Public administration

An essential part of the work of an Ombudsman is dealing with complaints from members of the public. The public administration division deals with complaints from individuals who feel they have been treated unfairly or unreasonably by state government agencies and local councils.

As well as resolving complaints whenever we can, we work with agencies to bring about improvements to their systems so that the same problems do not keep happening. We travel across the state to visit adult correctional centres to take complaints from inmates, speak with staff to resolve issues and observe conditions and routines.

We use information from complaints to identify and proactively investigate public interest issues. In this way we can benefit a large number of people, often those who are less likely to come forward and complain.

This year we continued our work about the management of asbestos (see page 33) and conducted a major investigation into the operation of Kariong Juvenile Correctional Centre, the only custodial facility for young people in NSW managed and operated by the adult correctional system (see page 37).

We established a specialised unit to carry out our new functions in relation to public interest disclosures. In addition to dealing with protected disclosures and complaints about how disclosures are handled by agencies, we have a role in providing advice, information and training public as well as monitoring and auditing public sector agencies' compliance with the new Public Interest Disclosures Act (see page 47).

Highlights

- In response to our report to Parliament on asbestos the government agreed to appoint a Heads of Asbestos Coordination Authorities, develop a state-wide plan for asbestos, fund a public awareness campaign and provide funding to remediate the Woods Reef asbestos mine. SEE PAGE 33
- Investigated how the NSW Trustee and Guardian makes financial decisions on behalf of vulnerable people. SEE PAGE 35
- Encouraged the provision of better and more accessible information for parents with children at school, TAFE students, young people using legal aid, and people involved in motor vehicle accidents in NSW. SEE PAGES 31, 34
- Conducted an investigation into the behaviour management program at Kariong Juvenile Correctional Centre, and recommended wide-ranging changes to improve the management and evaluation of the program. SEE PAGE 37
- Monitored how inmates were disciplined at a range of centres, and negotiated a range of successful individual outcomes as well as improvements to overall policies and procedures. SEE PAGE 38
- Achieved a number of positive outcomes for people who complained about delays in councils investigating and taking action about their complaints. SEE PAGE 43
- Produced model internal reporting policies for state government agencies and local councils, and five practice notes to help agencies implement the new PID Act. SEE PAGE 48

In this Section

Departments and authorities

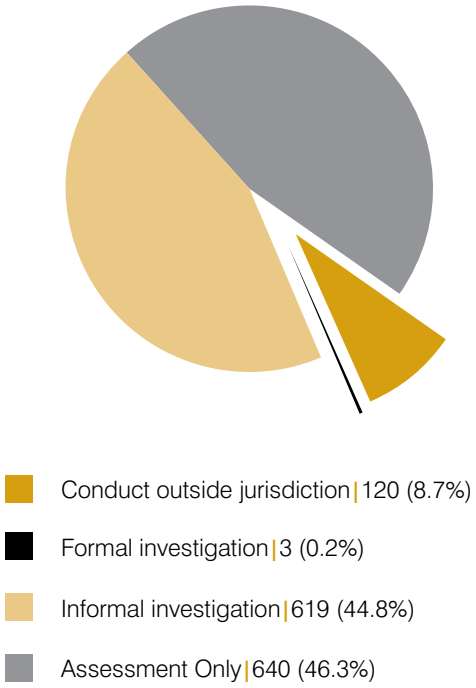
Complaint trends and outcomes

This year we were contacted on over 4,200 occasions by people with concerns about NSW departments and authorities, other than complaints concerning police, community services, councils, corrections and Freedom of Information, 1,381 complaints were made in writing (which we call formal complaints) and 2,903 were made over the telephone or in person (which we call informal complaints) – see figure 21. We conducted 619 preliminary or informal investigations and three formal investigations that involved using the Ombudsman's coercive investigation powers – see figure 20.

Disappointingly, the most common issue complained about was customer service. Over 17% of the complaints we received were primarily about poor customer service – see figure 22. With the new state government's focus on improved customer service across the public sector, we trust there will be a reduction in this figure in the coming year.

In 2009-2010, we reviewed and changed our internal arrangements for handling complaints about human services agencies – Housing, Health and Juvenile Justice. Previously complaints about Housing NSW and Health were included in our complaint figures for departments and authorities. From this year, we will report separately about complaints for these two agencies – see figure 24. Complaints about Juvenile Justice are reported in the human services section – see page 73.

Figure 20: Formal complaints finalised



Current investigations at 30 June 2011	No.
Under preliminary or informal investigation	74
Under formal investigation	3
Total	**77**

Figure 21: Formal and informal matters received and finalised

Matters	06/07	07/08	08/09	09/10	10/11
Formal received	1,158	1,348	1,349	1,438	1,381
Formal finalised	1,167	1,354	1,310	1,414	1,382
Informal dealt with	3,465	3,962	3,949	3,777	2,903

* This figure does not include complaints about public sector agencies that fall into the categories of police, community services, local government, corrections, human services or FOI.

Figure 22: What people complained about

This figure shows the complaints we received in 2010–2011 about NSW public sector agencies broken down by the primary issue in each complainant. Please note that while each complaint may contain more than one issue, this table only shows the primary issue.

Issue	Formal	Informal	Total
Approvals	38	149	187
Charges/fees	117	439	556
Child abuse-related	0	2	2
Complaint-handling	205	244	449
Contractual issues	24	43	67
Correspondence	15	36	51
Costs/charges	9	35	44
Customer service	198	543	741
Enforcement	59	87	146
Hardship	7	15	22
Information	71	173	244
Management	72	47	119
Misconduct	36	43	79
Natural justice	19	40	59
Issue outside our jurisdiction	48	195	243
Nominations and third party	7	11	18
Object to decision	195	446	641
Object to decision/ application forms	129	136	265
Other administrative issue	31	115	146
Policy/law	95	96	191
Records	6	8	14
Total	**1,381**	**2,903**	**4,284**

Figure 23: Performance indicators

2010-2011 criteria	Target	Result
Percentage of complaints assessed within two days	90	98
Average time taken to finalise complaints (not including complaints about FOI)	7 weeks	5 weeks
Complaints resolved by providing advice or through constructive action by the public sector agency (%)	65	69
Recommendations or suggestions for changes to law, policy or procedures in formal investigation reports (%)	90	100
Recommendations made in investigation reports that were implemented by public sector departments and authorities (%)	80	83

NB: These statistics include complaints about departments and authorities, corrections, local government and FOI.

Helping to improve performance

As well as resolving individual complaints, we help departments and authorities improve how they do their work. Wherever possible, we try to identify changes that will help an agency improve its service and avoid the same problems occurring again. This could involve the agency reviewing and changing a policy or procedure, providing training to staff, or improving their communication with members of the public – case studies 1 – 4 illustrate this.

Case study 1: A problem with noise

We received a complaint from a resident who lived next to a Sydney Water pumping station. They alleged the former Department of Environment, Climate Change and Water (now the Office of Environment and Heritage or OEH) had not dealt appropriately with their complaint against Sydney Water in a dispute about which location at the complainant's property was most affected by noise from the pumping station. OEH's industrial noise policy provides guidelines for measuring noise from industrial activities and determining the most affected point. After reviewing the complaint we determined that the policy was ambiguous on where noise impacts should be measured and how disputes could be resolved if there was a disagreement between the noise generator and the affected party.

We wrote to OEH suggesting they review whether their current procedures were adequate and in keeping with industry practice, and take steps to amend their policy if appropriate. We also suggested they consider whether dispute resolution mechanisms should be included in the policy and what the role of OEH should be in resolving any disputes. OEH advised that disputes of this nature are rare but agreed to review their policy, taking our concerns into account.

Case study 2: Better information for students

A student complained about the delay in receiving a certificate for a permaculture course she had completed. The course was auspiced by TAFE. She also raised concerns about the way the course was conducted, including the treatment of students by teachers and a lack of awareness of the complaint-handling process.

TAFE acknowledged there was a need to improve communication with students. They said they would send a survey to students each semester, and make sure that each student was given a TAFE student guide at the beginning of their course outlining how to make suggestions and complaints.

Case study 3: Who is liable for costs?

As a result of a complaint to us, the Roads & Traffic Authority (RTA) reviewed and rewrote their policy on determining liability for costs resulting from motor vehicle accidents – such as damage to RTA property, traffic control and clean-up costs.

A father had objected to the RTA's decision that his son was liable for the costs of an oil spill, but was given confusing advice about how to dispute liability. He was also made to submit a formal application for access to the information that the RTA had relied on as evidence of liability. When he finally received this information, he found it contained no evidence his son was liable for the costs.

Our inquiries highlighted the need for the RTA to review their processes for issuing invoices and recovering costs relating to accidents. They resolved the particular complaint and have significantly changed their procedures. People are now given clear advice about how to dispute liability when they receive an invoice for costs, and the RTA has developed internal procedures to guide staff when deciding if there is sufficient evidence to establish liability.

Case study 4: Paying school fees

We received a complaint that alerted us to possible problems with information given to parents about voluntary fees collected by schools. Contrary to Department of Education and Communities policy, we learnt that a school was invoicing parents and carers but not telling them that the fees were voluntary. A parent had complained to the Director General, but after receiving an inadequate response she contacted our office. Although the problem had been brought to the attention of the school, they were going to wait until the next school year to give out the correct information. After our intervention, the school was directed to put the correct information into a newsletter as soon as possible.

We decided to look at what other schools did about school fees and found many other examples of schools giving incorrect or confusing information about voluntary contributions and subject fees.

We raised our concerns with the department who told us they received very few complaints about this issue. Given that we found many cases where schools were not following the correct policy, we did not think that the number of complaints could be used as a measure of schools complying with the policy. The department agreed to our suggestions about including the policy about voluntary contributions as a standard item on individual school websites and reminding regional directors and principals of the voluntary nature of contributions.

Housing issues

In last year's annual report we discussed the expansion of the community housing sector under funding from the Commonwealth Government. Our office does not have jurisdiction to handle complaints about non-government community housing providers. The Registrar of Community Housing, appointed in 2009, has a regulatory responsibility for community housing providers. We regularly liaise with the Registrar and with the Community Housing Division (CHD) of Housing NSW to coordinate our respective responsibilities for complaints about public and community housing.

Helping people with a mental illness access and sustain housing

We have been monitoring the progress by agencies in implementing the recommendations we made in our special report to Parliament in 2009 about the *Joint Guarantee of Service (JGOS) for people with mental health problems and disorders living in Aboriginal, community and public housing.*

This year we asked Housing NSW about their progress with developing the new Housing and Mental Health Agreement – this agreement is intended to replace the JGOS and address the recommendations of our report. In response to concerns raised with us by non-government organisations in the homelessness and mental health sectors, we emphasised to Housing NSW the importance of communicating with these organisations about the steps taken to develop the agreement to date and consulting with them about future plans. We suggested that Housing NSW arrange to meet with the relevant peak bodies as soon as possible.

In December 2010, Housing NSW responded by giving us their schedule for planned consultations. In March 2011, they also gave us a draft copy of the Housing and Mental Health Agreement. We recommended that the draft be revised to have a stronger focus on governance arrangements – including how the implementation of the agreement will be demonstrated and monitored. We have since provided more detailed feedback on a later draft, and we understand that the agreement will soon be finalised. We will continue to monitor progress through our regular liaison meetings with Housing NSW.

Resolving complaints from public housing tenants

In 2010-2011, we finalised 309 formal complaints from or on behalf of public housing tenants – up by 39% from 2009-2010 (223 formal complaints).

The complaints we received were primarily about:

- delays in processing and making decisions about applications for public housing, particularly applications for priority or emergency housing
- arrangements for and delays in providing housing maintenance and repair services
- disputes about rents and utility fees
- customer service and complaint-handling.

This year we conducted preliminary or informal investigations into 60% of the formal complaints we received. We resolved or made suggestions for improved services in 74% of cases. Most of the remaining complaints were finalised by referring tenants to Housing NSW so they had an opportunity to resolve the complaint directly.

We regularly meet with representatives from Housing NSW to discuss issues arising from complaints, and their plans for addressing these issues and improving their frontline complaint-handling.

Figure 24: What people complained about

This figure shows the complaints we received in 2010–2011 about Housing NSW and Health. Please note that while each complaint may contain more than one issue, this table only shows the primary issue. Note from this year, we are reporting complaints for these separately.

Issue	Formal	Informal	Total
Approvals	63	125	**188**
Charges/fees	28	61	**89**
Complaint-handling	35	83	**118**
Contractual issues	72	184	**256**
Customer service	74	340	**414**
Enforcement	4	16	**20**
Information	16	68	**84**
Management	7	20	**27**
Misconduct	6	14	**20**
Natural justice	2	12	**14**
Issue outside our jurisdiction	23	58	**81**
Object to decision	37	178	**215**
Other	16	48	**64**
Policy/law	4	19	**23**
Property	1	1	**2**
Classification	1	0	**1**
Records/administration	4	1	**5**
Total	**393**	**1,228**	**1,621**

Case study 5: A positive outcome in the end

The mother of a 15 year old disabled boy and a seven year old girl complained about a delay of more than 12 months in Housing NSW's assessment of her application for housing. The woman explained that she had left her previous home because of domestic violence. She and her children initially lived with her parents, but as this was no longer an option they had been living in a succession of hotels, motels and caravan parks. This arrangement had been going on for nearly 13 months.

We contacted Housing NSW and they advised us that there was a high demand for housing in the area where the complainant lived, and her application was one of a large number awaiting assessment. At our suggestion, Housing NSW agreed to meet with the woman to discuss her circumstances and options. They subsequently assisted her and her family to obtain supported housing in a location close to the health and other services she needed.

Case study 6: Phone problems solved

After Housing NSW transferred an elderly woman and her husband to a new property, the woman complained that there was a problem with the phone connection. The couple depended on a working phone to access necessary health and medical supports.

Housing NSW referred the woman to the phone provider who charged for a technician to visit the property. The couple could not afford the charge and asked Housing NSW to meet with them to discuss an alternative solution. When Housing NSW did not do so, the woman complained to our office. After we referred the matter to Housing NSW, they quickly arranged for the necessary repairs to be completed with no cost to the couple.

Reforming asbestos management

Our report to Parliament

In November 2010, we tabled our report to Parliament on *Responding to the asbestos problem: The need for significant reform in NSW.* Given the significant problems we found in the way asbestos issues were being handled by government, we recommended that the NSW Government:

- establish and adequately fund an Asbestos Coordination Authority
- introduce an Asbestos Act to facilitate effective measures to appropriately address asbestos issues
- develop a statewide plan for dealing with asbestos and allocate adequate funding to implement it.

We also recommended allocating funding for the remediation of the Woods Reef asbestos mine site near Barraba, developing a comprehensive public awareness program about asbestos for all sections of the community, the Division of Local Government issuing a model asbestos policy to all councils, and introducing vendor disclosure laws to provide mandatory certification of the presence of asbestos in residential buildings.

In August 2011, the Minister for Finance and Services tabled the government response to our report. We welcomed the government's positive response to our recommendations. It was clear that serious consideration had been given to the significant issue of asbestos in our community and the government's proposals are a good first step towards meeting the challenges of dealing effectively with the management of asbestos.

The government supported the findings in the report and in large part has agreed to the recommendations we made. Of the recommendations not accepted, the government put forward alternative measures and will establish a new Heads of Asbestos Coordination Authorities to coordinate the issues we identified.

We will continue to monitor this important issue and the work of the new coordination body to ensure effective and comprehensive reform is undertaken.

Asbestos surveys in NSW schools

We are currently investigating the management of a contract by the Department of Services, Technology and Administration for carrying out asbestos surveys in public schools. We are concerned that certain conditions of the contract may not have been complied with in relation to the qualifications and experience required of the people who did the on-site inspections and that, as a result, the accuracy of asbestos registers in schools may be in doubt. We expect to report on this investigation later this year.

Investigating the release of airborne dust containing asbestos

A complaint we received alleged that a contractor engaged by the RTA to remove materials containing asbestos from a road construction site near a housing estate in Queanbeyan had failed to take appropriate measures to prevent dust and asbestos fibres becoming airborne. We found that there were deficiencies in how the incident was investigated by the relevant government agencies – including a failure to interview workers at the site and other witnesses. We met with WorkCover to discuss our concerns about how they conduct investigations into workplace incidents. They agreed to examine best practice models for investigating workplace OH&S issues and review their policies, practices and procedures in this area.

We will continue to monitor how WorkCover addresses these important issues.

The Woods Reef asbestos mine was a focus of our recent investigation and report to Parliament.

Knowing how and where to complain

As well as having good complaint-handling systems, agencies need to tell members of the public about them. This is particularly important for large, dispersed government departments such as the Department of Education and Communities that has schools and offices all over the state. Parents and carers may not be aware of the structure of government or that the school their child attends is part of a large department. We encourage departments to do all they can to make people aware of how to complain – see case studies 7 and 8.

Agencies should also have mechanisms in place to collect information from complaints to improve their business processes. Complaints can give agencies valuable information about how well policies are being implemented at a local level, if procedures are being complied with across the organisation, and what changes may be needed to fix systemic problems.

Case study 7: Beneficial changes for all parents

A mother of two primary students complained about bullying and that the school did not contact her when one of her sons fractured his wrist. She was not happy with the school's response to her concerns, but she did not know who else to contact. When her husband phoned the regional office of the Department of Education and Communities, the staff member he spoke to told him that he found it hard to believe the allegations about the school. The woman then wrote to the Director General's office but did not get a response, so after six weeks she contacted us.

We were concerned about what happened in this case and that insufficient information may be available to parents about how to make complaints. We found that:

- the department only had a general policy on its website that did not clearly explain the process for school complaints and the role of the regional office
- the individual school did not tell parents how to escalate a complaint
- the phone call to the regional office was not handled appropriately – the staff member did not appear to have dealt with the matter impartially and did not record or act on the complaint
- there was a problem with communication between the Director General's office and the regional office about who should respond.

After speaking with the department, they agreed the information currently available might not be clear to parents and carers and needed to be changed. They updated their complaint guidelines to reflect the different types of complaints the department might receive and what to do. A new system was introduced to stop confusion between the Director General's office and regional offices, and complaint-handling issues were also discussed with Regional Directors.

The complainant was satisfied that her experience had helped to improve the system for all parents.

Case study 8: Making information accessible

A father complained that Legal Aid did not respond to a written complaint by his 13 year old daughter after she was interviewed by an Independent Children's Lawyer (ICL) as part of family court proceedings. Interviews with ICLs are conducted only with the young person – there is no third party present. We made inquiries and found that Legal Aid's complaint-handling policy was not followed in this case. It was not recorded as a complaint and the ICL contacted the young person after receiving the complaint to set up a meeting to discuss her concerns – without having another person present.

As a result of our inquiries, Legal Aid agreed to improve their website to make it clearer on how to make a complaint. They also changed their factsheet to include a new paragraph 'What if you are unhappy with your lawyer?'. The factsheet also has contact details for our office. Legal Aid intends to liaise with us about proposed changes to their website, including providing better information for young people about the complaints process.

Improvements in handling complaints by the Office of Liquor, Gaming and Racing

Complaints about a lack of action on complaints about noise from licensed premises in Sydney and the Newcastle area prompted us to visit the Office of Liquor, Gaming and Racing to review their files and interview staff responsible for dealing with noise disturbance complaints. We were extremely concerned at what we found.

Although we appreciate there have been significant changes to the legislation and to the agency, it appeared there was a lack of guidance to staff about how complaints should be handled – including the circumstances in which conferences would be held, the criteria for deciding when to hold a conference, time frames in which matters should be dealt with, and who the decision-makers were. Record-keeping was poor – with very few file notes of phone calls received or made by staff, emails to and from the agency were not on file, and key decisions were not documented.

The agency responded with commendable frankness. As well as taking action on the complaints, they provided detailed information about the changes being implemented in the agency. These included measures to deal with the backlog of noise disturbance complaints, new administrative procedures and key performance indicators, improvements to record-keeping, and the introduction of a case management system.

At a follow up site visit six months later, we found that considerable improvements had been made. These included:

- significant improvements in record-keeping practices – with well-ordered files, file notes of telephone conversations, and copies of emails and other correspondence on file
- prompt responses to emails and telephone calls
- key decisions being documented with reasons
- timely progress being made on files.

Decision-making at the NSW Trustee and Guardian

The NSW Trustee and Guardian manages the financial estates of people who lack the capacity to manage their own money, so their role is crucial to the wellbeing of a significant number of vulnerable people. This year we started a wide-ranging formal investigation into the standard of their administrative decision-making.

We are aware that the Trustee and Guardian has had a number of organisational challenges over recent years – including a major restructure of the former Office of the Protective Commissioner, relocating from the Sydney CBD to Parramatta, the merger of the Public Trustee and Office of the Protective Commissioner, and inadequate and incompatible IT systems. We appreciate that considerable time and resources have had to be allocated to managing these changes.

Although the Trustee and Guardian has demonstrated a commendable willingness to acknowledge that problems exist, to share information about measures being taken internally, and to accept suggestions about how to address deficiencies, we continue to receive complaints which suggest that administrative processes and procedures are not improving.

We are working collaboratively with them to investigate:

- delays in decision-making
- delays in implementing suggestions from our office that have been agreed to
- lack of compliance by staff with changes when they have been actioned
- failures to identify systemic issues in administrative practices
- failures to respond to correspondence and phone calls.

Managing representations about fines

We have been looking at the administrative arrangements at councils for managing representations about fines. The service level agreements all councils have with the State Debt Recovery Office (SDRO) can result in members of the public having dealings with both the SDRO and their local council when making representations for a fine to be waived. Under these agreements, the SDRO provides administrative services for processing penalty notices issued by councils and for enforcing outstanding fines and penalty notice amounts.

We have invited a number of councils to participate in a project to improve our understanding of how this dual system works in practice – particularly how it affects members of the public making representations. The project involves reviewing a council's policies and procedures for dealing with representations about fines, auditing a number of representations made to that council, and interviewing staff about how they do their work in practice. We anticipate reporting back to councils and the SDRO on our findings later this year.

Are they part of government or not?

As the provision of government services becomes more complex, the relationships between the public, private and non-government sectors can be unclear. Case studies 9 and 10 highlight the issues that can arise and the need to carefully manage these relationships.

Case study 9: Referral service could be unfair

The owner of a plumbing company operating in the Newcastle area complained that Hunter Water had a referral service on their website that directed customers to one particular company which they called their 'partner'. Customers of Hunter Water could call the referral service and be connected with a 'trusted plumber' 24 hours a day.

The complainant thought this referral service and the endorsement of a single plumbing company was likely to dissuade people from using other plumbing companies in the area, such as his own.

Hunter Water told us they had set up the referral service to provide customers with a reliable plumber to contact for assistance, after receiving feedback from customers that they had difficulty locating a good plumber.

It seemed to us that Hunter Water was effectively promoting and advertising the services of a single, privately owned plumbing company in the area. We wrote to them expressing our concerns about the negative effect that this might have on other plumbers in the region. It seemed that the benefit of the referral service to the plumbing company was substantial, including the potential business from the 445 customers that were referred by Hunter Water and 194 referral cards left by Hunter Water in letter boxes.

We also expressed the view that by referring to the company as a 'trusted, licensed plumbing partner' Hunter Water was explicitly endorsing the company.

Hunter Water agreed that they would consider opening up the referral service to other plumbing companies in their upcoming re-evaluation of the scheme.

Case study 10: Monitoring accredited providers

We are currently investigating how Sydney Water accredits and monitors their accredited providers. When land is developed, approval must be obtained from Sydney Water to do work that might affect its assets – such as the sewer line. The developer must get a Sydney Water-accredited provider to perform what is called a 'peg-out' to verify the location of the sewer. The providers are accredited by Sydney Water, but not employed by them. The peg-out can only be done by either Sydney Water or one of its accredited providers.

We received a complaint from a developer who had contracted an accredited provider to perform a 'peg-out.' The provider incorrectly plotted the location of the sewer and, as a result, the builder hit the sewerage pipe. The complainant estimates that the combined cost of the damage to his property and his neighbour's property was around $50,000.

At that time, Sydney Water did not require its providers to have insurance to cover such eventualities so the complainant was unable to recover any money from the provider. Sydney Water also denied any liability for the actions of the provider, so the complainant was unable to recover any of the cost of the damage from them.

Although Sydney Water might not be legally liable for the damage to the property, we felt that they had a responsibility to ensure that accredited providers – doing work that Sydney Water would have performed under other circumstances – were properly trained, monitored and insured, and that developers such as the complainant were not adversely affected by the contracting out of this work. The investigation is ongoing.

Corrections

The Prison Ombudsman

Providing comprehensive oversight of the correctional system requires a balanced approach – a mix of reacting to and trying to resolve the individual complaints we receive and proactively addressing matters that may potentially affect large numbers of inmates.

Our approach includes:

- responding to complaints – small improvements accumulate and add to overall accountability and transparency and help increase the human rights focus of the system. Several individual, even small complaints can lead to inquiries and resolutions that may affect more people, a whole centre or even be implemented system-wide
- conducting proactive inquiries and reviews – using our 'own motion' powers. The issues we look at come from a range of sources, like visits, evaluating complaints, reading reports or other information in the public arena about corrections. We are also able to review and hopefully rectify issues before they lead to complaints.

To help us implement this balanced approach, we have a specialist corrections unit with five staff. They each have a thorough understanding of the operational aspects of the correctional system, as well as experience in working within the unique and complex environment it presents. Our corrections unit is assisted by other Ombudsman staff to provide our extensive program of visits to correctional centres. When large-scale investigations are undertaken, such as the one involving Kariong, they are also able to call on specialist investigators from within our office.

Meeting the challenges

Our staff are available to people involved in the correctional system in a variety of ways – primarily by phone, but also by receiving letters, emails and online complaints and through our visits. Regardless of how we receive an inquiry or complaint, it is fully assessed to check that it is in our jurisdiction, what the person has already done to sort out the problem, and what would be the benefit – to the individual or to the community – if we take some action. This type of assessment is common to all areas of the Ombudsman's work, but in the correctional environment there are further hurdles. If an inmate decides to call us, then our initial assessment must be done within the time constraint of their 10 minute phone call – which becomes only seven minutes by the time it is answered by an investigation officer in our corrections unit or the inquiries team. Although the call to us is free of charge to the inmate – and not monitored by correctional staff – it is a very short period in which to gain a thorough understanding of the issues and decide if we should take any action, or even to just provide advice.

This year we have taken more than 3,000 calls in the corrections area which have involved this initial assessment, as well as many hundreds more in responding to already open complaint cases. We took some kind of investigative action in about 400 of those cases.

The challenges of working in the correctional environment go beyond the short phone calls – and the inability to call an inmate back if you miss their call or have something to discuss with them about their case. There are also the difficulties of sourcing evidence in a closed system, overseeing complaint-handling within a culture that is unique because those being complained about generally are also responsible for every aspect of the complainant's daily life, and the limited opportunities for the complainant to be an equal partner in securing an outcome to their complaint.

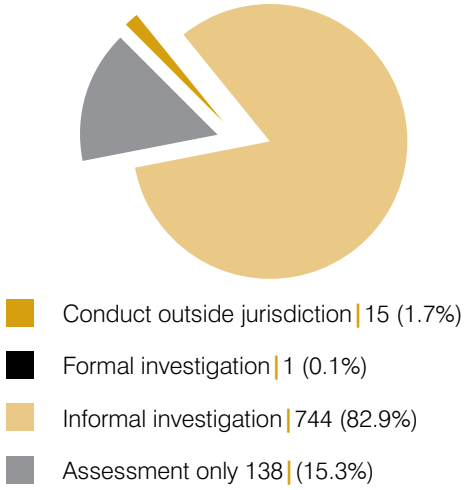
These challenges are one of the reasons our visits to correctional centres are so important. A primary focus of these visits has always been to help the inmates with complaints – providing an inquiry and referral service, but also actually helping them to make a complaint if necessary. Our visits give the inmates an opportunity to fully discuss their concerns and to present any relevant documents – all of which helps us to give them the best advice.

Complaints and trends

While the number of overall contacts received in the corrections area rose by only just over 2%, the number of these which were formal complaints increased by 22%, up from 671 in 2009-2010 to 821 this year (see figure 27). We were able to keep up with this increase, and in fact finalised 24% more complaints this year than we did in the previous year.

The breakdown of issues about which people complained show the largest areas of complaint remained consistent with previous years – being daily routine, access to health services and lost property (see figure 26). These are all endemic issues in correctional systems. While complaints alleging officer misconduct dropped, there were significant increases in those about classification and segregation, and complaints about food rose from 59 to 105. This dissatisfaction with the food is unsurprising when we see the large number of prison-provided meals which are thrown away uneaten by many inmates each time we visit correctional centres.

Figure 25: Formal complaints finalised



Current investigations at 30 June 2011	No.
Under informal investigation	36
Under formal investigation	4
Total	**40**

Figure 26: What people complained about

This figure shows the complaints we received in 2010–2011 about correctional centre concerns, broken down by the primary issue in each complaint. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Formal	Informal	Total
Buy-ups	19	106	125
Case management	17	88	105
Classification	31	179	210
Community programs	1	6	7
Court cells	1	6	7
Daily routine	183	489	672
Day/other leave/works release	15	37	52
Fail to ensure safety	22	55	77
Food and diet	28	77	105
Legal problems	10	57	67
Mail	14	72	86
Medical	49	435	484
Information	15	56	71
Issue outside our jurisdiction	13	41	54
Officer misconduct	74	169	243
Other	37	193	230
Periodic/home detention	1	12	13
Probation/parole	20	123	143
Property	100	313	413
Records/administration	59	119	178
Security	20	61	81
Segregation	30	84	114
Transfers	29	166	195
Unfair discipline	26	129	155
Visits	45	185	230
Work and education	5	92	97
Total	**864**	**3,350**	**4,214**

Figure 27: Formal and informal matters received

Matters	06/07	07/08	08/09	09/10	10/11
Formal					
Correctional centres, CSNSW and GEO	566	779	686	671	821
Justice Health*	69	61	64	53	43
Subtotal	**635**	**840**	**750**	**724**	**864**
Informal					
Correctional centres, CSNSW and GEO	3,010	2,902	2,825	3,096	3,088
Justice Health*	266	241	237	303	262
Subtotal	**3,276**	**3,143**	**3,062**	**3,399**	**3,350**
Total	**3,911**	**3,983**	**3,812**	**4,123**	**4,214**

*Justice Health provides services to correctional centres. For simplicity, all Justice Health matters are reported in this figure.

Issues in corrections

Although we focus on the NSW correctional system, our staff are in regular contact with other offices in Australia and overseas that provide similar roles for their correctional systems. It is often noted – especially in complaint-handling – that there are various issues which are common to correctional systems around the world. Some of these common issues include the:

- vulnerability of certain inmates – such as women, young people, people with disabilities and older inmates – each bringing their own challenges and needs
- use of force and restraints and how inmates are disciplined
- increasing number of inmates who have mental health illnesses
- increasing use of multi-bunk accommodation
- ageing facilities in which inmates are accommodated that no longer meet the needs of a modern correctional environment
- long term segregation/separation of some inmates
- large numbers of Aboriginal people in custody.

We have included several case studies showing how these issues have arisen in our correctional system and what we have tried to do to address them.

We may also become involved if a staff member at a correctional centre complains about 'non-industrial' type issues relating to employment. During the past year we received several complaints from staff about delays by Corrective Services in dealing with complaints that had been made about them. In those cases we did make contact about the delays – not dealing with a complaint in a timely manner is an administrative action (or inaction) and not related directly to the officer's employment. Generally, the matters raised with us were resolved after our inquiries.

Investigating the behaviour management program at Kariong Juvenile Correctional Centre

Kariong Juvenile Correctional Centre is unique in that it is neither a juvenile justice centre nor an adult correctional centre. It is operated by Corrective Services NSW and the inmates are young men aged between 16 and 21 years old. They are all maximum security inmates due to their offence or their poor behaviour – this is why they are placed at this centre rather than a juvenile justice centre.

In last year's annual report, we flagged our concerns about the behaviour management program at Kariong and this year we conducted an 'own motion' investigation to examine those issues. The program determines almost every aspect of an inmate's day-to-day life – from the property they can have in their cells, the number of phone calls they can make, their buy-ups, the length of time they can spend out of their cells and units, their attendance at school and their participation in recreational activities.

Our investigation included an analysis of information provided by Corrective Services about the program, an audit of inmate records to see how the program worked in practice, and interviews with operational and program staff at both Kariong and head office as well as staff from Justice Health.

We found deficiencies with:

- compliance with the requirements of the program
- the adequacy and extent of programs and activities
- the oversight of the program.

The staff at Kariong are managing a number of substantial challenges. Although they accommodate only a small number of adolescent inmates, some of them have significant behavioural issues and others have committed serious offences. There is considerable turnover in the inmate population, with some being on remand and others being sentenced. Some will become eligible to return to a juvenile justice centre or transfer to an adult correctional centre, but others will stay at Kariong for years.

We found that what is happening in practice at Kariong falls short of what is required by the documented program. The lack of any evaluation means there is no assurance that the program – even if it was implemented appropriately – would achieve its objectives. The lack of oversight, management reporting and evaluation means that Corrective Services cannot know how successful or unsuccessful the program is at modifying behaviour. As the program has been in place for over six years with only minor changes, this is of considerable concern.

Corrective Services responded positively to the deficiencies we identified in our investigation. After being notified of our provisional findings, the Commissioner authorised immediate changes to particular aspects of the program – such as limiting the amount of time a newly received inmate can remain on the assessment phase - and a comprehensive review of the entire program. We anticipate working constructively with Corrective Services to monitor the implementation of the further wide-ranging changes, which recognise the age and immaturity of the inmates in the centre, that need to be made.

Inmate discipline

Discipline in a correctional centre is important. Following rules contributes to rehabilitation, and is also an integral part of communal living. The Crimes (Administration of Sentences) Regulation sets out a disciplinary system including types of correctional offences and permitted punishments. This is supported by policies and procedures that guide staff and management in charging and punishing inmates. Last year we wrote of our intention to proactively monitor the disciplining of inmates as there are several areas where we believe the overall disciplinary process can be improved.

Case study 11: Inconsistent decisions

When an inmate at Wellington Correctional Centre refused to 'pick up rubbish' he was charged with a correctional offence for disobeying a direction. The charge was adjudicated by a principal officer of the centre who made a recommendation it be dismissed, but did not record his reasons. When the general manager of the centre reviewed the recommendation, he found the inmate guilty and punished him with 28 days loss of amenities. Again, there were no details about why the general manager had made this decision – except that he had been in the area when the inmate was told to pick up the rubbish. However, he had not provided any evidence of this to the original misconduct hearing. Corrective Services's operations procedures did not say what should happen if the general manager – who becomes the final decision-maker in the process – is involved in the offence the inmate is charged with. We suggested to Corrective Services this should be clarified. The Commissioner accepted this suggestion and issued further procedural information as a result.

Case study 12: A fair hearing

The disciplinary process is designed to include procedural fairness, so when an inmate is told the initial adjudicator is recommending they be found guilty they can ask to put their case to the general manager. An inmate at the Mid North Coast Correctional Centre complained when he was not given the opportunity to do this. When we made inquiries, the general manager told us he thought it was at his discretion whether or not to hear the inmate's case. After reviewing the procedures he contacted us again and agreed the inmate should be heard – and he was.

A problem associated with inmate discipline – and about which we have had many complaints over the years – seems to have finally been addressed by Corrective Services. A standard form of punishment is to remove an inmate's amenities or privileges - such as a television - but when they share a cell this also punishes their cellmate. The Official Visitors also saw this as a serious problem and when they raised it at their conference in June 2011, the Commissioner finally issued a direction to all staff that inmate punishments should not affect cellmates. We will be looking to ensure this direction is consistently implemented across all centres in the coming year.

Extra bunks in cells

Over the past few years we have been involved in extensive and ongoing inquiries with both Corrective Services and Justice Health about the health issues arising from introducing additional beds or bunks into cells in some of the more recently built correctional centres that were not designed for so many inmates. We made specific inquiries about Wellington and Mid North Coast Correctional Centres. After inspections and liaison between Corrective Services and Justice Health, we received advice in March 2011 that the additional bunks introduced retrospectively into those centres would no longer be used. This was because the numbers in the correctional system had dropped and a new centre at Nowra had opened, relieving some of the pressure.

This was a positive outcome. However we decided to monitor the physical removal of these beds because we were concerned that, despite the current assurances, any rapid increase in the inmate population would see them returned to use again. Before this could happen, we visited Wellington Correctional Centre and were once again confronted with inmates complaining of being in the affected cells with all bunks being used. This was quickly resolved with local management at the time of our visit, but it showed there was cause for our original concerns. We have recently written to the Commissioner once again about this matter and have now included similar issues in relation to Area 5 at Parklea Correctional Centre.

The South Coast Correctional Centre which opened this year at Nowra does have cells containing three bunks cells, but Corrective Services's request to NSW Health for permission to breach the Public Health Regulation to allow this to happen within the cells as they were originally designed was rejected during construction so additional space was added to the affected cells. This does give more space to the inmates who must use the cells.

Regardless of any extra space allocated to a cell, or exemptions provided by NSW Health, there are still significant privacy and decency issues when two or three inmates are forced to use a toilet and shower within the one cell, as well as eat and sleep there. The reduction in the inmate population during 2010 – which the Commissioner

noted in July 2011 had left many hundreds of 'empty beds' in the system – should mean these extra bunks are no longer needed, and could be removed.

Visiting correctional centres

Simply being in a correctional centre is an important part of our oversight. Our regular visits to centres provide opportunities for us to receive and resolve complaints and pass on advice. Visits also help us to keep up-to-date with what is happening in the centres, the people who work there, and how issues are managed. We talk with staff and managers and try to resolve any problems that are raised with us on the visit or that we have received in the office. These 'problems' range from issues about the very basic necessities, such as not having a pillow or enough clean clothes, to wider issues affecting the whole correctional system.

Case study 13: A simple request

An inmate at the Metropolitan Remand & Reception Centre (MRRC) told us he had not been given a pillow, so we arranged for him to receive one before we left the centre.

When we visited Bathurst Correctional Centre in May, six inmates came to complain they had no pillows. Again we raised this with local management who later told us stores had been ordered and pillows distributed to all inmates who needed them.

To anyone not in custody it is difficult to understand how someone could not be able to resolve a complaint themselves about not having a pillow. Correctional centres are funny places where even pillows can be a commodity, and of course sometimes people just do not take care of them. Often the problem occurs because the ordering system has not worked, because no one cared enough to put in the order, or there simply was not enough money in the budget at that time to order more linen.

Case study 14: Laundry facilities

On a visit to Parramatta Correctional Centre in March last year we found out that inmate clothing was only being laundered once a week. When we looked at the Corrective Services policy about clothes issued to inmates, we realised that having three t-shirts with laundry being done only once a week was not very hygienic. We also had access to a report Justice Health had prepared covering issues such as the laundering of inmate clothing and linen. We therefore suggested to Corrective Services that they review both the amount of clothing issued to each inmate and how frequently it is laundered. During the year we received regular advice from Corrective Services about their actions to follow up on our suggestions. Additional clothing is now being issued to inmates when they first come into custody and laundry facilities have been improved – including providing extra machines and laundry days at most centres.

Case study 15: Poor procedures

At John Morony Correctional Centre an inmate complained that when he was strip searched the officers had made him firstly lift his penis for inspection of his groin area and then use his fingers to hold his mouth open. He was rightly concerned that performing the search in that order was unhygienic and undignified. We agreed with him and raised it with the general manager who ensured all staff were made aware of the correct operational procedure.

Grafton Correctional Centre

In our annual reports we have sometimes noted concerns about the standard of accommodation at some correctional centres, such as Grafton. Parts of Grafton Correctional Centre are very old (it was originally built in 1893), so inmates are often living in conditions that are far from ideal. However, Corrective Services needs to use these old centres to be able to provide inmate accommodation across the entire state. In responding to our earlier concerns about the minimum security 'dormitory' conditions at Grafton, the Commissioner noted this was the only way sufficient numbers of beds could be provided for inmates from the region.

When we went to Grafton in February this year, a few inmates complained about the cells in the maximum security wing. Our first impression of the wing was the lack of air. In February it is hot and humid on the north coast and, in a not very effective attempt to address this, staff had provided an 'industrial' sized fan in the middle of the wing and the inmates had strategically placed cardboard in the windows of their cell door to try to direct some breeze into their cells. Our greater concern was when we went into the cells and saw the bunks, and noted the number of hanging points they provided. We are aware there were plans several years ago to build a new correctional centre in the Grafton area, but there has been no recent further news about those plans. We wrote and asked the Commissioner what action he could take to make the cells safer and he told us the bunks are considered to be suitable for use, and in fact are found in several other correctional centres. The Commissioner outlined strategies staff employ to monitor and prevent attempts at self-harm which we acknowledge. However we are still concerned the current beds provide a mechanism for self harm for those inmates who are not subject to special management or extra watches – and make a spontaneous decision when something goes wrong or they get bad news.

All deaths are not preventable but all steps should be taken to prevent those that can be averted. We will continue to pursue this issue with the Commissioner.

Wearing identification badges

Corrective Services staff are supposed to wear a badge which identifies them while they are on duty. The Commissioner has issued several memos to all staff reminding them of this, as it is both an accountability and customer service component of their staff conduct and ethics guide. As we visit correctional centres across the state, we have noticed a very low compliance rate – specifically among non-commissioned officers – so we have been communicating with the Commissioner about how this can be improved.

Wearing a form of personal identification is of great importance in maintaining accountability for the actions taken by staff. When most people are wearing a uniform, it is very difficult for a complaint to be followed up if the only identification is that it was 'the person with black hair who was wearing a blue uniform'. We have suggested to Corrective Services various ways of resolving this issue, such as using combinations of letters and numbers and will continue to discuss this with them until there is a resolution.

Safety, dignity and humanity

Much is lost by a person who goes into full-time custody – many rights and many more privileges. Each inmate however is a person and is entitled to be safe, have due dignity and be treated with humanity. These are fundamental to our society. Sometimes, along with the rights and privileges, these 'fundamentals' get overlooked. This can particularly be the case with inmates from especially

vulnerable groups such as those with disabilities, mental health illnesses, and those who are significantly older or younger than the average inmate. Often these are the types of issues that inmates will contact us about – and which we try to help them resolve.

Case study 16: Setting up a phone account

When an inmate arrives at a correctional centre it can take a couple of days for their phone account to be set up. One man who met us at the MRRC had both an identified intellectual disability and a physical disability. He told us he had been waiting for a long time to have his phone activated. He was sure he had given the right information to the officers about his phone numbers and that his mum had put money into his account. We asked the Area Manager about this and when he checked he found that although the account had been set up it had also been deactivated in error. The problem was immediately resolved.

Case study 17: Fearful of a hair cut

The Metropolitan Special Programs Centre (MSPC) includes several wings designated as providing additional support for inmates who need assistance because of either an intellectual or physical disability. One of the men from this area called us (assisted by his wing delegate) because an officer had allegedly told him if he did not remove his 'rats tail' hairstyle within 24 hours he would be held down by 'the squad' while it was cut off. We called the centre and the Manager of Security told us he had previously told staff to advise inmates not to have the rat's tail hairstyle because another inmate suffered serious head injuries when it was used against him in a fight. The manager spoke to the staff member in the area and made sure the officer returned and told the inmate he would not be held down and have his hair forcibly cut. The inmate called us later to say the officer had spoken with him again and apologised.

Many inmates must also deal with mental health problems, ranging from general anxiety about being in custody to significant mental health illnesses. This provides increasing challenges to both correctional and Justice Health staff in managing their behaviours and their illness needs. Some inmates have both mental health issues and intellectual and physical disabilities.

Case study 18: Not understanding why

If an inmate threatens either the good order of a correctional centre or the safety of officers they may be placed into administrative segregation, removing them from association with other inmates. A man who called us said he was in segregation and he didn't know why. He said he had a brain injury and epilepsy. We agreed to find out what had happened and ensure someone spoke with him. The officer we spoke with explained the inmate had sent letters to his mum threatening to kill correctional officers. Staff were aware the inmate had previously been identified as at risk of self harm, and although the threats were seen as childish they still had to ensure the safety of their officers. The Area Manager explained the inmate had been told what was happening to him, but agreed to speak with him again about why he was segregated – he also indicated this segregation would finish in the coming days.

Case study 19: Problems on 'watch'

When inmates are at risk of self-harm they are jointly managed by corrections and Justice Health staff. This may include being placed in a cell on their own with little access to their property. They will also be checked at regular intervals or even watched continually by CCTV. An inmate at Grafton had returned to custody under stressful circumstances and asked for a sleeping tablet, so he was placed on 'watch'. He complained to us this also meant he was under bright light 24 hours a day and had been told this would last for 14 days when he would be reviewed again. When we spoke with Justice Health they advised the inmate was reviewed each day and it had been recommended he now be located with another inmate as a form of safe housing. The need for the light to be on was a decision made by Corrective Services to ensure he could be easily observed at all times.

Many women who come into custody are also the primary caregivers for their children. Although there are some limited programs and locations that allow greater levels of contact and interaction between mothers and children, most have to rely on phone calls to keep in touch.

Case study 20: Keeping in touch

A woman at Silverwater Women's Correctional Centre had difficulty making phone contact with her family and her housing provider and needed to sort out an urgent problem. She had asked for assistance from staff at the centre and when they were unable to help she contacted us. We immediately advised her she could call the housing provider via a freecall number on her inmate phone, in a similar way to how she had called us. We also called the Manager of Security who told us there had been some issues with the phones, but the problem seemed to be the woman didn't have enough money in her account to call her family. The manager agreed if this was the case he would make sure staff made a 'welfare' call available to her, so she could sort out the urgent family problem.

Inmates are vulnerable for the same reasons as the rest of the community – including being the victims of crime while they are in custody. It is not possible for them to pick their cellmate and so it is vitally important those who do allocate cellmates have all the relevant information to make a sound decision.

Case study 21: Sharing a cell

A 19 year old inmate was sexually assaulted by another inmate. The perpetrator was charged and convicted of the offence. At the time he committed this offence, he was in custody for committing a similar assault on another cellmate. Our inquiries indicated that there were not sufficient checks and alerts done before decisions were made about who should share a cell. We suggested some ways computer and other checks could be improved and Corrective Services NSW agreed to make changes.

Dignity and humanity also includes having access to basic needs, such as enough to eat.

Case study 22: Improving food supplies

Phone contact from an inmate late in the day often relates to a complaint about food. A call from Junee was made by one inmate, but several more could be heard in the background supporting what he was saying. There were 37 inmates in the pod and they were claiming they had not received enough food for everyone that night. They described the meal and we agreed it didn't sound reasonable. Pod staff were unable to arrange for any additional food to be brought from the kitchen. After we contacted the general manager, he had the food checked the following evening after it left the kitchen and found it lacking. He outlined to us various steps he then put in place for improving the overall quantity and quality control of inmate food at the centre.

During the year we have also responded to complaints about the Commissioner's decision to bar all inmates from having photos taken to be sent to their families – because one inmate's photo had appeared on Facebook. For those who are serving a long sentence, and especially for women with children the total ban was a harsh reaction. We wrote to the Commissioner about this issue as photographs are an important way of maintaining an inmate's relationship with their family, increasing the likelihood of a positive return to their community. We were recently advised the Commissioner had reviewed this decision and would allow medium and minimum security inmates to have photos sent to their families. Our concern is that those inmates who have a maximum security rating are the ones who will usually spend longer periods in custody, and whose relationships are generally subject to greater strains than others.

In the High Risk Management Correctional Centre (HRMCC) the property an inmate can have in their cell is controlled and limited. An inmate asked for access to his 'legal documents' including the brief of evidence and judgement so he could begin work on an appeal. His request was denied and he was told only inmates who already had an appeal underway could have such documents. It was difficult to see how the inmate could decide about proceeding with an appeal without reading these documents and we also felt the policy may be improperly impeding their legal rights. Our inquiries prompted Corrective Services to seek advice from their legal branch and subsequently to send out a direction advising all staff that inmates are to be given access to their legal documents even if they do not have a current appeal.

Another inmate in the HRMCC complained about the new high security inmate transport vehicle used by Corrective Services to take him to court. We made arrangements with the Inmate Transport area to see these new vehicles, as well as a sample of all other types of vehicles used to move inmates. After inspecting the van complained about, we understood why the inmate might be uncomfortable as the area in which they sit does not allow a great range of movement. However Corrective Services provided certification to show that the vans comply with all relevant requirements. We were also told the entire fleet of trucks used to move inmates around the state will have responsive intercom systems installed by 2013. This will improve inmate safety if they become ill or are assaulted by other inmates.

Community offender services

The government and the community is increasingly looking for ways to divert offenders from full-time custody, as well as help those who are released to not return. Community Offender Services is the area of Corrective Services with responsibility for this work.

We received a complaint from a woman who was concerned she had not been given proper information about the man she had been living with, who had subsequently abused her daughter. This raised issues about how decisions had been made about the woman and her children – and the offender – by a variety of agencies, including Community Offender Services, Community Services and the NSW Police Force. The inquiries we made covered all of these agencies and the outcomes are discussed further in the Stakeholder engagement chapter at page 95. To read about the circumstances of this matter see page 68 in the Children and young people chapter.

Case study 23: Problems with property

Community Offender Services Programs (COSPs) centres are a relatively recent initiative of Corrective Services. These centres are available to help offenders who are leaving custody by providing short-term accommodation and support in adjusting to community life and any court or parole requirements. After we were contacted by some offenders who had been returned to custody after living in different COSPs, we found some deficiencies in the policy and procedures relating to their property and what should be done with it when they left suddenly. Corrective Services responded positively and the policy and procedures were clarified and reissued to ensure all property held by residents in the COSP complied initially with what they are allowed to have, was accurately recorded as in their possession, and then properly dispersed if that becomes necessary.

Aboriginal inmates at Goulburn

For several years Aboriginal inmates at Goulburn have complained they are not treated or accommodated in the same way as other inmates at that centre. Certain changes were made to the management of Aboriginal inmates at Goulburn after a very serious incident in 2002. Inmates at Goulburn are separated into wings and yards depending on their race, so it is possible for treatment of various groups to differ. We have spoken regularly on our visits with management at the centre about the concerns raised with us. For example, Aboriginal inmates are not allowed to have a 'sweeper' from among their own group, they have double security doors, and the windows in the cells are covered – causing a lack of air and encouraging mould and mildew. This year one inmate who complained to us also told us he had made a similar complaint to the Anti-Discrimination Board. We are waiting to hear the outcome of his matter which is now before the Administrative Decisions Tribunal before deciding what future action we may need to take.

Justice Health

Inmates in custody and offenders in court cells receive medical attention and treatment from Justice Health, which is part of NSW Health. Their objective is to provide health care in the correctional system of an equivalent standard to that available in community settings. Resources are limited and there are often problems in retaining sufficient medical and other professional staff to provide the level of services desired. Although most inmates can be triaged relatively quickly by nurses at their correctional centres, there are often long lists of inmates waiting to see a doctor, dentist, optometrist or other specialist provider. This, of course, leads to complaints.

Case study 24: Delays in getting medication

Coming into the correctional system as someone who is prescribed medication in the community does not necessarily mean you will receive that medication straight away. If an inmate can provide details of their community prescribing doctor and contact can be made, Justice Health staff will try to find out details of the prescription and arrange for it to be continued in custody. Sometimes this does not happen because, for example, the medication is not able to be used in a custodial setting. One inmate who called us complained he had not been prescribed his psychotropic medication after 12 days in custody. There are severe side effects when this type of medication is stopped suddenly and the inmate was very aggressive. When we spoke to the Mental Health Nurse at his centre we were told the inmate was unable to be given a prescription from a community-based doctor and so he needed to be seen by a psychiatrist to get a new prescription. There was also a concern he had not in fact been consistently taking his medication for several days before he came into custody. We were told he was on the list to be seen by a psychiatrist, but the list was long – and continues to grow daily because of the increasing number of people coming into custody with mental health needs.

Local government

Investigating and assisting councils

In recent years we have completed a number of significant investigations that have identified serious and systemic administrative failures in councils, and have made formal recommendations to help councils improve their services to the community.

However, the majority of our work with councils is carried out in a largely informal and consultative manner. We believe it is important for us to be able to assist councils – by, for example, giving them strategies for improvement and providing guidance publications – without the need for resource intensive formal investigations.

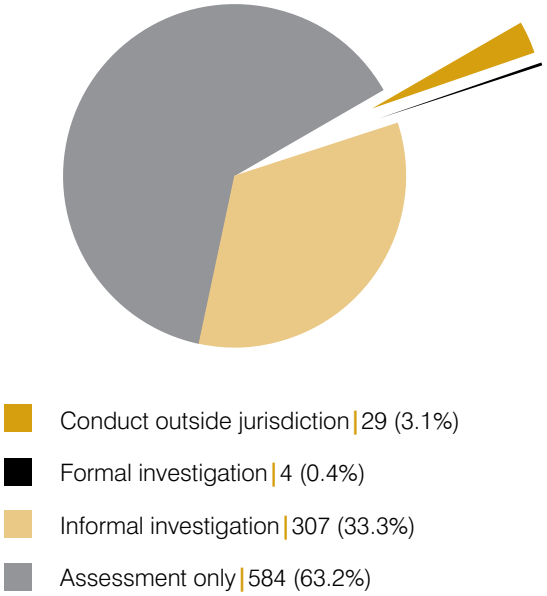
Although complaints about customer service are trending downward, customer service was still the focus of many of the complaints we received about councils this year. We have developed a number of guidelines to help councils improve their administrative practices and we reinforce the benefit of these publications wherever possible. From time to time, we also have to give guidance on the appropriate use of those guidelines if they have been misinterpreted.

Complaint trends and outcomes

There was further increase of 8% in the number of complaints we received about councils this year, on top of the 20% increase last year (see figure 29). This can be partly explained by the increase in complaints about Manly Council after our comprehensive investigation last year. Another substantial source of complaints was Pittwater Council, following a development proposal for a Woolworths store in Newport - 61 complaints compared to 17 last year.

There has been a marked increase in development complaints (53%), accounted for by the Pittwater Council complaints. Complaints about strategic planning also increased from 10 last year to 53 this year, as many councils are reviewing and bringing their statutory planning instruments up to current standards. A pleasing trend is a continuing drop in customer service complaints by 31% (see figure 30).

Figure 28: Formal complaints finalised



Current investigations at 30 June 2011	No.
Under informal investigation	26
Under formal investigation	1
Total	**27**

Figure 29: Formal matters received and finalised and inquiries

Matters	06/07	07/08	08/09	09/10	10/11
Formal received	841	768	702	843	912
Formal finalised	837	788	672	875	924
Inquiries dealt with	1,992	1,965	1,795	1,720	1,979

Figure 30: What people complained about

This figure shows the complaints we received in 2010–2011 about local government, broken down by the primary issue in each complaint. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Formal	Informal	Total
Community services	7	18	**25**
Corporate/customer service	159	454	**613**
Development	142	315	**457**
Enforcement	133	264	**397**
Engineering services	97	153	**250**
Environmental services	79	166	**245**
Management	3	9	**12**
Misconduct	38	96	**134**
Issue outside our jurisdiction	30	36	**66**
Objection to decision	89	176	**265**
Rates, charges and fees	81	196	**277**
Strategic planning	53	19	**72**
Uncategorised	1	77	**78**
Total	**912**	**1,979**	**2,891**

Case study 25: Some progress made

Last year we reported on a major investigation into Manly Council's poor administrative practices, making 24 recommendations for improvement.

Council has now established a Councillors Implementation Working Group to 'monitor and provide feedback to the Ombudsman on the implementation of his recommendations' and they have dedicated a page on their website to updating their progress.

Although council has taken steps to comply with a number of our recommendations, there have also been some outcomes that do not reflect our recommendations. For example, we recommended that council should apologise to certain complainants and make an ex-gratia payment for their legal costs, but they refused to do so.

We continue to monitor their responses to our recommendations, and look forward to seeing the results of the promoting better practice review that the Division of Local Government (DLG) are currently undertaking at Manly Council.

Helping councils to handle unreasonable complainant conduct

We expect both councils and complainants to act reasonably in relation to handling and making complaints. One of our most recent publications – the *Managing Unreasonable Complainant Conduct practice manual* – has been widely used by councils, but we are still struck by the number of complainants who we believe have acted inappropriately.

Case study 26: Making unreasonable demands

We recently took the extraordinary step of informing a complainant that we believed he had acted unreasonably and made unreasonable demands on a council. A comprehensive and exhaustive review of his complaint found that after some 15 years – in which he had made numerous voluminous complaints to his council and to us about a number of issues – we could see no evidence of any conduct that would warrant us investigating the council.

Another complainant, frustrated by an action taken against him by their council, sent a further email to us after the council had taken what we believed to be reasonable steps to resolve his issue. This 32 page email was also sent to some 23 Ministerial offices and almost 100 media individuals. We provided the complainant with guidance about more appropriate ways to make a complaint in the future.

Case study 27: Giving reasons for restrictions

A man complained that Upper Lachlan Shire Council had declared him vexatious and refused to deal with him any further – without giving him their reasons for this. After making inquiries with the council we reinforced with them that, although they were entitled to decide to restrict the access of complainants in defined circumstances, they should also inform the complainant about the reasons and circumstances surrounding their decisions. We also highlighted that complainants should not be personally labelled as vexatious, but their conduct could be identified as falling within areas of unreasonable behaviour. Council agreed with our suggestion to apologise to the complainant and explain their reasons for restricting his access.

Case study 28: Managing unreasonable conduct

A complainant objected to having her contact with council limited to the general manager only. He had cited occupational health and safety as his reason for preventing her from contacting staff in council's rates section. We contacted the general manager and were able to provide informal guidance on managing unreasonable conduct and satisfy ourselves that no further action on our part was required. The general manager in turn agreed to develop a policy on handling unreasonable complainant conduct that has been drafted for adoption by council.

Failing to act on complaints

Complainants frequently come to us when they feel that their council has ignored their complaints. Unfortunately, there are times when it is clear that some councils have no intention of resolving issues raised by complainants without our intervention, despite their responsibility to do so. We have achieved a number of positive outcomes for complainants, but we also focus on suggesting improvements to council to ensure they don't repeat poor service.

Case study 29: A long history of inaction

A man complained to us about Narrabri Shire Council not taking any action in response to his complaint about lack of access to his remote property and their failure to repair damage done to his property by council quarrying. He had been pursuing legal access to his property since soon after buying it in 2003. He said council had misrepresented the status of the only road to his property, listing it as a shire road when this was not the case. In 2005, council passed a resolution to remedy the situation but, for reasons which were unclear, had failed to act on the resolution. Over the years the road had become virtually impassable, restricting his use of the property. Council had also refused to rehabilitate land around a quarry on his property despite there being significant erosion, denying they had used the quarry as recently as the complainant claimed. Despite making a formal written complaint to the general manager in April 2010, the matters remained unresolved.

As a result of our inquiries, council agreed to remediate the quarry damage and ensure the dedication of the first 1.4km of the road to the complainant's property. This positive response to part of the complaint was welcomed. However, we were concerned it took council some five months to respond to our inquiries – and even then with a very limited response. They didn't adequately address significant issues raised by the complainant – including the status of the remainder of the road, their poor handling of the matter over many years, the incorrect information given by council staff to the complaint about their obligations to remediate property damage, their management of external legal advisors, and the adequacy of their record-keeping practices and complaint-handling system.

In addition to not adequately addressing all of the complainant's concerns, it appeared to us that council had not investigated the history of the matter to the extent necessary to identify administrative and procedural deficiencies in their processes and procedures. They needed to do this to prevent the same problems happening again.

We made a series of detailed suggestions about action to resolve the remaining issues, which council accepted. We will carefully monitor council's compliance.

Case study 30: Unexplained delays

A property owner complained about the way Blue Mountains City Council had handled her concerns about damage to her property caused by stormwater flowing from five neighbouring upslope properties. She felt that council had not take sufficient action to require her neighbours to undertake the necessary drainage works to lessen the amount of water flowing onto her property. She was also dissatisfied because when she first complained to council they did not respond and then, when they did respond, she felt bullied and intimidated by the council officer.

It is not our role to make a technical judgment on council's decision about what action was necessary to address the stormwater problem. However, we were concerned about how they had handled the complaint. When we first became involved, council acknowledged that they had not responded nor kept the property owner informed of the action they had taken to address her concerns. They offered an apology and assured us that, when the further work due to be done in the next week was completed, they would let her know.

Close to two months later, the property owner advised us that she had still heard nothing from council. When we contacted council, they explained the reasons for the delay and completed the work within the week. However, in their letter to the property owner telling her the outcome of the work, they did not mention – much less apologise – for the delay.

We suggested that council could handle these situations better in the future if they were to formally adopt their complaints policy and provide training to staff. They have since advised us that they expect to put a reviewed policy before council in June 2011 and they will consider training for staff, depending on the resources available.

Councils failing to act on complaints is highlighted in case study 30 about stormwater damage.

Code of conduct issues

All councils are required to adopt a code of conduct which sets out the standards of conduct expected from council officials. Each council's code has to incorporate the terms of the model code of conduct (see section 440 of the *Local Government Act 1993*) prepared by the DLG. The code applies to councillors, the general manager and all council staff. As well as expected standards of conduct, the code also sets out obligations for managing conflicts of interests and provides a mechanism for dealing with allegations of breaches of the code.

Generally, we don't investigate complaints about breaches of a council's code of conduct. We encourage the complainant to raise their concerns directly with the council for them to deal with it in accordance with the provisions of the code. If a person claims that a council has not adequately dealt with such a complaint, we generally refer them to the DLG as they monitor councils' compliance with the code and review the model code and the guidelines.

We have discussed with the DLG the need for improvements to the current code and guidelines, and in June 2011 they released a discussion paper for councils in NSW for a review of the model code. We will continue to work with DLG to improve consistency and clarity in this important area of local government.

Case study 31: Wasting scarce resources

We have received approximately 30 complaints this year about the poor handling of alleged code of conduct breaches. Some of these complaints have been from councillors aggrieved about:

- being the subject of a complaint
- being investigated for possibly breaching the code
- inadequate action being taken on their complaints about the conduct of others.

We have also received complaints and phone calls from exasperated general managers besieged by councillors making accusation and counter accusation against each other. These have then spilled over to accusations against the general manager and others appointed to review the alleged breaches. We are aware of some councils who now find it nearly impossible to appoint independent reviewers to investigate alleged breaches due to the difficulties and complaints previous reviewers have been subjected to while conducting their investigations.

It appears the code of conduct – although providing a needed set of minimum standards of conduct – has become yet another means for some councillors to engage in political point-scoring and mischief-making. In the process, considerable resources are being spent by councils already under financial pressure, on matters that do not justify such expense. Sadly, even when a council has attempted to deal with matters promptly and fairly, one party will sometimes pursue the matter externally to the Ombudsman, ICAC or the DLG in their pursuit of 'justice'. We can quickly decline to be involved in such matters, but councils can be embroiled in them for years. It is unfortunate that councils are unable to recoup the costs incurred from those people who misuse the complaints process for political ends.

Of course, we have also received complaints that raised genuine and serious concerns about the conduct of councillors and council staff – as well as about the poor handling of complaints by councils and independent reviewers. There can be considerable differences in the processes, timeframe and assessment criteria used by reviewers, so it is perhaps understandable that someone may feel aggrieved by being apparently treated differently from another person accused of similar conduct.

Freedom of information

A successful transition

Under the transitional provisions of the *Government Information (Public Access) Act 2009* (the GIPA Act), we received 49 Freedom of Information (FOI) complaints about applications that were lodged before the GIPA Act came into operation.

As expected, the number of complaints gradually reduced over the course of the year. We received 52 complaints with the last complaint recorded in February 2011. We finalised 89 FOI complaints in this period, clearing our backlog from the previous year (see figure 31). We formally investigated four complaints, while the rest were resolved or finalised through informal means.

Figure 31: Formal matters received and finalised and inquiries

Matters	06/07	07/08	08/09	09/10	10/11
Formal received	208	225	186	145	52
Formal finalised	205	197	224	136	89
Inquiries dealt with	316	422	407	263	127

Figure 32: What people complained about

This figure shows the complaints we received in 2010–2011 about Freedom of Information, broken down by the primary issue in each complaint. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Formal	Informal	Total
Access refused	26	14	**40**
Agency inquiry	0	13	**13**
Amendments	0	1	**1**
Charges	1	1	**2**
Documents not held	2	7	**9**
Documents concealed	0	4	**4**
General FOI inquiry	0	56	**56**
Issue outside our jurisdiction	2	2	**4**
Pre-application inquiry	1	14	**15**
Pre-internal review inquiry	2	10	**12**
Third party objection	4	2	**6**
Wrong procedure	14	3	**17**
Total	**52**	**127**	**179**

Figure 33: Significant outcomes achieved in relation to complaints about FOI finalised in 2010–2011

Issue	Total
Review of case/conduct/decision/finding by agency	2
Internal processes reviewed or to be reviewed by agency	3
FOI search made and documents found	2
Documents released or to be released by agency fully/partly	18
Policy/procedure to be changed by agency/ Minister	5
Apology given by agency	1
Decision/finding changed by agency	6
Reasons provided by agency for decision/ action/finding	4
Fees and charges to be reduced/waived/refunded by agency	3
Otherwise resolved to Ombudsman's satisfaction	2
Further information provided to clarify/explain issue or agency action	11
Referral of complainant to appropriate body	1
Total	**58**

The following case studies are a sample of our FOI work.

Case study 32: Ministerial advisor salaries

The Office of the former Leader of the Opposition applied under FOI for salary details of ministerial media advisers. The Department of Premier and Cabinet provided a document that set out the salary ranges, but decided to exempt the exact salaries and the names of the advisors.

We suggested the exact salaries be released without the names, but the department refused. This was due to concerns that the names of the media advisors could be easily worked out from other sources and this would lead to unreasonable disclosure of their personal affairs.

During our investigation of the complaint, one of the media advisors argued that the release of her salary details would have an adverse impact on her spouse's financial affairs. She maintained that if the details of her salary became known, it would hamper her spouse's ability to ask for increased rent from tenants at their investment properties. Another media advisor argued that because she directed senior staff of a government agency, the release of her salary would be embarrassing to her. We expressed concern to the department about ministerial media advisors directing agency staff.

The department complied with our recommendation to release salary bands and offered to release further details of expenditure on ministerial media advisors to the complainant.

Case study 33: Accessing taser videos

Last year we reported on the NSW Police Force's (NSWPF) initial refusal to comply with our suggestion that copies of videos of police officers using tasers be released, after the faces of the subjects had been obscured. We formally investigated the matter and recommended releasing copies of the videos. We also recommended that the NSWPF develop a policy – in consultation with the NSW Information Commissioner – for dealing with and determining any future applications under the GIPA Act for access to taser videos. NSWPF agreed with our recommendations, released the taser videos to the journalist, and began drafting the policy.

Case study 34: Redundancy payments for ministerial staffers

The Office of the former Leader of the Opposition complained about the Department of Premier and Cabinet's refusal to provide specific information about redundancies paid to staff previously employed in a ministerial office, who were then re-employed with either the same or a different Minister.

The department provided an aggregate figure of $705,734 representing redundancies paid to 19 staff between 2005 and 2010, but refused to provide the amounts of individual redundancies, stating this would be an unreasonable disclosure of the staff's personal affairs. We made three formal suggestions to the department for the release of the individual figures. They refused to follow our suggestions, arguing that due to the small number of staff affected their identities could be worked out from other sources. We wrote to the department expressing our view that while it may have been possible to find out which ministerial employee received a particular redundancy payment, the information was not evident from the document itself. In our view there was an overriding public interest in the disclosure of the details of all individual payments of public funds, particularly in the several cases where a ministerial employee was re-employed by the same office or re-employed in another ministerial office not long after receiving a redundancy payment.

As a general principle, it seemed to us that information about the remuneration paid to a public official should not be treated as if it were a matter of complete secrecy. In late March, the department advised us they were reviewing their determination in accordance with our suggestions. However, before we received final advice from the department about whether the details would released, the applicant had withdrawn the complaint following the NSW state election.

Case study 35: Poor practices at Manly Council

We received a complaint from a resident of Manly Council about its determination of his FOI application for documents about a long-standing barking dog complaint. We began a formal investigation into council's handling of the FOI matter as well as issues related to the substantive complaint.

During our investigation, we found a number of concerning practices in council's dealing with FOI applications, including:

- making applicants attend council chambers to view documents when they requested copies
- charging for photocopying
- referring to so-called restricted documents and withholding them without giving reasons
- improperly excluding material from the scope of applications without providing reasons.

Council agreed to implement most of our recommendations, but advised that they would not stop their practice of charging photocopying fees for access to documents, as they believed section 7(2) of the GIPA Act enabled councils to charge such fees. We wrote to council noting that section 7(2) of the GIPA Act relates to information that is proactively released by an agency and does not apply to access applications. We also referred the matter to the Office of the Information Commissioner as they are now the appropriate regulatory body for this issue.

The Information Commissioner agreed with us that an agency has no basis under the GIPA Act to apply photocopying charges distinct from any processing fees and advised they would follow up with council to confirm the requirements under the Act.

Documents that should have been released

In last year's annual report, we included a case study about Sydney Water's failure to release documents to a journalist under the FOI Act. The documents disclosed the names of the top 50 commercial water users and the amount of water they used in certain years. Sydney Water released information about aggregate data, but maintained that the documents disclosing the names of the companies were exempt as they concerned the business affairs of the companies and were therefore confidential. They argued that their customer contract obliged them to keep information about the water use of their commercial customers confidential, and – although information about water usage was not confidential in itself – in combination with the names of the users it 'could provide an opportunity to other competitors'.

At the time that last year's annual report was published, we had written to Sydney Water suggesting that they should release the documents as it was in the public interest. We considered that members of the public had a right to know which businesses were consuming the most water in NSW and whether or not those businesses were taking action to reduce their water consumption. We also asked the Information Commissioner about whether she believed the documents should be released, and she agreed with our conclusions.

We have now finalised our investigation into Sydney Water's conduct in this matter and have sent a copy of our final report to the journalist who made the original complaint, Sydney Water and the relevant Minister. In that report, we maintained our view that the documents should be released. Sydney Water subsequently told us it is redetermining the application.

Public interest disclosures

Implementing large-scale reform

There have been major changes to the protected disclosures system in NSW. In our last annual report, we spoke about the Parliamentary Committee for the Independent Commission Against Corruption's (the ICAC Committee) final report after their review of the *Protected Disclosures Act 1994*. In October, the government introduced legislation to amend the Act in line with the ICAC Committee's recommendations. The Bill passed through Parliament and came into operation in March this year. The changes to the Act will come into force in three stages.

The first stage

The first stage included a new name for the Act. We have argued for some time that the name needed to be changed to place greater emphasis on the purpose of the legislation – rather than on the mechanism for achieving that purpose. The new name of the Act – the *Public Interest Disclosures Act 1994* (PID Act) – now reflects its purpose. This change also brings the title of the Act into line with most other Australian jurisdictions.

The initial changes in March also included the establishment of the Public Interest Disclosures Steering Committee. This committee is responsible for providing advice to the Premier on the operation of the PID Act and recommending any necessary reforms, as well as providing advice to the Premier on reports of our work under the Act. It is made up of the following members:

- the Ombudsman, who is the chair of the committee
- the Director General of the Department of Premier and Cabinet
- the Auditor-General
- the Commissioner for the Independent Commission Against Corruption
- the Commissioner for the Police Integrity Commission
- the Chief Executive of the Division of Local Government
- the Commissioner of Police.

There were a number of issues the ICAC Committee noted, but did not recommend any changes. This was because they received insufficient evidence during their review to reach a firm view. They therefore recommended that the Steering Committee consider these matters such as:

- how the PID Act applies to volunteers
- including additional types of conduct within the PID Act
- including the Heath Care Complaints Commission as an investigating authority
- whether third party service providers should be able to receive and deal with reports of wrongdoing on behalf of agencies.

The Steering Committee met for the first time on 3 August 2011. It is scheduled to meet four times a year, with additional meetings to be held if necessary.

The second stage

From 1 July 2011, our office has a range of additional functions under the PID Act. These are discussed in more detail in the following sections. Agencies will also have to start developing their own internal reporting policies and procedures, based on our guidance material and model policies. These policies and procedures must be in place by 1 October 2011.

The third stage

From 1 January 2012, agencies will have to start recording information about the disclosures they handle under the PID Act. Details about the information to be recorded and reported on will be set out in regulations to the Act. These regulations will be developed in consultation with the Steering Committee.

Making further legislative changes

One of the incoming government's commitments as part of its 100 Day Plan was to improve protections for those who report wrongdoing in NSW. These changes are set out in the Public Interest Disclosures Amendment Bill 2011, which at the time of writing is being considered by Parliament.

The Bill will make a number of important changes to the PID Act, including:

- changing all references to 'protected disclosure' to 'public interest disclosure'
- introducing legislative responsibilities for heads of agencies
- introducing a requirement for agencies to report to us regularly on the disclosures they deal with.

We will amend our guidance material to incorporate any changes this Bill makes to the PID Act.

An expanded role for the Ombudsman

The PID Act expands our role. We have always been responsible for receiving and dealing with protected disclosures about maladministration, as well as receiving complaints about the way disclosures are handled by agencies. We will continue to perform these roles, but will also be responsible for a number of other areas. Our role now includes:

- giving information, advice, assistance and training to public sector agencies and their staff on any matters relevant to the PID Act
- issuing guidelines and other publications to help public sector agencies fulfil their functions under the PID Act and draft their internal reporting policies and procedures, plus assist their staff to understand the protections available to them under the PID Act
- monitoring and auditing whether public sector agencies are complying with the Act and reporting to Parliament on both these functions
- preparing reports and recommendations for the Premier about legislative and administrative changes to achieve the objectives of the PID Act
- providing support to the new Public Interest Disclosures Steering Committee, including preparing an annual report on their work.

This is both a challenging and exciting new area of responsibility for us. For the system around public interest disclosures to work effectively, we have to work towards a change in culture across the NSW public sector. This will see public sector staff recognising the value of reporting wrongdoing and accepting that making such reports is part of their everyday responsibilities.

We have four key objectives that we believe will help us to achieve this change. These are to:

- increase awareness of the procedures for making protected disclosures and the protections provided by the PID Act
- improve the handling of disclosures and the protection and support for people who make them
- improve the identification and remedying of problems and deficiencies revealed by disclosures
- ensure an effective statutory framework is in place for making and managing disclosures and protecting and supporting the people who make them.

The Ombudsman has established a public interest disclosures unit (PID unit) to achieve these objectives.

Consulting and providing information

We will be consulting widely with the people involved in dealing with public interest disclosures and the people who make them. This includes public authorities, their staff, other investigating agencies, unions, academics, journalists and commentators and interest groups such as Whistleblowers Australia. We have started this process with several information sessions.

The first session was held in May and was facilitated by Dr AJ Brown. It was an opportunity to bring together many of the people who have an interest or involvement in whistleblowing, including people who contributed to the Whistling While They Work research project. We provided the group with an outline of the changes, including our new role. We also gave them drafts of our objectives under the PID Act, as well as our model internal reporting policy for agencies. We received very useful comments both during the session and in the weeks afterwards.

We have held a number of information sessions since then for agency staff involved in handling disclosures. We provided information about the changes to the PID Act including the timeframe, as well as the roles and responsibilities of agencies and their staff. We will continue to hold these sessions as agencies change their systems.

Developing guidelines and model policies

Ever since the *Protected Disclosures Act 1994* came into operation in 1995, we have realised the importance of providing guidance material to agencies. This is why we produced our Protected Disclosures Guidelines, which were in their sixth edition when the changes to the Act started this year. In light of the changes to our role and the Act, we decided that a different approach was needed.

Our guidelines are now in the form of a series of individual practice notes, that can be read together or as individual topics. The first five topics were released on 1 July 2011. They covered management commitment, internal reporting policies and procedures on who can report wrongdoing, what should be reported, and the roles and responsibilities of key players. All of our guidance material is available on our website. We plan to have the remaining 25 practice notes finalised by the end of the year.

We have also produced two model internal reporting policies – one is for state government agencies and the other local councils. They provide guidance to agencies and their staff about dealing with reports of wrongdoing appropriately.

Separating a complaint from an industrial dispute

In May 2008, six staff members in Macquarie university's Centre for Policing, Intelligence and Counter Terrorism (PICT) wrote twice to the Vice-Chancellor and Deputy Vice-Chancellor expressing serious concerns about a number of issues. These issues included recruitment processes, workload issues, and decisions to assign traditionally academic work to administrative staff. They also alleged that there was general harassment and bullying of staff, which became worse in retaliation for individual staff raising concerns with PICT management.

The concerns were raised in the context of a broader industrial dispute about the working conditions of staff.

In June 2009, one of the staff members made a protected disclosure to our office. They claimed that the concerns of the staff members had never been taken seriously and each person had suffered some form of retribution for having complained. Some of them had resigned after being harassed and others had not had their contracts renewed.

Our primary concern was about the way the university had handled the complaints. They did not appear to have recognised that – in addition to a number of industrial issues that were being negotiated with the union – the complainants had also alleged that they had suffered retribution for having complained in the first place.

Following involvement from our office and the ICAC, the Internal Audit Bureau (IAB) investigated the allegations in 2010. They found that many of the allegations were substantiated and there were 'justifiable perceptions that the processes of recruitment and selection are corrupt' although none amounted to 'corruption.' The IAB made a number of recommendations for systemic improvements, most of which were accepted. The university had already made structural changes to the PICT which they believed addressed some of the issues.

The IAB also found that there was no evidence the university had investigated the May 2008 complaints, beyond providing a copy of one of the letters to the Director of the PICT for his response. This response informed the Deputy Vice-Chancellor's view that the complainants were a group of people making vexatious claims.

We found the university's attitude towards criticisms of the way they had handled the original 2008 complaints to be of some concern. In particular, they did not accept responsibility for failing to make any inquiries into the complaints. Instead, they claimed the complainants failed to provide particulars and also questioned the validity of a number of conclusions in the IAB report.

Allegations by staff that they are bullied and harassed in retaliation for complaints is a serious issue that should be looked into. If an organisation ignores such concerns, they risk staff not reporting serious wrongdoing for fear of reprisals. In our view, the university was responsible for asking the complainants for further details to support their allegations. The complainants should not have had to escalate the matter to two oversight bodies for an investigator to look into their concerns.

One of the IAB report's recommendations was that the university apologise to the complainants for mishandling their complaints. This had not occurred by March 2011, when the IAB report was leaked to The *Australian newspaper* and made the subject of three critical reports over a three week period.

The second newspaper article was written by one of the complainants and quoted an internal email that was sent by a dean at the university to all of his staff in response to the first newspaper article. The dean attempted to reassure staff that 'there was no evidence of wrongdoing [meaning criminal behaviour] found', that 'I find the article today a highly coloured version which puts everything in the worst light possible. But that is what newspapers will do … and all this happened ages ago in a context which no longer exists … [and] it has been fully dealt with within the university … as soon as it was received.' In our view this message was clearly misleading.

On 22 March 2011 the six complainants wrote an open letter to the Vice-Chancellor, outlining their perception that the university's response to the IAB report was 'insufficient' and demanding an official apology from the university for failing to respond to their complaints.

After we sought clarification from the university, it became clear that they still had not recognised the problems with their approach. Staff willingness to report wrongdoing largely depends on how they perceive their organisation is going to handle their report. In this case, we were concerned that university staff would perceive that the university had dismissed the complainants' concerns as a media beat-up, and had refused to apologise because they took no responsibility for the ongoing dissatisfaction of the complainants. This might act as a disincentive for anyone thinking about making a protected disclosure in the future.

We believe the complainants reported honest concerns about the way PICT was operating. They wanted the problems to be fixed. The appropriate response would have been to support what they did, make further inquiries into their concerns and – if their concerns showed the university where positive systemic improvements could be made – tell them about those improvements and acknowledge the contribution they had made.

Instead, when the complainants first reported their concerns, they suffered retribution. When they complained about that, the university ignored them. Even when it was confirmed by an investigation, the university disputed the validity of the findings and blamed the complainants for not providing enough details when they made their initial complaints.

After discussing our views with the university, they have agreed to apologise to two of the complainants who escalated the matter to our office and the ICAC, 'in respect of any failure of due process in dealing with their complaints.' They have advised that they are reviewing their complaint-handling and investigation procedures and will continue to promote a culture in which staff feel confident that their genuine concerns will be handled appropriately.

Delivering training

We are starting to provide training to agencies and their staff to raise awareness of the PID Act. We will be developing more targeted training courses for staff dealing with disclosures, as well as senior staff and supervisors.

Even with targeted training, we will not be able to reach everyone covered by the Act. We are therefore developing e-learning tools to provide quick advice and guidance to staff about their rights and responsibilities.

Offering guidance

Agencies will have to build their internal reporting systems and deal with reports of wrongdoing appropriately. While we cannot do this work for them, we are available to provide advice and guidance. Our PID Unit is almost fully staffed, and we will provide whatever assistance we can to agencies and their staff. For more information, please contact our office and ask to speak to someone in the PID Unit.

Handling complaints

The number of protected disclosures we received in 2010-2011 remained largely the same as last year (see figure 34). We expect the number of public interest disclosures complaints to increase next year as a result of greater public sector awareness and understanding of the PID Act.

It is important that agencies deal with as many matters as they can themselves as, in our experience, this leads to a better outcome. We prefer to focus on dealing with complaints about disclosures being handled badly by an agency.

We will also deal with disclosures that are made about heads of agencies. Even in agencies with the best possible systems, those making disclosures might be worried that the head of an agency will influence how their matter is handled. Our model policy includes advice to staff to report suspected wrongdoing involving their agency head directly to one of the investigating bodies listed in the PID Act.

In future, our work will go beyond handling disclosures. We plan to give greater focus to the issues that arise after the subject matter of a disclosure has been largely dealt with. The Bill before Parliament will expand our capacity to perform a conciliation role. This will allow us to help solve some of the underlying problems, which can often do more damage to the reputation of an agency than the subject of the disclosure.

We have also noticed a recent trend for complainants, particularly councillors, to announce publicly they have made a protected disclosure. We assume they do this either to gain political advantage or to provide their complaint with a level of importance it may not have otherwise received. Reporting wrongdoing should not be used as a political tool. The objects of the PID Act are to provide protections against reprisals and remove barriers to reporting wrongdoing. We recognise there may be circumstances where a councillor may require protection against reprisals, but we would question whether they require the protection if they are willing to announce their disclosure.

Figure 34: Protected disclosures received

Matters	06/07	07/08	08/09	09/10	10/11
Informal	42	53	47	43	41
Formal	34	43	42	35	39
Total	**76**	**96**	**89**	**78**	**80**

Case study 36: Keeping people informed

A member of staff made a disclosure about a government agency to the ICAC and the agency at the same time. The disclosure was investigated and the allegation was not substantiated. Other allegations made against the person who was the subject of the disclosure were found to be true and the person was dismissed. The complainant then complained to us that they were not told what had been done.

We looked into the matter and found the agency had handled the disclosure properly. They had been in constant contact with the complainant as the matter had progressed because the complainant was assisting them with their inquiries. However, they had not written a letter advising the complainant of the final outcome as they thought this was the ICAC's responsibility.

We suggested the agency amend their procedures so there was more certainty if a similar matter arose in the future. They have now changed their procedures and will consult with the investigating body to check who is responsible for responding to the person who made the disclosure.

Police and compliance

We are committed to working with police to ensure their complaints system achieves fair and just outcomes for all concerned. We also aim to help police use the complaints system to identify how they can improve the way they operate.

Our work includes independently reviewing the way the NSW Police Force (NSWPF) handles complaints about serious misconduct and investigating particular areas of police practice, if it is in the public interest to do so. We check how police handle less serious complaints, and regularly audit the way their complaint-handling processes are working to ensure they are effective and comply with legislative requirements.

We use information from complaints to identify and proactively investigate public interest issues.

This year we started our second review of the use of tasers by police as we were concerned about the number of incidents involving tasers (see page 59). Our other public interest investigations include NSWPF's compliance with their guidelines for in-car video (see page 58) and the use of excessive force (see page 58). We also undertook an audit of complaints that raised domestic violence issues (see page 61), which led to a report to Parliament in May 2011.

Our police and compliance branch also has responsibility for dealing with witness protection appeals (see page 62) and complaints as well as reviewing law enforcement agency compliance with a range of legislation that gives them authority to undertake covert operations (see page 63).

Highlights

- Finalised five direct investigations on a range of matters including use of excessive force. SEE PAGE 57
- Reviewed the NSWPF's complaint handling guidelines making 25 recommendations to improve them. SEE PAGE 54
- Finalised our report on the use of in-car video. SEE PAGE 58
- Made recommendations to the Commissioner about NSWPF procedures for handling bullying, harassment and workplace discrimination. SEE PAGE 60
- Reviewed the impact of CINs on Aboriginal and Torres Strait Islander communities and tabled a report in Parliament in July 2010. SEE PAGE 62
- Audited the NSWPF's handling of domestic and family violence complaints, resulting in a report to Parliament. SEE PAGE 61
- Re-negotiated a new agreement with PIC about the types of complaints to be notified. SEE PAGE 52

In this Section

Policing

Our role in the police complaints system

Every year, approximately 5,000 formal and informal complaints are made about police. These come from both the public and from police officers themselves. The complaints enable the NSWPF to identify systemic problems, as well as address individual instances of misconduct. We directly assess approximately 60% of complaints about police. The *Police Act 1990* gives the NSWPF the primary responsibility for investigating and resolving all complaints about police. Our role is to oversee the way the police complaints system works – both through reviewing investigations of individual complaints and checking that the processes police use to resolve complaints are working fairly and effectively.

The NSWPF must notify us about more serious complaints – such as those involving allegations of criminal, corrupt or improper conduct. We closely consider these complaints to ensure they have been investigated properly and in a timely manner and that the action taken is appropriate. As part of doing this, we may:

- ask for additional information
- monitor the police investigation as it is being conducted
- prepare a report about the investigation if we think it is deficient
- ask police to review the action if we consider it is inadequate
- investigate the matter of our 'own motion'
- report to Parliament if there are issues of significant public interest.

In February 2011, we entered a new agreement with the Police Integrity Commission (PIC) about the types of complaints that must be notified to the Ombudsman. Some less serious complaints – such as complaints about poor customer service, rudeness or minor workplace conduct issues – may be resolved by local area commanders without our direct oversight. Police are still required to register the details of these complaints on their complaints system, and we regularly audit the way these complaints are handled to ensure they are appropriately addressed.

Under the new agreement, police must also notify us about a range of additional complaints. This includes complaints about:

- the unreasonable use of tasers, capsicum spray or batons
- apprehended violence or stalking by police
- police pursuits and responses to urgent duty resulting in death, injury or significant financial loss.

Trends in police complaints this year

This year we received 3,256 formal or written complaints about police for assessment and review – a slight increase compared to the previous three years. This includes complaints we receive directly as well as those notified to us by police or referred from the PIC. We finalised 3,278 complaints. In addition to these formal complaints, we received 2,596 informal complaints or enquiries by telephone or in person. We dealt with these by providing advice and referral information. Figure 35 shows the number of complaints we have received and finalised over the past five years.

Figure 35: Formal complaints about police received and finalised

	06/07	07/08	08/09	09/10	10/11
Received	3,466	2,969	2,948	3,032	3,256
Finalised	3,555	3,254	3,094	3,093	3,278

Of the complaints we received, figure 36 shows the proportion that were made by police officers and the public over the past five years.

Figure 36: Who complained about the police

This figure shows the proportion of formal complaints about police officers made this year by fellow police officers and from members of the general public, compared to the previous four years.

	06/07	07/08	08/09	09/10	10/11
Police	1,268	1,056	1,158	1,090	1,208
Public	2,198	1,913	1,790	1,942	2,070
Total	**3,466**	**2,969**	**2,948**	**3,032**	**3,278**

Figure 37 shows a breakdown of the kinds of complaints that were notified to us this year (some complaints may contain more than one allegation). Appendix A provides more detail about the types of complaints and the way they were handled.

Figure 37: What people complained about

Subject matter of allegations	No. of allegations
Arrest	149
Complaint-handling	215
Corruption/misuse of office	293
Custody/detention	134
Driving-related offences/misconduct	78
Drug-related offences/misconduct	172
Excessive use of force	596
Information	675
Inadequate/improper investigation	805
Misconduct	1,613
Other criminal conduct	474
Property/exhibits/theft	178
Prosecution-related inadequacies/misconduct	287
Public justice offences	190
Search/entry	116
Service delivery	1,103
Total	**7,078**

Note: Please see Appendix A for more details about the action that the NSW Police Force took in relation to each allegation.

This year, 899 (27%) of the complaints were assessed as not requiring investigation for reasons such as the availability of alternative and satisfactory means of redress, for example raising matters in court. Another 398 (12%) were assessed as local management issues and referred to commands for resolution without any oversight by this office.

We closely reviewed the quality of the way police investigated or resolved complaints, and found that 1,645 (83%) had been handled satisfactorily. However in 333 matters (17%) we considered the handling of the complaint to be deficient. Of these, 157 matters were deficient only because there were unreasonable delays in investigating or resolving them.

Unfortunately, the NSWPF is still not meeting their own timeliness standard for completing investigations and resolving complaints – and delays have increased from last year (see figure 38).

In 176 matters (9%), we believed the investigation or the proposed management action in response to the investigation findings was deficient. Following our advice, police remedied the deficient investigation or management actions in 64% of these cases. This is a 10% drop in matters remedied since last year.

We also provided commanders with written feedback in 93 matters where we considered the police investigation satisfactory – but identified opportunities for them to improve complaint-handling and investigation practices when dealing with similar matters in the future.

Managing complaints

The NSWPF can take a range of actions in response to complaints about police. Some of these 'management actions' are reviewable by the Industrial Relations Commission (IRC) – including a decision by the Commissioner to remove an officer or reduce their rank, seniority or salary. Other management actions are not reviewable by the IRC – such as officer counselling, training, restricting duties, issuing warnings and reprimands, transferring officers, mentoring and increased supervision. In response to complaints, police may also make changes to policies and practices or apologise to complainants.

Police took management action in 56% of complaints that we oversighted this year. This is a slight drop, back to 2006-2007 levels (see figure 39).

Last year we reported on Project Lancaster – the Professional Standards Command's (PSC) review of the disciplinary processes used by the NSWPF for proven officer misconduct.

As a result of the review, the PSC drafted a new reporting template for evidence-based investigations to improve procedural fairness in complaint investigations. We provided feedback to the PSC on the draft. The reporting template has been in use since January 2011 and we will be monitoring the impact it has on the way investigations are conducted and reported.

The NSWPF has also changed their approach to management action as a result of Project Lancaster. They now emphasise taking non-reviewable action (such as issuing conduct management plans or warnings) in response to sustained findings of misconduct, rather than reviewable action. Our independent review of this work in assessing the adequacy of management action is particularly important given this changed approach.

In some serious misconduct matters, an officer may be charged with a criminal offence. In 2010-2011, 64 police were charged with a total of 215 offences. This is a significant fall in charges and officers charged compared with last year however, this figure is more consistent with the trend from 2006-2007 to 2008-2009 – see figure 40.

Many of these matters arise from complaints made in previous years, and these figures do not include charges against officers in this year that have not been finalised.

Some of the charges include:

- summary criminal offences – such as engaging in conduct to obtain financial advantage from a Commonwealth entity or offensive language (71 charges were laid against 26 officers)
- indictable criminal offences – such as larceny, forgery and using false documents (43 charges were laid against seven officers)
- common assault (26 charges were laid against 17 officers)
- sexual or indecent assault (20 charges were laid against three officers)
- driving offences including drink driving, unnecessary speeding and dangerous driving (19 charges against 16 officers)
- drug offences (seven charges against four officers)
- unauthorised access to or disclosure of information (13 charges against four officers)
- public justice offences such as perverting the course of justice or fabrication of evidence (10 charges against four officers).

Some officers received charges in more than one offence category.

This year a total of 14 police officers and probationary constables were removed from the NSWPF and another 11 resigned following the initiation of disciplinary procedures.

Figure 38: Timeliness of the completion of investigations and informal resolutions by the NSW Police Force

Percentage of	06/07	07/08	08/09	09/10	10/11
Investigations less than 90 days	28	34	40	44	42
Informal investigations less than 45 days	14	15	41	47	39

Figure 39: Action taken by the NSW Police Force following complaint investigations

	06/07	07/08	08/09	09/10	10/11
No management action taken	1,000	901	741	781	874
Management action taken	1,287	1,177	1,095	1,112	1,107
Total investigations completed	**2,287**	**2,078**	**1,836**	**1,893**	**1,981**

Figure 40: Police officers criminally charged in relation to notifiable complaints finalised

Number of	06/07	07/08	08/09	09/10	10/11
Complaints leading to charges	63	50	63	92	68
Officers charged	60	49	60	95	64
Total charges laid	**184**	**136**	**259**	**300**	**215**
Officers charged following complaints by other officers	48	32	45	68	49
Percentage of officers charged as a result of complaints by other officers	80%	65%	75%	72%	77%

Figure 41: Action taken in response to formal complaints about police that have been finalised

Action taken	08/09	09/10	10/11
Investigated by police and oversighted by us	1,395	1,145	1002
Resolved by police through informal resolution and oversighted by us	443	751	979
Assessed by us as local management issues and referred to local commands for direct action	468	340	398
Assessed by us as requiring no action (eg alternate redress available or too remote in time)	788	857	899
Total complaints finalised	**3,094**	**3,093**	**3,278**

Reviewing complaint-handling guidelines

This year we completed a review of the NSWPF's complaint-handling guidelines and made 25 recommendations to improve them.

Our report coincided with a review of the guidelines by the PSC. They have advised that they will implement 22 of our recommendations.

An important issue we identified during our review concerns the guidance given to commanders about using evidence-based investigation techniques and informal or outcome-focused investigation techniques. Our view is that evidence-based investigation techniques should always be used in the first instance to investigate complaints of serious misconduct. This ensures that investigations are rigorous and evidence is collected in a form that can be used to start criminal proceedings or take reviewable management action if the complaint is substantiated. The PSC does not share our view – they support a system where complaints about serious misconduct are the subject of informal inquiries unless or until incriminating evidence is identified. We will continue to monitor this issue closely.

There continues to be an increase in the use of informal resolution by police to address complaints, and a decrease in the use of evidence-based investigation (see figure 41).

Overseeing investigations into serious misconduct

As well as making sure that individual complaints are effectively handled, we contribute to the quality of complaint investigations and outcomes by providing feedback to police about potential problems in investigative approaches, and by highlighting operational issues that may not have been identified.

Investigating criminal allegations against police

The Police Act contains an anti-corruption provision that requires police officers to be charged if there is sufficient evidence of criminal conduct. However, the Commissioner or other senior police have the discretion not to authorise these proceedings.

When the discretion to not prosecute is used, a protocol established between the NSWPF, PIC and the Office of the Director of Public Prosecutions (ODPP) provides for the independent review of the decision by the ODPP to ensure accountability and transparency. The ODPP must also review matters if there may be a doubt about pursuing criminal prosecution due to complex legal issues or sufficiency of evidence. In the last year, we have come across a number of cases where the NSWPF neglected to refer decisions not to prosecute to the ODPP for independent review.

In case study 37, the NSWPF did not investigate alleged criminal conduct at the outset. It demonstrates how such decisions can potentially circumvent the processes aimed at ensuring that criminal conduct by police is not covered up.

Case study 37: Young person assaulted

Two officers patrolling the streets of a country town late on a Saturday night stopped and spoke to an intoxicated 15 year old male. The young man repeatedly swore at the officers while being questioned about the contents of his backpack.

One of the officers walked up behind the young man and slapped him to the head with an open palm, causing him to stumble forward. A short time later, the same officer grabbed the young man around the neck and pushed him up against the police vehicle, telling him to stop carrying on stupidly. At this point, the officer's partner intervened and the officer let go of the young man. At the end of the shift, the officer reported 'losing it' with the young man to the shift supervisor.

The commander spoke to the officer who admitted assaulting the young man. At the suggestion of the commander, the officer apologised to the young man in the presence of his mother. The young man signed the commander's notebook indicating that he was satisfied with the apology and that he did not want the officer charged.

The police investigation made a sustained finding for 'unreasonable use of force'. The commander referred the matter to the Internal Review Panel, recommending that the officer be placed on a conduct management plan 'to assist the officer to deal with emotions when reacting inappropriately'.

We raised concerns with the commander about the failure to conduct a criminal investigation into the alleged assault. We also noted that the management action proposed by the commander appeared lenient, given the officer's complaint history. Two years earlier, he had slapped another person to the head at a police station. On that occasion, the ODPP found sufficient evidence to prosecute the officer, but determined that he could be dealt with internally by police rather than being prosecuted. The Police Commissioner considered dismissing the officer but instead issued a warning notice stating that he would not tolerate any future failures to comply with acceptable standards. The officer's pay was also reduced for 18 months.

Although we appreciated that the young male accepted the officer's apology and did not want the officer charged - we believed it was appropriate for a report to be prepared to the Police Commissioner and Minister for Police on the need for a criminal investigation into this matter. Although the wishes of the victim are relevant to the question of whether there is sufficient evidence to prosecute, they did not justify the failure to conduct a criminal investigation into the alleged assault. We considered that it may have been appropriate to prosecute the officer – given that the action taken for the previous assault did not change his behaviour, and his partner would have been able to give credible and reliable evidence if he had been charged.

The NSWPF accepted these views and agreed to amend their complaint-handling guidelines to clarify that there is an obligation to ensure that alleged criminal conduct by police is appropriately investigated. They also agreed to increase awareness of the obligation to refer any exercise of the discretion not to prosecute to the ODPP for independent review.

The Commissioner considered whether to dismiss the officer. While observing that the officer's conduct had again fallen below the standards expected by the community and the NSWPF, the Commissioner decided that he still had confidence in the officer's suitability to be a police officer and issued another warning notice. The officer was also put on a six-month conduct management plan and could only perform restricted duties.

Monitoring investigations and requiring police to investigate

Sometimes we may disagree with a decision by the NSWPF that a complaint does not need to be investigated. We can require the NSWPF to investigate matters that they have initially declined to investigate, as we did in case study 38. We also monitored the investigation that we required police to undertake, as we did in case studies 39 and 47. Monitoring investigations allows us to observe interviews with complainants, witnesses and officers, or review investigation records progressively during the course of the investigation. It also allows us to liaise with police investigators to ensure all relevant lines of inquiry are fully considered.

Often the complaints we choose to monitor involve complainants from vulnerable groups, or those who have communication difficulties. This year we used our monitoring powers to closely scrutinise 17 investigations.

Case study 38: Police decline to investigate

An officer alleged that he had been indecently assaulted by another officer who had touched him on the genitals with the back of his hand, and that he had seen the officer do the same thing to other police. These allegations were made to the officer's supervisor who failed to report the matter.

The inspector made enquiries and identified a second officer who said that he too had been touched on the genitals by the subject officer. However after he told the subject officer to stop, the assaults were not repeated. This officer did not report the assaults at the time, but was prepared to provide written evidence if needed.

The inspector took steps to minimise contact between the officers and to monitor the subject officer's behaviour. The NSWPF declined to investigate the complaint because the alleged conduct had happened some time ago, and the first alleged victim did not want to make a formal complaint or participate in a criminal investigation.

We disagreed with the police decision not to investigate, and asked for an evidence-based investigation with a view to addressing issues about a problematic workplace culture. We monitored the investigation, attending the interviews with the second alleged victim and with the subject officer.

We were also concerned that the inspector had not reported the initial complaint and asked that this also be investigated.

The subsequent investigation made sustained findings against the subject officer for indecent assaults on the two officers and he was transferred from the unit. The investigation also found that the inspector failed to report the misconduct and he was reminded of his responsibilities in these matters.

Case study 39: Building community relationships to better address complaints

We received four complaints in quick succession from the Aboriginal Legal Service (ALS), each alleging that police had used excessive force during separate arrests of Aboriginal young people. In relation to two of the matters, the ALS also alleged that police had questioned the young person without a support person present. The ages of the young people ranged from 13 to 15 years. The force alleged included incidents involving the inappropriate use of a taser weapon and OC spray, officers having their firearms drawn, and assault.

Because of the serious nature of the complaints, we decided to monitor all four inquiries and sent an investigator from our Aboriginal Unit to observe the police interviews of each of the four young people in relation to their complaints.

That investigator and a team leader from our police division also met with the local commander and other staff from the command to discuss the complaints and the command's work with local Aboriginal communities generally. We learned that the two Aboriginal Community Liaison Officer (ACLO) positions had been vacant for about 18 months, but that one of the positions had been recently filled. The new ACLO had been instructed to give priority to establishing a Local Area Command Aboriginal Consultative Committee (LACACC) with local Aboriginal community members.

There had also been a delay in police appointing a new Aboriginal portfolio holder to replace an officer who was awaiting a transfer. The portfolio holder is the senior officer who has responsibility for implementing the police force's Aboriginal Strategic Direction (ASD) initiatives at a local command level. An appointment is expected to be made shortly.

Following our meeting, the commander and his professional standards duty officer met with the ALS solicitor to discuss the complaints. They also agreed to meet regularly to discuss any concerns and how best to address them. The commander sent a LAC-wide memo to officers informing them that concerns had been raised about the use of excessive force during the arrests of some Aboriginal young people, and reminding officers to remain professional at all times.

We also met with staff from the ALS, the new police ACLO and the coordinators of the Circle Sentencing program, the Aboriginal Community Justice Group and an Aboriginal women's service, the Goorie Galban Aboriginal Corporation. Our staff agreed to maintain contact with these services and to provide information and training to the justice group and to Goorie Galban on the role of the Ombudsman's office.

We are currently waiting for police to finalise their complaint investigations and will continue to monitor the command's work in improving the police relationship with the local Aboriginal community.

Misuse of instant messaging

Last year we reported about the misuse of the NSWPF email system to distribute highly offensive material. Our main concern was that NSWPF systems did not ensure consistent assessment, investigation and management action for what was often identical misconduct. The NSWPF issued a practice note in January 2010 to achieve consistency in its handling of email complaints. An emerging and similar form of misconduct involves the misuse of NSWPF's instant messaging 'chat' function. These complaints raise similar issues about consistency in assessment, investigation and outcomes. See case study 40.

Case study 40: Inappropriate messages

In 2010, we received a number of complaints from police about the excessive use by other police of the instant message 'chat' system for gossiping and exchanging highly explicit messages. Users of the system appeared to be unaware that the messages were retained by the NSWPF, as evidenced by one officer who said 'I wonder if any members of the public realise we get paid $80,000 each to talk dirty on an instant chat all week? Now that's funny'.

The complaints included allegations that officers spent hundreds of hours chatting about non-work-related topics. For example:

- two sergeants exchanged over 2,000 non-work-related messages in one day
- a very senior officer engaged in explicitly sexual chat sessions with at least two junior female officers.

We asked the NSWPF for information about the rationale for introducing instant messaging and how they intended to minimise the risk of misuse. They suspended the system within five days of our letter, pending a full review. That review identified what the NSWPF considers to be a number of valid uses for the instant messaging system. They propose to develop an information and communications strategy for the proper use of instant messaging before reactivating the system. We will continue to work with the PSC to ensure appropriate measures are in place to identify and respond appropriately to any misuse of the system.

Problems with information and record-keeping

Police use a database – the Computerised Operational Policing System (COPS) – to record their activities, including information about alleged criminal incidents and other occurrences attended by and reported to police. The COPS database also includes information used in policing, such as information about the bail conditions of accused people. Problems with recording information can adversely affect police and members of the public, as shown in case study 41.

Case study 41: JusticeLink, COPS and bail checks

When a magistrate or judge makes a decision to vary or dispense with bail, this decision will be recorded on the 'JusticeLink' case management system of the Department of Attorney General and Justice (DAGJ) by a member of the court staff. Data from JusticeLink should automatically be transferred to COPS, so that police will have up-to-date information about court decisions.

Police have reported that the interface between JusticeLink and COPS is not working properly, resulting in inaccuracies in the information on COPS – such as information about bail conditions not being up-to-date. Police are therefore having to manually update court decisions about bail conditions onto COPS to ensure they have accurate and up-to-date information for bail compliance checks.

Despite the manual process, police have been unable to keep COPS up-to-date and this has resulted in police officers wrongly arresting people for breaching bail conditions. In the past year, we received 16 complaints about police arresting young people for breach of bail when the bail conditions were no longer enforceable.

NSWPF and the DAGJ have prepared business cases seeking additional resources to improve the JusticeLink/COPS interface and resolve this problem.

In the interim, the police have developed practical strategies to reduce the delays in having COPS updated with new court outcomes about bail and reduce the risk of wrongful arrests. Now, if a person says their bail

conditions are no longer enforceable, police will check with the NSWPF criminal records unit and they will check JusticeLink before any further action is taken.

A class action has been commenced against the NSWPF in relation to the alleged wrongful detention of young people for breach of bail.

The *Criminal Records Act 1991* deems certain minor convictions as being 'spent' after a crime-free period or after a finding of guilt where a court orders that no conviction be recorded. A person does not usually have to disclose spent convictions when asked questions about their criminal history.

The legislation aims to overcome any long-term prejudicial or discriminatory effects that convictions for minor offences may have on someone. It is an offence for a person with access to records of convictions to disclose information about spent convictions without lawful authority.

The Criminal Records Section of the NSWPF responds to requests for information about criminal histories and is responsible for ensuring that information is released consistent with spent conviction provisions. See case study 42.

Case study 42: Disclosing spent convictions

We received a complaint about the disclosure of a South Australian cannabis offence on a National Police Certificate issued by the NSWPF. The offence related to a 2002 charge where the magistrate found the then 19 year old complainant guilty of cultivating two cannabis plants, fined him $200, and directed that no conviction be recorded.

The complainant advised us that he had attempted without success to resolve the complaint with the NSWPF. He did not accept the NSWPF's view that the legislation only related to offences committed in NSW and therefore permitted the disclosure of the cannabis offence on the certificate. The complainant noted that the legislation states that offences committed in places other than NSW can be dealt with under the NSW legislation, and a conviction is spent immediately if a court orders that no conviction be recorded.

We wrote to the NSWPF asking for an explanation of their decision to disclose the cannabis offence. They responded by re-stating their position that the conviction was not spent under the NSW legislation. However they nevertheless issued the complainant with an amended certificate by adding the words 'without conviction' next to the cannabis offence.

We again wrote to the NSWPF suggesting that they obtain independent legal advice as our view was this was an incorrect interpretation of the law. The magistrate had directed that the cannabis offence not be recorded, but they were disclosing the offence as part of the complainant's criminal history.

As a result of legal advice provided by the Crown Solicitor, the NSWPF issued a further certificate to the complainant without the cannabis offence. They apologised to the complainant for the error and undertook to update their internal guidelines to reflect that convictions from other jurisdictions are capable of becoming 'spent' under the NSW legislation.

Although the final outcome for the complainant in this matter was positive, we have received a further two complaints involving the improper disclosure of spent convictions by the NSWPF – including one where the complainant alleges that he did not gain employment as a result. We are following up the reasons for these disclosures with the NSWPF.

See pages 78-79 in Children and young people in relation to problems associated with the creation of multiple Central Names Indexes (CNIs) for individuals on the COPS database in the context of applications for child-related employment.

Investigations by the Ombudsman

As well as overseeing the way police have investigated complaints, we can choose to directly investigate matters of significant public interest. This year we finalised five investigations of alleged police misconduct. Case studies 43 and 44 are examples of our investigative work.

Case study 43: Perverting the course of justice

We reviewed a complaint by a police officer alleging another officer had not properly investigated a motor vehicle accident. The subject officer had failed to send the driver's blood samples for testing to check if he could be charged with driving under the influence of prohibited drugs. The officer later charged the driver with negligent driving on the day before the offence was to become statute barred. The complainant felt there was insufficient evidence to support this charge and recommended the charge be withdrawn.

The NSWPF's initial investigation sustained three issues against the subject officer. They were:

- a failure to investigate
- entering false information in COPS
- failing to comply with a direction to withdraw the charge.

However, the evidence suggested that the subject officer had been untruthful about serving the Court Attendance Notice (CAN) on the driver. When filing the matter in court, the officer said the CAN was served personally on the driver at his home address, but the driver was in prison at that time.

We wrote to police about our concerns that the investigator had failed to question the subject officer about his apparent untruthfulness. We also noted that the proceedings for the charge were not commenced in accordance with legislative requirements. We asked the command to investigate further, and to consider applying for an annulment of the driver's conviction, as it appeared that the driver was convicted after an ex-parte hearing where he was not given reasonable notice of the charge against him.

The NSWPF failed to respond to our concerns for 10 months. When they did respond, they advised that additional inquiries had been unable to determine whether the officer had been untruthful, and they would further review the circumstances of the motor vehicle accident to decide whether to apply for an annulment of the driver's conviction.

Dissatisfied with this response, we started a direct investigation and concluded that the subject officer had been untruthful about serving the CAN on the driver, which we considered may have amounted to perverting the course of justice as the officer had falsely declared that he served the CAN on the driver.

Following our recommendation, the NSWPF had the driver's conviction annulled and apologised for starting proceedings against him without reasonable notice.

The conduct of the subject officer was referred to the ODPP. They determined that there was sufficient evidence to support a prosecution against him for perverting the course of justice and he has now been charged with this offence.

Case study 44: Using excessive force

We received a complaint from a police officer that a highway patrol officer had used excessive force on more than one occasion when dealing with a member of the public. The NSWPF conducted a non-criminal investigation which found the subject officer had used unreasonable force and inappropriate language on one occasion. The officer was rotated out of highway patrol for three months.

Our concerns about the handling of this investigation included the failure to:

- investigate the matter criminally
- consider the officer's use of force on another occasion
- take adequate management action.

The officer's complaint history since 2003 included four previous matters involving unreasonable force.

We began a direct investigation, uncovering allegations of two further unreasonable uses of force by the subject officer, and information that one of the involved officers may have been untruthful in response to our inquiries.

We found that the subject officer had assaulted a member of the public on two occasions. We recommended that an additional 'unreasonable use of force' finding be added to the subject officer's history, and that police:

- conduct a criminal investigation into the further allegations of assault and untruthfulness
- review the management action taken against the subject officer
- suspend his 'Leading Senior Constable' designation.

The NSWPF accepted all of our recommendations and we were satisfied with their subsequent investigation. The subject officer's Leading Senior Constable designation was removed and he was issued with a Commander's warning notice and placed on a six month conduct management plan.

Checking progress on our recommendations

After we finish an investigation or a report about the way the NSWPF have handled a complaint investigation, we check how they are implementing our recommendations. Case studies 45 and 46 are examples of our ongoing work in following up on our recommendations.

Case study 45: Delays in destroying records of fingerprints

In last year's annual report, we reported on our investigation of NSWPF practices for destroying the fingerprints of people who were found not guilty, were acquitted, or had the charges against them withdrawn or dismissed. As a result of our investigation, police agreed to re-assess the 414 applications for destruction that they had not acted on and to write to applicants advising them of the outcome of their previous applications.

This year, two applicants contacted us advising they had not heard anything from the NSWPF. When we followed this up, we discovered that police had:

- failed to destroy their fingerprint records
- decided that almost two-thirds (261 of 414) of the remaining applications did not meet the criteria for destruction.

As a result of us following up on this issue, police have now destroyed the fingerprint records of the two applicants and apologised to them for the 'regrettable administrative oversights' that led to the initial failure to destroy their records. They reviewed the remaining 261 applications and advised some applications were not actioned because the applicants had been convicted, no fingerprints had been taken, or the applications related to charge photographs or other records.

Case study 46: Using in-car video

In February 2011, we finalised our report on NSWPF compliance with legislation and police guidelines for using in-car video (ICV). ICV can provide valuable video and audio evidence of interactions between police and motorists, and police are required to use ICV for traffic policing if it is fitted to the police vehicle.

Our investigation found a number of instances of very effective use of ICV. We also found a number of unexplained failures to activate ICV, particularly ICV audio, and poor use of ICV as a source of evidence. This sometimes led to officers making important decisions based on information which, when later checked with the ICV, was clearly incorrect. We made 12 recommendations including that:

- police better enforce the requirement that officers provide an explanation if ICV policy has not been followed
- ICV audio be required to be activated during pursuits
- police review their guidelines about removing people from ICV view
- police view ICV footage before completing records of incidents – such as witness statements or criminal charge narratives
- highway patrol supervisors regularly review ICV to identify and manage risks and reinforce good practice.

When we consulted police before issuing our report, they indicated support for all our recommendations. But when our final report was issued they changed their stance on a number of recommendations. We have since met with the Commissioner and he has indicated that police will support the recommendations. Police have now also advised us that they will seek a legislative amendment to require the activation of ICV audio during pursuits.

Ongoing concerns about the use of tasers

In November 2008, we reported on our investigation into the use of tasers by specialist commands. Although we found no evidence of the misuse of tasers, we identified serious risks with the decision to provide tasers to general duties police officers and made recommendations to strengthen the standard operating procedures (SOPs), training and accountability mechanisms for using tasers.

Last year we reported that the NSWPF had not implemented our recommendation to amend the SOPs to make clear that tasers should not be used as a compliance tool against individuals offering passive resistance. Following our report, the Minister for Police announced that the SOPs would be amended in accordance with our recommendation.

During the same month, a number of incidents involving taser use by police in NSW and other states of Australia attracted media attention and public interest. One incident involved a man, armed with two knives, who died soon after being tasered by police in NSW. In Queensland, a man died shortly after he was tasered up to 28 times by police. In October 2010, the Corruption and Crime Commission in WA reported on an incident where an Aboriginal man had been tasered 13 times by police in a watch-house.

Because of the risks associated with the use of tasers and the need for the NSWPF to have appropriate policies, procedures and accountability mechanisms, we decided to start a second review of taser use by police.

We have been reviewing a large volume of information provided by the NSWPF concerning the use of tasers by general duties police. We aim to determine whether tasers are being used in accordance with the NSWPF SOPs, whether the procedures are appropriate, and whether they are being implemented in an effective manner. We are examining the reasons recorded by police for the use of tasers over a six month period, viewing the tasercam footage of each incident, and the records made by senior police officers that reviewed each incident. This includes over 2,000 records relating to over 600 incidents in which the taser was used by police. We will conduct focus groups with operational police to gain a detailed understanding of the perspectives of rank-and-file police about the use of tasers. More broadly, we are conducting a literature review of issues relating to the use of taser across the world to assess developments in other jurisdictions and seeking to evaluate the impact of tasers including the level of injuries suffered by police and members of the public.

This review will be completed in 2012.

Performance indicators

2010-2011 criteria (%)	Target	Result
Formal reports about police conduct that made recommendations relating to law, policy or procedures	70	82
Recommendations in formal reports supported or implemented by the NSW Police Force	80	90

Keeping the complaints system under scrutiny

As well as reviewing investigations of individual complaints, we proactively review general complaint-handling practices and keep the complaints system under scrutiny. Section 160 of the Police Act requires us to do this and to inspect the NSWPF's records at least once every 12 months to see if they are appropriately recording and managing complaints.

Registering complaints

Last year we reported on our investigation into the NSWPF's practices for deciding whether to register complaints on their complaints database, 'c@tsi'. Proper registration of complaints, including details of investigations conducted and management actions taken, allows us to audit and assess complaint-handling. It also allows the NSWPF to track individual officer complaint histories and complaint trends across the state, encourages consistency in decision-making, and promotes transparency and accountability. This investigation suggested a widespread failure to comply with the process for registering complaints, identifying more than 250 complaints that had not been registered.

This year we entered a memorandum of understanding (MOU) with the PIC and the NSWPF about the registration of complaints. This MOU will be reviewed in two years and provides guidance about which complaints need not be registered on c@tsi.

Every year we inspect the records of a range of local area commands (LACs) to ensure that complaints are being properly identified and complaint-handling processes are being followed. This year we inspected records across six different LACs, identifying 35 matters that should have been notified to us but had not been. Steps have been taken to have these matters notified as complaints.

We also check whether police are notifying us about complaints of serious misconduct. This year we conducted two audits, finding 65 matters that should have been notified to us. These complaints have now been properly notified so we can review how they were handled.

Auditing PoliceLink

This year we audited the PoliceLink Command – one of the main avenues for members of the public to contact the NSWPF. PoliceLink primarily manages calls by members of the public to the '000' emergency line, the Police Assistance Line and Crime Stoppers. PoliceLink also receives calls about complaints via the Customer Assistance Unit and the Corruption Hotline.

Our audit considered those areas within PoliceLink that were tasked with or likely to receive complaints about police conduct. Before the audit, PoliceLink advised that in 2010 they had received approximately 700 complaints about police and 600 other contacts that were classified as 'concerns'. We found that there were shortcomings in the way in which PoliceLink was managing and recording complaints, and that many of the matters classified as 'concerns' were actually complaints. We provided our audit report to NSWPF in June 2011 and await their response.

Bullying, harassment and discrimination within NSWPF

In 2006, following evidence of sexual misconduct at the Goulburn Police Academy, the then Commissioner of Police commissioned Ms Chris Ronalds SC to prepare a report on sexual harassment and discrimination in the NSWPF.

The Ronalds Report found that:

- inappropriate workplace conduct was occurring in pockets throughout the NSWPF
- there was an absence of coordinated, comprehensive and ongoing training programs on discrimination and harassment in the workplace
- there was a lack of experienced investigators with knowledge of discrimination and harassment issues
- NSWPF had no central point of contact for providing accurate and reliable advice and assistance on workplace equity issues
- inconsistent decision-making processes were resulting in perpetrators avoiding the consequences of their misconduct.

In response, the NSWPF created a Workplace Equity Unit (WEU) and in April 2009 produced resolution procedures for handling workplace equity complaints.

In late 2009, we began an audit to assess the implementation of these new procedures. We examined relevant complaints, reviewed the WEU's systems and records, and spoke with WEU staff and management.

Our audit found that key aspects of the procedures had not been implemented effectively. Our overall concern was that the WEU lacked sufficient input and responsibility for monitoring and improving the handling of workplace equity complaints. We found a lack of compliance with the procedures, and a lack of suitable administrative systems within the WEU – including the absence of any capability to measure complaint trends.

We also identified a number of complaints that did not appear to have been investigated in a timely and effective manner. In particular, the assessment and investigation of complaints about sexual harassment had been inconsistent and insufficiently rigorous.

We made 12 recommendations to strengthen the WEU's role in providing advice and quality assurance for key decisions made by commands – including initial assessments, investigation findings and management actions. We also recommended that NSWPF survey police officers to determine their level of awareness, satisfaction and confidence in the procedures for making and resolving workplace equity complaints.

In June 2011, the NSWPF accepted all the recommendations in our draft report. We look forward to further consultation with them about the implementation of our recommendations.

Policing domestic violence

Our 2006 investigation into the policing of domestic violence continues to generate improvements in this area. This year the NSWPF has focused particularly on enhancing the service received by victims who are required to attend court, a specific area of focus for our 2006 report. For example it has worked to identify and develop a cohort of prosecutors to become domestic violence 'specialists'. These are prosecutors who have a specific interest in this area of court work, and the capacity to 'lead' good practice.

The NSWPF also progressed the development of a specialist domestic violence training course for police prosecutors, a recommendation of our 2006 report. We provided advice to inform this process. The course will comprise both face-to-face and 'e-learning' components, and will have focus on practical court room skills. The roll-out of the course is due to begin in early 2012.

This year the NSWPF also commenced trialling two initiatives aimed at better engaging victims of domestic violence in the court process. 'Domestic violence clinics' have been introduced at Katoomba, Lithgow and Burwood courts. A partnership between police and local Women's Domestic Violence Court Assistance Schemes (WDVCAS), the clinics are aimed at preparing victims for court by educating them about the criminal justice process and what their participation in it will involve. Victims who have a court date approaching are invited to participate in a structured group discussion led by the police prosecutor and Domestic Violence Liaison Officer (DVLO), who familiarise themselves with the circumstances of each of the participating victims prior to the clinic. Where individual issues are identified during the clinic, the DVLO, prosecutor and WDVCAS are able to provide appropriate follow-up.

The second initiative is running at Campbelltown, Fairfield, Sutherland and Wollongong local courts and involves individual 'conferencing' for victims of domestic violence participating in defended hearings (both charges and Apprehended Violence Orders). The objective of the conferences is to provide a structured opportunity for police prosecutors to build rapport with the victim and to be better informed about all relevant aspects of their matter. The aim is to achieve increased prosecutions rates, particularly by decreasing the number of victims who 'withdraw' from the court process.

A hybrid model of both of the above initiatives will shortly be introduced on the North Shore. We understand that all of the initiatives will be evaluated to determine their potential state-wide application

Case study 47: Reinvestigation results in convictions

A criminal investigation conducted by the PSC recently resulted in a man being convicted in NSW District Court of 17 out of 20 charges relating to domestic violence offences over a 20 year period. This investigation stemmed from a complaint lodged by the victim that police in a number of commands had failed to act in response to her ongoing allegations of domestic violence. We monitored the handling of this complaint and referred it to the PSC for a coordinated response, as the complaint involved the actions of numerous local area commands over a number of years. PSC did a comprehensive and sensitive review of her complaint allegations and reinvestigated her allegations against the man resulting in the man's conviction of attempted manslaughter and other offences.

Police response to complaints about domestic violence

In May we tabled a special report to Parliament, *Audit of NSW Police Force handling of domestic and family violence complaints*. The report presented the findings and recommendations from our detailed audit of 289 complaints received by the NSWPF in 2008 that raised domestic violence issues. The audit was conducted as part of the requirement in our legislation that we 'keep under scrutiny' the NSWPF's systems for handling complaints. It also built on our 2006 investigation and report on the policing of domestic violence.

Complaints are an important source of information about key issues and concerns. Used properly, they can provide insights into areas that might need improvement, and evidence to test the validity of recurring criticisms of particular police practices. Responding effectively to complaints is vital to maintaining – or in some cases, restoring – the confidence of victims of domestic violence who have sought assistance from police but feel they have not received an appropriate response. It can also help police to build goodwill with community sector partners who advocate on behalf of domestic violence victims.

The audit enabled us to assess concerns and provide feedback to the NSWPF, support services in the domestic violence sector and the broader community about whether domestic violence-related complaints are being appropriately and effectively handled. Our aim was to contribute to efficient, high-quality police complaint-handling.

NSW Police recorded 25,528 domestic violence-related assault incidents in 2008. In a number of commands, responding to domestic violence incidents accounts for the majority of police officers' time. By comparison, the number of domestic violence-related complaints was low.

Our audit found that domestic violence-related complaints received in 2008 were generally well-handled by the NSWPF.

In most cases, police correctly assessed the issues raised by complaints, notified them to the Ombudsman when required and, when warranted, took appropriate action to address the issues raised. In addition, police generally initiated protective action on behalf of victims in response to complaints. Some form of management action was taken in relation to the majority of complaints referred for evidence-based investigation and we were satisfied with the nature of that action in most cases. There was a reasonable level of complainant satisfaction where our audit was able to determine this.

However, we did identify some instances where complaints were not well-handled by police. Although there were few such complaints, the audit highlighted the very serious consequences that can occur when police respond poorly to incidents of domestic violence. Although the report focused on the handling of domestic violence-related complaints, it also included some related observations about operational policing issues.

The NSWPF has responded positively and constructively to the audit results, endorsing the 19 recommendations made to improve how domestic violence complaints are handled and the way information from complaints can be used to enhance operational policing. The NSWPF commitment to implementing the recommendations and strengthening its response to domestic violence includes developing a Domestic and Family Violence Complaint Practice Note to address many of the issues raised. We have provided comments to the NSWPF on the draft of the Complaint Practice Note which will now be finalised and distributed shortly.

Overall, the positive findings of the audit should enable victims, their advocates and the wider public to be confident that, if they complain to the NSWPF about how police have responded to domestic violence, their concerns will be handled in an appropriate and responsive manner.

Reviewing the implementation of legislation

Since 1998, the NSW Parliament has required the Ombudsman to keep under scrutiny a range of additional powers conferred on police. We independently and impartially analyse the exercise of these new powers, taking into account the perspectives of police officers, agencies and the people affected by their use.

Appendix B lists our legislative review activities in 2010-2011.

Terrorism powers

In December 2010, the NSW Parliament gave us an ongoing role to review the exercise of powers conferred on police and other officers under Parts 2A and 3 of the *Terrorism (Police Powers) Act 2002*. Under Part 2A, a person can be detained by a court order for up to 14 days to prevent, or preserve evidence of, a terrorist act. Part 3 allows police and Crime Commission staff to obtain covert search warrants if this would help them respond to a suspected act of terrorism. These powers have not been used since we last reported. The preventative detention powers, which also exist in all other states and territories, have never been used in NSW or any other jurisdiction.

We are currently finalising a further report under the Act. In it, we consider the way recommendations from our previous report have been implemented, and whether there is any ongoing utility in the powers in light of their very limited use. We hope to provide our report to the Attorney General and Minister for Police early in 2011-2012.

Criminal organisations

The *Crimes (Criminal Organisations Control) Act 2009* gives police the power to apply to an eligible judge for an organisation to be declared a criminal organisation, and then to apply to the Supreme Court for control orders on members of that organisation. The Act also created a range of offences, such as association between controlled members and recruiting people to join criminal organisations.

Under the legislation, controlled members can be prevented from engaging in a range of prescribed activities – including working in the security industry, carrying on a business buying, selling or repairing motor vehicles, possessing firearms licences or licences to sell liquor, operating a casino, operating a tow truck and a range of activities in the racing industries.

In July 2010, the NSWPF lodged an application to have the Hells Angels Motorcycle Club declared a criminal organisation. However on 23 June 2011, in response to a case lodged by the Hells Angels, the High Court of Australia found the Crimes (Criminal Organisations Control) Act invalid as it was repugnant to, or incompatible with, the institutional integrity of the NSW Supreme Court. The Attorney General has announced he is reviewing the implications of the High Court's decision.

To date, our review has included observing the way police have implemented the legislation, reviewing the significant volumes of documentation lodged by the NSWPF in support of their application against the Hells Angels, and attending court proceedings.

Implementing recommendations from our reports

The response to recommendations from our review of the Terrorism (Police Powers) Act has been positive. Of the 37 recommendations in our September 2008 report, 28 have been implemented and five are supported but awaiting implementation. The four that were not implemented recommended changes to the Act which, while not made, have been addressed by police through their SOPs.

Our review of the impact of Criminal Infringement Notices (CINs) on Aboriginal and Torres Strait Islander Communities was tabled in July 2010. The Attorney General gave support in principle to 22 of our 25 recommendations, convening a working party to consider how changes to the CINs scheme could be implemented. At the time of writing, the working party has not finalised its activities.

We have still not received advice about the implementation of the 77 recommendations we made in our May 2009 report about the *Law Enforcement (Powers and Responsibilities) Act 2002*. This report looked at the exercise of powers to conduct personal searches on arrest and in custody, establish crime scenes, and require the production of documents. Police have declined to report on the implementation of our recommendations pending the finalisation of a policy review by the NSWPF and the DAGJ. That review has not yet been finalised. Many of our recommendations were about improvements to police procedures and training, and it is not clear why the policy review process should delay implementing this type of operational recommendation.

Witness protection

The witness protection program was established under the *Witness Protection Act 1995*. It is designed to protect the safety and welfare of crown witnesses and others who have given information to police about criminal activities. The Ombudsman is responsible for hearing appeals about the exercise of certain witness protection powers by police and handling complaints from people in the program.

Appeals

The NSW Commissioner of Police has the power to refuse a person entry to the witness protection program or to remove them from it. A person who is directly affected by such a decision can appeal to the Ombudsman who must make a decision within seven days. The Ombudsman's decision is final.

This year we received and determined two appeals under the Act.

Complaints

Every person taken onto the witness protection program has to sign a memorandum of understanding with the Commissioner of Police. This memorandum sets out the basic obligations of the participant and the police, and:

- prohibits the participant from engaging in certain activities
- governs arrangements for family maintenance, taxation, welfare, and other social and domestic obligations or relationships
- sets out the consequences of not complying with the provisions of the memorandum.

All witnesses have a right to complain to the Ombudsman about the conduct of police in relation to any matters covered in the memorandum.

Historically, we have received very few complaints from participants in the witness protection program, and received only two this year. When complaints have raised systemic issues, the NSWPF have generally responded positively and resolved those issues. These ongoing improvements in the management of the program have in turn lead to fewer complaints.

Covert operations

Under the *Telecommunications (Interception and Access) (New South Wales) Act 1987* and the *Surveillance Devices Act 2007,* the NSWPF, the NSW Crime Commission, the Independent Commission Against Corruption and the PIC can intercept telephone conversations and plant devices to listen to, photograph or video conversations and track the position of objects.

Controlled or 'undercover' operations can also be carried out under the *Law Enforcement (Controlled Operations) Act 1997* which allows activities that would otherwise involve breaches of the law, such as the possession of illicit drugs. The Australian Crime Commission, the Australian Federal Police and the Australian Customs and Border Protection Service are also authorised to conduct controlled operations under the NSW legislation.

Operations of these kinds involve significant intrusions into people's private lives. Agencies must therefore follow the approval procedures and accountability provisions set out in the relevant legislation. Reviewing the compliance with these requirements is an important function of the Ombudsman.

Controlled operations

Controlled operations are an important investigation tool. They allow law enforcement agencies to infiltrate criminal groups – particularly those engaged in drug trafficking and organised crime – to obtain evidence to prosecute criminal offences or expose corrupt conduct.

The head of the law enforcement agency gives approval for controlled operations without reference to any external authority. To ensure accountability for these undercover operations, we have a significant role in monitoring the approval process.

Agencies must notify us within 21 days if an authority to conduct an operation has been granted or varied, or if a report has been received by the agency's chief executive officer on the completion of the operation. Retrospective authorities for controlled operations must be notified to us within seven days of being granted.

We inspect the records of each agency at least once every 12 months to ensure they are complying with the requirements of the legislation. We also have the power to inspect agencies' records at any time and make a special report to Parliament if we have concerns that should be brought to the attention of the public.

During 2010-2011, we inspected the records of 385 controlled operations.

We report in detail on our monitoring work under the Law Enforcement (Controlled Operations) Act in a separate annual report that is available on our website. We include details about the type of criminal conduct targeted in the operations and the number of people who were authorised to undertake controlled activities, as well as information about the results of the operations.

Telecommunications interceptions

The Ombudsman has been involved in monitoring compliance by law enforcement agencies with the requirements of the telecommunications interception legislation since 1987.

Our role does not include scrutinising the approval process for telephone intercepts because a judicial officer or member of the Administrative Appeals Tribunal grants a warrant for a telephone interception.

We check whether the agency carrying out the telecommunication interception has complied with record-keeping requirements. Records must document the issue of warrants and how the information gathered was used. All telephone intercept records have to be kept under secure conditions by the agency and destroyed once specified conditions no longer apply. Some records must be provided to the Attorney General.

We are required to inspect each agency's records at least twice a year and also have the power to inspect their records for compliance at any time. We report the results of our inspections to the Attorney General. The *Telecommunications (Interception and Access) (NSW) Act 1987* prevents us from providing any further information about what we do under that Act.

Surveillance devices

The *Surveillance Devices Act 2007* (the SD Act) sets out the requirements for the installation, use and maintenance of listening, optical, tracking and data surveillance devices. It restricts the communication and publication of private conversations, surveillance activities and information obtained from using these devices. NSW law enforcement agencies are given power under the SD Act to use surveillance devices to investigate crime and corrupt conduct.

Applications are made to eligible judges for warrants to authorise the use of most surveillance devices. In the case of tracking devices – or retrieval warrants for tracking devices – applications can be made to eligible magistrates.

The Act imposes a number of record-keeping, reporting, use and security responsibilities on law enforcement officers granted a warrant. It also requires us to inspect the records of each agency from time to time to determine the extent of compliance with the Act, and to report to the Attorney General at six monthly intervals on the results of those inspections.

This year, we carried out four inspections under the SD Act. On 1 October 2010 we reported to the Attorney General on our inspections of surveillance device records up to 30 June 2010, and on 1 April 2011 we reported on our inspections up to 31 December 2010. Both reports are available on our website.

Inspecting records of search warrants

Covert search warrants

Part 19 of the *Law Enforcement (Powers and Responsibilities) Act 2002* requires the Ombudsman to inspect the records of the NSWPF, the NSW Crime Commission and the PIC every 12 months to determine whether they are complying with the requirements of the Act in relation to covert search warrants. We have to prepare a report of our work in this area for the Attorney General and Minister for Police.

This year we carried out two inspections of the records of the NSWPF – where we inspected 21 files and the NSW Crime Commission, where we inspected three files. The PIC did not apply for any covert search warrants.

Criminal organisation search warrants

On 19 May 2009, the *Criminal Organisations Legislation Amendment Act 2009* introduced a new form of search warrant – a criminal organisation search warrant – which police can seek from an eligible judge of the Supreme Court. These warrants allow police to search premises for things connected with an 'organised criminal offence'. These are serious indictable offences arising from, or occurring as a result of, organised criminal activity.

The powers conferred in these warrants are the same as for usual search warrants, except that they operate for seven days instead of 72 hours and have a lower evidentiary threshold ('reasonable suspicion') compared to ordinary search warrants ('reasonable belief'). Applications to the eligible judge must be approved by a police officer of the rank of superintendent or above.

Under the legislation, we have to inspect and report on the records of the NSWPF every two years to ensure that the requirements of the Act are being complied with.

Criminal organisation search warrants are not covert, but we inspect them as part of our general program for inspecting records of covert operations. This year we conducted one inspection of criminal organisation search warrants.

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 convenor 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

In this Section

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

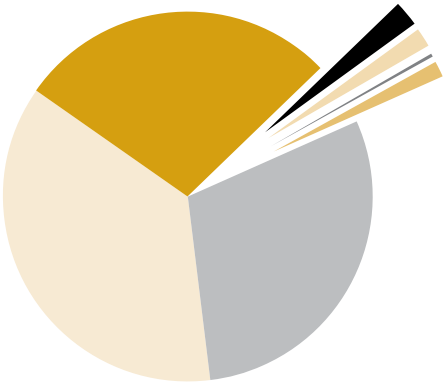
In 2010-2011, we received a similar number of complaints about child and family services (1,488) as we did in 2009-2010 (1,493). However, there was a 12% decrease in the number of formal complaints and a 6% increase in the number of informal complaints. Most complaints (1,318) were about out-of-home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



- Complaint declined at outset | 143 (28.3%)
- Service improvement comments or suggestions to agency | 10 (2.0%)
- Direct investigation | 9 (1.8%)
- Referred to agency concerned or other body for investigation | 1 (0.2%)
- Complaint outside jurisdiction | 8 (1.6%)
- Complaint resolved after inquiries, including local resolution by the agency concerned | 150 (29.7%)
- Complaint declined after inquiries | 184 (36.4%)

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.

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.

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 convenor 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 convenor 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

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, whcih 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

- Complaint declined at outset after assessment | 7 (9.1%)
- Service improvement comments or suggestions to agency | 2 (2.6%)
- Complaint outside jurisdiction | 3 (3.9%)
- Complaint resolved after inquiries, including local resolution by the agency concerned | 32 (41.6%)
- Complaint declined after inquiries with substantive advice, information provided | 33 (42.8%)

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

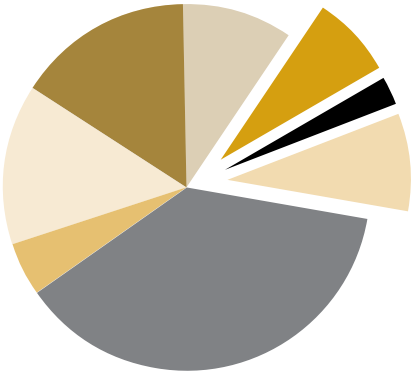
Figure 47: Formal notifications received by agency – a two year comparison

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



- Outside our jurisdiction | 60 (7.5%)
- Ill-treatment | 19 (2.4%)
- Neglect | 69 (8.6%)
- Physical assault | 301 (37.4%)
- Behaviour causing psychological harm | 40 (4.9%)
- Sexual misconduct | 113 (14.1%)
- Sexual offences | 124 (15.4%)
- Misconduct that may involve reportable conduct | 78 (9.7%)

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

- Agency's investigation monitored | 305 (37.9%)
- Outside our jurisdiction | 60 (7.5%)
- Agency's investigation oversighted | 439 (54.6%)

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

- Complaint declined at outset | 17 (10.3%)
- Service improvement comments or suggestions to agency | 9 (5.4%)
- Direct investigation | 4 (2.4%)
- Complaint outside jurisdiction | 9 (5.4%)
- Complaint resolved after inquiries, including local resolution by the agency concerned | 78 (47.0%)
- Complaint declined after inquiries | 49 (29.5%)

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.

Cross jurisdiction

An important part of our role is to help members of the public and agencies to deal with complaints and related issues. We also actively reach out to various stakeholders to increase awareness of our role, identify critical issues, bring about positive changes, and look for ways to improve our service.

This section reports mainly on the work of our inquiries and resolution team and strategic projects division. For completeness however, work of other areas of the office around stakeholder engagement, training, publications and some project and complaint work is also reported here.

The strategic projects division leads major projects and investigations that go across the Ombudsman's various operational areas, including much of our work with Aboriginal communities and young people. It is also responsible for our community education and training work.

This year we focused our resources on growing our training program for agencies and the non-government sector (see page 101). This strategy was a response to ongoing budget issues. The revenue that we have generated has been used for public interest projects and investigations.

We have continued our work on the audit of the Interagency Plan to Tackle Aboriginal Child Sexual Assault (see page 105) as well as finalising a inquiry into service provision to the Bourke and Brewarrina communities (see page 106). We brought together our work in addressing Aboriginal disadvantage in a report to Parliament in October 2011 (see page 106).

Developing our relationship with our stakeholders is important to us. We continued to participate in community events, consult widely with community members and develop resources to assist both the public and public sector agencies and organisations within our jurisdiction (see page 91).

We convened a number of forums and workshops that brought together relevant agencies and other stakeholders to discuss issues of concern and to develop action plans (see page 94). These forums are an effective way of addressing major concerns and will continued be used in the future.

Highlights

- Received more than 24,000 inquiries and responded by helping people to make a complaint,explaining the actions of agencies, providing referrals and advice. SEE PAGE 90
- Convened specialist forums with various agencies to identify strategies to improve outcomes for young offenders and victims of child sexual assault. SEE PAGE 94
- Supported new and developing Ombudsman offices and other oversight bodies in our region through our membership of APOR and the POA. SEE PAGE 99
- Gave ongoing feedback to ADHC on their Aboriginal Cultural Inclusion Framework and other strategies for supporting Aboriginal people with disabilities. SEE PAGE 109
- Provided more than 296 information, education and training activities reaching over 10,091 people, including a total of 156 training workshops delivered to 3,091 participants. SEE PAGE 101
- Held 27 focus groups across Australia as part of Stage 2 of the Managing Unreasonable Complainant Conduct Project. SEE PAGE 102
- Completed extensive consultations and research in connection with our function to audit the Interagency Plan to Tackle Aboriginal Child Sexual Assault culminating in the preparation of a major report to Parliament. SEE PAGE 105

In this Section

Inquiries

Our inquiries and resolution team handle the highest number of contacts with our office. People from across the state, the country and even internationally ask us to resolve their complaints. On one level we wish we could, it can be personally very rewarding. However, it is not practical for us to follow up on every complaint, and not every complaint warrants further action.

Assessing complaints

Everyday, the inquiries and resolution team are questioned on a broad range of technical, legal and policy-based issues relating to the work of agencies across the NSW public sector. Our staff use their extensive knowledge and resources to give advice or to take appropriate action. Some advice is procedural, some is based on our experience with a particular issue or agency, and other advice is provided after we have researched relevant legislation or policy.

Providing referrals

Often complainants and agencies can resolve the complaint directly. The agency benefits from receiving and handling complaints as it encourages openness and helps their staff recognise that complaints help the agency improve the work that they do.

About a quarter of our inquiry work involves helping complainants to understand the complaints process and giving them the confidence to work with the relevant agency to resolve their complaint. We explain how to make a complaint and discuss what reasonable expectations are – including response times and possible outcomes.

The level of awareness of our office means that people often contact us about problems we do not have the jurisdiction to handle. In about a third of contacts, even though we have no jurisdiction, we make sure complainants are aware of the relevant statutory and industry Ombudsman, government enforcement and regulatory bodies, legal advice services and relevant peak and consumer bodies.

Advising complainants

An agency doesn't always get it right and complainants contact us after trying to resolve their complaint directly with the agency. Agencies sometimes fail to reply to correspondence or communicate with the complainant within a reasonable time, leading complainants to believe that either the agency has not dealt with their complaint, or has otherwise acted inappropriately. This may or may not be the case.

In about 10% of contacts, we advise the complainant to complain to us. We discuss reasonable outcomes and timeframes (as we do when referring complainants back to agencies) and what information we need to formally assess their complaint.

Explaining the actions of agencies

People contact us about matters that on assessment we do not believe disclose wrong conduct. Sometimes they are not sure themselves, but in other cases they are convinced that what the agency has done or not done is completely wrong. Our focus is on whether the conduct was 'reasonable' – and in about one in four inquiries within our jurisdiction we spend time explaining to the complainant why we don't believe the agency is wrong.

Complaints can result from misperceptions or misunderstandings. Mere disagreement with an agency's decision does not make it wrong. If we assess an agency's decision to be legal, supported by policy, soundly reasoned and there is no other evidence to indicate it is wrong, we have no grounds to investigate the decision further.

Inquiries staff tackle this issue daily and it can cause conflict with complainants. It is therefore rewarding when complainants sometimes tell us that – although they still disagree with an agency's decision – they understand and appreciate our explanation about why it seems valid and reasonable.

Acting on urgent complaints

There are regularly complaints or complainants that need immediate action or help. We accept complaints orally if our assessment indicates a possible problem with an agency's imminent action or inaction and there are serious consequences. We also recognise certain members of the community need help to ensure their complaint is heard and appropriately addressed. In these cases, we immediately contact the agency concerned and try to resolve the complaint.

The following case studies provide some examples of the complaints we handled this year.

Case study 72: Reducing fines to cautions

Our inquiries with the State Debt Recovery Office (SDRO) led to fifteen hundred dollars of fines issued to three young people for travelling without valid concession passes and offensive behaviour reduced to cautions and put on hold respectively. The parents of the three young people asked the SDRO to review all the fines. However, their reviews were rejected – even though their school provided evidence that they had not issued the correct concession passes, and CityRail was investigating their complaints about how the young people were treated in relation to the offensive behaviour matters. CityRail will decide on any further action about the offensive behaviour fines when they have finished their investigation.

Case study 73: Budget reviewed

A woman under a financial management order called complaining that the NSW Trustee and Guardian (NSWTG) was not providing her with sufficient income to afford the wheelchair accessible taxis she uses. We found that there was no note of her disability and the NSWTG undertook to review her budget, including applying for various allowances she may be eligible for.

Case study 74: Providing clearer information

Changes to the *Fines Act 1996* early last year resulted in a number of fine recipients receiving advice from the SDRO that their court election opportunity had expired, even though they were still at the penalty reminder notice stage of the fines process. Previously, this would not generally occur until the fine was at the enforcement stage. We received a number of complaints about these changes and, as a result of our work with the SDRO, the correspondence they issue and the information on their website is now much clearer.

Case study 75: Housing problem resolved

A complainant having financial difficulties contacted us after his private landlord did not receive the Rent Start payment that Housing NSW had approved weeks before. Housing NSW told us they had already issued two cheques, but it seems they both went to the wrong address. This was because the update of their new database HOME did not automatically update the finance database. As the result of our call a third cheque was issued to the correct address, the tenant maintained his tenancy and Housing NSW addressed their database issue.

Case study 76: Immediate action on maintenance

A tenant called us in late October complaining she could not get her serious maintenance issues resolved. Her unit had water streaming down the walls causing considerable damage. Housing NSW had been aware of these maintenance issues in August and had listed them for completion by December. The tenant tried for some weeks to speak with the right housing officer, but after failing to do so she called us. Housing NSW's subsequent inspection resulted in immediate action and work started within a week.

Case study 77: Helping inmates

Many inmates complain about correctional centre life, and they can have good reason. Their limited access and ability to resolve everyday problems often means they contact us for help.

Inmates at Tamworth and Bathurst called us this year complaining that they only had one set of clothing after two weeks in the correctional centre. Another inmate at Junee complained the unit washing machine had for some weeks stunk of dead animals caught in the newly sealed base. All claimed they had tried to sort out these issues internally without success. Our calls to the centres resolved these issues very quickly.

We also receive calls about safety and welfare. A Junee inmate called distressed that a proposed internal move would put him at risk. He had spoken with correctional staff, but was not sure his concerns were being fully considered. We confirmed with centre staff that they were aware of his concerns and the need for discussion with him.

A Dillwynia inmate called on behalf of another inmate too upset to speak with us. The day before the woman had been told by the clinic at the centre that she may have miscarried her pregnancy. It was unclear what help she had asked for, or was receiving, so we contacted the clinic. They agreed to ensure the woman was given the opportunity to discuss her problems.

We also receive contact from the families of inmates. A man called complaining that he could not get a message to his brother at Junee. He needed to make sure he was sufficiently aware of the state of health of his mother after a serious operation. We contacted the centre who confirmed this should normally happen and undertook to speak with our caller to address his concern. An inmate at the Metropolitan Reception & Remand Centre complained about the limited time he was allowed out of his cell. The centre manages a wide variety of inmates and this creates a challenging environment. However, exercise and time out of cells is an important part of maintaining reasonable mental health and is covered by the correctional centre regulations. We contacted the centre who undertook to ensure staff were aware of their legal obligations.

Stakeholder engagement

Effectively engaging with key agencies, service providers and individuals on a wide range of issues is an important part of our work. Maintaining professional and cooperative relationships with a diverse group of stakeholders enables us to identify and respond to critical issues as they arise and look for ways to make further improvements.

We also need to make sure we are accessible to disadvantaged, vulnerable or hard to reach groups that might have a particular need for our services – including communities in regional and remote areas, Aboriginal people, young people, refugees and other recent migrants, and detainees in correctional and juvenile justice centres. This includes helping frontline agencies and services to address any difficulties in reaching out to these often 'high-need' communities.

Who are our stakeholders?

Our stakeholders include consumers of our services, local agency staff, community workers, peak bodies, advocacy groups, members of the public and other agencies. The consultations we do as part of our audits and investigations are important to our work and allow us to engage different groups on priority issues. We try to be proactive in seeking the views of our stakeholders and convene forums and roundtables about specific issues, as well as participating in liaison meetings and community outreach activities to help inform our work.

We maintain close relationships with other agencies within our jurisdiction and with other oversight bodies both within Australia and overseas. This year we continued to support new and developing Ombudsman offices in our region by sharing our knowledge and experience.

Improving our processes

After our organisational restructure last year, we started developing a new stakeholder engagement plan. Key priority areas have been identified and these will be built in to the business plans for each of our divisions. We aim to be more responsive when stakeholders raise issues that are in the public interest, for our work to add value, and our services are accessible.

This year we have focused on streamlining the way we capture information about our stakeholder engagement and education activities. Our new processes are designed to:

- improve information sharing across our organisation
- more readily identify opportunities for joint work with other agencies and oversight bodies
- record the feedback from our stakeholders about how our work adds value.

These processes are also important for making sure that our operational work is reflected in our various corporate plans – such as our disability and multicultural action plans – as well as allowing us to more readily identify gaps and improve how we engage with all our stakeholders.

Reaching out to a diverse community

The largest group of people we have contact with are complainants. During the year we handled more than 24,000 complaints informally and more than 8,000 formally. The informal complaints are mostly dealt with by our inquiries staff over the telephone or in person at our office.

Our website provides information about the role of our office, including how to resolve matters without our help and how to make a complaint. There are a range of publications available – such as guidelines, fact sheets and brochures in other languages. This year we have reviewed our website and will be redesigning it in 2011-2012 to make it more accessible and easier to use.

Our Aboriginal Unit, youth liaison officer, community education and training unit and other specialist staff actively reach out to stakeholders – by attending community and cultural events, delivering workshops and training sessions, and helping complainants to resolve issues.

Our senior staff also take part in these events, and the resulting discussions are critical to informing our systemic review, auditing and investigative work.

Participating in community events

We organise and participate in a range of community events, festivals and conferences. We also work with other government agencies and service providers in events that provide a one-stop shop for communities – giving people the opportunity to raise a wide range of questions and concerns about government services. This year we delivered a total of 140 presentations, forums, information sessions and other educational activities reaching over 7,000 people in 32 different locations across NSW.

One new strategy that has greatly enhanced our outreach to regional areas is our regular participation in the Aboriginal Community Information & Assistance Road Shows, organised by the Department of Premier and Cabinet. These events typically run for three or four days in different towns within the one region, bringing representatives of between 50 and 60 government and non-government agencies together to present information about their work and provide services to members of the public. These road shows are very popular, attracting hundreds of people from surrounding areas.

Travelling to regional and remote communities

This year we visited at least 59 regional and remote communities in NSW. We visited correctional and juvenile justice centres, conducted consultations for our investigations and audits of services, participated in community events and information sessions, and delivered presentations, training sessions and forums. These visits provide our staff with the opportunity to address other concerns raised with our office – including meeting with local agencies, service providers or community representatives to assist with critical issues.

We delivered over 55 training workshops, presentations and information sessions in regional NSW this year. For more details, see page 101 in Community education and training.

For more information about our work in regional and remote communities, see page 105 in Working with Aboriginal communities.

Places visited 2010-2011

Albury
Balranald
Batemans Bay
Bathurst
Bega
Bourke
Broken Hill
Canberra
Coffs Harbour
Cooma
Dubbo
Eden
Forster
Gosford
Goulburn
Grafton
Griffith
Gunnedah
Guyra
Hunter Valley
Illawarra
Junee
Kariong
Karuah
Katoomba
Kempsey
Lightning Ridge
Lismore
Lithgow
Menindee
Moree
Moruya
Mudgee
Muswellbrook
Nambucca Heads
Narooma
Narrabri
Newcastle
Nowra
Oberon
Orange
Port Macquarie
Purfleet
Quirindi
Richmond
Springwood
Tamworth
Taree
Terrigal
Toomelah-Boggabilla
Tuggerah
Tweed Heads
Wagga Wagga
Walgett
Wallaga Lake
Wellington
Wollongong
Woy Woy
Wyong

Visiting juvenile justice and correctional centres

We have systems in place to ensure that detainees have reasonable access to our services while they are in a juvenile justice or correctional centre. Our staff are available to detainees in a number of ways – primarily by phone, but also via secure post and through our visits to centres across NSW.

When we visit a centre, our role as an impartial observer enables us to ensure decisions made about detainees are fair and just. It also gives detainees the opportunity to raise issues directly with us. Where possible, staff from our Aboriginal Unit take part in these visits – ensuring that Aboriginal detainees have an opportunity to speak with another Aboriginal person about any concerns.

This year we conducted 38 correctional centre visits and 16 juvenile justice centre visits across the state. At least 15 of these visits were to regional and remote areas. For further details on our work see page 36 in Corrections and page 73 in Human Services.

Strengthening our relationships with young people

Engaging with young people, youth advocates and agencies that provide services to children and young people is a central part of our efforts to ensure that our services are accessible, relevant and effective.

In June 2010, we appointed a new youth liaison officer (YLO). The YLO plays an important role in raising awareness about problems affecting young people and focusing our complaint-handling work on systemic issues. They also work directly with young people and their advocates to increase their awareness of the work we do with agencies that provide services to young people.

A new youth issues group

Our YLO has undertaken a major internal review of how we handle youth-related enquiries and complaints to assess how we help groups with particular needs. As an outcome of this review, we are considering a number of changes – especially the need to improve how we record and report on our work in this area. The YLO has established a youth issues group made up of frontline staff and investigators from across the office. This group aims to monitor and improve our capacity to address concerns raised by young people and their advocates, especially concerns about new or emerging systemic issues. By critically reviewing our practices we are able to help agencies be more strategic about the services they provide to children and young people.

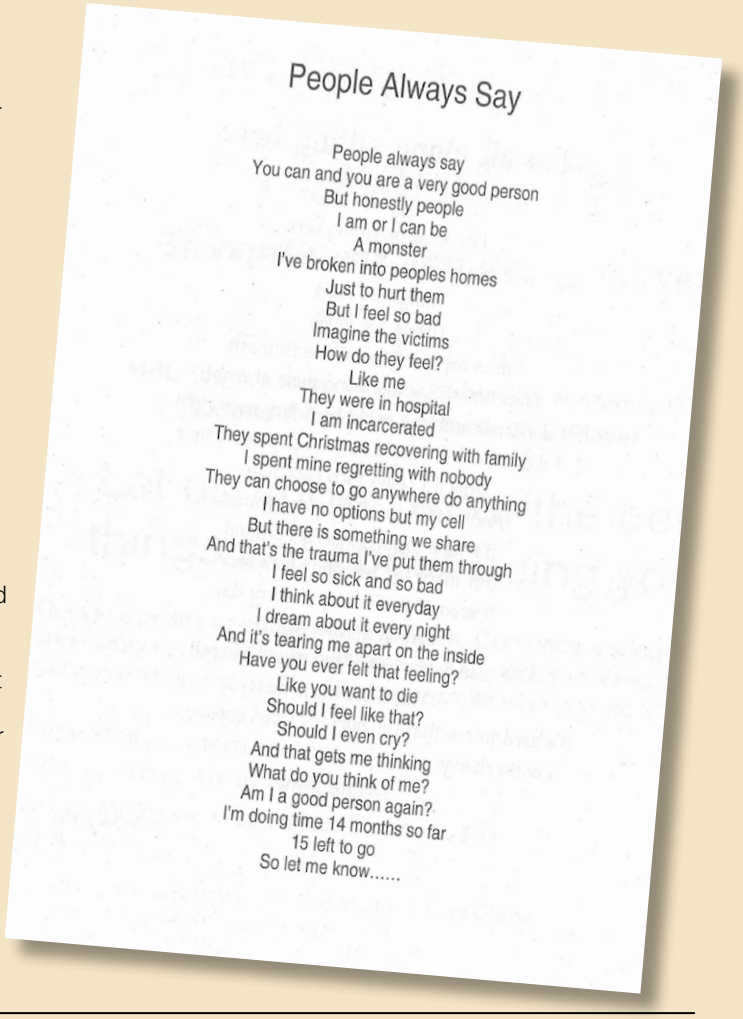
We have developed a youth web survey to distribute to services and agencies that work directly with young people.

Youth Week 2011

During Youth Week 1-10 April 2011, our YLO and other staff organised and participated in a range of activities. The week began with a staff morning tea featuring a guest speaker, an amazing young woman who shared her personal experiences about overcoming barriers in relation to being homeless. Throughout the week we sold balloons to staff in the office to raise funds for a youth-related charity nominated by our guest speaker. She requested that the money raised be donated to YPSpace, a service based in Kempsey.

Another highlight was our participation in the largest Youth Week event in NSW, the 'Bring it on Festival' at Fairfield Showground. We had an information stall and arranged for a giant jenga game as an ice-breaker to encourage young people to stop by, have some fun, and then speak with our staff. As an incentive to participate, we entered everyone who played the jenga into a draw to win an iPod nano portable music player. The winner was Natalie Zora of Fairfield.

To include young people in juvenile justice centres, we held a competition for them that used the Youth Week theme — 'Own It'. The competition invited young people to 'own it' by responding creatively to the question: What are the best things about being you? Young people were encouraged to design a poster, create some art work, or write a song or poem. We had a number of great entries. First prize went to a young man from Riverina Juvenile Justice Centre who submitted an outstanding poem called, *People Always Say*. He received a football jersey for his efforts. The runner-up prize of a portable DVD player was a joint entry from two brothers from Cobham Juvenile Justice Centre, who submitted a CD with an original song they had composed and performed.



People Always Say

People always say
You can and you are a very good person
But honestly people
I am or I can be
A monster
I've broken into peoples homes
Just to hurt them
But I feel so bad
Imagine the victims
How do they feel?
Like me
They were in hospital
I am incarcerated
They spent Christmas recovering with family
I spent mine regretting with nobody
They can choose to go anywhere do anything
I have no options but my cell
But there is something we share
And that's the trauma I've put them through
I feel so sick and so bad
I think about it everyday
I dream about it every night
And it's tearing me apart on the inside
Have you ever felt that feeling?
Like you want to die
Should I feel like that?
Should I even cry?
And that gets me thinking
What do you think of me?
Am I a good person again?
I'm doing time 14 months so far
15 left to go
So let me know.....

The survey asks about their clients' needs, what issues they raise, and how our work with young people could be improved. The survey is intended to inform our outreach work with specific groups, particularly groups or youth services in areas that have little or no contact with our office.

Focusing on systemic issues

Our focus on systemic issues has led to a number of important initiatives in the youth area this year. For example, at the request of the Police Commissioner we recently brought together senior representatives of the NSW Police Force (NSWPF), Legal Aid NSW and the Aboriginal Legal Service (NSW/ACT) to identify changes needed to broaden and improve the use of diversionary options under the Young Offenders Act. We are also working with police to address ongoing concerns about bail compliance checks with young people and police acting on bail conditions that were no longer enforceable. For further details on this issue see page 108.

At the invitation of Legal Aid, we participated in a meeting with staff from the Children's Legal Service at a community agency in Western Sydney that provides outreach services to recent migrants. A group of young people alleged that they had been subjected to police harassment and racism. We took an oral complaint from one young person in relation to the use of OC spray and intend to monitor the complaint.

Recent feedback from youth services and informal complaints from other sources have highlighted difficulties that homeless young people encounter when trying to access different forms of emergency accommodation. Our YLO and our youth issues group will look at these access issues, as well as the support and services for young people at risk of homelessness, to assess the concerns raised and what can be done to address the problems.

We are also reviewing the information we provide to students about our services and encourage young people to visit our office. This includes a recent presentation to a group of legal studies students from Kempsey, with staff from each of our divisions providing overviews of what we do. We will continue our commitment to students by providing further opportunities for young people to visit our office.

Working with other agencies and groups

Our YLO plays a pivotal role in strengthening our relationships and communication with peak representative bodies and government agencies that work with young people. Throughout the year, she regularly met with groups such as the Youth Justice Coalition, YFoundations, and with staff from key agencies including the NSWPF, Juvenile Justice and Justice Health. Her work with these organisations helps broaden our links beyond our day-to-day complaint-handling, audit and oversight work. She also regularly attends and makes presentations at conferences, open days and youth events, and attends juvenile justice centre visits with other Ombudsman staff.

See pages 66-80 for more information about our work with children and young people.

Working cooperatively with agencies and key stakeholders

Holding regular liaison meetings with agencies, convening forums on specific issues, and participating in committees and advisory groups helps to keep us informed of current issues. This is an increasingly important part of our work.

Our audit, investigation and review work also enables us to work with a large number of agencies and service providers. For example, this year we have consulted broadly with the people involved in dealing with public interest disclosures and the people who make them – including public authorities, their staff, other investigating agencies, unions, academics, journalists and commentators, and interest groups such as Whistleblowers Australia. These sessions enabled us to provide information about our new role, as well as the roles and responsibilities of agencies.

This year we also provided briefings and information sessions to a range of services and community groups including Tranby Aboriginal College, the Aboriginal Community Gathering in Wollongong, Sydney Institute of Criminology's child sexual assault seminar, Southern Sydney Koori Interagency meeting, Western Region Professional Standards Duty Officer and Executive Officer Forum, and the Aboriginal Legal Service's annual conference in Terrigal.

Convening forums and workshops to identify and address concerns

A useful strategy for identifying and responding to complex problems is to convene forums that bring specialists, frontline staff and managers together to examine the issues and identify potential solutions. We have found that this approach is an efficient and especially useful way of dealing with systemic issues that require 'operational' input from a number of services and agencies. In many cases, frontline staff might be trying their best to respond to serious concerns – but issues such as a lack of coordination between agencies can prevent them from being able to achieve positive outcomes.

This year we hosted specialist forums and roundtables to seek the input of stakeholders from various agencies and services into investigating sexual assault, improving the police use of youth diversionary options under the Young Offenders Act and addressing poor school attendance at a remote school. We also organised roundtable meetings with disability, child, youth and family peak bodies to canvass their views on current issues identified through our monitoring activities and to promote improved service delivery.

The value of this approach is demonstrated by the outcomes achieved by a roundtable forum that we convened in April 2010 to look for ways to improve probity standards in non-government organisations that are funded almost $2 billion per year to deliver a range of community-based services on behalf of the NSW Government - see page 96.

Policing sexual assault

In April 2011, we invited a number of senior police officers to attend a roundtable to discuss issues related to the policing of sexual assault. The meeting – chaired by our Deputy Ombudsman (Human Services) who is also the

Community and Disability Services Commissioner – was well attended, with twelve officers from several operational and policy areas within the NSWPF participating.

The majority of the discussion was about our audit of the implementation of the NSW interagency plan to tackle child sexual assault in Aboriginal communities. We sought the views of attendees about a range of issues associated with the overall implementation of the interagency plan and related initiatives. In particular, we canvassed the particular challenges associated with policing child abuse in rural and remote locations, the availability of forensic medical examiners for victims of child sexual assault, and the management of offenders on the Child Protection Register. For more information about our audit of the Interagency Plan, see page 105 in Working with Aboriginal communities.

We also discussed two issues concerning employment-related child protection – problems arising from the existence of multiple CNIs, and the feasibility, benefits and risks of enabling relevant police intelligence holdings to be considered when a person applies for child-related employment. For further details about these issues, see page 78 in Children and young people.

As a result of the roundtable, it was agreed that we would convene a twice-yearly forum with the NSWPF to share information and provide feedback about systemic areas of common interest.

Promoting interagency communication

Sometimes individual complaints can alert us to serious or systemic concerns that necessitate bringing agencies together to resolve issues. For example, we were alerted to a matter where the agencies involved had not communicated effectively with each other so it was not clear whether any of them had taken the action needed to address urgent concerns about a child at serious risk of harm.

In case study 49 in the Children and young people section, we reported on our investigation into a matter involving a person on the Child Protection Register (CPR). A young girl disclosed that she had been sexually abused by this person, who was her mother's partner, over a period of three years. He was subsequently charged with a number of offences and has since been convicted. We found that Community Services had failed to take appropriate protective action on behalf of the girl when they were originally advised by Corrective Services and the NSWPF that the person intended to move in with the girl and her mother.

To discuss ways of strengthening interagency cooperation for managing individuals on the CPR and the potential risk they pose to children, we convened a meeting with all three agencies. As a result of the meeting, the agencies agreed to jointly draft an interagency document clearly setting out the respective roles, responsibilities, powers and limitations of each agency for managing child sex offenders. Community Services also reported that systems are now in place to alert senior staff when a report is made that involves someone registered or suspected to be registered on the CPR. They also agreed to improve expertise within their organisation for handling matters involving CPR registrants – including the need for timely and effective communication with Corrective Services and the NSWPF.

A range of additional initiatives aimed at addressing the deficiencies identified by our investigation were also agreed to by the agencies. For example, Corrective Services are revising their policies for managing child sex offenders. We will continue to closely monitor these agencies' progress against their commitments in this area.

See page 41 in Corrections for further details on community offender services.

Helping young offenders

At the request of the Police Commissioner, we held a roundtable meeting with Legal Aid NSW (the Children's Legal Service), the Aboriginal Legal Service (NSW/ACT) and the NSWPF in April 2011 to assess the adequacy and effectiveness of the current referral protocols and share information about the operation of the *Young Offenders Act 1997*. This followed a similar review in mid-2005 that succeeded in addressing key concerns raised by each of the agencies and led to improved outcomes for young people for some time afterwards.

The forum concluded with broad agreement on several key actions to reinvigorate and improve the use of the cooling off period through the young offender legal referral scheme, and support the involvement of respected community members in the cautioning of young people under the Young Offenders Act. See page 108 in Working with Aboriginal communities for more details.

Children, young people and families

In April 2011 the Community and Disability Services Commissioner, convened a roundtable of child and family peak organisations. This forum enabled us to update the child and family sector on key areas of our current work in the child protection area. This included:

- our review of Aboriginal child sexual assault
- our work in connection with service delivery to rural and remote communities in Western NSW
- the transfer of the Child Death Review Team to our office
- our monitoring of *Keep Them Safe?*
- early intervention initiatives.

Supporting improved school attendance in Western NSW

Aboriginal students have consistently lower rates of school attendance than non-Aboriginal students, and many Aboriginal communities see improving school attendance rates as a priority.

A number of different school liaison positions are funded by the Office of Education to support school practices that promote regular attendance. However in regional and remote NSW these positions are hampered by the extensive geographical area they cover and the large numbers of schools they support.

In Wilcannia, school attendance and retention rates are a persistent concern. Disquiet among local community members about school suspension practices reached a peak in July 2010. As a result, we convened meetings with the then Director-General of the Department of Education, the CEO of Aboriginal Affairs and the NSWPF to discuss ways to address this issue. A number of principals that we have consulted over the past year have told us that a school

liaison police position can often exert greater influence over families than Education's home school liaison officers because of the authority that comes with being a police officer. For this reason, we raised the possibility of trialling a dedicated school liaison police position at Wilcannia to work with the school and parents to provide the necessary supports to get children to school each day. In March 2011, the Ombudsman and Deputy Ombudsman met with these agency heads to help consolidate their efforts towards trialling this position. We now understand that approval has been granted to establish the trial in Wilcannia. Discussions are currently taking place between the NSWPF and Aboriginal Affairs NSW about implementation details.

Disability issues

In February 2011, our Community and Disability Services Commissioner convened a roundtable of peak disability organisations. These meetings provide a useful forum for exchanging information about issues of concern affecting people with a disability, and the current work and priorities of our office and the organisations attending.

The issues we discussed included:

- the closure of large residential centres and the compliance of replacement accommodation with the Disability Services Act
- the rights of people with a disability in licensed boarding houses
- access of people with a disability to social housing
- self-directed funding and the need for planning about safeguards, probity and training
- people with mental illness and their access to appropriate accommodation and support
- current actions for early childhood intervention.

DFACS commits to strengthening probity standards – progress made

In December 2010, we tabled a special report to Parliament, Improving probity standards for funded organisations, explaining the need for government to help funded organisations improve their screening of prospective employees, board members and others involved in the planning or delivery of government-funded services to vulnerable people.

The report highlighted the growing importance of the estimated 3,000 non-government organisations (NGOs) that receive almost $2 billion in funds and subsidies annually to deliver a range of community-based services on behalf of the NSW Government. We highlighted the apparently piecemeal array of probity checks currently used by NGOs in the health and human services sectors and recommended that the (then) Department of Human Services, in consultation with the NGO sector and NSW Health, take steps to create a streamlined probity checking framework that strengthened standards, addressed inconsistencies and reduced duplication and waste.

Our report centred on concerns raised by a roundtable forum that we convened in April 2010 to bring together NSW government agencies with responsibilities for health and human services (funding agencies), peak bodies that represent many of the thousands of NGOs funded to deliver services (funded organisations) and oversight and regulatory bodies with responsibilities in this area. In summarising the concerns raised by forum participants, we argued that the system should include consistent baseline checks of all paid employees and others with key responsibilities in planning and delivering services (such as board members), take into account the vulnerability of clients who use these services, and have the flexibility to strengthen or relax checking requirements in appropriate circumstances.

We received a preliminary response to our report in June this year, when Ageing, Disability and Home Care (ADHC) asked for feedback on a chapter entitled 'Probity in Employment' and a 'policy settings matrix' that the agency had drafted for inclusion in a governance manual, It's Your Business. ADHC drafted the materials in conjunction with National Disability Services (NDS), a national industry association that represents 700 NGOs in the disability sector. The draft materials had a number of impressive elements, including sound advice on various 'best practice' strategies that NGOs could use to develop stronger, more consistent probity checking standards. In addition, ADHC and NDS were promoting the materials to funded services in the disability sector through a statewide program of training and workshops.

Although ADHC's draft guide recommended that funded organisations adopt stronger processes and standards, we were concerned that there were still no direct requirements for them to do so. Our feedback to the Department of Family and Community Services NSW (DFACS) praised the many positive elements of the draft materials. Nonetheless, we concluded that unless the guidance was also accompanied by stronger, clearly articulated minimum standards, then their contribution to the development of more consistent, efficient and rigorous probity checking across the health and human services sectors would remain limited.

In August we received a formal response from the Acting Director General of DFACS, endorsing the direction taken in our report and supporting many of our recommendations. DFACS indicated that the probity advice drafted for ADHC's It's Your Business manual would become the standard for all DFACS agencies, including ADHC, Community Services, Housing NSW and the Aboriginal Housing Office.

Significantly, DFACS noted its ability to use funding agreements to 'embed, request and monitor' adherence with probity policy. 'ADHC are planning to reflect this in funding agreements for next year, and this will be applied across the rest of the department as part of our broader work to reduce red tape'. This is a significant step forward. In addition, the inclusion of general probity requirements in funding agreements will be supplemented by 'targeted support and strengthening for some NGOs'.

As noted in our report to Parliament, a key challenge will be to streamline checking and strengthen standards, while minimising the associated costs or red-tape imposed on funded NGOs. DFACS promised to 'work closely with peaks, non-government organisations and NSW Health to address the issues outline by the report, with a focus on consistency of information, training and guidelines for funded services'.

DFACS committed to providing a progress report in December this year. By then, it expects to have a better understanding of 'the scope and possible impact of proposed National Regulator of Not-for-Profits, due to be implemented in July 2012'.

Ombudsman Outreach program

As part of our growing Ombudsman Outreach program, we visited Taree in March and Orange in May this year. These forums are aimed at community sector workers and consumers in regional and rural centres. At the forums, the Community Services and Disability Commissioner and senior staff from our community services division provide an overview of the role of our office, particularly the work we do in the community services sector. Although these events focus mainly on providing information to local services and individuals, they provide us with valuable feedback about issues and concerns affecting the regions we visit. We plan to hold four more forums in other regional centres in the second half of 2011. See page 103 in Community education and training for more details.

University complaint-handlers

In February this year we hosted our third annual forum for university complaint-handlers. These forums have been popular events for exchanging information and ideas about a range of issues concerning complaints in higher education.

In the past decade there has been a significant rise both in the number and complexity of complaints about universities. Following the release of our *Complaint-Handling at Universities: Best Practice Guidelines* in 2006, every university in NSW has introduced reforms to their complaint-handling structures. The forum in February offered an opportunity to find out how these changes have worked in practice. Guest speakers from a number of universities both in NSW and interstate also gave presentations on topics such as the implication of changes to the legislation for public interest disclosures in the university environment, procedural fairness in disciplinary decision-making and complaint-handling, the media and new social media.

Participants were keen to attend another forum next year, confirming the event remains a relevant and practical way for university complaint-handlers to share experiences and gain ideas.

Public interest disclosures consultation forums

Our newly formed Public Interest Disclosures (PID) unit hosted a consultation forum in May that was attended by a range of representatives from NSW government agencies, oversight bodies and whistleblower interest groups. It provided a useful opportunity to discuss the new *Public Interest Disclosures Act 1994* and the proposed role of the NSW Ombudsman. Participants also provided us with useful feedback on our draft model policy and guidelines.

Official community visitors

Each year we organise an annual conference for people involved in the official community visitors (OCV) scheme. 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 on current issues and initiatives affecting residents of visitable services. We also ran complaint-handling workshops and training on developing skills as a mentor. For more information about this work, see the discussion on OCVs at page 87.

Deputy Ombudsman forum

In May this year we hosted the twice yearly Deputy Ombudsman Forum, which brings together deputies from Ombudsman offices across Australia and New Zealand. The meetings enable participants to showcase the work and achievements of their respective jurisdiction. It also provides an opportunity to discuss common concerns, as well as projects such as investigation training and managing unreasonable complainant conduct.

Deputy Ombudsman's Forum

Ombudsman investigators

In November 2010, in conjunction with our biannual National Investigation Symposium, we hosted a half day forum that brought together senior investigation officers from the Victorian, Queensland and West Australian Ombudsman offices. This meeting enabled investigators to share expertise and information about current work including:

- investigative methodologies
- significant investigative work being done
- issues associated with managing complaints.

Maintaining good relationships

It is important for us to foster good working relationships with the agencies we oversee and investigate. Maintaining strong links and professional relationships with agencies helps give staff in those agencies the confidence to be more forthcoming with information and receptive to our recommendations. It also helps speed up preliminary inquiries and investigations, and enables us to reduce waste and reach better outcomes.

Holding meetings and discussions

We regularly meet with, give presentations to and convene discussions with a range of organisations that advocate on behalf of members of the public and advise government on policy issues. We also meet regularly with government agencies such as Community Services, Housing NSW, NSW Health, Juvenile Justice, Ageing, Disability and Home Care, the NSWPF, Aboriginal Affairs NSW (AANSW), and the Department of Education and Communities (DEC).

For example, this year we:

- held a number of meetings with staff from the Commission for Children and Young People to exchange information and discuss arrangements to transfer resources to our office. The Commission transferred the Child Death Register and some administrative and child death files to us in February this year
- attended quarterly meetings with the Independent Commission Against Corruption (ICAC) and the Division of Local Government to discuss local government issues and exchange information about complaints

- held quarterly meetings with senior officers from the NSWPF to discuss strategies for improving police complaint-handling systems, share information about current projects and initiatives, and resolve mutual concerns
- visited 10 NSWPF local area commands in metropolitan and regional locations to observe complaint management team meetings and to invite feedback about complaint trends and complaint issues generally
- attended the inaugural meeting of Disability Commissioners from across Australia to exchange information and identify systemic issues. These meetings also allow us to explore potential avenues for systemic work on a national level. We will be hosting the next Disability Commissioners meeting in November 2011
- attended quarterly meetings with representatives from the DEC's Employee Performance and Conduct Unit (EPAC) to discuss emerging issues and how they can be addressed
- met with representatives of agencies involved in protected disclosures and the implementation of the new Public Interest Disclosures Systems – such as the ICAC, DLG, Office of the Director of Public Prosecutions and the NSWPF – to discuss their various approaches to the new *Protected Interest Disclosures Act 1994*. These meetings will inform our work in the future, including recommendations for legislative changes
- consulted the NSWPF Sex Crimes Squad in relation to our child protection work. This has given us access to prompt information and advice and enabled us to give appropriate guidance to agencies responding to reportable allegations of a criminal nature. We also attend the quarterly Sex Crimes Squad & Joint Investigation Response Squad Advisory Council meetings which provide an opportunity for interagency liaison and case discussion about a range of child protection issues
- 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 for responding to children at risk of harm
- held three information sessions on protected disclosures for more than 65 public sector staff, briefing them on the changes to the Public Interest Disclosures Act and the changes to their agencies' responsibilities under the Act. This is the start of a much broader campaign to inform and educate agencies on their new responsibilities under the Act.

PID Forum

We gave regular presentations about our role to various stakeholders and staff from a range of agencies, peak bodies and community organisations including groups of police officers. We also provided information sessions and briefings for a range of other groups including schools, foster care support groups, area health services and a range of inter-agency groups. See page 101 in Community education and training for more details of our work in this area.

Participating in committees and advisory groups

Our staff are also members of a number of advisory groups and committees. These groups help us keep informed of current issues and give us the opportunity to update agency staff on specialist areas of our work. For example, we have an expert advisory committee to help us perform our disability death review function. The committee provides the Ombudsman with valuable advice on complex disability death matters, policy issues and health practice issues.

We have been a member of the Police Aboriginal Strategic Advisory Committee (PASAC) for several years. PASAC is chaired by the Police Commissioner and includes representatives from Aboriginal peak bodies as well as Aboriginal Affairs NSW and the Attorney-General's Aboriginal Justice Advisory Committee.

Examples of the other forums and information sessions we have participated in this year include the Child Protection and Sex Crimes Squad Steering Committee, Out-of-Home-Care Interagency Forum, Youth Homelessness Forum, Tenants Advocacy Forum, Asbestos Co-Regulators Working Group, Corruption Prevention Network, and the Complaint-Handlers' Information Sharing and Liaison Committee – this is a network of complaint-handling schemes covering a range of jurisdictions that meet to share information, resources and opportunities for joint activities. See Appendix X for more details.

Working with other oversight agencies

As well as seeking feedback from the agencies we oversee, we also liaise with other oversight bodies to share good practice and exchange information. This year we:

- assisted the Australian Crime Commission's National Indigenous Intelligence Task Force to bring together Commonwealth stakeholders – such as the Coordinator General for Remote Services Delivery and the Commonwealth Ombudsman – with state oversight bodies such as the NSW Auditor General. They examined issues that require state and federal coordination – particularly better coordination around service planning and funding and accountability mechanisms for monitoring service outcomes
- co-hosted with the ICAC and the Institute of Public Administration a two day National Investigations Symposium. This attracted delegates from more than 80 agencies across Australia, plus some from New Zealand, Papua New Guinea and other Pacific countries
- participated in discussions with the Office for Children and Portfolio Coordination, Victoria to discuss the National Bill about children's services. Victoria is the lead jurisdiction with responsibility for drafting the Education and Care Services National Law Bill
- worked with Australian Ombudsman investigation officers to coordinate responses to legislation introducing increased oversight of private colleges for overseas students. This allowed us to share information, provide an update on legislation, and agree on a coordinated response

- worked with the ICAC to deliver training on better management of protected disclosures for 91 people from a range of public agencies, including local councils. These workshops provided information about protecting whistleblowers – people who report improper, corrupt or unlawful behaviour in the public sector – and managing their disclosures
- together with the Commonwealth Ombudsman visited the Metropolitan Remand Reception Centre (MRRC) to assess the management of immigration detainees who had been moved into corrections custody as a result of an incident at the Immigration Detention Centre.

National Investigations Symposium
From left to right: Nick Kaldas Deputy Commissioner NSW Police Force; Bruce Barbour; The Hon David Ipp AO QC Commissioner, Independent Commission Against Corruption; Richard Macrory, Professor of Environmental Law, University College London

- met with OCVs and the Office of the Children's Guardian to negotiate a memorandum of understanding that sets out how we will work together to promote the best interests of children and young people in statutory/supported residential out-of-home care services
- worked with the Association of Children's Welfare Agencies, the Commission for Children and Young People and the Children's Guardian to promote awareness of child protection responsibilities in the out-of-home care sector
- met with the Queensland Commission for Children and Young People and exchanged information about child protection practices and the role of the Child Death Review Team
- suggested improvements to the model code of conduct for councils and will continue to work with DLG to improve clarity in this important area
- provided advice to Queensland's Crime and Misconduct Commission about our work in auditing police local area commands – this examined how well police implemented their NSW Police Aboriginal Strategic Direction. Our work in this area enables us to provide guidance to police about the key issues they need to address to ensure ongoing improvements in Aboriginal-police relations
- provided advice to the West Australian Ombudsman's office about our work with Aboriginal communities and information from our visit to the Kimberley region last year in relation to the outcomes of the WA Police Force's child sexual assault policing operations
- established a regular liaison meeting with the NSW Auditor General's performance auditing division to ensure that our work is complementary.

Engaging with our international partners

This year we maintained and strengthened our support for new and developing Ombudsman offices and other oversight bodies in our region by sharing our knowledge and experience on ways to promote effective and accountable public administration.

Much of our work in this area is through our membership of the International Ombudsman Institute (IOI), which includes membership of the Australasian and Pacific Ombudsman Region (APOR) chapter of the IOI, and through the Pacific Ombudsman Alliance (POA) and its member organisations.

Meeting with APOR members

On 23 March 2011 the Ombudsman attended the annual APOR members meeting at the Control Yuan in Taipei, Taiwan. At this meeting, members discussed the internal and external training modules they provided, the potential benefits of exchanging training materials, and the possibility of developing training initiatives for the Australasia and Pacific region.

All APOR members agreed to provide information about their current training so we can consolidate this information and assess the similarities and differences that exist between training programs. Our office agreed to coordinate the process and report back to the group on the information provided.

The APOR meeting was followed by a two day conference hosted by the Control Yuan, which focused on the international development of Ombudsman and human rights. At this conference, the NSW Ombudsman presented a paper on *Ombudsman and Human Rights: Working with vulnerable communities.*

Supporting the Pacific Ombudsman Alliance

The POA is made up of Ombudsman offices and allied institutions from countries that are part of the Pacific Islands Forum, and is funded by AusAID and the New Zealand Government.

We provide specialist training placements for our colleagues from overseas. This year this included providing in-house training and mentoring to Ombudsman staff from Vanuatu, Samoa, Papua New Guinea and from the newly established Ombudsman of the Republic of Indonesia.

In November 2010 we hosted a successful one day workshop for senior staff who were visiting Sydney to attend the National Investigations Symposium (NIS) in Manly. The visitors were from Papua New Guinea (Mr Daniel Taka, Mr Phillip Morris), the Solomon Islands Ombudsman (Mr James Maneforu, Mr Aaron Kodo), the Solomon Island Leadership Code Commission (Mr George Leslie Oli), the Cook Islands Ombudsman (Ms Jeannine Daniel), the Samoan Ombudsman (Mr Vaiao Eteuati, Mauala Pepe Seiuli), and the Vanuatu Ombudsman (Ms Patricia Kalpokas, Ms Charlotte Kellen).

Presentations by our Ombudsman, former Deputy Ombudsman Greg Andrews, the Commonwealth Ombudsman Allan Asher, the Commonwealth's former Deputy Ombudsman Ron Brent, and NSW Ombudsman staff focused on systemic investigation case studies and detailed the approach, analysis and outcome of each investigation. The feedback for the day was very positive as it allowed senior investigators the opportunity to learn from each other's experiences in a collegiate environment. The NIS conference that followed was also well received and provided attendees with exposure to a considerable range

of topics as well as the opportunity to meet and network with other investigators from across the region.

In December 2010 one of our senior managers, Brendan Delahunty, participated in a forum hosted by the Vanuatu Ombudsman to discuss proposed legislative reforms to the Vanuatu Leadership Code Act and the Ombudsman Act. Other specialist advice was provided by Mr Vergil Narakobi, Counsel, Ombudsman Commission of Papua New Guinea (OCPNG), and Ms Lynley Ducker, Director International, Commonwealth Ombudsman.

The Vanuatu Ombudsman convened a pre-forum workshop to discuss the matters that would be raised at the forum and to set the final agenda. Mr Narakobi gave a detailed presentation to staff of the Vanuatu Ombudsman's office on the OCPNG, its structure, operating methods, and its role under the organic law on the duties and responsibilities of leadership. Then, over the two days, representatives from relevant agencies, such as the police and the public prosecutor, discussed issues with community representatives and Ombudsman staff. Past difficulties were aired and solutions proposed. The forum provided a way for the reform to move forward, leading to a detailed set of proposed legislative amendments being put to Vanuatu's Council of Ministers.

In June we participated in the 2011 Annual Meeting of the POA in Honiara, the third annual meeting of the alliance since it was formed in October 2008. The two day meeting was held in Honiara to coincide with the Solomon Islands Ombudsman's 30 year anniversary, the opening of their new office, their restructure and other key changes.

A key outcome of the meeting was an agreement to develop five-year action plans, tailored to the needs of each member country but based upon regionally identified challenges. Members also endorsed a regional approach to dealing with common issues, and developed an action plan for legislative reform, investigation skills training and information sharing. This involves working with the Pacific Island Forum to support Pacific leaders in promoting better governance, transparency and accountability throughout the region.

The two day meeting was opened by the Prime Minister for the Solomon Islands and was chaired by the Commonwealth Ombudsman. Representatives from NSW, New Zealand, Solomon Islands, Papua New Guinea, Samoa, Vanuatu, Tonga, Niue, Nauru, Palau and Timor Leste also attended – sharing information about the challenges facing new and emerging member organisations and discussing strategies to address those challenges. They also thanked our Deputy Ombudsman Greg Andrews, who retired this year. Greg was a part-time member of the Secretariat that supports the POA's work and also assisted in providing a range of expert advice on POA projects and training placements.

All of the delegates stayed on for a day long public event to celebrate the Solomon Islands Ombudsman's 30 year anniversary.

From left to right: Maiava Toma, Ombudsman, Samoa; Sprent Dabwido MP, Nauru; Lucio Ngirawet, Ombudsman, Palau; Justin Kamupala, Head of the Department of Justice, Lands and Survey, Niue; and NSW Ombudsman Bruce Barbour following the Pacific Ombudsman Alliance's third annual meeting in Honiara, Solomon Islands. The meeting coincided with an event to celebrate the 30th anniversary of the Solomon Islands Ombudsman's Office.