in the regulation group.

We recommended that the lead agency develop a protocol to facilitate the timely exchange of case information between partner agencies. The lead agency accepted our recommendation.

6.5 REFERRALS

Regulators in a regulation group should have systems in place to ensure notifications are referred to the most appropriate regulator in a timely way and do not get 'lost in the system'. The referral process should also provide minimum inconvenience to the notifier because members of the public do not usually have any preference as to which government regulator responds to their notification, as long as some regulator does.⁶⁹

Further, poor referral practices can place strain on relationships between partner agencies.

6.5.1 What we have found

Every year, we receive a number of complaints from members of the public who have made a notification to one regulator, which referred them or their notification to another regulator. Sometimes, the notification is referred back and forth between the two regulators several times.

These complainants frequently claim that both regulators have failed to meaningfully address their notifications.

⁶⁹ Also recognised in Canada; see External Advisory Committee on Smart Regulation-Canada (2004) *Smart Regulation: A Regulatory Strategy for Canada*, retrieved 22 January 2007 from the world wide web: www.regulatoryreform.com/pdfs/Canada%20Smart%20Regulation%20Report%20Sept%202004.pdf at page 12.

CASE STUDY 51

Our investigation of the regulatory practices of two regulators that often referred notifications to each other revealed that:

- referrals were not made in a timely manner
- the referring regulator did not ensure the other regulator had accepted or attended to the cases
- notifiers had not been advised of the referrals
- in some referred cases, the receiving regulator did not make a timely decision, as to whether it accepted the referral and, if accepted, which parts of the case it would address
- the receiving regulator did not advise the referring regulator in writing of its response to the referral. (This advice may have been provided orally but, if it was, no record was kept.)

6.5.2 What we recommend

Regulators in a regulation group should have arrangements in place (ideally, supported by a memorandum of understanding) that ensure:

- the referring regulator sends referrals to the receiving regulator in a timely way
- the referring regulator confirms the receiving regulator has accepted the referral before closing its case
- the referring regulator maintains communication with the notifier until the referral is accepted
- the receiving regulator advises the referring regulator as soon as practicable whether it accepts responsibility for dealing with the referral
- the regulator that ultimately decides to deal with the case advises the notifier of that decision as soon as practicable.

CHAPTER 7: COMMUNICATION WITH THE PUBLIC

It is clear that the community expects regulators and decision-makers to have effective processes in place for providing information about their regulatory policies and practices. This applies both to the broader public and the section of the public whose activities are governed by the regulatory scheme:

... issues commonly identified [by business groups about regulators] include ... poor and ineffective communication, and a lack of certainty and guidance to business about compliance requirements.⁷⁰

Effective communication with the section of the public whose activities are being regulated by the scheme will achieve higher levels of compliance, as discussed below.

7.1 MAKING POLICIES PUBLICLY AVAILABLE

Section 20 of the *Right to Information Act 2009* (RTI Act) provides that an agency must make copies of its policy documents available for inspection and purchase by the public.⁷¹ 'Policy document' is widely defined to cover documents about how an agency proposes to administer statutory powers or administer schemes that may affect the rights or interests of members of the community.⁷² Importantly, s.20(3) provides that the policy cannot be applied to the prejudice of any person if the policy was not available, the person was unaware of its provision and the person could have lawfully avoided the prejudice had they been aware of the policy.

Also, s.21 of the RTI Act provides that agencies must publish, or have published on their behalf, a publication scheme setting out the classes of information that the agency has available, and the terms on which it will make the information available, including any charges.

Agencies must ensure that the publication scheme complies with any guidelines about publication schemes published by the Minister administering the RTI Act, on the Minister's website. At the time of publishing, it appeared the relevant Minister was the Premier, although no guidelines had yet been published on the Premier's website. However, the Department of the Premier and Cabinet and many other agencies have elected to publish both the names of their policy documents and also provide links to those documents on the internet.

Apart from s.20 and s.21 of the RTI Act, there are other good reasons for regulators publishing these policies, such as:

- transparency
- regulators may save time and resources on enforcement action as ready access to the policies may lead to potential offenders having a better understanding of their obligations and being less likely to commit breaches through ignorance.

⁷⁰ Australian Government (2006) *Rethinking Regulation: Report of the Taskforce on Reducing Regulatory Burdens on Business*, Belconnen: Commonwealth of Australia at page 7.

⁷¹ Note that s.20(2) authorises agencies to delete 'exempt matter' from a copy of a policy document.

⁷² See definition of 'policy document' in the schedule 6 dictionary.

7.1.1 What we have found

Many officers of regulators are not aware of their obligations under s.20 of the RTI Act, nor are they aware of the scope of the term 'policy' which, under s.20 of the RTI Act,⁷³ includes:

- enforcement policies, such as enforcement action philosophy and guidelines
- policies about heightened levels of enforcement action (known as 'crackdowns')⁷⁴
- policies about different or altered enforcement responses for a problem class of activities
- policies about proactive compliance programs.

CASE STUDY 52

Our officers examined a regulator's policies and queried why some were publicly available on its website, but others were not. From the responses of the regulator's officers it was evident that they were not aware of the obligation under the then FOI Act for a regulator to make its policies publicly available. Some officers wrongly believed that 'policy' has a narrow meaning and does not apply to written documents with titles such as 'guidelines' or 'procedures'.

7.1.2 What we recommend

Regulators should:

- identify all policies within the meaning of 'policy document', as defined in the dictionary in schedule 6 to the RTI Act
- publish at least the names of its policy documents, in accordance with s.21 of the RTI Act
- make those policies available for inspection and purchase by members of the community, in accordance with s.20 of that Act.

An easy way to publish these policies is via the regulator's website and many agencies are doing so, as part of their publication schemes, although it should be noted that s.20 authorises an agency to charge for copies of its policies.

⁷³ Subject to whether the publication of the policy would prejudice an investigation.

⁷⁴ For further discussion, see chapters 9, 10 and 11 of Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press, particularly at page 133.

CHAPTER 7: COMMUNICATION WITH THE PUBLIC

7.2 UPDATES TO NOTIFIER

It is good practice to keep a notifier advised of the progress of the investigation (to the extent that this does not prejudice the investigation or breach an obligation to maintain confidentiality) because otherwise the notifier may:

- form a view that the regulator is unresponsive and that there was little point in making the notification in the first place
- complain about the regulator's perceived lack of response to the notifier or another entity such as our Office
- if the notifier is a self-notifier, become suspicious of the regulator's motives (this will discourage further self-notifications, which is ineffective regulation).

7.2.1 What we have found

The following case studies are examples of poor communication with notifiers at various stages of the investigation.

CASE STUDY 53

The regulator investigated a notification. The notifier was dissatisfied with the regulator's investigation and complained to us.

Our review of the regulator's file showed that prior to the investigation report being finalised there was no correspondence with the notifier acknowledging his notification or providing him with information about the role of the regulator.

We told the regulator that failure to contact the notifier to acknowledge the notification and provide information about the role of the regulator could reasonably lead to suspicion and distrust in the mind of the notifier. We recommended that in future the regulator contact all notifiers and provide that information.

CASE STUDY 54

Our review of a sample of a regulator's case files revealed that, in many cases, no record existed that:

- the notification had been acknowledged
- the notifier had been informed that the intake unit had allocated the case to an enforcement officer for investigation. Therefore, it would have been difficult for a notifier to know which officer to contact about their notification
- the notifier had been kept informed of the progress of the investigation
- the notifier had been advised of the outcome of the investigation.

We recommended that the regulator address the communication deficiencies we had identified.

CASE STUDY 55

A notifier complained about an activity at industrial premises near to their house.

The regulator had previously received a notification about the activity from another person and was already investigating the case.

We were satisfied that the second notifier had never been updated on the progress of the investigation as there was a record on the file to that effect and the notifier later complained about the activity a second time by way of a fresh notification.

CASE STUDY 56

Our investigators interviewed a number of potential offenders who had notified the relevant regulator of their potential breaches of a regulatory scheme. Each of the potential offenders reported that the regulator did not keep them up to date on its investigation. The potential offenders reported that this lack of communication made them suspicious of the regulator's motives and less inclined to openly communicate with the regulator.

We recommended that the regulator develop and implement a policy requiring officers to regularly update a potential offender that made the initial notification of an incident on the progress of the regulator's investigation, to the extent those updates do not jeopardise the integrity of the investigation. Also, we recommended that where the regulator decides not to investigate the incident or concludes the investigation, the relevant officer should advise the potential offender.

CHAPTER 7: COMMUNICATION WITH THE PUBLIC

CASE STUDY 57

A regulator's powers include the right to enter an owner's premises and carry out works where the owner has not complied with the regulator's direction to carry out those works. In such circumstances, the owner is legally obliged to reimburse the regulator for the cost of the works.

The regulator exercised those powers over premises owned by an alleged offender. Before commencing the works, the regulator gave him a grossly inaccurate estimate of the cost of the works. Specifically, in early August, the regulator estimated the works would cost about \$24,000. In mid-August, the cost of the works had reached \$79,000, but the regulator did not inform the owner. In late August, the regulator advised the owner's representatives that the cost of the works was about \$100,000.

We considered that the regulator had failed to take reasonable steps to inform the owner of the escalating costs of the works.

We recommended that in cases where the cost of the works significantly exceeds, or is likely to significantly exceed, the estimate given by the regulator to the owner, the regulator should ensure that timely advice is provided to the owner about progress against the estimate, together with any reasons for variations.

If an estimate cannot be made, information should be provided to the owner of the basis on which the regulator will be charging for the work. The owner can then consider his/her position, including whether to accept that the regulator is best placed to carry out the work or explore other options for carrying out the work (e.g. by private contractors).

7.2.2 What we recommend

Regulators should develop and implement policies that ensure:

- an acknowledgement of all notifications is provided, either orally or in writing, as soon as possible after receipt of the notification
- where the acknowledgement is given orally, the officer should make and keep a record that it was given
- when a case is allocated to a new officer, the regulator should advise the notifier of that fact and the contact details of the case officer
- all notifiers (including potential offenders that have reported their own potential breaches) are kept informed of the status of their notifications at regular intervals, to the extent that it does not prejudice the investigation or breach an obligation to maintain confidentiality
- where two or more notifiers have reported the same activity, each notifier is kept updated on the progress of the investigation. The regulator cannot assume that notifiers are in contact with each other.

7.3 COMMUNICATION WITH PERSONS AFFECTED

It is also good practice to keep other persons with an interest in the outcome of potential enforcement action advised of the progress of an investigation (to the extent that this does not prejudice the investigation or breach an obligation to maintain confidentiality) so they are not left to find out through another source that a significant decision has been made.

7.3.1 What we have found

The following case study is an example of a regulator's poor communication with people with a genuine interest in the outcome of enforcement action.

CASE STUDY 58

A regulator investigated whether an employer had breached a regulatory scheme in respect of an incident which resulted in an employee's death.

The regulator decided that there was insufficient evidence to warrant a prosecution being commenced against the employer but did not communicate its decision to the deceased's parents. They first became aware of the decision when they read about it in two newspaper articles.

Acting on our recommendation, the regulator apologised to the parents and changed its procedures.

7.3.2 What we recommend

Regulators should develop and implement policies that ensure persons with a genuine interest in the outcome of enforcement action are kept up to date on the progress of the investigation and informed of the outcome in a timely way, to the extent that this does not prejudice the investigation or breach an obligation to maintain confidentiality.

7.4 CONFIDENTIALITY OF NOTIFIER DETAILS

At sections 3.3.4, 3.3.5 and 3.3.6, we discussed the importance of not giving anonymous notifications a lower priority or ignoring them merely because they are anonymous.

This section deals with requests from notifiers that their details not be disclosed.

7.4.1 What we have found

Regulators frequently receive such requests from notifiers. Typically, the request is made if the notifier resides or works in close proximity to the potential offender, is employed by the potential offender or has some other association with the potential offender that could lead to the potential offender becoming aware of the notifier's identity.

CHAPTER 7: COMMUNICATION WITH THE PUBLIC

Because of the operation of the RTI Act, officers should not give notifiers a blanket guarantee that their details won't be released. Some officers do not realise that under this Act, a person has a right to obtain access to documents held by a regulator. In certain circumstances, documents are exempt from disclosure if their disclosure would cause a public interest harm by revealing personal information of a person.⁷⁵ The fact that an individual acting in a personal capacity has provided information (including a notification) to a regulator has itself been determined to be information concerning that individual's personal affairs.⁷⁶

However, FOI decision-makers may be obliged to release documents that disclose the details of the notifier if to do so would be in the public interest. Also, despite the best intentions of the officer who gave the undertaking, it is always possible that another officer or person may inadvertently release the notifier's details as illustrated in the following case study.

CASE STUDY 59

While we were investigating a complaint against a local government, one of its councillors, who was also a journalist for the local newspaper, reported in that newspaper on the substance of our letter to the local government. The newspaper article included the complainant's allegations, our views on the complaint and the local government's response to it.

We discussed our concerns about the councillor's conduct with the CEO of the local government. The CEO advised measures would be put in place to avoid a recurrence of such conduct.

7.4.2 What we recommend

Regulators should develop and implement policies that ensure:

- the identity of a notifier remains confidential wherever possible
- if it becomes necessary, during the course of an investigation, to disclose a notifier's identity, the regulator will advise the notifier of the proposed disclosure before it is made
- officers do not give blanket guarantees that the regulator will not release the notifier's name and other identifying information.⁷⁷

⁷⁵ Section 49 and section 6 of schedule 4 of the RTI Act.

⁷⁶ *Re Godwin and Queensland Police Service* (1997) 4 QAR 70 at 95 (paragraph 64) – decision of the Queensland Information Commissioner.

⁷⁷ Note that notifications constituting 'public interest disclosures' within the meaning of the Whistleblowers Protection Act must be dealt with in accordance with that Act.



CHAPTER 8: REGULATORY SCHEME

A good regulatory scheme is one that:

- clearly defines jurisdictional issues
- where more than one regulator has jurisdiction over aspects of a regulatory scheme, provides those regulators with mutually exclusive jurisdiction
- provides that the one regulator is responsible for all stages of regulation (for example, licensing and enforcement)
- clearly defines activities that are unlawful
- ensures factual inquiries required to determine questions of jurisdiction are straightforward
- contains penalties that are consistent and of an appropriate range.

8.1 JURISDICTION

A good legislative scheme clearly identifies the regulator responsible for taking enforcement action for breaches of the scheme.⁷⁸ If responsibility is unclear, time and resources will be wasted.

8.1.1 What we have found

The following case studies are examples of the problems that can arise where investigative responsibility is not clearly defined.

CASE STUDY 60

A notification was made to regulators A and B about how a regulated activity was being conducted. The regulators repeatedly referred the notification to each other for action. The reasons for these multiple referrals were not apparent from our review of the case files.

The determining jurisdictional factor was the size of the activity but neither regulator had taken the steps necessary for making this assessment.

Eventually, both regulators undertook a site inspection to make the assessment after the notifier contacted their local councillor to complain about a lack of action by either regulator. This amounted to duplication of resources.

We recommended that regulator A consider seeking legislative amendment to allocate enforcement responsibility on another basis.

⁷⁸ The concern was also discussed in Australian Government (2006) *Rethinking Regulation: Report of the Taskforce on Reducing Regulatory Burdens on Business*, Belconnen: Commonwealth of Australia at pages 166 to 168; see also State of Victoria, Department of Treasury and Finance (2005) *Victorian Guide to Regulation*, Melbourne: State of Victoria at page 3-11.

CASE STUDY 61

A notification was made to regulator A about how a regulated activity was being conducted.

Under the legislation, having regard to the size of the activity, regulator B had the responsibility to investigate the activity.

The officers of regulator A apparently did not appreciate that the investigation of the incident was regulator B's responsibility. It is not clear what action regulator A took in relation to the notification.

Regulator B became aware of the incident about 10 months after it happened. Its officers told our investigators that the delay in its being notified may have prejudiced its response to the incident because, among other things, the 12-month limitation period on commencing a prosecution against the potential offender had nearly expired.

CASE STUDY 62

Legislation provided that regulator A could not investigate certain notifications more appropriately dealt with under another law.

A notification was made to regulator A about how an activity was being carried out on certain premises.

Regulator A advised the notifier that regulator B had the responsibility to investigate the notification because regulator B had issued a licence under other legislation in respect of those premises many years ago.

Regulator B disputed that the notification was more appropriately addressed under the other legislation but ended up dealing with the notification when regulator A refused to act.

CASE STUDY 63

Regulator A received notifications about how a regulated activity was being carried out.

Under the regulatory scheme, regulators A and B each had jurisdiction for regulating the activity in different, mutually exclusive circumstances. However, the legislation did not clearly define the circumstances.

Each regulator interpreted the legislation differently and suggested the other had responsibility to investigate the notifications, which led to a delay in the notifications being investigated.

8.1.2 What we recommend

Regulators should work together to seek necessary amendments to regulatory schemes to ensure:

CHAPTER 8: REGULATORY SCHEME

- jurisdictional issues are clearly defined
- where more than one regulator has jurisdiction over aspects of a regulatory scheme, they are given mutually exclusive jurisdiction
- any factual inquiries required to determine questions of jurisdiction are straightforward.

Where a legislative solution is not possible, regulators should enter into arrangements (such as a memorandum of understanding) that ensure the effective management of jurisdictional issues.

8.2 OVERLAPPING REGULATORY SCHEMES

The way a regulator administers a regulatory scheme can impact on another regulator's enforcement responsibilities under a related scheme.

8.2.1 What we have found

The following case study illustrates the type of problem that can arise in such situations.

CASE STUDY 64

A local government approved a development application for the construction of a building in which a light industrial activity was authorised to be conducted.

A state regulator had enforcement responsibility under a separate regulatory scheme for aspects of the activity.

The approval issued by the local government did not include any conditions relating to the aspects of the activity regulated by the state regulator, although the local government had power to impose such conditions.

A notification was made to the state regulator about how the activity was being carried out. The state regulator was obliged to respond to the notification, which may not have been made had the local government imposed conditions on the development approval, relevant to the state regulator's jurisdiction.

8.2.2 What we recommend

Partner agencies should have appropriate arrangements in place (supported by a written agreement such as a memorandum of understanding) requiring them, in enforcing the regulatory scheme, to have regard to each other's responsibilities to facilitate each other's work.

8.3 PENALTIES

A good legislative scheme contains penalties that are consistent and of a range appropriate to breaches of different levels of seriousness.

8.3.1 What we have found

The following case studies relate to regulatory schemes in which the range of penalties was inadequate.

CASE STUDY 65

Some local governments had the delegated authority to regulate the discharge of solid or liquid rubbish and/or sediment to drains or otherwise into a water catchment contrary to the Environmental Protection (Water) Policy 1997 and to issue a fine of between \$300 and \$600.

However, some local governments complained that the fine did not deter many businesses from perpetrating those breaches, as the businesses were of the view that the local governments did not have the resources to prosecute them and that, in any event, the fine was tantamount to a minor business expense.

CASE STUDY 66

Under repealed legislation, the penalty for failing to ensure the workplace health and safety of an employee under the Workplace Health and Safety Act⁷⁹ was 500 penalty units or one year's imprisonment if the breach caused bodily harm or 800 penalty units or two years' imprisonment if the breach caused death or grievous bodily harm.

However, the penalty under the Electricity Regulation⁸⁰ for failing to take reasonable steps to ensure a person can work safely or for failing to ensure electrical work is not performed in proximity to exposed high voltage conductors (s.128) was only 20 penalty units, even though the consequences of a breach could be fatal.

On our recommendation, the penalties were reviewed and amended.

8.3.2 What we recommend

Legislation establishing a regulatory scheme should provide for a range of penalties that is:

- appropriate to breaches of different levels of seriousness
- consistent with the range of penalties provided in overlapping regulatory schemes in relation to breaches of a similar kind.

8.4 CLEARLY DEFINING UNLAWFUL ACTIVITY

A good legislative scheme facilitates the making of clear judgements about the lawfulness of particular activities so that the regulator may confidently act to enforce the law.

⁷⁹ Section 24 of the Act.

⁸⁰ Section 126 of the Regulation.

CHAPTER 8: REGULATORY SCHEME

8.4.1 What we have found

The following case study relates to inconsistent provisions in overlapping legislation establishing a regulatory scheme. As a result, it is unclear whether certain activity is legal or illegal.

CASE STUDY 67

Under s.62 of the *Nature Conservation Act 1992* (NC Act), a person must not take fish, invertebrate animals and/or mud crabs from national parks under certain licences or permits or other authorities but may take fish, invertebrate animals and/or mud crabs in a prescribed place but not for a commercial purpose.

Section 27 of the *Nature Conservation Regulation 1994* (NC Reg)⁸¹ provided that a person may take fish, invertebrate animals and/or mud crabs in prescribed areas within certain national parks unless:

- the animals caught are in breach of the then Department of Primary Industries and Fisheries' ('DPIF') size, number, method, species and location limits
- it is prohibited to catch that animal in that particular area under a regulatory notice.

There had been differing interpretations as to whether these two provisions:

- allow or prohibit commercial fishing in national parks
- allow commercial fishing in national parks where the fisher holds a DPIF licence.

In March 1999, the then Minister for the Environment, the Honourable Dean Wells MP, addressed these differing interpretations in respect of Lakefield National Park by prohibiting commercial fishing in that park.

In 2003, a native title claim was lodged in Queensland that included waters of a national park. Among others, members of the Queensland Seafood Industry Association (QSIA) held licences issued by the DPIF to commercially fish in that national park.

Two of those members sought, through a notice of motion, to be joined as parties to the native title proceeding on the basis that they were persons whose interests might be affected by the determination in the native title claim.

The Federal Court of Australia ruled on the motion.⁸² The judge who heard the motion made the following assessment:

The motion is, in truth, the vehicle selected by the QSIA ... to test a conflict that has emerged between commercial fishermen and the Queensland Environmental Protection Agency ... It is a striking feature of the case that, though there has been in force since 1994 what counsel for the State of Queensland contends is a clear prohibition on commercial fishing in national parks, the Queensland Department of Primary Industries ... has continued to issue annual licences which ... authorise commercial fishing in national parks.⁸³

⁸¹ In force during our investigation.

⁸² *Birri Gubba v State of Queensland* [2003] FCA 276.

The judge understood the State of Queensland's argument to be 'if holders of such licences seek to exercise the right to fish commercially in national parks ... they will contravene the prohibition contained in the [NC Act]⁸³ and that if it is held to be unlawful for the two members to fish in the national park that was part of the native title claim, then the two members would not have a sufficient interest in the native title claim to be joined as parties to it.

The Court ruled that the two members were exempt from the prohibition in s.62 of the NC Act so long as they complied with the conditions referred to in s.27 of the NC Reg. The Court's reasoning included:

- section 27 of the NC Reg operates to impose the restrictions contained in it on all fishermen, including but not limited to recreational fishermen, who fish in national parks
- the predecessor of s.62 of the NC Act appeared to allow commercial fishing in national parks
- the 'long standing and widespread practice of commercial fishermen being permitted by their licences issued [by the DPIF] to fish in certain waters of certain national parks'
- when changes to the NC Act were made in 1994, the then Minister explained that the changes would enable 'the [Environmental Protection Agency] to authorise and regulate [some] recreational fishing' but he did not mention that another intent of the amendments was to prevent commercial fishing in national parks.

The Court also said that the prohibition in s.62 of the NC Act on a person taking fish, invertebrate animals and/or mud crabs for a commercial purpose 'is not a general prohibition against commercial fishing in national parks. It is expressly limited to qualifying the permission contained in [s.62] to take fish [invertebrate animals and/or mud crabs] from national parks'. The Court said that the provision 'should be read as confined to preserving the right of recreational fishermen to fish in certain national parks'.

We recommended that the regulator seek to clarify the situation, if necessary, by legislative amendment.

CASE STUDY 68

In one investigation, we found evidence that notice was not being given to relevant people, contrary to the statutory requirements of the regulatory scheme. The regulator then informed us that it was aware its officers were not complying with the notice requirement in all cases.

We told the regulator that if it considers that the notice requirement is not necessary, the appropriate action is to seek legislative amendment. On the other hand, if it is considered that the regulatory scheme is appropriate, it is incumbent on the regulator to take action to ensure its officers enforce the requirements.

⁸³ *Birri Gubba v State of Queensland* [2003] FCA 276 at paragraph 8.

CHAPTER 8: REGULATORY SCHEME

8.4.2 What we recommend

A regulator should periodically review legislation relating to any regulatory scheme it administers to:

- identify any ambiguity or inconsistency in the application of the legislation to particular circumstances
- identify any inconsistency with legislation relating to an overlapping regulatory scheme
- seek appropriate amendments to clarify the ambiguity or inconsistency.



CHAPTER 9: REGULATORY INDEPENDENCE

9.1 WHERE POTENTIAL OFFENDER IS ANOTHER REGULATOR

A regulator that is a potential offender should be treated consistently with other potential offenders. This should not be confused with special approvals that may be needed as a matter of government policy for one government agency to take civil proceedings against another. In New South Wales, the Premier's Department has issued a memorandum⁸⁴ and attached guidelines clarifying the distinction, which provide:

2.1 Government authorities have a responsibility to comply with the law and can be subject to the same penal sanctions as the rest of the community ...

...

2.3 Nothing in these guidelines is meant to in any way interfere with the normal prosecution discretion as to whether or not to commence prosecution proceedings or to discontinue prosecution proceedings ...

2.4 However, it is appropriate that Government authorities vested with the power to commence prosecutions should consult with the Government authority against whom a prosecution is contemplated ...

2.5 This consultation process is consistent with the normal processes that are followed by a prosecution agency when determining whether or not, in all the circumstances, prosecution action is the most appropriate way of dealing with a possible breach of law and is not meant to imply that Government authorities are treated any more favourably than other defendants.

9.1.1 What we have found

Regulators are sometimes reluctant to take prosecution proceedings against another regulator.

CASE STUDY 69

A regulator's responsibilities overlapped those of other regulators that were also potential offenders. Some officers of the first regulator told our investigators that they considered it was not in the public interest to issue proceedings against any of those other regulators 'because taxpayers would just be paying the bill'.

9.1.2 What we recommend

Regulators should develop and implement policies that ensure regulators that are potential offenders are treated consistently with other potential offenders.

⁸⁴ NSW Premier's Department (8 October 1997) Memorandum No. 97-26: *Litigation Involving Government Authorities*, NSW Premier's Department.

9.2 CONFLICT OF INTEREST AND BIAS

A conflict of interest occurs when an officer's private interests interfere, or appear to interfere, with the officer's duty to put the public interest first.⁸⁵

Conflicts of interest can arise as a result of:

- **Pecuniary interest** – that is, the enforcement officer will gain or has the potential to gain personal financial benefit from their official duties (including by avoiding financial disadvantage)⁸⁶
- **Non-pecuniary interest** – that is, family or other personal relationships or interests (including involvement in sporting, social or cultural activities) or even strongly held personal convictions.⁸⁷

Conflicts of interest can result in bias (actual or apprehended) in decision-making. Apprehended bias occurs where a 'reasonable person' aware of the conflict of interest would conclude that the regulator's decision in respect of a potential offender is not or will not be impartial.⁸⁸

It is obvious that conflicts of interest should be avoided where possible and most regulators address the issue in their codes of conduct. If they cannot be avoided, they should be appropriately managed to ensure questions of bias do not arise.

Officers should also be aware of s.9(2)(b) of the Public Sector Ethics Act, which provides that a public official should ensure that any conflict between the person's personal interests and official duties is resolved in favour of the public interest.

⁸⁵ Independent Commission Against Corruption (ICAC) and Crime and Misconduct Commission (CMC) *Identifying Conflicts of Interest in the Public Sector*, retrieved 27 April 2007 from the world wide web: <http://www.cmc.qld.gov.au/asp/index.asp?pgid=10849>; see also Queensland Integrity Commissioner (February 2006) Information sheet 2: Conflicts of Interest in the Public Sector, retrieved 27 April 2007 from the world wide web: <http://www.integrity.qld.gov.au/html/publications.shtml>.

⁸⁶ Independent Commission Against Corruption (ICAC) and Crime and Misconduct Commission (CMC) *Identifying and Managing Conflicts of Interest in the Public Sector* retrieved 27 April 2007 from the world wide web: <http://www.cmc.qld.gov.au/asp/index.asp?pgid=10849>.

⁸⁷ Independent Commission Against Corruption (ICAC) and Crime and Misconduct Commission (CMC) *Identifying Conflicts of Interest in the Public Sector*, retrieved 27 April 2007 from the world wide web: <http://www.cmc.qld.gov.au/asp/index.asp?pgid=10849>; see also Queensland Integrity Commissioner (February 2006) Information Sheet 2: Conflicts of Interest in the Public Sector, retrieved 27 April 2007 from the world wide web: <http://www.integrity.qld.gov.au/html/publications.shtml>.

⁸⁸ The CMC discusses 'perceived conflict of interest', see Independent Commission Against Corruption (ICAC) and Crime and Misconduct Commission (CMC) *Identifying and Managing Conflicts of Interest in the Public Sector*, retrieved 27 April 2007 from the world wide web: <http://www.cmc.qld.gov.au/asp/index.asp?pgid=10849>. A 'perceived conflict of interest' is an example of apprehended bias. However, it is possible for an apprehension of bias to arise in the absence of a conflict of interest (for example, the way a decision-maker talks to an applicant may lead a reasonable third party to perceive that the decision-maker dislikes the applicant and therefore is not making the decision impartially).

CHAPTER 9: REGULATORY INDEPENDENCE

9.2.1 What we have found

A regulatory scheme may itself create a conflict of interest for the person investigating an alleged breach, as the following case study illustrates.

CASE STUDY 70

At the relevant time, s.62 of the Electricity Act provided that 'the chief executive of the department is the regulator'. In practice, most of the electrical safety regulatory functions were delegated to officers of the Electrical Safety Office.

The regulator's functions were described in s.63 of the Act and included obligations 'to ensure the safety requirements under this Act are complied with' and 'to monitor compliance with this Act'.

The Act required that all electrical incidents be reported to the regulator.

Under s.71, the regulator could appoint officers and employees of the public service and employees of electricity entities as authorised persons, that is, persons who the regulator considered had 'the necessary expertise or experience'.

The Act gave authorised persons powers to investigate offences.

Section 171 provided that, on receiving a report of an incident, an electricity entity must ensure an authorised person immediately investigated the incident and must provide that report to the regulator.

Under s.120(3) of the Act, an electricity entity was not required to provide the regulator with information that 'might tend to incriminate the entity'.

Authorised persons employed by electricity entities commonly investigated incidents involving infrastructure controlled or operated by their employers and clearly had a conflict of interest where their investigations were relevant to potential breaches of the Act by their employer.

Alternatively, the conflict of interest may be directly created by the regulator and inappropriately managed, as the following case study illustrates.

CASE STUDY 71

An employee of a company operating within a regulated industry was seconded to the regulator with regulatory responsibility for that industry. The regulator gave the officer a role in the investigation of a potential breach by the company.

The following case study illustrates how work-based associations can create a conflict of interest, leading to apprehended or actual bias in the performance of duties.

CASE STUDY 72

The regulator's officers were friendly with employees of an entity operating within a regulated industry because of ongoing work related contact and because many of the officers had previously been employed by that entity.

Because of this relationship, officers appeared to accept without question statements prepared by employees of the entity in cases where the entity was the potential offender.

The following case study demonstrates that an enforcement officer should not be involved in the investigation of the notification if they have some involvement in the subject of notification itself.

CASE STUDY 73

We received a complaint from a notifier who was not happy about the way the agency handled her notification about a decision of the senior officer.

Particularly, the agency had decided that the senior officer should conduct the investigation of the notification. That decision was unreasonable because the senior officer had made the decision that was the subject of the notification.

As there was clearly a perception of bias, we recommended that the chief executive apologise on behalf of the agency for that decision.

9.2.2 What we recommend

Regulators should:

- seek amendments to any regulatory scheme that directly or indirectly creates potential conflicts of interest for its officers
- develop and implement policies that ensure conflicts of interest are recorded and reported to supervisors and appropriately dealt with to prevent situations arising that involve actual or apprehended bias
- ensure officers are trained in recognising and dealing with conflicts of interest.

9.3 REGULATORY CAPTURE

'Regulatory capture' is the theory that a regulator and the entities in the industry it regulates build working relationships that have the potential to lead to the regulator becoming unwilling to perform its compliance tasks diligently and impartially in respect of the entities so as to avoid jeopardising those relationships.⁸⁹

⁸⁹ The concept of regulatory capture is concisely explained in Marsden, S., Kathy, G. and Hollingsworth, C. (February 2000) Tasmania's environmental improvement programs and the 'Brown Issues': environmental accountability or regulatory capture?, *Environmental and Planning Law Journal*, 17(1), 24-33.

CHAPTER 9: REGULATORY INDEPENDENCE

9.3.1 What we have found

Regulatory capture is a particular risk where a regulator with responsibility for promoting the development of a particular industry is also responsible for the regulation of all or part of that industry. The following case study is an example of such a situation.

CASE STUDY 74

One of our recommendations during the WEP was for the appointment of a Ministerial Reviewer to conduct a strategic and management review of the former Electrical Safety Office. That recommendation was accepted and a Ministerial Reviewer was engaged to perform this function.

In his final report, the Ministerial Reviewer raised the issue of regulatory capture when discussing the lack of compliance activity by the Electrical Safety Office during the five year period ending June 2001. He stated:⁹⁰

It is difficult to pinpoint one single cause for this obvious reluctance to assume the regulatory role. One suggestion for the seeming reluctance to become involved with investigations and prosecutions relates to the issue of regulatory capture. The theory of regulatory capture espouses the view that regulatory organisations particularly within the context of a single industry become 'captured' by the industry itself and are unable or unwilling to perform any tasks that may jeopardise the relationship between the entities. A recent article by Briody, M. and Prenzler, states:

Capture theory describes the process by which government agencies responsible for corporate regulation, serving the interest of the corporate regulation, shift from enforcing public interest law to serving the interests of the corporate identities being 'regulated'.

While it is hard to argue against the theory, any future role of the ESO [Electrical Safety Office] will have to be particularly vigilant in ensuring such a situation never occurs again. The continuing and hopefully closer arrangement between the ESO and WH&S [Workplace Health and Safety] may provide some light that ensures the ESO understands its role as regulator. This may hold one of the keys to resolving this complex issue.

⁹⁰ Department of Industrial Relations (April 2001) Ministerial Review of the Division of Workplace Health and Safety and the Electrical Safety Office – Final Report, Queensland Government: Brisbane at page 36, cited in Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocution Project*, Brisbane: Queensland Ombudsman at page 145.

CASE STUDY 75

We conducted an own initiative investigation of the enforcement practices of a regulator. One of the issues we investigated was whether the regulator had been captured by the industry it regulated. Our investigation found many signs of possible regulatory capture. These included:

- the regulator (whose role was to regulate safety in the industry) was located within the agency responsible for promoting the economic interests of the industry
- in agency publications, safety appeared merely as one goal alongside others such as economic development
- the regulator had a low level of prosecution activity
- the legislation applying to the regulator allowed wide discretion to act
- decisions on whether to prosecute were made by the chief executive of the agency on the recommendation of a committee that had no legislative basis, was not publicly acknowledged and comprised some members from outside the regulator
- there was a marked preference for informal recommendations and advice, which were not properly recorded. Therefore, the full extent of the regulator's enforcement activity was not being reported and, as a result, observers believed the regulator was ineffectual
- there was a high turnover of enforcement officers to the industry, where they were able to earn significantly more than they earned as enforcement officers
- the regulator's budget and resources were insignificant compared with those in the industry
- there was frequent social collaboration between the industry and the regulator, with many personal friendships formed over many years
- regulatory work often took place in isolated regional communities where 'everyone knows everyone else' and enforcement officers often relied on the industry's hospitality and resources to conduct their work.

We considered that the existence of these indicators gave rise to a reasonable perception of regulatory capture. However, our investigation did not reveal any evidence of inappropriate political, union or industry interference or influence in the way the regulator performed its functions.

Therefore, we recommended that the regulator take steps to address some of the indicators listed above to remove or reduce the perception of regulatory capture.

CHAPTER 9: REGULATORY INDEPENDENCE

The *Queensland Executive Council Handbook* explains:

Administrative Arrangements set out the principal Ministerial responsibilities of Ministers and the Acts that they administer. The Arrangements are determined solely by the Premier and are made by Order in Council in accordance with section 44 of the Constitution of Queensland 2001 ...

Amendment Orders arise when a Minister or Ministers write to the Premier requesting the transfer of administrative responsibility for legislation or amendment to the description of their Ministerial responsibilities. A letter from the relevant Minister usually requests the transfer of administrative responsibility from one Minister to another. All Ministers affected by the proposed changes must sign the letter, or write independently to the Premier ...⁹¹

Departmental functions and responsibilities are also the responsibility of the Premier. A Departmental Arrangements Notice is prepared to amalgamate part or parts of Departments, create an entity and add that entity to any Department and matters of a like nature, as specified within the Public Service Act 1996 ... The administration of these matters is undertaken by the [Office of the Public Service Commissioner] ...

Consolidated Departmental Arrangements Notices are prepared on the Premier's instructions following a general election. In addition, amendments to Departmental Arrangements Notices are made from time to time with the approval of the Premier.⁹²

The Executive Council Secretariat administers changes to administrative arrangements.

9.3.2 What we recommend

A regulator should:

- seek legislative and/or administrative changes if it considers that the regulatory scheme it administers is set up in such a way that there is the potential for the regulator to be captured by the industry it regulates⁹³
- in formulating proposals for legislation establishing a regulatory scheme for an activity, ensure, as far as practicable, that the regulator responsible for administering the scheme does not have other responsibilities for the activity that are inconsistent with the perception of impartial and independent enforcement.

⁹¹ Queensland Department of the Premier and Cabinet *Executive Council Handbook – Machinery of Government Changes – Administrative Arrangements Orders*, retrieved 30 April 2007 from the world wide web: www.premiers.qld.gov.au/About_the_department/publications/policies/Governing_Queensland/.

⁹² Queensland Department of the Premier and Cabinet *Executive Council Handbook – Machinery of Government Changes – Departmental Arrangements Notices*, retrieved 30 April 2007 from the world wide web: www.premiers.qld.gov.au/About_the_department/publications/policies/Governing_Queensland/.

⁹³ See also pages 36 and 37 of Baldwin, R. and Cave, M. (1999) *Understanding Regulation: Theory, Strategy and Practice*, Oxford: Oxford University Press.



CHAPTER 10: RECORDKEEPING

Agencies⁹⁴ are required to make 'full and accurate records' in accordance with the Public Records Act.⁹⁵ Information Standard 40 – Recordkeeping (IS40),⁹⁶ published by Queensland State Archives, has been developed primarily to help public authorities meet their recordkeeping obligations under the Public Records Act. The Best Practice Guide to Recordkeeping⁹⁷ (Best Practice Guide), Compliance Guideline⁹⁸ and Compliance Checklist⁹⁹ support IS40 and may be used by public authorities to develop their own policies and procedures.

Every regulatory system should give prominence to the need to make and keep appropriate records because¹⁰⁰:

There are well-established benefits of government agencies maintaining comprehensive records of both their decisions and the processes undertaken in making those decisions. Similarly, there are serious risks for agencies that fail to document their decisions, and decision-making processes properly. Some of the benefits of proper record keeping are as follows:

- *Effective record keeping leads to improved decision making by providing decision makers with comprehensive, detailed information on which to base their decisions.*
- *A proper record of the steps taken to arrive at a particular decision assists the decision maker to prepare a comprehensive statement of reasons.*
- *Proper records enable the agency to establish how particular decisions were made, in the event that the agency needs to revisit a matter for any reason in the future.*
- *Proper records assist review bodies to understand why and how a decision was made.*
- *Proper record keeping enhances transparency in government by enabling agencies to respond meaningfully to requests under the Freedom of Information Act 1992.¹⁰¹*
- *Accountability in government is also enhanced by agencies maintaining proper records of decisions and decision-making processes.¹⁰²*

⁹⁴ Referred to as 'public authorities' in the Public Records Act.

⁹⁵ Section 7(1)(a) of the Public Records Act.

⁹⁶ Queensland State Archivist, Recordkeeping (IS40) [Information Standard 40], retrieved 30 April 2007 from the world wide web: www.governmentict.qld.gov.au/02_infostand/standards/is40.htm.

⁹⁷ Queensland State Archivist Compliance Checklist for Queensland Public Authorities to Self-assess Compliance with Information Standard 40: Recordkeeping, retrieved from the world wide web: www.archives.qld.gov.au/publications.asp#government.

⁹⁸ Queensland State Archivist Compliance Guideline for Queensland Public Authorities to Self-assess Compliance with Information Standard 40: Recordkeeping, retrieved from the world wide web: www.archives.qld.gov.au/publications.asp#government.

⁹⁹ Queensland State Archivist Compliance Checklist for Queensland Public Authorities to Self-assess Compliance with Information Standard 40: Recordkeeping, retrieved from the world wide web: www.archives.qld.gov.au/publications.asp#government.

¹⁰⁰ Department of Tourism, Fair Trading and Wine Industry Development, and Queensland Ombudsman (2005) *Better Decisions Project: A Framework for Effective Administrative Decision Making Systems*, Brisbane: Tourism, Fair Trading and Wine Industry Development, and Queensland Ombudsman.

¹⁰¹ Now the RTI Act.

¹⁰² Department of Tourism, Fair Trading and Wine Industry Development, and Queensland Ombudsman (2005) *Better Decisions Project: A Framework for Effective Administrative Decision Making Systems*, Brisbane: Tourism, Fair Trading and Wine Industry Development, and Queensland Ombudsman at paragraph 93.

10.1 MEANING OF RECORD

The Best Practice Guide explains that there is a difference between 'documents' and 'records':¹⁰³

To identify the point at which a document is regarded as a record, assess the significance of the transaction in which the record is involved or the significance of the document in terms of its value as information ... This requires an appraisal decision. The appraisal process is explained in Information Standard 31: Retention and Disposal of Government Information and Ellis, J (1993).

...

... reference to the relevant disposal authority approved by the State Archivist will assist public authorities in ensuring that the appropriate records are captured and retained for as long as those records have value.¹⁰⁴

Information Standard 31, also published by the Queensland State Archivist, explains:

The appraisal process involves identifying and analysing the functions and activities of agencies and assessing the value of the related records according to a set of criteria that includes consideration of accountability, legal, administrative, financial, research and socio-cultural requirements and expectations.

For accountability purposes appraisal decisions should be documented in an appraisal report and a disposal schedule developed for authorisation by the State Archivist to support the systematic and legal disposal of public records.¹⁰⁵

One of the services provided by the Queensland State Archives is the appraisal of records to establish their value as archives and/or how long they need to be kept to meet business requirements and community expectations.¹⁰⁶

¹⁰³ See pages 3 and 4 and the definitions of 'documents' and 'records' in the Queensland State Archives (November 2006) *Best Practice Guide to Recordkeeping*, V1.04.00, retrieved 2 May 2007 from the world wide web:
http://www.governmentict.qld.gov.au/02_infostand/downloads/IS40%20Best%20Practice%20Guide.pdf.

¹⁰⁴ See page 4 of the Queensland State Archives (November 2006) *Best Practice Guide to Recordkeeping*, V1.04.00, retrieved 2 May 2007 from the world wide web:
http://www.governmentict.qld.gov.au/02_infostand/downloads/IS40%20Best%20Practice%20Guide.pdf.

¹⁰⁵ Queensland State Archivist *Retention & Disposal of Public Records (IS31)* [Information Standard 31], retrieved 30 April 2007 from the world wide web:
www.governmentict.qld.gov.au/02_infostand/standards/is31.htm.

¹⁰⁶ Queensland State Archives *Records Management*, retrieved 30 April 2007 from the world wide web:
www.archives.qld.gov.au/Government/recordsmgmt.asp.

CHAPTER 10: RECORDKEEPING

10.1.1 What we have found

Enforcement officers are often unsure whether particular documents constitute records for the purpose of the Public Records Act and should be kept. For example, during the negotiation of the conditions for a licence under a regulatory scheme, there may be frequent, significant changes to the proposed licence conditions with the result that the final conditions vary greatly from the conditions originally proposed. Some enforcement officers may be unaware that, in some circumstances, they may be required to keep drafts of licence conditions in addition to the final settled licence conditions.

10.1.2 What we recommend

Regulators should develop and implement a policy providing guidance to officers on:

- what constitutes a record for the purposes of the Public Records Act
- their obligations to make and keep records under that Act.

If necessary, regulators should seek the advice of Queensland State Archives in developing the policy.

Regulators should also:

- provide appropriate training to officers on recordkeeping
- conduct regular audits of files to ensure records are being properly kept.

10.2 COMPLETE RECORDS

As we have stated, the Public Records Act requires regulators to make and keep full and accurate records.

10.2.1 What we have found

Failure to make adequate records can create significant problems for officers if their decisions are the subject of review, as shown by the following case studies.

CASE STUDY 76

A note 'All okay' appeared in an officer's personal notebook in relation to an inquiry the officer had made about a child's welfare. However, no entry about that event appeared in the regulator's electronic case management system until 49 days after the event occurred. By that time, the child had died and the officer was aware of the likelihood that the officer's handling of the case would be reviewed. The note the officer created in the electronic case management system read:

Case Note – Phone call to group home 24 July 2001

House mother reports that all is going well. [Mother] is in good spirits and has demonstrated that she is capable of caring for [child]. The only problem seems to be that [mother] is reluctant to get up to [child] in the night for feeding. Housemother has informed [mother] that she is reporting back to the department and this could be a concern if it continues. House mother also stated that sometimes in the morning [mother] needs a bit of a 'shove' to fix [child] if [mother] is playing on the Nintendo, but there are no significant concerns regarding [mother's] care of [child].

The brevity of the initial record cast doubt on the credibility of the electronic record created much later.

CASE STUDY 77

An intra-office memorandum on a file stated that a witness's solicitor did not desire the witness to be interviewed.

The regulator's records contained no correspondence from the solicitor or file note of a telephone or other conversation with the solicitor about the issue. After noting several other instances of incomplete records during the same investigation, we recommend that officers record the substance of all operational contacts. The regulator agreed with our recommendation.

CHAPTER 10: RECORDKEEPING

CASE STUDY 78

A regulator's officers conducted a detailed inspection of a site to verify whether a potential offender's business activities were being conducted in compliance with a notice issued by the regulator.

According to the relevant policy, a site inspection of this level (the highest level) had to be planned and scoped, involve a multi-disciplined team, examine compliance with the legislation (in addition to the regular examination of statutory documents) and be supported by extensive documentary evidence.

The only records located by our investigators of the site inspection and outcome of the inspection were the following entries in the electronic case management system:

Site Inspection-Level C

4 [hours spent on inspection]

Inspection of [plan for management of the activity] progress

They complied.

CASE STUDY 79

The regulator investigated a notification. The notifier was not happy with the regulator's investigation and complained to us.

Our review of the regulator's file showed that there was no evidence on file to indicate that the notifier was advised that the regulator would only be examining one specific issue (although the notifier had raised a number of issues).

The regulator advised us that the enforcement officer did discuss the scope of the investigation with the notifier on several occasions, but as this type of discussion was commonplace it was not documented.

We told the regulator that it was a requirement to keep records, including records of discussions with the notifier as to the scope of the investigation. We also impressed upon the regulator that, if such records were kept, they would have assisted us and other external reviewers to decide whether the complainant was adequately informed of the scope of the investigation. It may also help to advise notifiers of the scope of the investigation in writing.

10.2.2 What we recommend

The policies and training recommended at 10.1.2 should highlight the requirement in the Public Records Act that sufficiently detailed records are made and kept of all operational activities.

10.3 CONTEMPORANEOUS AND SEPARATE RECORDS

Version 1.01.00 of the Best Practice Guide¹⁰⁷ recommended that records be made contemporaneously and that separate records be made of distinct events.

10.3.1 What we have found

Some officers of regulators are in the habit of recording information a considerable time after the event to which the information relates, as the following case study illustrates.

Case study 76 demonstrates the difficulties that arise where a sufficient record of an operational action is not created contemporaneously.

The following case studies relate to a failure to create separate records of distinct events.

CASE STUDY 80

A regulator received a notification of non-compliance by company A with a regulatory scheme. An officer telephoned a person from the company on three occasions to discuss the alleged non-compliance. The only records made of these conversations were as follows:

15-NOV-2004

Telephone Call

Spoke with Ken from company A on 1/11, 3/11 and 6/11 regarding the allegations of non-compliance from their site

Company A agreed to [do certain things] to remedy the non-compliance.

CASE STUDY 81

In one of our investigations, an enforcement officer told us that it was his practice after making inquiries to type notes of the inquiries into his computer and then incorporate those notes into a final report without keeping the original notes.

This practice meant that, once the officer had completed his investigation, the supervisor or an external reviewer (such as my Office) would be unable to readily determine:

- the source of the information upon which his conclusions were based
- when the evidence was obtained
- the circumstances in which the evidence was obtained.

We considered this to be an inappropriate recordkeeping practice and made recommendations to the regulator designed to improve its recordkeeping.

¹⁰⁷ Queensland State Archives (January 2003) *Best Practice Guide to Recordkeeping*, V1.01.00, Brisbane: Queensland State Archives at clause 7.3.1.1.

CHAPTER 10: RECORDKEEPING

10.3.2 What we recommend

The policies and training recommended at 10.1.2 should highlight the desirability of making records of operational activity as contemporaneously as possible.

10.4 REASONS FOR DECISIONS

Regulators must record proper reasons for their decisions in order to comply with the Public Records Act and in the interest of consistency and transparency.

Reasons should:

- **Set the scene** – that is, explain the legislative framework for the decision and what factors need to be taken into account to make the decision
- **Refer to specific evidence** – that is, refer specifically to different pieces of evidence that support the conclusion reached rather than to 'all the evidence' or to a lengthy document upon which the decision-maker relied
- **Discuss the weight of evidence** – that is, explain how conflicting evidence was treated and why more weight was given to some evidence than other evidence in reaching the conclusion
- **Be presented in a logical order** – that is, in a chronological or some other appropriate order.

Version 1.01.00 of the Best Practice Guide stated that compliance with IS40, Principle 7, is indicated by, among other things, 'records of deliberations involved in the making of decisions'¹⁰⁸ and records 'of the individual exercise of discretionary judgment'.¹⁰⁹

Therefore, if an officer or a committee makes a decision of any significance about a case, they should record both the decision and the reasons for it.

10.4.1 What we have found

Our investigations frequently reveal that officers of regulators do not record reasons, or sufficient reasons, for their decisions, as the following case studies illustrate.

¹⁰⁸ Queensland State Archives (January 2003) *Best Practice Guide to Recordkeeping*, V1.01.00, Brisbane: Queensland State Archives at page 66.

¹⁰⁹ Queensland State Archives (January 2003) *Best Practice Guide to Recordkeeping*, V1.01.00, Brisbane: Queensland State Archives at page 66.

CASE STUDY 82

Our investigators examined a sample of files of a regulator to determine whether its responses to potential breaches were reasonable. In many instances, our investigators could not determine whether the action taken was reasonable or not because:

- the enforcement officer did not make any written recommendation as to the appropriate enforcement action
- there were no records or insufficient records of a supervisor's instructions
- the minutes of meetings of a committee that met to consider cases did not record the substance of the discussions in relation to cases considered at the meetings and the committee's reasons for its decisions.

CASE STUDY 83

This case study is based on the same investigation as case study 57. As mentioned in case study 57, the regulator has powers to enter an owner's premises and carry out works (to be reimbursed by the owner) where the owner has not complied with the regulator's direction to carry out those works.

While carrying out the works, enforcement officers removed numerous items from the owner's premises. However, they did not make a written inventory of the items that were removed and dumped. The regulator told us that the preparation of a written inventory was not a requirement under its procedures.

Although the regulator's officers took about 100 photographs of the owner's property (including before and after the work commenced), there was no clear documentary evidence of the items removed or dumped. Therefore, it was difficult for the regulator to refute the owner's claims that valuable specified materials had been removed from the property.

We agreed with the regulator that, in deciding whether to prepare a complete inventory of the items removed, it was necessary to consider competing demands such as cost, risk to public health, workplace health and safety considerations and resourcing issues.

We therefore recommended that:

- The regulator require that enforcement officers make an adequate record of items they remove from properties while carrying out such works.
- Officers be given the discretion to select the recordkeeping option that best fits the circumstances of the particular job, (such options include photographing the property, video recording with commentary, and making written inventories).
- The regulator provide guidance to its enforcement officers on the actions to be taken where, in carrying out such works, an item is identified that is clearly valuable or that the property owner claims to be valuable.

CHAPTER 10: RECORDKEEPING

Officers of regulators often fall into the trap of believing that by recording the outcome of a case (often in accordance with a standard formula), they are recording the reasons for their decisions. They are not. Reasons address the who, what, when, where, why and how of a decision, not the outcome.

The following are some examples of inadequate reasons for decisions to take no enforcement action recorded by regulators in various cases we investigated:

- 'The evidence died with the worker'
- 'The incident was due to circumstances over which there was no control'
- 'There was likely operator error'
- 'It is considered unlikely that sufficient evidence to support a successful prosecution could be gathered'
- 'Despite a detailed investigation, insufficient evidence was gathered to support a breach of any legislation administered by this department'
- 'NFA - [Regulator] otherwise satisfied'
- 'The evidence has been reviewed. We do not consider it appropriate to pursue the matter any further'
- 'You should pursue your own remedies'.

These are mere assertions rather than reasons and invite questions, such as:

- What evidence died with the worker?
- What were the circumstances over which there was no control?
- What was the nature of the 'likely operator error'?
- What additional evidence was required to support a prosecution?

CASE STUDY 84

In the course of investigating a regulator's regulatory practices, our investigator (I) recorded the following exchange with an enforcement officer (E):

- E: *My initial investigation was really only to cover what happened and how it happened. I haven't really got into why it happened.*
- I: *But on [date], you recommended no prosecution.*
- E: *Yes.*
- I: *Without finding out why [it happened].*
- E: *Well I couldn't find out why.*
- I: *Well, I suppose the problem with that is that your memorandum doesn't say that, does it?*
- E: *No, it doesn't.*
- I: *So when someone comes and does an external review like we're doing, we don't have anything to support your story. We can't find anything on the file where you've made any file note about your concerns.*
- E: *No, you won't find that.*

The following case study is also an example of a regulator failing to provide adequate reasons.

CASE STUDY 85

A regulator made a decision that adversely affected the complainant. The letter advising the decision:

- contained general discussion regarding the relevant Act of Parliament
- referred generally to a number of lengthy documents as being the basis of the decision
- quoted the relevant section of the Act
- essentially stated that the statutory test had not been satisfied.

The letter provided no details of the issues and evidence taken into account in making the decision. The complainant advised that she did not understand how the decision could have been reached and asked for an explanation. The regulator advised that it had carefully considered the matter and confirmed the result.

The complainant complained to us that the regulator could not possibly have reached the conclusion it did having regard to the evidence she had provided. Our officers discussed the matter with the regulator and obtained from it details about how it reached the decision, what specific evidence it took into account and how it assessed the conflicting evidence.

We resolved the matter informally through our discussions and the regulator's agreement to provide the complainant with full reasons for the decision, including information that the complainant did not previously have. Although the complainant was still not satisfied with the outcome, she finally understood the reasons for the regulator's decision.

10.4.2 What we recommend

The policies and training recommended at 10.1.2 should highlight the need for enforcement officers, and their supervisors, to make and keep a sufficient record of the reasons for any decision of operational significance.

10.5 RECORDS OF 'ANONYMOUS' INFORMATION

At sections 3.3.4, 3.3.5 and 3.3.6, we discussed the importance of not dismissing anonymous notifications or giving them a lower priority, merely because they are anonymous. At section 7.4, we also explained why officers should not give a notifier a blanket guarantee that the regulator will not release information provided by the notifier of a personal nature.

This section discusses the requirement in the Public Records Act that agencies must keep a record of all personal details given by a notifier.

10.5.1 What we have found

Our investigations have shown that some officers do not understand this requirement, as the following case study illustrates.

CHAPTER 10: RECORDKEEPING

CASE STUDY 86

From time to time, a regulator received notifications of breaches of a regulatory scheme from persons who had given their name and/or their contact details to the regulator but requested to remain 'anonymous'. There appeared to be no consistent practice among officers as to how these types of notifications were recorded. In some cases, the word 'anonymous' was entered in the field in the case management system where the notifier's name should have been entered, even though the officer was aware of the notifier's identity.

10.5.2 What we recommend

The policies and training recommended at 10.1.2 should highlight the need for enforcement officers to:

- keep a record of all personal details given by a notifier and of any request by a notifier to remain anonymous or that the notifier's identity not be disclosed to a specified person or persons
- make appropriate arrangements for the security of the information in accordance with the level of sensitivity of the information.

10.6 AVOIDING UNPROFESSIONAL COMMENTS

Officers of regulators should avoid recording gratuitous and derogatory remarks because:

- it is contrary to the ethical principle in the Public Sector Ethics Act to treat all people with respect
- it is unprofessional
- it could be indicative of bias
- in the absence of an applicable exemption, such remarks may have to be released under the RTI Act¹¹⁰ to an applicant. Embarrassment is not a ground of exemption under the Act.

10.6.1 What we have found

Some officers of regulators do not appreciate the need to avoid making gratuitous and derogatory remarks, as the following case study illustrates.

¹¹⁰ A right to information request applies to 'documents' in the possession or under the control of the agency at the time the application is made, not just to 'records' within the meaning of the Public Records Act.

CASE STUDY 87

A note on a case file read:

Received phone call from Mr A, he is about 85 years old and a very erratic individual. He was complaining about the application he had lodged – seemed pretty upset with no good reason. Said he had been waiting for a letter from us for over 6 months ...

From what I know of his application, there is no chance of it being approved.

10.6.2 What we recommend

The policies and training recommended at 10.1.2 should highlight the need for officers to avoid making gratuitous and derogatory remarks in official records.

10.7 UNATTACHED RECORDS

Version 1.01.00 of the *Best Practice Guide*¹¹¹ advised that records should not be stored separately from the file.

10.7.1 What we have found

This practice is often not followed and we have found that officers sometimes use multiple record systems, as the following case study illustrates.

CASE STUDY 88

We investigated the adequacy of actions of certain government agencies in relation to the safety and wellbeing of a child¹¹² who died aged 10 weeks.

Upon receiving notification of the sudden unexplained death of a child, the Queensland Police Service's procedures required an authorised police officer to initiate a search of the relevant regulator's electronic case management system. One of the purposes of the search was to provide the medical practitioner conducting the post-mortem examination with any relevant information relating to the child. However, many records of the regulator relating to the child were not stored in the electronic case management system, but in hard copy, such as daily log books, case note books, loose pieces of paper and desk pads. In some cases, the contents of these records were later entered into the electronic system.

As a result, the information the police officers gathered from the searches of the regulator's electronic case management system, and the information they passed on to the pathologist, was incomplete.

¹¹¹ Queensland State Archives (January 2003) *Best Practice Guide to Recordkeeping*, V1.01.00, Brisbane: Queensland State Archives.

¹¹² *Report of the Queensland Ombudsman: An investigation into the adequacy of the actions of certain government agencies in relation to the safety, wellbeing and care of the late baby Kate, who died aged 10 weeks*, October 2003, Brisbane.

CHAPTER 10: RECORDKEEPING

10.7.2 What we recommend

The policies and training recommended at 10.1.2 should highlight the need for officers to ensure that records are not stored separately from the electronic file or, where this is not practicable, that the electronic file identifies the unattached records and their location.

10.8 ORGANISATION OF RECORDS

Records should be stored in files maintained in a format that is logical and easy to search because where records are poorly organised:

- it is difficult to track the actions taken in response to a notification or the findings of proactive compliance inspection and follow-up inspections without reading the entire file. The problem is magnified if one file has been maintained over a number of years in relation to all regulatory action taken in respect of a potential offender
- there is a risk that issues relating to a particular notification or proactive compliance inspection will not be followed up because an enforcement officer has overlooked relevant documents on a paper file containing a large volume of unrelated documents. These problems are exacerbated if the officer who has knowledge of a file is transferred, takes extended leave or permanently leaves the regulator
- it is difficult and time consuming for an officer to respond to a request for documents under the RTI Act and/or a request for a statement of reasons under the *Judicial Review Act 1991*
- it may be difficult for officers to later explain their actions and decisions to their supervisors or to external review bodies.

10.8.1 What we have found

The following case studies demonstrate the problems that can arise from poor file management.

CASE STUDY 89

Our examination of the records of a regulator revealed the following inadequate recordkeeping practices:

- files were not maintained in a logical order and were therefore difficult to follow
- there was no way of identifying whether the files were complete
- the location of physical evidence was not recorded
- the significance of various named individuals to the investigation was not apparent
- the dates of file movements and reviews were not consistently recorded
- file notes had not been made of some significant operational actions
- facts were not recorded clearly
- where opinions were recorded, they were generally not accompanied by any explanation of the basis on which the opinions were held.

CASE STUDY 90

During an interview between our investigators and a regulator's enforcement officer (E), the officer was repeatedly unable to locate documents relevant to the investigation he wished to draw to our investigator's (I) attention:

- E: ... I investigated this incident and my report is attached. Now, if these things are in the proper order it would be sitting right at the beginning of one of them.
- I: It would be nice wouldn't it.
- E: All I've got here is a mishmash of documents all over the place.
- I: Yes.
- E: Oh, well, can't find it ... Now, it should be on the file. It's not evident on the file ... I am sure it's somewhere in there. If the file was in the right order I'd be able to point it out to you.

CASE STUDY 91

The practice of some units of a regulator was to keep a single file for all issues relating to a potential offender. Documents relating to a variety of issues were stored within those files in no logical order. In many instances, the one file contained documents relating to:

- licence arrangements
- notifications by unrelated people about unrelated incidents
- proactive compliance inspections.

10.8.2 What we recommend

Regulators should develop and implement a policy that ensures separate files (or separate sections in a paper file) are maintained for documents concerning a potential offender that relate to any of the following:

- each incident, including an incident the subject of notifications by more than one notifier
- each proactive compliance inspection/activity and follow-up
- other more general issues, such as documents concerning licence arrangements.

10.9 PROJECT MANAGED CASES

Project management is a specialised discipline for planning, assigning and controlling work and completing it in accordance with predetermined milestones. Project management is usually the responsibility of an individual project manager.

The project management approach requires:

CHAPTER 10: RECORDKEEPING

- the appointment of the project manager and members of the project team
- the completion of a project plan (similar to an investigation plan – see paragraph 4.1.1 and Appendix A – but also identifying the project team and their responsibilities)
- assignment of the project work to the members of the project team
- control of the execution and completion of the project work by the project manager in accordance with the project plan.

Good recordkeeping practices are of critical importance to effective project management of cases to ensure good communication is maintained with the project team.

10.9.1 What we have found

Some regulators do not realise the critical importance of recordkeeping in the project management process, as the following case study illustrates.

CASE STUDY 92

In December 2005, a project managed investigation was approved. There was no record of the project team members and the roles and tasks of each member.

Until at least May 2006, no further action was taken in connection with the case as it appeared the specialist investigations unit was waiting for certain information from the original enforcement officer. The original enforcement officer appeared to be unaware of his role in the further investigation.

10.9.2 What we recommend

Regulators should develop and implement policies requiring that records are made of significant operational activity relating to a project managed case and kept on the relevant file or files so that the members of the project team are aware of their responsibilities from time to time.

10.10 INTERNAL SELF-ASSESSMENT TOOLS AND/OR INTERNAL AUDITS

Version 1.01.00 of the *Best Practice Guide*¹¹³ suggested that public authorities develop internal self-assessment tools and/or internal audits for records management practices, systems and procedures.

10.10.1 What we have found

Our investigations frequently show that regulators do not utilise such tools.

¹¹³ Queensland State Archives (January 2003) *Best Practice Guide to Recordkeeping*, V1.01.00, Brisbane: Queensland State Archives at clause 7.1.2.

CASE STUDY 93

Our investigation of a regulator's practice revealed significant deficiencies in the agency's recordkeeping practices. The regulator was unaware of these deficiencies and, in all likelihood, would not have become aware of these deficiencies as it did not conduct audits of its records and did not utilise effective internal self-assessment tools.

10.10.2 What we recommend

Regulators should develop and implement policies that ensure:

- internal self-assessment tools and/or internal audits are used to identify whether officers are complying with IS40
- any identified breaches are corrected.

CHAPTER 11: ELECTRONIC DATA CAPTURE

As mentioned, IS40 is supported by the *Best Practice Guide*,¹¹⁴ which has advised regulators to 'make the [electronic] capture of records as easy as possible or transparent to the user'.¹¹⁵

The *IS40 Compliance Checklist* also suggests that regulators 'incorporate effective searching and retrieval tools'¹¹⁶ in recordkeeping systems.

Effective data capture practices will enhance the reliability of the data and therefore the effectiveness of a regulator's electronic case management systems for both case and performance management and for statistical reporting.

11.1 ACCURACY OF DATA

A regulator needs to act both proactively and reactively to minimise the amount of inaccurate data entered in its case management system.

11.1.1 What we have found

The following case study contains examples of types of inaccurate data that can result from poor data entry practices.

CASE STUDY 94

Our inspection of the electronic case management system of a regulator showed the following types of incorrect entries in fields that were relevant to whether it was meeting its performance targets:

- site inspections undertaken in response to notifications were incorrectly recorded in the system as having been undertaken proactively
- inspections of documents provided by licence holders relevant to licence renewals were entered as site inspections
- three notifications from different sources that related to the same incident were entered into the same electronic record, although they should have been entered as three separate cases so as to maintain accurate data about the number of notifications received
- the regulator publicly reports an estimate of the amount potential offenders spend on rectifying alleged offences in each year as a result of its intervention. Enforcement officers had been requested to enter these amounts in a specific field when a potential offender had completed work carried out to comply with an enforcement action. At our request a senior officer audited compliance with this procedure and ascertained that it was not being followed consistently.

¹¹⁴ Queensland State Archives (December 2003) *Best Practice Guide to Recordkeeping, Version V1.01.00*, Brisbane: Queensland State Archives.

¹¹⁵ Queensland State Archives (December 2003) *Best Practice Guide to Recordkeeping, Version V1.01.00*, Brisbane: Queensland State Archives at page 33.

¹¹⁶ Queensland State Archivist *Compliance Checklist for Queensland Public Authorities to Self-assess Compliance with Information Standard 40: Recordkeeping*, retrieved from the world wide web: www.archives.qld.gov.au/publications.asp#government.

Our examination of the regulator's policies relating to data entry indicated that they provided inadequate guidance to officers. Furthermore, the regulator had no procedure for auditing the accuracy of its data.

11.1.2 What we recommend

Regulators should develop and implement policies that ensure the entering of inaccurate data in case management systems is minimised by taking:

- proactive measures, including the development of business rules for the entry of data in case management systems and the provision of training
- reactive measures, such as using internal self-assessment tools and/or internal audits to identify and correct inaccurate data and poor data entry practices.

11.2 DATA IN FORM USEFUL FOR CASE MANAGEMENT

Enforcement officers and supervisors are required to take into account the history of potential offenders (for example, licence changes, annual reviews, notifications, proactive compliance activities and outcomes of previous cases) when making decisions about regulatory action (such as the appropriate enforcement action and submissions to be made to a court on penalty).

Their consideration of such information can be facilitated by recording and maintaining it in a logical and readily accessible way.

11.2.1 What we have found

Some regulators' case management systems make it difficult for officers to retrieve the data they require, as the following case study illustrates.

CASE STUDY 95

Officers of the regulator complained that their electronic data system was only designed to capture statistics for reporting on overall performance of the regulator. They resented having to enter data that they felt was no use to them in their day-to-day management of cases.

11.2.2 What we recommend

Regulators should implement electronic case management systems that enable enforcement officers and supervisors to:

- conveniently view the history of regulatory compliance by, and action in relation to, a potential offender in chronological order
- efficiently search for cases with facts similar to the case they are investigating.

CHAPTER 11: ELECTRONIC DATA CAPTURE

11.3 AUTOMATIC REPORTING

Where possible, a regulator's case management system should be capable of producing reports on its performance against its key performance indicators¹¹⁷ and should be used for that purpose.

11.3.1 What we have found

In one case we investigated, the regulator's case management system, although capable of producing certain reports on operational activity, was not being used for that purpose.

CASE STUDY 96

Enforcement officers in district offices stated that they regularly received requests from head office to provide certain case related data, which the officers believed head office could have obtained from the electronic system. Officers complained that responding to these requests was very labour intensive.

We recommended to the regulator that it make optimal use of its case management system rather than requiring enforcement officers to manually collate data.

11.3.2 What we recommend

Regulators should implement case management systems capable of producing reports on its performance against its key performance indicators and effectively utilise those systems for reporting purposes.

¹¹⁷ Key performance indicators should measure what the agency is really trying to achieve. Setting such measures is a challenge for many regulatory agencies. As Sparrow notes, 'If true value in regulatory performance involves problems solved, compliance rates improved, risks mitigated, then regulators must persevere in the search for performance measurement and reporting techniques to match that kind of performance', in Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press at page 122; Queensland Office of Regulatory Efficiency.



CHAPTER 12: COMPLAINT MANAGEMENT

This chapter refers to complaints about the regulator itself.

As stated in the WEP report,¹¹⁸ a complaint management system encompasses an agency's policy, procedures and practices for, and the technology applied to, the handling of complaints. Good complaint management is an integral part of quality customer service and also provides benefits for the agency and staff. Effective systems:

- enable poor decisions to be quickly and efficiently rectified before they become serious and/or systemic
- provide information that can be used to identify areas for improvement.

12.1.1 Our Complaints Management Program

Our Complaints Management Program is a long term, multi-phased initiative that aims to improve the complaints management systems of state government agencies and local councils.

During Phase 1, completed in 2005, we helped eight state government agencies and three councils develop their systems to satisfy the Australian standard for complaint handling.

During Phase 2, completed in March 2008, we encouraged all state government agencies and local councils to develop and implement fair and effective complaint systems using our complaints management resources.

In November 2006, the Public Service Commissioner, acting on the Ombudsman's recommendation, issued *Directive 13/06 – Complaints Management Systems* for state government agencies.

Directive 13/06 required state government agencies to implement visible, accessible and responsive complaint management systems to better handle community complaints by 11 November 2007. The directive also required agencies to develop written policies and/or procedures, to devise a mechanism for recording complaints data and to make available appropriate resources (including trained staff).

During Phase 3 of the program, we assessed the extent to which state government agencies had complied with *Directive 13/06* and other best practice indicators. We also continued to give advice and make recommendations to agencies about ways of improving their systems.

During 2008-09, we continued to audit state government agencies' compliance with *Directive 13/06* by asking them to complete questionnaires and provide copies of their complaints policies and procedures for our assessment. Between July and December 2008, we audited the 38 responses we received and identified areas for improvement. We also audited agency websites to assess the visibility and accessibility of their complaints management systems. We also reviewed agency policies, procedures and other documents.

We then wrote to participating agencies informing them of our assessment of their level of compliance and making recommendations for improvement.

¹¹⁸ Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocutation Project*, Brisbane: Queensland Ombudsman at page 146.

During 2008-09, we also commenced an audit of the compliance of local councils' complaints management systems against:

- the General Complaints Process outlined in the Local Government Act
- other best practice complaints management indicators.

We distributed self-audit toolkits to 56 councils in February 2009. All councils responded and we are presently assessing their responses. In May 2009, we also completed an audit of councils' websites that assessed the visibility and accessibility of their complaints management systems.

12.1.2 Complaints management requirements

As mentioned, *Directive 13/06* applies to state government agencies. The purpose of the directive is to 'establish complaints management systems in agencies and to specify the minimum standards for such systems'.

In the directive, 'complaints management system' means the 'policy, procedures, personnel and technology used by an agency in receiving, recording, responding to and reporting about complaints'.

Clause 6.1 of the directive provides that 'All agencies must implement and maintain a system or systems for complaints management'. Clause 6.2 provides that 'An agency's complaints management system is to be supported by written policies and/or procedures'.

Local councils are required to have a general complaints process complying with chapter 6, part 5 (General Complaints Process) of the *Local Government Act 1993*.

The following case study demonstrates the confusion that can result when a regulator does not have an adequate complaints management system.

CASE STUDY 97

In one of our investigations, we noted there appeared to have been some confusion about the way complaints should be raised with the agency.

An officer told us the complainant made no attempt to report his claims to the agency's district office before contacting the agency's head office. The officer had refused to address the issue until 'the chain of command was adhered to'.

However, we were unable to locate any information on the agency's website advising the public on the correct process for raising complaints with the agency.

We recommended that the agency implement a complaints management system and make information about the system publicly available so that people would know how to raise a complaint with the agency and how their complaint would be managed.

CHAPTER 12: COMPLAINT MANAGEMENT

12.1.3 What we recommend

As a starting point, regulators should have a complaints management system that complies with:

- for state government agencies, *Directive 13/06*
- for local councils, the requirements of a general complaints process as specified in chapter 6, part 5 of the *Local Government Act 1993*.

To achieve this, each regulator needs to ensure that its complaints management system has, as a minimum, the following elements:

- visibility and access
- responsiveness
- assessment and action
- feedback
- monitoring effectiveness.

The *Complaints Management Program*¹¹⁹ and *Complaints Management Resources*¹²⁰ pages of our website provide suggestions on how regulators may enhance their complaints management systems by adding various best practice features.

119

<http://www.ombudsman.qld.gov.au/PublicAgencies/EffectiveComplaintsManagement/ComplaintsManagementProgram.aspx>.

120

<http://www.ombudsman.qld.gov.au/PublicAgencies/EffectiveComplaintsManagement/ComplaintsManagementResources.aspx>.



CHAPTER 13: AUDITS OF REGULATORS

13.1 PERFORMANCE AUDITS

The International Organisation of Supreme Audit Institutions (INTOSAI) is a professional organisation for the external government audit community.¹²¹ It develops guidelines and standards for the conduct of regularity (financial) audits and performance audits. Chapter IV of its *Auditing Standards*¹²² is titled Reporting Standards in Government Auditing.

The Auditing Standards explain:

*In a performance audit, the auditor reports on the economy and efficiency with which resources are acquired and used, and the effectiveness with which objectives are met. Such reports may vary considerably in scope and nature, for example covering whether resources have been applied in a sound manner, commenting on the impact of policies and programs and recommending changes designed to result in improvements.*¹²³

Further:

*In contrast to regularity audit, which is subject to fairly specific requirements and expectations, performance audit is wide-ranging in nature and is more open to judgement and interpretation ... As a consequence performance audit reports are varied and contain more discussion and reasoned argument.*¹²⁴

The Auditing Standards require the audit and its report to have reference to the 'Objectives and scope' of the audit. In deciding the objectives and scope of the audit, the auditor should have regard to the particular legislative objects of the regulator to be audited.

Also:

*Audit opinions and reports should indicate the auditing standards or practices followed in conducting the audit, thus providing the reader with an assurance that the audit has been carried out in accordance with generally accepted procedures.*¹²⁵

13.2 AUDITS OF REGULATORS

Regulators can identify efficiencies by commissioning internal and external audits of their performance, using the principles of performance auditing as a guide.

¹²¹ Members of this community are supreme audit organisations (SAIs) such as Auditors-General (INTOSAI (2006) *International Organization of Supreme Audit Institutions*, retrieved 20 November 2006 from the world wide web: www.intosai.org/en/portal/about_us/).

¹²² INTOSAI (2006) *Auditing Standards*, retrieved 20 November 2006 from the world wide web: www.intosai.org/en/.

¹²³ INTOSAI (2006) *Auditing Standards*, retrieved 20 November 2006 from the world wide web: www.intosai.org/en/ at page 60.

¹²⁴ INTOSAI (2006) *Auditing Standards*, retrieved 20 November 2006 from the world wide web: www.intosai.org/en/ at page 65.

¹²⁵ INTOSAI (2006) *Auditing Standards*, retrieved 20 November 2006 from the world wide web: www.intosai.org/en/ at page 62.

13.2.1 Regulator's audit tool

We have developed a Regulator's Audit Tool, based on the recommendations contained in this report.¹²⁶ However, as discussed in the *Auditing Standards*, the tool is a 'procedure' for use in preparing the audit report, but like any procedure is a guide only.¹²⁷

Where novel circumstances (such as a unique legislative object of the regulator audited) result in the tool producing an incomplete view of the regulator's endeavour, a qualification should be made in the audit report regarding the findings.

13.2.2 What we recommend

Regulators should:

- conduct regular performance audits of their enforcement action
- consider using the Regulator's Audit Tool in Appendix B, or a similar tool, to guide that process.

¹²⁶ See Appendix B to this report; also, for ideas on measuring the performance of regulators, see Crompton, M. 'Light Touch' or 'Soft Touch' – Reflections of Regulator Implementing a New Privacy Regime, retrieved 23 January 2007 from the world wide web: http://www.privacy.gov.au/news/speeches/sp2_04p_print.html; and Sullivan, G. and Cantwell, P. (2007) *Auditing Regulatory Agencies*, Brisbane.

¹²⁷ See <http://www.aelert.com.au>.

CHAPTER 14: CONCLUSION

It is not uncommon for regulators to claim that they have insufficient resources to effectively discharge their regulatory responsibilities. Whether a regulator's claim is a valid one, it is highly likely it will be able to improve its operational effectiveness by reviewing its regulatory practice and systems in accordance with the recommendations in this report.

As we have noted,¹²⁸ regulators must not only carry out their regulatory responsibilities effectively, they must also act consistently and in a transparent and accountable manner. Therefore, some of our recommendations are directed to this aspect of regulators' performance.

Regulators sometimes defend their poor record on this aspect of their performance by claiming that they cannot afford to divert resources away from their core business. However, they need to recognise that meeting reasonable standards of consistency, transparency and accountability is also part of their core business.

Furthermore, initiatives aimed at improving consistency, transparency and accountability, even where they entail some initial investment of funds, frequently have a positive impact on a regulator's effectiveness and economy.

For example:

- an audit undertaken to identify inconsistencies in operational decision-making and practice may reveal:
 - lack of supervision or training
 - inefficiencies in the way some units are carrying out their responsibilities compared with other units
 - unauthorised practices that could have had serious adverse consequences for the regulator had they not been discovered
 - the allocation of resources to a particular type of activity that is not consistent with the policy or priorities of head office
- a well structured system for prioritising cases will assist a regulator to make more effective decisions about the use of resources
- a case management system that provides regular, reliable reports on performance will inform decisions about resourcing as well as identifying system deficiencies and ways of improving the regulator's business processes and, ultimately, the quality of the service the regulator provides to the community¹²⁹
- regulators with overlapping responsibilities need to have arrangements in place to effectively coordinate their regulatory activity to minimise duplication of effort and avoid any gaps in the regulatory framework.

¹²⁸ Section 1.5.

¹²⁹ see Crompton, M. 'Light Touch' or 'Soft Touch' – Reflections of Regulator Implementing a New Privacy Regime, retrieved 23 January 2007 from the world wide web:
http://www.privacy.gov.au/news/speeches/sp2_04p_print.html.

These are issues regulators simply cannot afford to ignore.

I encourage the chief executive officers and senior officers of regulators to use this report as a resource for reviewing and evaluating their regulatory systems.

APPENDIX A: INVESTIGATION PLAN TEMPLATE

INVESTIGATION PLAN

Allegations	Issues for investigation	Legislation, policy, other benchmarks	Facts to be proved	Tasks/avenues of inquiry

Source: NSW Ombudsman (2004) *Investigating Complaints: A Manual for Investigators*, Sydney: NSW Ombudsman at page 28.



APPENDIX B: REGULATOR'S AUDIT TOOL

The concept

'... there are some fundamental minimum requirements for a regulator to meet the standard of a competent regulator ...

... there is sufficient commonality between regulators to make possible meaningful comparison of regulatory capability using a single audit system.'

'Auditing Regulatory Agencies'

Greg Sullivan – 3rd AELERT National Conference, Sydney, November 2006

Audit tool

The Queensland Ombudsman has developed a Regulator's Audit Tool, based on the recommendations contained in his report, *Tips and Traps for Regulators*.

The tool can be used as a resource by public sector agencies with regulatory functions in assessing their policies and practices for those functions.

Like any procedure, the tool is intended as a guide only.

Agencies using the tool should also have regard to the Ombudsman's report, which explains the significance of the criteria comprising the checklist.

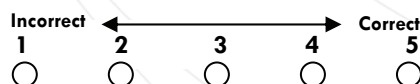
Who should use the audit tool?

Depending on the size and structure of your agency, the tool may be applied by one person or may require a team effort. Ideally, a senior member of management should be involved. Some statements may need to be referred to particular officers.

Participant instructions

The checklist is a self-assessment diagnostic tool. Each section corresponds to key issues common to regulatory agencies and contains statements that participants need to assess.

Use the following five-point scale to assess each indicator with one being incorrect and five being most correct for the applicability of each statement to your agency's practice and procedures.



A low score for a statement or for several statements relating to one area (e.g. recordkeeping) may indicate that your agency needs to make improvements to its regulatory practice in that area.

You should also consult the relevant parts of the Ombudsman's report, *Tips and Traps for Regulators*, for ideas on improvements your agency can make to its systems and practices.

The recommendations in *Tips and Traps for Regulators* are necessarily of a general nature as each regulator is different. We invite you to seek the assistance of the Ombudsman's Administrative Improvement Unit in implementing the suggested improvement measures in the way that best suits your agency's circumstances.

Incorrect ← → Correct
 1 2 3 4 5

Recruitment practices

- | | | | | | | |
|----|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1) | The selection criteria for enforcement officer positions place appropriate emphasis on investigative knowledge, technical knowledge and skills and values, as relevant to the regulatory scheme. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2) | ‘Gaps’ in the knowledge, skills and values of new recruits are identified and bridging training is arranged promptly. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3) | Procedures are in place to ensure that new staff do not monitor entities for which they have recently worked. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Policies and manuals

- | | | | | | | |
|----|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 4) | The regulator has manuals for enforcement officers that cover: | | | | | |
| | a) legislation and available enforcement options | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | b) investigative and other enforcement practices | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | c) regulatory strategy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | d) recordkeeping | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | e) appropriate relationships with the regulated industry. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Training

- | | | | | | | |
|-----|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 5) | The regulator's training program covers its policies and encompasses appropriate types of training, whether provided externally or internally, such as standard training, bridging training, refresher training, advanced training, or training to enhance professional or technical skills. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6) | The regulator's training program is reviewed at regular intervals. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7) | An identified officer is responsible for managing the training program. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8) | Participant feedback is routinely obtained and used to ensure training is responsive to the needs of enforcement officers. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9) | Training is provided in all areas of regulatory practices, including recordkeeping. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10) | The regulator has a performance review and planning process for the continuing development of competencies for enforcement officers. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

APPENDIX B: REGULATOR'S AUDIT TOOL

	Incorrect	←————→			Correct
	1	2	3	4	5
11) The regulator has a mentoring program for its enforcement officers and other appropriate officers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12) All enforcement officers are promptly advised of changes to legislation and policies relevant to their work, as well as the intent and effect of those changes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prioritisation systems					
13) Cases are prioritised in accordance with a priority rating system.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14) Greater investigative resources are allocated to cases with higher ratings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15) Wherever practicable (and subject to the regulator's legislation), cases with the lowest priority ratings are addressed in less formal and more cost effective ways.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prioritisation of anonymous notifications					
16) Anonymous notifications are assessed against the same criteria as other notifications, including whether the notification is capable of investigation, and are not routinely classified as 'low priority'.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Balancing reactive and proactive work					
17) The regulator's enforcement strategies include both reactive and proactive work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18) The regulator has appropriate policies providing a basis for its regulatory strategies.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Note: If the regulator does not undertake proactive work, go to statement 27.					
19) The regulator's enforcement program and focus of proactive work are clearly set out in an operational plan or similar.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20) The reasons for focusing on those areas are recorded (not necessarily in the operational plan).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Note: If the regulator does not use risk ranking to identify and prioritise areas for proactive work, go to statement 24.					
21) Guidelines are provided on the justification for allocating the various risk rankings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Incorrect ← → Correct
 1 2 3 4 5

- 22) The level of officer authorised to set and/or change the risk ranking is specified. 1 2 3 4 5
- 23) The reasons for setting or altering the risk ranking are recorded. 1 2 3 4 5
- 24) The various levels of proactive work are adequately described (e.g. the meaning of a level one or level two inspection). 1 2 3 4 5
- 25) The circumstances in which each level of proactive work will be undertaken are described. 1 2 3 4 5
- 26) Supervisors monitor the performance of proactive work to check if it is being carried out in accordance with the policies. 1 2 3 4 5
- Prior warning**
- 27) Advance warnings of audits of particular premises on a particular day are not routinely given. 1 2 3 4 5
- Duty to assess notification**
- 28) Set criteria are applied to the assessment of each case to determine the extent to which it will be investigated. 1 2 3 4 5
- Consistency in enforcement**
- 29) Specified types of activities are not given blanket exemptions from prosecution or other enforcement action. 1 2 3 4 5
- 30) Guidelines are provided to ensure enforcement officers take prosecution or other enforcement action in a consistent and transparent way. 1 2 3 4 5
- 31) The regulator has in place a system for regularly auditing compliance by enforcement officers with relevant legislation and policies and, in the case of regulators with a decentralised enforcement model, uses a centralised system to promote consistent enforcement action. 1 2 3 4 5
- Investigative planning**
- 32) Unless there are good reasons for not doing so, every investigation of any significance is the subject of an appropriate investigative plan. 1 2 3 4 5

APPENDIX B: REGULATOR'S AUDIT TOOL

	Incorrect	←————→			Correct
	1	2	3	4	5
33) Investigative activity does not commence until the plan has been approved by a supervisor except where there is a risk that evidence will be lost or become difficult to obtain unless immediate action is taken.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34) Investigation plans are regularly reviewed and changed if circumstances require.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35) Supervisors give a high priority to enforcement officers preparing investigative plans and to reviewing those plans to ensure all relevant lines of inquiry are followed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enforcement options					
36) Enforcement officers have access to a range of enforcement options appropriate to minor and major breaches of the regulatory scheme.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Training in evidence gathering					
37) Enforcement officers are provided with the requisite training in the laws of evidence and evidence gathering, so that they are able to make informed decisions about the nature of the evidence required to prove the elements of an offence and how to obtain the evidence.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38) Enforcement officers are provided with training on the need to ensure that their administrative decisions (e.g. whether there are sufficient grounds to issue a warning notice) are supported by evidence that bears a logical connection to them.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of legal advice					
39) Legal advice is obtained where there is uncertainty as to the rights, obligations and liabilities of the regulator or the meaning of the legislation it enforces, where the issue has a significant bearing on the regulator's operations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expert witnesses					
40) A central register is maintained of all internal and external expert witnesses that includes details of the expert witnesses' qualifications and experience.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bring-up systems					
41) The regulator's electronic case management system records the dates by which critical operational actions must be completed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Incorrect ← → Correct
 1 2 3 4 5

42) The regulator's electronic case management system generates reminders/bring-ups prior to the due date for an action. 1 2 3 4 5

43) The regulator's electronic case management system notifies the appropriate supervisor when an action has not been completed by the due date. 1 2 3 4 5

Systems for effective investigation

44) The regulator has a system for verifying if potential offenders have taken steps they have been directed to take or have agreed to take and does not rely solely on the potential offender's assertion to that effect. 1 2 3 4 5

45) Where a potential offender conducts its own investigation of a potential regulatory breach by its employees and concludes that no breach has occurred, the regulator carefully reviews the investigation and findings. 1 2 3 4 5

Supervisory systems

46) Supervisors review enforcement officers' decisions/recommendations that enforcement action be taken or not be taken. 1 2 3 4 5

47) Supervisors make an appropriate record of why they supported or did not support the decision/recommendation. 1 2 3 4 5

48) A written procedure requires that officers of a stated level of seniority authorise the closure of different categories of cases depending on their seriousness. 1 2 3 4 5

49) The performance of supervisors is regularly assessed under a formal system that does not give undue importance to the number of cases closed by their subordinates without taking any compliance action. 1 2 3 4 5

Review systems

50) A sample of cases is reviewed at regular intervals, with emphasis on cases closed without enforcement action being taken, to identify inconsistent decision-making and inefficient or unauthorised practices. 1 2 3 4 5

51) The sample is selected in such a way as to be reasonably representative of the total case population and, generally, is weighted in favour of the more serious cases. 1 2 3 4 5

APPENDIX B: REGULATOR'S AUDIT TOOL

	Incorrect	←————→			Correct
	1	2	3	4	5
52) Case reviews are undertaken by an officer or officers of sufficient seniority and experience.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
53) A system is in place to ensure that appropriate action is taken in response to instances of inconsistent decision-making and inefficient or unauthorised practices identified through case reviews.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Approval systems					
54) The regulator has approval processes in place to ensure, to the extent possible, consistency in decisions about whether to take prosecution action or other enforcement action.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
55) Audits are conducted at regular intervals to ensure the approval processes are being complied with.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delegations					
56) If it is considered appropriate that a senior officer make all decisions of a certain type, the situation is monitored to ensure a bottleneck does not develop.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
57) Written delegations are in place and are regularly reviewed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
58) A system is in place to ensure enforcement officers are aware of the limits of their delegated authority.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Organisational structure					
59) The regulator reviews its organisational structure at regular intervals to ensure it provides optimal support in achieving its goals and objectives.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Review of policies					
60) Officers are allocated responsibility for the review of specified policies.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
61) A system is in place to remind an officer responsible for the review of a policy when it is time to undertake the review.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
62) In reviewing a policy, the officer responsible properly consults with officers in the field who frequently apply that policy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Note: If the regulator does not have any partner agencies, go to statement 69.

Incorrect ← → Correct
 1 2 3 4 5

Lead agency and partner agencies

63) Partner agencies have appropriate arrangements in place in accordance with the relevant legislation (supported by a written agreement such as a memorandum of understanding), identifying which regulator is the lead agency for specified categories of cases and the responsibilities of partner agencies. 1 2 3 4 5

64) The lead agency ensures that cases within the jurisdiction of the regulation group continue to be appropriately assessed and actioned where another regulator refuses to carry out its regulatory responsibility. 1 2 3 4 5

65) The regulator's policies regarding the administration of its regulatory responsibilities can be conveniently accessed by partner agencies. 1 2 3 4 5

Sharing of case records

66) Written arrangements are in place to facilitate the exchange of relevant case information between partner agencies in a timely way, subject to any requirements to maintain confidentiality (e.g. a memorandum of understanding). 1 2 3 4 5

Referrals

67) The regulator sends referrals to the receiving regulator in a timely way. 1 2 3 4 5

68) The regulator ensures the receiving regulator has accepted the referral before closing its case. 1 2 3 4 5

69) The regulator maintains communication with the notifier until the referral is accepted by the receiving regulator. 1 2 3 4 5

70) The receiving regulator advises the referring regulator as soon as practicable whether it accepts responsibility for dealing with the referral. 1 2 3 4 5

71) Where the receiving regulator decides to deal with a case that has been the subject of a referral, it advises the notifier of that decision as soon as practicable. 1 2 3 4 5

APPENDIX B: REGULATOR'S AUDIT TOOL

Incorrect ← → Correct
1 2 3 4 5

Making policies publicly available

72) The regulator:

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a) identifies 'policy document' as defined in the dictionary to the Right to Information Act | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b) makes those policies available for inspection and purchase by members of the community, in accordance with s.20 of the Act. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Updates to notifier

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 73) An acknowledgement of all notifications is provided, either orally or in writing, as soon as possible after receipt of the notification. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 74) Where the acknowledgement is given orally, the officer makes and keeps a record that it was given. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 75) When a case is allocated to a new officer, the regulator advises the notifier of that fact and the contact details of the case officer. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 76) All notifiers (including potential offenders that have reported their own potential breaches) are kept informed of the status of their notifications at regular intervals, to the extent that this does not prejudice the investigation or breach an obligation to maintain confidentiality. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Note: If the regulator does not have any partner agencies, go to statement 82.

Communication with persons affected

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 77) Persons with a genuine interest in the outcome of enforcement action are kept up to date on the progress of the investigation and informed of the outcome in a timely way, to the extent that this does not prejudice the investigation or breach an obligation to maintain confidentiality. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|

Confidentiality of notifier details

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 78) The regulator maintains confidentiality in respect of the notifier's identity wherever possible. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|

Incorrect ← → Correct

1 2 3 4 5

- 79) If it becomes necessary, during the course of an investigation, to disclose a notifier's identity, the regulator advises the notifier of the proposed disclosure before it is made.
- 80) Officers do not give blanket guarantees that the regulator will not release the notifier's name and other identifying information.

Jurisdiction

- 81) Each partner agency's jurisdiction is clearly defined.
- 82) Where more than one regulator has jurisdiction over aspects of a regulatory scheme, each has mutually exclusive jurisdiction.
- 83) Any factual inquiries required to determine questions of jurisdiction are straightforward.
- 84) Partner agencies have appropriate arrangements in place (supported by a written agreement such as a memorandum of understanding) requiring them, in enforcing the regulatory schemes, to have regard to each other's responsibilities and to facilitate each other's work.

Penalties

- 85) The legislation establishing the regulatory scheme provides for penalties that are appropriate to breaches of different levels of seriousness.
- 86) The legislation establishing the regulatory scheme provides for penalties that are consistent with the range of penalties provided in overlapping regulatory schemes in relation to breaches of a similar kind.

Review and clarification

- 87) The regulator periodically reviews legislation relating to any regulatory scheme it administers to identify any inconsistency with legislation relating to an overlapping regulatory scheme.
- 88) In respect of any such ambiguity and/or inconsistency identified, the regulator seeks appropriate amendments to address the ambiguity or inconsistency.

APPENDIX B: REGULATOR'S AUDIT TOOL

Incorrect ← → Correct
1 2 3 4 5

Where potential offender is another regulator

- 89) The regulator treats other regulators that are also potential offenders consistently with the way it treats other potential offenders. 1 2 3 4 5

Conflict of interest and bias

- 90) The regulatory scheme does not, directly or indirectly, create potential conflicts of interest for its officers. 1 2 3 4 5
- 91) Conflicts of interest are recorded and reported to supervisors and appropriately dealt with to prevent situations arising that involve actual or apprehended bias. 1 2 3 4 5
- 92) Enforcement officers are trained in recognising and dealing with conflicts of interest. 1 2 3 4 5

Promoting perception of regulatory independence

- 93) The regulator does not have other responsibilities for the activity it regulates that are inconsistent with the perception of impartial and independent enforcement (e.g. promotion of the activity). 1 2 3 4 5
- 94) There is a clear and well-publicised procedure for reporting conflicts of interest. 1 2 3 4 5
- 95) Particularly in rural and remote areas, the regulator has clear guidelines for staff to help them avoid social and other situations outside work that may give rise to a perception of bias. 1 2 3 4 5
- 96) Regional staff are regularly involved in activities with headquarters to promote organisational identification and cohesiveness. 1 2 3 4 5
- 97) The regulator conducts unannounced inspections wherever possible. 1 2 3 4 5
- 98) Officers formally record reasons justifying why they are not proceeding with compliance action, where this is the outcome of an investigation. 1 2 3 4 5
- 99) Informal or oral warnings are recorded on the agency's database. 1 2 3 4 5
- 100) The regulator regularly and publicly reports on its compliance activities. 1 2 3 4 5

Incorrect ← → Correct
1 2 3 4 5

101) The regulator does not rely on the regulated industry for support, e.g. travel to and from sites, accommodation, meals and hospitality.

102) The regulator has an adequate range of compliance tools available to it.

Recordkeeping

103) The regulator provides appropriate training to enforcement officers on recordkeeping and their obligations under the *Public Records Act 2002* to make and keep records.

104) The regulator conducts regular audits of files to ensure records are being properly kept.

105) A system is in place for monitoring compliance with the requirement that sufficiently detailed records are made and kept of all operational activities.

106) Records of operational activities are made as contemporaneously as possible.

107) A record is kept of all personal details given by a notifier and of any request by a notifier to remain anonymous or that the notifier's identity not be disclosed to a specified person or persons.

108) Appropriate arrangements are made for the security of the information in accordance with the level of sensitivity of the information.

109) Supervisors conduct regular audits of records to ensure that enforcement officers:

- a) are complying with the Public Records Act
- b) do not record gratuitous or derogatory remarks in those records.

110) Where the regulator uses an electronic case management system, the existence and location of any paper records are identified on the electronic file.

111) In relation to project managed cases, records of significant operational activity relating to a case are kept on the relevant file or files so that the members of the project team are kept apprised of developments and their responsibilities.

APPENDIX B: REGULATOR'S AUDIT TOOL

Incorrect ← → Correct
1 2 3 4 5

112) Internal self-assessment tools and/or internal audits are used to identify whether officers are complying with IS40. 1 2 3 4 5

113) A process exists to ensure any identified breaches of IS40 are corrected. 1 2 3 4 5

Electronic data

114) Proactive measures are taken to minimise inaccurate data being entered on case management systems, including the development of business rules for the entry of data and training. 1 2 3 4 5

115) Reactive measures are taken to minimise inaccurate data being entered on case management systems, such as using internal self-assessment tools and/or internal audits to identify and correct inaccurate data and poor data entry practices. 1 2 3 4 5

116) Enforcement officers and supervisors can conveniently view the history of regulatory compliance by, or action in relation to, a potential offender in chronological order. 1 2 3 4 5

117) Enforcement officers and supervisors can efficiently search for cases with facts similar to the case they are investigating. 1 2 3 4 5

Performance reporting

118) The regulator's case management system is capable of producing reports on its performance in respect of its key performance indicators and these reports are effectively utilised for reporting purposes. 1 2 3 4 5

Complaint management – State agencies

119) The regulator has a complaints management system complying with the Queensland Public Service Commissioner's Directive 13/06 called Complaints Management Systems. 1 2 3 4 5

Incorrect ← → Correct
1 2 3 4 5

Complaint management – local councils

120) The council has a general complaints process that complies with the relevant local government legislation.

Performance audits

121) The regulator conducts periodic performance audits of its enforcement activities.

BIBLIOGRAPHY

- Abbot, C. (2005) The enforcement of pollution control laws in England and Wales: a case for reform?, *Environmental Protection Law Journal*, 22, 68-81
- Arthur, P. (2002) Environmental protection orders, restraining orders and private prosecutions: an examination of the Environmental Protection Act 1994, *Queensland Environmental Practice Reporter*, 8 (40), 220-236
- Attorney-General's Department (30 September 2001) *Legal Services Directions*, ACT: Office of Legal Services Coordination
- Attorney General's Department of NSW (September 2004) *Model Litigant Policy*, Attorney-General's Department of NSW
- Australian Capital Territory (1992) *Model Litigant Guidelines*
- Australian Competition and Consumer Commission (2000) *Collection and Use of Information*, ACT, Australian Competition and Consumer Commission
- Australian Competition and Consumer Commission (July 2002) *ACCC Cooperation Policy for Enforcement Matters*, ACT: Australian Competition and Consumer Commission
- Australian Competition and Consumer Commission (2003) *Access to Public Registers*, ACT: Australian Competition and Consumer Commission
- Australian Competition and Consumer Commission (2004) *Enforcement Register*, retrieved 8 December 2005 from the world wide web:
<http://www.accc.gov.au/content/index.phtml/itemId/585905>
- Australian Competition and Consumer Commission (2005) *Compliance Review Requirements*, retrieved 8 December 2005 from the world wide web:
<http://www.accc.gov.au/content/index.phtml/itemId/529262/fromItemId/12226>
- Australian Competition and Consumer Commission (2005) *Enforceable Undertakings*, retrieved 8 December 2005 from the world wide web:
<http://www.accc.gov.au/content/index.phtml/itemId/268269>
- Australian Competition and Consumer Commission (2005) *Enforcement Priorities*, retrieved 8 December 2005 from the world wide web:
<http://www.accc.gov.au/content/index.phtml/itemId/344494>
- Australian Competition and Consumer Commission (2005) *Trade Practices Compliance Programs*, retrieved 8 December 2005 from the world wide web:
<http://www.accc.gov.au/content/index.phtml/itemId/54418/fromItemId/12226>
- Australian Government (2006) *Rethinking Regulation: Report of the Taskforce on Reducing Regulatory Burdens on Business*, Belconnen: Commonwealth of Australia
- Australian Law Reform Commission (April 1999) Government as a litigant, *Law Institute Journal*, 73 (4), 31

Australian Law Reform Commission (April 2002) *Securing Compliance: Civil and Administrative Penalties in Australian Federal Regulation: Discussion Paper*, Sydney: Australian Law Reform Commission

Australian Public Service Commission (2005) *Working Together: Principles and Practices to Guide the Australian Public Service*, retrieved 23 January 2007 from the world wide web: <http://www.apsc.gov.au/mac/workingguide.htm>

Australian Quarantine and Inspection Service, Department of Agriculture, Fisheries and Forestry (Cth) (8 April 2003) *Enforcing Australia's Import and Export Laws*, retrieved 15 December 2005 from the world wide web: <http://www.affa.gov.au.../output.cfm?ObjectID=D2C48F86-BA1A-11A1-A2200060A1B00113>

Australian Quarantine and Inspection Service, Department of Agriculture, Fisheries and Forestry (Cth) (20 August 2003) *Quarantine Laws and the Role of AQIS*, retrieved 15 December 2005 from the world wide web: <http://www.affa.gov.au.../output.cfm?ObjectID=D2C48F86-BA1A-11A1-A2200060A1B0057>

Ayres, I. and Braithwaite, J. (1992) *Responsive Regulation: Transcending the Deregulation Debate*, New York: Oxford University Press

Baird, R. (September 2000) Spotlight on illegal dumping, *Law Institute Journal*, 74 (8), 58-60

Baird, R. (2003) Environmental prosecutions in Victoria – full benefit of amendments limited by prosecution structure, *Environmental and Planning Law Journal*, 19 (2), 83-88

Baldwin, R. and Cave, M. (1999) *Understanding Regulation: Theory, Strategy and Practice*, Oxford: Oxford University Press

Bar Association of Queensland (10 June 2005) *2004 Barristers Rule*, Bar Association of Queensland

Beaufoy, M. (27 November 2003) *The Cumulative Effect of Alternative Sentences for Corporations*, Clayton Utz, Insights, retrieved 2 November 2005 from the world wide web: http://www.claytonutz.com/areas_of_law/

Beckett, S. (June 2005) Practice and procedure of indictable matters set for reform, *Law Society Journal*, 43 (5), 32-35

Better Regulation Task Force (April 1999) *Enforcement*, London: Better Regulation Task Force

Better Regulation Task Force (September 2003) *Imaginative Thinking for Better Regulation*, London: Better Regulation Task Force

Better Regulation Task Force (2006) *Principles of Good Regulation*, retrieved 22 January 2007 from the world wide web: <http://www.brc.gov.uk/publications/principlesentry.asp>

Briody, M. and Prenzler, T. (1998) The enforcement of environmental protection laws in Queensland: a case of regulatory capture?, *Environmental and Planning Law Journal*, 15 (1), 54-71

BIBLIOGRAPHY

Budavari, R. (November 1998) Australian Capital Territory contaminated land: Environment Protection (Amendment) Bill 1998, *Australian Environmental Law News*, 3 & 4, 5-6

Byrnes, B. (2004) Contaminated Sites Act WA – a review, *Australian Construction Law Bulletin*, 16 (6), 64-66

Collier, B. (15 March 2004) *The view from ASIC: a perspective on current activities and enforcement powers* (speech), Australian Securities & Investments Commission

Cork, S. (2005) Liquidators, lenders and contaminated land in New South Wales, *Insolvency Law Journal*, 13, 33-41

Council of Australian Governments (amended 2004) *Principles and Guidelines for National Standard Setting and Regulatory Action by Ministerial Councils and Standard-Setting Bodies*, retrieved 22 January 2007 from the world wide web: www.coag.gov.au/meetings/250604/coagpg04.pdf

Crime and Misconduct Commission (CMC) (April 2003) *Regulatory risks: minimising misconduct risks in agencies with regulatory functions*, Building Capacity Services, No. 2, retrieved 27 April 2007 from the world wide web: <http://www.cmc.qld.gov.au/asp/index.asp?pgid=10849>

Crompton, M. (2004) 'Light Touch' or 'Soft Touch' – Reflections of Regulator Implementing a New Privacy Regime, retrieved 23 January 2007 from the world wide web: http://www.privacy.gov.au/news/speeches/sp2_04p_print.html

Crown Law (September 1999) *Hot Tips for Enforcement Officers: Evidence for a Prosecution, Alert: A legal update for Crown Law clients*, Brisbane: Crown Law

Crown Law (March 2004) *Public Records: What You Need to Know!, Legal Update: A legal update for Crown Law clients*, Brisbane: Crown Law

Department of Environment and Conservation (NSW) (October 2003) *Report on the Review of the Protection of the Environment Operations Act 1997*, Sydney: Department of Environment and Conservation (NSW)

Department of Environment and Conservation (NSW) (2006) *Annual Report NSW Department of Environment and Conservation: 2004/2005*, Sydney: Department of Environment and Conservation (NSW)

Department of Environment and Conservation (NSW), NSW Environmental Protection Agency (July 2001) *EPA Prosecution Guidelines*, Sydney South: Department of Environment and Conservation (NSW), NSW Environmental Protection Agency

Department of Environment and Conservation (NSW) (various dates) Various media releases, retrieved 19 December 2005 from the world wide web: <http://www3.environment.nsw.gov.au/npws.nsf/>

Department of Industrial Relations (April 2001) *Ministerial Review of the Division of Workplace Health and Safety and the Electrical Safety Office – Final Report*, Queensland Government: Brisbane

Department of Natural Resources and Mines (23 February 2004) *Environmental Management and Regulation of Mining in Queensland*, retrieved 13 January 2006 from the world wide web: <http://www.nrm.qld.gov.au/mines/environmenta/regulation.html>

Department of Natural Resources and Mines (2005) *Annual Report 2004-05*, Brisbane: Department of Natural Resources and Mines

Department of Natural Resources and Mines (2005) *Statement of Affairs*, Brisbane: Department of Natural Resources and Mines

Department of Natural Resources and Mines (23 March 2005) *Queensland compliance the envy of other states* (media release), retrieved 13 January 2006 from the world wide web: http://www.nrm.qld.gov.au/about/media/mar/23_compliance_envy.html

Department of Natural Resources and Mines (August 2005) *Compliance Investigations Manual*, Brisbane: Department of Natural Resources and Mines

Department of Natural Resources and Mines (23 August 2005) *DS4.1 Authorised Officers Functions, Powers and Responsibilities* (Version 1), Brisbane: Department of Natural Resources and Mines

Department of Natural Resources and Mines (30 November 2005) *IM 4.6 Issuing a Show Cause Notice* (Version 1), Brisbane: Department of Natural Resources and Mines

Department of Natural Resources and Mines, *Compliance* (no date) (pamphlet), Brisbane: Department of Natural Resources and Mines

Department of Natural Resources and Mines, Compliance Co-ordination Unit (February 2005) *NR & M investigations* (electronic recording), Brisbane: Department of Natural Resources and Mines, Compliance Co-ordination Unit

Department of Natural Resources and Mines, Compliance Co-ordination Unit (March 2005) *Investigations: What to Expect*, Brisbane: Department of Natural Resources and Mines, Compliance Co-ordination Unit

Department of Natural Resources and Mines, Compliance Co-ordination Unit (March 2005) *Trespass on State-owned Land*, Brisbane: Department of Natural Resources and Mines, Compliance Co-ordination Unit

Department of State Development (2007) *Guidelines on Alternatives to Prescriptive Regulation*, retrieved 22 January 2007 from the world wide web: http://www.sd.qld.gov.au/dsdweb/v3/guis/templates/content/gui_cue_doc.cfm?id=5496

Department of the Environment and Heritage (Cth) (August 2004) *Compliance and Enforcement Policy*, Department of the Environment and Heritage

Department of the Premier and Cabinet (2007) *Executive Council Handbook – Machinery of Government Changes – Administrative Arrangements Orders*, retrieved 30 April 2007 from the world wide web: www.premiers.qld.gov.au/About_the_department/publications/policies/Governing_Queensland/

BIBLIOGRAPHY

Department of the Premier and Cabinet (2007) *Executive Council Handbook – Machinery of Government Changes – Departmental Arrangements Notices*, retrieved 30 April 2007 from the world wide web: www.premiers.qld.gov.au/About_the_department/publications/policies/Governing_Queensland/

Department of the Premier and Cabinet, Service Delivery and Performance Commission (2006) *Review of Legislative and Regulatory Reform Initiatives in the Queensland Government Phase 1*, Brisbane: Service Delivery and Performance Commission

Department of the Premier and Cabinet (2007) Service Delivery and Performance Commission details, retrieved 24 January 2007 from the world wide web: http://www.premiers.qld.gov.au/About_the_department/publications/newsletters/Sectorwide/2006_Editions/June_06/Service_Delivery_and_Performance_Commission/

Department of Tourism, Fair Trading and Wine Industry Development, and Queensland Ombudsman (2006) *Better Decisions Project: A Framework for Effective Administrative Decision Making Systems*, Brisbane: Tourism, Fair Trading and Wine Industry Development, and Queensland Ombudsman

Director of Public Prosecutions for New South Wales (20 October 2003) *Prosecution Guidelines*, Director of Public Prosecutions for New South Wales

Environment ACT (November 1998) *General Environmental Protection Policy*, ACT: ACT Government

Environmental Protection Agency (2004) *Annual Report 2003-04 – Environmental Protection Agency*, Brisbane: Environmental Protection Agency

Environmental Protection Agency (2005) *Annual Report 2004-05 – Environmental Protection Agency*, Brisbane: Environmental Protection Agency

EPA Victoria (April 2003) *Environmental Auditing in Victoria*, Publication 902, EPA Victoria

EPA Victoria (July 2005) *Enforcement Policy*, Southbank: EPA Victoria

EPA Victoria (October 2005) *Annual Report 2004-2005*, Melbourne: EPA Victoria

EPA Victoria (various dates) Various media releases, retrieved 19 December 2005 from the world wide web: <http://epanote2.epa.vic.gov.au/>

European Parliament and Council (21 April 2004) Directive 2004/35/CE of the European Parliament and of the Council of 21 April 2004 on environmental liability with regard to the prevention and remedying of environmental damage, *Official Journal of the European Union*, L143 at 56

External Advisory Committee on Smart Regulation – Canada (2004) *Smart Regulation: A Regulatory Strategy for Canada*, retrieved 22 January 2007 from the world wide web: www.regulatoryreform.com/pdfs/Canada%20Smart%20Regulation%20Report%20Sept%202004.pdf

Fagg, S. (24 February 2006) Business attacks regulators, *Lawyer's Weekly*, retrieved 6 March 2006 from the world wide web: <http://www.lawyersweekly.com.au/articles>

Feaver, S. (December 1997) A regulatory analysis of Australia's anti-dumping law and policy: statutory failure or regulatory capture?, *Australian Journal of Public Administration*, 56 (4), 67-78, retrieved 8 February 2002 from the world wide web: <http://global.vgw10.global.epnet.com>

Forbes, J. R. S. (2004) *Evidence Law in Queensland*, 5th edn, Pyrmont: Lawbook Co.

Fynes-Clinton, T. (10 July 2003) Environmental offences ... no longer a slap over the wrist, *Brisbane Lawyer*, 5, 18

Gerber, P. (2003) When is plea bargaining justified?, *QUT Law Journal*, 3 (1), 210-215

Girle, A. (2006) *Future Directions in Enforcement Litigation*, Brisbane: Environmental Protection Agency

Grabosky, P. and Gant, F. (2000) *Improving environmental performance, preventing environmental crime*, Research and Public Policy Series No. 27, Canberra: Australian Institute of Criminology

Griffith, C. (21 July 2005) Court acts on sewage spills, Brisbane: *The Courier-Mail*

Heydon, J. D. (1996) *Cross on Evidence*, North Ryde: Butterworths

Howard, T. (August 2000) Liability of directors for environmental crime: the anything-but-level playing field in Australia, *Environmental and Planning Law Journal*, 17 (4), 250-271

Hutton, D. (1999) Mining and the environment of Queensland: where the law begins and enforcement fails: regulatory capture and implementation failure, *Australasian Journal of Natural Resources Law & Policy* 6 (2), 149-173

Independent Commission Against Corruption (ICAC) and Crime and Misconduct Commission (CMC) (2006) *Identifying and Managing Conflicts of Interest in the Public Sector*, retrieved 27 April 2007 from the world wide web: <http://www.cmc.qld.gov.au/asp/index.asp?pgid=10849>

Independent Commission Against Corruption (ICAC) and Crime and Misconduct Commission (CMC) (2006) *Managing Conflicts of Interest in the Public Sector: Toolkit*, retrieved 27 April 2007 from the world wide web: <http://www.cmc.qld.gov.au/asp/index.asp?pgid=10849>

INTOSAI (2006) *Auditing Standards*, retrieved 20 November 2006 from the world wide web: www.intosai.org/en/

INTOSAI (2006) *International Organization of Supreme Audit Institutions*, retrieved 20 November 2006 from the world wide web: www.intosai.org/en/portal/about_us/

Johnstone, R. and Sarre, R. (2004) *Regulation: enforcement and compliance*, Research and Public Policy Series, No. 57, Canberra: Australian Institute of Criminology

Kennedy, J. (2 February 2005) Overflowing sewers cost \$1.5m, *South-East Advertiser*

BIBLIOGRAPHY

- Kenny, R. G. (2003) *An Introduction to Criminal Law in Qld and WA*, 6th edn, Sydney: Butterworths
- Knowles, D. (30 January 2005) What a mess!: Health alarm as raw sewage spills contaminate our waterways, Brisbane: *The Sunday Mail*
- Local Government Association of Queensland (24 September 1999) *Three-year agreement strengthens Queensland's environment partnership* (news release), retrieved 15 December 2005 from the world wide web: <http://lgaq.asn.au/>
- Local Government Association of Queensland (2006) *General Information*, retrieved 25 August 2006 from the world wide web: <http://www.lgaq.asn.au/portal/dt?JSPTabContainer.setSelected=LGAG&last=false>
- Lohe, C. (30 July 2003) *The Model Litigant Principles*, Brisbane: Crown Solicitor
- Marsden, S., Kathy, G. and Hollingsworth, C. (February 2000) Tasmania's environmental improvement programs and the 'Brown Issues': environmental accountability or regulatory capture?, *Environmental and Planning Law Journal*, 17 (1), 24-33
- Martin, R. (July 2003) Alternative sentencing in environment protection: making the punishment fit the crime, *Law Institute Journal*, 77 (7), 32-36
- State of Victoria (2007) *Model Litigant Guidelines – Guidelines on the State of Victoria's Obligation to Act as a Model Litigant*
- Mohr, R. and Fox, R. (2005) Status liability anxiety – director convicted for environmental crime of company, *Australian Environment Review*, 20 (6), 7-8
- Moore, David S. and McCabe, George P. (1993) *Introduction to the Practice of Statistics*, 2nd edn, New York: W. H. Freeman and Company
- Neumann, W. L. (1997) *Social Research Methods: Qualitative and Quantitative Approaches*, 3rd edn, Sydney: Allyn and Bacon
- Northern Territory Government (19 October 2005) *NT Government takes next step towards environment protection agency* (media release), Darwin: Northern Territory Government
- NSW Environmental Protection Agency (7 February 2005) *Comprehensive Approach to Environmental Compliance*, retrieved 2 November 2005 from the world wide web: <http://www.environment.nsw.gov.au>
- NSW Environmental Protection Agency (June 2005) *Powers of Authorised Officers – A Guide to your Power under the Environment Protection Legislation*, NSW Environmental Protection Agency
- NSW Environmental Protection Agency (29 July 2005) *Compliance Audit Program*, retrieved 2 November 2005 from the world wide web: <http://www.environment.nsw.gov.au/licensing/complianceaudit.htm>
- NSW Environmental Protection Agency (2005) *Guidelines for Seeking Environmental Court Orders*, retrieved 2 November 2005 from the world wide web: http://www.environment.nsw.gov.au/legal/envirion_court_orders.htm

NSW Environmental Protection Agency, Department of Environment and Conservation (NSW) (2005) *About the Public Register (POEO)*, retrieved 15 December 2005 from the world wide web: <http://www.environment.nsw.gov.au/prpoeo/index.html>

NSW Environmental Protection Agency, Department of Environment and Conservation (NSW) (2005) *Various searches of the public register (POEO)*, retrieved 15 December 2005 from the world wide web: <http://www.environment.nsw.gov.au/prpoeo/>

NSW Ombudsman (2004) *Investigating Complaints: A Manual for Investigators*, Sydney: NSW Ombudsman

NSW Premier's Department (8 October 1997) *Memorandum No. 97-26 Litigation Involving Government Authorities*, NSW Premier's Department

Office of the Director of Public Prosecutions (ACT) (2005) *Prosecution Policy*, retrieved 16 November 2005 from the world wide web: <http://www.dpp.act.gov.au/policy.htm>

Paulson, L. (September 2005) Environmental Protection Authority offers civil penalty negotiations in lieu of criminal prosecution, *Australian Property Law Bulletin*, 20 (3), 34-36

Power, T. (July 2000) Environmental Protection (Enforcement and Penalties) Bill, *Australian Environment Review*, 15 (7), 9-10

Queensland Audit Office (July 2002) *Guidelines for the Conduct of Audits of Performance Management Systems (Revised)*, Brisbane: Queensland Audit Office

Queensland Integrity Commissioner (February 2006) *Information Sheet 2: Conflicts of Interest in the Public Sector*, retrieved 27 April 2007 from the world wide web: <http://www.integrity.qld.gov.au/html/publications.shtml>

Queensland Legislative Assembly (9 September 1994) *Hansard*, 9535-9538

Queensland Legislative Assembly (18 May 2000) *Hansard*, 1182-1183

Queensland Office of Public Service Merit and Equity (2004) *Seamless Government: Improving Outcomes for Queenslanders, Now ... and in the Future*, retrieved 1 May 2007 from the world wide web: www.opsme.qld.gov.au/seamless/seamless_final.pdf

Queensland Ombudsman (2005) *Complaints Management Project Phase 1 Report*, Brisbane: Queensland Ombudsman

Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocution Project*, Brisbane: Queensland Ombudsman

Queensland Ombudsman (April 2007) *State Perspective*, Issue 3, retrieved 4 May 2007 from the world wide web: http://www.ombudsman.qld.gov.au/cms/images/stories/PDF_Publications_Reports/state_perspective_issue3_april07.pdf

Queensland State Archives (December 2003) *Best Practice Guide to Recordkeeping*, V1.01.00, Brisbane: Queensland State Archives

BIBLIOGRAPHY

Queensland State Archives (November 2006) *Best Practice Guide to Recordkeeping*, V1.04.00, retrieved 2 May 2007 from the world wide web:

http://www.governmentict.qld.gov.au/02_infostand/downloads/IS40%20Best%20Practice%20Guide.pdf

Queensland State Archivist (2007) *Compliance Checklist for Queensland Public Authorities to Self-assess Compliance with Information Standard 40: Recordkeeping*, retrieved from the world wide web: www.archives.qld.gov.au/publications.asp#government

Queensland State Archivist (2007) *Recordkeeping (IS40), Information Standard 40*, retrieved 30 April 2007 from the world wide web: www.governmentict.qld.gov.au/02_infostand/standards/is40.htm, Brisbane: Queensland State Archives

Queensland State Archivist (2007) *Retention & Disposal of Public Records (IS31), Information Standard 31*, retrieved 30 April 2007 from the world wide web: www.governmentict.qld.gov.au/02_infostand/standards/is31.htm

Rowe, G. (1984) Economic theories of the nature of regulatory activity, in Tomasic, R. (ed.), *Business Regulation in Australia*, pp 147-173, Sydney: CCH

Samuels, G. (2004) *Enforcement of Regulation by an Independent Regulator*, retrieved 23 January 2007 from the world wide web: www.accc.gov.au/content/index.phtml/itemId/629720

Samuels, G. (12 November 2005) *The enforcement priorities of the ACCC (speech)*, Australian Competition & Consumer Commission

Seifman, R. and Freiberg, A. (April 2001) Plea bargaining in Victoria: the role of counsel, *Criminal Law Journal*, 25, 64-74

Smith, D. Commissioner (26 May 2005) *The regulator's approach to compliance: crackdown, confrontation or compliance culture (speech at Australian Compliance Institute conference)*, Australian Competition & Consumer Commission

Smith, S. (1995) An iron fist in the velvet glove: redefining the role of criminal prosecution in creating an effective environmental enforcement system, *Criminal Law Journal*, 19, 12-20

Smith, S. (1995) Doing time for environmental crimes: the United States approach to criminal enforcement of environmental laws, *Environmental and Planning Law Journal*, 12, 168-182

Sparrow, Malcolm K. (2000) *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*, Washington DC: Brookings Institution Press

Standards Australia (2006) *AS ISO 10002-2006 Customer Satisfaction Guidelines for Complaints Handling in Organisations*, Sydney: Standards Australia

Standards Australia/Standards New Zealand (2004) *Risk Management – AS/NZS 4360:2004*, Sydney/Wellington: Standards Australia/Standards New Zealand

Standards Australia/Standards New Zealand (2004) *Risk Management Guidelines Companion to AS/NZS 4360:2004*, Sydney/Wellington: Standards Australia/Standards New Zealand

State of Victoria, Department of Treasury and Finance (2005) *Victorian Guide to Regulation*, Melbourne: State of Victoria

Sullivan, G. and Cantwell, P. (2007) *Auditing Regulatory Agencies*, Brisbane

The Commonwealth of Australia, the State of New South Wales, the State of Victoria, the State of Queensland, the State of Western Australia, the State of South Australia, the State of Tasmania, the Australian Capital Territory, the Northern Territory of Australia, and the Australian Local Government Association (1 May 1992) *Intergovernmental Agreement on the Environment*, retrieved 16 January 2006 from the world wide web:
<http://www.deh.gov.au/esd/national/igae/>

The Courier-Mail (17 March 2005) Trouble brews down at the EPA, Brisbane: *The Courier-Mail*

The Hon. Rodney Welford MP (17 May 2000) *New Legal Unit Strengthens EPA* (Ministerial Media Statement), retrieved 2 November 2005 from the world wide web:
<http://statements.cabinet.qld.gov.au>

The Honourable Desley Boyle MP (2005) *Ministerial Portfolio Statement: Minister for Environment, Local Government, Planning and Women: State Budget 05-06*, Brisbane: Queensland Government

The Honourable Desley Boyle MP (2006) *Ministerial Portfolio Statement: Minister for Environment, Local Government, Planning and Women: State Budget 06-07*, Brisbane: Queensland Government

The Premier of Queensland (3 November 2005) *Government Priorities*, retrieved 3 November 2005 from the world wide web: <http://www.thepremier.qld.gov.au/priorities/index.shtm>

Tomkins, K. (March 2005) Police, law enforcement and the environment, *Current Issues in Criminal Justice*, 16 (3), 294-306

Tranter, M. (1998) A path beginning to wear: prosecutions under the Environmental Protection Act 1994 (Qld), *Queensland Environmental Practice Reporter*, 4 (19), 175-187

United States Sentencing Commission (27 October 2005) *Guidelines Manual (Part Q)*, Washington: United States Sentencing Commission

Wills, G. Sullivan, G. and Collings, T. (October 2005) *Prioritisation Systems: Sorting the Wheat from the Chaff* (AELERT Conference paper), Brisbane: Department of Natural Resources (NSW), and Department of Natural Resources and Mines (Qld)

Young, M. and Hayes, S. (November 2001) Enforcing environmental laws: when will the EPA prosecute?, *Keeping Good Companies*, 53 (1), 613-616

Zurich Financial Services Australia Limited (2005) *Submission on Reducing the Regulatory Burden on Business*, retrieved 23 January 2007 from the world wide web:
<http://www.regulationtaskforce.gov.au/submissions/sub123.rtf>



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