

Human Services

Our Human Services Branch handles inquiries and complaints about a range of human service agencies.

We review the delivery of community services and oversee the handling of allegations of child abuse made against employees in the child-related employment field. We also visit juvenile justice centres in NSW to speak with detainees and staff and inspect facilities and programs.

We use information from inquiries and complaints to identify and investigate public interest issues. As a result of changes to the child protection system we decided to investigate more matters about child protection issues – focusing on those agencies with the greatest responsibility for child welfare (see page 67). We also focused our resources on reviewing the progress of implementing *Keep*

Them Safe: a shared approach to child wellbeing (see page 66). Our review resulted in a report to Parliament.

Other significant work included examining restoration support for children on short term care orders (see page 72), and our work relating to the safety, health, welfare and rights of people living in licensed boarding houses that resulted in a report to Parliament in August 2011 (see page 85).

This year saw the transfer of the Child Death Review Team to the Office. The Ombudsman is the convener of the team and we provide it with substantial research support (see page 71). We also support the Official Community Visitors which included the roll-out of a new reporting and claims database (see page 87).



Highlights

- | Reviewed key aspects of the implementation of *Keep Them Safe*. [SEE PAGE 66](#)
- | Increased the number of child protection investigations into important systemic issues. [SEE PAGE 67](#)
- | Worked with the NSWPF to finalise SOPs that will help reduce risks to children by improving police support to employers who are handling criminal child abuse allegations made against their staff. [SEE PAGE 78](#)
- | Issued a practice update to clarify for employers the types of behaviours that fall within the definition of sexual misconduct. [SEE PAGE 79](#)
- | Began an inquiry into the access of people with mental illness to accommodation and support under the *Disability Services Act 1993*. [SEE PAGE 83](#)
- | Prepared a report on our reviews of the deaths of people with disabilities in care, highlighting issues such as managing risks and access to health programs. [SEE PAGE 84](#)
- | Completed a report to Parliament calling for reform of the boarding house sector. [SEE PAGE 85](#)
- | Took on responsibility for supporting the Child Death Review Team. [SEE PAGE 71](#)
- | Consulted with over 300 families of children with disabilities. [SEE PAGE 83](#)

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Children and young people

Our work to protect children living in NSW covers a range of areas. It includes:

- | monitoring changes to the child protection system
- | investigating how agencies have handled child protection issues
- | handling complaints about community services for children
- | reviewing the deaths of children in care and children whose deaths are due to abuse or neglect or occur in suspicious circumstances
- | supporting the NSW Child Death Review Team
- | reviewing the circumstances of children in care
- | working with young people in detention
- | overseeing investigations into reportable employment-related child protection allegations and scrutinising systems for preventing this type of conduct.

Our responsibilities for protecting children are included in the *Community Services (Complaints, Reviews and Monitoring) Act 1993* and Part 3A of the *Ombudsman Act 1974*.

Monitoring changes to child protection

In January 2010, a new system for responding to children at risk of harm came into operation. This system is part of the five-year reform plan known as *Keep Them Safe: a shared approach to child wellbeing* – the then Labor government’s response to the Wood Special Commission of Inquiry into Child Protection Services in NSW.

Keep Them Safe emphasises that protecting children is a shared responsibility and introduced a range of legislative and structural changes. These included new intake and referral pathways, narrowing the statutory role of Community Services, and placing greater responsibility on other human service and justice agencies to respond to child protection concerns. Among other things, these changes were intended to allow Community Services to concentrate their efforts on children and young people who are most at risk of experiencing serious harm.

Other key reforms included a legislative amendment to permit the exchange of relevant child protection information between organisations working with children, and making habitual non-attendance at school an additional legislated criteria for risk of significant harm.

In last year’s annual report we noted some of the potential issues that may arise in this reform environment and the need for government to anticipate and manage these issues.

Over the past year we have met and consulted with government agencies, non-government peak associations, and staff from child wellbeing units about policy and operational issues affecting the implementation of the new system. In addition – through handling complaints, reviewing child deaths and investigating child protection matters – we have gained insight into how *Keep Them Safe* is functioning.

It is now almost two years since *Keep Them Safe* started. Therefore we believed it was timely to document and discuss the progress that had been made, as well as the challenges currently facing the service sector. An important starting point for this work involved us analysing data from Community Services about the agency’s current operating environment.

In most high-risk cases, a visit from a child protection caseworker to the child’s family is necessary to properly assess the child’s circumstances. Comparing the period

before the Wood Inquiry started with the post-inquiry period between 24 January 2010 and 31 December 2010, there was a 55% drop in the number of responses to recorded reports that resulted in a comprehensive face-to-face assessment – 19,826 compared to 46,757.

Given that child protection reports to community services centres (CSCs) had reduced under the new system by over 100,000 – or more than 50%, we were concerned that the evidence suggests there had been a substantial decrease in the number of comprehensive assessments carried out.

While the data pointed to the need for more resources, it also demonstrated a need for greater productivity and efficiency. In addition, we found that there are other major challenges that have to be met before the Special Commission of Inquiry’s vision for an improved child protection system can be realised.

All of these issues were canvassed in our recent report to Parliament, *Keep Them Safe?.* Together with a range of recommendations aimed at system reform, the report concludes by noting that – in light of the very substantial weaknesses in the current system – it is inconceivable that a strong and integrated child protection system will be able to be delivered in the near future. There is an urgent need to establish clear priorities for prompt action, including substantially improving the capacity of the system to respond to child protection reports indicating risk of significant harm.

We stressed that while this and a number of other areas must be responded to as a matter of urgency, there is also the need to properly consider ‘where we are at’ against the challenges that must be met to more effectively deliver on the whole of the Special Commission of Inquiry’s vision. Our report is available on our website.

Transitioning out-of-home care to the non-government sector

Keep Them Safe provides for the gradual transition of most out-of-home care to the non-government sector. There are risks if this does not take place in a way that matches the capacity of the sector to undergo what will be a massive expansion in services and workforce.

Our views about this transition are informed, in part, by work we carried out last year in relation to Life Without Barriers (LWB). Since its inception, LWB has grown rapidly and is currently the largest non-government provider of out-of-home care services in NSW, as well as a significant provider of disability and other community services.

Since 2005 we have dealt with a range of concerns about LWB’s services, including their out-of-home care services. In 2010, we identified a number of specific problems relating to the circumstances of 12 children in the care of LWB. These matters related to the children’s welfare and also brought into question the effectiveness of LWB’s actions over time to improve the delivery of their out-of-home care services.

We therefore initiated an investigation into these matters and, together with the Children’s Guardian, also asked the LWB to examine the effectiveness of the actions they had taken to address key practice issues identified from their own previous management reviews.

Our investigation found that all 12 children were exposed to unacceptable levels of risk and, in many cases, actual harm. We also found very poor practice in carer assessment, authorisation and placement matching – that is, matching to

ensure a child is placed with a carer family best able to meet the child's needs.

Following our investigation of the circumstances of these 12 children, we made various recommendations to resolve the children's situations and to address related systems and practice issues.

In August this year, LWB finalised their *NSW Out of Home Care Review 2011*. In the context of the serious shortcomings in practice we identified, this review is an important step in acknowledging what needs to be done to address systems and practice issues in the delivery of out-of-home care services. Equally critical will be testing whether the agency can achieve ongoing improvements.

We welcome LWB's commitment to developing a comprehensive quality assurance and improvement plan, in consultation with the Office of the Children's Guardian and the Department of Family and Community Services. These agencies will also actively monitor the plan's implementation, including the Children's Guardian linking the implementation results with LWB's re-accreditation process.

Given the NSW Government's commitment to transfer responsibility for the delivery of out-of-home care services to the non-government sector, we believe it would be in the public interest for the department and the Children's Guardian to report publicly on the results of LWB's improvement plan.

Investigating carer assessment and authorisation practices

In late 2010, the Ombudsman received a number of complaints from employees of LWB. The complaints alleged poor practices in relation to foster carer recruitment and authorisation, and related outcomes for children placed in care.

The complainants were particularly concerned about the agency's model of carer recruitment which involved using contracted 'Supporters of Carers' (SOCs), paid on the basis of how many carers they recruited and how many children they placed with those carers. There were concerns that contracted SOCs were recruiting too many carers, some of whom were not suitable, and placing too many children in their care – many of whom had complex and competing needs. The very significant financial incentives for contracted SOCs were seen by the complainants to be operating at the expense of the safety and wellbeing of children in care.

The complainants drew our attention to the authorisation of three carers in particular, and the ongoing assessment of an applicant carer – the partner of one of the three carers – who seemed to pose a very high-risk to children, given his background.

As part of our investigation, we required LWB to produce their files for each of the carers, the applicant carer, and all the children placed with any of these carers.

After reviewing these files, we had significant concerns about their assessment and authorisation of these carers and the outcomes for the children in their care. We also had serious concerns about the contracted SOCs model of carer recruitment.

In one case, a carer was assessed and authorised on the basis that she and her husband were separated and living apart. Personal references, which indicated otherwise, were not queried by the agency so the husband was not subjected to a probity check.

The first child placed with the carer alleged that the carer's husband had indecently assaulted her, while the carer was asleep at another house. The child did not want to talk to police, and the agency accepted the carer's version of events. The Ombudsman was not notified of this indecent assault allegation when it was made in early 2008, because the husband was not an 'employee' at the time.

After the child was removed from the placement, four other children were placed with this carer. Not only did this exceed her authorisation in terms of numbers of children, but it took place in the context of the allegations concerning her husband's access to children in her care.

When it later became clear that the carers were a couple, living as a family across two households, the agency carried out a probity check. Police records indicated that the husband had a criminal conviction for assaulting a young person while he was working as a security guard.

Despite this, the agency authorised the husband as a carer in his own right. A child placed with him the following year later alleged that the carer had punched him and kicked him in the abdomen, knocking him to the ground.

We also found evidence on the children's files of serious neglect by their carers. Medical conditions were left untreated, glasses prescribed were not provided, and appointments with counsellors and speech therapists were missed. In one case, three young siblings left a placement significantly underweight with tooth decay, lice infestations, inadequate clothing and few possessions.

Investigating child protection issues

In the past year, we started 13 child protection investigations and finalised five. This significant increase over the previous year is in the context of the sweeping changes to child protection since *Keep Them Safe* was introduced.

We have current investigations into the actions of Community Services, the Department of Education and Communities (DEC), NSW Health and the NSW Police Force (NSWPF) – the agencies with the greatest responsibility for child welfare – all grappling with a new environment of shared responsibility for child protection.

Case study 48 provides an example of where a number of agencies failed to share information about a highly vulnerable child, resulting in escalating risks for the child that were not addressed.

Case study 48: Effective communication

We are currently investigating a matter involving a child who had a life-threatening condition and whose parents had substance abuse and mental health issues and were not meeting his health needs.

The child was admitted twice to hospital and treated in the intensive care unit. Both times, the child's treating team recognised that the parents behaved unusually and did not seem to understand the seriousness of their child's health condition.

After some months of failure by the parents to address the child's health needs, a doctor advised Community Services that the child was at risk of harm if his condition was not treated. However, the child's case was not allocated for ongoing casework. Health professionals did not make a further notification to Community Services when the parents did not bring the child for appointments over the following six months.

This child had a number of serious risk factors present in his life. Apart from his serious and life-threatening condition, his parents had a history of chronic drug dependence and had failed to ensure that he received the medical care he needed. The child was also absent from school for protracted periods of time with little intervention from education professionals.

This case highlights the critical need for effective interagency communication and planning in high-risk cases. We will be highlighting this, and a number of other important practice issues, in our final investigation report.

Case study 49 illustrates the importance of effective cooperation between agencies.

Case study 49: Risk not adequately assessed

This year we investigated a matter involving a person on the Child Protection Register (CPR). A girl disclosed that the person, who was her mother's partner, had been subjecting her to sexual abuse for the previous three years. He was subsequently arrested, charged with a number of offences, and has since been convicted.

The person had been on the CPR since 2004, having been convicted of a previous sexual offence against a child. As required under the *Child Protection (Offenders Registration) Act 2000*, he sought approval from Community Offender Services (COS) and the NSWPF to move in with the woman and her daughter in 2007.

Both agencies contacted Community Services to inform them of this and asked them to undertake an assessment and provide advice. The police, in particular, expressed strong concern about the potential risk posed to the girl. Community Services interviewed the woman, determining that she knew about her partner's offending history and was capable of protecting her daughter from harm. They informed the COS and police of this and advised that they would not be taking any further action.

We found that Community Services failed to adequately assess the risk to the child and initiate appropriate protective action. In turn, this impacted on the way COS and police perceived the level of risk posed to the girl by her mother's partner. COS approved the new living arrangements and the police took no further action.

We recognise that management of child sexual assault offenders in the community presents challenges to all the agencies involved. It is critical that agencies have a clear understanding of their respective roles and responsibilities in this area. To discuss ways of strengthening interagency cooperation in this area, we convened a meeting with Community Services, the NSWPF and COS. For further details of the outcomes of this meeting, see page 95 in Stakeholder engagement.

In the context of Community Services limiting its statutory responsibility to children at risk of significant harm (ROSH), our concern about cases continuing to be closed 'due to competing priorities' has become more acute. We are investigating cases where significant numbers of ROSH reports have been generated for certain children, but little or no casework has been done before the matter was closed. Often cases are repeatedly opened in response to new

ROSH reports and then closed again 'due to competing priorities' – with little recognition of the increasing evidence that demonstrates escalating risk. We are examining this issue in a case involving a very vulnerable adolescent (see case study 50) and a family where the children were repeatedly reported to be at risk of harm (see case study 51).

Case study 50: Lack of support

We received a complaint about Community Services's response to ROSH reports for a 14 year old girl with mental health vulnerability and an acquired brain injury.

In mid 2010, the girl suffered damage to her frontal lobe as a result of a car accident. Doctors indicated that she needed to be discharged to a stable and supportive environment where she could receive the considerable care she required.

Community Services determined that adequate supports were in place and the child was returned home. Since that time, more than ten ROSH reports have been made – by police, her school and medical professionals – raising serious and immediate concerns about her safety and extreme vulnerability. Supports in place following her discharge from hospital have proven ineffective. Community Services has undertaken minimal casework and the majority of reports have been closed due to competing priorities.

We are currently investigating Community Services's actions in relation to this matter. The information available raises concerns about their capacity to work effectively with adolescents, to respond appropriately where children or young people have a dual diagnosis – mental health and brain injury, and work effectively with other services to address issues of significant risk.

Case study 51: Multiple reports but no action

During 2009, there were multiple ROSH reports made to Community Services about three children under the age of 10 living in appalling conditions and witnessing serious incidents of domestic violence, involving parental substance abuse issues. One of the reports alleged risk of possible serious abuse to one of the children. The child was not interviewed and it appears Community Services did not take any action.

In the first half of 2010, there were three further ROSH reports of possible abuse to another child in the family. Community Services did not take any action until October 2010, when a caseworker interviewed both the child and a sibling. The sibling disclosed witnessing an incident where the other child was subjected to abuse by an adult. The record of this interview was not created until a month later and no action followed.

In March 2011, we reviewed the records of the family and decided to investigate Community Services's response to the reports of abuse and neglect.

In response to our investigation, Community Services agreed that there were significant practice failings in their response to this family – stating that 'competing priorities' were a contributing factor to their inadequate response. Community Services are now actively working with the family to address the risks to the children.

Non-attendance at school and risk of harm

Under NSW education law, parents are required to ensure that their children receive an education. Separate child protection laws recognise that chronic absenteeism may represent a risk of significant harm to a child or young person. Taken together, the legislation establishes a role for agencies – including schools and Community Services – to respond to cases of habitual absenteeism.

For several years, our work has included scrutiny of cases where habitual school absenteeism featured as one of a number of risks to a child. Our 2009 report into the death of Ebony is a prime example of this.

This year, we have started an investigation into Community Services's response to reports of habitual school absence. This work raises important questions – including when and how Community Services, schools and other agencies should work together to address these matters.

In our recent report to Parliament *Keep them Safe?*, we have discussed a range of issues relating to the need to tackle very significant school non-attendance by certain children. The report notes that data obtained from Community Services indicates that close to 50% of all reports made to the Helpline about educational neglect are assessed as not meeting the ROSH threshold. In addition, around 50% of those reports that are assessed as meeting the ROSH threshold are closed on the basis of 'competing priorities'. Less than 10% of all educational neglect reports that are assessed as meeting the reporting threshold result in a comprehensive face-to-face assessment, compared to 21% for all reports.

We believe that this serious social issue can only be addressed when the role that various agencies – such as DEC, the NSWPF, Community Services and the non-government organisations (NGO) sector – should play in tackling this problem has been determined. In this context, it is pleasing to note that Community Services recently advised us that they are developing, in collaboration with DEC, 'a joint business process to be followed when managing [educational neglect] matters [that] will address alternative approaches to responding to cases where educational neglect is a reported issue and the case will not be allocated by Community Services'.

Homeless children

In our last annual report, we noted that Community Services did not have a policy or protocols in place to support children in youth refuges – a problem they acknowledged over six years ago.

Early this year, Community Services released a draft policy for unaccompanied children in specialist homelessness services. In our comments on the draft, we raised concerns about whether the policy adequately responded to the individual needs and circumstances of children presenting to homelessness services. We also queried whether it adequately promoted the sharing of information to promote the safety, welfare and wellbeing of young people in line with Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998 (NSW)*.

Complaint trends and outcomes

In 2010-2011, we received a similar number of complaints about child and family services (1,488) as we did in 2009-2010 (1,493). However, there was a 12% decrease in the number of formal complaints and a 6% increase in the number of informal complaints. Most complaints (1,318) were about out-of-home care and child protection services (see figure 43).

Of all the complaints received, 53% (271 formal complaints and 517 informal complaints) were about out-of-home care services. These are services either provided by Community Services or provided by NGO funded by Community Services and accredited by the Office of the Children's Guardian. The most frequent complaints were about the quality of case management and casework, particularly concerns about how individual services planned for the specific – and often high and complex – individual needs of the children and young people in their care.

Complaints about child protection services made up 36% of the total complaints we received (172 formal complaints and 358 informal complaints). The most frequently raised concerns were about how responses to child protection reports were managed and the decisions made after these reports were investigated and assessed.

This year, we helped to resolve 30% of the formal complaints received about child and family services – down from 36% last year.

Figure 42: Outcomes of formal complaints finalised in 2010–2011 about agencies providing child and family services

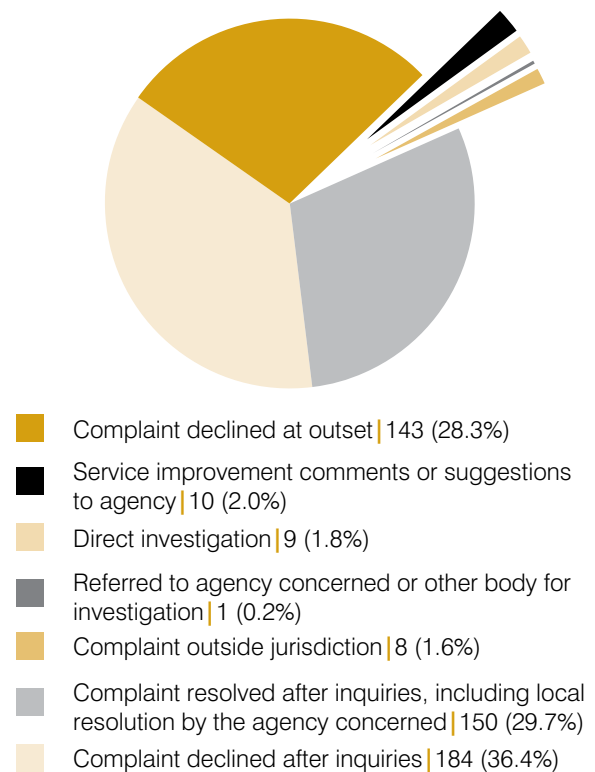


Figure 43: Formal and informal matters received in 2010–2011 about agencies providing child and family services

Issue	Formal	Informal	Total
Community Services			
Child protection services	167	347	514
Out-of-home care services	240	455	695
Children's services	5	20	25
Family support services	9	14	23
Adoption	2	2	4
Subtotal	423	838	1,261
ADHC			
Child protection services	0	1	1
Family support services	0	0	0
Out-of-home care services	0	1	1
Subtotal	0	2	2
Other government agencies			
Child protection services	1	1	2
Out-of-home care services	0	0	0
Children's services	0	0	0
Family support services	0	0	0
Adoption	0	0	0
Subtotal	1	1	2
Non-government funded or licensed services			
Child protection services	4	9	13
Out-of-home care services	31	62	93
Children's services	25	41	66
Family support services	1	3	4
Adoption	1	0	1
Subtotal	62	115	177
Non-specific inquiries			
Other (general inquiries)	0	25	25
Agency unknown	1	15	16
Outside our jurisdiction	1	4	5
Subtotal	2	44	46
Total	488	1,000	1,488

Case study 52: Positive outcome for foster carer

A foster carer contacted us stating that she could not afford to repair her car which had suffered extensive damage in an accident. She had applied to Community Services for help with repairing or replacing the vehicle. Although staff were sympathetic to her cause, they had indicated that paying for the repairs was beyond the normal scope of assistance provided by Community Services. However they said they would look into it. The complainant told us that the decision over whether support would be provided was taking too long and she could not meet the needs of the children in her care without her car.

We explained to the complainant that the information she received from Community Services staff was correct. However, we made contact with the agency on her behalf and they subsequently acknowledged the critical need she had for a car and made an 'out of guidelines' decision to pay for the repairs.

Case study 53: Delays in leaving care planning

We received a complaint from a pregnant 17 year old, who was under the parental responsibility of the Minister for Family and Community Services. Her complaint was that Community Services had not developed her leaving care plan. She wanted to have the plan finalised before giving birth, partly to ensure she had access to financial support. She also wanted help to resume contact with family members, to apply for victims' compensation, and to see her personal history.

Following our inquiries, the young woman's leaving care plan was endorsed and finalised. In closing the complaint, we commented to Community Services that the delays in developing and finalising the young woman's plan were not in line with timeframes outlined in both its own policies and Ministerial guidelines. This is an issue we identified in our 2009-2010 review of young people leaving statutory care.

Case study 54: Contact with families

The parents of a young man with an intellectual disability and mental illness complained to us about the funded group home he was living in. The parents alleged that the group home had not gained their consent to increase his dosage of anti-psychotic medication. They also alleged that the service provider had refused to let their son return to the group home after a hospital stay unless he was medicated at a higher dosage.

We conducted a thorough analysis of all the evidence and found that although the use of a higher dose of medication was permitted by the treating psychiatrist, the service provider had not properly communicated with the family about this. We contacted the service provider and identified some areas where there was scope for improvement in practice, particularly in regards to conducting regular case meetings and formal communication.

Following our involvement, ADHC organised more suitable supported accommodation for the young man.

Case study 55: Breach of privacy

A parent of two children in care complained to us that she saw her children's foster carer drive past her home on more than one occasion. The complainant and the carer lived ninety minutes apart. The complainant alleged that a Community Services's staff member had given her personal details to the carer, breaching the agency's privacy policy and NSW privacy laws.

After inquiries from our office, the agency reported that the carer received access to the complainant's personal records from a medical practitioner via immunisation records – and not from the agency itself. However, the agency apologised to the complainant for the distress caused by the incident and provided counselling and training to the carer.

Case study 56: Keeping in touch with family

We received a complaint from a grandmother about not having contact with her grandsons. The boys had been placed with a paternal aunt because of parental neglect and drug use. The aunt was refusing to allow contact because she feared that the grandmother might allow them to have contact with their parents.

Community Services had not met with the mother since final orders were made. Caseworkers had changed, the case had transferred from one office to another, and it was unallocated. Initially, the manager said she had never heard of the grandmother and she would need to put her complaint in writing. We reminded her that this was not in the spirit of CS-CRAMA and she agreed to meet with her.

After reviewing the case, Community Services acknowledged a number of shortcomings in practice. For example, there was no real explanation on file about why Community Services had not sought to maintain contact between the boys and their grandparents.

The boys were allocated a caseworker and they both expressed their desire for contact with their grandparents. The grandparents were asked to sign undertakings agreeing not to allow unsupervised contact with their daughter or her partner. The boys are now visiting their grandparents for three hours once a week and they are establishing relationships with maternal aunts, uncles and cousins. It is hoped that, at some stage in the future, the grandmother will be able to supervise contact between the boys and their mother. In the meantime, the frequency of contact visits between the boys and their mother have been increased and an independent agency will supervise these visits.

The purpose of our reviews is to identify trends and make recommendations to prevent or reduce the risk of similar deaths in the future.

The Ombudsman is required to present a report to the NSW Parliament about reviewable deaths every two years. This year, our work included preparing our sixth – and first biennial – report on reviewable child deaths. This report considers issues raised through our reviews of the deaths of 76 children that occurred in NSW in 2008 and 2009. It was tabled in August 2011 and is available on our website.

Transferring the Child Death Review Team to the Ombudsman's office

In February 2011, legislation was proclaimed to enable the NSW Child Death Review Team (CDRT) to transfer from the NSW Commission for Children and Young People (CCYP) to our office. The CDRT reviews the deaths of all children in NSW. The Ombudsman is now the convener of the team and we provide it with support and assistance.

The team's functions under the *Commission for Children and Young People (NSW) Act 1998* (CCYP Act) include maintaining a register of child deaths, analysing information about those deaths, undertaking research, making recommendations aimed at preventing or reducing the likelihood of child deaths, and reporting annually to Parliament on child deaths in NSW.

We welcomed the transfer of the CDRT to our office, but there have been a number of challenges in progressing the important work of this team.

Shortly after the decision to transfer the team, we tabled a special report to Parliament, *Unresolved issues in the transfer of the NSW Child Death Review Team to the Office of the NSW Ombudsman*. This report detailed anomalies and administrative complexities arising from legislative arrangements to transfer the team to our office, and outlined our concerns about the effect of retaining the legislation governing the operation of the CDRT within the CCYP Act.

In November 2010, the NSW Government made minor amendments to CS-CRAMA and the CCYP Act to address a number of the anomalies we identified. The amendments adjusted the reporting period for reviewable deaths to a calendar year, in line with the reporting period of the CDRT. A clear provision was also included in the CCYP Act to make certain the legality of an integrated approach to using relevant information across the CDRT and reviewable death functions. The CDRT convener was also empowered to set the rates of remuneration for 'expert advisers' to the team.

The retention of the legislation within the CCYP Act remains an ongoing concern. It effectively ties certain CDRT functions to the Commission and incorporates provisions relevant to the functions of that agency, even though the Commission no longer has a role in reviewing child deaths. Some of these requirements are not in keeping with the independence of the Office of the Ombudsman – including the requirement to seek approval for some functions from, and to report to, a Minister. It also means the Ombudsman must report to two Joint Parliamentary Committees in relation to different but complementary aspects of our work in child deaths.

In addition, shortly after we took on the role of supporting the CDRT, we identified that the team was not legally constituted. Team membership was below the minimum

Reviewing the deaths of children

Our review work in 2010

Under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA), we are responsible for reviewing the deaths of children in care, the deaths of children who died as a result of abuse or neglect or in suspicious circumstances, and the deaths of children who were in detention when they died.

number required by the legislation, and the terms of some members who were still serving on the team had expired. This meant that the team could not function effectively until formal appointments were made. In April 2011, we advised the Premier and the Minister of this problem. In early May 2011, we made urgent representations to responsible Ministers seeking their prompt nomination of agency representatives. The Ombudsman, as convenor, made appropriate nominations for the independent members of the team to the Minister for Citizenship and Communities.

Supporting the work of the CDRT

Although the CDRT was not properly constituted during the reporting year, the following activities were undertaken for the team in this period. This is in accordance with section 45P(2)(a) of the CCYP Act. Work was done by both the Commission and by our office.

Commission for Children and Young People

Before the transfer of the team to the Ombudsman's office in February 2011, the Commission held four CDRT meetings.

In October 2010, the Commission tabled the *Annual Child Death Review Report 2009* in Parliament. This report provided information on the deaths of 565 children, continued an examination of a discrete set of causes of death, and made three recommendations to NSW Health relating to youth suicide.

Also in October 2010, the Commission tabled *A Preliminary Investigation of Neonatal Sudden and Unexpected Death in Infancy 1996-2008: Opportunities for Prevention*. The aim of this report was to define the demography, risk factors and circumstances of neonatal sudden unexpected deaths in infancy and consider prevention strategies. The report identified that 90% of neonatal infants who died during the reporting period died in circumstances where at least one modifiable risk factor was present. Preventative strategies were needed to address the risks associated with unsafe sleeping, especially those associated with co-sleeping and bed sharing where the carer may accidentally fall asleep. The report made two recommendations to NSW Health and one to SIDS and Kids.

The findings of this report were presented by Professor Heather Jeffrey at the *Joint Conference of the International Stillbirth Alliance and the International Society for the Study and Prevention of Infant Death* in October 2010.

NSW Ombudsman's office

Throughout 2010 and 2011, we held a number of meetings with Commission staff to exchange information and discuss arrangements for transferring resources.

In February 2011, the Commission transferred the Child Death Register and administrative and child death files to our office. We also recruited the one staff member who had been employed by the Commission for CDRT work.

Since February 2011, we have:

- conducted an informal meeting of team members
- trained staff in the use of the Child Death Register, developed review tools, and started reviews of child deaths that were registered in NSW in 2010
- employed additional review and research staff for CDRT and reviewable child death work

- introduced streamlined processes to ensure there is no duplication of effort for agencies providing records and information for child death reviews
- arranged for nominated CDRT members Dr Jonathan Gillis and Dr Bronwyn Gould to assist with the work of reviewing child deaths, in a capacity as 'expert advisers' under the Act
- organised a visit by Dr Marian Brandon, an academic from the University of East Anglia in the UK and expert in child death review. We sought Dr Brandon's advice on our work and the integration of the CDRT. She also conducted a masterclass, which was attended by a number of staff and team members for equivalent child death inquiry and review bodies from other states.

We also successfully argued for an increase in funding - receiving \$539,000, which was \$318,000 more than had been provided to the CCYP.

Disclosing information

The convenor of the CDRT - now the Ombudsman - may authorise the disclosure of information relating to child deaths if it is in connection with research to help prevent or reduce the likelihood of deaths of children in NSW. For the year commencing 1 July 2010, no such disclosures were authorised.

Children in care

Restoration support for children on short-term care orders

The *Children and Young Persons (Care and Protection) Act 1998 (NSW)* places emphasis on permanency planning for children who are placed in out-of-home care. This requires timely decisions about whether there is a realistic possibility of restoration for a child or whether alternative long-term arrangements need to be found. If restoration is the permanency plan, the Children's Court will make short-term care orders - generally of two years duration.

The Special Commission of Inquiry into Child Protection Services in NSW identified some concerns about restoration casework practice, especially with assessments and the support for parents to meet requirements once the child is restored to their family. More recently, the Boston Consulting Group reported to the then Labor government on the increase in costs in out-of-home care. The report made a number of recommendations, including the need for a greater focus on restoration and family preservation when children first enter care.

In 2010, we reviewed a group of 63 children on short-term care orders. The purpose of the review was to examine the adequacy of restoration planning and support being provided to children and their families. Community Services helped us to identify 203 children on short-term care orders with a view to restoration. From this group we reviewed the circumstances of 63 children, approximately three to five months before their care order was due to expire. We found that:

- mostly, Community Services's actions to start care proceedings were timely and final orders were made within, or close to, the time standards set by the Children's Court
- restoration-focused care plans rarely detailed how improvements to parenting capacity and child safety would be assessed. Few care plans outlined what supports needed to be in place after the child had gone home

- there were inconsistencies in the level and quality of casework support provided by Community Services to children on short-term care orders
- for over half of the children (35), the services that parents needed to meet their obligations relating to restoration were arranged and provided. However for 28 children, the services were either not provided or were not fully provided
- some children were returned to their parents without adequate assessment. In other cases, even though restoration was no longer a viable option, there were significant delays in returning the case to the Children's Court.

In our report, we recommended that Community Services ensure that their staff have the key competencies needed to carry out restoration work. They agreed that a review of their policy, procedures and guidance to support restoration practice was needed, and they intend to update their out-of-home care policies and procedures.

Supporting young people leaving care

In our last annual report we described our findings from a group review of young people leaving statutory care, which we released in June 2010. We found that the guidelines on supporting care leavers were not being consistently implemented across NSW. For example, many young people were leaving care without an endorsed leaving care plan. Also, the administrative arrangements for approving and providing financial assistance – including arrangements to support young people still at school when they turn 18 – were cumbersome and protracted. Although we found that young people with disabilities who need ongoing assistance when they turn 18 were generally well supported after leaving care, other young people with high support needs were not.

In January 2011, Community Services reported that they had developed information resources for young people and their carers. These resources included a guide to help carers prepare young people for leaving care and an independent living skills checklist for young people. A new case plan template is being developed to support young people in statutory out-of-home care to make a successful transition to independence.

Victims' compensation for children and young people in care

In June 2010, we tabled a special report to Parliament on victims' compensation for children and young people in care. In response, Community Services have taken positive action including:

- ensuring that claims are lodged for all eligible children at the end of care proceedings
- providing training to legal officers and caseworkers
- reviewing all the files of children and young people currently under the parental responsibility of the Minister
- developing a memorandum of understanding (MOU) between Community Services, the Department of Attorney General and Justice, and Legal Aid NSW, which provides an avenue for people who have left care to pursue a claim against Community Services if a victims' compensation claim has not been lodged on their behalf.

Young people in detention

Complaint trends and outcomes

This year we received 356 complaints from or on behalf of young people in juvenile justice centres, up 25% from 2009-2010. There was a 7% increase in formal complaints and a 31% increase in informal complaints compared to last year.

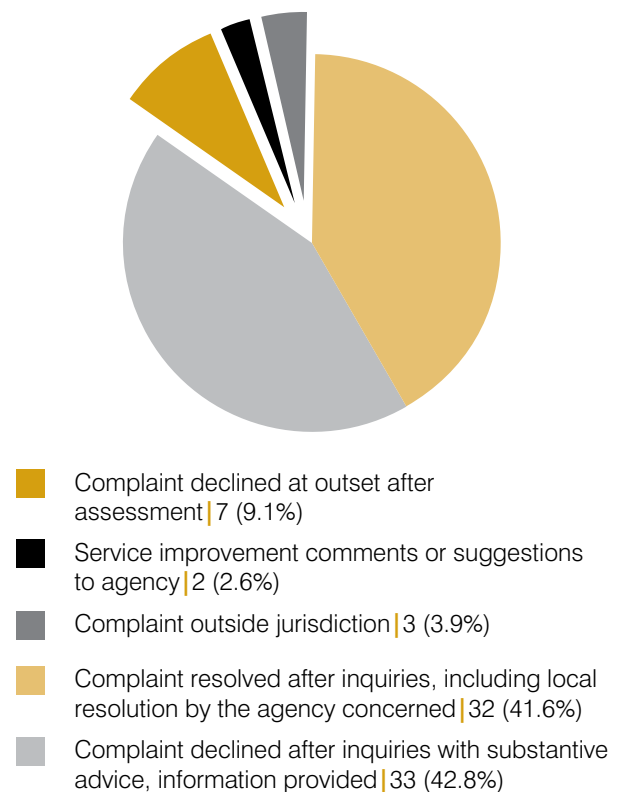
The majority of complaints were made by young people in detention – either during centre visits by Ombudsman staff or by telephone calls to our office. The key issues they were concerned about were conflicts with staff, unreasonable punishments, daily activities including schooling, and the quality and quantity of food.

We resolved many of these matters informally with the managers and staff of the centres, and sent a feedback form outlining the action we had taken. In particular, we resolved or made suggestions to improve services in 45% of the 78 formal complaints about juvenile justice that we finalised this year.

Figure 44: Formal and informal matters received and finalised

Matters	06/07	07/08	08/09	09/10	10/11
Formal received	49	99	70	72	77
Formal finalised	47	98	73	62	78
Informal dealt with	219	243	255	212	279

Figure 45: Outcomes of formal complaints finalised in 2010-2011 about juvenile justice



Case studies 57 and 58 illustrate the types of practical issues we dealt with.

Case study 57: Better remand support

An official visitor to a juvenile justice centre contacted our office to discuss the circumstances of a young man who had been on remand since December 2009. The visitor was concerned about the length of time he had been on remand, the number of court appearances, delays handling the criminal charges, and the quality of his legal representation. The young man was under the care of the Minister but had not been visited by caseworkers from Community Services or the non-government agency providing case management.

We made inquiries and were informed that new legal representation had been organised, Community Services and the NGO were going to organise a joint meeting with all key stakeholders, and caseworkers from the NGO would visit the young man in custody.

This matter raised questions about whether each agency understood their roles and responsibilities, whether these were adequately communicated, and what action each agency took. Of particular interest was whether the procedures in the MOU between Juvenile Justice and Community Services were followed. We have written to each of the three agencies involved seeking further information about their actions to address the needs of this young man.

The NGO has acknowledged its failings and committed to developing a policy to guide its staff on supporting children in detention as part of their case management responsibilities.

Case study 58: Risk management plan reviewed

A detainee phoned us to complain about the conditions of his risk management plan. Under the plan, he had to wear handcuffs when he exercised and not mix with other boys in the centre. The centre had felt that the young man posed a high-risk to staff and other detainees because he had a history of aggressive and violent behaviour.

We acknowledged that historically the young man had been violent to staff, but there had been no such incidents in the previous twelve months. We questioned whether this had been considered in relation to his risk management plan.

In addition, we noted that he did not appear to have the opportunity to demonstrate that he no longer posed the same level of risk to staff and other detainees. We wrote to Juvenile Justice with our concerns. Centre staff then reviewed and amended the detainee's risk management plan – this led to his handcuffs being removed and his gradual re-introduction into the centre's routines.

Visiting centres

We visited each of the eight juvenile justice centres in NSW twice this year. As well as addressing individual complaints, we take the opportunity during visits to talk with centre management and staff about issues affecting detainees. This year, Juvenile Justice and Justice Health released the results of their Young People in Custody Health Survey 2009. Its primary aim was to gain a picture of the health status of

young people in juvenile detention across NSW by surveying 361 young people in custody. The survey results highlighted the social disadvantage, poor physical and mental health, and prevalence of high-risk behaviours – such as alcohol and drug abuse – among young people in custody.

Given the results of the survey, we are keen to monitor the strategies of key agencies to better support these young people – particularly in the period leading up to and after their return to the community.

In a positive development, Juniperina Juvenile Justice Centre advised us that they had extended their accommodation support service for young women leaving custody, and successfully placed a number of young women in public housing who were at risk of entering custody. The young women will receive a minimum of 12 months case management and support.

Employment-related child protection

The heads of all government and some non-government agencies – including non-government schools, children's services and agencies providing substitute residential care – are required to notify us of any reportable allegations or convictions involving their employees within 30 days of becoming aware of them.

These reportable allegations include:

- | sexual offences and sexual misconduct
- | physical assault
- | ill-treatment and neglect
- | behaviour causing psychological harm.

We oversee how agencies investigate and respond to these allegations. We also scrutinise the systems that agencies have in place to prevent this type of conduct and to respond to allegations against their employees.

Giving greater priority to serious allegations

The employment-related child protection scheme has now been in operation for more than 12 years. Over that time, we have seen substantial improvements in the handling of reportable allegations against employees – particularly the handling of lower risk matters. Agencies have better systems in place to investigate allegations against employees, staff are more aware of the type of behaviour that is unacceptable, and investigators are better trained to manage investigations. This means that we are now increasingly able to focus our resources on areas where the system needs to be strengthened.

Over the past two years, we have developed a comprehensive picture of reporting trends and the quality of agency investigations. We have used this information to develop a more streamlined, outcome-focused approach to our oversight of investigations. We have also been able to exempt certain 'classes' of reportable allegations from being notified to us where agencies can demonstrate good child protection practices. For example, in 2010-2011, we extended 17 existing class or kind agreements resulting in a 42% decrease in the number of notifications received compared with the previous year.

This decrease has allowed us to deal more efficiently with the less serious allegations and give greater priority to the most serious allegations. One of the ways that we have done this is through an increase in our direct investigation work. Last year we started four child protection investigations – this year we initiated 10 investigations.

Our investigations have focused on important systemic issues – such as the screening of foster carers, agency responses to serious criminal allegations, and the adequacy of Community Services's Mandatory Reporter guide in responding to historical allegations of sexual abuse. We also started a complex investigation into Life Without Barriers, the largest non-government provider of out-of-home care services in NSW (see page 66-67).

Case studies 59 and 60 are examples of our investigative work.

Case study 59: Probity checking a new partner

Community Services notified us that a young foster child with a physical and intellectual disability had suffered a significant injury, allegedly while in the care of an unauthorised person.

In the year before the child's injury, Community Services received information that the foster carer's circumstances had substantially changed, including that she had entered into a new relationship. The reporter had reason to believe that the foster child was at risk of harm in the context of these changed circumstances.

A Community Services caseworker met with the carer to assess the risk to the child and concluded there was none.

Community Services then received information that the carer had failed to disclose the actual nature of her new relationship. Community Services telephoned her about this information, she downplayed the nature of the relationship and the Community Services caseworker saw no need to conduct any background check of the new 'partner'.

Our investigation found that Community Services had sufficient evidence in the year before the injury to warrant a probity check of the carer's 'partner'. In addition, we found that they failed properly to investigate specific concerns indicating that the child was at risk of harm. We also found that there was an unreasonable failure to conduct a thorough examination of the placement, particularly in light of the allegations that had been made, the level of vulnerability of the child and the significant changes that had occurred in the carer's household.

From a system perspective, we noted that Community Services's policy was not clear in relation to the issue of probity checking of people who have 'joined the household' of a carer. We recommended that Community Services revise this policy. In response, Community Services have agreed to work on the development of a policy that better identifies when background checks need to be done for adults who are, or become, part of a carer's household.

The child has since been placed with a new carer.

Case study 60: Historical allegations and the Mandatory Reporter Guide

An employer notified us that they had received allegations from a young man that one of their teachers had groomed and indecently assaulted him for several years in the 1990s, when he was a child. The teacher, the subject of the allegation, was still working with children at a school.

The employer asked Community Services for access to any relevant information about their employee. Community Services released a report of similar historical sexual abuse allegations against the teacher that they had received a few months before. This earlier

report had been made by a mandatory reporter whose client had been taught by the same teacher in the 1980s, at a different school.

We decided to investigate why Community Services had not told the employer about this report when it was made, and found that the matter had been closed by the Helpline with no further action.

Helpline is designed to take reports about current risks of significant harm to children or a 'class of children'. However, due to the historical nature of the allegation, it appears that the Helpline did not consider risk of harm to the 'class of children' with whom the teacher may have had current ongoing contact.

The Mandatory Reporter Guide (MRG) is designed to help mandatory reporters decide whether an allegation needs to be reported to the Helpline. The internal Helpline tool is designed to help Community Services's staff decide what to do with information they receive. We found that neither tool deals adequately with historical allegations where there may be a current risk of significant harm to a 'class of children', and Community Services have agreed to review both tools.

Receiving notifications

This year, we received 804 notifications of reportable conduct and finalised 1,251 (see figure 46). The most noticeable decreases this year relate to Community Services, Juvenile Justice and the substitute residential care sector (see figure 47).

Figure 46: Formal notifications received and finalised

Matters	06/07	07/08	08/09	09/10	10/11
Received	1,995	1,850	1,667	1,366	804
Finalised	1,749	1,921	1,672	1,442	1,251

Figure 47: Formal notifications received by agency – a two year comparison

Agency	09/10	10/11
Ageing, Disability and Home Care	13	8
Catholic systemic	54	39
Child care centres	74	81
Community Services	303	71
Corrective Services	13	6
Councils	6	3
Department of Education and Training	380	316
Department of Health	24	20
Family day care	15	18
Independent schools	65	63
Juvenile Justice	57	20
Other prescribed bodies	0	0
Other public authority — not local government	35	22
Sport and Recreation	2	0
Substitute residential care	321	133
Agency outside our jurisdiction	4	4
Total	1,366	804

Figure 48: What the notifications were about — breakdown by sex of the alleged offender

Issue	Female	Male	Unknown	Total
Ill-treatment	12	7	0	19
Misconduct — that may involve reportable conduct	25	53	0	78
Neglect	60	9	0	69
Outside our jurisdiction	31	29	0	60
Physical assault	164	135	2	301
Behaviour causing psychological harm	27	13	0	40
Reportable conviction	0	0	0	0
Sexual misconduct	20	93	0	113
Sexual offences	20	104	0	124
Total notifications received	359	443	2	804

Figure 49: What the notifications were about — breakdown by allegation

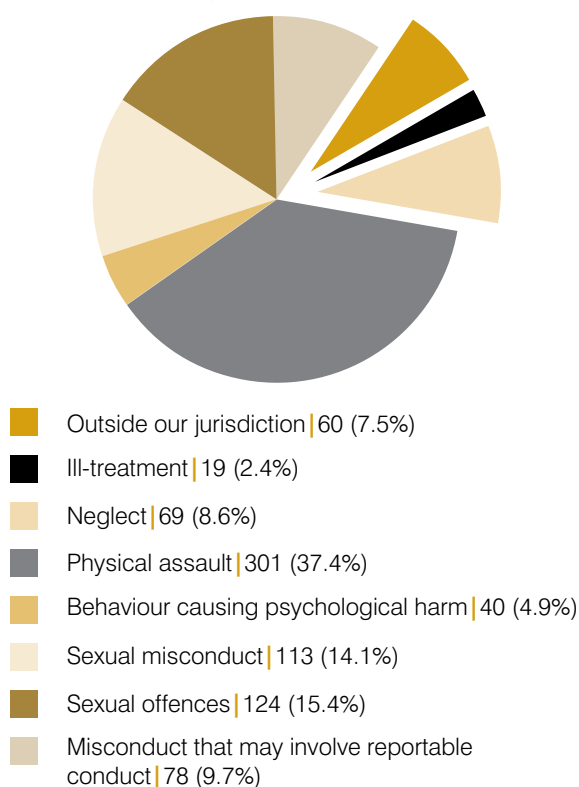
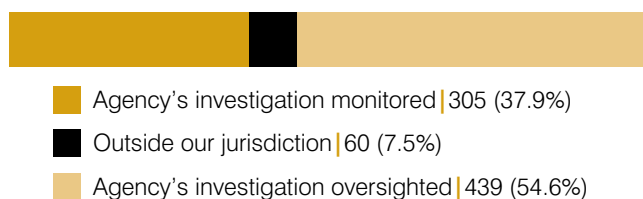


Figure 50: Action taken on formal child protection notifications finalised in 2010–2011



More than a third of the notifications we received (37%) involved allegations of physical assault, and nearly a third (29%) involved sexual offences or sexual misconduct (see figure 49). Figure 50 outlines the action taken on formal child protection notifications that were finalised and figure 48 breaks down the notifications received by the sex of the alleged offender.

The majority of notifications finalised were satisfactorily handled, although some required intervention from us before

being finalised. If there are deficiencies in an agency's investigation, we may provide feedback and suggestions for handling matters better in the future. If we consider it is in the public interest to address the issues identified more directly, we may request further information or ask the agency to pursue other lines of inquiry or formally request a review of their agency's findings.

If we identify significant systemic issues arising from a notification, we may audit the agency's systems or start a direct investigation. We also provide positive feedback when we identify particularly good investigative practice by an agency.

Monitoring agency investigations

When we receive a notification, we assess the level of scrutiny and assistance we need to provide to the agency. This assessment is based on the seriousness of the allegation, the vulnerability of the alleged victim, our knowledge of the agency's systems, and the complexity of the situation. When we monitor an individual matter, we may offer advice about developing the investigation plan and provide guidance about evidentiary issues and related findings (see case study 61).

This year we closely monitored 305 agency investigations, or 38% of all finalised matters.

Case study 61: Failing to identify neglect

Ageing, Disability and Home Care (ADHC) notified us of allegations that their youth workers had neglected a 12 year old child with a disability, resulting in him suffering severe scalding which required hospitalisation. One of the youth workers had been assisting with showering the child when he received burns to 9% of his body. The child had to be sedated due to the pain and was provided with morphine when he was discharged. The alleged incident, which was investigated internally and found to be accidental, occurred eight months before being reported to us.

We requested a review of the investigation. In response, ADHC appointed an external investigator to re-examine the case. The external review established that two people should have been in the shower with the child at all times. The scalding had resulted from both youth workers failing to follow established practice and procedure. ADHC found the allegation of neglect sustained against both employees. The employees have been moved to non-child-related employment and are subject to ongoing monitoring.

Handling inquiries and complaints

We received 647 inquiry calls this year, a slight increase from the 636 received last year. Most inquiries were from agencies with queries about our jurisdiction or wanting advice about how to manage an investigation. However, we also received inquiries from employees who were the subject of investigations and families of alleged victims. As in previous years, employees' most commonly raised concerns were about a perceived lack of procedural fairness and the notification process to the Commission for Children and Young People. A quarter (25%) of all inquiries received related to children's services, including child care centres and family day care services.

This year we received 61 complaints and finalised 53. In many of these matters, we finalised the complaint after making inquiries with the agency or asking them to take certain action to respond to the concerns raised by the complainant. Although our complaint-handling continues to be a small component of our employment-related child protection work, it provides us with valuable information about the systems agencies have for handling reportable allegations.

Sharing information

In October 2009, Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* came into effect. This chapter allows certain government and non-government agencies to share information that promotes the safety, welfare and wellbeing of a child or young person, and specifically overrides any other legislation (including privacy legislation) that conflicts with this objective. The provision significantly opened up the scope for relevant agencies to exchange information with each other. For a number of years, we have argued strongly in favour of legislative reform of this kind.

We have taken an active role in promoting the use of this provision and will often recommend information exchange between relevant agencies in the cases we oversight (see case studies 62 and 63). We also use section 34(1)(b1) of the Ombudsman Act to release information to agencies if it relates to the safety, welfare or wellbeing of a child or a class of children.

Case study 62: Criminal history not identified

A non-government out-of-home care agency notified us of allegations that one of their foster carers had neglected a child in her care. The notification mentioned that the carer's adult son was living in the foster home.

We became aware that the son had a serious criminal history which made him unsuitable to live with foster children. The agency informed us that the son had been probity screened, including a Working With Children Check (WWCC) and a criminal records check. We were concerned that the probity checking process had returned no results. After lengthy inquiries with multiple agencies, we established that the son had provided a false date of birth on his probity checking authorisation forms. As a result, the police did not identify his criminal history for either check and gave him an 'all clear'.

We facilitated multiple Chapter 16A information exchanges to ensure that the agency and police became aware of the correct date of birth and the agency received an accurate criminal history of the son. They subsequently assessed that the son's criminal profile meant he was not a suitable person to be living with foster children.

Case study 63: National approach to reporting

We were contacted by a school in another state investigating allegations against one of their teachers. The school was aware that the teacher had been the subject of investigation in NSW, but not the specific nature of the allegations. Our records revealed allegations of sexual misconduct reported to us by the NSW school where the teacher had previously worked. Some of these allegations had been sustained by the school and reported to the Commission for Children and Young People.

Given that the NSWPF and Community Services also had significant information about the teacher, we consulted with them about their respective holdings and what information needed to be shared with the school to enable them to conduct an appropriate risk assessment.

As a result of these discussions, the Ombudsman provided relevant information to Community Services who forwarded this, along with their own holdings, to the government child protection agency in the state where the school was located. The school was then advised to contact their state's child protection agency to obtain information to inform its response.

This case highlights the importance of effective cross-agency liaison in difficult matters of this kind. It also demonstrates the need for a rigorous and consistent national approach to the reporting, investigation and oversight of serious child abuse allegations made against employees in child-related employment. As there is currently no such system in place nationally, there is no guarantee that high-risk cases of this kind will be appropriately identified and managed.

Dr Joe Tucci, CEO of the Australian Childhood Foundation, has also called for a rigorous and consistent national approach to protecting children.

“It is not enough to have a nominal national framework with ambitions to create child safe organisations. It is clear that legislative-based oversight and often direct action is the only way to ensure that bureaucratic and policy barriers are challenged and addressed. It is also not enough to focus on criminal convictions as a measure of an individual's risk to children. Just as police share 'intelligence' across borders, child protection systems need to share 'intelligence' about individuals who are identified time after time with concerning behaviour towards children. This can only occur if there is proactive coordination and review by statutory bodies, like the NSW Ombudsman, whose remit is to uphold the rights of children to live, play and learn in environments where individuals cannot abuse or exploit them. It is time for the Commonwealth to take the model of practice reflected in the role and approach adopted by the NSW Ombudsman and implement it nationally ...”

Improving Working With Children Checks

Last year, we reported on our submission to the statutory review of the *Commission for Children and Young People Act 1998*. This review is ongoing and, over the past year, we have continued to identify and address concerns with the current system.

Any future child-related employment screening scheme must guarantee that the findings from significant relevant employment proceedings are taken into account as part of the screening process – so any serious risks to children are identified.

Using police intelligence holdings to help protect children

In a number of matters last year, we found evidence of credible police intelligence that indicated certain individuals were a high-risk to children – but that information did not come to light before these individuals were employed in child-related employment. (We are unable to report the details of these matters as they are the subject of ongoing criminal proceedings.)

We appreciate the reasons why the WWCC does not include an assessment of relevant police intelligence holdings. However, it may be appropriate for police to release information arising from credible and relevant intelligence holdings to prospective employers in certain circumstances – particularly where the potential risk to children is very high.

In fact, on occasions, police already inform existing employers of credible information they possess that indicates a current employee may pose a very significant risk to children. We acknowledge that this complex issue requires the need to balance the benefits of using significant police information to protect children against the infringement of civil liberties that arise if this information is wrongly and/or unfairly used.

To date, we have had some early discussions with police around some of the challenging issues associated with the use of police intelligence in this way. One area that we are keen to explore further is whether it is possible to establish a fair and rigorous system that ensures critical police intelligence of this type is identified and only used in circumstances that are both fair and justified.

Referring criminal matters to the police

Notifications about allegations of criminal conduct are among the most serious reportable conduct matters that we monitor. We give particular attention to these matters to ensure they are being promptly and properly handled.

The NSWPF are responsible for investigating criminal allegations in NSW. However, through our oversight of a number of cases, we found allegations of this type that had not been referred to police.

In several of these cases, we started investigations (see case study 64). Community Services are currently working on revised policy guidance to staff about what types of allegations must be referred to police.

Case study 64: Handling criminal allegations

An independent school notified us of allegations that a teacher had been inappropriately touching 12 and 13 year old students. Our assessment of the information was that it contained criminal allegations. We advised the school to contact the police. The school told us that they had reported the matter to Community Services and been advised that the allegations were not of a criminal nature and they could investigate the matter themselves.

After discussions with our office, the school reported the matter to the police and the Joint Investigative Response Team (JIRT) began a criminal investigation. Unfortunately, this investigation had been compromised by the school's own investigation. Also, the teacher – who had been reinstated after the school's investigation – was suspended for a second period, pending the outcome of the JIRT's inquiries.

We decided to conduct an investigation into the adequacy of Community Services's response to the Helpline report from the school. Community Services have now acknowledged that the Helpline should have referred the matter to the JIRT for further assessment in the first place. They are also taking steps to ensure that staff are made aware of the procedures for referring appropriate matters to JIRT and/or local police.

We also try to ensure that agencies are well supported when they do refer criminal allegations to the police. For example, we have worked with the police to develop standard operating procedures (SOPs) for handling employment-related child abuse allegations. These procedures have now been approved and adopted by the NSWPF.

In the past, we have found that if agencies referred criminal allegations to the police protracted periods of time might pass while police investigated the matter. The agency often had little information about what was happening while the police investigation ran its course. The new SOPs highlight to police at local area commands the industrial context faced by employers in such matters, and emphasise the escalated risks that are associated with the fact that the alleged offender has contact with children through their employment. The SOPs escalate these matters for priority within commands and should improve timeliness and accountability.

Over the past year we have developed closer networks with the police and regularly liaise with the Sex Crimes Squad about issues associated with our work. This has provided us with access to prompt information and advice and enabled us to give appropriate guidance to agencies in responding to reportable allegations of a criminal nature. We also attend the quarterly Sex Crimes Squad & Joint Investigation Response Squad Advisory Council meetings which have been an excellent opportunity for interagency liaison and case discussion about a range of child protection issues.

Problems with multiple profiles

In the course of our work, we have identified that multiple civilian profiles – called CNIs – can be created for single individuals in the police database. If these details don't contain adequate identifying data such as a date of birth, they may not be 'linked' on the database. This can result in a failure to identify risks when a WWCC is conducted. When carrying out a criminal record check on an individual, police

may fail to identify the multiple CNIs and therefore remain unaware of relevant holdings – leading them to provide incomplete information to the CCYP.

After being aware of a number of cases involving a failure to identify risks because of the existence of multiple CNIs, we raised the issue with the NSWPF. We suggested that the Command Management Framework (CMF) – the NSWPF's tool for auditing the performance of police local area commands – could be used to audit the police database to ensure that multiple CNIs are not being created, and that they are appropriately linked when identified. The NSWPF agreed with this suggestion. A number of additional steps have been taken to address the problem at an operational level. The NSWPF have also advised us that they have formed a working group which is progressing a number of issues about managing identifying information about individuals. We understand that the working group is in the final stages of preparing recommendations for the Police Commissioner to consider.

Case study 65: History of sexual assault missed

An out-of-home care agency notified us of allegations that a male foster carer had indecently assaulted a female child in his care. The reporter alleged that the carer had a history of sexually abusing family members and had previously been charged with the sexual assault of a young adult. The out-of-home care agency sought information from the police about any relevant charges against the carer. The police provided a criminal profile for him that did not include the sexual assault charge. Based on this information, the out-of-home care agency concluded that the reporter had provided inaccurate information.

We became aware that the carer had at least five civilian profiles in the police database, not all of which had been linked. The reporter's information about the sexual assault charge was correct. We contacted police to alert them to the possibility that they had inadvertently failed to provide full and accurate information to the agency. The police confirmed they hadn't identified one of the carer's profiles that contained the sexual assault charge. We requested that the police link the profiles and provide the agency with the information, which they promptly did.

Risks to children must take priority

From a number of matters that we have reviewed, we are concerned that there is a culture in some adult counselling services which is at odds with the current child protection legislation in NSW. Under the legislation, the safety, welfare and wellbeing of children is paramount and must take precedence over an individual's privacy. It is essential that these services ensure that they act to protect children in circumstances where they receive allegations that their client was seriously abused as a child by someone who still poses a very significant risk to children. As part of responding to this issue, these services need to have in place procedures that ensure that their adult clients are made aware of the service's responsibility to report matters of this kind – in contrast to the usual confidentiality requirements.

Following our investigation this year into a matter that raised these important practice issues, NSW Health have agreed to review and clarify their policies on privacy and information exchange in child protection matters of this kind. They have also made a commitment to educate staff about the related changes.

Being clear about what constitutes sexual misconduct

In August 2010, we issued a practice update to clarify for employers the types of behaviours that fall within the definition of sexual misconduct. Sexual misconduct includes sexually explicit comments and sexually overt behaviour towards, or in the presence of, a child or children. Conduct of this nature on the higher end of the scale of seriousness has tended to be readily identified by employers. The practice update makes it clear that inappropriate conversations with a child that are of a sexual nature, including one-off comments, can also constitute sexual misconduct.

From our analysis of cases over the years, we know that a high proportion of sexual offences that occur in employment contexts such as schools are preceded by the employee engaging in conduct with or towards a child that is in breach of professional standards. As the conduct does not always involve behaviour of an overtly sexual nature, it is crucial that employers are able to identify early signs of inappropriate conduct of this nature and take adequate action to address it (see case study 66).

Case study 66: Early signs ignored

In 2008, the DEC notified us of allegations that a teacher was allowing groups of students to go to his home, communicating with the students online, playing online games with them, and driving one student in his car on a regular basis.

The school concluded that the alleged behaviour had occurred, but that it did not constitute reportable conduct. We were concerned about this conclusion and wanted to ensure the situation was appropriately risk-managed.

The school did not accept our assessment of the risk. However, they did direct the teacher to stop engaging with students in an inappropriate way and they undertook to formally monitor his conduct. Three months later, we received notice of further allegations of a similar nature against the same teacher. A month after that, we were notified that he had allegedly engaged in a sexualised conversation with two year 6 students online while naked in a spa and had sent one of them a pornographic image.

After a criminal investigation in June 2010, the teacher pleaded guilty to a number of charges – including several counts of producing child pornography, aggravated indecent assault, and using the internet to groom a child for sex.

Our practice update clarifies that the behaviour identified in the first notification constituted sexual misconduct.

Against the background of cases of this kind, we made it clear in our practice update that sexual misconduct includes behaviour that can reasonably be construed as crossing professional boundaries. This may be through an employee's inappropriate and overly personal or intimate relationship with or conduct towards a child or young person, or a group of children or young people. While we have cautioned employers against too readily concluding sexual misconduct, we have noted that persistent less serious breaches of professional conduct in this area – or a single serious 'crossing of the boundaries' by an employee – may constitute sexual misconduct, particularly if the employee either knew, or ought to have known, that their behaviour was unacceptable.

Promoting better practice

Our aim is that every sector is able to demonstrate that they have the necessary core competencies for effectively handling employment-related child protection allegations, and that agencies within each sector work cooperatively to protect children.

We continue to focus on areas where child protection systems need to be strengthened – with significant work undertaken with the independent school, out-of-home care and children's services sectors. We have also worked with Community Services to strengthen their systems for investigating reportable allegations.

This year we completed 23 audits as part of our ongoing scrutiny of agency systems and processes for preventing and handling allegations of reportable conduct. The audit program included juvenile justice centres and juvenile justice community offices, which were reviewed as part of an ongoing statewide review of Juvenile Justice. An additional two Aboriginal out-of-home-care services were reviewed as part of a continuing complete sector audit.

We also identified a need to offer child protection training to agencies. In 2010-2011, we conducted 11 sessions of our 'Responding to allegations against employees' workshop and a further 13 sessions of our workshop, 'Handling serious allegations'. Some of the sessions were conducted regionally and for peak bodies, such as ABSEC and the Board of Studies. We also provide short information sessions to agencies and special interest groups free of charge.

The continuing positive feedback from workshop participants reaffirms the Ombudsman's investment of resources in keeping agencies skilled and up-to-date with their responsibilities to children and employees.

During 2010-2011 we also updated all our child protection fact sheets and published revised online notification forms to make it easier for agencies to notify us of reportable allegations. For further details, see our Community education and training chapter.

Strengthening child protection in schools

In 2010, the Association of Independent Schools (AISNSW) proposed limiting current 'class or kind' agreements to AISNSW member schools and providing more rigorous processes for supporting, training and accrediting member schools managing class or kind investigations. In response, we have drafted a revised agreement and proposed a 12 month project to gather evidence about the quality of employment-related child protection policies, procedures and systems across a range of AISNSW member schools. This project will provide a snapshot of current child protection practice and identify areas for improvement.

To ensure consistency across the sector, we also began discussions with the Christian Schools Association (CSA) and Christian Education Network (CEN) about developing a framework to support their member schools fulfil their child protection responsibilities. CSA and CEN have now developed proposals which, if implemented, will provide significant support to their schools in this area.

Through our work overseeing investigations into reportable allegations, we identified the potential benefits of having a consistent set of standards across the education sector for employee/student relationships in schools. The DEC has dealt with this issue in their code of conduct, but there are no consistent practice guidelines for Independent and Catholic schools. We have therefore asked their representative bodies to consider and advise us on whether there is scope for a model code to be developed that outlines appropriate standards for relationships between students and school employees.

Improving skills in children's services

On 1 January 2012, a new national regulatory framework for children's services will come into operation. It will cover all long day care, family day care, preschool and out-of-school hours services. This will have a considerable impact on us, as an additional 1200 out-of-school hours services will potentially fall within our jurisdiction. In addition, child protection training will be mandatory for all employees in children's services.

Last year, we reported that we had identified the childcare sector as an area of high priority because many services within the sector lack child protection expertise. Recent commentary in the media also cited a series of examples which point to poor practices in regard to child protection.

In light of our concerns and the upcoming changes in the sector, we have started negotiations with Community Services and the CCYP to explore ways to improve the knowledge and skills of the children's services sector in relation to key aspects of child protection practice – including identifying, managing and investigating reportable allegations.

Developing awareness in out-of-home care

Over the past year we have worked closely with the Association of Child Welfare Agencies (ACWA), the CCYP and the Children's Guardian to develop practical strategies to promote awareness of employment-related child protection responsibilities across the out-of-home (OOHC) care sector. This work will continue next year with the implementation and promotion of an extended class or kind agreement for OOHC agencies with five year accreditation. At the same time, the CCYP propose to implement a class or kind agreement with all OOHC agencies exempting low-risk matters from being notifiable under the WWCC scheme.

Working with the reportable conduct unit

In May 2010, Community Services centralised the investigation of allegations undertaken by their reportable conduct unit (RCU). To ensure that all outstanding reportable conduct matters notified by Community Services were managed appropriately, we worked closely with them to make sure all matters were finalised and reviewed. Twelve months on, we are now part of a project with Community Services to evaluate the success of centralisation and to measure the quantity and quality of investigations undertaken by the RCU.

People with disabilities

Our responsibilities under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) include:

- | handling and investigating complaints about disability and other community services
- | inquiring into major issues affecting people with disabilities and disability service providers
- | reviewing the care, circumstances and deaths of people with disabilities in care
- | monitoring, reviewing, and setting standards for the delivery of disability services
- | coordinating official community visitors (OCVs) in their visits to licensed boarding houses and supported accommodation.

For more details about our work with OCVs, please see page 87.

Handling and investigating complaints

This year, we received 321 complaints about disability services. Of these, 167 (52%) were about disability accommodation providers; that is, accommodation operated, funded or licensed by Ageing, Disability and Home Care (ADHC). (See figure 52)

Complaints about disability accommodation services

The main issues reported in complaints about disability accommodation services concerned the adequacy of the planning undertaken to support an individual's entry into a service or transfer to different accommodation; the compatibility of residents; access to meaningful and fulfilling community activities; and the adequacy of action to ensure the safety of residents.

Figure 51: Outcomes of formal complaints finalised in 2010-2011 about agencies providing disability services

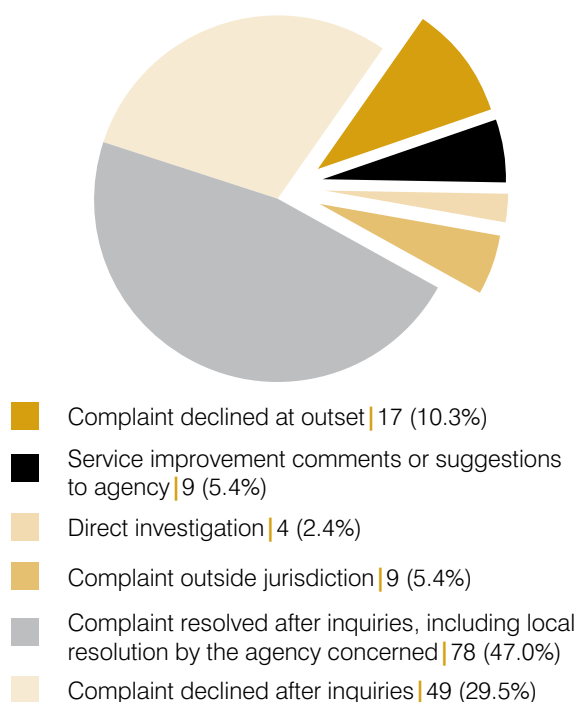


Figure 52: Formal and informal matters received in 2010-2011 about agencies providing disability services

Agency category	Formal	Informal	Total
Community Services			
Disability accommodation services	0	1	1
Disability support services	1	2	3
Subtotal	1	3	4
ADHC			
Disability accommodation services	27	41	68
Disability support services	42	38	80
Subtotal	69	79	148
Other government agencies			
Disability accommodation services	0	0	0
Disability support services	1	4	5
Subtotal	1	4	5
Non-government funded or licensed services			
Disability accommodation services	53	39	92
Disability support services	27	21	48
Boarding houses	2	3	5
Subtotal	82	63	145
Non-specific inquiries			
Other (general inquiries)	0	6	6
Agency unknown	1	10	11
Outside jurisdiction	0	2	2
Subtotal	1	18	19
Total	154	167	321

Case study 67: Communicating effectively with stakeholders

The parents of a woman living in a non-government group home complained to us that the service had failed to adequately investigate an incident in which their daughter had allegedly been humiliated by a staff member, and had not taken adequate steps to resolve complaints and respond to health issues. The service had recently undergone significant internal changes following a review.

We made inquiries with the service and then met with them to resolve the complaint. We found that many of the concerns raised with us stemmed from how the service had communicated with parents and other stakeholders about recent changes in the organisation. We made suggestions to the service about improving their complaint-handling and provided strategies to effectively communicate about changes that have a direct impact on residents and their families.

Case study 68: Improving behaviour management strategies

We received information from a service worker about circumstances in a non-government group home for adults with disabilities. The concerns raised with us were that:

- | one resident was displaying aggressive and violent behaviours towards staff and another resident
- | these behaviours were not being adequately addressed by the agency
- | the other resident was being placed at risk of continual aggression and violence and was becoming more withdrawn and frightened.

The staff member did not wish to be identified as the complainant. As the group home was a visitable service, we asked an OCV to visit and confirm the information we had received. The visitor lodged a report to the agency immediately, outlining the concerns and seeking a quick response, particularly around how the agency was ensuring the safety of both residents and staff.

We also made formal inquiries with the agency about long-term planning for both residents, including behaviour management, and asked for copies of their relevant policies and procedures to review.

The agency's prompt response outlined the suspected causes of the resident's aggressive and violent behaviours. They identified shortcomings in the way the behaviour strategies had been implemented and referred to steps they were taking to address this issue – including consulting with external behaviour specialists for input into their review of the resident's behaviour, incident response plans and routines at the group home. In addition, the agency was rostering additional staff when required, providing counselling for the other resident, and maintaining regular communication with the guardians and families of both residents.

The agency also had discussions with ADHC about alternative accommodation options and other support needed. As a result, the resident who had been targeted was moved to another group home and reported being 'much happier there.' Alternative accommodation places were also being sought for the remaining resident who wanted to be nearer her family.

Complaints about disability support services

We also received 154 complaints about disability support services; that is, services operated or funded by ADHC that provide community-based support for people with disabilities. This support includes Home and Community Care (HACC) services, post-school and day programs, respite, case management services and drop-in support. The main issues reported in complaints about disability support services this year concerned access to support; the conduct of staff; and the adequacy of support to meet the needs of the individual.

Case study 69: More help for kinship carer

During our consultations with parents and carers of children with disabilities, a kinship carer complained to us about the adequacy of support provided by agencies to her family. The woman told us that she was caring for five of her relative's children, including an eight year old child with cerebral palsy. She complained that:

- | Housing NSW had not addressed significant maintenance issues and the need for wheelchair access in her current accommodation
- | ADHC would not provide therapy for the child with a disability in the home due to occupational health and safety risks
- | Community Services was not helping to resolve the issues or obtain the necessary equipment for the child, including a hoist and a new wheelchair.

We made inquiries and met with Housing NSW, ADHC and Community Services to resolve the complaint. At the meeting, the agencies agreed to help the family to find a new place to live and provide increased support.

Three months later, we were concerned that little progress had been made by Housing NSW and Community Services to meet their agreed responsibilities. We asked each agency to review their actions in relation to the family. These internal reviews found that both agencies had failed to provide adequate care and support to the family, and identified systems failures that needed to be addressed.

The family have since moved into alternative Housing NSW accommodation that has been modified to meet the needs of the child with a disability and received improved casework and support services.

Investigating access to SAAP services for people with physical disabilities

This year we completed our investigation into the access that people with physical disabilities have to services provided under the Supported Accommodation Assistance Program (SAAP), now known as Specialist Homelessness Services.

We found that Community Services had not addressed the lack of access by people with physical disabilities to SAAP services, or met their stated commitments to do so. We also found that – since a report we did on this issue in 2004 – Community Services had provided misleading information about the extent of their work in this area and the likely improvements that would result.

In response to our provisional recommendations, Community Services told us that they were working with Housing NSW to improve access to homelessness services for people with physical disabilities. For example, 10 properties would be upgraded in 2010-2011 to improve disability access and a further 10 properties would be upgraded in the second year of the program.

We will monitor Community Services' actions through progress reports scheduled for December 2011 and 2012. They also apologised to us about provided misleading information about their work in this area.

Consulting with families of children with disabilities

Last year, we consulted over 300 parents and carers who have a child with a disability living at home about their experiences in obtaining information, services and support.

The key themes and messages from our consultations were included in our September 2010 submission to the Inquiry by the Legislative Council Standing Committee on Social Issues into services provided or funded by ADHC.

After meetings with ADHC, NSW Health and the Department of Education and Communities (DEC), we released a final report from the consultation project in June 2011. Our report noted that, while there have been significant changes in the disability service system since 2006, work still needs to be done to:

- | make it easier for families to obtain clear and helpful information about available services
- | reduce unnecessary bureaucracy and inefficiencies
- | give people with disability and their families greater choice and control over their supports

- | improve the coordination of services and support
- | improve the inclusion of children with disabilities in all services.

The report outlines actions that agencies are taking to address the issues raised by parents and carers during our consultations. These actions include reforming aids and equipment and respite programs, increasing the provision of early intervention packages, and planning for the delivery of self-directed support. Given the critical importance of adequate and timely support for children and young people with disabilities, we will pursue the issues raised by families, monitor the progress of relevant work by agencies, and seek to test whether the issues are effectively addressed in practice.

The report – *Consultations with families of children with disabilities on access to services and support* – is available on our website.

Inquiring into support for people with mental illness

In late 2010, the Public Guardian raised concerns with us about the number of people under their guardianship who were continuing to be accommodated in mental health facilities because of a lack of appropriate alternative accommodation and support in the community. At the same time, the Mental Health Review Tribunal raised concerns with us about people with mental illness being discharged prematurely from psychiatric facilities due to the demand for limited beds.

People with a disability due to a psychiatric impairment are eligible for services and support under the *Disability Services Act 1993*. However, people with a primary diagnosis of mental illness are currently excluded from supported accommodation provided or funded by ADHC – apart from the boarding house relocation program – because NSW Health is considered to be responsible for their support.

Against this background, we have started an inquiry into the availability and provision of accommodation and support for people with mental illness under the Disability Services Act. We will examine the roles and responsibilities of key agencies in providing community-based accommodation and support, and identify blockages and service gaps that contribute to people with mental illness remaining in mental health facilities beyond the point considered clinically necessary.

This work will take into account our 2009 investigation into the Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing. Information about the outcomes of this investigation is reported at page 32 in Departments and authorities.

Improving service delivery to Aboriginal people with disabilities

Last year we reported on our review of ADHC's implementation of their Aboriginal Policy Framework and Aboriginal Consultation Strategy, which aim to ensure that Aboriginal people with disabilities and their carers have equal access to ADHC's planning and decision-making.

For details about ADHC's progress in this area see page 109 in Working with Aboriginal communities.

Planning for young people with disabilities leaving care

Last year, we facilitated a meeting between the Public Guardian, the Guardianship Tribunal and Community Services to discuss concerns raised with us by the Public Guardian about planning and support for young people with disabilities leaving the care of the Minister for Community Services. A key concern was that the Public Guardian was often not involved in the leaving care planning until late in the process, to the detriment of the young person leaving care.

During the meeting, it was agreed that Community Services would identify young people in out-of-home care who have turned 16 and are likely to need at least some aspects of guardianship after leaving care. They would then start guardianship applications for these young people to appoint a guardian. This guardian would then advocate for the young person during the ages of 16 to 18 years to ensure their smooth transition to after care services and support.

This year, there has been considerable progress on this issue, including improved interagency coordination to support these young people. The Public Guardian, Community Services and ADHC have developed a memorandum of understanding to guide the interagency work, and will jointly deliver training to their staff on implementing the agreement.

Reporting to Parliament on people with disabilities living in large residential centres

In August 2010, we tabled a special report to Parliament about the needs of people with disabilities living in residential centres. This was in the context of the planned closure of these centres. The report drew on evidence from our 2009 review of individual planning in ADHC's large residential centres, and information from the joint Ombudsman/Disability Council Devolution Forum that was held in June 2010.

Our recommendations included that ADHC should report to us each year on their actions to:

- | progress the closure of the residential centres
- | ensure that people with a disability living in residential centres, their families and other representatives have meaningful and direct involvement in the planning for closing those centres.

Since the release of our report, the government issued *Stronger Together: the Second Phase*, which includes the commitment to close all of the large residential centres by 30 June 2018. We are actively monitoring the work in this area.

We plan to meet with families of residents in ADHC's large residential centres to discuss the report and the closure of the centres. While we did not consult with the families of the residents in our 2009 review, we recognise the critical importance of families being actively involved and consulted about the needs and wishes of their relatives in large residential centres, and in the planning for future accommodation and support. It is important that we hear directly from families and people living in the centres about their involvement in the planning process and consultation regarding individual needs.

We will also visit the new premises accommodating the former residents of ADHC's Grosvenor, Lachlan and Peat Island centres and examine whether the accommodation and support provided is in line with the *Disability Services Act 1993* and the UN Convention on the Rights of Persons with Disabilities.

Reviewing the deaths of people with disabilities in care

Our sixth report on the deaths of people with disabilities in care was tabled in Parliament in September 2011. The legislation was changed in 2009 requiring us to report every two years rather than every year. This was our first biennial report since the change in legislation.

The report concerns the deaths in 2008 and 2009 of 193 people with disabilities – 160 people who lived in disability services and 33 who lived in licensed boarding houses. The report also draws on key data and information relating to the 651 people who died between 2003 and 2009.

An important part of this work involves undertaking research or other systemic work to help identify strategies to reduce or remove preventable risk factors. The report contains an analysis of causes of death between 2003 and 2009, and a more detailed examination of the main causes of death for people who were living in disability services and licensed boarding houses. This work includes consideration of:

- | key data and other information about the people who died
- | the known risk factors for those causes of death
- | the existence of those risk factors in relation to the people who died and any actions taken to reduce or remove these risk factors

- | the major findings from our work in reviewing the deaths of those individuals.

Key issues identified through our reviews and highlighted in this report include:

- | Management of risks – we have noted continuing problems in the actions of some services to effectively identify risks faced by individuals and to support them to manage or minimise those risks. This has included:
 - the adequacy of actions to identify and address nutrition, swallowing, respiratory, and safety risks
 - actions to manage the medication risks of people in disability services and licensed boarding houses
 - support for licensed boarding house residents to address or minimise risks relating to heavy smoking, obesity and lack of exercise.
- | Access to health supports and programs – our reviews indicate low rates of access to specialists, chronic disease management programs, and other out-of-hospital programs. We found:
 - low rates of involvement of medical specialists despite individuals with complex and chronic health problems, such as chronic obstructive pulmonary disease
 - no involvement in chronic disease management or other out-of-hospital programs for people who had chronic diseases, despite meeting the benchmark of 'high-risk' or 'very high-risk' patients.

The report details the progress made by NSW Health and ADHC in meeting our previous recommendations, and includes new recommendations to address the key systemic issues. Following the release of this report, we will explore strategies for effectively communicating the main messages and areas for action, such as the development of simplified and targeted fact sheets.

Monitoring the work to support people with intellectual disability in contact with the criminal justice system

We have been monitoring the work of the Senior Officers' Group (SOG) on people with intellectual disability and the criminal justice system since 2004. In August 2008, we tabled a report to Parliament about the work of the SOG since 2004. We noted that, although a number of significant initiatives had started, overall progress had been slow and more needed to be done to strengthen cross-agency service delivery for people with intellectual disability in, or at risk of, contact with the criminal justice system.

Reports provided to us by the SOG in 2009 and 2010 indicate that considerable progress has been made in developing an interagency agreement to guide the work of the agencies and action plans for carrying out this work. We consider it to be critical that the impetus is sustained and that a multi-agency approach to improving the outcomes of people with intellectual disability in, or at risk of, contact with the criminal justice system becomes a routine and systemic part of the work of the SOG agencies.

This year we met with ADHC, OCVs, the NSW Council for Intellectual Disability, the Intellectual Disability Rights Service and the Public Guardian to discuss the Community Justice Program. This program provides accommodation and support services for people with intellectual disability leaving the criminal justice system. We also visited the units for inmates with intellectual disability at Long Bay.

Reporting to Parliament on people living in licensed boarding houses

Under the *Youth and Community Services Act 1974* (YACS Act), boarding houses must be licensed by ADHC if they accommodate two or more people with disabilities who require supervision or support. Licence conditions and regulations specify the requirements expected of the licensee, licensed manager and staff.

Licensed boarding houses were brought within the jurisdiction of our office in 2002. Over the past nine years, we have undertaken considerable work in relation to licensed boarding houses, including three investigations and an inquiry into ADHC's conduct in licensing and monitoring licensed boarding houses; and six reports on the deaths of licensed boarding house residents.

This work, in addition to complaints and information provided by OCVs, has highlighted a range of issues relating to the safety, health, welfare and rights of people living in licensed boarding houses. This includes a lack of occupancy rights; inadequate health care support and medication management; restrictions on individuals' access to the community, family, friends and support services; and inadequate protection against assaults and harassment by staff and other residents.

We have also identified and reported on recurring problems with ADHC's licensing and monitoring activities, including serious deficiencies in the agency's actions to promote the welfare of residents and fulfil its responsibilities under the YACS Act. This has included the failure to undertake monitoring activities in accordance with practice requirements, and to enforce the conditions of licence.

However, the problems are much larger than poor monitoring and enforcement. The current legislation governing licensed boarding houses and the standards expected in such facilities are inadequate to protect already vulnerable residents from harm and violations of their fundamental human rights. People living in unlicensed boarding houses have even fewer safeguards and protections.

Significant reform is required to provide adequate protections and appropriate support, and to uphold the rights of people

living in the boarding house sector. At a minimum, our work demonstrates that there is a critical need for legislative change to improve the circumstances of, and outcomes for, people living in licensed boarding houses.

In 2010, new YACS regulations were enacted that strengthened the minimum requirements in licensed boarding houses. All licence conditions are now legally enforceable and additional requirements have been introduced about first aid and administering regular prescribed medications. However, while these changes to the regulations are positive, they took place 11 years after ADHC first received legal advice that certain licence conditions may not be enforceable. In addition, the new regulations do not remedy the broader problems with the legislation.

This year, there has been some progress in relation to broader reform. In December 2010, Cabinet asked the Interdepartmental Committee on Reform of the Shared Private Residential Services Sector to undertake targeted consultations with key stakeholders to test options for reform, and to submit a report for the government to consider. The Committee submitted a report to government in June 2011.

We welcome the move towards boarding house reform. The recent legislative amendments concerning licensed boarding houses and the work of the Interdepartmental Committee are important and promising developments. However, the progress of work in this area has been very slow, and prior opportunities to undertake the necessary reforms have not resulted in any outcomes. Against this background, in August 2011 we tabled a special report to Parliament on boarding houses and the need for reform of the sector.

The report – *More than board and lodging: the need for boarding house reform* – details our work over the past nine years, outlines the history of reform initiatives, and stresses the need for concerted and sustained cross-government action to achieve real and improved outcomes for people in licensed and unlicensed boarding houses. The report is available for download on our website.



Our work involves official community visitors visiting licensed boarding houses. Issues raised are dealt with by the visitor or are forwarded to us for resolution or further investigation.

Providing education and training

We are in the process of expanding our range of training workshops targeted at the disability sector. Some of these workshops include:

- | revising *The Rights Stuff* workshop – we plan to work with advocacy groups to identify people with disabilities who would benefit from the training, and examine options for providing the training in alternative formats online
- | working with NDS and ADHC to devise a training program on developing an effective complaints management system designed to suit the needs of the disability sector
- | developing a Handling Serious Allegations training workshop for the disability sector
- | rolling out a new Disability Awareness training workshop.

Making submissions to key inquiries

This year, we made a number of submissions to key inquiries into issues affecting people with disabilities. For example, we made submissions to the NSW Legislative Council Inquiry into services provided or funded by ADHC and to the Productivity Commission Disability Care and Support Inquiry.

Our submissions to the Legislative Council inquiry highlighted the need to expand the supported accommodation options available to people with disabilities – including greater access to social and affordable housing, and greater flexibility in accommodation and support options to meet their diverse individual needs. We also drew attention to the need for reform of the boarding house sector, and detailed the initial information from our consultations with families of children with disabilities. This submission is available on our website.

Our submissions to the Productivity Commission inquiry emphasised our support for developing a national disability scheme to deliver simplified and reliable access to services and support for people with disabilities. Any national disability scheme needs to be closely aligned to the National Disability Strategy and consistent with the UN Convention on the Rights of Persons with Disabilities. There also needs to be clear and simple entry to the scheme, equity of access – irrespective of the type of disability, and support that is portable, flexible and responsive.

We also emphasised the need for a clear complaints and appeals process. People with disabilities must have the opportunity to appeal against key decisions, such as decisions about eligibility. They should have access to a rigorous internal complaints process as well as an external, independent agency that can handle complaints about the operation of the scheme.

The draft report from the Productivity Commission inquiry was released in February 2011, and proposed a National Disability

Insurance Scheme (NDIS) and a National Injury Insurance Scheme. We made a further submission in response to the draft report, noting significant strengths in the proposed model for an NDIS and associated National Disability Insurance Agency (NDIA). These strengths included:

- | a clear focus on supports being tailored to, and driven by, the person with a disability
- | simple and accessible means for people with disabilities and their families to find information and to access services and supports
- | consistent and portable support through a national disability system and national standards
- | maintaining support across key life stages, including the option for people with disabilities to maintain NDIS-funded supports after pension age.

Our comments on the draft report focused on the need to ensure that people with a mental illness are not excluded from NDIS-funded services and supports, and reiterated our views about the importance of having a rigorous complaints and appeals process. Given that the decisions of the NDIA are likely to have significant consequences for people with disabilities and their families, all efforts should be made to ensure that the NDIS complaints and appeals mechanisms are robust, transparent and procedurally fair.

Meeting with Disability Commissioners

In May 2011, we attended the inaugural meeting of Disability Commissioners from across Australia. These meetings provide the opportunity to exchange information about the key issues in each jurisdiction and discuss potential avenues for systemic work on a national level. The first meeting, held at the Office of the Disability Commissioner in Victoria, included discussions on proposed systems for recording disability complaints information across services.

We are currently exploring options for developing a system for capturing all complaints across disability services in NSW, including those that are handled internally by services. Access to information about the number and type of complaints services received and how they were resolved would enable sector-wide analysis and reporting of complaint issues and complaint-handling practice. This year, we will meet with the Office of the Disability Services Commissioner in Victoria to examine their annual complaints reporting tool, and with relevant stakeholders to inform our work in this area.

We are also having discussions with the other Disability Commissioners about the possibility of a national system for capturing complaints about disability services. This will be a key topic on the agenda when we host the next Disability Commissioners meeting in early November 2011.

Official community visitors

The Ombudsman is responsible for monitoring and administering the official community visitor (OCV) scheme, which has been operating for 16 years. OCVs are independent statutory appointees that help to ensure people living in residential care in NSW receive the highest standard of care possible. They are appointed by the Minister for Community Services and the Minister for Disability Services for a period of up to six years. There are currently 31 OCVs and approximately 1,550 visitable services across NSW.

What do OCVs do?

OCVs visit residents who live in services funded, licensed or authorised by either Community Services or Ageing, Disability and Home Care (ADHC). This includes services for people with disabilities, children and young people in out-of-home care (including those with disabilities), and people living in licensed boarding houses.

On their regular visits to services, OCVs:

- | observe the standard and adequacy of care being provided
- | talk to residents, staff and management
- | help to resolve any grievances and concerns residents may have
- | provide information and assistance about advocacy.

If OCVs are unable to resolve an issue or the issue is a serious one, they may decide to refer their concerns to the Ombudsman or the relevant Minister.

Administering the scheme

We administer the OCV scheme, set visit priorities and provide support to the OCVs. For example we:

- | monitor the operation of the scheme
- | recruit, induct and train OCVs
- | support OCVs at meetings with services and agencies – including conciliations aimed at resolving complaints between service providers and residents
- | provide administrative support, including help with travel and accommodation bookings
- | meet and consult with OCVs about the operation of the scheme.

Streamlining day-to-day work

On 1 July 2010, OCV Online – the scheme's electronic reporting and claims database – was rolled out. This new online database replaced a paper-based reporting system and complicated claiming requirements. The database has now been operating successfully for 12 months. The transition to the new OCV Online system progressed smoothly and OCVs have expressed their appreciation about how it has helped to streamline their day-to-day work.

OCV Online benchmarks service issues identified by OCVs against the Disability Service Standards and the Children's Guardian's out-of-home care (OOHC) standards and accreditation framework. Each time an OCV visits a service, they write a report raising issues of concern or providing positive feedback. This visit report is provided directly to the service provider via email through the OCV

Online system. Statistics are gathered on each service provider and these help to inform the systemic and complaint work of the Ombudsman.

Appointing new OCVs

Thirteen new OCVs were appointed this year. The new OCVs are drawn from areas throughout the state and visit services across all regions and sectors. They come from a variety of professional backgrounds and are recruited based on their negotiation and resolution skills and with their experience in the relevant sectors – such as out-of-home care (OOHC), disability-supported accommodation and licensed boarding houses.

Working together

In 2010, the Ombudsman, OCVs and the Office of the Children's Guardian negotiated a memorandum of understanding (MOU). This MOU sets out how we will work together to promote the best interests of children and young people in statutory/supported residential OOHC services. It aims to ensure that relevant information about these services is shared between the Ombudsman, OCVs and the Children's Guardian.

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* was amended in January 2010 to support the MOU and enable OCVs to share information about residential OOHC services with the Children's Guardian.

Providing training

We also coordinate an annual conference for OCVs. The theme of this year's conference was substitute decision-making. The conference was opened by the Minister for Disability Services and addressed by key sector agencies discussing current issues and initiatives affecting residents of visitable services. We also organised and conducted complaint workshops and training on developing skills as a mentor.

Issues raised by OCVs

In 2010-2011 the budget for the OCV scheme was \$732,000. This supported 31 OCVs to go to 1,447 services, conducting visits to 7,494 residents. OCVs provided 5,927 hours of service to residents.

During 2010-2011, OCVs identified 1,907 issues of which 926 were finalised (48.5%). Services resolved 840 (91%) of the finalised issues, with the assistance and oversight of OCVs.

OCVs continue to monitor services' actions relating to 981 ongoing issues.

Some of the most common issues identified by OCVs this year, in order of frequency, related to:

- | individual, health care and behaviour management plans and strategies
- | the cleanliness, maintenance and suitability of premises, fittings and facilities
- | access to health assessments, screening, specialists and reviews.

Figure 53: Outcome of issues identified by official community visitors in 2010–2011*

Services	Total No. of issues raised	Finalised issues		Ongoing issues	
		No.	%	No.	%
Boarding houses	55	28	51	27	49
Out-of-home care	398	205	52	193	48
People with disabilities	1,454	693	48	761	52
Total	1,907	926	(49)	981	(51)

Figure 54: Outcome of finalised issues by official community visitors in 2010–2011*

Services	Finalised issues resolved		Finalised issues unresolved	
	No.	%	No.	%
Boarding houses	19	68	9	32
Out-of-home care	169	82	36	18
People with disabilities	652	94	41	6
Total	840	(91)	86	(9)

Figure 55: Visits by official community visitors in 2010–2011*

Service type	Services	Residents	Visit hours
Boarding houses	32	766	389
Out-of-home care	215	487	1,117
People with disabilities	1,200	6,241	4,421
Total	1,447	7,494	5,927

* The new OCV Online data system was implemented on 1 July 2010. As a result, reports about OCV activities, visits and issues will differ from previous annual reports.

Outcomes achieved by OCVs

Each year, we report to Parliament on the work of the OCVs and provide further details about the issues and outcomes that have been achieved for residents in care. Case studies 70 and 71 are examples of the outcomes our OCVs have achieved this year.

Case study 70: Problems solved

An OCV visited a woman living in a semi-independent unit next to a group home. She lived with another woman and they undertook their day-to-day activities with minimal support. Staff dropped by a few times a day to see them and help if necessary.

The OCV noticed that the woman seemed sad during her recent visit. The woman told the OCV she was unhappy with many aspects of her life. The OCV reviewed her file and found that the woman had a history of anxiety and depression and on a number of occasions had gone missing from the house. The service had previously helped her see a psychiatrist who prescribed medication.

Staff told the OCV they had significant concerns about the woman's wellbeing and felt that she was at risk of self harm. The OCV immediately contacted the service management and suggested that the woman might need support from specialist mental health workers. She explained her experience of them assisting people with a dual diagnosis of mental illness and disability. Although the manager initially thought the woman had enough support from staff, they agreed to make the referral.

On the next visit, the OCV found the woman had a mental health case worker and was being regularly reviewed by the local mental health team. An emergency plan was in place if she went missing again and staff had strategies to assist her if they noticed her anxiety levels rising. When she spoke to the woman, the OCV found that she was much calmer and happier.

Case study 71: Plans and reviews updated

OCVs have many options for assessing the quality of care for residents, including reviewing their individual plans and health care files. An OCV did this when visiting three male residents in a group home. On a previous visit, the OCV had reported a concern to the service management that the files of the residents were out of date – and had warned that he would follow this up on the next visit.

At the next scheduled visit the files were still not up-to-date and a number of serious health issues had not been followed up. The individual plans for each of the men were more than 12 months out of date. So too, were the behaviour management plans for two of them. Annual medical reviews had not occurred for more than two years. This was significant for the third male as he had a medical condition that required follow up and no action had been taken.

Concerned with the service's lack of action, the OCV reported the issues to management again and said he would review the matter in six weeks. The OCV indicated that if the matter wasn't resolved, it would be raised with the Ombudsman as a complaint.

On the OCV's return six weeks later, all of the behaviour management plans had been reviewed and updated, the medical reviews had been completed, and follow-up appointments organised – including ongoing appointments to monitor the third man's health conditions. Interim individual plans were in place with dates set for completion of the annual plans. The OCV was satisfied that the service had committed to resolving the matter and the residents' health issues were being addressed.